The Pennsylvania Psychologist

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JANUARY 2015 • UPDATE

REMINDER

New Child Abuse Reporting Laws

In 2013 and 2014, the Pennsylvania General Assembly passed numerous laws that substantially changed the standards and procedures for reporting suspected child abuse. One of those laws, Act 31 of 2014, requires that – starting in 2015 – all licensed health care professionals and funeral directors are required to receive a minimum of two (2) hours of continuing education in child abuse recognition and reporting to renew their licenses. Only programs approved by the Department of Human Services and the Department of State can be used to meet this requirement. Programs that meet the Act 31 requirement can count toward the 30 hours that psychologists must have in order to renew their licenses. Programs that meet Act 31 requirements may not count toward the ethics requirement. A list of approved courses can be found at http://www.portal.state.pa.us/portal/server.pt/community/con_ed_providers/21920.

To help psychology licensees meet this requirement, PPA has developed a home study, written by Samuel Knapp and Rachael Baturin, which was mailed to all licensed psychologists in late November.

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June 17–20

PPA2015

Innovative Models for the Future

The president's theme: **Innovative Models for the Future** is not only an interesting theme for the PPA Annual Convention, but also an intriguing concept for all PPA members.

The ongoing evolution of health-care reform has presented psychologists with many challenges which have stimulated numerous innovative programs in Pennsylvania. This year's convention will celebrate Pennsylvania's psychologists' innovations in such areas as integrative care, evidence-based treatments, the use of technology, models of medical homes, and emerging strategies to expand internship/training opportunities for pre- and post-doctoral students.

With the Affordable Care Act in full swing, how has your practice changed? Has it changed? Has it only survived this year, or have you thrived? What have you implemented that has made 2014 a successful year? These are all questions that will be discussed and examined at PPA2015 in June. Best-practices; practices that maybe weren't the best, but have been improved upon; questions answered and new questions that arose based on those answers. You don't want to miss this convention!

The deadline for workshop proposals was December 19, and the dedicated volunteers of the Convention Committee will be meeting in mid-January. If you have a topic that you were considering submitting and you think it would fit well with the theme, contact Judy Smith (judy@papsy.org) to see if it can still be considered for presentation.

Tell us what you want to see at the 2015 convention! **#PPA2015** on Twitter and Facebook.

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NEW CHILD ABUSE REPORTING LAWS

Continued from page 1

Psychologists can simply read through the materials, complete the answer sheet and evaluations, and mail them along with the registration fee to the PPA office. Licensees can also take this home study online by going to www.papsy.org. This CE program can be used to fulfill licensing renewal requirements for psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, nurses, and physicians.

Reporting for Act 31 differs from reporting for ordinary continuing education. All licensees must prove that they have fulfilled their Act 31 requirements before they can have their licenses renewed. Every continuing education provider who is authorized to fulfill the Act 31 requirements must transmit certain information about the licensee to the Pennsylvania Department of State. Licensees who fail to provide this information will not have their licenses renewed. This requirement also applies to newly licensed psychologists.

Psychologists who took a course in child abuse recognition and reporting as part of Act 126 requirements (pertaining to school employees) may complete a form and be exempted from Act 31 requirements. The form is on the State Board of Psychology website: (http://www.dos.state.pa.us/portal/server.pt/community/state_board_of_psychology/12521).

Also, psychologists will need to change their informed consent documents to reflect the changes in the child abuse reporting law. These changes should be made to all informed consent forms, even those dealing with adults, because psychologists are now required to report suspected child abuse any time any individual, even an adult, provides information that would lead a psychologist to have a reasonable suspicion that a child is being abused. The recommended changes in the informed consent procedures can be found on the members-only section of the PPA website. Members can click on CE/Events (at the top of the page), then click on Act 31, then click on Informed Consent changes.

Awards

Deadlines Approaching

This is your chance to nominate a deserving colleague, co-worker, or business for the recognition that they deserve. Let PPA share in your appreciation for those who have positively impacted your career or the profession of psychology in Pennsylvania.

