The Pennsylvania
Psychologist
DECEMBER 2023
VOLUME 83, NUMBER 9

PSYCHOLOGICAL MYTHS

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION
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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.*

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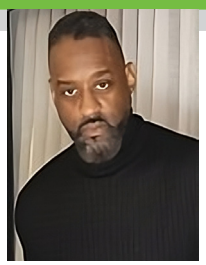

A WELCOMING AND SAFE PPA

TIM BARKSDALE, PsyD

While COVID tends to highjack any conversation about social patterns and activities, when did you last attend a PPA Convention? Would you say that in-person PPA Conventions and conferences facilitate a safe and welcoming environment? How do you feel when you begin reviewing your email and see a message from the listserv? While many have experienced The Pennsylvania Psychological Association as a place of warmth, welcome, and feelings of safety for decades now, there are some who report experiencing chilling and disappointing encounters at last year's Convention. This has PPA's leadership in recovery and reimagining mode to restore and extend the sense of family that has been enjoyed for years by so many.

Last year, PPA staff and volunteers organized an excellent, well-run, informative, and entertaining Convention in State College. However, there were occurrences in some of the workshops and main events that made some attendees feel unwelcome and at times, unsafe, especially by those from the global community or of various intersectional identities. A few examples include one ethics workshop, with approximately 100 people in a relatively small room. Unbeknownst to the two presenters, an attendee in the rear became disruptive, making comments about "those people," referring to veterans. Later, two attendees noted that another participant mumbled racist statements throughout the workshop. In a different workshop the next day on psychological evaluation for immigration purposes, within the first few minutes into the presentation, two attendees challenged the presenters, two young non-immigrant female psychologists, throughout the workshop. The provocateurs reportedly made comments about immigrants being criminals who do not pay taxes. The presenters reported this conduct and shared with us that undocumented immigrants, upon entering this country, are required to pay taxes and collectively pay $90 billion in taxes every year (Internal Revenue Service, 2023). Additionally, immigrants are often more likely to be the victims of crime than American citizens (Freemon et al., 2022). At yet another workshop, a well-respected psychologist commented that he was not "woke enough" to know what ethnicities were normed for an assessment he was presenting. It is likely that this presenter was not knowledgeable about how the term woke has been taken from and weaponized against the Black community as their history is slowly being outlawed. Other acts that projected unwelcomeness included someone discounting requests from a female of color to increase sound volume while the same request was honored by a White attendee, misuse of pronouns, and a member who took the liberty to speak Mandarin to a member of Asian descent without knowing his or her language. PPA's mission is to effectively communicate to the public, policy makers, and membership the value of evidence-based and ethical practice. The disruption of workshops and projections of hostility is not in alignment with our mission or values.

Had I experienced these things in my first attendance to a Convention, I am not sure I would still be a member. There were several factors that have contributed to my continued Convention attendance, membership, and involvement in leadership. For one, an essay submission facilitated my receipt of the Matthew H. Small Memorial Award given in honor of the brother of Dr. Richard Small. A member of that award review committee, the late and great Diane Salter, greeted me warmly as did her sister, Beatrice Salter, whom I met earlier in the hallways of the Convention. Second, my school, Philadelphia College of Osteopathic Medicine (PCOM), had faculty and students ahead of me who were active in PPA leadership and as I have shared with anyone who would listen, previous PPA Director of Professional Affairs, Dr. Sam Knapp, was my ethics professor. Board Member, Beatrice Chakraborty, helped me write my internship letter. PPA members asked me to teach workshops with them and a professor, Dr. Eleanora Bartoli, whom I approached after her mesmerizing workshop, invited me to join the Committee of Multiculturalism (the CoM) as she was the chair. Two years later she insisted that I, a student working on my dissertation, take over for her as committee chair upon the end of her term. I have been in leadership ever since.

To recap, I knew people who attended the Convention, I was greeted and supported by PPA members and leaders, I was warmly received, I was invited to conduct Convention workshops, and I was asked to take on a leadership role all before graduating. My path is not likely typical of the majority of new and existing PPA members, but our goal is to help others have similar experiences.

At PPA, we are working with the Electronic Media Coordination & Committee

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HAPPY NEW YEAR! SOME NOTABLE ACCOMPLISHMENTS OF 2023 TO CELEBRATE

ANN MARIE FRAKES, MPA

First, I want to recognize that even though our world this past year was full of challenges and trauma, there is still so much to be thankful for and celebrate. THANK YOU for your continued membership and support of PPA.

Here are 10 items of note from 2023, that we would like to highlight for you, our members:

1. Iva Brimmer, PPA's long-time Director of Administration, will be officially retired by December 31, 2023, after 30 years of outstanding service and several attempts at retirement. Congratulations to Iva on a stellar career, always serving the members, volunteer leaders, and staff with the highest possible level of customer service. Happy Retirement Iva! We sure will miss you!

If you would like to send retirement cards and good wishes to Iva, please address them to Iva Brimmer here at PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112. We will be sure to send them directly to her.

2. On September 5, 2023, in anticipation of Iva's retirement, Justin Danner started as our new Business Manager. He brings much energy and initiative to the position and has already completed some important projects around the office, like replacing the carpet and upgrading the phone system. He looks forward to helping you with your next membership or CE question. Please welcome Justin to the PPA team.

3. Membership in PPA continues to hold steady. We are happy to report that our total membership is currently 3,046. That includes 2,428 dues-paying psychologists, 484 doctoral students in psychology, and 132 undergraduate psychology majors. Thank you to all our members for your continued support. Please help us by recruiting a new member today! There are still more than 3,000 licensed psychologists in Pennsylvania who are not currently members of PPA. Please reach out to your friends and colleagues and share with them all the reasons you belong to PPA.

4. We tried something new this year! PPA joined with several other state psychological associations to offer high-quality, APA-approved continuing education webinars. Joining forces with our fellow psychological associations has allowed us to be able to offer presentations from internationally known psychologists at a fraction of the cost, if we did it on our own. So far, we have taken part in four such programs and have earned approximately $35,000 in non-dues revenue. Be on the lookout for more webinars like this being offered in 2024.

