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The Aging Therapist

Rachel Ginzberg, Ira Orchin, Libby Shapiro, and Chera Finnis

"What happens if you die?" my patient asked at the beginning of his session. I took a deep breath and asked him to explore what he was thinking about. "I just wouldn't want to show up for my appointment without knowing something had happened." Thankfully, I was able to reassure him that I had a plan (albeit a sketchy one). My patient's question made me realize that I had some work to do – work beyond filling in the details of my incomplete plan: the difficult emotional work of facing my own inevitable deterioration and death. I was surprised that I did not have a better plan in place, and I wondered what may have been getting in the way.

I spoke with some colleagues who are wrestling with similar thoughts and were willing to join me in exploring the reality of aging – what it means for our continued practice of psychotherapy and for our responsibilities to our patients and ourselves. We hope that this article serves as a catalyst for exploring the psychological and practical challenges of preparing for the end of your practice and provides guidance for constructing a professional will.

The Elder Clinicians Club

The authors formed the Elder Clinicians Club, a support group that meets monthly via video conference to discuss concerns that arise at the intersection of our personal and professional lives. We confront our anxieties about the reality of our weakening bodies, worsening memories, and diminished vision and hearing. We have agreed that we cannot simply keep doing what we have been doing, and we encourage each other to be more mindful about managing our energy.

Aging bodies need exercise as well as rest. Our memories may require different strategies to help us keep track of our schedules and our patients' details. Some of us desire more vacation, a lighter patient load, fewer referrals, or being more selective about the types of patients we treat.

Acknowledging our own Aging and Mortality

Being a psychologist requires putting our patients' needs above our own. When in session, we try to avoid thinking about being tired or thirsty so we can be present to our patients. We are making an important discovery: our patients will benefit from our facing our needs as we go forward into our futures. As we face our humanity, we help our patients face theirs too. This must certainly include our own aging, deterioration and death.

Our Responsibility to our Patients and Ourselves

Professional organizations urge us to prioritize self-care so that we can look after our patients. Facing cognitive or physical decline requires courage and an honest assessment of one's capabilities and a willingness to experience the grief of letting go of our work. Many of us know colleagues who continue to work past their expiration date.

> *An elderly colleague, a man well into his 80s and a well-respected clinician and teacher, when asked if he had considered retirement, immediately replied, "Why would I retire? I have no spouse or other family at home." This colleague had recently buried his wife.*

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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Avoiding an empty house with evening patients and adoring students is understandable, but postponing retirement due to a paucity of social connections outside of work puts the therapist's needs ahead of the patient's needs. While we cannot be certain about what was driving this individual, we are concerned that his justification was based upon his own needs rather than a thoughtful reflection on his abilities and the needs of his patients. We have a responsibility to our patients to assess our motives especially when our financial security, identity, or purpose is at stake.

> *In a related case, an 85-year old colleague manifested disorganization, forgetfulness and cognitive decline in social interactions and a supervision group. No therapist felt comfortable addressing this in the group setting. When several colleagues gently approached the therapist individually, he discounted and minimized their concerns, insisting that his patients were doing well. When invited to discuss any grief about ending his practice, he said it was not a problem for him. Given the severity of cognitive impairment, colleagues felt it was imperative to pursue this further. They decided to enlist the help of his family to help him face his limitations. Through a lengthy and collaborative process, they were able to encourage this therapist to seek a consultation with his physician and a psychologist that successfully enabled him to close his practice.*

Ten years ago, one of us continued practicing while experiencing serious back pain. We wonder to what extent the pain or medication reduced effectiveness. In hindsight a formal consultation was in order. In reviewing this experience, it is stunning that not a single colleague ever approached this therapist to question her fitness to practice. We collude with each other and avoid these conversations because we may identify with the impaired therapist and fear being confronted with the same questions. We may also be overly protective of colleagues we care about. Moreover, for many of us, it is a new idea to think of ourselves as our brothers' and sisters' keepers.

> *In a more dramatic and acute case, a highly esteemed therapist in her 50s wrestled with a cancer diagnosis. She had been quite responsible in crafting a professional will and designated a colleague to carry out her instructions. Nonetheless, she did not comprehend the severity of her illness. She believed that her chemotherapy was going to be successful and expected to return to her practice. However, her illness progressed so rapidly that she did not have time to tell her patients what had happened, nor to say goodbye, or even to leave her proxy with sufficient guidance to best help her patients. Many patients found out about her death from the obituaries before they had been contacted. Several patients did not hear of her death until they arrived at her office and found a note on the door.*

Strategies for Dealing with the Inevitable

There is little guidance on the subject of aging and a dearth of articles, workshops, and explicit guidelines from professional organizations and licensing boards. Whether senior practitioners or therapists earlier in their career, we are all at risk for sudden disability or death. Have you considered what would happen to your patients if you were diagnosed with a serious, debilitating illness or had a fatal accident?

