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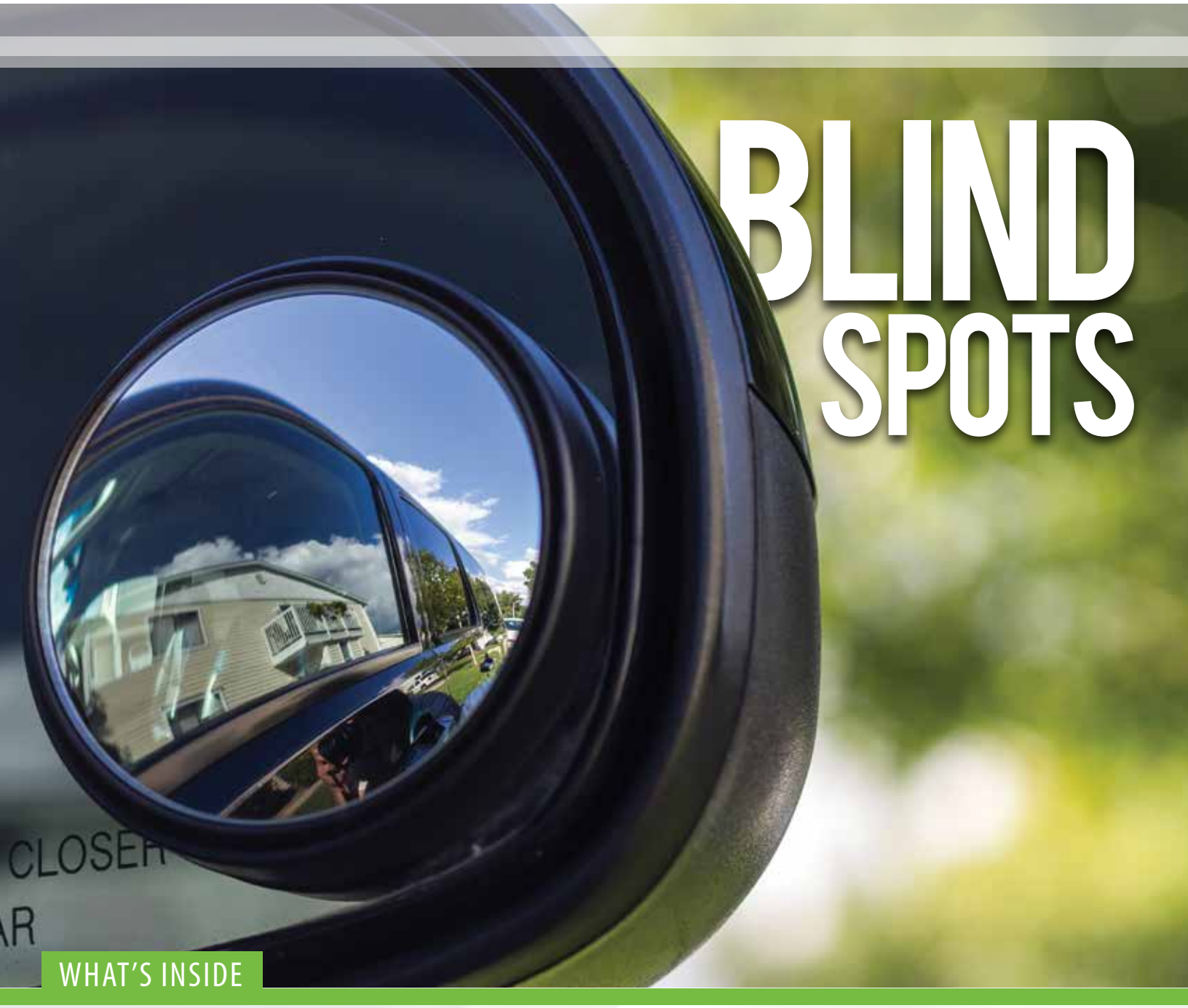

BLIND SPOTS

WHAT'S INSIDE

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If you are interested in submitting an article to be published in *The Pennsylvania Psychologist* please contact Publications Chairperson, Helena Tuleya-Payne, DEd at *publications@papsy.org.*

Publications Committee Chairperson:
Helena Tuleya-Payne, DEd
Copy Editor:
Michaelene Licht
Graphic Design:
Graphtech, Harrisburg


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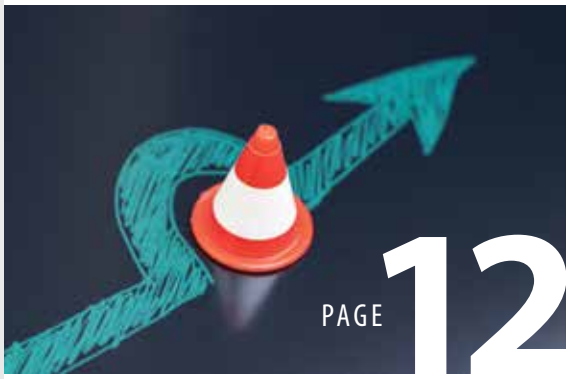
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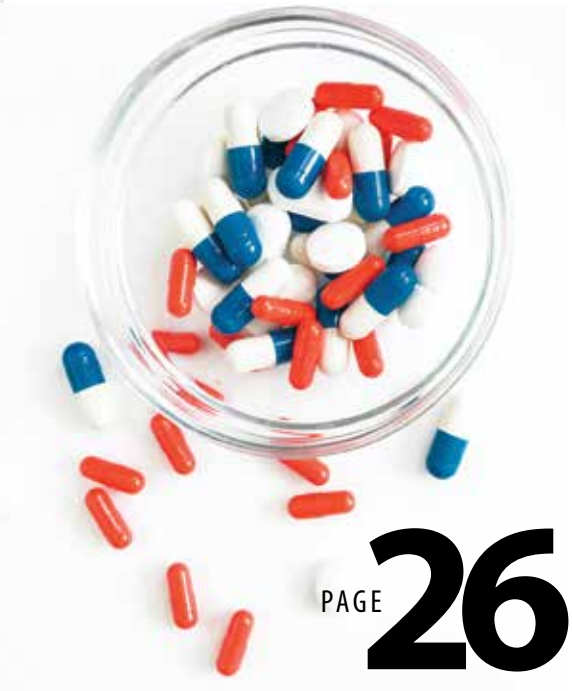
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COMMUNITY SERVICE DIRECTLY FROM OUR OFFICE CHAIRS

BRAD NORFORD, PhD

"I can't find any place to get therapy right now and we really need help!" Nearly all of us in applied settings continue to hear this refrain of distress. These times are unparalleled with the degree to which the public is seeking to access mental health services. Stress associated with the pandemic, virtual access to many who have not previously sought therapy, and greater public awareness and acceptance of the benefits of mental health treatment have all contributed to the influx.

Sadly, we also hear discouraged callers rightly complain that far too often when they reach out to practices for help, their calls are not even returned or are met days later with a cursory, "Sorry, but we're full." As we know, this can be demoralizing to an individual or parent to hear at a desperate time in their lives. Perhaps it took them months to get up the nerve to make that call for help only to be met by a dead end that turns them off to trying again. Maybe it is an emergency.

According to Merriam-Webster, *community service* is "work that is done without pay to help people in a community." The current volume of requests for care is coming at a time when psychologists are also stretched thin in their workplaces and personal lives. Time fielding these requests is not compensated. However, a few empathic and helpful moments being spent on the phone or through a thoughtful email response at that critical juncture for a hurting person may offer considerable benefit for the caller and extends a welcoming hand from our profession. Hopefully, we all have heard relief and appreciation from callers, whom we are not be able to treat ourselves if we are full or do not have their requested specialty, but with whom we have spent time trying to connect with potential resources.

This is an investment in the greater good. It may take some creativity as well as some extra time on our part. **Thinking of it as community service is a helpful reframe.** Some thoughts for managing calls when we have no room:

1. A few minutes can go a long way. We are all skilled at being empathic and kind listeners—a highly valued starting point for any stressed individual receiving a call back. (We can redirect before long and avoid dispensing specific clinical advice.)
2. Keeping curated lists of local, relevant resources so as to offer several options that are tailored to the caller's needs. Examples include:
   a. Psychologists who treat children
   b. Specialists in addictions
   c. Specialists in eating disorders
   d. Psychologists who do testing
   e. Medicare providers and those treating seniors
   f. Specialists in divorce and/or coparenting
   g. In-network practices (if you work out of network and the caller needs to use their insurance)
3. Provide training, if needed, to others in the practice who are handling calls, including front office staff, so that they are striking the right tone with callers and have resources on hand.
4. Help parents to know how to access testing and support through the school district if that is the appropriate course.
5. Provide guidance on how and where callers can access psychoactive medication consultation if that is requested, including through their physician.
6. Explain (or send them a prepared email) how to search on Psychology Today or the APA Locator to identify local therapists through search parameters for insurance, patient demographics, and provider specialty.
7. If needed, identify resources for callers mentioning suicidal concerns:
   a. The local ER or a county mobile crisis team (have the number on hand)
   b. Call 1-800-273-TALK (Suicide Prevention Lifeline)
   c. Text "Home" to 741741 (Crisis Text Line)
   d. Text "Start" to 678678 (Trevor Project for LGBTQ)

Know that you are performing a valued community service when taking the time to help callers who you know in advance you will not be able to treat yourself.

I wish all of you the best this holiday season, both personally and professionally!

GOOD-BYE 2021— SOME NOTABLE ACCOMPLISHMENTS TO CELEBRATE

ANN MARIE FRAKES, MPA, *Executive Director*

This year was again full of challenges for everyone, including our members and our organization. Despite everything that has happened in the world, there is still so much to be thankful for and celebrate. THANK YOU for your continued membership and support of PPA. Here are ten awesome accomplishments that we would like to highlight for you, our members:

1. As most of you know, Dr. Sam Knapp, PPA's long-time Director of Professional Affairs, officially retired on July 31, 2021, after 34 years of outstanding service. Congratulations to Sam on a stellar career, always advancing the ethical practice of psychology. Sam, we hope you are enjoying your retirement to the fullest!

2. On August 3, 2021, Dr. Molly Cowan stepped into the position of Director of Professional Affairs. She brings much energy and practical knowledge to the position and has already completed more than 200 individual consultations with members. She looks forward to helping you with your next practice-related or ethical issue. We are so happy that she is part of the PPA staff team.

3. Membership in PPA continues to grow. We are happy to report that our total membership is currently 3,318. That includes 2,507 dues paying psychologists, 453 doctoral students in psychology, and 358 undergraduate psychology majors. Thank you to all our members for your continued support.

4. Almost every year since 1996, PPA has conducted an annual survey of its members to determine its priorities in legislation, preferences for association services, preferences in continuing education, and other professional issues. This year **807 PPA members responded, which is more than twice the number of survey respondents in recent years**. Ninety-one percent of those respondents identified themselves as licensed psychologists. Thank you to everyone who completed the survey. This information will help us to make more informed decisions as we move forward.