5. Last December, myPPA, our interactive platform for PPA members was rolled out to all PPA members. Right now, we have more than 1,000 PPA members registered on the platform, but only a few hundred are actively taking part. This platform is a secure, self-contained "Facebook like" communications system just for PPA members. We hold meetings on this platform and share information. You can ask members questions and post in the Marketplace if you have something to sell, space to lease, or a job opening. myPPA is somewhat less restrictive than PPA's LISTSERV, because it is not managed, watched, or owned by APA. And like Facebook, we can at once remove specific posts when they are no longer relevant or if they are out of compliance with our code of conduct. If you haven't registered or need assistance with myPPA, please reach out to Erin Brady, our Communications & Education Manager at erin.papsy.org. Please join us on myPPA so you can stay current with all that is happening at PPA!

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. We now have 24 SIGs. Last year at this time we had six. Please visit myPPA to learn more about these groups and to join. If you have an idea for a SIG and would like to serve as SIG Leader, please review the information sheet and submit a proposal for a new group.

7. PPA continues to represent all Pennsylvania psychologists in Harrisburg. We have several bills in motion this session, most notably HB 1000 (Prescriptive Authority for Psychologists) lead by Rep.

Dan Frankel. Our RxP Taskforce, with support from our Legislative and Government Affairs Committee, continues to build strong relationships within the House Professional Licensure Committee to move the bill out of committee before the end of the year. In addition, psychologists are also reaching out to the Governor and his staff to make sure that we are part of the conversation about overall mental health in PA. Pennsylvania Psychological Political Action Committee (PennPsyPAC) continues to support elected officials and candidates in Pennsylvania who support legislation that strengthens the practice of psychology and recognizes the needs of psychologists. Please contribute to PennPsyPAC to keep this momentum going.

8. The Pennsylvania Psychological Foundation's Third Annual Auction & Raffle was a huge success under the leadership of co-chairpersons Dr. Gail Karafin and Dr. Julie Meranze-Levitt. We auctioned off a total of 66 items and packages and raised $21,000 of unrestricted income for PPF. THANK YOU to everyone who made this event a HUGE success, especially our item donors and our auction bidders. Get ready for our Great Get-away Auction and Raffle in 2024.

9. PPA was recognized at APA's Practice Leadership Conference in March with the 2023 SPTA Diversity Award from APA's Division 31 for State, Provincial, and Territorial Psychological Association Affairs. Thank you to everyone who has contributed to our work in diversity, equity, and inclusion, making PPA a safer and more welcoming organization for all.

10. It is my pleasure to thank and recognize our PPA staff team for their dedication and hard work that moves PPA forward. I am honored to work alongside this group of professionals:

Director, Government, Legal & Regulatory Affairs – Rachael Baturin, JD, MPH
Director, Professional Affairs – Molly Cowan, PsyD
Manager, Communications & Education – Erin Brady
Business Manager – Justin Danner

Thank you again PPA staff! You are ROCK STARS!

Finally, 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 time for your own self-care this month. We wish you HAPPY HOLIDAYS and GOOD HEALTH (mental and physical) in the NEW YEAR!

Remember, the PPA office will be closed from December 22 through January 1.

A WELCOMING AND SAFE PPA
(CONTINUED FROM PAGE 2)

(EMCC) to keep our online communication civil and reflect our mission. We have developed a Safe and Welcoming PPA Task Force that has been developing methods to better support presenters and attendees during the convention. With comedians and dance parties already in the works, this year's planning gives us great hope that the PPA 2024 Convention at the Downtown Marriot in Lancaster may be the best experience in many years pre- and post-COVID. Remember we are all PPA, and we ask you as members to do your part to increase the positive, safe, and welcoming experience of this great association, by adhering to the following:

1. Make it a goal to invite students and psychologists to become PPA members and Convention attendees.
2. Invite students to present at workshops with you or to attend the Convention with you and attend workshops together.
3. Be supportive of workshop presenters when rare disruptions occur.
4. Be an ally when you see anyone mistreated or spoken to in a disrespectful manner by adding to their voice or at least by being kind and supportive.
5. Introduce yourself to unfamiliar faces. Invite new faces to join your table during workshops or to join you for a meal.
6. Be mindful of your audience and of the pronouns you use.
7. Regardless of your political views, liberal or conservative, our shared times and spaces are opportunities to put our differences aside and to unite based on our common interests in the field of psychology.

It is these little steps that make a huge difference and combined they will help ensure that PPA is truly a welcoming and safe space for all. This calls to mind a quote, which is often misquoted, "If we could change ourselves, the tendencies in the world would also change. As a man changes his own nature, so does the attitude of the world change towards him" (Mahatma Gandhi; later reworded and attributed to him as "Be the change you want to see in the world").

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OUTSIDE OF THE BINARIES: From either/or to both/and

I learned the concept of "both/and" experiences during my second year of a doctoral program in psychology when a professor vulnerably, helpfully, and meaningfully shared about her privileged and marginalized identities. This coexistence of seemingly disparate experiences would resonate throughout my formal training in psychology and beyond. I started the program in August 2003, pre-Facebook, pre my having a cell phone, pre my living independently as a post-college adult, pre Obergefell v. Hodges, but post the beginnings of the coming out process, as part of LGBTQ+ communities, not to all but to many people in my personal and professional lives.

The program, situated in a large eastern U.S. city, did not explicitly describe itself as progressive. Naively, I thought all psychologists would be progressive and open to dialogue. This was and is a myth.

Many of the full-time professors, all of whom at the time were White and tenured, were trained as psychologists when homosexuality was still in the DSM and sadly, gender identity disorder would remain for over a decade. No professors in the program were out though there were rumors, literal whispers in the hallway, lounge, and testing library. They began their professorship before there was a greater recognition that cultural responsiveness and humility are needed for effective counseling, assessment, teaching, consultation, and for overall empathic interactions. Indeed, there was just a mild focus on intersectionality of identities but mostly within classes whose titles included the word diversity. A classmate and friend, the sole African American person in my cohort of over 15 individuals, was scolded, outside of class, for not knowing an aspect of the school's culture that was not explicit. We talked after, partly frustrated, partly sad. I realized more now than then, I stumbled in my efforts to be a White ally, during and after this interaction, despite my efforts.