All nominations should include a one-page narrative describing the person's contributions and his/her CV with contact information.

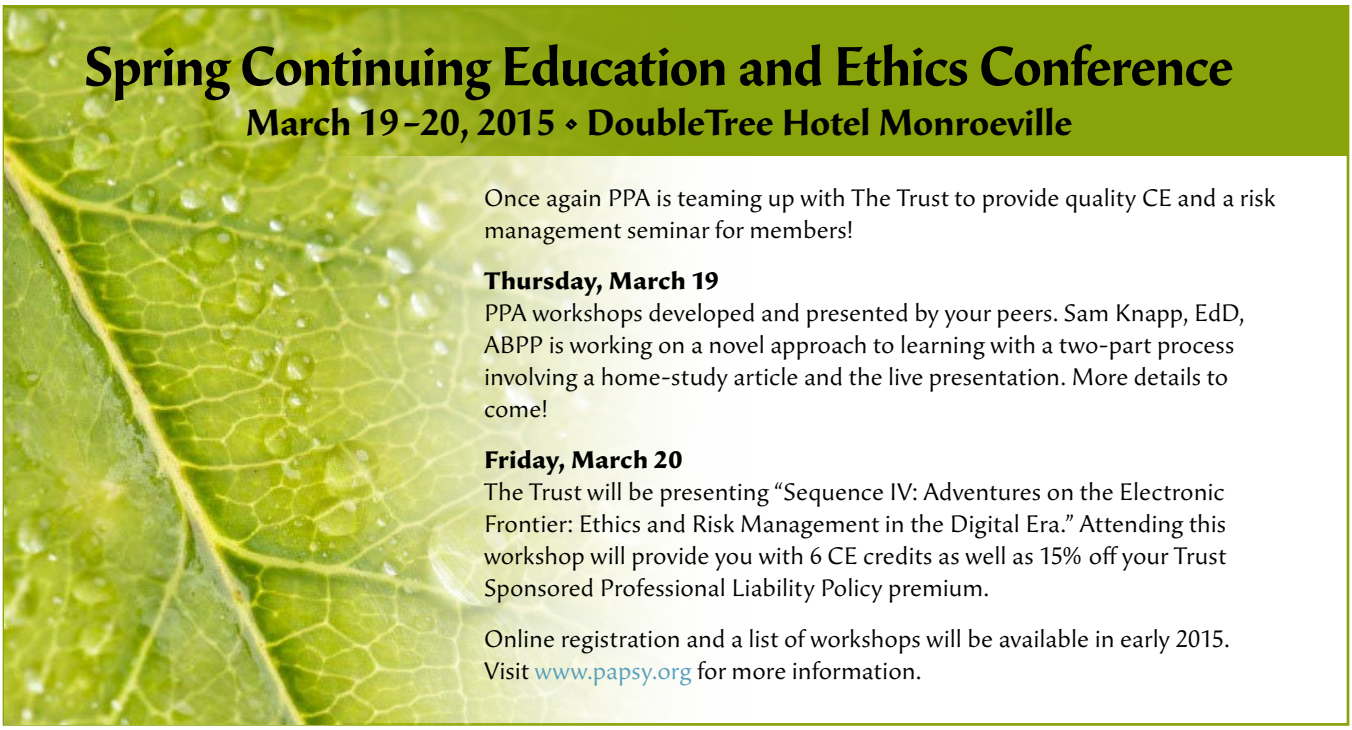
DEADLINES

January 31, 2015
Award for Distinguished Contributions to School Psychology

January 31, 2015
Psychology in the Media Award

January 31, 2015
Early Career Psychologist of the Year Award

January 31, 2015
Student Multiculturalism Award



Spring Continuing Education and Ethics Conference

March 19–20, 2015 • DoubleTree Hotel Monroeville

Once again PPA is teaming up with The Trust to provide quality CE and a risk management seminar for members!

