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INTRODUCTION TO

Boundary and Multiple Relationship Issues

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Dr. Samuel Knapp

This issue of the *Pennsylvania Psychologist Update* includes several articles dealing with boundary and multiple relationship issues. Some boundary questions are easy to resolve: do not have sex with patients, do not go into business with patients, etc. We all learned those early in our graduate careers and there is no point repeating them.

The boundary issues discussed in these articles are subtle and often defy quick and easy responses.[2] Often conscientious psychologists will disagree on how to respond to them because they require balancing competing values and interests each of which, if looked at in isolation, has merit.

Consider this situation:

> A patient with a terminal illness asked his psychologist to attend his funeral. The patient appeared to appreciate the services that the psychologist had provided. Agreeing to attend would appear to make the patient feel better and respect his wishes.

But are there other factors to consider? Would the family want the psychologist there? Would it embarrass some family members if it became known that their loved one received mental health treatment? Furthermore, did the request really represent a decision on the part of the patient that was thought through, or was it a spontaneous reaction that needs to be explored further?

Methodology for Considering Dilemmas

When dealing with these and similar boundary questions I try to implement the APA Ethics Code while maximizing adherence to the overarching ethical principles underlying the Ethics Code (such as beneficence, respect for patient autonomy, nonmaleficence, fidelity and justice; these are defined in Table 1). Sometimes the application of the Ethics

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Table 1. Overarching Ethical Principles

Principle	Brief Definition
Beneficence	Promoting the well-being of patients
Nonmaleficence	Avoiding harm to patients
Respect for Patient Autonomy	Deferring to the informed choices of patients
Fidelity (or Veracity)	Following through on commitments to patients
Justice	Treating patients fairly
Public Beneficence	Protecting the well-being of the public in general

[1] I thank Drs. Donald McAleer and Jeanne Slattery who made constructive comments on earlier versions of these articles.

[2] All of the cases presented in this and other articles are based on real situations, although details have been changed.

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The Conundrum

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

How would you respond to this situation?

> A psychologist saw a man in therapy and suddenly realized that he was also seeing this man's neighbor. There was great animosity between them which had resulted in a lawsuit concerning the deeds to their properties. The two patients lived on different streets The psychologist was not familiar with that area of town and did not realize that their residences were adjacent until recently. The psychologist was well into therapy with both patients. Both felt attached to him and both needed more therapy, perhaps months more.

This is a variation on a theme that occurs often. In college counseling centers, sometimes psychologists will end up treating patients who are dating each other (or used to date each other) or who were (or are) roommates. Sometimes psychologists will be treating a marital couple, only to later realize that they are also treating "the other woman" or "the other man" (the party who was or is having an affair with one of the spouses).

How should psychologists respond? To my knowledge no one solution fits every situation. If the psychologist figures out there is a conflict during the intake, then it may be easy to refer the patient before treatment really begins. The psychologist might say, "given all of the information you have presented me, I think that a referral to Dr. Mxy would be best," or something along those lines. Or, if one of the patient's is near termination, then it is often prudent just to sweat it out for a couple of weeks before therapy terminates naturally. However, how should psychologists respond if both patients are well into therapy, need more therapy, have connected with the psychologist, and are making progress?

The first step is to consider the relevant ethical principles. Unfortunately, Standards 3.05 and 3.06 of the APA Ethics Code offer little guidance since the conflict of interest was neither expected nor avoidable. Instead we must now look at the relevant ethical principles to guide our behavior.

One could argue, on the basis for respect for patient decision making, that the psychologist should continue to treat both patients, since that is what they both want. Of course there is no way to fully inform patients of all of the conditions regarding their therapy (the relationships with the other party) without violating confidentiality. Consequently, the ability of the patients to fully consent is compromised.