I was then, and even more so now, grateful that there were allies to me including program faculty, staff and, among some of my classmates, one who also identified as queer. My new therapist, a social worker pursuing psychoanalytic training after a career in the arts and another helping profession, was supportive though we rarely directly discussed social locations—her own or mine. Somehow, I knew that she was the age of one of my grandmothers. Our pronouns were assumed by each other. Her nonverbal communication sometimes alluded to her not only understanding about being queer but identifying that way herself. My first externship supervisor, a seasoned psychologist for decades, was out, in his personal life, as gay. He referred to his partner who used he/him pronouns, but rarely discussed, in our supervision, how his identity affected his work. Perhaps, because of societal queerphobia, since he worked with youth, he was concerned about being out to a greater extent even in a school with an inclusive, diverse, and equitable reputation. I am not sure if his past professional experiences were unsafe or his privileges as White and upper middle class shielded him at the placement as well. Though our supervision was full and even meaningful, with rarely a pause, we never discussed my intersecting identities as they applied to the work I was newly doing. I thought about sharing an article with him about such focus areas, even photocopying it and carrying it in my backpack for several weeks, but I lacked the courage to open the bag.

As my identities evolved, so did an interest in an LGBTQ+ history within psychology and mental health more broadly. Professors supported my course research papers in these fields and provided helpful feedback. A professor was understanding when I did not attend his class and instead participated in a live, in-person training on "Transgender Emergence" (Lev, 2004) . That night changed everything regarding my research and future clinical focus areas with trans and gender-diverse communities.

Around that time, I was engaged in a practicum working with adolescents in an outpatient setting. My main individual supervisor, a self-described "Archie Bunker type," was up front about some of his implicit and explicit biases as a White, temporarily able-bodied, cisgender male with upper middle class socioeconomic privilege and seniority at the clinic. During one supervision, he made comments that were queerphobic, laughing when he saw my facial expressions of confusion, sadness, and frustration. His attempts at humor might have been to add levity to his microaggressions. However, he never said that he did not actually mean what he said. He had also made negative comments about aspects of my vocal tone and overall countenance—a joke he said. Given the power differential and some of

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RISK MANAGEMENT FOR SUPERVISORS OF THOSE WHO ARE OBTAINING THEIR EXPERIENCE FOR LICENSURE

RACHAEL BATURIN, MPH, JD

At some point in their careers, psychologists may want to take on the role of supervisor to those who are obtaining their experience for licensure. As such, it is important for supervisors and supervisees to be aware of the regulations around supervision and to make sure that there is a process in place so that supervisors and supervisees are clear about the boundaries of the supervisory relationship.

To be a supervisor, a psychologist must complete either a course in supervision through a psychology doctoral program or a three-credit continuing education course in supervision before providing supervision. This requirement provides the supervisor with a basic understanding of the sections of the State Board of Psychology regulations that deal with supervision (49 Pa. Code §§ 41.32 and 41.33). In addition to providing an understanding of the rules, these programs go over some common situations that may arise when providing supervision.

Once this course is complete, a psychologist may supervise those who are obtaining their experience for licensure. One of the first things that a supervisor should prepare is a document that outlines the roles and expectations of the supervisee. This document is important because it will outline the boundaries of the relationship and what is expected during the supervisory relationship. This document should make sure it includes information from the supervision regulation (49 Pa. Code § 41.33) and it should outline the expectations between the supervisor and supervisee. In addition, the supervisor should make sure that the supervisee is aware of rules regarding patient confidentiality, duty to report, mandated reporting, and the policies and procedures of your office. Last, the supervisor should make it clear to the supervisee that the supervisee is working under the license of the supervisor and therefore the supervisor is ultimately responsible for the services provided by the supervisee.

If a psychologist is going to supervise someone who is obtaining hours for another license such as a licensed professional counselor, the supervisor should be aware of the supervisory requirements for that profession. Supervision guidelines are not the same for every profession and it is important for the supervisor to be familiar with the requirements. Therefore, the supervisor should go to the Department of State's website and review the supervision regulations for each profession before agreeing to supervise someone.

Under the psychology supervision regulations, supervisors are required to meet with the supervisee individually 2 hours per week (face to face or via virtual supervision using a HIPAA-compliant platform with synchronous audio and video communication). During these sessions, the supervisor and the supervisee will review cases and discuss any issues that arise in the treatment of a patient. In addition, the supervisor can provide feedback to the supervisee (and must do so on a quarterly basis) on their work and provide guidance and information on how to improve the services provided. It is important that supervisors keep detailed notes on these sessions, especially if an issue arises with a patient (multiple relationships, failure to make a mandated report, etc.) or if there is any concerning behavior from the supervisee (not keeping proper notes of

sessions, demeanor with patient or staff, etc.). Again, it is important to understand that the supervisor is responsible for the services provided by the supervisee. If the supervisee has done something inappropriate, it is important for them to inform the supervisor immediately so that steps can be taken to try to remediate the problem.

For psychology supervisees, if the supervisor is unable to provide 2 hours of individual supervision to the supervisee, the supervisor may delegate 1 hour of supervision to a delegated supervisor. Delegated supervisors can also be used if the supervisee would like to get specialized training as part of their experience. The primary supervisor is responsible for monitoring the supervision provided by the delegated supervisor.

At the end of the supervision, the supervisor is required to provide the State Board of Psychology with an honest assessment of the supervisee. The evaluation must assess the supervisee's level of professional competence and theoretical knowledge in the areas of assessment, diagnosis, effective interventions, consultation, evaluation of programs, supervision of others, strategies of scholarly inquiry, cultural/individual diversity, and professional conduct. This evaluation must be signed by the supervisor and included as part of the verification of post-doctoral experience submitted to the Board with the applicant's application for licensure.