Thursday, March 19
PPA workshops developed and presented by your peers. Sam Knapp, EdD, ABPP is working on a novel approach to learning with a two-part process involving a home-study article and the live presentation. More details to come!

Friday, March 20
The Trust will be presenting "Sequence IV: Adventures on the Electronic Frontier: Ethics and Risk Management in the Digital Era." Attending this workshop will provide you with 6 CE credits as well as 15% off your Trust Sponsored Professional Liability Policy premium.

Online registration and a list of workshops will be available in early 2015. Visit www.papsy.org for more information.

Bridges to Health: The Case of Sally

Ben Daniels, PsyD

Dr. Ben Daniels

Although the United States spends trillions of dollars annually on health care, the distribution of this spending does not occur equally across the population. About 10% of the population accounts for 64% of all health-care costs. As a pre-doctoral clinical psychology intern at WellSpan Health's Bridges to Health (BtH) program, I got to see this phenomenon first-hand. BtH is a small intensive primary care practice where a multidisciplinary team works collaboratively to provide comprehensive care for super-utilizers of the health-care system.

Working with one of the super-utilizers in the BtH program illustrates how difficult this work can be. Sally is a 29-year-old female patient with type 1 diabetes, gastroparesis (failure of the stomach to empty), factitious disorder, an unspecified eating disorder, and chronic abdominal pain. When she was referred to me, she was essentially living in the hospital. In the 12 months preceding her enrollment in the program, Sally had 11 hospital admissions and spent a total of 211 days as an inpatient, for reasons such as nausea and vomiting, consequent dehydration, and frequent episodes of diabetic ketoacidosis, a potentially life-threatening complication of her diabetes often caused by poor treatment compliance. Her health-care team believed that she was self-sabotaging her treatment and potential discharge from the hospital by misusing her medications, tampering with healing wounds, and inserting feces into her wounds.

The limited time Sally spent outside the hospital made it difficult for the BtH team to get to know her and establish a rapport. The nurse and social worker started visiting Sally in the hospital and the BtH physician started weekly consultations with her inpatient provider.

Whenever team members would talk about Sally, they would always tell me "We need you to fix her." They had tried everything they knew, and had no luck – they hoped I would have a magical solution.

The inpatient team felt that, despite their best intentions, they may have contributed to the problem – their compassion and trying to befriend Sally to gain her trust and confidence had resulted in her having more friends in the hospital than out; she had even friended several nurses on Facebook. Despite the complex medical diagnoses, the consensus was that the overarching issue was Sally's factitious disorder.

Building a rapport with this client was especially important. Previous attempts to address the factitious disorder head-on were met with the perception that health-care providers had been "accusing" her of self-harm behavior. This led Sally to become defensive and to withhold information. To avoid precipitating the same reaction, I had to come to her with a naïve curiosity – "tell me what's going on, I'm not sure I understand. The nurse said she found syringes in your room; what happened with that?" I very much had to avoid anything confrontational – even the perception that something could be an accusation.

An important aspect in working with Sally was to look at what is reinforcing. Whenever she would come to the hospital, she would get lots of attention and care, escape from the stress at home, get opioid pain killers for her reported constant pain, and privacy she never has otherwise. To change the operant consequences, nurses were instructed to keep interactions professional and minimal and to facilitate discharge as quickly as medically feasible. The use of painkillers was reduced and then eliminated. There was tension between Sally and her health-care providers as they tried to change the calculus behind her decisions to harm herself to stay in the hospital, so my rapport with her became even more important. Part of this change occurred by helping Sally to identify and address her harmful and unproductive thoughts, especially regarding her hopelessness and beliefs about her family's behavior.

Building a rapport with this client was especially important.