One could also argue, on the basis of beneficence, that the psychologist should continue to treat both parties to allow them the benefit of therapy. Or on the basis of nonmaleficence, it could be argued that the psychologists should not terminate either of the patients because such a termination would harm them. But, here is the rub: we do not really know whether continuing to treat both parties would be helpful or harmful. We can make informed predictions, but those predictions are flawed by the inherent uncertainty of treatment under these circumstances.

Specifically, we could ask about the degree of betrayal that the patients may feel if one of the parties learns about the relationship of the psychologist with the other party. Of course the psychologist should be certain to schedule the patients at different times of the week so that they would not accidentally meet in the waiting room, but even then it is possible for one of the patients to drop into the office to reschedule or for some other legitimate reason related to treatment. Or there is always the risk that the psychologist may inadvertently allow some information to slip that was learned—not from the patient—but from the other party. In a similar situation, a wife found that the "other woman" was seeing the same psychologist because she was trailing her and saw her enter the office of the psychologist.

Some psychologists will opt to terminate one or both of the patients. Of course they cannot tell the patient why the termination is being made other than a vague statement such as, "it has come to my attention that there is a conflict of interest." One psychologist told me that she did just that. The psychologist picked the marital couple who had started therapy the most recently to terminate, instead of the "other woman" who had started therapy earlier. I asked her how it went. She told me that the husband seemed to understand why therapy was being ended and accepted it, but the wife did not and insisted that the psychologist give her more details about this conflict that necessitated a termination. It occurred to the psychologist afterward that the husband might have figured out what the conflict of interest was, whereas the wife did not. This raises the possibility that even though the psychologist did not mention that the "other woman" was a patient, the husband inferred it. Despite the uncomfortable conversation, I am not critical of the psychologist and it may have been, looking at the totality of circumstances, the best or the least worst, decision.

One could argue, on the basis for respect for patient decision making, that the psychologist should continue to treat both patients, since that is what they both want.

I know no good answer to this conundrum. My only recommendation is for psychologists to be aware of the pitfalls and make a judgment that appears to maximize the benefits and minimize the harm to the individual involved.

INTRODUCTION TO BOUNDARY . . .

Continued from page 1

Code is clear and a simple reference to the appropriate standard is sufficient. Many times it is not clear and we need to look at the overarching ethical principles to guide our behavior.

When considering boundaries, it may be useful to consider the difference between boundary crossings and boundary violations. A boundary crossing is any behavior that deviates "from the usual verbal behavior . . . to advance therapy in a constructive way that does not harm the patient" (Guthiel & Gabbard, 1998, p. 410). Selective self-disclosure designed to promote the well-being of the patient would be an example of a boundary crossing. On the other hand, a boundary violation is any deviation that a psychotherapist should have known would risk harming the patient.

Although the APA Ethics Code does not use the words "crossings" or "violations," it is written in such a matter to allow that distinction. Standard 3.05 (a) (Multiple Relationships) of the APA Ethics Code states that

> A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologists' objectivity, competence, or effectiveness in performing his or her functions as a psychologist or otherwise risk exploitation or harm to the person with whom the professional relationship exists.

In addition, Standard 3.06 (Conflict of Interests) states that

> Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, effectiveness in performing their functions as a psychologist or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

However, the Ethics Code also notes that "multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Standard 3.05 (a)).

The APA Ethics Code says little about relationships with former patients, except that psychologists should refrain from sexual contact with them. Nor is it specific about gift giving, self-disclosure, hugging, or many other issues related to how to manage patient relationships in treatment. Instead, psychologists rely upon a set of rules of thumb or strategies developed through clinical literature and informed by ethical principles to guide themselves in those situations. Dr. John Gavazzi refers to these as "ethics memes," or traditions of behavior that pervade a culture or subculture.

