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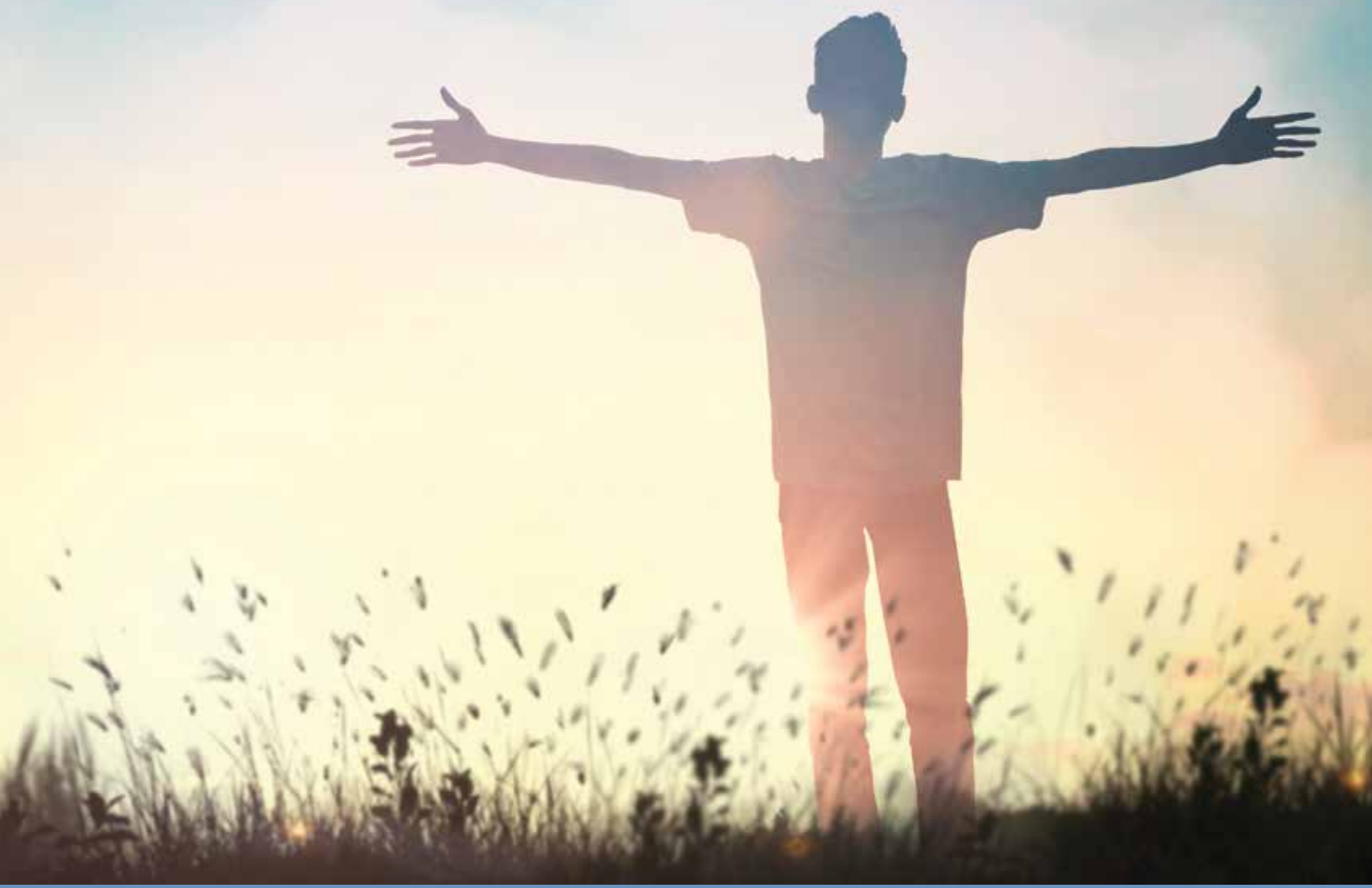
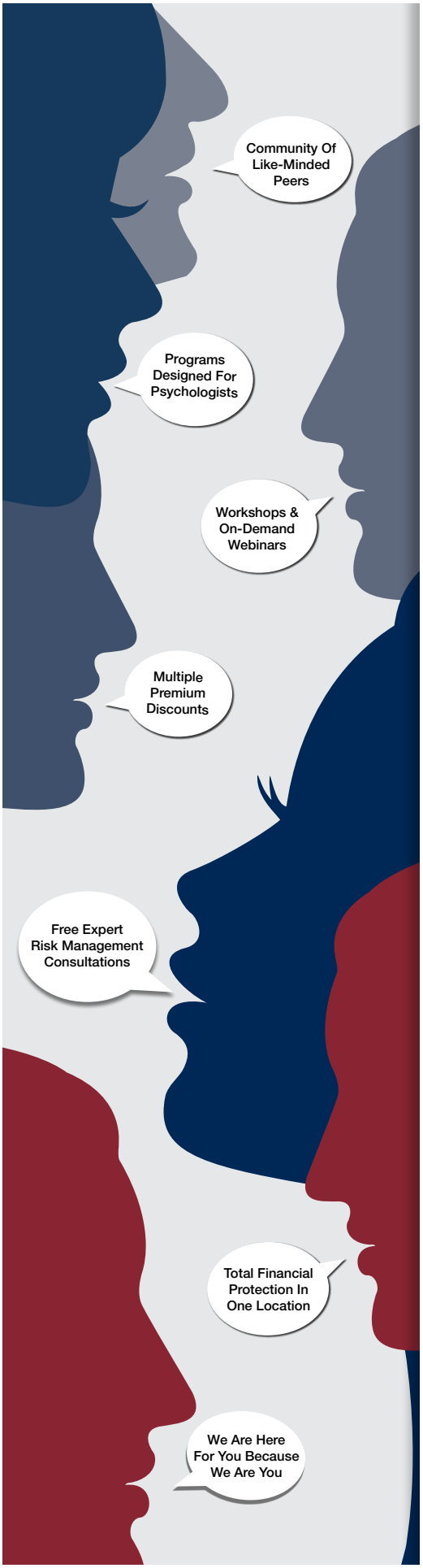
Psychology & RELIGION





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REGULAR FEATURES

HAPPENINGS ON THE HILL

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SCHOOL PSYCHOLOGY SECTION

ETHICS IN ACTION

ALSO INSIDE

Leading by Example

Marie C. McGrath, Ph.D.

Happy September, PPA colleagues! I'm writing this column a few weeks after our tremendously successful Annual Convention and feeling just as "PPA proud" and energized today as I did in Pittsburgh. During her presidential year, Dr. Nicole Quinlan emphasized that, by embodying the virtues of compassion, wisdom, justice, and courage, we can all be wonders and put our psychology superpowers to good use in our communities, workplaces, and professional organizations. The individuals honored at Convention for their professional service (described later in this issue) provide proof that psychologists can be everyday heroes. Dr. Quinlan was at the center of each of those efforts, modeling not only the aaforementioned virtues, but also grace, humor, and collegiality as she, in partnership with Ann Marie Frakes and our stellar PPA staff, led PPA through both good and difficult times. PPA's first superhero presidency is a hard act for a mere mortal to follow, but I'm excited to take on the challenge!

In the upcoming year, we will be implementing several initiatives that will help our members to be effective leaders in their workplaces, professional organizations, communities, and beyond. Our training as psychologists; our problem-solving, communication, and interpersonal skills; our understanding of motivation and behavior change; and our adherence to ethical principles provide us with many of the skills that we need to lead effectively, and the research base on transformational leadership gives us some ideas as to how we can apply these professional skills in leadership contexts.

Transformational leaders demonstrate four key characteristics, which I'll summarize briefly here. First, leaders behave as, and are perceived as, role models; they behave ethically and are perceived as competent and worthy of trust. Second, leaders are enthusiastic and optimistic. They motivate others to do meaningful work. Third, leaders emphasize creative problem-solving and question old assumptions and practices. Finally, leaders are supportive mentors who help others to develop their skills and reach their potential.

By combining our skills as psychologists with leadership-specific knowledge, we can become more effective leaders. We lead by sharing our enthusiasm; we lead with creativity; we lead by modeling and mentoring; and sometimes we lead by stepping aside and letting others move into positions that will allow them to fulfill their own leadership goals. In short, we lead by example. By this, I don't mean that we'll always be perfect models – that we'll always know just what to do or say, that we'll always step up (or step back) at the right time, that we'll always truly feel the motivation and optimism that we wish to exemplify, or that we'll always manage to perfectly blend creativity and vision with pragmatism – but, as with other learned skills, we can continue to improve and expand our skill set with practice. As PPA president, I'd like to offer all of you the opportunities to do so over the next year.

In recent years, one of PPA's main leadership development initiatives has been our Emerging Leaders Program, which focuses on providing skill-building and mentorship opportunities to student and ECP members. While we've gotten very positive feedback from the program's participants, it's been a small-scale program by design, and we've also received requests that these opportunities be extended to a broader audience. In response, we'll be offering a variety of opportunities throughout the year for PPA members to participate in face-to-face CE sessions, webinars, and other offerings that will address a variety of topics related to leadership skill-building. We're also planning to expand our mentoring networks to include members at any career stage who are interested in exploring new professional opportunities.

Marie C. McGrath,Ph.D.

In the coming year, we will also be reviewing and revising PPA's bylaws, a process that we complete decennially in order to make sure that our structure, practices, and policies remain relevant and serve the organization well. Though phrases like "bylaws revision" don't generally tend to inspire great enthusiasm, I am very excited about the possibilities that the process holds for the future of our organization. We've assembled a workgroup of PPA members and leaders who are committed to helping PPA succeed over the coming decade and beyond by keeping what currently works and changing what could work better. Among the group's charges will be to ensure that we have a governance structure in place that not only allows us to nimbly address the many issues that confront our profession and our members, but also reflects our commitment to diversity and inclusion by ensuring that diverse individuals are actively recruited to service in meaningful and visible leadership positions throughout PPA, and that diversity-related initiatives are not delegated to a small group of volunteers or committees, but infused throughout all aspects of our organization. We will be updating you on the workgroup's efforts throughout the year.