In sum, it is important for psychologists to determine whether they want to take on the responsibility of becoming a supervisor to those who are obtaining their experience for licensure. As discussed, the supervising psychologist will be responsible for the services provided by the supervisee. As such, the supervising psychologist should make sure that they are aware of and understand the requirements outlined in the regulations for the profession that they will be supervising. In addition, it is extremely important that the supervisor explains the roles and expectations of the supervisee so that the supervisee is clear on the boundaries of the supervisory relationship. Last, it is important that the supervisor keeps good notes on the sessions with the supervisee and on any issues that may arise in the course of treatment of a patient.

REFERENCES

49 Pa. Code § 41.32 (relating to experience qualifications).

49 Pa. Code § 41.33 (relating to supervisors).

OUTSIDE OF THE BINARIES: From either/or to both/and (CONTINUED FROM PAGE 5)

my past experiences with him, I chose to remain verbally silent, vowing privately and with trusted friends to be different as a supervisor. Some clients would also engage in or describe engaging in biased behavior though I felt uncomfortable to discuss this in supervision. There were allies at the placement despite its being a relatively closed system with the aforementioned supervisor holding much power. At the same time, I did genuinely learn some helpful elements about therapy. It was hard then as it is now to reconcile that both/and.

I tried to channel the anger and disappointment of these placement experiences into what I hoped would be positive change. I felt newly empowered and applied for an externship at an LGBTQ+ therapy center while also beginning to volunteer at a related peer therapy center.

Those experiences were radically meaningful for which I am grateful—the clinical work moving, challenging, and rewarding as was the supervision. Though there existed disappointing biases in those spaces, particularly about the gender binary, for the most part, I felt like I was in an environment where those experiences could be somewhat named and even processed, and that I could express more of the parts of my authentic self.

As I recall the above experiences, I am filled with many emotions including empathy. I feel that many people I met along the way of graduate school had positive intent and trying their best with limited external resources. Still, actions and inactions stung many of us. I remain engaged with education regarding trans and gender-diverse communities and I hope to remain engaged with PPA. I have guilt and embarrassment for not speaking up more publicly and for not engaging in more complexity earlier this past year when there were microaggressions and misunderstandings on the listserv regarding gender. Fear of receiving microaggressions, not having the emotional bandwidth, and concerns about my comments being misperceived contributed to my not being a different kind of ally.

I aspire to have more courage and recognize my many privileges in that process. Thank you to all the people who spoke up and out, who called in and called out. I am grateful to you.

Also, I have appreciated PPA's values of diversity, equity, and inclusion as well as cultural responsiveness and humility. From my own experiences and those of others, I believe that the organization's leadership supports these. Yet another both/and: More growth is needed throughout PPA's spaces—conventions and the listserv alike—to more consistently cultivate spaces where these values are supported publicly and privately, and that all PPA members feel their identities are respected. This is not a myth.

WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT SUPERVISION

MOLLY COWAN, PsyD

There are now three options for obtaining the required experience listed under Section 49 Pa. Code § 41.32 for licensure in Pennsylvania: (1) complete a postdoctoral year (1750 hours), (2) obtain 1750 practicum hours, and (3) a combination of practicum and postdoctoral hours totaling 1750 hours. Regardless of the path a trainee opts to take, it's important to understand the supervision requirements that are in place until a trainee is licensed.

First, supervisors must meet all of the requirements outlined in 49 Pa. Code § 41.33 including that supervisors must "own, be an employee of, or be in contract status with the entity employing the psychology resident," be currently licensed in good standing, and not be involved in a dual relationship with the trainee (including being related to the trainee by blood or marriage or having a current or past therapeutic relationship with the trainee). Additionally, supervisors cannot accept gifts or fees from the trainee; this differs from supervision in other professions where trainees can (and often do) pay for supervision toward licensure. Supervisors must also have completed a course in supervision through a psychology doctoral program or three continuing education credits in supervision.

Supervisors must meet individually face to face with the supervisee for an average total of 2 hours per week. Although the regulations specify "face to face," it is important to note that the PA State Board of Psychology issued a statement of policy clarifying that virtual supervision counts as face to face if a HIPAA-compliant platform with synchronous audio and video communication is used in the context of a secure setting. This allows supervisors to fulfill the requirement using appropriate telehealth platforms without the need to be in the same room as the supervisee. Supervisors must maintain notes of all supervisory sessions until the trainee obtains a license (or 10 years, whichever is greater). Additionally, supervisors must prepare written evaluations of a trainee's strengths and areas for growth on at least a quarterly basis. Supervisors may also delegate up to 1 hour per week of supervision to a delegated supervisor; the delegated supervisor must also meet the requirements outlined in 49 Pa. Code § 41.33.

PPA staff often receive questions regarding the period between completing the required hours for licensure and receiving one's actual license. Pennsylvania regulations speak to this as well. As detailed in 49 Pa. Code § 41.32(6), once the required hours are completed, trainees must continue to receive supervision, although the supervisor has a bit more flexibility regarding frequency of supervision, because supervisors can follow the standards for the employment and supervision of unlicensed persons with graduate training in psychology (49 Pa. Code § 41.58). **It is important to note that unlicensed persons cannot practice independently until they have received their license.** Both 49 Pa. Code § 41.32 (2)(ii) and 49 Pa. Code § 41.58(a) speak to this, with the former stating "no experience may be obtained where the psychology resident acts independently," while the latter states "psychologists licensed by the Board may employ 'professional employees with graduate training in psychology,' who 'shall perform their duties under the full direction, control and supervision of a licensed psychologist.'" While there are a few exempt settings (see 63 Pa. Stat. § 1203 for more detail), in most cases this means that individuals may not open their own practices or operate under their own LLC/PLLC until they are independently licensed, or risk being accused of practicing without a license and/or jeopardizing their ability to become licensed as a psychologist in Pennsylvania.