5. We had our very first **fully virtual convention** this year. After consulting with other state psychological associations, we decided to utilize a virtual platform called WHOVA. It allowed us to network and visit with colleagues, exhibitors, sponsors, and speakers as well as view and listen to high-quality CE sessions and governance presentations. It was a challenging endeavor, but we are happy to report that we had 442 psychologists and other mental health professionals participate in our virtual convention. Because our expenses were so much less than hosting an in-person convention, we were able to NET approximately $73,000. Since most of the CE sessions were recorded, they are now being offered as webinars to all PPA members and non-member psychologists, so we continue to earn revenue even 5 months after the event occurred. Thank you to all who attended and made PPA2021 a HUGE SUCCESS!

6. The creation of **Special Interest Groups (SIGS**) has taken off within PPA. The main purpose of a SIG is to facilitate networking and the sharing of ideas between members in an identified interest area related to the practice of psychology in Pennsylvania. We currently have five official SIGS:

   - Late Career Psychologists
   - Psychologists Practicing in Rural Pennsylvania
   - Outreach and Advocacy for International Students
   - Clincal and Applied Behvior Analysis and Organizational Behavior Management
   - Information and Technology

   If you have an idea for a SIG and would like to serve as SIG Leader, please send me an email at annmarie@papsy.org.

Continued on page 5

MY WHITE FRAGILITY MOMENT

JEFFREY L. STERNLIEB, PhD, *jsternlieb@comcast.net*

I had just shared with our PPA listserv a link to an editorial that I thought was inspiring. It was written by a retired basketball star, and, in my post, I referred to his writing as "his usual articulate and eloquent self." Among a number of colleagues who had been sharing resources on our state psychology listserv, several had read the editorial and commented positively about it. And then, I received a back channel email commenting, "To point out as gently as possible that I am sensitive to the use of the term 'articulate' to describe the speech of a Black person." In addition, the writer added, "there was a book a few years ago entitled *Articulate While Black* that may be of interest." The writer said she assumed no bad intent on my part, and added a brief explanation.

In that "email reading moment," I experienced my own white fragility! I became defensive, annoyed, and wondered about the writer's agenda (blaming?) in addition to other uncomfortable emotions. I thought, "That's the last time I'll post something about racism." I also recall experiencing my own physical activation that often accompanies combinations of anger, resentment, and annoyance. I couldn't sit still; I felt like I had to physically move, as if moving would somehow change what I read. Or maybe I thought that moving would help me hide or run away or reduce the excess energy coming from inside of me. "Walking it off" had served me well in the past; rather than running away from something, walking helped me to get more in touch with what I was feeling. Fortunately, during a walk in a nearby park, I was able to recognize and then let go of this excessive reaction along with recognizing the embarrassing emotional thoughts and feelings that were hiding under my indignation. After cooling down emotionally and becoming more curious than furious, I looked up the definition of *articulate* and immediately realized that I, in fact, had chosen a word that had an uncomplimentary connotation. I thought I was saying something positive, and was a little surprised I had used a word with a commonly misunderstood and demeaning impact. My intent was to be totally complimentary to the writer of the op-ed whose name, by the way, she also mentioned (gently) I inadvertently misspelled—another correction! His name is Kareem Abdul-Jabbar.

My initial defensive reaction will be a touchstone experience for me as a reminder to add the small step of curiosity and understanding a question or comment before defending.

Once I accepted the corrections and accepted being corrected, I responded to the back channel emailer with an acknowledgment and appreciation. In addition, I sent a correction to the listserv along with a description of my emotional process in order to publicly recognize how difficult and risky it can be to start a conversation like this, and to share the example that our colleague set with this privately done, sensitive effort to educate and inform while taking the risk of offering an uninvited correction. I hoped that it would be helpful to recognize that any one of us may experience our own fragility as we work on our own antiracism agenda, and to establish a safe setting to have such conversations.

To me, the more personally challenging aspect of this experience is a somewhat shameful or embarrassing recognition of my investment in being right or having done something good, as if having part of my post being questioned invalidated the post. Related to this is my reaction to being

Maybe another way to look at the challenge of identifying blind spots is to identify and own the many other ways we have privilege—whatever its nature.

asked to be sensitive to someone else's experience, again tapping into some sense of not having been sensitive enough.

My initial defensive reaction will be a touchstone experience for me as a reminder to add the small step of curiosity and understanding a question or comment before defending. I need to ask myself: "What am I defending?" I have sometimes wondered about others' lack of curiosity or failure to ask questions before claiming to not be colluding or not being racist. It wasn't until I had my own experience and recognized my own defensiveness that I "got it." It is an example of Robin DeAngelo's explanation (in her book *White Fragility*) why it's so challenging to have conversations with white people about racism. Apparently, my reaction is not unique. We have all been socialized in a culture that is imbued with a binary frame of right versus wrong, good versus bad, innocent versus guilty. No wonder I defend, deflect, blame, or use humor or any other way of avoiding shame or embarrassment. It's the frame itself that's defeating.

That the killing of George Floyd has pierced my and so many other white ego defenses is unmistakable. It feels like it is finally no longer possible for the outrage to abate. It is also clear to me that it is past time for me to reinvigorate my own antiracism work. And it is equally obvious to me that African Americans and other marginalized groups never have the freedom to relax or let down their guard against racism and its consequences.

Maybe another way to look at the challenge of identifying blind spots is to identify and own the many other ways we have privilege—whatever its nature. Fifteen years ago, I wrote an article titled "White Privilege: How Would I Know?" My whiteness is not my only characteristic that confers privilege to me. I also have male privilege, heterosexual privilege, able-bodied privilege, and so on. There's a really good chance that I have unexplored blind spots for every way I experience unearned privilege. I have also written about another experience during an Ethics Educators workshop that was evidence about our difficulties addressing these topics. If I am serious about shining light on blind spots, there are plenty of opportunities to look inward as a path to looking outward.

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7. Pennsylvania Psychological Political Action Committee (PennPsyPAC) hosted a virtual Wine Experience and Toast to Dr. Sam Knapp to raise money to support elected officials and candidates in Pennsylvania who support legislation that strengthens the practice of psychology and recognizes the needs of psychologists. Fifty-eight households supported the event and the PAC netted over $5,800. Thank you to all our PAC supporters. A BIG thank you to Dr. Sal Cullari and Cullari Vineyards and Winery for your guidance and generosity.

8. The Pennsylvania Psychological Foundation had its first ever Silent Auction in 2021. We auctioned off a total of 55 items and packages and raised over $11,000 of unrestricted income for PPF. THANK YOU to everyone who made this virtual event a HUGE success, especially our Foundation President and Auction Chairperson, Dr. Nicole Polanichka.

9. This September, the PPA Board of Directors voted to assist the Pennsylvania Psychological Foundation in encouraging donations to the foundation by agreeing to match all unrestricted gifts from now until June 30, 2022, up to $25,000. The foundation will have more flexibility to support a wider variety of projects and causes if they have more unrestricted funds available. The matching gift campaign will begin on Giving Tuesday, November 30, 2021. Please support PPF and help us reach our goal of raising $25,000 before June 30, 2022.

10. Finally, congratulations again to Dr. Sam Knapp, the winner of the ***2021 American Psychological Foundation's Gold Medal Award for Life Achievement in the Practice of Psychology.*** Please join us in congratulating Sam on receiving this well-deserved, national award.

Thank you for your dedication to and continued support of PPA. We could not do all this without you, our members! Remember to give yourself a gift and find some time for your own self-care this month. We wish you Happy Holidays and good health (mental and physical) in the new year!

UNDERSTANDING THE BUSINESS STRUCTURES FOR PSYCHOLOGISTS IN PRIVATE PRACTICE

RACHAEL L. BATURIN, MPH, JD, *Director of Governmental, Legal & Regulatory Affairs*

One of the major decisions that psychologists must make if they want to go into private practice is how to choose their business structure. Not only is this one of the first decisions that a psychologist has to make, but it can also be one of the most important decisions for tax and nontax (liability) reasons. This article will review the business structures available for psychologists.

There are several different business structures available to professionals who want to set up a private practice. The most common are: sole proprietorships, general partnerships, limited partnership, registered limited liability partnerships, limited liability corporations, S corporations, and C corporations. The decision to use one of these business structures should be based on careful analysis of the tax and nontax characteristics (e.g., separate legal entity status, expense and formalities of the organization, management structure, continuity of existence, ease of financing, transferability of interests and limited liability) of each entity and on the unique attributes of the business and the potential owners.

The simplest business structure from both a tax and nontax perspective is the sole proprietorship. In a sole proprietorship, one individual, the sole proprietor, is the sole owner, operator, decision maker, and principal provider of services. The sole proprietors are completely autonomous and are free to manage their business as they see fit. The only constraints are the business and customs of the marketplace and management practice to provide customer satisfaction. The sole proprietor reaps all the benefits of a profitable business and is liable for all of the debts and other liabilities of the proprietorship. It is operated as a self-employment venture with the tax benefits and liabilities flowing directly to the individual. Income and losses from the business are reported on the individual's income tax return (Schedule C).

If multiple professionals choose to practice together, a partnership structure should be considered. A partnership is more complicated to manage than a sole proprietorship but is less complicated than an S corporation or a C corporation. There are three different types of partnerships: general partnerships, limited partnerships, and registered limited liability partnerships.

A general partnership is the least costly of the three types of partnerships. A general partnership is created by the intent of the partners and there are no formal filing requirements at the state or federal level. However, it is always advisable to have a partnership agreement in writing for the benefit and protection of the partners. All partners have equal rights in the management and conduct of the business unless the partnership agreement states otherwise. All liabilities incurred by the partnership flow directly to the individuals and not to the partnership as a separate entity. As such, each partner is joint and severally liable for claims against the partnership. Partners owe fiduciary relationships to each other and each may

act as an agent for the other partners. The partnership as an entity is not taxed, rather the income, gains, losses, deductibles, and credits are passed out to the partners equally, unless otherwise provided in the partnership agreement. As such, the individual tax benefits are preserved for the partners.

The next type of business entity a professional may want to consider forming is the limited partnership. Limited partnerships (LPs) are formed by filing a Certificate of Limited Partnership with the Department of State. In an LP, there are two types of partners: general partners and limited partners. General partners have virtually complete authority to manage the partnership, whereas limited partners have almost no control with respect to management. If limited partners participate in management activities beyond that which is allowed by state law, they risk losing their status of being a limited partner. General partners have unlimited liability for debts and obligations of the limited partnership, whereas the limited partner's liability is restricted to the capital investment. In an LP, there must be at least one general partner who is personally liable for the claims against the partnership. Like general partnerships, the LP, as an entity, is not taxed and the tax benefits flow directly to the partners.

The last type of partnership a professional may want to consider forming is the registered limited liability partnership (RLLP). An RLLP is formed when a general or limited partnership files a Statement of Registration with the Department of State. RLLPs allow general partners to protect themselves from personal liability for the misconduct or negligent acts committed by their partners or acts of those whom an acting partner is directly supervising. This protects the partner's personal assets from claims involving the wrongful acts of another partner. However, in an RLLP, a partner remains liable for (1) debts of the partnership not arising from the negligence or misconduct, (2) debts and obligations arising from the negligence or misconduct of the partner or a person under such partner's direct supervision or control, (3) debts for which the partner has agreed in writing to be personally liable, and (4) situations where the RLLP has not maintained the liability insurance required by the Act.

In order to maintain its RLLP status, the RLLP must maintain liability insurance or other sufficient security that provides coverage for the negligent acts or misconduct of the partners or agents of the RLLP. This liability insurance must be in the minimum coverage amount of $100,000 multiplied by the number of general partners in excess of one, but in no event less than $100,000 or more than $1,000,000.