Finally, we'll be sharing information with all of you on how to get more involved with PPA. Did you know that we currently have over two dozen committees that cover an extremely wide range of interests? The upside of this is that there's something (or somethings) for everyone! The downside is that figuring out how to get involved can be overwhelming. Therefore, we'll be

Continued on page 4

Coordinating Prescriptions of Medical Marijuana: When Patient Demands Exceed Scientific Evidence

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Rachael L. Baturin, MPH, JD; Director of Government, Legal, and Regulatory Affairs

Most professional psychologists will encounter patients who are using marijuana either recreationally or medically. Often, patients will use marijuana to relax or socialize (Patrick et al., 2016) and most of those who use marijuana infrequently experience few negative effects (Pearson et al., 2017).

In addition, many patients acquire marijuana legally or illegally to address their health or mental health issues. Marijuana appears to be more socially acceptable, especially now that Pennsylvania and many other states, have made medical marijuana an option for certain medical conditions. Pennsylvania's Medical Marijuana Act allows health care professionals to prescribe marijuana when a patient has a terminal illness ("A medical prognosis of a life expectancy approximately one year or less if the illness runs its normal course"), or when a patient has a diagnosis of any of certain medical conditions including cancer, HIV, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), Parkinson's disease, multiple sclerosis, epilepsy, inflammatory bowel disease, neuropathies, Huntington's chorea, Crohn's disease, post-traumatic stress disorder, anxiety disorders, Tourette's disorder, intractable seizures, glaucoma, sickle cell anemia, autism, spinal cord damage, and severe neuropathic pain where conventional treatments are contraindicated or ineffective.

The strength of the evidence on the effectiveness of marijuana-based treatments on the above-mentioned medical conditions varies considerably. On the one hand, the FDA has approved THC-based medications for the treatment of nausea for patients undergoing chemotherapy for cancer and to simulate appetite in patients experiencing wasting syndrome secondary to AIDS. Strong evidence suggests that marijuana can reduce chronic pain, spasms associated with multiple sclerosis (Alexander, 2016), and non-cancer nausea and vomiting. On the other hand, the evidence for the health benefits of medical marijuana for autism or anxiety is less robust.

The most mental health research with marijuana has been done on its use with PTSD. Some preliminary research on marijuana with PTSD has been promising, although these studies lack strong methodological controls and no definitive conclusions can be made about its efficacy (Hoch et al., 2019). Nonetheless, medical marijuana could be indicated for patients who have failed to benefit from traditional methods of treating PTSD and do not have a history of substance misuse. As with any non-traditional intervention, patients should be informed of the limits of the evidence of the benefit of medical marijuana for PTSD.

Dr. Samuel Knapp

Rachael L. Baturin

Practical Implications for Health Care Professionals

Despite the limited scientific evidence supporting the use of marijuana for many medical conditions, many patients use it to replace or supplement the traditional medications that they are already taking. Some patients are taking illegally obtained marijuana to alleviate medical conditions such as muscle spasms, pain, or anxiety. Other patients perceive marijuana because to be a natural remedy, and thus healthier than more traditional medications (whether medical marijuana is more natural than other medications is a source of dispute, however). Many patients do not tell their physicians that they were supplementing their prescribed medications with marijuana or substituting marijuana for the prescribed medication (Piper et al., 2017).

Psychologists can find themselves in a dilemma in which, if they emphasize the limited scientific support for medical marijuana too strongly, they risk alienating those patients who feel very invested in marijuana-based treatments. On the other hand, if psychologists fail to discuss the limited scientific support for medical marijuana, they risk having patients committed to a treatment that may be therapeutically inert. Psychologists will be best able to influence patients if they listen carefully to the concerns of their patients and adopt a collaborative attitude without shaming or embarrassing their patients.

Marijuana does involve some health risks. Pennsylvania's Medical Marijuana Act requires physicians to engage in an informed consent process with their patients that includes potential harmful effects of the medication. Patients considering marijuana as a medical intervention should know that:

- Regularly smoked marijuana can cause bronchitis or other lung diseases. Although Pennsylvania physicians will prescribe non-smoked marijuana, many patients will purchase marijuana illegally, although they intend to use it for medical reasons.
- Teenagers who use marijuana heavily show an increased risk of psychosis emerging later in their lives (Ranganathan et al., 2016).
- Medical marijuana could be contraindicated for persons with a history of misusing substances.

Continued on page 4

LEAD BY EXAMPLE

Continued from page 2

developing a concise guide that you can use to learn more about joining and participating in PPA committees.

I am honored to have been entrusted with PPA's presidency this year, and I hope that you share my enthusiasm and optimism for the future of our organization. I look forward to continuing to develop my own leadership skills alongside you in the year to come, and to benefiting from your knowledge, skill, ingenuity, and flexibility as we work together to move our organization forward. If you have ideas to share or questions about becoming more involved with these activities or with PPA in general, please get in touch!

COORDINATING PRESCRIPTIONS OF MEDICAL MARIJUANA: WHEN PATIENT DEMANDS EXCEED SCIENTIFIC EVIDENCE

Continued from page 3

- Pregnant women should not use marijuana unless under medical direction.
- Marijuana use can cause short-term impairments in cognitive functioning that eschew driving or other cognitive activities.

Unfortunately, at the PPA office we have become aware of two situations where patients did not appear to be adequately informed of the limits of medical marijuana and were prescribed medical marijuana in a manner that appeared to be clinically contraindicated. In both these situations, the psychologists were not informed that the patients had sought medical marijuana until after the medication had already been prescribed. It is not known if the physicians failed to ask about past mental health treatment or the patient's history with substance misuse, or whether the patients had misled the prescribing physicians.

Nonetheless, these events highlight the importance of establishing a close working relationship with patients, wherein they feel comfortable talking to their psychologists about the prescription or non-prescription medications that they are taking without fear of censure or embarrassment. Patients may withhold information from their psychologists for many reasons, such as fear of being criticized or a lack in faith in traditional treatments.

Psychologists should ask all patients about their use of medications, over the counter medications, herbal remedies, and other substance use including marijuana. When discussing treatment options, psychologists need keep communications open with patients about their substance use and, using therapeutic timing, discuss the advantages and limitations of these medications with their patients.

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The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of July 23, 2019

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House
SB 67	PSYPACT Legislation.	Sen. Judy Ward	Support	2nd consideration Senate Floor	N/A
SB 90	Adding a provision for Extreme Risk Protective Orders.	Sen. Thomas Killion	Support	Referred to Senate Judiciary Committee	N/A
SB 621	Training for those who carry guns in schools.	Sen. Mike Reagan	Support	Enacted into Law Act 67 Passed Senate	Passed House
SB 706	Loan Forgiveness Program for Graduates Entering the Mental Health Intellectual Disability and Drug/Alcohol Treatment Professions.	Sen. Scavello	Support	Referred to Senate Education Committee	
SR 168	Study of Mental Health Services Shortages in PA.	Sen. Michelle Brooks	Support	Referred to Senate Health & Human Services Committee	N/A
HB 672	An act enabling certain minors to consent to medical, dental and health services, declaring consent unnecessary under certain circumstances," further providing for mental health treatment and for release of medical records.	Rep. Jason Ortitay	Support	Referred to Senate Health & Human Services Committee	Passed out of House with vote 195-0
HB 1075	Extreme Risk Protective Orders-Providing Due Process for Gun Owners and Reducing Firearms Deaths by Temporarily Disarming People in Crisis.	Rep. Todd Stephens	Support	N/A	Referred to House Judiciary Committee
HB 1293	Bans Conversion Therapy for children under 18.	Rep. Brian Sims	Support	N/A	Referred to House Health Committee
HB 1397	Presumption of Joint Custody.	Rep. Susan Helm	Oppose	N/A	Referred to House Judiciary Committee
HB 1415	Trauma Informed Education Initiative.	Rep. Ryan MacKenzie	Support	N/A	Referred to House Education Committee
HB 1500	Amends school code to include licensed school social worker.	Rep. Dan Miller	Oppose	N/A	Referred to House Education Committee
HB 1525	Providing for more access to mental health professionals in schools.	Rep. Tarah Toohil	Support	N/A	Referred to House Education Committee
HR 193	Shortage in Mental Health Workforce.	Rep. Jeanne McNeill	Support		Adopted June 4, 2019 196-0
HR 345	Assess ACES in Schools.	Rep. Mike Sturla	Support	N/A	Referred to House Education Committee

Religion and Spirituality in Psychology: Why Psychologists Should Take an Interest

Thomas G. Plante, PhD, ABPP
Santa Clara University and Stanford University School of Medicine

Psychology as an academic discipline and as an applied clinical health profession has often experienced a rather mixed and tumultuous relationship with religion and spirituality (Hage, 2006; Plante, 2009; Russell & Yarhouse, 2006). Although William James and Carl Jung are well known for their thoughtful writings and reflections on the psychology of religion (e.g., James, 1890), so many of our leaders in the field including Sigmund Freud, John Watson, and Albert Ellis were not only negative but rather hostile towards religion and those actively engaged in the religious traditions and communities (e.g., Ellis, 1971; Freud, 1927/1961; Watson, 1924/1983). Research informs us that psychologists, overall, are less likely to be affiliated with or engaged by religious communities relative to most other professions (including those in STEM, i.e., science, technology, engineering, and mathematics) and that they get very little, if any, training on the psychology of religion and spirituality (Delaney, Miller, & Bisono, 2007). In fact, research has found that the majority of clinical internship directors of APA-accredited programs do not foresee training in this area being available in their programs any time soon (Russell & Yarhouse, 2006).