We recommend three steps:

1. Monitor and assess your own professional competence and diminishment.

   We recommend forming a collective or establishing an "advisory board" with trusted colleagues to provide feedback about cognitive functioning and impairment. As an initial step, this feedback can serve as a springboard for further objective professional consultation. We in the Elder Clinicians Club are serving that function for each other.

2. Establish a plan and professional will.

   We recommend establishing a well thought out and written plan in case your ability to practice is compromised or impossible. Designating a colleague with access to patient contact information as well as clinical and billing records to carry out your wishes can provide a sense of security.

   Informing clients at the time of your first contact with them of the name(s) of your designated person(s) who will contact them in the event of an untoward event. This normalizes the process and provides them with this information at a time outside of a traumatic event, i.e., illness or death. Consult the guidelines and sample professional will on the PPA website: https://www.papsy.org/page/ProfWill

3. Consider our shared responsibilities for impaired colleagues.

   We should always throughout our careers to be alert to ways that we can help our colleagues, keep in touch with them, assist them when they appear to be having problems. This becomes especially important as we age. We urge increased awareness and open conversations about impaired colleagues and our responsibilities to each other and our patients. We believe that intentional discussions about retirement are necessary in light of the graying population. Furthermore, we share an ethical responsibility to open conversations about fitness to practice and to consider creative and collaborative interventions when a gentle nudge is not enough.

We must face our vulnerability and our mortality. It may be tempting to think we can just keep working until we are unwilling or unable to, but our patients deserve more. Our patients count on us to be consistent, to be a measured voice of reason and to help anticipate consequences. In this instance, we must confront our physical and cognitive decline, and in doing so, inspire our patients to do the same.

PENNSYLVANIA PSYCHOLOGICAL FOUNDATION STUDENT MULTICULTURALISM AWARD

The Pennsylvania Psychological Foundation in collaboration with the Pennsylvania Psychological Association's Committee on Multiculturalism established a Student Muliculturalism Award in 2010.

The award will be given to a psychology student who is attending school in Pennsylvania and who has produced distinguished psychology related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. The submission may be a formal paper, or other product, such as a notable community service project, work history, or other activity that demonstrates considerable sophistication in advancing the field's understanding of, or ability to positively impact, issues related to diverse populations.

The submission should include:

- Description or actual work sample that meets the identified criteria for the award (all documents, including dissertation presentations, must not exceed a 20-page synopsis)
- A current resume or CV of the nominee
- A letter of nomination from student or primary sponsor outlining the qualifications of the individual for the award

The award will be presented at the Annual Banquet and Award Ceremony on Thursday, June 18, 2020, during the Pennsylvania Psychological Association's Annual Convention. The Convention will be held in Lancaster, PA at the Lancaster Marriott at Penn Square from June 17 - 20, 2020.

The deadline for submissions for the 2020 award is March 15, 2020.

Submissions should sent to:
5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112
Submissions may also be emailed to Ann Marie Frakes at annmarie@papsy.org as one complete PDF document

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Foundation
LEAVING A LEGACY

You Have Had A Very Good Career, But...

Samuel Knapp, Ed.D., ABPP, Director of Professional Affairs

"You have had a very good career and helped many people. The profession and the public owe you a debt of gratitude. Now, I think it is time for you to retire." That is what I said to an older psychologist who was showing a significant decline in his cognitive abilities and work performance. We had multiple data points on his work performance, and the decision to hold this conversation was made by a group of individuals who knew the psychologist well. I was aware of the sensitivity of the process. I meant every word I spoke about the success of his career. In many ways he was far more successful as a psychologist than I would ever be. He had taken great pride in his work and it was reflected in the high esteem that his colleagues felt for him.

Some hospital systems subject older physicians to mandatory examination to identify those who begin to show a decline in their competence.

Sometime in the future, some younger psychologist might say the same words to me. I hope that I would exit the profession before others perceive a need to tell me to leave. But it can be difficult to know when to retire. I do not want to leave my career too late and risk harming the public; nor do I want to leave while I still have a contribution to make. We must all be alert to the predictable changes that can occur with aging, but we also must be alert to the pernicious impact of ageism.