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the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF OCTOBER 2023

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
SB 59	Providing for the establishment and funding of a center to conduct research on gun violence in this Commonwealth.	Senator Hughes	Support	Referred to State Government 1/19/2023		
SB 119	Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in public assistance, providing for behavioral health and physical health services integration.	Senator Phillips Hill	Support	Referred to Health and Human Services 1/18/2023		
SB 178	Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," in general provisions, repeals and effective date, providing for acute care mental health bed registry and referrals.	Senator Barlotta	Support	Referred to Health and Human Services 1/19/2023		
SB 276	An Act amending the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, in general provisions, providing for duty to warn.	Senator Langerholc	Still reviewing bill language	Referred to Health and Human Services 1/31/2023		
SB 445	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, providing for Collaborative Care Model and Primary Care Behavioral Health Model Implementation Program; and making an appropriation.	Senator Farry	Support	Referred to Health and Human Services 3/14/2023		
SB 605	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Senator Collett	Support	Referred to Heath and Human Services 4/19/2023		
SB 739	An Act relating to telemedicine; authorizing the regulation of telemedicine by professional licensing boards; and providing for insurance coverage of telemedicine.	Senator Vogel	Support	Re-referred to Appropriations 10/3/2023		
HB 341	An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in intermediate units, repealing provisions relating to psychological services; in professional employees, further providing for definitions and providing for school social workers; and, in school health services, further providing for health services and providing for school counselors, school psychologists, school social workers and school nurses.	Rep. D. Miller	Support		Referred to Education Committee 3/13/2023	
HB 1000	An Act amending the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act, further providing for definitions; and providing for prescription certificate, for prescribing practices.	Rep. Frankel	Support		Referred to Professional Licensure Committee 7/23/2023	

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 849	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Rep. Schlossberg	Support	Referred to Health and Human Services	Passed House 173-30 6/14/2023	
HB 575	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Benham	Support		Referred to Health 3/20/2023	
HB 1725	An Act amending the act of February 13, 1970 (P.L. 19, No. 10), entitled "An act enabling certain minors to consent to medical, dental and health services, declaring consent unnecessary under certain circumstances," further providing for individual consent, for mental health treatment and for release of medical records; and providing for parent or legal guardian access to medical records.	Rep. Borowicz	Oppose		Referred to Health 9/27/2023	

Special Section:

Psychological Myths

INTRODUCTION TO THE SPECIAL SECTION: Psychological Myths

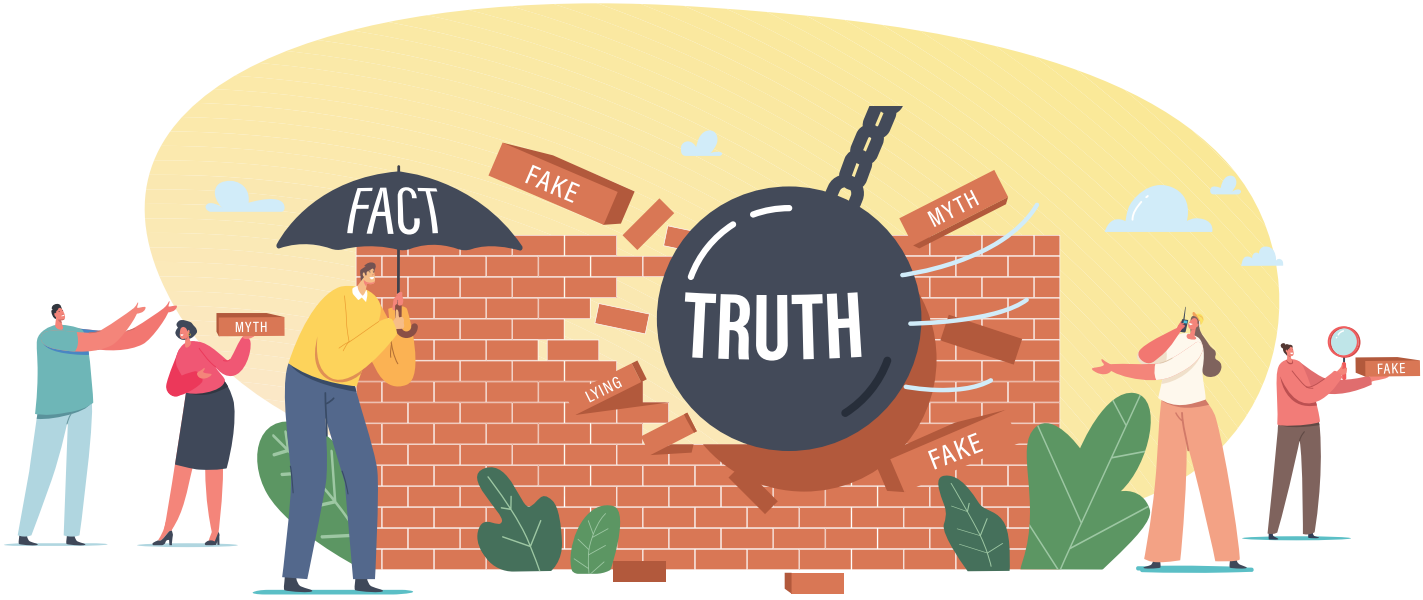
The variety of articles we received examine various areas of psychological practice that may be influenced by "myths" rather than fact. Dr. Pauline Wallin addresses misunderstandings about the ethics in marketing clinical practices. Dr. Bob Gordon weighs in on whether the "Goldwater Rule" applies to psychologists assessing political figures. Psychologists have let go of many myths about suicide; Dr. Sam Knapp examines one that still persists. As scientist-practitioners, psychologists consume research to inform practice. Dr. David Starkey cautions us against accepting all research as valid and discusses tactics and methods that call into question some published findings. Dr. Edward Zuckerman examines additional myths in psychology including the therapeutic value of expressing anger.

Myths about practice affect our practice in the schools, Dr. Jessica Black discusses beliefs about addiction that may interfere with effective treatment. Dr. Shirley Wonka debunks the myth that only children with U.S. citizenship have the right to free, public education. The belief that children outgrow ADHD is one of the myths discussed by Dr. Woika and a group of Penn State school psychology graduate students she supervises.

FIVE PSYCHOLOGICAL MYTHS

EDWARD ZUCKERMAN, PhD

The public is often encouraged to believe ideas contradicted by research because it benefits the persons and organizations advocating the myth.