In more recent years, secularized versions of spiritual or religious practices have become popular in the psychological community and with the general public. Perhaps the best examples of this include mindfulness meditation and yoga (e.g., Horovitz & Elgelid, 2015; Kabat-Zinn, 2003; Langer, 2014). Although mindfulness meditation comes from the Buddhist tradition (and has close variants within other traditions such as centering prayer within Christianity) it has been secularized and popularized in such a way that it appeals to many people regardless of their spiritual or religious background or interests (Plante, 2016). Similarly, yoga has also become very popular across the country and historically is rooted in the Hindu tradition. Like mindfulness, yoga has also been secularized and popularized to appeal to a diverse health conscious population (Horovitz & Elgelid, 2015). Many who practice mindfulness or yoga may not even be aware, or care, that these helpful and popular practices come from the Buddhist or Hindu traditions.

Recent trends suggest that secularized spiritual practices are popular while religiously based ones are not in psychology. Religion, in America and elsewhere, has gotten a great deal of bad press in recent years and decades and it appears that for many psychologists, among others, religion is bad while spirituality might be at least okay or maybe even good. Religious based intolerance, discrimination, bias, violence, financial and sexual abuse scandals, and so forth have made regular front page headlines and presents a rather unflattering view of religion for many. Hot topic issues that can be politically and culturally divisive such as abortion, homosexuality, gender identity, immigration, terrorism, and so forth often are associated with particular religious groups and identities all giving the casual observer a very negative impression of religion.

Recent trends suggest that secularized spiritual practices are popular while religiously based ones are not in psychology. Religion, in America and elsewhere, has gotten a great deal of bad press in recent years and decades and it appears that for many psychologists, among others, religion is bad while spirituality might be at least okay or maybe even good.

Psychology's relationship, or lack of relationship, with the spiritual and religious traditions and communities are problematic from a variety of perspectives. First, unlike psychologists, most Americans report that religion and spirituality are important areas of their lives and that they are engaged with spiritual and religious communities. Second, the religious and spiritual communities often offer a variety of supportive and helpful services such as pastoral counseling, spiritual direction, stage of life rituals, homeless shelters and food pantries, social support services, and so forth. Many health care services including major hospitals as well as educational institutions from the preschool through the university level are run by religious based groups and organizations. Many religious based services are completely free, and thus accessible to many, as well. Third, the religious and spiritual traditions offer a wide variety of coping with life strategies that can be used to help people manage the various "womb to tomb" challenges in their lives. These include prayer, meditation, community support and engagement, rituals, volunteerism, a focus on positive psychology principles such as forgiveness, compassion, and gratitude, highlighting the sacredness of life, and so forth (Plante, 2009). And finally, ethically we are asked to consider religion and spirituality as a multicultural issue similar to how we view other areas of multiculturalism and diversity related to gender, gender

identity, race, ethnicity, socioeconomic status, and so forth. In fact, our APA Code of Ethics states: "...psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability...." (American Psychological Association, 2002).

Although many psychologists may not have any or much training in the psychology of religion and spirituality or on cultural competencies related to religion and spirituality during their graduate or post-graduate training there are many helpful resources now available. For example, Division 36 of the APA (the Society for the Psychology of Religion and Spirituality) offer many resources including an APA journal, an active and engaging listserv, a great deal of programming at the annual APA Convention, and so forth. APA has also published a number of books in recent years as well on this and related topics including, *The APA handbook of psychology, religion, and spirituality* (Pargament , Exline, Jones, Mahoney, & Shafranske, 2013) and also one of my own entitled, *Spiritual practices in psychotherapy: Thirteen tools for enhancing psychological health* (Plante, 2009). APA also offers an applied journal, that I now edit, entitled, Spirituality in Clinical Practice as well. The journal publishes not only empirical articles but reviews, reflections, and case studies too. The mission of the journal "aims to inform and inspire practitioners and researchers by publishing clinical research and standards of practice about spiritually oriented interventions." Topics of interest and consideration are quite broad and highlight spiritually informed mental and physical health care, innovative new as well as established assessment and treatment strategies, ethical issues, and diversity issues. All spiritual and religious traditions are included as well as factors related to both the advantages and disadvantages of spiritualty integrated training, assessment, interventions, and consultation.

Regardless of one's personal views or experience with religion and spirituality, professional and competent psychologists simply can't ignore the tremendous influence that spirituality and religion play in the lives of our clients and within our broader culture. Ethically, we need to be informed and respectful of religion and spirituality, using the tools and resources available to us, to better serve those who seek our assistance. Luckily, there are many resources and consulting colleagues available for interested professionals to further their training and expertise. We should certainly take advantage of them.

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APA's Spirituality in Clinical Practice journal https://www.apa.org/pubs/journals/scp/

Considerations for Incorporating Spirituality and Religion with Clients who Desire an Integrated Treatment Approach

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Spirituality and religion are an important part of many people's lives (Rosmarin, 2018; Vieten, Pilato, Pargament, Scammell, Ammondson & Lukofff, 2013). As the *Religious Landscape Study* found 51% of adult Pennsylvanians' reported that religion was very important in their lives, 56% of respondents pray daily and 16% pray weekly (Pew, 2014). In addition, many clients would appreciate the opportunity to discuss and perhaps incorporate spirituality and/or religion into their mental health treatment (Rosmarin, 2018). While spirituality and religion may contribute positively to wellbeing it is important to note that for others spirituality and religion plays little or no role in their lives and/or it may be associated with negative experiences (Pew, 2014; Rosmarin, 2018).

As psychologists we strive to appreciate, respect and understand the unique diversity of our clients (APA, 2017). This commitment to diversity, that includes spirituality and religion, contributes to efficacious and ethical treatment (Hodge, 2011; Rosmarin, 2018). Understanding the role of spirituality and religion in the lives of our clients can be helpful in developing the working alliance, gathering information for case conceptualization and addressing the client's symptoms and treatment goals (Rosmarin, 2018).

Four ethical principles seem to be particularly relevant when exploring the role of spirituality and religion in psychology. These principles are: beneficence, competence, consent and respect (APA 2017; Vieten et al., 2013). For example, the purpose of addressing spirituality and religion within the clinical setting is to help clients to address their symptoms and to achieve their treatment goals and *not* to further their spiritual or religious growth (Rosmarin, 2018). Therefore, psychologists are functioning within their role and not as pastoral counselors or spiritual guides. Similarly, assessment and interventions related to this domain should be congruent with the client's values and informed consent obtained throughout treatment.

There are a variety of empirically based assessment and treatment interventions that integrate spirituality and/or religion (Center for Spirituality, Theology and Health Duke University). In the book *Spirituality, Religion and Cognitive-Behavioral Therapy: A guide for clinicians* Rosmarin (2018) provides a four-step cognitive-behavioral process that can be used regardless of a client's spirituality and religiosity or religious tradition (please see the text for a full description). The first step is called orientation and includes obtaining informed consent and then assessing the clients' spirituality and religiosity. The second step is the functional assessment and it explores if and how the client's spirituality and religiosity are related to their symptoms and the presenting problem. If spirituality or religion are not related to symptoms and/or presenting problems, then the process stops there. However, if the spiritual or religious issues are clinically relevant and the client desires spiritually integrated treatment then the psychologist and client proceed to step three - collaboration. Collaboration involves ongoing observation regarding how spirituality and religiosity are related to their symptoms and presenting problem as well as experimentation with spirituality and religious interventions that are congruent with the client's beliefs and values and are introduced into treatment with an approach of "collaborative empiricism" (Rosmarin, 2018, p.109). Step four is monitoring, in which the client and clinician observe how the spiritual and/or religious intervention(s) are positively or negatively affecting the symptoms and treatment plan and modified accordingly. Rosmarin (2018) suggests that step one and two should be provided to all clients and steps three and four when clinically indicated.

Mindful of the aforementioned ethical considerations and while not empirically validated, an example of a homework assignment that I have begun to explore with some of my clients who desire integrating spirituality into their treatment is a spiritual exercise known as the examen prayer (Hamm, 1994; Manney, 2011; Thibodeaux, 2015).

The examen prayer is simple five-step exercise that is grounded in gratitude and love and can be completed in about ten to fifteen minutes. While the themes and format of the examen are flexible the first step usually begins by inviting the person to call to mind that they are in the presence of a good and gracious God and to ask God for a "graced understanding" as they begin the prayer exercise (Hamm, 1994, p. 23). The second step is thanksgiving during which the person recalls the many good things, from the simple to the profound, that have filled their day. The third step is to review their day with their God and notice any feelings or significant moments that have occurred. The fourth step is spent praying about one of the significant feelings or moments that were identified during the review of their day. Finally, examen concludes by looking toward the upcoming events of the day in prayer.

While the examen can be completed anywhere (at home, walking in nature, or even commuting to or from work) it may be helpful for clients to experiment with developing a regular time and place to make this exercise. In addition, clients may consider reflecting on their prayer experience and briefly recording any feelings or emotions that may have arose in a journal (Miller, 2014; Pennebaker, 1997). The journal entries can then discuss in the next therapy session in order to identify patterns and themes that may be related to the case conceptualization and treatment plan.

To summarize, spirituality and religion are an important part of many people's lives and some clients may wish to include this aspect of their lives in treatment. As psychologists we appreciate this fact. A growing body of empirically based treatment protocols have been developed that integrate spirituality, religion and psychology. Rosmarin (2018) details a four-step process to assess if spirituality and religion is related to a client's symptoms treatment goals and if indicated and desired by clients how it can be integrated into a cognitive-behavioral approach to treatment. While not empirically validated, the examen prayer and journaling is an example of how a spirituality/religious intervention can be incorporated in order to assist the clients in managing their symptoms and reaching their treatment goals.