I feel the impact of my aging. I cannot drive at night unless I am familiar with the location. My hearing is starting to decline, and I notice that I miss parts of conversations. I get tired more easily. I sometimes struggle to find the right word. Yet I simply will get an uber somewhere if I must travel at night. The audiologist noted a hearing decline, but said it was not enough for a hearing aid at this time. She told me to come back later in two years. My course evaluations remain high and my cognitive decline apparently isn't too steep as I just had another article accepted for publication by a peer-reviewed APA journal. But the time will come when my accommodation strategies will no longer sufficiently compensate for my age-related declines.

Many of us are now "senior psychologists." PPA does not have data on the age of its members, but 28% of our members have been licensed for 30 or more years (Leitzel & Knapp, 2018). Psychologists tend to like their careers, and many continue to practice psychology long after the average retirement age. I have known several psychologists who retired, only to return to work a few years later.

Some hospital systems subject older physicians to mandatory examination to identify those who begin to show a decline in their competence. Airlines will require their older pilots to take simulation tests to ensure their continued competence. Psychologists who work in institutions have the benefit of institutional performance reviews to alert them when their skills are declining. But, psychologists in independent practices have no such built-in mechanism and must find other ways to supplement their own self-insight as to when to retire.

Here Are Four Questions That We Can Ask Ourselves

Here are four questions that psychologists can ask themselves to help them decide about continuing their careers. Several of these overlap with those identified by Ginzberg et al. (this volume).

Do you have compensatory strategies to account for normal changes in aging?

Normal aging includes changes in hearing, vision, strength, endurance. It can also involve changes in thinking and reasoning ability. Crystallized intelligence or the accumulation of facts and information often remains stable over time. However, fluid intelligence, or the ability to think through problems may decline with age. Many older physicians who kept working had discontinued some of the more difficult procedures that PCPs commonly perform. Many anesthesiology departments exempted older anesthesiologists from night calls. Many older psychologists will restrict the number of hours that they work, become more selective in who they treat, or otherwise restrict the work that they do.

Do you have procedures for evaluating the quality of your work?

Ideally, all psychologists will monitor the quality of their work, even if it is as simple as routinely asking patients about their progress and satisfaction in treatment. A general rule of thumb for psychologists is to be especially vigilant about progress when working with difficult or complex patients where the risk of treatment failure is high. Similarly, a general rule of thumb for psychologists is to be especially vigilant about one's work after one has reached a certain age.

Patients may not be able to identify substandard treatment easily. A psychologist with 40 years of experience may have conducted thousands of intake interviews and the sequence of questions and the manner of eliciting responses has become a deeply engrained habit. The patients in the intake interview might have noticed nothing to suggest that the psychologist had a cognitive decline. However, another professional in the office might see the cognitive decline in the quality of the notes written or the case conceptualization. In one situation the psychology interns noted the decline in their supervisor who often confused the names of patients and once fell asleep during supervision.

Do you have a supportive social network that will help you make career decisions?

We need to look out for each other. Regardless of our age, we tend to do better when we help each other, show concern for each other, and help each other do our best work. Those in independent practice may need to seek out and create their own supportive communities through participating in consultation groups, participating with a regional psychological association, or otherwise involving themselves with other professionals. Ideally, our close friends and colleagues will honestly address their concerns about our performance. Ideally, we will be honest with our close friends and colleagues about our self-doubts or our perceptions of our limitations.

Have you considered the pragmatics of building a new life beyond work?

Retirement brings many changes including changes in income, daily activities, connection with professional peers, and so on. A planned transition into retirement may require thinking through what we want to do with our time, what activities will replace the work-related ones that dominated our lives for so long, and what relationships will replace the professional relationships that formed the basis of our identity for many decades.

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Strange Practice Situations with Ethical Implications: "What Would You Do If . . .."

Samuel Knapp, Ed.D., ABPP[1], Director of Professional Affairs

Psychologists will sometimes encounter strange situations where the optimal course of action is not obvious. These unusual cases are not routinely discussed in ethics texts or presentations, although they have ethical implications to them. Nonetheless, psychologists may sometimes need to respond quickly in these situations. Here are a few such situations that have been brought to my attention. Details have been altered to ensure the privacy of the psychologists and patients involved and, in one case, to enhance the ethical conflicts involved. Often these situations appear to place respect for patient autonomy in conflict with beneficence, or the obligation to promote the well-being of the patient. Nonetheless, none of these ethical principles is unbounded and sometimes psychologists need to balance these competing ethical demands.