People and organizations naturally spread their ideas for their benefit. Unfortunately, for others, some of those ideas are both harmful and unsupported by research. Considered below are five good examples of myths widely accepted by the public.

MYTH 1. VENTING ANGER IS THERAPEUTIC.

If you don't blow off steam, you will explode into dangerous aggression. Repeated research has shown no benefit and often makes for more resentment, hostility, and aggression at innocent others. Instead, time outs dissipate the arousal, cognitive behavior therapy (CBT) challenges enraging irrational beliefs, and simple deep breathing calms the sympathetic nervous system. Olatunji et al. (2007), for example conclude:

In study after study, subjects who vented anger against inanimate objects, who vented directly against the person who induced their anger, who vented hostility by playing football or who vented verbally about an employer—all showed more resentment than those who had not vented. In some experiments, venting led to aggression against innocent bystanders. Even those who firmly believed in the value of venting ended up more hostile and aggressive after thumping pillows or engaging in other expressions of anger (as cited in Jaquish, 2007, para. 6).

As Olatunji et al. (2007) conclude, "What people fail to realize is that the anger would have dissipated had they not vented. Moreover, it would have dissipated more quickly had they not vented and tried to control their anger instead" (as cited in Jaquish, 2007).

MYTH 2. DEPRESSION IS CAUSED BY A CHEMICAL IMBALANCE, SPECIFICALLY LACK OF SEROTONIN, IN THE BRAIN. ANTIDEPRESSANT DRUGS CORRECT THIS.

This myth is widely found in professional and lay literature, and selective serotonin reuptake inhibitors (SSRIs) are widely prescribed. Indeed, about 10% of the population take them (Ahrnsbrak & Stagnitti, 2021).

The majority of the aetiology reviews supported the hypothesis, including some

that were entirely devoted to describing research on the serotonin system, and those that reviewed the aetiology of depression more broadly. Research papers on the serotonin system in depression were highly cited and most of them strongly supported the serotonin theory. All textbooks supported the theory, at least in some sections, and devoted substantial coverage to it, although some also acknowledged it remained provisional (Ang et al., 2022, p. 100).

The logic of this theory is that SSRIs are believed to be quite effective. However, a meta-analysis by Pigott et al. (2010) found that "antidepressants are only marginally efficacious compared to placebos and document profound publication bias that inflates their apparent efficacy" (p. 267). They added that their true effectiveness was probably even lower due to dropout rates, switching of the measures used, and submission to the Food and Drug Administration of only studies with positive results.

A second source of support for the hypothesis was the disease mongering by Big Pharma. Healy (2015) has documented Big Pharma's marketing that SSRIs were magic bullets that reversed the underlying abnormality. His thorough book places their practices within a set of financial constraints and government policies. In fairness, the original hypothesis has been modified considering new knowledge. For specifics, see Albert et al. (2012).

MYTH 3. "CRACK BABIES," CHILDREN BORN TO COCAINE-ADDICTED MOTHERS, WILL HAVE SEVERE DEVELOPMENTAL DELAYS AND OTHER DISABILITIES.

In fact, such children have persistent differences that are very mild and "due partially or wholly to other factors, such as exposure to other substances (including tobacco, alcohol, or marijuana) or to the environment in which the child is raised" (Aronson, 2008, p. 517).

The flawed initial research led to a moral panic with prosecution of women who used cocaine during pregnancy, and this panic contributed to the stigmatizing of them and their children. The idea served the political agendas of both liberals and conservatives: Conservatives wanted to demonize cocaine users; liberals wanted more money for social programs. And racism was deeply involved in all of this.

MYTH 4. PSYCHODYNAMIC THERAPIES ARE NOT AN EFFECTIVE APPROACH OR, AT BEST, TREAT A FEW DISORDERS.

By the 1970s, the wisdom in the field was that psychoanalysis was an endless indulgence for the well-heeled worried well and clinicians should learn mainly CBT because of its massive evidence of effectiveness (Amerian Psychological Association [APA], 1995). These treatments emphasized short-term procedures that could be manualized and more easily learned. Treatments that were more complex, systemic, feminist, and narrative were not represented. A cultural war ensued about "researchability" and the value of research methods for therapy, but the results did not change until Jonathan Shedler's (2010) thoughtful and inclusive paper documented the effectiveness of psychodynamic therapies. Much research has led to their being well included in the current list of effective approaches, which can be found at https://div12.org/treatments/.

MYTH 5. ABORTION IS PSYCHOLOGICALLY HARMFUL.

I can think of no issue on which the research is clearer. First, for the vast majority of those who had abortions, there were no negative consequences, especially no "post-abortion syndrome" involving depression. Second, the life consequences (psychological, financial, social, educational, familial, etc.) for those denied an abortion were not much less than catastrophic. These and many other findings of the Turnaway Study on these two groups can be found in ANSIRH (2023) and Foster (2021). APA (2008) and Lawrey (2022) wrote readable summaries of these findings.

We are all vulnerable to oversimplifications and emotional reasoning so we can easily believe its ideas that deserve the label myths. As professionals and scientists, we must continually examine our beliefs and use our best judgment in what we teach and act on. Progress in understanding is never straight forward; there are zigs and zags, myths, and bad ideas, but persistence and open-mindedness can salvage truths.

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MYTHS IN PSYCHOLOGICAL PRACTICE: I Must Keep My Suicidal Patient Alive

SAMUEL KNAPP, EdD, ABPP

The noted suicidologist Thomas Joiner (2010) wrote The Myths of Suicide, in which he identified popular myths about suicidal persons, such as they are cowards, they take the easy way out, or they are selfish. Psychologists know that these statements are false. Those who die from suicide represent a wide range of personalities, but the heroes of our society (e.g., police, firefighters, or soldiers) have an increased risk of suicide. Suicide is not "easy" because it requires overcoming the instinct toward self-preservation. Finally, many people who attempt suicide believe they are acting with altruistic motives because they believe that others would be better off if they were dead.