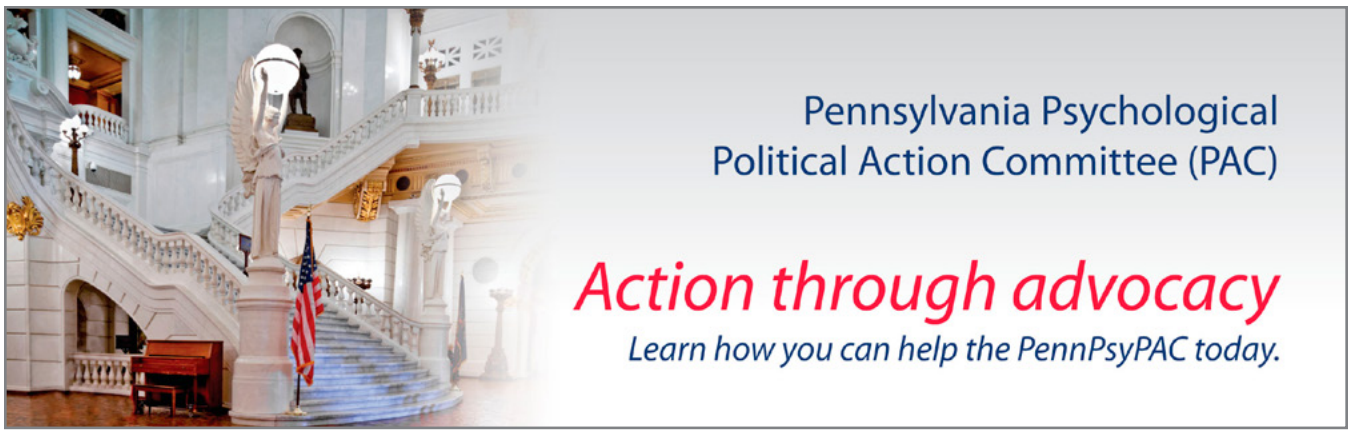
The following articles will look at a few of the boundary issues encountered by psychologists. In these articles I present few answers. Rather I raise issues for psychologists to consider as they develop their responses. In the first article, "The Conundrum," I present a difficult clinical situation which, in my mind, has no correct answer. Instead the goal of the psychotherapist would be to develop the "least-worst" answer based on the context of the particular case.

The second article, "Within Session Boundaries," argues for a balanced approach to boundaries with patients. Over time, the profession of psychology has developed some helpful "rules of thumb" for dealing with issues such as self-disclosure or gift giving. These rules generally serve us well. But they are only useful to the extent that they reflect overarching ethical principles. Psychologists need to show flexibility in interpreting these rules for some patients. The most effective psychotherapists understand when to hold firm on boundaries and when to bend.

The third article, "Dual Roles," considers situations when psychologists find themselves in a multiple relationship with their patients, often through unavoidable encounters or situations.

Reference

Guthiel, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*, 409-414.



Within Session Boundaries

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

In the introductory article to this issue I noted the distinction between boundary crossings (deviations from strictly verbal interactions that are benign or even helpful) and boundary violations (deviations from strictly verbal interactions that a reasonable psychologist would know to risk harming the treatment relationship). These concepts are relevant to the issues presented below.

> Consider these little scenarios: Before psychotherapy began a patient asked to charge her phone into the outlet of her psychologist. Or another patient arrived at a therapy session with a cup of coffee and sipped it during the session. Still another patient saw a book on the psychologist's bookshelf that interested him. He asked to borrow it. How would you respond? Are these boundary crossings (benign deviations from a strictly neutral position), or boundary violations (deviations from a strictly neutral position that a reasonable psychologist should know risks harming the quality of treatment)?

The Ethics Code offers no explicit guidance on how to handle these boundary intrusions in therapy. Consequently, we fall back on the overarching ethical principles. How can we maximize beneficence, nonmaleficence, etc. in these types of situations?

Actually, asking "how would you respond?" is probably not the best question. It would probably be better to ask, "what factors or circumstances would influence your responses?" Ideally responses would vary according to the clinical context and its impact on the patient.

One common issue in handling within session relationships deals with the amount of self-disclosure that psychologists should have with their patients.