You Deserve More

A psychologist did a seemingly routine intake interview of a patient who at the end of the session gave her a check for considerably more than the agreed upon amount. The patient explained that he does not have confidence in anyone who charges less than he does for professional services. The psychologist was taken aback but took the check. Later the psychologist reexamined the issue and decided to talk about it with her patient at the next session.

The psychologist decided that psychotherapy could not proceed unless the issue of payment was resolved. The psychologist wondered if the payment issue and associated comments represented a lack of respect that would make psychotherapy unlikely to succeed. Would the patient refuse to agree to some basic instructions in psychotherapy because of a lack of respect for the psychologist? Or would the patient assume an entitled position and make clinically contraindicated demands on the psychologist? Does this represent narcissism on the part of the patient that has implications for the course of treatment, and so on?

Ordinarily psychologists respect the autonomy of patients concerning matters in psychotherapy and this would suggest that the psychologist should accept the higher payment. But respect for patient autonomy is never absolute and needs to be balanced with beneficence and other ethical principles. Here the psychologist had a legitimate concern that respecting the patient's autonomy could lead to substandard patient care. The psychologist correctly concluded that the additional payment had implications concerning the quality of services that needed to be resolved before psychotherapy could continue.

In another situation a psychologist had a patient who invited her and her husband to a weekend retreat at his "country home." There would be numerous activities such as hunting, fishing, tennis, and card games, and the host would serve plenty of alcohol. The patient said he often has these events and invites his physician, accountant, lawyer, and several business partners. The psychologist declined and tried to explain the role of boundaries (patient privacy would be lost, the neutrality of the psychotherapist might be compromised, etc.), but the patient appeared incredulous about her rejection of the invitation and dropped out of treatment.

Do You Know My Name?

One psychologist was treating a patient who declared at the end of the third session that he was using a pseudonym. There was little time left in the session to discuss the issue, and the patient never came back for his subsequent session and never rescheduled another appointment. In another situation a patient stated that he was using a pseudonym. He said he would pay for services a week in advance so, if he did not show up for some reason, the psychologist would still get paid. Another patient gave a street address which the psychologist later learned did not exist. When asked about this, the patient admitted making up his name and contact information.

One could argue that respecting patient autonomy should require psychologists to accept their patients desire to remain anonymous. I know of no law that prohibits people from using false names, unless in the commission of a crime. Also, we know that patient non-disclosure of important information is common. Often patients feel embarrassed or have internalized the stigma of mental illness. Sometimes they fear that their disclosures would trigger a legal response, such as a mandated report of child abuse. It could be argued that, over time, patients will become more trusting of their psychologists and eventually disclose accurate information about themselves. The later assumption assumes that the patients would only lie about their identity but be forthright in other communications with their psychologists.

Nonetheless, psychologists should consider two caveats. First, if insurance were involved it would be fraud to use someone else's insurance. Second, the failure to know the name or address of the patient could violate the ethical principles of beneficence if the patient were to experience a life-endangering emergency. For example, in a life endangering situation psychologists would not be able to send the police on a safety check if they did not know the location of the patient or if the police arrived at a house for a person whose name was not recognized by the residents of that

1. The author thanks members of the PPA Ethics Committee for their review of this article.

house. Also, aside from an emergency which is admittedly rare, would the failure to insist on accurate information inadvertently confirm an implicit belief on the part of the patients that psychotherapists cannot be trusted with private information, or that honesty is not essential for effective psychotherapy?

I Would Be Willing to See You If . . .

A patient contacted a psychologist for psychotherapy but would agree to be a patient only if the psychologist did not take any notes. On the surface, psychologists would generally respect patient autonomy, but there are at least two problems with this patient request. First, keeping notes is consistent with beneficence in that keeping records benefits patients. Psychotherapists are better able to remember details about their patients and the notes can be of benefit to concurrent or consecutive treatment providers.

Second, the State Board of Psychology requires psychologists to keep notes. The failure to keep notes would put the psychologists in violation of the Professional Psychologists Practice Act. Generally, I believe that moral agents should only violate laws if there is an overwhelming ethical imperative to do so. Second, disobeying the law would mean that the psychologists and patient were colluding to violate the law. It sets a poor example for the patient and makes the psychologists vulnerable to patient blackmail.