Sally and I often focused on how her health issues negatively impacted her ability to live her life. She didn't have friends outside the hospital and couldn't do the things she wanted to do. She was depressed. I framed everything we did on how we can get her to where she wants to be. Her goals were to help her find a way to get back to living the life she wanted to live. This included:

- Managing her diabetes and gastroparesis
- Improving mood and reducing depression
- Building coping skills for managing emotions (especially anger and frustration)
- Eliminating/reducing barriers to engaging in enjoyable activities
- Improving her relationship with her mother

The work on this last goal, with her mother, was instrumental. BtH involved Sally's mother in monitoring Sally's eating habits and medications. First, having the mother there was crucial to provide information that Sally was not

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BRIDGES TO HEALTH

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sharing, such as harmful behaviors or more accurate reporting of her eating and medication adherence. Second, the conflict with her mother was a major stressor for Sally and likely was a motivation for avoiding home. In fact, the chaos at home and the lack of any support or privacy makes the hospital seem like a dream vacation. Visiting her at home and seeing this first hand allowed me to connect better with her experiences (she was living on a couch and shared one bathroom with six people). I felt overwhelmed the moment I walked in and I could not imagine living there.

Some of the most important work we did with mom was directly addressing the conflict when mom would not follow through on her promises to visit. Helping mom to be clearer with Sally about obstacles, such as weather or transportation problems, helped reduce conflict and improve their supportive relationship.

Subjectively, Sally believes she is improving. She is actively working to achieve her life goals that match her values, including planting a garden. Her satisfaction with her relationship with her mother and her support at home has increased. She now can reflect on and identify those behaviors that she did previously that harmed her care and she talks more about her desire to stay at home.

As the health-care landscape changes around us, psychologists need to be flexible in working with other health-care professionals and complex patient presentations.

Objective outcome measures include health-care utilization (cost to the system), inpatient days, and emergency department (ED) visits. Using December 2013 (month 15, when a new care plan was implemented) as a breakpoint, her utilization before that date was $1,910,216 (average of $61,620/month), and after that date has been $27,600 (average of $9,200/month). As mentioned previously, in the 12 months preceding her enrollment in BtH, Sally had 11 hospital admissions and spent a total of 211 days as an inpatient. In the last 3 months, she had only one brief admission. However, her emergency room visits did increase.

I derived a few conclusions from my work with Sally and BtH as a whole. As the health-care landscape changes around us, psychologists need to be flexible in working with other health-care professionals and complex patient presentations. We will be asked to meet new needs and fulfill new roles. As psychologists, we get to prove our worth to the entire health-care system. Finally, I learned that factitious disorder is very, very difficult to treat. Be patient.

Ethical Issues Involved With Countertransference With Difficult Patients

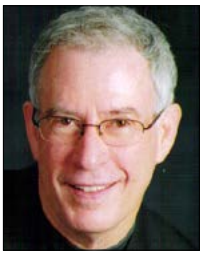
Devin Hussong, Qianna Snooks, and Robert M. Gordon, PhD, ABPP

May 16 was the occasion of the 16th annual Ethics Workshop PPF Fundraiser. Over 59 practitioners heard Robert M. Gordon and two of his assessment practicum doctoral students, Devin Hussong and Qianna Snooks from Chestnut Hill College, present a review of countertransference and its implications for ethical dilemmas and risk management. They also presented a video of a difficult patient and how to best intervene. Dr. Gordon presented his original research on countertransference to various levels of personality severity and personality disorders.

Since Sigmund Freud coined the term in 1910, there has existed controversy surrounding countertransference (CT), pertaining to both its definition and its usefulness within the therapeutic session. Some have posited that the CT consists of those thoughts and feelings provoked by the client, viewing these thoughts and feelings as obstacles to be overcome. Totalists took the broader view that all of the therapist's attitudes and feelings should be considered as CT, and that it could help therapists improve their understanding of their clients. And later, theorists argued for a relational quality of CT, in which it is mutually constructed by the client and the therapist (Hayes, Gelso, & Hummel, 2011). Ultimately, we find that CT is a normal and essential aspect of any therapeutic relationship. In fact, therapists who consider its implications do more than avoid ethical dilemmas; they enhance their capacity for accurate and effective personality conceptualization.