Professionals may practice as partners in an RLLP. However, all of the partners in a partnership that renders professional services must be licensed. An RLLP that renders professional services shall continue to be subject to regulation by the applicable government agency.

An RLLP should continue to be taxed as a partnership on both the federal and state levels even after it has registered as an RLLP. In addition, an RLLP must file an annual registration statement with the Department of State and pay an annual registration fee equal to $200.00 multiplied by the number of persons who are general partners at the end of such year and who reside or are organized and existing in Pennsylvania.

Professionals may also want to consider forming a limited liability company (LLC). An LLC is a relatively new entity that is a hybrid of a partnership and a corporation. The owners of an LLC, known as members, are treated like shareholders of a corporation for purposes of determining liability. Where an LLC is used to practice a profession, the individual malpractice liability of the professionals remains.

An LLC is formed by filing a Certificate of Organization with the Department of State. The structure of an LLC will be set forth in a written operating agreement, which will be similar to an amalgamation of corporate bylaws and a shareholders' agreement. An operating agreement will address items such as management of the LLC, restrictions on the transfer of membership interests, and provisions for withdrawal. The operating agreement should also be carefully drafted to ensure that the LLC qualifies for taxation as a partnership for federal income tax purposes. Note: Psychology falls into the category of restricted professional services; therefore, psychologists would form a restricted professional company (RPC), which is an LLC that provides professional services through its licensed professional members and which elects RPC status in its Certificate of Organization.

The most complex business entities are S corporations and C corporations. An S corporation is a corporation that has made an election under subchapter S of the Internal Revenue Code that allows for special tax treatment. S corporations are small corporations and may have no more than 35 shareholders. The S corporation shares many features of a partnership except that most liability for the conduct of the practice now flows to the corporation rather than to the individuals within the corporation. The advantage of being an S corporation is that shareholders do not have to pay double taxation. All of the income and losses of the corporation pass through to the shareholders who can report them on their tax returns.

The C corporation is the most complex and costly of the business structures to maintain. One of the benefits to electing this type of business structure is that it provides the best liability protection and is probably the most effective vehicle for managing a large practice. In addition, it is a more effective tool for managing salary and other compensation issues. The main disadvantage to electing this type of business structure is double taxation. In a C corporation, the corporation pays income tax on profits of the corporation. If the corporation pays a dividend to the shareholders, this money is taxed again as income to the shareholders.

Please note: This article was written to give a basic understanding of the different types of business entities. For more information about setting up a particular business entity, psychologists are advised to consult with an attorney to determine which option is best for them.

COMMITTEE SPOTLIGHT:
PPA School Psychology Board Public Policy Committee

The PPA School Psychology Board, Public Policy Committee strives to advance the profession of School Psychology in Pennsylvania through education and policy advocacy. The committee reviews proposed legislation, regulations, and other government policies to determine the potential effect on the practice of school psychology, on education, and on child and adolescent psychology. The committee educates PPA membership through continuing education, articles in *The Pennsylvania Psychologist,* position statements, and online communication tools. In June, the committee worked with the School Psychology Board to provide testimony in support of a proposed change to Chapter 49 that would allow school psychologists to obtain Special Education Supervisory Certification after the requisite years of service and completion of the appropriate graduate coursework. Our support for this proposed policy change is based on the training, skill set, and experience of public school psychologists. School psychologists regularly work with special educators to develop educational programming for students, monitor the progress and effectiveness of these programs, and conduct professional development for general and special educators on topics related to special education and meeting the needs of students with disabilities. The committee also provided written and oral testimony in August at the Public Hearing on Mental Health convened by the PA House Children and Youth and Education Committees. At this hearing, the committee representative had the opportunity to educate the Children and Youth and Education committee members on the training and roles of school psychologists in Pennsylvania and their vital contributions to school-based mental health services. The hearing also allowed the committee representative to underscore the fact that the school psychologist shortage in Pennsylvania negatively affects the services that public schools can provide to students. If you have an interest in working with the School Psychology Board, Public Policy Committee please reach out to Monica McHale-Small, Chair at monica.mchale.small@gmail.com.

We are excited to announce that PPA has agreed to support the Pennsylvania Psychological Foundation with a $25,000 matching gift. The campaign started on Giving Tuesday (November 30) and will run until June 30, 2022!

Details of the matching gift:

All unrestricted donations to the Foundation will be matched by PPA up to $25,000.
Unrestricted donations to PPF allow for flexibility to support a wide variety of projects and programs!

How to donate:

- Visit www.papsy.org/Foundation to donate online. Enter General in the reference line.
- Mail a check to the PPA Office: 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112
  - Checks must be made payable to Pennsylvania Psychological Foundation.

the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF NOVEMBER 10, 2021

Bill Number	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 102	Amends the Public School Code, in intermediate units, repealing provisions relating to psychological service; in professional employees, for school social workers; and, in school health services, for counselors, psychologists, and nurses.	Rep. Daniel Miller (D)	Support		Referred to House Education Committee 1/11/21	
HB 131	Amends Title 63 (Professions & Occupations), in powers and duties, further providing for hearing examiners.	Rep. Greg Rothman (R)	Support		Referred to House Professional Licensure Committee 1/12/21	
HB 171	Act limiting restrictive covenants in health care practitioner employment agreements.	Rep. Anthony DeLuca (D)	Support		Referred to House Health Committee 1/14/21	
HB 325	An Act amending Title 63 (Professions and Occupations (State Licensed)) of the Pennsylvania Consolidated Statutes, in powers and duties, further providing for civil penalties. Allowing for boards to give advisory opinions.	Rep. Keith Greiner (R)	Support	Referred to Senate Consumer Protection & Prof. Licensure 3/25/21	Passed the House 3/24/21	
HB 681	An Act prohibiting enforcement of covenants not to compete in health care practitioner employment agreements.	Rep. Torren Ecker (R)	Support		Removed from the table, 9/21/21 [House] Set on the House Calendar 10/4/21	
HB 729	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Brian Sims (D)	Support		Referred to Health 3/3/21	
HB 972	Act providing for sport activities in public institutions of higher education and public school entities to be expressly designated male, female or coed; and creating causes of action for harms suffered by designation.	Rep. Barbara Gleim (R)	Oppose		Referred to House Education Committee 4/5/21, Hearing held 8-4-21	
HB 1075	An Act amending Title 64 (Public Authorities and Quasi-Public Corporations), establishing the Pennsylvania Broadband Development Authority to provide broadband Internet access to unserved and underserved residents; and providing for powers and duties of the authority, for financial assistance and for grants.	Rep. Pam Snyder (D)	Support		Referred to House Consumer Affairs 4/1/21	
HB 1420	An Act amending the Human Services Code, in general powers and duties of the Department of Public Welfare, providing for COVID-19 mental health public awareness campaign.	Rep. Wendi Thomas (R)	Support	Referred to Senate Health and Human Service 6/14/21	Passed the House 6/14/21	
HB 1690	An Act addressing the shortage of Mental Health Services in Underserved Areas.	Rep. Michael H. Schlossberg	Support		Referred to Health 6/24/21	
SB 40	An act providing for behavioral health services and physical health services integration in public assistance.	Senator Kristin Philips-Hill	Oppose	Referred to Senate Health and Human Service 1/20/21		
SB 78	An Act amending Titles 23 (Domestic Relations) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, in child custody, further providing for definitions, for award of custody, for factors to consider when awarding custody, for consideration of criminal conviction, for guardian ad litem for child, for counsel for child and for award of counsel fees, costs and expenses; and, in Administrative Office of Pennsylvania Courts, providing for child abuse and domestic abuse education and training program for judges and court personnel.	Senator Lisa Baker (R)	Oppose	Passed the Senate 6/24/21	Referred to House Judiciary, Subcommittee hearing set for 11/15/21	
SB 705	An Act relating to telemedicine; authorizing the regulation of telemedicine by professional licensing boards; and providing for insurance coverage of telemedicine.	Senator Elder Vogel (R)	Support		Third consideration final passage in Senate 10/26/21 (46-4) Currently in House Insurance Committee 10/27/21	

THE MEANING OF BLIND SPOTS

We can use the physiology of the eye as a metaphor. In each eye is a small area of the retina in which there are no light receptors and so it is a "blind" "spot." We simply do not sense what is projected there. However, the metaphor offers a second meaning in that we are unaware of the phenomena – we are blind to our blind spots. To learn the missing information, we need to act on both levels. Our eyes compensate for the blind spot with saccadic movements providing visual data for that location, and our brains fill in the missing data seamlessly and unconsciously. We are routinely completely unaware of our blindness, and this can be the basis of bad decisions and other mistakes. The articles in this issue will address several kinds of normal blind spots.

It might be noted that readers of this publication are a tough audience for blind spot education. We are trained to be alert to our own and others' meanings and actions, habitually curious about motivations (especially the more hidden ones), and professionally and personally devoted to sharing these insights. On the other hand, we are usually confident and sometimes wrongly overconfident about our own awareness – this is a blind spot bias.

BOUNDARY ISSUES
You May Not Have Considered

PAULINE WALLIN, PhD, *drwallin@drwallin.com*

We are all familiar with boundary issues from a clinical perspective. These are designed for the benefit of the client. It is our ethical duty to strive to avoid exploiting our clients (even inadvertently), and to protect their privacy and confidentiality.

Some boundary issues are quite clear, such as not dating your patients or going on vacation with them. Other boundary issues are more ambiguous. For example, what if one of your clients joins the church choir of which you are a member? Should you quit? Or, what if you find out that two of your adult clients with different last names are mother and daughter?

Boundary Issues Focused on Clinicians' Needs

Another set of boundary issues focuses on the benefit to the psychologist's practice. These include things like enforcing policies on fees and missed appointments, and getting paid for time-consuming work, such as extended phone calls, letter writing, and consultations with other professionals.

Such boundary issues are not necessarily at odds with those that focus on the client. In fact, to the extent that they help protect you from feeling taken advantage of, they reduce potential countertransference, which ultimately can be to the client's benefit. They also help establish predictability and mutual accountability in the therapeutic relationship.

Compromised Business Boundaries Can Affect the Therapeutic Relationship

In their informed consent documents, psychologists typically address, in addition to clinical matters such as confidentiality, their policies about appointments, fees, and other business matters. While it is extremely rare that they would deliberately violate their confidentiality policies, they frequently make exceptions to their business policies. Consider the following example.

Alan, a psychologist in solo practice, notes in his informed consent agreement that cancellations made less than 24 hours before the scheduled appointment will be billed in full. However, he has not enforced this policy because he feels guilty about charging for services he did not deliver, and he also worries that the client might get angry and file a licensing board complaint.

At the same time, Alan finds himself feeling resentful toward clients when they cancel without notice or fail to show up. At their next session, he is mildly distracted by the countertransference triggered by his resentment, thus less attuned to the client's words and actions. As a result, both Alan and the client are affected when he fails to enforce his cancellation policy.