We can create scenarios in which each of these behaviors on the part of the patient could be appropriate. If a patient ordinarily respected boundaries and used therapy time productively, it may be appropriate for the psychologist to grant her request to use the outlet to charge her phone because the request has no significant underlying meaning. In the second situation, a patient may have respectfully asked the permission of the psychologist to drink coffee during therapy. In the third case, the psychologist might have discussed with the patient the benefits of bibliotherapy and suggested that he peruse the collection of books on the office shelves of the psychologist for one that may be helpful.

We would be likely to respond differently if the patient who asked to use the outlet had a history of using therapy time unproductively or frequently challenged boundaries. Or we might have responded differently if the patients who drank coffee or asked to borrow a book also showed an inconsiderate or self-centered attitude that revealed itself in other ways that impacted therapy. So for one patient, allowing the use of an outlet might simply be a common courtesy; for another patient it may have implications concerning the quality of therapy.

Self-Disclosures and Psychologist Competence

One common issue in handling within session relationships deals with the amount of self-disclosure that psychologists should have with their patients. The general rules of self-disclosure are that it should be infrequent and focused on patient needs. Also, psychologists need to remember that even though they are bound by confidentiality,

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WITHIN SESSION BOUNDARIES

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patients are not. Psychologists should not reveal anything that they would not want seen on the front page of a newspaper.

The application of this general rule can be difficult in some circumstances. In rural Pennsylvania, potential patients sometimes ask psychologists "are you a Christian?" When I did an ethics workshop in Fort Smith, Arkansas, one of the participants noted that potential patients with connections to the military often asked the psychotherapists if they were Republicans. Individuals with marital problems often ask their therapists if they were married. Those with child problems may ask their psychologists if they had children themselves.

Again, the APA Ethics Code offers little guidance here. It could be argued that extensive self-disclosure could divert the course of therapy if it led patients to construe the relationship as more of a social than a professional relationship. However, we are not discussing excessive self-disclosure, rather more limited disclosure. Consequently, we rely on the overarching ethical principles to determine which responses, under which circumstances would do the most to maximize adherence to overarching ethical principles.

Competent psychologists vary how they respond to direct questions about their religion, marital status, or other personal information. Some will answer the question, but refuse to give more information. Others will not reveal that personal information, but will to the issue behind these questions, which is often, "Will you respect my world view?", or "Do you have competence or experience sufficient to help me?" Patient questions about respect for the world view of the patients or professional competence should be addressed, as doing so would be consistent with the overall ethical principle of respecting patient autonomy.

Competent psychologists vary how they respond to direct questions about their religion, marital status, or other personal information.

I defer to individual psychologists whether they prefer to answer brief or very limited personal questions. I know of no empirical evidence that a limited disclosure (their religious affiliation, marital status, etc.) would benefit or harm a patient. But I urge psychologists to address the underlying concern and to avoid going down an endless cascade of follow up questions.

But here again we need to be careful not to fossilize "rules of thumb" and apply them in situations where it would be harmful to patients. One metaphor to use is to think of the use of the Queen in the game of chess. Ordinarily chess players would not sacrifice their Queens, which is their most potent offensive weapon. However, players may encounter some unusual situations where sacrificing the Queen would be essential to winning a game.

Similar situations may occur in psychotherapy where the ordinary rules of thumb for patient relationships do not promote the well-being of patients. As noted by Guthiel and Gabbard, "boundaries must be regarded as standards of good practice rather than lists of generally forbidden behavior" (1998, p. 409). They are useful only to the extent that they allow psychologists to adhere to overarching ethical principles.

For example, patients from rural China may be more reluctant to open up, until they know something personal about their therapist. They come from communities where personal connections with professionals including health professionals are important for ensuring trust and cooperation. A psychotherapist who refused to reveal anything about herself may be losing the opportunity to develop a good relationship with the patient (Littlefield, 2007). Although I would be reluctant to tell an ordinary American patient information about my parents' occupation, for example, I would be more willing to provide this and other personal information to some patients if I thought it was necessary to ensure trust.