In another situation a patient started an intake interview by objecting to the content in the privacy notice that had been mailed to her, especially the portion that allowed psychologist to create an exception to confidentiality if there was imminent danger of substantial physical harm to an identifiable third party. She stated that she would not proceed in treatment unless the psychologist would guarantee complete confidentiality. The psychologist assumed that the reason the patient was concerned was the possible exception to confidentiality in life-endangering situations, although it is possible that the patient had a concern about confidentiality in general.

One could argue that the psychologist should promise complete confidentiality just to get the patient talking and to learn if there was a third party at risk of imminent harm. Then, if necessary, the psychologist could decide whether it was necessary to break the promise of confidentiality in order to protect the endangered third party. That option would pit the overarching ethical principle of public beneficence (the obligation to protect third parties from harm) with the overarching ethical principle of fidelity (the obligation of psychologists to keep their promises). However, that option is fraught with difficulties. Warning third parties is only one option for diffusing danger and often it is not the best option. Psychotherapeutic efforts to diffuse danger are

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False Deniers and Minimizers: Strategies to Increase Patient Willingness to Disclose Suicidal Thoughts

Samuel Knapp, Ed.D., ABPP[1], Director of Professional Affairs

False deniers are patients who have suicidal thoughts but do not reveal them. Most non-fatal suicide attempts occur among patients who have not revealed suicidal thoughts. Levy et al. (2019) found that 38% of respondents in their sample did not disclose suicidal thoughts to their health care provider. Berman (2018) found that 75% of patients who died from suicide did not mention suicide in their last visit with a health care professional. Perhaps some of these patients did not develop suicidal thoughts or plans until after their last appointment. But likely many had thoughts but were not asked about them or denied those thoughts when they were asked. Finally, data from the Center for Collegiate Mental Health (2018) showed that 9.5% of their clients had suicidal thoughts but only 1.5% of them considered it as their primary reason for seeking treatment. This suggests that some patients may minimize the clinical significance of suicidal thoughts and thus be less inclined to report them because they do not view them as directly relevant to their most pressing problems.

A few times I (SJK) have had calls from psychologists who had a patient die from suicide. They might say, "I had asked him about suicide ideation, and he had denied it" or words to that effect. I believe them. Many suicidal patients will deny suicidal thoughts to their mental health professionals.

Also, false denying may not be dichotomous because some patients may minimize the severity or frequency of their ideation, admit suicidal thoughts but fail to reveal past attempts, or otherwise withhold some relevant information about suicide. Perhaps these could be called *suicide minimizers* as opposed to suicide deniers.

Reasons for Denying Suicidal Thoughts

Patients may have many reasons for failing to disclose their suicidal thoughts. Some of the more common reasons are listed below, although many patients may have more than one reason.

1. Self-stigma or the internalizing of negative societal stereotypes about suicidal persons (Stanley et al. 2018);
2. Fear of a punitive or a disapproving response by their psychotherapist, such as conveying a perception that the patient is weak or a coward;
3. Self-management preference: desire to "do it on my own;"
4. Fear of loss of control over their treatment (e.g., being sent to a hospital or being made to take medication, or having family notified against their wishes);
5. Minimizing importance of symptoms: belief that suicidal thoughts were "normal" (Czyz et al., 2013);
6. Belief that treatment would not be effective; or
7. Being so committed to dying that they would not want any psychotherapist to learn about their plans and interfere with them.

Levy et al. (2019) found that embarrassment or fear of being judged were the most common reasons for withholding information.

Increasing the Identification of False Deniers in the Initial Assessment

It is recommended that all patients over the age of 12 be asked if they have suicidal thoughts both in response to a written question and in response to a direct question from their psychologists (Knapp, 2020). Some patients with suicidal thoughts will acknowledge them in response to a written question but deny them in response to a direct question from an interviewer, and vice versa. Consequently, giving patients both a written and an oral question will identify more suicidal patients than either means of eliciting information alone. Also, cultural factors need to be considered. For example, in Islam suicide is a very serious sin and almost never acknowledged, but such patients would be willing to acknowledge a desire to die or a loss of interest in living.

Unfortunately, there is no conclusive data on risk factors that could distinguish those who attempt but denied suicidal ideation and those who attempted suicide but acknowledged suicidal ideation. It is possible that the false deniers were responding more to situational variables that arose quickly, whereas those who acknowledged suicidal ideation had chronic thoughts of suicide (Bernecker et al., 2019).