Business Boundary Issues Can Occur With Colleagues as Well as With Clients

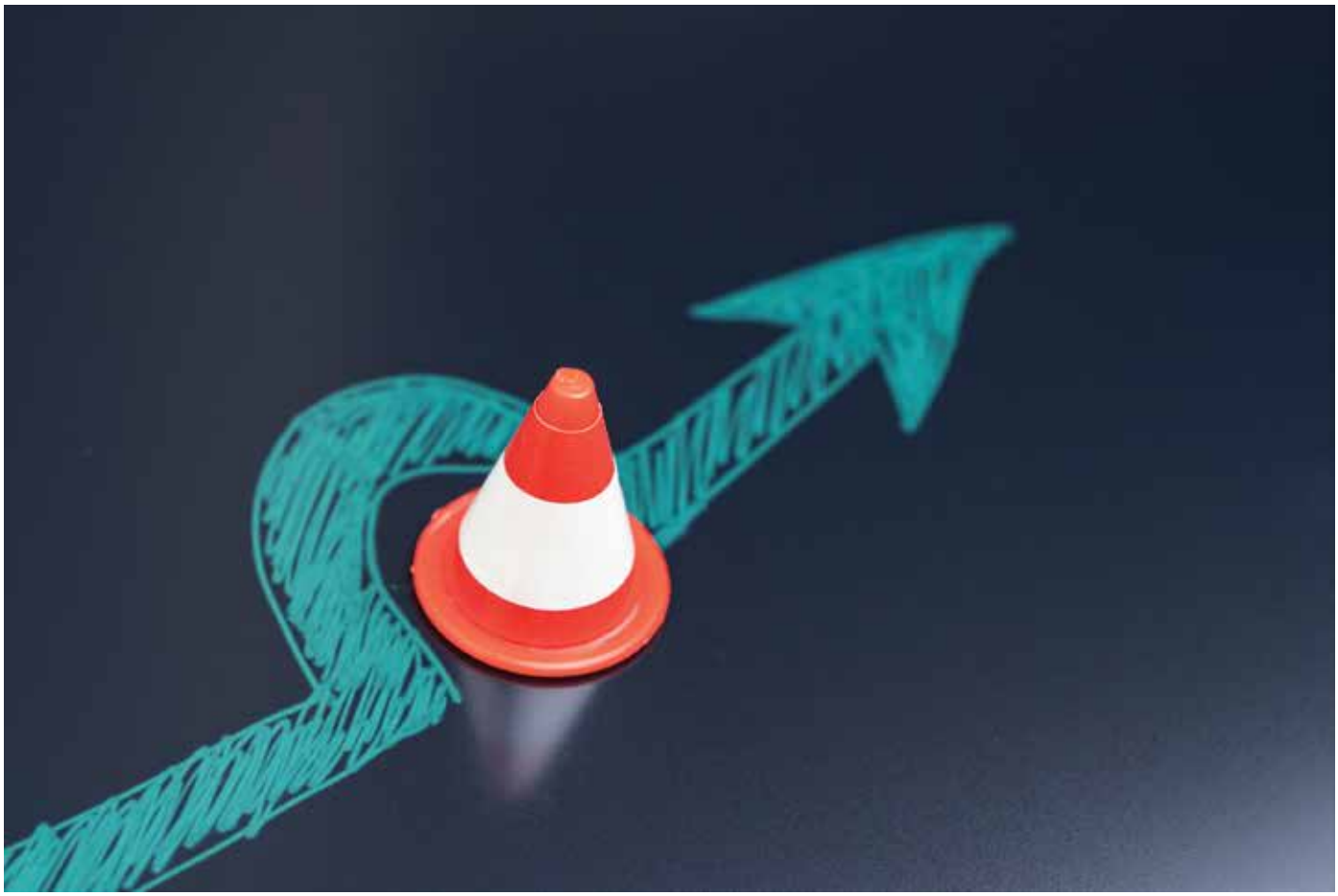
Consider the example of Beth, a psychologist who provides office space to colleagues working in her group practice. Her contract with the clinicians states that they are expected to generate a minimum income for the practice, and that any month in which they do not meet the minimum, they must pay a determined fee to cover overhead.

Carol, a clinician and personal friend of Beth who has been working in the practice for 2 years, has recently taken time off after the birth of her baby. She asked Beth if she could suspend her overhead payments while out on maternity leave, given that she is not earning any income.

Sympathizing with Carol's situation, Beth agrees to waive the payment requirement for 3 months. Nevertheless, she still has rent and other bills to pay, which drains her own bank account. But Beth is willing to do this, because she does not want to jeopardize their friendship. She further justifies her decision, noting that Carol has been very productive and will bring a lot of money into the practice over the long term.

News of this reaches other clinicians in the practice. Dan asks for a month's waiver while he takes time off to care for his father with Parkinson's disease. He claims that it is only fair that he be excused from paying for overhead during his absence, given that Carol is getting a break.

Beth now wonders whether the other two clinicians in the practice will expect exceptions to their contractual obligations as well. Her initial sentiment of generosity toward Carol has morphed into feeling exploited by her colleagues. She has also come to realize that her personal friendship with Carol has implications for the practice's culture.



Define Your Business Boundaries and Stick to Them . . . or Change Them

As a clinician and a business owner, it is important to address the needs of your clients, but not at the expense of your own sense of fairness and integrity. Similarly, in your business arrangements with colleagues, it is also important to feel that you are not being taken advantage of.

The two examples above illustrate what can happen when you do not consider the potential consequences of making exceptions to your business policies.

Business boundary violations are rarely sudden. Most of the time they are a slippery slope, beginning with a small exception to your policy. For example, at the end of a session, a client says he cannot pay today, but promises to do so next time. Next time he asks for another extension, and so on.

Or, a client texts you while you are at your child's baseball game, asking a "quick question" about the homework assignment you gave her. After you reply with your brief clarification, the client has follow-up questions, and by the time the conversation is over, you have missed the first two innings of your child's game.

Setting business boundaries does not mean that you must rigidly apply your policies and procedures. Similar to clinical boundaries, it is important to consider the implications of taking one action versus the other. It is also important to show compassion and to consider when exceptions to your policies are warranted.

When a client has a true emergency, you might waive your late cancellation fee. But note that this is a rare exception to your policy.

In maintaining boundaries with colleagues, such as in Beth's case above, it need not be an all-or-nothing decision. For example, Beth could have negotiated with Carol and Dan an option that was less than the full overhead expense, but acceptable to each, and perhaps paid over time.

If you find that you repeatedly make exceptions to your business policy and end up feeling resentful, you may want to consider amending the policy to terms that you do feel comfortable enforcing. At a future date, you can review your business policy and change the terms to be more (or less) restrictive as needed.

DANGER: BLIND SPOTS IN ETHICAL DECISION MAKING

EDWARD ZUCKERMAN, PhD, *edzucker@mac.com*

"To make the diagnosis you have to think of the diagnosis." —*Anonymous*

When a client describes an intensely pleasurable sexual encounter, which happens to be extramarital, have you ever found yourself, even briefly, vicariously enjoying their experience? Your attention has been focused on the sexual and hedonic parts and distracted from the moral elements. In their book, *Blind Spots,* Bazerman and Tenbrunsel (2011) call this ethical *fading*. If you continue to downplay, ignore, or never even think of the moral aspects, it is a moral *blind spot*.

Looking at a broader view, we are almost always blind to our own blind spots. Together, these two levels restrict our moral awareness and then, when we naturally engage in System 1 thinking, the decisions can be unethical. System 1 thinking is described as automatic, quick, effortless, self-protective, and short term. Only when System 1 fails do we try the more rational, systematic, effortful System 2. Kahneman (2011) notes that System 2 has one distinct characteristic—it requires attention and can be disrupted when attention shifts (or is absent, as with blind spots). Attention is the opposite of fading, so System 2 is essential for ethical decision making.

In some cases, the situation is seen or framed as involving just legal, financial, business, technical, or religious issues, and the moral aspects are simply excluded or seen as irrelevant. This is called "bounded ethicality" by Bazerman and Tenbrunsel (2011). It restricts morality to only some areas of concern when making decisions and excludes it from others. For example, a psychologist might naively and automatically comply with a request for all records and reports from any source because it is written on the stationary of a prominent attorney, without considering the impacts on others involved. In this case, the psychologist viewed the issue only in a legal framework and failed to consider the professional ethics of the situation. This is a typical example in which well-intentioned people, because of their cognitive limitations, make decisions inconsistent with their own ethical beliefs and commitments.

Parallel cases arise from incomplete or failed professional acculturation. An incompletely acculturated psychologist might not recognize the ethical principles of our profession in making choices. Their ethicality is bounded by their previous culture and not by the different or more complex rules called for by our Code of Conduct. For example, encouraging and enacting a close friendship with a client is not excluded by the common ethical rules but is by the professional rules. The psychologist involved simply did not know or attend to this exclusion because the friend relationship was not seen as an issue of professional ethics.

Testing and Prevention

What can we do to lessen our blind spots and improve our ethical decisions? Some recommendations from the research literature are:

1. **Leave more time to decide.** Sleep on it. Search the internet. Recall similar situations. Think it over. Let other (especially the ethical) perspectives rise into your consciousness.
2. **Consult your ethics consultant** (who may not be a psychologist but just a highly ethical civilian). If you did not see its relevance others may notice the ethical aspects.
3. **Ask questions.** Although the idea of asking questions seems obvious, individuals often fail to realize that they can obtain more information than what is in front of them. Kahneman (2011) calls this the WISIATI (What I See Is All There Is) error.
4. **Maybe the question is not "yes or no."** Maybe there are more options or more aspects. For example, in the Challenger space shuttle disaster, NASA pushed the engineers to look at the data available and then decide: "Launch or don't launch?" Asking instead, the

moral question, which had been used previously, was "Is it safe enough to risk the lives of the seven people aboard?" This is also an example of both ethical fading, as the technical questions about temperatures dominated the moral question, and WISIATI because more relevant information was not sought.

5. **Qui bono, qui patiens?** Who profits, who suffers from the contemplated actions? Who else is involved, indirectly, later? What are the ramifications, the externalized costs, the long-term consequences? Will the saving of costs in one area increase to costs or suffering in another?
6. **Ask those involved if they have any doubts or suspicions** about the information provided or the contemplated actions of those involved. This approach was very effective in preventing poor investment decisions.
7. **Attend to rationalizing phrases and justifying reasons.** "We have done enough." "It is simply a legal issue." "Lots of others do it too."
8. **Create tailored checklists** or even the hoped-for ethics-supporting app can help spot what is otherwise unnoticed.
9. **Do a "premortem."** Imagine that it is a year later and the decision has led to a disaster. Where did it go wrong? What did you not anticipate because it was made invisible by your blind spots?

Even Daniel Kahneman (2011), the discoverer of many biases, stated that his awareness rarely prevented him making errors, but that he did catch on to them more quickly. Blind spotting is a kind of critical thinking and requires practice (and failures). So, forgive yourself. Biases and blind spots are just part of the way humans are.

The Metaphor

The consequences of the visual metaphor should be recognized when applying it anywhere else. A blind spot is a mechanical thing. It is built into peoples' bodies—permanent, universal, and unnoticed. What we are considering as ethical reasoning can be better understood as dynamic and evolving perceptual and decisional *processes* with varying degrees of awareness affected by situational and psychological factors like motivation, defensiveness, and the consideration of others. For example, the use of fading suggests that the stimulus lessens in intensity and locates the deficiency outside the individual. Using the term salience focuses on the individual's internal, especially cognitive, processes and can be more productive for psychological interventions.