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Another Example of Flexibility in Accepting Gifts

Another issue that arises in therapy is whether to accept gifts from patients. The "rule of thumb" concerning gifts is that psychologists may accept token or symbolic, especially if given at special situations such as termination from treatment or holidays. But accepting expensive gifts from Americanized patients is very problematic. I know of patients who gave gifts of substantial value to their psychologists and then expected forbearance in collecting bills, influence over how a letter to a third party would be phrased, or advocacy in a legal issue (that the psychologist did not know about at the time). Sometimes a gift is not really a gift. Or, as Dr. Steven Cohen told me, "sometimes free costs too much" (personal communication, September 16, 2016).

The psychotherapist failed to understand that gift giving has a special meaning in Japanese culture including the manner in which the gift is offered and received.

But here again, special situations may occur. One Japanese patient surprised her psychotherapist by offering her a moderately expensive gift, which the psychologist rejected after explaining the ethical rules concerning gift receiving in the United States. The patient never came back and never responded to follow-up calls (Hoop et al., 2008). The psychotherapist failed to understand that gift giving has a special meaning in Japanese culture including the manner in which the gift is offered and received. Refusing a gift would result in a disruption of any personal relationship.

Maintaining good within session boundaries is essential for good care. Certain "rules of thumb" concerning boundaries are very helpful, but psychotherapists need to consider whether, in this particular case, they are consistent with the overarching ethical principles that they purport to uphold.

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Dual Roles

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Standard 3.05 of the APA Ethics Code states that psychologists should not engage in relationships that could reasonably impair their objectivity, or be clinically contraindicated or exploitative. Many situations are clear cut. I have known psychologists who went into business with patients; these usually ended poorly. But sometimes our ability to reasonably expect harm or exploitation is unclear. Consider this situation:

> A patient with a terminal illness asked the psychologist to take care of his dog when he died. He had no relatives who had the capacity to take care of the dog. Other family members thought it would be a good idea. The psychologist liked the gentle and affectionate dog.

The Ethics Code Standard 3.05 requires psychologists to refrain from promising to enter into a future relationship that would impair their objectivity or be exploitative. So the psychologist needs to ask whether the promise to care for the dog would impair her objectivity. Assuming that the psychologist was interested in caring for the dog, would it be a problem if the psychologist agreed to care for the dog following the death of the patient?

In these situations, it is useful to assess the degree to which the behaviors promote the well-being of the patients (beneficence). Here we may ask whether the roles of psychotherapist and future dog-owner are inherently in conflict, or whether the promise to care for the dog gives the psychologist disproportionate power or influence over the patient. We can also ask whether accepting care of the dog will require greater personal disclosure on the part of the psychologist unrelated to patient needs, or whether it will sacrifice the welfare of the patient to the needs of the psychologist (modified from Fisher, 2012).

Remember that multiple relationships are not inherently unethical, just as a deviation from a strictly neutral position within therapy is not necessarily a boundary violation.

Or consider this second example:

> A psychologist at an integrated health care center entered a treatment planning meeting and realized that they were discussing a neighbor of his. He immediately told the team that he knew this man socially and exempted himself from this portion of the meeting.

The Ethics Code prohibits entering into a professional relationship with an individual with whom one has a current social or business relationship if it could be likely to lead to loss of objectivity, be clinically contradicted, or exploitative. Most of us would agree that participating in the treatment decisions for this neighbor would be providing a professional service and thereby creating a multiple relationship. Consequently, the psychologist wisely withdrew from that portion of the meeting.

We can muddy this vignette up by supposing that the psychologist knew that the patient (his neighbor) had a recent suicide attempt and appeared to be at a very high risk of completing a suicide. Could the psychologist stay in the planning meeting long enough to ensure that the treatment team understood the severity of the danger?