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Classifieds

Everything-Sensitive Psychological Practice

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Brother Bernard Seif

Who of us has not felt the sting or wounding of microaggressions or, for that matter, macroaggressions? They come in the form of verbal and/or behavioral slights rooted in stereotypes, pre-judgments, and blind spots about religion, race, sex, ethnicity, and just about any aspect of the human person. Little by little they wear us down until we sometimes either personally or communally explode--or just give up. Although my personal philosophy is that spirituality and religion are ways to relate to a loving, though often enigmatic Being called by many names, they can also provide ways to cope with the erosion of the human psyche and spirit in response to the above.

The work of pioneers in the field of the psychology of religion, along with my own research (Seif, 1981b; 1981a), demonstrates a link between internalized/intrinsic religious values and freedom from prejudice, along a continuum to externalized/extrinsic religious values which are associated with higher levels of prejudice, lower levels of moral development, less transcendent experiences, and less ability for a client or patient to perceive the core therapeutic qualities of the psychologist who may be extrinsically religiously oriented. Here is how I stated it in APAs *The Humanistic Psychologist* (Seif, 2018):

I broadly categorize religious expression into healthy and unhealthy domains herein. The former springs from a positive motivation to choose a faith-based way of being in the world that is relatively free of ego, and with social status being of little importance as it relates to faith and roles that flow from it (Seif, 1981a). This expression of faith yields good fruit, not a guarantee for a life of bliss of course, but perhaps one of relative inner peace and ultimately making individuals and our world a bit better in the process. The latter or unhealthy expression of religion springs from early catechism or Hebrew school notions that have not been deeply reflected upon or revisited as an adult, or simply from distorted views of religious teachings, and can manifest in prejudice of various kinds, and ultimately disillusionment for ourselves and others (Seif, 1981b).

Some of this material is presented in a much too brief TEDx talk on the topic given by me at Lehigh University in 2016.

Division 36 of the American Psychological Association, Society for the Psychology of Religion and Spirituality, has had several name changes over the years, most recently choosing the above name. Many people today view "religion" as the more legalistic or institutional expression of church, synagogue, or mosque. Alternatively, "spirituality" can be viewed as the value system or the soul, if you will, of organized religion. What appears to be a small matter of a name change reflects sensitivity on the part of Division 36 leadership and may help to prevent religious microaggressions. Thus, it follows, that we can experience micro-*healings* and macro-*healings* as well.

Some years ago, I was invited to contribute an article to a special edition of the *New Jersey Psychologist* dedicated to psychology and religion. My topic dealt with spiritually-sensitive psychotherapy (Seif, 2010). Taking that concept to the next level, let us consider the wisdom of developing a mindset wherein *everything* is dealt with in a sensitive manner. Taken to an extreme, this can foster neuroticism, but when this attitude is utilized as a way of helping free us of the blind spots all humans have (Banaji & Greenwald 2013), it can be life giving for all. It can also help us to embrace our imperfection and still love ourselves and others. Thus, the name and concept for this brief article has become "*everything*-sensitive psychological practice."

Recommendations for fostering that attitude include mentoring, supervision, spiritual direction, personal psychotherapy, or any process that helps us to hold ourselves accountable and facilitates the removal of our human blind spots and to help us *internalize* our spiritual or philosophical values. Additionally, working with the "Six Steps to Speak Up!" created by the PPA Multicultural Committee is invaluable. This two-sided hand out is available from the committee and I will list those six steps next. The actual hand out has a paragraph or so operationalizing each step.

1. Be Ready
2. Identify the Behavior
3. Appeal to Principles
4. Set Limits
5. Find an Ally/Be an Ally
6. Be Vigilant

The co-founder of my Catholic Christian monastic lineage, St. Francis de Sales (along with St. Jane de Chantal) counsels us that: "Nothing is so strong as gentleness, and nothing is so gentle as real strength." I can't help but add that he also gave us a quote which is sometimes more associated with Mary Poppins than Francis de Sales: "You can catch more flies with a spoonful of honey than a barrel full of vinegar."

Someone I know summed up the psychology of healthy religion this way: "It fills me with joy to know that I love a

God who, especially in these days of church scandals, is broader, deeper, and beyond any institution."

In conclusion, the deceptively simple wisdom found in the above quotes is drawn from the *same* wise Source, in my opinion, be some version of it spoken by Martin Luther King, St. Francis de Sales, Jesus, Mohammed, or the God of Sarah and Abraham. May we all continue to use our psychological skills to access and share this wisdom as we continue striving to heal.

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Wounded Blessing

John Bixler, Ph.D. 2019

Creator of all,
    Take not this wound away from me I pray,
    Not until I find within it Your Blessing.

Healing Divine,
    Let me find your blessing
    I the deepest places of this wound
    In the places where the division is greatest
    And the rending most severe.

God of the Deep,
    Take me down into my wound
    This wound of my own creation,
    This wound of your gift,

Unwrap me from the ways
    I deceived myself and others
    And caused this wound,
Unwrap:
    My blinded eyes
    My bound feet
    My stilled heart...
Place me in the presence of this pain
    The center of this horror...
That I may know that which I have done,
    And how I listened not to your True Pure Voice.

Let me silence my own chattering mind,
    And hear again that Still Small Voice
    Which I have drowned in a sea of daily commotion
    and noise.

Call the wind and the waves which I have created
    To be quiet,
That I may know
    In deep quiet waters,
    In deep dark blood,
The meanings of the wounds I have caused.

Bless me here I pray thee,
    That I may no more need to return.
Teach me in this wounded space
    The message I have neglected to live...
Except thus: To wound others and myself...
That I may never more again,
Injure in this way.
Creator of all,
    Take not this wound away,
    Not until you have blessed me in it...
And then, only then,
    Bring harmony to the divided,
    Bring flowing waters to the dammed

For against Thee only have I sinned
    And I would to sin no more...
So take me not way from this pain,
    Until Thy Blessing I receive.
Bless me that I may be whole.

A Time and Place for Forgiveness

Jeanne M. Slattery, PhD

Jeanne M. Slattery

Christianity, Buddhism, Judaism, and Hinduism have valued forgiveness and have given its practice an important place in their traditions. They should, as forgiveness of self and others is associated with many positive outcomes. People who report more forgiveness also report less stress, anxiety, anger, and depression and report fewer symptoms of posttraumatic stress (Cerci & Colucci, 2018; Smallen, 2019). At least in some research, people who forgive more also reported increased self-esteem.

Although forgiveness can be a good thing, feeling pressured to forgive a transgression can create rather than resolve problems; instead, some people report that refusing to forgive is empowering.

> I found it empowered me to draw the line, *my* line of what I deem forgivable, to protect myself. I don't owe anyone forgiveness and I won't be shamed if I don't forgive. Instead of telling someone they should forgive, tell the perpetrator not to do unforgivable things. (King, 2019, para. 8)

Why might forgiveness be a positive, growth-promoting process for some people *and* a shame-promoting process for others? My colleagues and I frame this difference in outcomes in terms of a person's meaning-making process (Park, Currier, Harris, & Slattery, 2017). When a person is traumatized in some way – rape, war, emotional abuse, assault, natural disaster – their sense of meaning and meaningfulness in the world can be damaged and the stories they tell about themselves can become more negative: "People aren't trustworthy," "The world is unsafe," "I am bad and shameful." (We say can, because different people draw different senses of meaning in the same situation.)

McAdams, Reynolds, Lewis, Patton, and Bowman (2001) have observed that such stories – where life is ruined, contaminated, or undermined by trauma (Contamination stories) – are maladaptive and associated with depression, lower life satisfaction and meaningfulness, and poorer self-esteem. Forgiveness and self-forgiveness can change the story a person tells: "He didn't mean to hurt me," "Not everyone is bad," "I am not shameful, but forgivable." People with Commitment stories such as these, stories where trauma is transformed and people redeemed, have more positive outcomes in terms of mood, satisfaction with life, meaningfulness, and self-esteem. Forgiveness can change the stories trauma survivors tell.

Forgiveness can be a positive and life-affirming act when it is *chosen*, but when someone feels *pushed* into forgiving, an additional trauma is added to the initial one: for example, emotional abuse and feeling pressured to prematurely forgive can be piled on top of child abuse. As King (2019) complained:

> When women express that they're upset or angry (and justifiably so), as a result of being hurt, people dismiss them as "bitter" and the validity of their feelings and experiences are questioned. (para. 3)

Rather than transforming a survivor's story from a Contamination story to a Commitment story, forced forgiveness reinforces the damaging story: "My feelings don't matter, my perceptions were wrong, and I am shameful." Rather than forgiveness healing the person transgressed against (e.g., helping them change their stories about themselves, letting go of unnecessary anger), it instead seems to be used to reduce the discomfort of the perpetrator or the perpetrator's friends and family – at the victim's expense.

These problems in how forgiveness is used come from a cultural misunderstanding of the process of forgiveness. Forgiveness should be given if and when the survivor is ready, not when the rest of us want it. Forgiveness does not wipe the slate clean. It is not the same as pardoning, condoning, excusing, or forgetting a transgression. Although it may bring about reconciliation between the survivor and the transgressor, reconciliation is not a necessary consequence. If forgiveness were any of these things, hurrying to forgive would make sense. Unfortunately, family, friends, and the greater community need to be patient and acknowledge that the time for forgiveness may never come.

Although it may be useful to forgive oneself and let go of anger, as King observed, sometimes it can be more important to draw a line; doing so can create a more positive sense of meaning, so that a person concludes, "My perceptions, needs, and feelings matter." In fact, for survivors of child abuse, forgiving oneself seems more related to decreased symptoms of PTSD than is forgiving the perpetrator (Cerci & Colucci, 2018).

There is a lot that we still do not know or understand about forgiveness, as much of the research performed has been problematic. It has been cross-sectional, not allowing for causal inferences, and with university populations who are young, educated, and more privileged than typical (Cerci & Colucci, 2018). We may not be able to generalize our findings to other populations. Still, considering forgiveness using a meaning-making model may help survivors, their families, and their psychologists make fewer mistakes in considering forgiveness, especially forgiveness before its time.