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TREATMENT OF SUBSTANCE USE DISORDERS: The Elephant in the Room

MARK D. SCHENKER, PhD, *mschenker@navpoint.com*

In 2002, Bill Miller wrote "thirty years ago, the addiction field was regarded largely as a scientific and professional Siberia into which few psychologists ventured" (p. 292). However, more recently, psychology has made important contributions to the field (Schenker, 2016). Psychologists have played primary roles in developing Cognitive-Behavioral Therapy for addiction (Beck et al., 1993), Motivational Interviewing (Miller & Rollnick, 2012), Twelve-Step Facilitation (Nowinski & Baker, 2018), and the Transtheoretical Model (Prochaska et al., 1992). These are among the most prevalent treatment models used today.

Substance use disorders (SUDs) are present in as many as 50% (more for adolescents) of those in treatment for other disorders (Ross & Peselow, 2012), yet are often undetected or underassessed by treating professionals (Freimuth, 2008). Apart from its direct effects, addiction exacerbates or mimics other symptomatology and interferes with the efficacy of psychotropic medication. This is a blind spot for the field.

Nevertheless, many psychologists may not be well prepared to work with patients with SUDs encountered in clinical practice; fewer than half of clinical psychology training programs provide any training in addiction treatment (Dimoff et al., 2017); fewer than 20% of these programs *require* SUD training (Corbin et al., 2012). Other contributing factors include ongoing stigmatization, poor dissemination of research into the clinical setting, and the belief that SUDs can only be treated in a specialist system (Miller & Brown, 1997). Since Miller and Brown's seminal review, these concerns remain relevant. The real challenge of our profession is expanding the base knowledge of general practitioners around SUDs. Stigma persists within our profession and in the general public (Yang et al., 2017).

Miller (2002) noted that psychologists are well suited to treat addiction. A primary factor in therapeutic outcome is therapeutic alliance, something of which all psychologists are aware. Additionally, psychologists have knowledge of co-occurring mental health problems, which, as noted earlier, are prevalent in an addicted population.

Psychologists may be dissuaded by the commonly held stereotype that addiction is unresponsive to treatment and is a frustrating clinical experience. McLellan et al. (2000) found that relapse rates for those with addictive disorders were comparable to those of other chronic illnesses, including asthma, hypertension, and diabetes. This view of addiction as a chronic disorder suggests that treatment requires ongoing monitoring and care, like with other chronic illnesses.

While the common therapeutic factors are necessary for successful outcome, specialized knowledge of addictive disorders is also necessary for treating those with SUDs. This begins with accurate assessment and diagnosis and includes an understanding of the nature of SUDs, an awareness of the system of specialized care, and the ability to engage patients in treatment recommendations.

In contrast to common perceptions, addiction does not appear to be a unitary disorder; an older categorical view of addiction is obsolete. Apart from altering some of the criteria for diagnosis, (significantly, eliminating the criteria of "legal involvement," due to recognition of racial disparities in this domain), DSM-5 has reconstrued addiction as occurring along a continuum, identifying mild, moderate, and severe levels of the disorder. This is a departure from the *DSM-IV* conception of SUDs as falling into one of

two categories: abuse or dependence (the latter emphasizing physiological factors). The introduction of the term *substance use disorders,* also serves to reduce stigmatizing language.

While this is not the forum for a full description of treating SUDs, a few concepts are critical. Many patients presenting with substance use problems fall in the mild range, and benefit from different interventions than those at the severe end (who form more of the stereotypical image of "addicts"). For example, "mild" patients may benefit from working toward moderation (Rotgers et al., 2002), rather than abstinence. (Some "mild" patients, however, may be in an earlier stage of progression to more severe problems and should be monitored for difficulty maintaining moderation.) Those with more severe problems are more appropriately directed toward abstinence, and many models exist to achieve that goal.

Apart from DSM criteria, other issues are important for triage. One useful system of assessment looks for signs of physical dependence (manifested by withdrawal symptoms), elevated tolerance (need for increasing amounts over time), and loss of control (often summarized as "continued use despite negative consequences"). Awareness of negative consequences as well as periods of prior sobriety may also be explored; both may prove to be motivational touchpoints.

In particular, the assessment of physical dependence is a key consideration in triage. The risk of serious, potentially life-threatening withdrawal is present, particularly for those in the more severe range. Presence of prior withdrawal symptoms, quantity of substance use, and physiological instability raise concerns. Recommendations for such patients should include medical intervention, such as referrals to emergency rooms and detox programs. Similarly, assessment of psychiatric stability must be evaluated; stabilization of psychotic or suicidal patients clearly needs to be addressed prior to the initiation of SUD treatment.

The presence of an SUD may complicate diagnosis of mental health problems. For example, depression and anxiety may be *consequences* of substance use, not primary disorders. In some cases, cessation of substance use may eliminate or significantly reduce these problems. In other cases, elimination of substance use may reveal independent psychological problems, which may then be more effectively addressed.

All clinicians should be aware of local detox, rehab, and crisis services, as well as community resources such as outpatient SUD programs, Alcoholics Anonymous, Moderation Management, and SMART Recovery.

As noted, perhaps 90% of patients receiving SUD treatment do so at the outpatient level. While specialized outpatient SUD programs are common, many patients can be effectively treated in individual practice, which depends on a certain level of familiarity and comfort with this area. As in all therapeutic endeavors, the most important factor is developing a positive working alliance with the patient, regardless of the path chosen.

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IS RXP A BLIND SPOT FOR YOU?

STEPHEN A. RAGUSEA, PsyD, ABPP

Some psychologists still have a blind spot about the inclusion of psychopharmacology in psychological practice. They fear that adding prescriptive authority (RxP) will negatively impact our practice patterns. Will RxP change psychological practice? There is good news!

Psychologists have now been safely and effectively prescribing psychoactive medications for over 25 years and may now legally prescribe in Louisiana, New Mexico, Iowa, Idaho, Illinois, in the military, and on Indian reservations. We anticipate introducing a bill to permit appropriately trained psychologists to prescribe in Pennsylvania as well.

Several studies have been conducted to help us understand how prescribing impacts the practice of psychology. Significant research was reported in an article appearing in *Professional Psychology: Research and Practice,* and I encourage you to read it (Linda & McGrath, 2017). And, of course, *The Pennsylvania Psychologist* published an excellent edition focused on RxP in the July–August 2021 issue.

The 2017 study by Linda and McGrath involved 30 prescribing psychologists from Louisiana and New Mexico as well as 24 of their medical colleagues. The study had three foci: assessing the perceptions of prescribing psychologists, analyzing the practice patterns of the psychologists, and investigating the confidence medical colleagues had in prescribing psychologists with whom they worked. What did the study find?

The news is that it appears psychologists are prescribing with a high degree of success over a wide range of patient groups from different socioeconomic classes, minority groups, and practice settings. Overall, psychologists appear to be fulfilling the goal of increasing access to care among underserved populations. Furthermore, none of the psychologists reported that they had abandoned psychotherapy but, rather, they appeared to have simply integrated prescribing into their normal clinical practice and improved the quality of care provided to their patients. The authors found "no evidence of bias toward the use of medications versus psychosocial interventions."

Best of all, the authors found an "overwhelmingly favorable evaluation of such prescribers" (p. 38) from both fellow psychologists and the prescribing psychologists' medical colleagues. Over 95% of psychologists and their medical colleagues agreed that prescribing psychologists are safe, adequately trained prescribers; have sufficient knowledge; and appropriately consult and refer patients when appropriate. Plus, prescribing psychologists reported increased income and more complex caseloads, rewarding RxP training and practice.

While working on my doctorate, I wrote a paper in 1977 supporting RxP, and my professor suggested I was ill informed and should change my thinking. From my perspective, he had a blind spot. However, based on the results of cumulative experience and available research, we now have significant evidence that we should stop questioning whether RxP is a good idea and instead focus on how that knowledge set can enhance the practice of psychology and maximize our contribution to society. I hope in the more than 40 years that passed; his perspective has changed.

That's great news for everybody!

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THE INCONSPICUOUS BULLY: Kids Who Exploit Their Social Power[1]

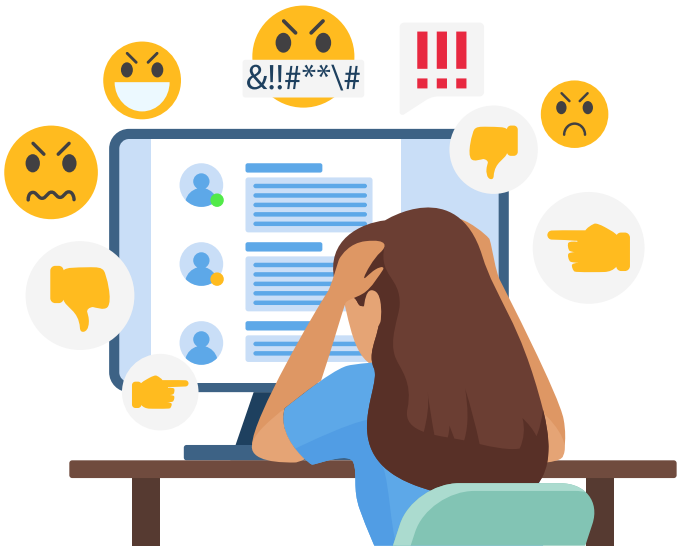
JANET SASSON EDGETTE, PsyD

Sharing the quiet neighborhood in which I grew up was a girl I'll call Marcie. Marcie wasn't a particularly nice girl, but that didn't stop me or any of the other kids in the neighborhood from trying to be her friend. She toyed sadistically and expertly with our wishes to be part of her "in" group.

One summer she made each of us pinkie swear that we believed her story about there being the decapitated Frankenstein heads underneath the sewer lids on our street. I didn't believe in Frankenstein, but I was afraid to not believe in Marcie. I spent one whole year engrossed in the terrible, tantalizing fantasy of lifting off those lids and finding heads in varying states of decay.

That same summer, Marcie turned 10-years-old. She planned a birthday party at her home and invited every kid in the neighborhood. On the morning of her party, I called Marcie to explain that I still needed my mom to go out and get some wrapping paper, and that instead of bringing her present with me when I came to the party, I'd bring it over right afterward. With overplayed indignation, Marcie seized the opportunity to punish me for my oversight and told me not to come at all. For three hours that afternoon I watched the birthday games of tag and dodgeball from the lawn across from hers. I was crushed, but still wanted nothing more than to be her best friend.

Marcie was a bully, but not everyone who knew her would have agreed. She said all the right things at the right time and smiled on all the right occasions. Her parents and teachers never heard her say or do anything mean. And most of the kids who were afraid of her wouldn't have been able to tell you exactly what she did that was so mean—she just was. She was that kind of bully.



When kids shout out insults or laugh conspicuously at others or post rumors on Facebook, we often can connect the person to the act, and the act to the victim's pain or distress. Kids like Marcie, however, wield their power inconspicuously, and it's harder to connect the person to the offensive behavior, and the behavior to the victim's distress. As a result, this kind of bullying is tough to spot and even harder to stop. It's a huge blind spot in our efforts to identify and curb bullying behavior among youth.