Remember that multiple relationships are not inherently unethical, just as a deviation from a strictly neutral position within therapy is not necessarily a boundary violation. Consequently, the psychologist could stay in the treatment planning session long enough to ensure that the team understood the severity of the problem. It would appear prudent for the psychologist to describe his current relationship with the patient to the treatment team and why he was staying for a portion of the meeting about the patient.

Consider this other example:

> A psychologist came home to find her teenage patient sitting at her kitchen table talking to her step son. The patient was as shocked as the psychologist. The patient did not know that her psychologist was the step mother of her friend. The psychologist and her step son had different last names.

Here the psychologist recognized the multiple relationship with her patient and her obligation to avoid harm or exploitation to her patient. The optimal response of the psychologist can be informed by a conversation with her patient to clarify the nature of the multiple relationship. Her response depends, in part, on the closeness of the relationship between her patient and her step son. Do they just know each other in passing and expect to have little or no contact with each other? In that case, therapy might continue, especially if the patient is near the end of therapy. On the other hand, if the step son and the patient have any meaningful connection or overlap in their social relationship, a referral would likely be in order. My general perspective is that, when in doubt, psychologists should err on the side of nonmaleficence (acting to avoid harm).

Readers will note that I use wiggle words in describing the options, such as therapy "might continue" or a referral "would likely be in order." Determining which helps or harms the patient is not always easy. So much depends on context. For example, we could then modify

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the scenario so that the patient has a serious condition that has only recently become stabilized due to the intervention of the psychologist and there are no other treatment providers in the area who can provide this type of care. Even though the teenager has some kind of relationship or overlapping social circles with the step son of the psychologist, it might be indicated for the treatment to continue. Similarly, we could construct a scenario where the teenager is so upset by the chance encounter that she no longer wishes to continue in treatment. Although the psychologist may think that their social circles overlap so little that the treatment relationship can be salvaged, deference to the patient's wishes (respect for patient autonomy) argues against continuing treatment.

But consider these last two cases that deal with interactions with former patients.

> The 8- year old son of a psychologist was chosen for a Little League baseball team. The coach was a former client of the psychologist.
>
> The elementary school daughter of a psychologist was friends with the daughter of a former patient. The psychologist expected that there will be play dates, birthday parties and other social situations where she will need to talk with her former patient.

The Ethics Code does not explicitly address boundary issues in consecutive multiple relationships, except for prohibitions against having sex with former patients or using former patients subject to influence from the psychologist for testimonials. Consequently, we look to the overarching ethical principles to guide our behavior. How should we act in a manner that promotes the well-being of the former patient and avoid harming them?

In the case of the former patients it might (but not necessarily) be indicated to speak to the former patient about the new relationship that you will have. The psychologists could explain that they will not breach of confidentiality and that they will engage in the new relationship like any parent does with another parent. I defer to the psychologists' judgement here. For some patients such a conversation would be unnecessary; for others it might be essential.

Reference

Fisher, C.B. (2012). *Decoding the Ethics Code* (3rd ed.). Thousand Oaks, CA: Sage.

Classifieds

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Leading the Way to a Psychologically Healthy Workplace

10 Ways to Measure Your Work Environment

Rex Gatto, PhD

Dr. Rex Gatto

Executives frequently talk about wanting to effectively lead, communicate and develop people. Many talk a good game but how many stay the course and really implement transparent opportunities for employee development based on surveys, performance feedback and meeting the competitive challenge?

Homeostasis – a state of bodily equilibrium in which all systems work in harmony for the greater good of the person – can guide us both in body and the workplace! What does the human body teach us? As systems in the body maintain, increase, or compromise health, so do systems in the workplace compromise its optimum operation. Ideally, both the body and the workplace attain peak performance. The skeletal, digestive, cardiovascular, endocrine, and central nervous systems all work together to create a well-functioning body. Each plays a vital part, and if even one of these systems is out of sync, the entire body is affected negatively. So too the workplace is comprised of important systems which include organizational leadership, followership, teamwork, training, communications, competence, efficiency, motivation, and praise. Each body and every organization is unique because of interactions among the various systems.