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"If I am not for myself, who will be for me? But if I am only for myself who am I? If not now, when?" -Ethics of Our Fathers

Richard E. Hall, Ph.D.


Richard E. Hall

I love this quote as I see it as our call to action, volunteerism and advocacy that so much defines our great profession and our association. I am very excited to be assuming the role of PPA School Psychology Chairperson. My predecessors in this role have done an outstanding job and I hope to continue their efforts and to work hard to keep our association at the forefront of professional advocacy by keeping us "at the table" as advocates for effective, research supported and expanded mental health services and sound, effective research supported educational policies in Pennsylvania.

My background in education and human services began as an undergraduate student at California State College (now California University of Pennsylvania) where I started as a Secondary Education major and an active volunteer at the campus mental health facility and the Suicide Action Hotline. In this capacity, I was fortunate to work with and be trained by a great and inspiring team of psychologists. It was the kind of work I wanted more of; good work that helped others through some challenging times. This experience led eventually to my graduate work in Special Education where I eventually received a M.Ed. in The Teaching of Children with Serious Emotional Disturbance (SED). My first employment after graduation was a truly life transforming experience. I worked as a "Prescriptive Teacher, Counselor and Liaison Worker" at the Pressley Ridge Residential Treatment Center in Pittsburgh, PA. It was difficult, often frustrating work requiring creativity, compassion, tenaciousness and openness to new learning. I found my calling, as they say. My time at Pressley Ridge has had a profound effect on me both professionally by giving me the opportunity to develop valuable skills in working with troubled children and youth and personally as I was fortunate to meet and marry a lovely coworker there, Margie Gordon, who became my life partner and soul mate. We have three incredible children, Gordon, now a school psychologist, Lauren a nurse and Jules an office manager for a medical practice. We also now have two grandchildren Ellie and Ian the joys of our lives. For the next seven years, I continued to work in educational and therapeutic programs both private and public which provided educational, behavioral and therapeutic support services for children and adolescents with emotional/behavioral and learning challenges.

Eventually I decided that I wanted to pursue a career in psychology where I could focus more on the root causes of child and adolescent mental health difficulties, behavioral maladjustment and learning disorders. One of my goals was to have a more systemic impact in encouraging and facilitating positive educational environments that support wellness, learning and positive social adjustment. So, I choose to become a school psychologist. My graduate studies started at Millersville University where I had the great fortune to be guided by professors Dick Hess, Betty Finney and Kate Green. My graduate studies eventually led me to enroll in the doctoral program at Penn State University under the guidance of the great Dr. Joe French who was program chairperson at the time and instrumental in my development as a school psychologist.

My work in school psychology has been immensely rewarding. This field has given me so much with so many opportunities for professional and personal growth. The students and families I've had the great privilege to work with over the years have taught me much about the challenges that can be overcome with support, encouragement and professional guidance. I have truly loved the work I do in this field.

In 1995, through the encouragement, guidance and support of Helena Tuleya-Payne, I began my work on the faculty at Millersville University in the School Psychology Program. My work at Millersville University as Adjunct Professor has given me the opportunity to help prepare a new generation of school psychologists for the challenges of a dynamic, exciting and rewarding profession. Because the field has given me so much, I relish the opportunities I have had to give back to the field by volunteering and advocacy as a member on the Pennsylvania Psychological Association (PPA) School Psychology Board, the Association of School Psychologists of Pennsylvania (ASPP) Membership Chair, ASPP President and state delegate to the National Association of School Psychologists (NASP) and now as PPA School Psychology Chairperson.

As PPA School Psychology Chairperson I am privileged to work with an exceptionally talented and hard-working group of board members. My overall goal for my tenure as Chairperson is to promote activities and collaborations by our association that will expand opportunities for school psychologists and improve outcomes for the children, families, schools, and communities in Pennsylvania.

I have some specific, and I think ambitious, goals for my time as Chairperson and hope that together we can work to achieve the following:

- To continue to increase our association membership.
- To encourage membership involvement and volunteerism within the association.
- To strive to be open and responsive to membership feedback.
- To work to expand opportunities for school psychologists' advancement within their practice, school districts and employment settings.
- To advocate for improved mental health services at the state legislative level.
- To establish and maintain positive working relationships with the other professional organizations and associations who share our values and goals.
- To fight against policies, which restrict opportunities for school psychologists, and which lead to poor outcomes for the families, children and adolescents in Pennsylvania.
- As an association and a profession to build a more visible and active presence throughout Pennsylvania.
- To strengthen our association's role as a critical resource for information, support and advocacy for improved mental health services and educational policies.
- To identify resources in existing structures that will support advocacy by and for school psychologists in Pennsylvania.
- To identify systems-level and individual opportunities to research, promote, and demonstrate advocacy by and for school psychologists.

I would like to thank our association and membership for this great privilege of serving as the Chairperson of Board of School Psychology I wish you all a relaxing and productive year. Please feel free to contact me and I will try to be as responsive as possible.

Expanding Career Ladders for School Psychologists: Role of State Associations

Helena Tuleya-Payne, D.Ed.


Helena Tuleya-Payne

A recent article in the LNP, the daily newspaper for the Lancaster area, recounted a local school district's decision to create a new position, i.e., Assistant to the Superintendent for Pupil Services. The functions of this position include maintaining the student accounting system and overseeing psychological, guidance, school health and social casework services. I was delighted to read that the individual hired for this position had begun her career as a school psychologist. Her career trajectory is an example of mobility within the education services realm desired by some school psychologists. This article discusses the efforts of the PPA Board of School Psychology and Association of School Psychologists (ASPP) to expand career opportunities for school psychologists in Pennsylvania.

In 2011, a National Association of School Psychologists (NASP) Fact Sheet, Alternative Careers & Additional Training for School Psychologists, described careers for which the skills and talents of school psychologists serve as a foundation. These include university faculty member, behavior specialist and school administrator. School psychologists who seek administrative positions need additional certificates awarded by the Pennsylvania Department of Education (PDE). Chapter 49 of the PA Code, Certification of Professional Personnel, lists requirements for educator credentials such as the Administrative Certificate or the Letter of Eligibility for Superintendents. School psychologists are eligible for both credentials following the appropriate graduate coursework and field experiences.

One example about possible careers cited in the NASP fact sheet was the position of Special Education Supervisor/Director. In Pennsylvania, school psychologists who are seeking this position must earn a Supervisory certificate obtained through additional course work and field experience as stipulated in Chapter 49. They experience a roadblock, however, if they have not had five years of experience as an instructor in an instructional area. Equivalent experience as a school psychologist does not meet the requirement despite the extensive knowledge base and skills school psychologists possess concerning serving students with disabilities who need special education.

Over the last three decades, Dr. Sam Knapp, myself and other PPA members have met with PDE representatives to argue for allowing experience as a school psychologist to satisfy the criterion for the Supervisory certificate. Each time we met with resistance, hearing statements such as "if we allow school psychologists to use professional experience, school counselors and other non-instructional educators will demand it as well."

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EXPANDING CAREER LADDERS FOR SCHOOL PSYCHOLOGISTS: ROLE OF STATE ASSOCIATIONS

Continued from page 15

Currently, Chapter 49 is again up for renewal. Last summer, Dr. Jason Pedersen (ASPP) and I attended a meeting sponsored by PDE to obtain feedback from stakeholders about potential changes to Chapter 49. A PDE official suggested that we develop a crosswalk demonstrating significant overlap in core competencies for teachers in special education and competencies of school psychologists relevant to special education.

Recognizing that it is more effective to speak with one voice when advocating for change, members of the school board and ASPP have worked together as follows:

1. Participating in preliminary hearings concerning revisions to Chapter 49
2. Participating as members of work groups organized by the PDE in revising the framework for training of school psychologists
3. Meeting with officials from PDE to identify strategies for making changes to the regulations
4. Developing a crosswalk document as described above.

The latest step in the process occurred in June 14 when Dr. Tammy Hughes, armed with the crosswalk and narrative summary prepared by Drs. Susan Edgar-Smith and Shirley Woika, provided testimony to the State Board of Education in Pittsburgh, PA concerning the appropriateness of school psychology experience towards satisfying Special Education Supervisory certificate criteria.

The above is an illustration of how state associations working together can more powerfully advocate for systemic changes that benefit career options for school psychologists. It is important to keep in mind, however, that advocating for changes in education policy must primarily illustrate benefits for students and not any particular group such as school psychologists. It is the firm belief of both state associations that children will benefit from increasing the pool of qualified educators who can serve as Supervisors of Special Education and that school psychologists are ideal to fill those positions. We now wait to see if state officials agree.

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Social Functioning in Adolescent Girls with ASD: Issues and Interventions

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Autism spectrum disorder (ASD) is a neurodevelopmental disorder characterized by difficulties in social interaction and communication and repetitive behavior across home, school, and community settings (American Psychiatric Association, 2013). Current CDC prevalence data indicate that 1 in 59 children in the United States have been identified with ASD (Baio et al., 2018). ASD occurs across all racial, ethnic, socioeconomic, and cultural groups, but is diagnosed approximately four times as often in boys as in girls. Recent research examining gender differences in symptom presentation suggests that this underestimates the true number of girls with ASD. Several hypotheses, ranging from sex-linked genetic factors to the use of diagnostic tools normed with already-diagnosed and predominantly male samples, have been posed as potential explanations for this disparity. An alternate hypothesis focuses on gender differences in both baseline levels of social skill and ability to compensate for social deficits.

Camouflaging behavior. Socialization patterns and communication styles vary by gender for both neurotypical and autistic children. Both neurotypical and autistic girls tend to exhibit stronger social skills, and to develop these skills at earlier ages, than their male counterparts (Jamison et al., 2017). Specifically, both groups of girls appear to self-monitor, self-censor, imitate gender-normative behavior, initiate friendships, maintain reciprocal conversation, and integrate verbal and non-verbal behavior more often than boys (Hiller, Young, & Weber, 2014; Lai et al., 2017). However, when compared to neurotypical same-sex peers, girls with ASD exhibit greater social difficulties. Although often less pronounced than those observed in boys with ASD, they nonetheless may create social stress for girls.