Let's take a closer look at what Marcie was doing to get my neighbors and me to oblige her every request: Before she had even finished grade school, Marcie had learned that she could effectively dominate and manipulate us kids by withholding something she had convinced us we wanted—her attention and, better yet, her approval. She didn't call us names, or physically threaten us. But her effect on the neighborhood was divisive and so, inadvertently, we did her dirty work for her, calling each other names and fighting

1. Adapted from *Bullying and Personal Power: Ideas for Parents and Teachers,* by J. S. Edgette, 2012 (https://www.niot.org/blog/bullying-and-personal-power-ideas-parents-and-teachers). Reprinted with permission.

among ourselves. By exploiting our anxiety about being singled out or left out, this clever but tragic young girl leveraged her keen sense of interpersonal dynamics and human nature into a form of social control.

Children need our help in identifying and deflecting this form of aggression as much as they've needed our help in responding to conventional forms of bullying. From a young age, they need us to talk with them—not once or twice, but many times—about personal power in social relationships; its uses and misuses, how it shows up in the cafeteria and at birthday parties and (for older kids) on dates, people's desires for it, the advantages and disadvantages of holding it, and how people—and especially kids—imbue and divest others of it. Leaving this stone unturned in our kids' education leaves them vulnerable to one of the more insidiously dangerous displays of power—*the kind you're not even aware exists.*

Ideas for Parents

You can help your own children understand these expressions of personal power by discussing and unpacking different social incidents in which these dynamics commonly play out. For instance, revisit with your son the time he kept trying to impress that loud-mouthed popular boy on his soccer team—the one he couldn't stand to listen to. Ask your daughter about the time she felt she had to go to so-and-so's party even though she didn't want to go, for example, "What did you worry would have happened if you declined the invitation?" Be sure to always ask with curiosity, and not to challenge.

Then listen to their answers, even if you think they're "ridiculous." Don't say things like, "Oh, you're making too big a deal over it. …" or "Why do you care what someone like him thinks?" You'll be defeating the whole purpose of asking your child in the first place. The idea is to talk about how we can be made to feel things we're neither comfortable with, nor understand, and then go ahead and act on them anyway.

These kinds of conversations don't need to be planned in advance or last more than five minutes. They can happen while standing in line at the grocery store after you and your daughter watched a strained, sarcastic interaction between the two teenage sisters who just checked out in front of you ("I thought that was a pretty sad situation with those two sisters. … The younger one looked as though she just idolized her older sister, but the older one didn't have the time of day for her, which only made the younger one try even harder to get her approval. It doesn't look like bullying, but it's mean, and the older one knows it. …").

The best conversations happen when you talk about your own experiences struggling with some of these same feelings, for example, after realizing you took advantage of your son's empathy about your bad day to get him to do an unreasonable amount of housework that day: "I owe you an apology, buddy. You were so understanding about my bad day at work and I kind of took advantage of it and made you do all this work around the house because I knew you wouldn't complain. But that wasn't right, and I'm sorry. …"

These are beautiful opportunities to show our children how easy it is to succumb to emotions and impulses you would rather not admit to having. It also helps to normalize these feelings so that kids don't feel weird admitting to them, and it humanizes us as parents. "Remember when you tried so hard to impress that kid, Jonah, the one you didn't even like? As a kid, you know, I did that same thing many times. I've even done it as an adult, whenever I get anxious about being left out of something I think is important. I don't like that I do it, but it's true. …"

And here's the funny thing about these kinds of very intimate, revealing conversations—no matter how much we stumble over our words or how awkwardly we tell our stories, our children will remain riveted by our candor. Kids find that expression of honesty and authenticity very compelling, and I believe we give them too few opportunities to experience us in that way. These are our most powerful and affecting tools of influence; shame on us if we let our self-consciousness, or our anxiety about appearing discomposed or blemished, keep us from capitalizing on our own humanity as a means of inspiring that of others.

Ideas for Teachers

Here are some questions that middle and high school teachers can use to stimulate class discussions about (a) different types of peer-to-peer exploitation that take place in social settings, (b) what makes certain children more or less vulnerable to them, and (c) what kids can do to recognize and resist them:

- Exactly how does someone become popular? Can a person just say all by himself or herself that he or she is popular, or do other people have to agree?
- Have you ever had two different feelings at the same time that didn't seem to go together, i.e., wanting to impress someone who you didn't like and didn't want to be friends with?
- How does a person know that he or she is popular? What are the signs?
- What can popular kids do that kids who aren't popular can't do?
- Is being popular the same as being well-liked? Why or why not?
- Are there popular kids who do not have a lot of friends? What's that about?
- What does this have to do with leadership? Is there such a thing as good leadership or bad leadership? What do those terms mean to you?
- What things have you done because you thought it might make someone like you?
- What does the word manipulation mean? Have you ever been manipulated to do something by another kid your age? How did you feel afterward? Thinking back on it, was there any way you could have avoided it?
- Have you ever tried to get other people to do something you knew they didn't want to do? Can you identify what you were hoping to gain that was so important you'd manipulate someone to get it?

PENNSYLVANIA STATE BOARD OF EDUCATION CHAPTER 49 UPDATE

RICHARD E. HALL, PhD, *Chairperson of the Pennsylvania Psychological Association: School Psychology Board*

Chapter 49 of the Pennsylvania School Code establishes requirements for the preparation, certification, and continuing professional education of professional personnel in Pennsylvania's pre-K–12 education system. The mandatory decennial review presented opportunities for the professional associations representing school psychologists to address an issue of unfairness to school psychologists. In Chapter 49, experience as a school psychologist cannot be applied toward the 5-year prerequisite to entering a supervisory certificate program for Special Education with the goal of earning supervisory certification in Special Education, despite training and skills appropriate to this role.

The Association of School Psychologists of Pennsylvania (ASPP) and the Pennsylvania Psychological Association School Psychology Board (PPA SPB) are advocating for changes in Chapter 49 that would allow school psychologists to use 5-year experience as school psychologists to satisfy the experience requirement for the Supervisor of Special Education certificate. In June 2020, Dr. Tammy Hughes, Professor of School Psychology at Duquesne University, provided testimony to the Pennsylvania State Board of Education (PA SBE) on this issue. Dr. Hughes, representing the PPA SPB and ASPP, provided compelling evidence comparing the preparation of school psychologists in their graduate training to the training of special education teachers. The overlap in

knowledge, experience, and skills is strong as are the skills school psychologists have in designing and enhancing educational programs. School psychologists are trained to evaluate and support students across all the disability categories providing additional benefit of serving as supervisors. She noted that experience as a school psychologist satisfies a requirement for principal certification and that principals supervise all teachers in their buildings, including special educators.

In June 2021, Dr. Monica McHale-Small, Chair of the PPA SPB Public Policy Committee and Dr. Susan Edgar-Smith, Dean of College of Education and Professor at Eastern University, provided written and oral testimony to the PA SBE in support of proposed changes to Chapter 49 that would allow school psychologists to obtain Special Education Supervisory Certification after the requisite years of service and completion of the appropriate graduate coursework. In their testimony, Dr. McHale-Small and Dr. Edgar-Smith offered support for this proposed policy change that was based on the training, skill set, and experience of school psychologists. They noted that school psychologists regularly work with special educators to develop educational programming for students, assist in monitoring the progress and effectiveness of these programs, and provide professional development for general and special educators on topics related to special education and meeting the needs of students with disabilities.

ASPP and the PPA SPB requested a modification to Chapter 49 to the experience requirement only. The intention was to keep the completion of a graduate program, requisite field experience hours, and satisfactory achievement in assessments (praxis exams) as requirements for school psychologists. The associations requested an addition to Section 49.111(a)(1) that reads:

> Have completed 5 years of satisfactory certified experience in the area in which the supervisory certificate is sought. Five years of experience as a school psychologist can be applied toward a supervisory certificate in PPS and/or SPLED.

This modification is consistent with regulations for Supervisory Certification for Curriculum and Instruction and Pupil Personnel Services for which experience as a school psychologist is acceptable.

ASPP and PPA were not asking that

school psychologists be awarded the Special Education Supervisory Certificate without going through required graduate coursework and field experience required in state certification programs. Instead, the request was that the 5-year experience of school psychologists could allow them entry into a Special Education Supervisory Certification Program.

The State Board of Education responded by including the provision that individuals may use their 5-year experience as school psychologists to satisfy the experience requirement for the Supervisor of Special Education Certificate in their first Chapter 49 draft. However, following a public comment meeting, the Independent Regulatory Review Commission (IRRC) expressed concern based on comments they received that school psychologists are not properly trained and capable of carrying out special education supervision. The IRRC summarized the concerns as follows:

1. School psychologists do not have the knowledge, experience, and skills to support, guide and evaluate special education teachers;
2. School psychologists do not have the knowledge, experience, and skills to design, assess, and implement instructional programs;
3. Allowing school psychologists to move into supervisory roles will not enhance the delivery of services to special education students;
4. Lowering the qualifications of this certificate will have serious implications for the equity and quality of special education services;
5. This may exacerbate the shortage of school psychologists.

These concerns indicate a limited knowledge of the training and functioning of school psychologist in Pennsylvania schools. Taking each of these concerns in turn:

1. School psychologists receive extensive training in school consultation. A primary role of school psychologists is to use their skills to guide special education teachers toward more effective, research-based instruction and intervention for students with disabilities.
2. On an almost daily basis school psychologists use their knowledge, experience, and skills to design, assess, and implement instructional programs for students with disabilities. School psychologists are trained to evaluate and support students across all the disability areas providing additional benefit to their serving as supervisors.
3. Because of their extensive training and experience in implementing scientific, research-based programming, allowing school psychologists to move into supervisory roles will in fact enhance the delivery of services to special education students.
4. The proposed changes in Chapter 49 do not lower the qualification requirement for this certificate.
5. The proposed changes to Chapter 49 would provide career advancement opportunities that would serve to draw more students to the field of school psychology and retain current practitioners, thus possibly alleviating the noted shortage of school psychologists.

Despite our concerted efforts to advocate for modifications to Chapter 49, the PA SBE in their final draft removed the provision allowing experience as school psychologists, likely due to the unfounded concerns reported by the IRRC following the public comment period. In fact, language was added making it clear that exceptions could not be made for the Special Education Certificate.

The state legislature can overrule this decision and PPA and ASPP will continue to work to persuade legislators to allow experience as a school psychologist to be applied toward the 5-year prerequisite to entering a supervisory certificate program for Special Education. The support of members of PPA and ASPP is critical for the continuation of this effort.

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HISTORICAL RESPONSE TO BLIND SPOTS

HELENA TULEYA-PAYNE, DEd
JOSEPH KOVALESKI, DEd

In May 2018, Dr. Kent McIntosh, Director of Educational and Community Supports at the University of Oregon, was a keynote speaker for the Pennsylvania Positive Behavior Supports Implementers' Forum. Dr. McIntosh, a school psychologist, focused on understanding and addressing implicit bias in school discipline. He described how we as educators may have biases of which we are unaware, leading to automatic responses to behavioral situations we encounter. Banaji and Greenwald (2013) used the term *blind spot* to describe hidden biases that can guide our behavior without our awareness of their role. Although these authors address the implicit biases of individuals, is it possible that a field of practice and research such as school psychology has, over its history, demonstrated blind spots in appropriately serving children? This article proposes several blindspots and looks at the responses of school psychologists and educators.