Devin Hussong

Qianna Snooks



Dr. Robert M. Gordon

The emotions clients elicit in their therapists during the course of treatment likely suggest a great deal about the kinds of feelings that they invoke in others with whom they interact. Attending to this information can enhance a clinician's understanding of the internal experiences of their clients and the relational patterns that may play out in their interactions outside of sessions.

Clinicians can also utilize their CT experiences as a barometer of client functioning, which can inform the type of intervention. A client may engage in splitting, projective identification and acting out, indicating that he or she is functioning at a borderline level. A therapist can then choose to utilize more supportive techniques.

CT is inevitable. Many animals (including human beings) have evolved a highly-tuned sensitivity to the negative mood states of others with whom they interact. This function may have evolved to help protect us from danger by allowing us to tacitly signal alarm to others. Our tendency to get caught up in the negativity of others around us is an unconscious and powerful phenomenon. Unfortunately, many of us have been trained, or at least warned, to ignore or mistrust those reactions when they arise. Ignoring these reactions means ignoring vital information about a client.

Try to understand the client beyond just the symptoms; personal emotional awareness can act as a bridge

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ETHICAL ISSUES . . . COUNTERTRANSFERENCE

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to empathic understanding of the client's process for coping with reality, especially daily interactions with others. Therapists should maintain appropriate boundaries, while keeping an appropriate quality of relationship. Have a defined session structure (i.e., how payments are handled; cancellation policy; session duration); and make certain to discuss this structure, as well as the roles and responsibilities at the start of therapy and at necessary times throughout the treatment. One sign that countertransference is occurring is when therapists change their rules or how they structure their sessions for clients. Finally, never underestimate the benefits of consultation, therapy for the therapist, and ongoing self-care.

Dr. Gordon presented his research (Gordon, et al., 2014) about how practitioners anticipate the countertransference (CT) to various levels of personality organization (neurotic, borderline, psychotic) and personality disorders (narcissistic, hysterical, dependent, etc.).

Finally, never underestimate the benefits of consultation, therapy for the therapist, and ongoing self-care.

They asked practitioners about their primary theoretical orientation, about risk management, and about CT to their patient and patients in general. Results indicated psychodynamic therapy (PDT) practitioners had significantly greater CT expectations in the differential diagnoses between neurotic and borderline-level pathologies than both cognitive behavioral therapy (CBT) and other practitioners (humanistic/existential, systems, eclectic). PDT practitioners were also significantly more sensitive to CT issues than CBT practitioners with respect to the range of personality disorders most associated with acting out and risk-management problems. CBT practitioners had the greatest difficulty understanding the differences between many of the personality disorders when it came to CT expectations. Dr. Gordon stated that the addition of CT insight as a diagnostic tool can alert the practitioner to difficult patients before many objective symptoms are known. These findings suggest that clinical training in insight to practitioners' subjective states such as CT, may be useful in helping to avoid ethical dilemmas, regardless of one's level of training or theoretical preference.

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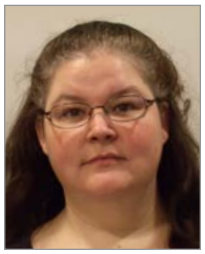
Hayes, J. A., Gelso, C. J., & Hummel, A. M., (2011). Managing countertransference. ***Psychotherapy, 48*****(1), 88–97. doi: 10.1037/a0022182**

ECP – Fostering Extraordinary Career Potential

Kimberly Richards, PsyD



Dr. Kimberly Richards

When you think of early career psychologists do you think of the "youngsters" of the psychology world? Maybe you think of inexperienced, "green" clinicians who are just entering the field. While many of us are younger, we are a group of professionals who are in the earlier stages of career development. We are a group of psychologists who are forging ahead in professional development, discovering new talents and interests, and unearthing our unique, extraordinary career potential.