However, here I focus on another myth about suicide that many psychologists still have. This is the myth that they alone are responsible for whether their suicidal patient lives or dies. Like many maladaptive beliefs, this can harm psychologists and their patients.

Personally, I had difficulty letting go of that belief. I hung on to it for far too long. My clinical career has been over for many years, and I thought I was good at dealing with suicidal patients. However, I could have been even better if I had surrendered that myth earlier in my career. Somehow, I thought that giving up the "my responsibility" belief would cause me to become callous toward my patients, betray their trust, or give me an excuse to deliver a lower quality of service. My assumptions were false.

PSYCHOLOGISTS CANNOT PROMISE TO SAVE THE LIVES OF THEIR SUICIDAL PATIENTS

The belief that they could prevent all patient suicides could set psychologists up for failure and needless self-condemnation. Paradoxically, it could also lead to less-than-optimal services for their patients. Under the influence of the myth of personal responsibility, psychologists may feel tempted to use highly intrusive interventions, even when their clinical justification is weak, or fail to involve their patients as full collaborators in their treatment.

Psychologists cannot prevent all patient suicides. When I worked as PPA's Director of Professional Affairs, I periodically received phone calls from highly competent

psychologists who had patients die from suicide. Often, they would say, "I never saw it coming. I asked about suicidal thoughts, and he said he had none." Or they might say, "I thought I did everything right. We had a safety plan. Lethal weapons were removed from the house." The loss of a patient by suicide is a horrible experience; any psychologist would feel substantial grief over such a loss. Nevertheless, they should not compound this grief by assuming they alone were responsible for whether the patient lived or died.

All mental health professionals have the risk of having a patient die from suicide. Simon (2011) repeated the clinical axiom that "there are two kinds of psychiatrists—those who have had patients die from suicide, and those who will" (p. 177).

It is impossible to predict suicide with any degree of certainty. Although people with suicidal thoughts are four times more likely to attempt suicide than those without suicidal thoughts (Hubers et al., 2018), only a small percentage (perhaps around 10%) will attempt suicide in the next year. One-half of suicides come from people with a low risk of suicide. These patients do not have the common features found in suicidal persons or may have denied suicidal thoughts when asked by a health care professional. Some may have had suicidal thoughts but falsely denied them. However, it is believed that most deniers did not have suicidal thoughts at the time that they were asked. Some may have had dormant suicidal thoughts that they mentally "put on a shelf" but then retrieved during periods of stress. Other patients may experience unexpected life events that cause them great distress and allow suicidal thoughts to emerge for the first time. A psychologist cannot predict all the intervening events in a patient's life or whether those events could precipitate a suicidal crisis. Of course, psychologists similarly cannot predict whether a patient will find "someone special" in their lives, get laid off from a job, have a severe reversal in the stock market, or become the beneficiary of a large inheritance.

A PSYCHOLOGIST CAN PROMISE TO DELIVER HIGH-QUALITY SERVICES

Instead of believing that they alone can save the life of a patient, psychologists should adopt a more productive belief summarized by Jobes (2023), "While we can never guarantee a nonfatal outcome, we can nevertheless provide the best possible clinical care to every patient, including those with suicidal thoughts" (p. 60, italics in original). The obligation of psychologists is to deliver the best clinical care they can that is consistent with professional standards, informed by evidence, interpreted with sound clinical judgment, and responsive to their patient's unique needs and preferences. Ultimately, patients must decide whether they will live or die from suicide.

Psychologists should not devalue the importance of this gift to their patients. It takes years of study and practice to develop the necessary competence and to deliver it with concerned alertness. Psychologists who have given up the myth that they alone can keep their patients alive feel freer to focus on the needs of their patients, listen carefully, and feel less pressured during sessions. Instead of arguing with patients that life has meaning and purpose, they give patients honest and authentic relationships that intrinsically make life worthwhile. Patients have reported enormous relief when they can talk openly about their secrets and hidden feelings of shame without being judged or criticized. Effective psychologists learn to validate the feelings of their patients (understanding the patient's perception of their lived experiences without endorsing the idea of suicide) and to collaborate with their patients to create lives worth living.

Effective interventions save lives. Safety planning-type interventions reduce suicide attempts by an average of 43% (Nuij et al., 2021), and even more attempts can be prevented when combined with lethal means counseling. Evidence-supported treatments reduce suicidal attempts compared to treatment-as-usual approaches. Psychologists should aim to deliver proven interventions with care and compassion and abandon the unrealistic expectation that they alone can save the lives of their patients.

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MYTHS KEEPING THE UNITED STATES MIRED IN ADDICTION

JESSICA J. BLACK, PhD

The United States is facing a major addiction problem. In 2021, there was a record number of deaths from drug overdose, with now more than 1 million deaths since 1999 (Centers for Disease Control & Prevention, 2021). Alcohol-related diseases and deaths are startlingly high (Esser et al., 2022). An estimated 16.5% of the population meets criteria for a substance use disorder (SUD), with 94% not receiving any treatment (U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). As experts in assessment and treatment of mental health conditions, psychologists have the potential to have a substantial positive impact in addressing the nation's addiction troubles through professional work and advocacy. An important first step is having accurate information about addiction, especially since many U.S. psychology graduate programs do not place an emphasis on SUDs (Dimoff et al., 2017).

MYTH 1. AN INDIVIDUAL MUST HIT ROCK BOTTOM AND ADMIT THEY ARE AN "ADDICT" BEFORE WE CAN ENGAGE THEM.

Many individuals who have come through struggles with addiction report having experienced multiple "rock bottoms," feeling at their all-time low emotionally or otherwise due to their drug use, yet positive reinforcement, negative reinforcement, habitual responses, or a combination tipped the scales toward continued use. These accounts align with research that individuals who use drugs are often ambivalent about their use (Wilson et al., 2012), suggesting a place for providers to intervene. Tied in with the myth of "hitting rock bottom" is the idea that hitting this low facilitates the adoption of a new and necessary identity, that of an "addict." Yet, there is no empirical evidence to support that identifying as an "addict" precedes positive change in substance use. Coercing one to adopt an addict identity has the potential to isolate some from support, as the cofounder of Alcoholics Anonymous Bill Wilson recognized (Miller & Kurtz, 1994).