The skeletal system of a person and the workplace organizational leadership structure both create formal structures; communications and the cardiovascular systems pump a steady stream of life force throughout the body; training can be viewed as the digestive system, taking ideas and converting them to energy and action to propel the organization forward; praise and motivation are the endocrine and central nervous systems that control growth and nutrients to sustain life. Thus, the workplace is as alive and dynamic as the human body, and can also be adversely affected if any part of any system is diseased.

To be healthy (having the right culture), an organization needs to begin with clarity of direction, with employees focusing their collective energy to accomplish the goals. The body is made up of individual cells coming together to create a phenotype, which denotes an individual's particular inherited characteristic. An organization is comprised of individual employees coming together to create the particular organizational culture, with its individualistic vision and goals.

10 Characteristics That Comprise a Psychologically Healthy Workplace

1. Quality benefits plans
2. Ways to measure job satisfaction
3. Effective leadership and communication
4. Policies and procedures supporting employee needs
5. Training programs
6. Equity among employees
7. Employee Assistant Programs (EAP)
8. Input from employees (employee engagement)
9. Physically and emotional safe work environment
10. Methods for employees to demonstrate potential

Executives and leaders need to identify and assess how the employees work together as they strive to achieve their organization's vision, goals and mission. Recognizing employee contributions to the organization enhances the quality of the whole work environment and experience. How is the health of a workplace assessed? Systems are evaluated, business goals for the organization are examined, and the ways in which the organization leads, develops followers, communicates with transparency, supports, motivates and basically cares for its employees are all evaluated.

In business today, employees can do everything right and still get caught in the downsizing changes that organizations are forced to make. The driving forces behind the instability or stability can be simplified into three key areas: change (technology is the main driver), competition (competitors continually challenge the market place), and educated customer (needs and demands). Bill Gates of Microsoft reminds us that the *"most unhappy customers are you greatest source of learning."* The healthy workplace is able to put its systems in sync, thus creating organizational homeostasis through leadership, effective communication, appropriate policies and procedures, and support of the employees. Maintaining a healthy workplace can be viewed as an art form which many large to small organizations are paying a great deal of money trying to acquire. There is no one right way for an organization to become and remain healthy. Establishing the healthy workplace is a formula that generates the flow for vigorous interactive organizational systems.

To assess the health of organizational systems, a survey should be administered that collects data on the organization's policies, procedures and supportive programs that indicate

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PSYCHOLOGICALLY HEALTHY WORKPLACE

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well-being of the employees, generational differences, diversity, leadership and followership, and openness of communication. The key focus is on employee development, family support, employee involvement, and how the organization provides a healthy and safe work environment. Leadership, communication, and employee morale come into play through these questions of how the employees are guided and supported in the workplace. To add strength to the survey process, employee comments are solicited and included.

The process gives employees organizational opportunities to provide supportive data toward creating a healthy workplace. It is beneficial for an organization to assess how it is doing through the eyes of its employees. This recognition supports all that an organization provides to its employees. Furthermore, the leaders need to promote the organization as a healthy workplace, which can give it a competitive edge. Leaders need to realize that understanding and engaging employees helps to attract and retain talented people. *"After you become a leader, success is all about growing others,"* says Jack Welch former chief executive officer of General Electric. Currently there are many troubling issues in our nation and in our workplaces, it is time for organizational leaders to communicate and feel good about the beneficial things they do for employees and their customers.

As people in organizations strive to be successful, they can remember the body metaphor, which illustrates that individual systems support the entire health of an organization, and if one system suffers, the entire organization suffers. George Lucas of Star Wars fame indicated that each of us needs to, *"Train yourself to let go of the things you fear to lose."*

While reading this article, have you been contemplating how your organization provides a healthy workplace for you, supporting you in demonstrating your abilities? I certainly hope so!