Researchers have also reported difficulty in reliably identifying girls with ASD due to their use of compensatory strategies to camouflage symptoms (e.g., Dean, Harwood, & Kasari, 2017; Lai et al., 2017). Parents of girls with ASD consistently report that camouflaging delayed or complicated ASD diagnosis in their daughters (Cridland, Jones, Caputi, & Magee, 2014). Although boys with ASD also camouflage, girls appear to do so to a greater extent during social interactions, masking difficulties through learned social and communicative behaviors, such as imitation (Lai et al., 2017).

Similar to neurotypical children, children with ASD tend to segregate by sex during periods of play at school, with boys more likely to play organized games and girls more likely to socialize

in groups (Dean et al., 2017). Girls with ASD play alone less frequently than boys. Rather, they often play on the periphery of girl groups, and so may appear more involved in those groups to the casual observer than they actually are. In a playground observation of children with and without ASD, girls with ASD were observed switching between engagement with peers and solitary play, generally remaining in close proximity to peers throughout the observation period. In contrast, boys with ASD were more often physically separated from other boys during play periods. It is important to note that, while girls with ASD may not face overt rejection by peers in group play, they are nonetheless often overlooked by peers in social contexts (Dean et al., 2017).

Finally, boys and girls with ASD also differ in demonstration of repetitive behavior and restricted interests in ways that may make it more difficult to identify girls with ASD (Duvekot et al., 2017; Jamison et al., 2017). Boys with ASD are more likely to behave in ways and/or to demonstrate interests considered to be unusual for typically-developing children, while girls with ASD tend to have interests that are relatively similar to those of neurotypical girls (e.g., dolls, stickers, animals) and to demonstrate stereotyped use of objects less frequently than boys.

As described above, ASD symptomatology in girls generally tends to take forms that are more subtle and/or appear more consistent with gendered behavioral expectations. These less obvious difficulties may go unnoticed by parents and teachers; even when they are noticed, they may be misperceived as independence, shyness, or anxiety (Jamison, Bishop, Huerta, & Halladay, 2017) As a result, these girls are less likely than boys with ASD to receive a diagnosis and/or ASD-specific interventions.

Difficulties in adolescence. Although girls with ASD present with less severe social difficulties during childhood, these difficulties may increase as time progresses. Neurotypical adolescent girls' social communication styles tend to be characterized by reciprocity and increased sharing of emotional content, making the social difficulties exhibited by girls with ASD more evident. Girls with ASD are also likely to have greater difficulty managing conflict and understanding and navigating the various relational problems common among adolescents, such as relational aggression (Cridland et al., 2014). These difficulties may place girls at risk for peer exclusion, particularly if they are perceived as purposefully, rather than inadvertently, violating social norms (Dean et al., 2017). Additionally, camouflaging of symptoms is an energy-consuming process that may lead to fatigue, irritability, and emotional or behavioral outbursts, all of which may hinder peer relationships (Duvekot et al., 2017). In undiagnosed adolescent girls, these mood or anxiety symptoms may continue to overshadow symptoms of ASD and serve as the focus of intervention; they may also be related to the peak in psychiatric comorbidities observed in girls with ASD during adolescence (Jamison et al., 2017).

Social skills curricula for adolescent girls with ASD. Increased social demands and expectations may lead to exclusion or isolation for girls with ASD as their social impairments become more apparent in comparison to typically-developing girls (Jamison et al., 2017). Therefore, interventions for adolescent girls should target development of these relational skills, as well as greater emotion recognition ability. One social skills intervention program that addresses some of these issues is the UCLA PEERS Program (Laugeson, 2014), which addresses friend choice, conversation skills, use of humor, and bullying, among other topics. Studies of PEERS' effectiveness with adolescents with ASD suggest that the intervention is associated with gains in social awareness, communication, motivation, and cognition, as well as decreased problem behaviors, externalizing behaviors, and ASD symptoms related to social responsiveness. However, the program's broad focus on basic verbal and behavioral skill development may not be sufficient for girls with ASD who need more specialized intervention targeting the complex and unspoken rules of socialization in adolescence (Dean et al., 2017).

To address this need, the "Girls Night Out" program, which focuses on conversation skills necessary for initiating and maintaining relationships, identification of shared interests, and self-care, was developed specifically for adolescent girls with ASD (Jamison & Schuttler, 2017). Participants are provided with specific skill instruction, visual supports, and, most critically, opportunities for practice and feedback on skill implementation in authentic settings. Preliminary outcome data suggest that girls who participated in this program perceived improvements in their quality of life and overall social competence, and decreases in internalizing symptoms, at the program's conclusion (Jamison & Schuttler, 2017).

As girls with ASD face the increasingly complex social demands of adolescence, understanding and carefully assessing the social difficulties they are likely to experience is critical. The use of social skills intervention programs such as PEERS and Girls Night Out, alone or in conjunction with other interventions to address the emotional and behavioral symptoms of ASD, may equip girls with ASD to better navigate the demands of their social environments in both adolescence and adulthood.

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Continued on page 18

PsyPACT Legislation (Senate Bill 67) Passes Senate Consumer Protection & Professional Licensure Committee

Rachael L. Baturin, MPH, JD, Director of Governmental, Legal & Regulatory Affairs

Senate Bill 67 introduced by Senator Judy Ward would permit Pennsylvania to adopt the Psychology Interjurisdictional Compact (PSYPACT) to increase public access to psychological services by allowing for tele-psychological practice across state lines as well as temporary in-person services.

In June, Senator Ward's legislation passed out of the Senate Consumer Protection & Professional Licensure Committee with a unanimous vote and is currently up for Second Consideration by the full Senate. Thank you to the PPA members that contacted their State Senators as it made a difference and got this legislation out of Committee.

When the General Assembly returns in the fall PPA will once again be advocating for this important piece of legislation. PPA is expecting it to pass out of the Senate quickly and then head over to the House for consideration.

It will be important for PPA members to contact their PA House Representatives once the bill moves over to that chamber and urge them to support this bill.

If you have any questions about this legislation or would like more information on how you can help PPA advocate for this legislation, please feel free to contact Rachael Baturin at rachael@papsy.org.

SOCIAL FUNCTIONING IN ADOLESCENT GIRLS WITH ASD: ISSUES AND INTERVENTIONS

Continued from page 17

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PPA2019 Review

Pittsburgh was host to PPA2019 – the first time PPA has been in Pittsburgh in over 15 years – and the city provided the perfect backdrop for our annual Convention!

The theme for PPA2019, "You are a Wonder", celebrated psychologists as heroes to each other, and to those you serve. "Heroes" use wisdom, courage, justice, and compassion to help others. PPA 2018-2019 president, Dr. Nicole Quinlan's hope with this theme was to promote mutual respect, support, openness, and a commitment to justice and equity regardless of differing views.

Dr. Kevin Nadal, this year's Keynote speaker, reinforced this theme with his presentation on "Becoming a Psychologist-Activist in the 21st Century." Dr. Nadal's background is working with the LGBTQ population, but he focused on how psychologists can face ethical dilemmas involving social justice and psychology.

With over 50 workshops, attendees had plenty of CE options to choose from, and great things to say about the sessions they attended!

- Presentations were high quality
- Workshops were informative & well presented
- The workshops were stimulating and interesting.
- There were a lot of opportunities to connect with folks that I really only see at conventions, and the quality of the seminars was excellent.
- The session on school psych-private evaluations. The discussions that occurred during the sessions.
- This was my first PPA conference and I really liked the diversity in workshops offered
- Strong, knowledgeable presenters. Topics of presentation were worthwhile. Excellent, engaging keynote speaker.
- I love the seminar offerings- diverse, well presented. I am impressed with the level of expertise within our ranks.
- Good topics, presenters, and location
- The presenters had a depth of experience they drew upon when they spoke. The Tree of Life presentation was outstanding. I was very proud of PPA.
- Workshops were very good. Well organized -vendors - food -
- Excellent workshops, nice setting
- Quality of the workshops, efficiently run, breakfast and snacks provided, ability to get ethics, child abuse, and suicide CE's in one day
- Workshops were very good quality.
- Loved the advanced ethics workshop

We were honored to recognize donors to both PennPsyPAC and the Pennsylvania Psychological Foundation at the Gratitude Luncheon on Wednesday afternoon. The support of our donors is important to the success of these organizations and our charitable giving and advocacy efforts. Thank you to everyone who donated in 2018-2019!

We were pleased to honor Drs. Beatrice Salter and Linda Knauss and PA Representative Michael Schlossberg at our Annual PPA Banquet & Awards Dinner on Thursday evening. PPA is proud to include this event each year to honor the accomplishments of our members as well as, this year, highlighting our amazing Student Foundation Award Winners. Congratulations to all of this year's awardees!

Friday marked PPA's Town Hall where we celebrated our PPA committee award winners, Dr. Shari Kim and Dr. Peter Langman, and saw the passing of the gavel from Dr. Nicole Quinlan to Dr. Marie McGrath. As one of her last duties as president, Dr. Quinlan gave out two presidential citations to Jewish Family Community Services and to Pittsburgh First Responders – both for their involvement in healing the community in the aftermath of the shooting that occurred at the Tree of Life Synagogue in October of 2018. This somber event was a highlight for some, the "Tree of Life presentation was outstanding. I was very proud of PPA."

Thank you to all the presenters, exhibitors, photographers, and committee members who were responsible for making this event such a success! A lot of work and planning happens behind the scenes, and members of PPA's Professional Development Committee and Proposal Selection Committee deserve acknowledgement for their hard work and involvement in this process.

Lastly, we want to thank everyone who attended PPA2019. Your energetic participation made this year's convention a rousing success. We look forward to bringing this energy and excitement as we move into 2020. We look forward to seeing you in Lancaster on June 17-20, 2020 for next year's Convention – PPA2020, and 2019-2020 president, Dr. Marie McGrath's theme for 2020: Lead by Example.