Increasing the Identification of False Deniers in Treatment

Some patients may deny suicidal thoughts but have many high risk factors for suicide such as a high degree of emotional distress, perception of themselves as a burden on others, hopelessness, acquired capability to kill themselves (meaning habituation to pain or suffering, and exposure to death), and access to the means to kill themselves. Many of these patients are not suicidal, but some are. However, psychologists cannot know ahead of time which patients are false deniers and which are not.

Psychologists must use their judgement in discerning which patients are most likely to be false deniers and attempt to proactively address potential reasons for denial. Here are possible reasons for concealment and potential responses:

Self-stigma	stating that it takes courage and strength to talk about unpleasant and unwanted experiences and adopting a caring and non-judgmental attitude
Fear of disapproval	non-judgmental and caring attitude
Prefer self-management	explain that your treatment relies heavily on self-management and that you expect patients to be involved in treatment decisions
Fear of hospitalization	explain that your treatment modality prefers patient agreement and involvement and that coercive methods are only a very last resort when there is no other way to save the life of a patient
Minimizing symptoms	keeping them talking about their feelings and help them to label their emotions and their impact on their daily lives.
Treatment will not work	Explain the outcomes with evidence-informed treatments
Commitment to die	Attempt to engender hope and a way that therapy can relieve their pain

Other Interviewing Tips

Respecting patient autonomy becomes important in helping patients open-up about their darkest secrets including suicidal thoughts. For example, psychologists can use the informed consent process to describe the importance of the patient's cooperation in the development of and the implementation of self-managed treatments, explain the outcome data with treatments used; and note the use of coercive treatments (hospitalizations) only as a last resort (Knapp, 2020).

Some questions have been effective in getting people to open-up. For example, when describing a particularly upsetting series of events, a psychologist might say, "A lot of people who have gone through that will have thoughts of killing themselves, do you ever have those thoughts?" (paraphrased from Shea, 2011)

Shame is a powerful motivator of behavior and usually in a bad way. In research, guilt is differentiated from shame. Guilt is viewed as a pro-social emotion that motivates individuals to correct their errors of the past and to rebuild relationships. Shame, on the other hand, is viewed as self-damning thoughts without the option of redemptive behavior. It may be indicated to take special notice of patients who show shame or guilt which is far out of proportion to the offense.

If patients ever open-up and disclose suicidal thoughts or past attempts, it is appropriate to thank them for sharing and to praise them for their courage in opening-up. If patients say that they attempted suicide in the past, it can sometimes be helpful to ask them how many times and to establish a high anchor. So, the psychologist might say, "how many times did you attempt suicide in the past? Was it 20 or 30 times?" Establishing a high marker makes it easier for patients to be more accurate in disclosing their past attempts (Shea, 2011).

Some of the same factors that make it difficult for patients to open-up about suicide may also inhibit their ability to benefit from treatment. For example, fear of coercion from their psychologists may make them more reluctant to open-up about suicidal thoughts and make it more difficult for them to develop a trusting relationship.

Some patients who minimize symptoms come from highly dysfunctional families where arguments, fights, and suicidal threats are common, causing them to view such behaviors as more normative. Instead of arguing with patients about what is normal or not, it may be preferable to help patients consider how these emotions or thoughts may keep them from reaching their life goals.

Summary

False deniers or minimizers represent a large percentage of the patients that psychologists treat. When treating patients with high risk factors who deny suicide, it may sometimes be indicated to keep open the possibility that they may be a false denier. Fortunately, psychologists have several therapeutic options open that can help some false deniers to become more forthcoming about their suicidal thoughts or plans.

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PENNSYLVANIA PSYCHOLOGICAL FOUNDATION

APPLY FOR A STUDENT EDUCATION AWARD TODAY!

$2,000 AWARDS AVAILABLE

APPLICATIONS ARE DUE NO LATER THAN MARCH 15, 2020

The Pennsylvania Psychological Foundation (PPF) has established monetary awards ($2,000) to be given to graduate students in psychology. The purpose of these awards is to help defray some of the many expenses incurred during graduate study that may not be covered by other stipends and scholarships.