Nominate a Deserving Colleague for a PPA Award

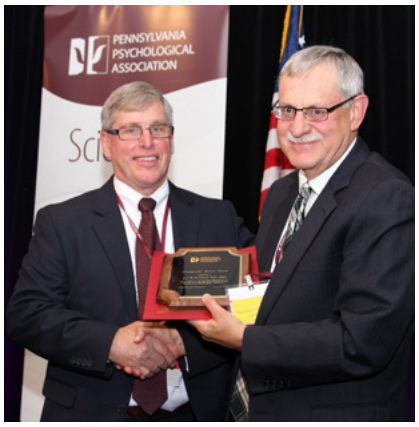
Do you know of a colleague that has distinguished himself or herself as an outstanding professional psychologist? If so, you should nominate that person for a PPA award. These awards, will be presented at the PPA2017 annual convention at the Omni Bedford Springs Resort.

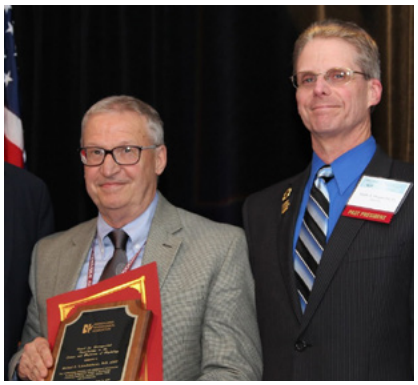
The award for Distinguished Contributions to the Science and Profession of Psychology is to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications.

The Distinguished Service Award is to be given to a member of the Association for outstanding service to the Pennsylvania Psychological Association.

The Public Service Award is to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the Association.

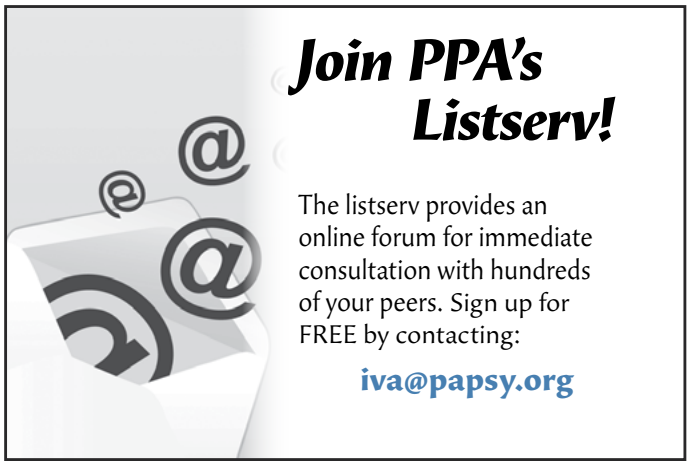
To nominate a deserving psychologist by Nov. 20 or for more information, contact Professional Development Specialist Judy Smith at 717-232-3817 or judy@papsy.org.





Top – Dr. Paul Kettlewell (left) receives the 2016 PPA Distinguished Service Award from Dr. Sam Knapp.

Bottom – Dr. Michael Schwabenbauer is presented with the 2016 PPA Distinguished Contributions to the Science and Profession of Psychology Award by Dr. Mark Hogue.



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Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

2017 Leadership Academy and Advocacy Day
TBD April/May 2017
Harrisburg, PA

2017 Spring Continuing Education and Ethics Conference
April 27–28, 2017
Sheraton Erie Bayfront Hotel
Erie, PA

PPA2017 – PPA Annual Convention
June 14–17, 2017
Omni Bedford Springs Resort
Bedford, PA

2017 Fall Continuing Education and Ethics Conference
October 26-27, 2017
Eden Resort & Conference Center
Lancaster, PA

Webinars and Home Studies
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Podcasts
Podcasts for CE credit by Dr. John Gavazzi are 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.

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

The Assessment, Management, and Treatment of Suicidal Patients (approved for Act 74)
1 CE Credit / 3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

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

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

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations, and Ethics**
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***This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

For all Home Study CE Courses above contact:
Judy Smith, (717) 510-6343, judy@papsy.org.