Thank you to everyone who completed the post-convention survey! We review all of your comments, good and bad, and use these as we work to plan future Conventions to make them even better than the year before! Below are a sample of "favorite moments" from respondents.

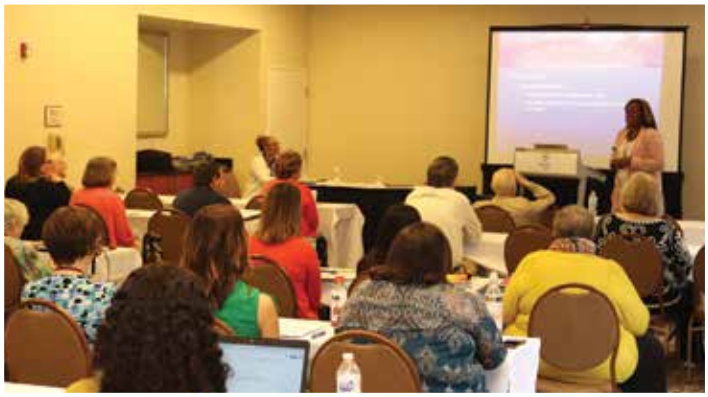
- Meeting colleagues I have not seen for a year
- Meeting some folks from the membership committee that I could enjoy! We all work hard to grow the membership.
- The conferences on human trafficking
- Recognizing the Jewish and first responder communities. The presentations were very impressiveand meaningful.
- A lunch with three other old guys I just met.
- The program on the heart of the soldier
- The keynote speaker and luncheon speaker were both AMAZING.
- The ethics workshops, the opportunity to network with others and see colleagues.
- Dr Quinlan was magnificent presenting the awards

PPA2019 Review

PPA Presidents - Back row (left to right): David Zehrung, PhD; Richard Small, PhD; David Rogers, PhD; Nicole Quinlan, PhD; Steven Cohen, PhD; David Palmiter, PhD; Donald McAleer, PsyD
Front row (left to right): Beatrice R. Salter. PhD; Mary Anne Murphy, PhD, MBA; Judith Blau, PhD; Linda Knauss, PhD; Dianne Salter, PhD, JD

Dr. Roger Brooke presenting at the Psychology in Pennsylvania Luncheon.

Distinguished Contributions to the Science & Profession of Psychology Award Winner Linda K. Knauss, PhD (center right) with Ann Marie Frakes, Nicole Quinlan, PhD and Jeffrey Knauss, PhD



Dr. Jade Logan and Dr. Cheryll Rothery presenting on Therapy, Teaching, & Supervision in the Current Era.

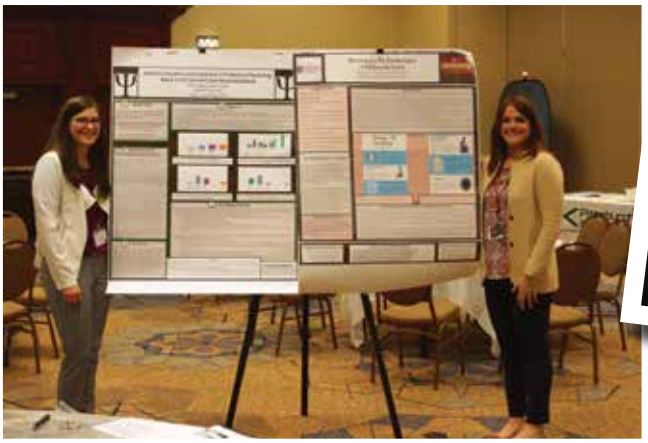
President Nicole Quinlan, PhD passing the "gavel" to President-Elect Marie McGrath, PhD.

Distinguished Service Award winner Beatrice R. Salter, PhD (center left) with Rachael Baturin, Nicole Quinlan, PhD and Ann Marie Frakes.

Student Foundation Award Winners - Back row (left to right): Nina Ventresco, MEd; Nina Collins, MSW; Whitney Quinlan, MS; Anna Salomaa, MS, PPA President Nicole Quinlan, PhD. Front row (left to right): Chenchen Dai, BS; Amelia Herbst, MS; Autumn Marie Chilcote, MA.

Dr. Brett Schur presenting to a full room on Ways to Improve the Treatment of Suicidal Patients.

Public Service Award Winner Representative Michael Schlossberg (center right) with Rachael Baturin, Madeleine Langman, PhD, and Nicole Quinlan, PhD.



Two of PPA's Emerging Leaders, Maggie King, PsyD (left) and Lauren Finnegan, PsyD (right) presenting their projects at PPA's poster session.

THANK YOU TO THE FOLLOWING ORGANIZATIONS FOR THEIR SUPPORT OF PPA2019!

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Gateway Rehab
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National Register
Pearson
Pennsylvania Department of Corrections
Pittsburgh Ketamine
Psychological Interjurisdictional Compact (PSYPACT)
White Deer Run Treatment Center

That Would Be Unwise

Jeanne M. Slattery, PhD and Linda K. Knauss, PhD

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the two of us, the respondents to this vignette included Drs. Claudia Haferkamp, Melissa Hunt, Jeff Pincus, and Max Shmidheiser. Rather than immediately reading our responses, consider reviewing and carefully working through the vignette first.

> Dr. Too Close lives in a very small town. He has been looking for a new home and believes he found the "perfect one," meeting his family's needs (for example, travel to work, a good school system, an accessible dog park), as well as the privacy he appreciates. His whole family is very excited.
>
> Dr. Too Close has been seeing DaJanaé for most of the last year around feelings of loneliness, depression, social anxiety, and self-injury. She has fairly porous boundaries, which often causes problems in her relationships. DaJanaé has been describing her excitement about the house next door selling, hoping that her new neighbors have children her children's age, and wanting to share social experiences and spend time around the pool.
>
> Dr. Too Close has been coaching her on how to better handle this situation, but then uncomfortably realized that he would be the new neighbor. He would like your advice on how to handle this situation if he and his family decide to purchase this home.

Identify the Options

We often start by identifying the options for responding to this dilemma. These include, at least, going ahead with the purchase as one would normally do, going ahead with the purchase while paying attention to ethical options that would safeguard this situation, and not making this purchase.

Multiple Relationships

Dr. Knauss pointed out that not all multiple relationships are unethical. The Ethics Code (APA, 2017) states, "multiple relationships that would not *reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Standard 3.05, p. 6, italics added).*

Some of us described "small community" interactions that could be worked out without problems (for instance, your child and your client's child both end up on the same soccer team). Nonetheless, sometimes relatively innocuous interactions can make clients (or their psychologists) uncomfortable. For example, Dr. Hunt recounted being observed shopping at a grocery store where her client worked. Her client expressed her discomfort, and Dr. Hunt began shopping at a different store.

Could we reasonably expect to live next door to a client, with "porous boundaries," and not expect problems? How would normal interactions among the two families, including the anticipated exchanges among children and at the pool, impact the course of treatment (Knapp, VandeCreek, & Fingerhut, 2017)? What about normal neighborly observations and disagreements? Although some of these impacts could have positive consequences, which

DaJanaé might argue, as a group we felt strongly that harm would be likely under these circumstances and that Dr. Too Close should not purchase this house. We found it unlikely that there would be only one dream home in his community.

Unethical or Unwise?

Nonetheless, Dr. Pincus pointed out that not everything that is unwise is unethical. It might be possible to discuss this scenario with peer consultants and DaJanaé to develop a plan for how to ethically continue treatment with DaJanaé as neighbors. Perhaps such a plan would have Dr. Too Close and DaJanaé develop an informed consent for this situation and outline what sorts of things they would agree to over the coming years. Or Dr. Too Close could refer DaJanaé to another therapist.

However, there are so many ways this could go wrong. The Dalai Lama (2009) observed that "morality is a frame of mind in which we refrain from placing ourselves in any situation that could be harmful to others" (p. 195). Dr. Shmidheiser framed this precept somewhat differently, "What would a reasonable professional expect in terms of likely outcomes?" Assuming that Dr. Too Close remains the therapist and also maintains Dajanae's confidentiality (which would not necessarily be the case), could Dr. Too Close and DaJanaé reasonably expect their partners and children would abide by their agreed-upon rules? And how would their families understand the rationale for such rules? Despite all of their attempts to create an ethical, honorable, and respectful response, the risk of problems seems too high. While buying this house could be done ethically, doing so is risky enough that all of us agreed it would be unwise.

Client Choice or Paternalism?

We considered how Dr. Too Close might talk with his family about being unable to purchase the home. He could ask for DaJanae's consent to tell his family that the house is next door to one of his clients. Or he could discuss this process with DaJanaé and ask for her suggestions and feedback. On the one hand, this could foster her autonomy and, thus, be in her best interest.

On the other hand, as Dr. Shmidheiser argued, we may be giving a client a burdensome choice, one where some clients may feel pressured to respond as they imagine their psychologist preferring. Could they freely admit to discomfort about having their psychologist move next door? Some clients could, as Dr. Hunt's story indicated, but others might not. It might be difficult for some of us to admit to our discomfort. Would we attempt to protect her from such a fraught decision? As a group, we were suspicious of and adverse to anything that smacks of paternalism: "I know best," "I don't think you can handle this situation."

Clients come to therapy because we can often see the larger picture, identify other options and strategies for responding, and recognize otherwise unanticipated consequences. Our greater experience with similar situations helps us recognize that this situation is risky and unwise, regardless of our best intentions entering this situation. Who among us has never had a bad neighbor? Can Dr. Too Close reasonably expect to maintain the desired level of objectivity to perform therapy well? As Dr. Knauss observed, "being ethical doesn't mean knowing all the answers in advance. Psychologists make their best possible effort to be ethical, despite not knowing all the things that need to be handled."