APPLICANTS WILL BE JUDGED ACCORDING TO THE FOLLOWING CRITERIA

- Financial need
- Academic performance
- Potential for service to the field
- Community service and involvement

Students should prepare a statement (two-pages, typewritten) that addresses these criteria and should note circumstances that may have presented a challenge to pursuing their graduate education. In determining the final list of award recipients, the Awards Committee will make efforts to assure that the group reflects ethnic and cultural diversity. Eligibility Requirements:

Applicants must be

- A full-time student in a graduate program leading to a doctoral degree in Psychology
- Enrolled at a Pennsylvania institution or be a resident of Pennsylvania

STUDENTS MUST SUBMIT THE FOLLOWING

- Personal Information cover sheet (Found at papsy.org/page/StudentAwards)
- Documentation of full-time enrollment in graduate doctoral program
- A typewritten statement (two-page limit) specifically addressing these four (4) areas: a) financial need, b) academic performance, c) potential for service to the field, and d) community service and involvement
- A curriculum vitae or resume
- A letter of support from their major advisor or program chair outlining applicant's potential for accomplishment and documenting their need

Please mail applications to:
Pennsylvania Psychological Foundation
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
Applications may also be submitted to erin@papsy.org as one complete PDF document
Applications must be postmarked by March 15, 2020

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far more likely to succeed if patients have faith in the honesty, integrity, and genuine concern of their psychologists for their well-being. Thus, the deception necessary to learn about the danger would undercut the ability of the psychologist to effectively diffuse the danger. With those concerns in mind, the psychologist refused to make the false promise of complete confidentiality and the intake interview ended.

Let Me Introduce You to . . .

A psychotherapist was treating a patient and offered to introduce her to a former patient of his. The former patient had given consent for the introduction to be made. This former patient was "on the same journey" (had similar problems) to the current patient. The apparent goal was that the psychotherapist would conduct counseling while the former patient would provide peer support.

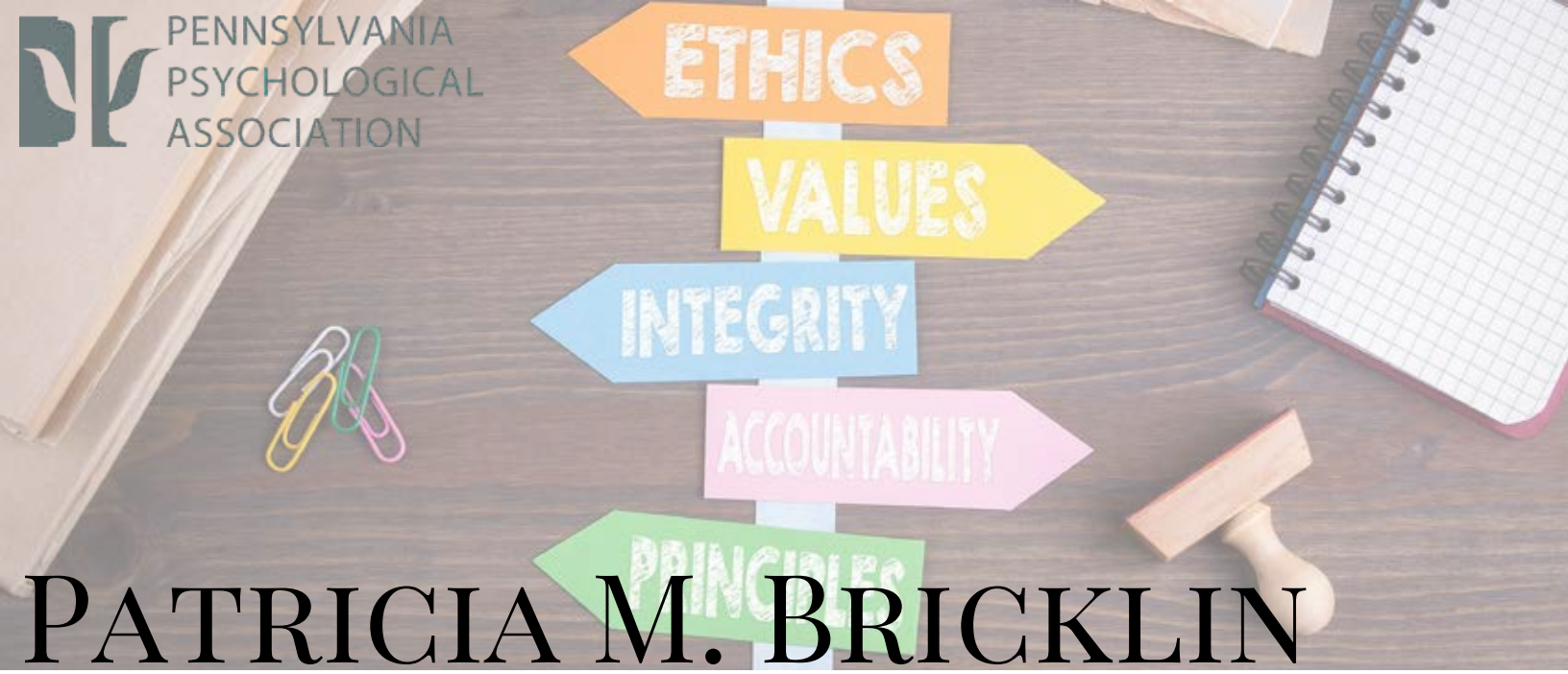
In a sense this was like referring the patient to a support group at a local hospital. But at least two issues arise. First can the psychologist ensure that his relationship with the former patient will not alter the dynamic between the former and current patient? Second, what can be done to ensure the quality of the support given by the former patient? Although the support group at the local hospital has a reputation, an articulated philosophy and perhaps some professional back-up, what are the quality indices for the former patient? Can the psychologist ensure that the former patient will have the necessary skills and acumen to benefit his current patient? Although it is not inherently unethical, the referral to a former patient for peer support raises clinical and ethical questions that psychologists need to consider carefully.