Blind Spot: Mainstreaming and Inclusion

The authors were graduate assistants at Penn State's school psychology program in the 1970s during which they were involved in a mainstreaming program in Pittsburgh schools. This practice laid the groundwork for inclusion and involved placing children needing special education in regular education classes, typically children identified as having learning disabilities. During this same period, a representative from the federal Office of Special Education Programs (OSEP) arrived on campus and admonished educators in attendance for failing to identify a sufficient number of students as needing special education. It appeared that OSEP may have had a blind spot about how students with disabilities benefit when educated with typical peers. It was not long after, however, that in 1975, the Education of All Handicapped Children Act (EHA, PL 94-142) was passed establishing the concept of education in the least restrictive environment that diminished the need for stand-alone classes for many students with disabilities.

Blind Spot: Parental Role in Educational Decision Making

A provision of the EHA and subsequent statutes was the increased emphasis on the role of parents in educational decision making. The value of caregivers may have been a blind spot for many who were accustomed to relying solely on educational professionals to make decisions. One of the authors recalls her reaction (negative) to needing to include a parent who, recently released from jail, was a self-described voodoo priestess with a diagnosis of serious mental illness. During the meeting, the parent sat quietly and then interjected an observation of her child and possible connection to behavior that had previously escaped the "experts" in the room. This author remembered feeling humbled by her preconceptions and it served as an epiphany about the value of parental input.

Blind Spot: The Role of Curriculum and Instruction in Student Educational Success

During our graduate training and early careers, the prevailing assumption about the practice of school psychology was that

a student who displayed academic or behavior problems in the classroom likely had a hidden disability, and it was the role of the evaluation team (including the school psychologist) to uncover the disability so that special education could be provided. It was further assumed that the general educational program of curriculum and instruction was working so that the problem resided in the student who failed to achieve or behave appropriately.

It soon became apparent to many of us that the failure to acquire basic skills was rampant in many, if not most, school districts. It was clearly a blind spot to focus solely on individual students when a plurality or majority of students were not proficient in reading, writing, and/or mathematics. The problem then seemed not to be based in the student but in the educational environment. This dawning realization among school psychologists and other educators led to two significant movements in the 1980s that have pervaded the field since that time. First, although the notion that school psychology was a hybrid of psychology and education had long been articulated in the literature, in reality, most school psychologists lacked a real understanding of effective classroom practices. That is, school psychologists needed to develop expertise in the nuts and bolts of classroom learning. They needed to develop skills in analyzing the curricular demands of a student's educational environment and determining whether effective instructional practices were being used. This understanding was actually codified in the Individual with Disabilities Education Act (IDEA; the successor to EHA) in its requirement to determine if a student's school problems were due to a lack of instruction and allowing evaluation teams to use response to intervention (RTI) as part of the determination of specific learning disabilities. Hence, both public law and school psychology training and practice supported assessment procedures that included the school milieu in addition to the student's skills per se.

The second resulting movement in the field was the establishment of teams of teachers and specialists who were tasked with improving classroom instruction and schoolwide discipline procedures as well as identifying students for supplemental interventions with the intent of preventing the need for special education. In Pennsylvania, this movement resulted in the establishment of instructional support teams (ISTs) in the 1990s, and positive behavior support teams in the early 2000s. Today, most schools have in place what is known as the multitiered system of supports (MTSS), which often addresses both academic interventions and schoolwide positive behavior supports. Although not all school psychologists embraced ISTs at first (one noted trainer exclaimed that we were "shooting school psychology in the foot"), many others recognized that the process was an opportunity to extend their impact to more students. Notably, school psychologists were at the forefront of RTI and MTSS at both the state and local levels as it rolled out in Pennsylvania in 2005. Clearly, the blind spot had been surmounted through enhanced training (in graduate programs and through PaTTAN) and the support of professional organizations.

It may be argued that recognition and response to blind spots have positively impacted educational service delivery. School psychologists need to continue monitoring research and policies that shine a light on relevant issues and practices. Openness to acknowledging blind spots is also critical.

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EMPATHIZING, EXPLORING, EXPERIENCING, AND EDUCATING:

Cultural Humility in College Mental Health

WHITNEY ROBENOLT, PsyD (SHE/HER/HERS)
SEAN MOUNDAS, PsyD (THEY/THEM)

Context always matters. We write this article as early- to mid-career college counseling clinicians, practicing in the field of college mental health in urban and rural areas of the United States when the nation and world are affected and polarized by the COVID-19 pandemic. Continued social injustices include racism, climate change, as well as responses to efforts to increase education regarding diversity, equity, and inclusion. The need for empathic connection and attunement, always critical, has seemed even greater. We also write about the importance of cultural humility with a continued awareness of our privileged (including regarding race) and marginalized identities and with a focus on individual counseling.

Several definitions and models are influential. Intersectionality, coined by scholar Kimberlé Crenshaw (Bartlett, 1991) and referring to how systems of power and privilege also intersect, also guides our work. Likewise, the ADDRESSING model (Hays, 1996) provides a framework for exploring intersections in the clinical space, though there are some identities, like military veteran/connected status, that are not yet included.

Cultural humility in health care practice emerged from the medical training literature (Tervalon & Murray-García, 1998) and refers to the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (Hook et al., 2013, p. 2 as cited in Waters & Asbill, 2013, p. 2). Cultural humility is self-reflective, occurring throughout the lifespan, and is not only about knowledge but also about adopting a critical perspective about power differentials and systems. Hook et al. (2017) concludes that embracing cultural humility requires both "being" and "doing" clinically: to inhabit a sphere of not completely knowing what it is like to experience the world as a client does given their identities, to reflect that back empathically, and to do more to learn about a person's realities and engage in actions that promote social change. Cultural humility development can be aided by empathy, exploration, experience, and education, and it is always affected by our own intersecting identities and experiences.

Empathize

Ask ourselves and clients alike, "What is the person feeling, thinking, doing, remembering, and reflecting about in this situation given their identities?" How can we continue to connect on the affective levels in particular, given our intersecting identities? Especially when working with clients who are engaging in microaggressions themselves, how can we, as clinically indicated, demonstrate an empathic perspective regarding those whom they affect? We strive to balance exploring our differences in the context of our commonalities and being mindful of self-disclosure as a therapeutic tool when in the service of a client feeling more understood and less isolated. Reflecting on whether we are the best matched clinician for the individual, given their goals and therapist preferences, can also be quite helpful including with consultation.

Explore

All practitioners experience some form of bias. Some bias is overtly displayed through explicit behaviors while others are more implicit. These biases are often developed as a consequence of our environment in the form of stigmas, witnessing and/or experiencing hateful actions, cultural isolation, and limited educational experiences. Without an understanding of our biases, further cultural humility is not possible. Reflecting on responses from the Harvard Implicit Association Test can be a

helpful step in this process as well as having continued dialogue in consultation spaces and one's own therapy.

Colleges and universities can be settings rich in change, diversity, and growth; however, if we lack the awareness of our own personal biases within a counseling setting, are we truly serving this population's needs to the best of our abilities? In order to build our awareness of our underlying biases, we need to be open to educating ourselves. Seeking further education regarding enhancing cultural humility can allow us to become more aware of our strengths and weaknesses and promote the expansion of our skills. If we are unwilling to explore and work on these limitations, we might not be able to provide empathic, individualized, culturally humble support to diverse campus communities. Students who feel isolated and not attuned will likely not reach out in times of mental health crises, forced instead to learn to address those concerns on their own. Additionally, college counseling centers are often young adults' foundational experience regarding obtaining mental health care. If those experiences are negative ones, due to lack of understanding (even with positive intent) by the practitioners, will it not impact their potential willingness to seek helping behaviors in the future?

Experience

Depending on our backgrounds and experiences, understanding of diversity, equity, and inclusion may be limited. Appreciating the diverse circumstances, identities, and experiences our students may present with is imperative to best meet students' individual needs.

Some of the ways we can do this is through developing connections with campus resources and educational organizations, especially those on campus that interact directly with the students, and inviting groups to present to colleagues. Having these connections increases our insight into students' experiences, increasing our empathic attunement. Additionally, it is important that we continue to seek out appropriate supervision and/or consultation when needed. Crucially, via this exploration, we do not just examine a student's presenting concerns, but also the impact of students' multicultural identities and experiences and how they intersect with our own.

Vignette

The vignette (see Box 1) examines some specific questions that may provide information concerning your own reactions and aspects of your client that support a culturally valid approach.

Educate

We can continue to educate ourselves via not only reading but also being part of an experiential group that focuses on the effects of privileges. As well, there are measures regarding the extent of cultural humility that can be used by clinicians independently and in supervision. PPA also offers many helpful resources regarding cultural humility, which can be found at www.papsy.org/Anti-Racism.

Conclusion

We wish to conclude with a call to action and reflection. What is something you can do differently to increase awareness of your biases, and then act on that awareness? What would it be like if there was a licensure requirement regarding diversity, equity, and inclusion?

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BOX 1

You are about to meet with a person for individual counseling for the first time. You know that the person is presenting with historical and recent experiences of isolation, emotional and physical fatigue, shame, and experiences of bias toward them. The person has numerous strengths including verbal intelligence, assertiveness, creativity, and compassion for others. The client has a history of therapy with positive and negative experiences, and prefers an active approach. The person shared not having any safety concerns and denied challenges with eating and substances. You log on to the session.

As you are reading this vignette, what thoughts, feelings, images, and/or sounds came to mind when you saw the word *person*? Did any assumptions, even biases, arise? Is the person more similar or different to you? What attributes came to mind? Which did not? Please take a few moments to reflect on this.

You might have noticed that there is no information about the individual's intersecting multicultural identities. All of these questions, from the brief vignette above, are unanswered. How old is the person? What pronoun(s) are used by the individual? How does the person navigate the world—literally and figuratively? Do they have indigenous heritage? How does the client identify racially and ethnically? With which sexual and gender identities does the person identify? Is the individual a military veteran? How do they characterize themselves regarding socioeconomic status? Are you about to meet with someone with acquired and/or developmental disabilities? If you were to have sessions in person, is your office accessible? Has the person ever experienced sizeism? Which language(s) are spoken by the individual? To what extent, if at all, is spirituality and religion salient to the client? What other identities may be important to the person?

To what extent did these questions enter your mind upon initial reading of the first paragraph? This question is not asked with intent of any kind of shaming or embarrassment; rather, it is in the service of cultural humility and reflection.

As a clinician, having and eventually learning information about a client's presenting concerns and strength and the histories of these and other parts of their life is critical. Equally crucial is becoming aware of and connecting with the person's privileged and marginalized identities and how they are perceived—and perhaps unfortunately misperceived and maltreated—by others, as our life experiences are lived in these sociocultural locations. Also important is how the client's and your identities of power and oppression connect and affect one another.

ethics in action

ANOTHER PERSPECTIVE
on a Client Selling His Medication

JEANNE M. SLATTERY, PhD, LINDA K. KNAUSS, PhD, and JOHN GAVAZZI, PsyD

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the three of us, respondents to this vignette included Drs. Gina Brelsford, Claudia Haferkamp, Sam Knapp, Jade Logan, Jay Mills, Max Shmidheiser, and Ed Zuckerman. Rather than immediately reading our responses, consider reviewing and carefully working through the vignette first.