Recently the definition of early career psychologist (ECP) has been modified. PPA previously considered ECPs as anyone within seven years of graduation. However, to share consistency with national organizations, specifically the American Psychological Association (APA), the time frame has changed to within ten years from graduation.

ECPs are psychologists who have varied experience within the psychology profession. Some ECPs are discovering new niches and developing the path of their career trajectories. Other ECPs are fully invested in their career paths and know exactly what their trajectory is. Some are in the middle – continuing to explore but more aware of their ideal career path. No matter where you may find yourself, if you're within ten years from graduation, you may call yourself an ECP.

For many early career psychologists, 10 years may not be long enough to consider themselves to be mid-career or seasoned psychologists. For some, it may take longer than 10 years to hit that mid-career stride. Many of the psychologists I have spoken with have shared that after 15 or even 20 years, they still have moments where they don't feel "seasoned."

Because of this, the ECP Committee supports career development through many facets. Education is a key component of career development and it doesn't stop at graduation. Licensed psychologists are required to obtain 30 continuing education (CE) hours every two years. The ECP Committee has determined that one of the initiatives moving forward is to provide educational opportunities that address the unique concerns of individuals in the beginning stages of career development. Some of these areas include: starting a practice; developing a professional identity; identifying career opportunities; balancing work and other aspects of life; self-care; emerging and non-traditional careers; as well as the use of technology in practice.

In addition to assisting ECPs in meeting their continuing education requirements, the ECP committee members are also invested in providing support and mentorship. A current initiative is to create social get-togethers in different regions in the state to encourage ECPs to meet, network, and find additional supports in their area. Mentorship includes welcoming students into the ECP status upon graduation, encouraging individuals to remain involved in PPA, and engaging with students and ECPs during the convention.

For example, the 2014 Convention included the addition of the Learning Lounge, which was developed by Ms. Marti Evans (retired) in collaboration with the Convention and ECP Committees. The Learning Lounge was developed to meet the needs of individuals who were attending the convention but who may not need CE workshops, and to offer an opportunity to meet informally with various identified speakers to engage in small group discussions. Topics from this year's convention included: predoctoral internship concerns, the postdoctoral year, opening a private practice, neuropsychology, business psychology, sports psychology, divorce mediation, and working as a psychologist within the Pennsylvania Department of Corrections.

ECPs are psychologists who have varied experience within the psychology profession.

Another initiative of the ECP Committee is the creation of an ECP handbook that can be used as a reference source. This compilation will be a go-to reference for information to assist in starting one's own practice, as well as areas like financial planning and loan repayment.

With all the forward momentum being fueled by today's early career psychologists there is no doubt that this is a group of individuals with extraordinary career potential. ECPs may be, on average, younger than their more seasoned colleagues, but they are the future of psychology and are forging many different paths leading to success in the field. If you have graduated in the last 10 years and are striving to develop your own extraordinary career potential, we invite you to proudly call yourself an ECP!

When Should Cruelty to Animals Be Raised as a Clinical Issue?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

Mental health workers who deliver services at the homes of their patients (such as through Behavioral Health Rehabilitation Services - BHRS) sometimes encounter difficult, upsetting, or unusual circumstances while in the homes of their patients. They may, for example, see a parent who is a compulsive hoarder, or a grandparent living in the home who is frequently intoxicated. Sometimes in-home workers have worked in homes where the parents were growing marijuana (I know of at least two situations where the in-home workers were present when the police raided these houses).

However, in-home workers report being most upset after observing cruelty to or substandard care given to animal companions (pets), usually dogs or cats. These workers have seen animals who were malnourished, sick (and not getting medical attention), or suffering from matted hair and skin infections, and other maladies. Sometimes the animals were physically abused. One in-home worker saw a heavy patient sit on top of a cat and giggle as the cat squealed in pain and squirmed to avoid being crushed.