Conclusion

Even the most experienced psychologists will encounter novel situations in which the most ethical course of action is not obvious. In these situations, the psychologists need to slow down their thinking, identify the relevant laws and ethical principles, and (if time permits), seek consultation.

Classifieds

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION



Patricia M. Bricklin Student Ethics Award

The PPA Ethics Committee has instituted the Patricia M. Bricklin Student Award which is given to a psychology student who is a resident of Pennsylvania or who is attending school in Pennsylvania who produces a meritorious work product dealing with ethics or law in psychology. The submission may be a formal paper, but it may be another work product such as a copy of a presentation to the class, analysis of vignettes, ethics diary, or other product that demonstrates considerable sophistication in understanding ethical rules or principles. The submission should include the authors name, address (and email address if any), telephone number, and college or university on a cover sheet only - not on the work product.

The award is named after the late Patricia M. Bricklin, PhD, a prominent ethics educator, PPA member and long-time member of the Pennsylvania State Board of Psychology, who did much to promote ethics education in Pennsylvania and nationwide. Since 1994, more than $12,000 has been distributed through this award.

The Ethics Committee will give $1,000 to the winner of this award which will be presented at the Annual Ethics Educators Conference in October 2020. Also, the award winner will be offered the opportunity to write an article for *The Pennsylvania Psychologist*.

Want to contribute to the award? The Patricia M. Bricklin Award is financed through contributions made to the Pennsylvania Psychological Foundation. Click here to donate! Please enter Patricia M. Bricklin Fund in the reference line.

Submissions should be sent to the PPA Ethics Committee, c/o Dr. Samuel Knapp, PPA
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
Submissions can also be emailed to sam@papsy.org as one complete PDF document
The deadline for submissions for the award is June 30, 2020.

2020 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2020, we are expanding the options. We hope you'll join us for one or more of these programs!

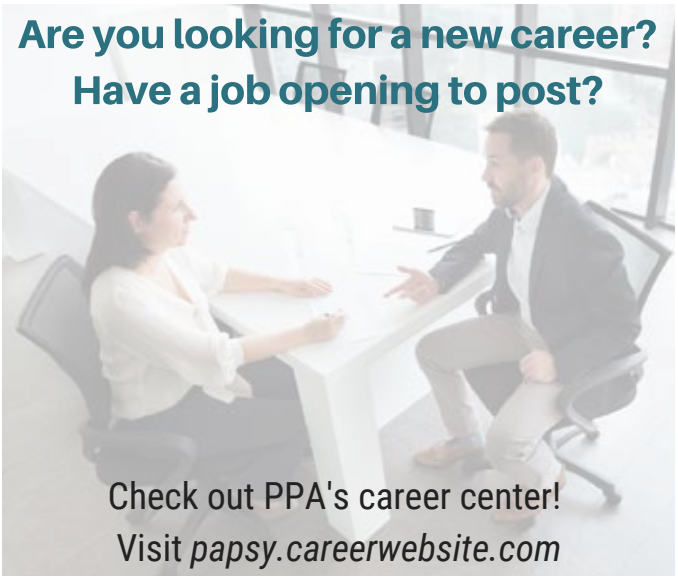
Calendar

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

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

Integrating Diversity in Training, Supervision, and Practice for Graduate Students (Podcast)—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.