Dr. Janssen has been treating Eli Lily for the past year. During a recent session, Mr. Lily stated that he had been having financial problems but noted that he can sell his medication to coworkers and neighbors. Dr. Janssen asked a few other questions, then Mr. Lily changed the subject. While writing notes, Dr. Janssen reviewed notes from the initial intake. Mr. Lily takes a variety of controlled substances, including Adderall for ADHD and Ambien for insomnia.

At the next session, Dr. Janssen asked more questions about the medications he had been selling. Mr. Lily reported that he sells Adderall and Ambien intermittently; however, he has had a medical marijuana card and has been selling various forms of medical marijuana on a regular basis. Mr. Lily receives prescriptions for medication from his physician's associate (PA), with whom Dr. Janssen has consulted about Mr. Lily. Mr. Lily obtained a medical marijuana card independent of the PA and has not disclosed the marijuana card, its use, or his selling to his PA.

Although Dr. Janssen is clearly concerned about these legal and clinical issues, he also wants to just forget he asked these questions; nonetheless, he called for a consultation.

Mandated Reporting?

This case raised a number of questions for us, especially whether Mr. Lily's report of selling his medications should be reported to either the police or the PA. Although the American Psychological Association (APA) Ethics Code says, "the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship" (APA, 2017, p. 7, Standard 4.01), there is no state or federal law indicating an exemption to confidentiality only because a crime will be or has been committed. This is in stark contrast to the situation of child abuse. In fact, the Ethics Code clearly says that disclosures without the consent of the client only happen under very limited circumstances: in order to provide needed services; obtain appropriate consultations; protect the client, psychologist, or others from harm; or obtain payment. None of these situations seem to apply when we consider disclosing Mr. Lily's reported drug sales to the police. Such disclosures occur under very specific situations so as to protect the psychologist's relationship with the client and their work together.

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

Confidentiality With Other Professionals

Dr. Janssen may want to disclose Mr. Lily's behavior to the prescribing PA, presumably one outside Dr. Janssen's own practice. The Ethics Code argues, "when indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately" (APA, 2017, p. 7, Standard 3.09). Standard 4.05 requires "appropriate consent" before the disclosure and Standard 4.06 notes that we can "disclose information only to the extent necessary to achieve the purposes of the consultation" (APA, 2017, p. 8).

Although the Code seems clear, Dr. Janssen and Mr. Lily might reasonably draw different conclusions about what is "effective" or appropriate. When there is some potential for disagreement, Dr. Janssen should carefully consider whether their actions "respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (APA, 2017, p. 4, Principle E). Disclosing Mr. Lily's actions without obtaining his consent first seems to violate the intent of Principle E and may undermine treatment.

Given these concerns, it would be best for Dr. Janssen to first discuss these issues with Mr. Lily—especially as they may be relevant to his treatment goals. Perhaps a fuller, more honest discussion might clarify treatment goals and identify possible unmet needs that may be indicated by his behavior within and outside of treatment. Perhaps they could agree that Mr. Lily would discuss his unmet treatment needs and his sales of his medication with his PA, which would then return Dr. Janssen's worry and perceived responsibility to Mr. Lily, who is the one who should be most worried about the issues raised in this vignette.

A Broader Context

In our discussions of this case, it was clear that some of us were thinking that Mr. Lily was a slick and shady person ripping off the system and selling drugs to frat boys or at his country club. Some of us questioned how we can ethically and effectively work with clients who cannot play it straight with their health care providers, and we wondered whether we could trust them in the future. Is Mr. Lily participating in his treatment plan in a good faith manner? Are we judging him for the illegality and questionable morality of this conduct? These stereotypes and attributions raised moral issues and questions about fairness for many of us.

This frame of Mr. Lily's behavior tended to divorce our personal ethics and morals from our professional ethics, what Handelsman et al. (2005) referred to as a *separated identity*. Operating only from our personal ethics can pull us off balance in our work, such that we want to report Mr. Lily's behavior, despite his disclosure being confidential. Psychologists often discover things that make them uncomfortable, especially regarding the interface of personal values and professional ethics; yet, paying attention to both personal and professional ethics can help us identify and prevent problems.

Dr. Logan argued that stereotypes about people selling drugs interfere with our understanding and empathy and blinds us to other perspectives on Mr. Lily's behavior. Psychologists may engage in ethically questionable behaviors inconsistent with their own preferred ethics—to be fair and unbiased—under situations of limited awareness (Bazerman & Sezer, 2016). When we are more reflective about our choices, we might make different and better decisions.

The frame that Dr. Janssen approaches this case with may or may not be correct, but he should consider Mr. Lily's motivations for selling his prescriptions. Does he have (or recognize) other options for feeding his children and paying his bills—especially if he was unemployed during the course of the pandemic? Would it be helpful to ask Mr. Lily to consider the risk he is incurring by selling the medications rather than focusing on the consequences of not having that money? How does this new frame of Mr. Lily's behavior shift the way that we see him and the nature of our interventions in a helpful way? Further, while we see ourselves as safe and nonjudgmental, from a less privileged position (e.g., what Mr. Lily might be in), would Dr. Janssen be perceived as a safe and nonjudgmental person to whom one could disclose illegal behavior? Nonetheless, Mr. Lily's disclosure does suggest increasing trust in Dr. Janssen and the therapeutic process. How does this second frame of his behavior shift the way that we perceive his "late" disclosure in treatment and his behavior?

Conclusions

The ways that we think about a situation has consequences. This and other less stigmatizing perspectives of Mr. Lily's perceived substance use and drug sales might open Dr. Janssen up to other possibilities in how he approaches his consultation with the PA. A more holistic perspective of Mr. Lily might facilitate more effective work with the PA and Mr. Lily as part of a coordinated team (Hodgson et al., 2013). Such an approach might have already led to discussions between Dr. Janssen and Mr. Lily about how to obtain signed informed consents and releases to exchange information with other practitioners. Consistent with Principle E, Respect for People's Rights and Dignity, Dr. Janssen should again discuss the limits of confidentiality, what he would like to disclose, and how that would only be with Mr. Lily's permission. Regardless of what they decided, these decisions are clinically significant and should be documented in the chart.

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CE QUESTIONS FOR THIS ISSUE

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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.

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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 services.

Boundary Issues You May Not Have Considered

1. One of the most important reasons to enforce your business policies is:
- a. To earn respect from clients
- b. To maximize your income
- c. To minimize intrusion of negative countertransference into your work
- d. To discourage employees from gossiping among themselves

2. If you find that you repeatedly make exceptions to your own business policies:
- a. Revise your policies to terms that you feel comfortable enforcing, and change them later if needed
- b. Post a sign in your office and on your website, that policies will be strictly enforced
- c. Negotiate your policies with each client individually
- d. Hire a practice management consultant

Danger: Blind Spots in Ethical Decision Making

3. A major contribution to efforts to make more ethical decisions is the researcher's identification of a metaphor called *ethical fading,* which is:
- a. Lowering the "volume" of the voice of our conscience, in a metaphorical sense
- b. The paradoxical increasing of the "light level" or "illumination" in which the moral action is considered
- c. The exclusion of the ethical issues from some area of decision making
- d. The backgrounding of the moral or ethical concerns about the harmful effects of a decision on the persons involved as legal, financial, time pressure of other considerations are brought to the foreground

Treatment of Substance Use Disorders: The Elephant In The Room

4. One of the most important tasks of a psychologist assessing an addiction problem is:
- a. Immediate referral to a rehab program
- b. Discussion of the importance of complete abstinence
- c. Assessment of psychiatric stability
- d. Involving family members for corroboration

5. One approach that is not commonly used for treating SUDs is:
- a. Cognitive-behavioral treatment
- b. Motivational interviewing
- c. Psychoanalysis
- d. 12-step facilitation

Is RxP a Blind Spot for You?

6. Dr. Ragusea states that specially trained psychologists
- a. Have now been safely and effectively prescribing psychoactive medications for over 25 years and they may now legally prescribe in Louisiana, New Mexico, Iowa, Idaho, Illinois, in the military, and on Indian reservations
- b. Have been prescribing only in the military
- c. Like Pennsylvania's Anita Brown can prescribe anywhere in Pennsylvania
- d. None of the above

7. Dr. Ragusea states that Linda and McGrath found
- a. An "overwhelmingly favorable evaluation" of prescribing psychologists from both fellow psychologists and the prescribing psychologists' medical colleagues
- b. Prescribing psychologists reported increased income and more complex caseloads, rewarding RxP training and practice
- c. No published research about the practice of prescribing psychologists
- d. Both a and b

The Inconspicuous Bully: Kids Who Exploit Their Social Power

8. Which of the following statements are true?
- a. It is never helpful to talk to your kids about your own experiences with being bullied
- b. Bullying is not a form of social control
- c. It is important to talk with kids about the persuasiveness of personal power in social relationships
- d. The most powerful and detrimental type of bullying is always physical

9. One way to help kids and teens recognize and resist social exploitation by peers is by having conversations with them about things such as:

a. What it means to be popular
b. Examples of social manipulation
c. A person's need to be liked
d. All the above

Pennsylvania State Board of Education Chapter 49 Update

10. What modifications to Chapter 49 did ASPP and PPA request regarding the Supervisory Certificate for Special Education?

a. Allow experience as a school psychologist to substitute for supervisory graduate program
b. Allow 3 years' experience as a school psychologist to satisfy the experience requirement
c. Allow 5 years' experience as a school psychologist to satisfy the experience requirement
d. Require school psychologists to earn an instructional certificate to qualify for the supervisory certificate

Historical Response To Blind Spots

11. In the past, school psychologists may have had blind spots about which of the following?

a. The value of caregivers in educational planning
b. Inclusion of students with disabilities in regular education
c. Effective classroom practices
d. All the above

12. The authors make the point that _____ can help surmount blind spots in service delivery.

a. Enhanced training
b. Support of professional organizations
c. Reliance on peer interaction
d. Both a and b

Empathizing, Exploring, Experiencing, and Educating: Cultural Humility in College Mental Health

13. Cultural humility:

a. Focuses more on process than product
b. Focuses mostly on knowledge
c. Is often life-long
d. Both a and c
e. All the above

14. Cultural biases:

a. Are mostly explicit
b. Are mostly implicit
c. Can affect the therapeutic alliance
d. Are not modifiable
e. None of the above

Ethics in Action: Another Perspective on a Client Selling His Medication

15. Bazerman and Sezer (2016) argued that a narrow frame of a situation can lead to problems. They suggested, instead:

a. Rejecting other perspectives
b. Exploring other perspectives
c. Following a "first hunch"
d. Ignoring other perspectives

16. Approaching a situation from only one's personal ethics

a. Is an example of a separated identity and leads to especially ethical work
b. Is less effective than integrating both personal and professional ethics
c. Is recommended by APA's Ethics Code
d. All the above

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, December 2021

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

1.	a b c d	5.	a b c d	9.	a b c d	13.	a b c d e
2.	a b c d	6.	a b c d	10.	a b c d	14.	a b c d e
3.	a b c d	7.	a b c d	11.	a b c d	15.	a b c d
4.	a b c d	8.	a b c d	12.	a b c d	16.	a b c d

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
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