In addition, Schaefer et al. (2007) reported that 28% of professional psychologists (most of whom delivered outpatient services) reported that at least one patient had mentioned the abuse of animals in therapy in the last five years. Sometimes patients admitted to abusing animals. At other times, patients were traumatized by witnessing the abuse of animals.

The confidentiality laws governing mental health professionals are clear in that psychologists and in-home workers and their supervisors must respect the privacy of their patients. There is no legal exception for breaking confidentiality because an animal is being abused. However, can the mental health professional even raise the abuse of animals in treatment? At first glance it may appear that this is a situation where the values of the mental health professionals and the values of the patients or parents of the child/patients differ. The mental health professional may view animals as having some rights, such as the right to food, shelter, health care, and emotional bonding with their companions. However, the patients or the parents of the child/patients may view animals as objects or commodities that have no rights at all.

However, the issues can get more complicated. Cruelty toward animals often predicts a generalized cruelty, insensitivity, or violence toward humans (see for example, Overton et al., 2012; Randour, n.d.). The correlation between animal and human cruelty is sufficiently strong so that cruelty to animals has implications for the mental health needs of the child and should be open for discussion by the mental health professional. Professional psychologists who learned of animal abuse from their patients reported that 87% of the time they believed that the abuse was linked to an important mental health issue (Schaefer et al., 2007).

Any parental behavior that harms a child needs to be addressed in therapy. For example, a psychologist would appropriately raise an issue if the compulsive hoarding of a parent was harming the child, just as the psychologist would address the behaviors of an alcoholic grandparent if that were also harming the child. Abuse or neglect of animals is no exception. In the case noted above where the mother purposefully sat on the cat, the child was being treated for defiance toward the parents and other authority figures. The mother often complained that the child acted as if her feelings did not matter to him. Here the in-home worker appropriately told the mother that she needs to model better behavior toward the cat because those who observe the abuse of animals often become insensitive to the sufferings of others and more defiant toward their parents.

Cruelty toward animals often predicts a generalized cruelty, insensitivity, or violence toward humans.

Of course, the patient or the parents of a patient may reject cruelty or neglect of animals as a clinical concern and ultimately, the mental health professionals need to respect that decision. Nonetheless, cruelty to animals is almost always linked to clinical concerns and needs to be addressed when the psychologist learns about it. Mental health professionals have clinical and ethical reasons to address the neglect or the abuse of animals as an issue for treatment.

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Change Your Informed Consent Forms or Privacy Notices

As readers know from previous articles in the *Pennsylvania Psychologist*, changes to the Child Protective Services Law will go into effect on December 31, 2014. One of the important changes in the law is that mandated reporters do not have to see the child in their professional capacity in order for a report to be made. As a result of these changes, a psychologist may be a mandated reporter if anyone who is 14 years old or older discloses that he or she engaged in child abuse, even if the abuse occurred many years ago and no child is currently in danger. In addition, psychologists will have a duty to report suspected child abuse if any patient or collateral contact discloses that they know of a child who is currently being abused.

Psychologists will need to modify their HIPAA Privacy Notice or informed consent agreements with patients to reflect these changes.

Here is suggested language that will accurately reflect the changes in the child abuse reporting requirement.

> If I have reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the Pennsylvania Department of Human Services. I am required to make such reports even if I do not see the child in my professional capacity.
>
> I am mandated to report suspected child abuse if anyone who is 14 years old or older tells me that they committed child abuse, even if the child is no longer in danger.
>
> I am also mandated to report suspected child abuse if anyone tells me that they know of any child who is currently being abused.

We recommend that psychologist also review this information verbally with their patients at the start of treatment or as soon as feasible, as well as including it in the Privacy Notice or the informed consent agreement. In addition, it may be necessary to remind patients of the reporting requirements periodically during the course of therapy.

Classifieds

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2015 CE Calendar

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

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

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

Contact: judy@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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