Psychologists' Rights

In discussions of ethics, we often focus on the client's rights, but psychologists also have rights. They have the right to privacy. Dr. Haferkamp discussed the potential intrusiveness of having a client neighbor, which might lead to a variety of boundary crossings including requests to borrow sugar, shoveled sidewalks (or irritation about unshoveled sidewalks), and interactions at block parties.

It's not just that psychologists have the right to privacy, but they have the right to live an unfiltered life with family, rather than always having to wear their psychologist hats. More accurately, perhaps we need to be able to take off our psychologist hats in order to maintain our psychological competence and the health of our relationships. Dr. Knauss asked to what extent our practice should dictate our personal life (our choice of gym, restaurants, and church). Although we need to maintain our clients' confidentiality, we also, to the degree possible, need to be transparent with our families. Lying about why our "dream house" is no longer desirable would likely undermine our relationships; nonetheless, many of us have developed some sort of code that helps our partners and family understand the confusing aspects of our profession (when we fail to introduce someone who talks to us, this may represent some professional boundary).

Finally, if the discovery were only made after Dr. Too Close's family moved in or purchased the home, we agreed without question that he should discuss this problem with DaJanaé and refer her to another therapist.

Conclusions

It would be easy for Dr. Too Close to hope that he could handle both being DaJanaé›s therapist and neighbor, but such a conclusion seems to ignore the likely risk associated with such a decision and an overestimate of his ability to prevent probable problems (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). Problems can develop despite our best intentions. Sometimes the best response is to say No.

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Would you like to be involved in future discussions of vignettes? Let us know by e-mailing jslattery176@gmail.com

CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112

To purchase and complete the test online, visit our online store at papsy.org. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before September 30, 2021.

Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological servicess.

Legal Column

1. The Federal Drug Administration has approved cannabis-based medications for
   a. Nausea from chemotherapy for cancer and wasting disorders, secondary to AIDS
   b. PTSD
   c. Anxiety disorders
   d. All the above

2. Research suggests that medical marijuana may be clinically contraindicated for
   a. Pregnant or breast-feeding women
   b. Patients taking opiods
   c. Patients over 50
   d. All the above

Plante

3. Which religiously based spiritual practice is similar to mindfulness?
   a. Yoga
   b. Centering Prayer
   c. Reconciliation and forgiveness
   d. Spiritual direction

4. The ethics code includes religion in their list of respectful and informed multicultural issues such as gender, ethnicity, and race.
   True
   False

Barbera

5. Orientation, functional assessment, collaboration, and monitoring are the four steps of the cognitive-behavioral process that Rosmarin (2018) recommends when incorporating spirituality and religion into clinical practice.
   True
   False

6. It may be helpful to inquire about a client's spirituality and religion as part of a routine assessment procedure.
   True
   False

Seif

7. Intrinsic religious values are associated with relatively less prejudice.
   True
   False

8. "Nothing is so strong as gentleness, and nothing is so gentle as real strength" is a quote from:
   a. Gandhi
   b. Martin Luther King
   c. St. Francis de Sales
   d. St. Jane de Chantal

Slattery

9. Forgiveness is always a growth promoting process.
   True
   False

10. Clinically conceptualizing forgiveness as a meaning making tool is not necessary if you are able to process forgiveness with the client as compassion.
    True
    False

Tuleya-Payne

11. Which Chapter of the PA Code is devoted to certification of professional personnel?
    a. 22
    b. 49
    c. 14
    d. 16

Scholl & McGrath

12. Which of the following statements are true?
    a. Neurotypical girls tend to develop stronger social skills at an earlier age than neurotypical boys
    b. Girls with ASD tend to develop stronger social skills at an earlier age than boys with ASD
    c. Girls with ASD tend to demonstrate more significant social difficulties in childhood than in adolescence
    d. A & B
    e. All of these statements are true
    f. None of these statements are true

13. Findings from playground observation studies suggest that girls with ASD tend to play in close proximity to same-sex peers more often than boys with ASD do.
    True
    False

Slattery & Knauss

14. Some decisions are:
    a. Unwise and unethical
    b. Unwise and ethical
    c. Wise and ethical
    d. All of the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, September 2019**

Please circle the letter corresponding to the correct answer for each question.

1.	a b c d	**5.**	T F	**9.**	T F	**13.**	T F
2.	a b c d	**6.**	T F	**10.**	T F	**14.**	a b c d
3.	a b c d	**7.**	T F	**11.**	a b c d		
4.	T F	**8.**	a b c d	**12.**	a b c d e f		

Satisfaction Rating

Overall, I found this issue of the Pennsylvania Psychologist:

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Please print clearly.

Name _____

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A check or money order for $20 for PPA members ($35 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

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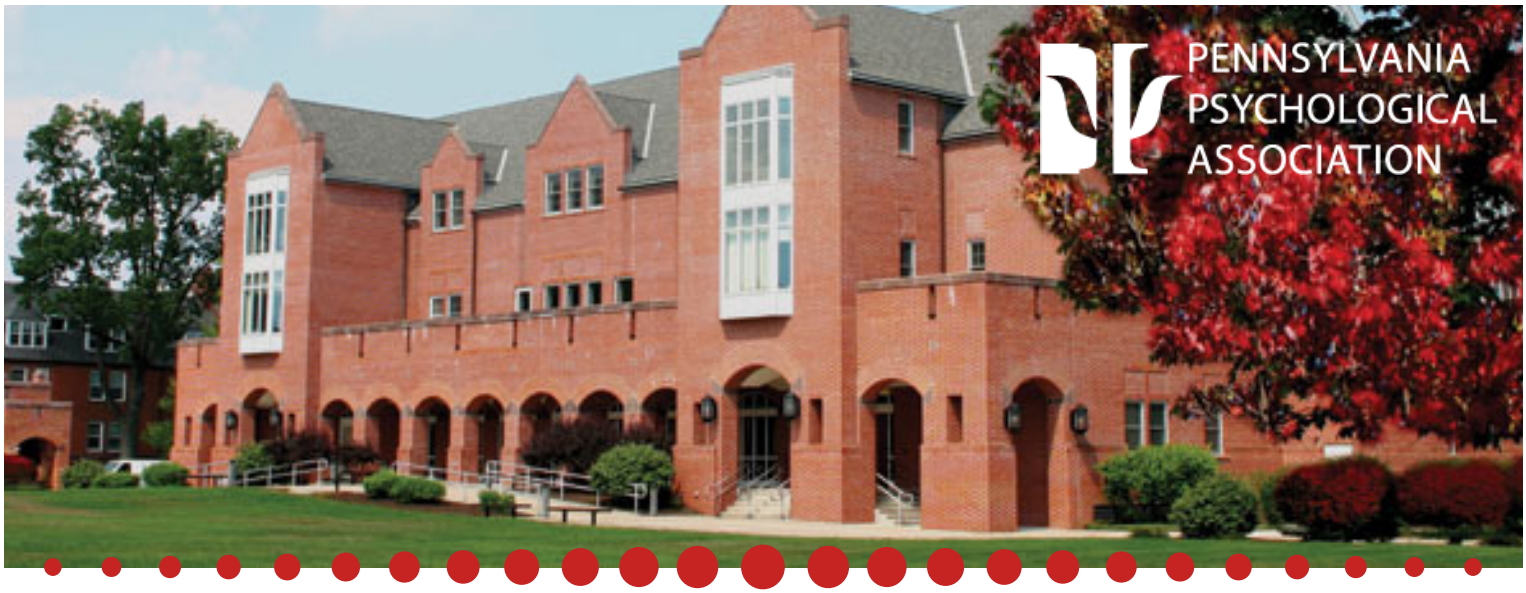

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What you need to know about license renewal

Psychologists in Pennsylvania must earn 30 CE credits per biennium. Biennia run from odd year to odd year. For example, December 1, 2017 – **November 30, 2019**

Credits for psychologists must come from:

- An APA approved provider/course
- An AMA approved provider/course
- A provider approved by the State Board of Psychology
- An accredited college or university with semester hours, related to the practice of psychology

Webinars: Live vs. Home Study

Live, interactive webinars happen in real time, when the speaker is able to interact with the attendees.

A webinar is considered *live* when "Instructors and participants can see, interact, and discuss information in real time" - If all three of these do not occur, then a webinar is considered to be a home study.

Pennsylvania Psychology License Renewal Checklist

30 credits required

- No more than 15 credits can be from distant learning workshops
- 3 Ethics - The word "ethics" must be part of the title, or the certificate must state that the credits apply for ethics credits
- 2 credits for Child Abuse Recognition and Reporting - Act 31
- 1 credit for Suicide Prevention

Call 717-232-3817 to request a PPA Home Study Catalog today!

For more information check out our Continuing Education Fact Sheet at *www.papsy.org*

Vol. 79, No. 8

The Pennsylvania Psychologist

September 2019 • QUARTERLY

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2019 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2019, we are expanding the options. We hope you'll join us for one or more of these programs!

Calendar

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

October 8, 2019
Bullying at School: What Parents and Educators Can Do About It
Milton Hershey School
Hershey, PA

November 7-8, 2019
Fall Continuing Education Conference
DoubleTree Valley Forge
King of Prussia, PA

April 3, 2020
Spring Continuing Education Conference
Hotel Monaco
Pittsburgh, PA

June 17-20, 2020
PPA2020 Annual Convention
Lancaster Marriott at Penn Square
Lancaster, PA

June 23-26, 2021
PPA2021 Annual Convention
Kalahari Resort & Convention Center
Pocono Manor, PA

Home Study CE Courses

Act 74 CE Programs

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE
Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs
Essential Competencies When Working with Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Ending the "Silent Shortage" in Pennsylvania through RxP (Webinar)—1 CE
Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each
*Introduction to Ethical Decision Making**—3 CEs
*Mental Health Consent and Confidentiality When Working with Children**—3 CEs
*The New Confidentiality 2018**—3 CEs

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

For a full listing of our home studies, download our catalog here, or visit our online store.

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

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