MYTH 2. MOST PEOPLE WITH ADDICTION NEVER RECOVER.

SAMSHA (2023) estimates that over 20 million Americans are no longer living in active addiction. For over 50 years, it has been well known in the addiction science field that many individuals do in fact recover, yet there's been a gap in conveying this to providers and society at large. Eighty to 90% of individuals struggling with substance use moderate or refrain from using as they age and most do so independently, without seeking formal treatment, often referred to as natural recovery or self-guided recovery (Bishop, 2018). Relaying accurate recovery statistics has the potential to increase hope and the delivery of recovery accelerants such as evidence-based psychotherapy, pharmacotherapy, and/or general social support.

MYTH 3. ADDICTION IS A DICHOTOMOUS DIAGNOSIS.

As with many other psychiatric disorders, addiction occurs on a continuum. In recognition of this, starting with the DSM-5 released in 2013, it is required that a SUD diagnosis be classified as mild, moderate, or severe. Yet, the idea that all addictions are severe and must be treated in higher levels of care permeates society prolonging the period of active addiction for many. The directors of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism recently released an opinion paper advocating for implementation of the term pre-addiction for more mild addiction, similar to the use of pre-diabetic, to help practitioners recognize the importance of identifying and treating problematic substance use early on (McLellan et al., 2022). Psychologists in outpatient treatment settings may be able to treat many individuals with less severe SUD.

MYTH 4. TREATING ADDICTION REQUIRES SPECIALIZED THERAPIES THAT ONLY CERTAIN PSYCHOLOGISTS CAN PROVIDE.

There is no known treatment modality that has been shown to be substantially superior to another for treating addiction (Black & Chung, 2014; Longabaugh & Wirtz, 2001). Treatments that many clinical and counseling psychologists are well trained in and highly skilled at delivering such as cognitive behavioral therapy and mindfulness have been shown to be efficacious for treating SUDs. Providers may perceive experience

with approaches often associated with addiction treatment, such as motivational interviewing (MI), as necessary to working with clients with SUD. However, at the core of MI is the employment of genuine empathy and a nonjudgmental spirit, and those are the provider qualities that are shown to result in the best outcomes (Moyers et al., 2016).

MYTH 5. ADDICTION OCCURS IN ISOLATION.

While many individuals in active addiction may not feel connected to others, it does not preclude others from feeling connected to them. Active addiction and overdose deaths are most common between the ages of 25 to 44, the prime parenting years (Hedegaard et al., 2018). Relatedly, there are a staggering number of U.S. children in foster or kinship care (Brundage & Levine, 2017). In addition to direct support, psychologists can connect families to resources as a means of lessening possible feelings of loneliness or shame. For adults, mutual support groups like Al-Anon or information sources like the Addiction Policy Forum may be helpful. For children, the National Association for Children of Addiction, the Wellness section on the Fred Rogers Center website, or videos on YouTube (e.g., youtube.com/@childrenandaddiction) may help promote healthy communication about a loved one's addiction.

In summary, beyond helping to promote good psychological health from a young age, psychologists are in a prime position to directly help mitigate the addiction crisis our society is steeped in. We can meet individuals where they are rather than waiting for the proverbial fall to "rock bottom" and consequent adoption of the addict identity. By doing so, we can promote change earlier on in the addiction process before the development of further severity or death. Finally, we can help bring children and families out of the shadows by recognizing addiction, normalizing the impact it can have on the family, and better connecting children and families to existing resources. We do all of this through meeting individuals with genuine empathy and a nonjudgmental attitude, something I believe many psychologists naturally excel at and can help model for society at-large.

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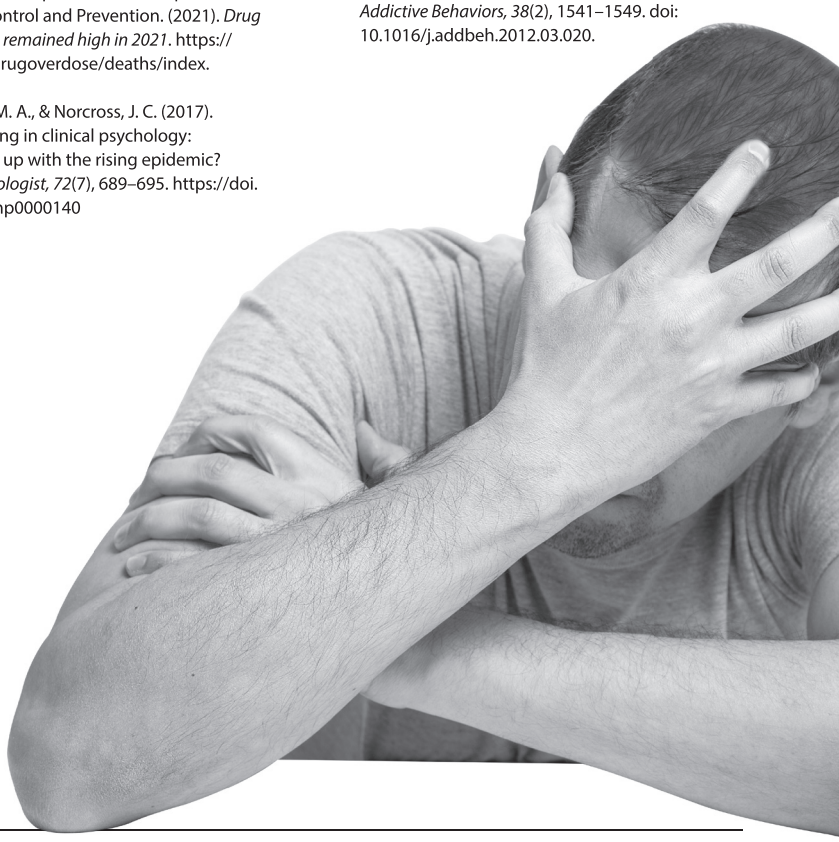


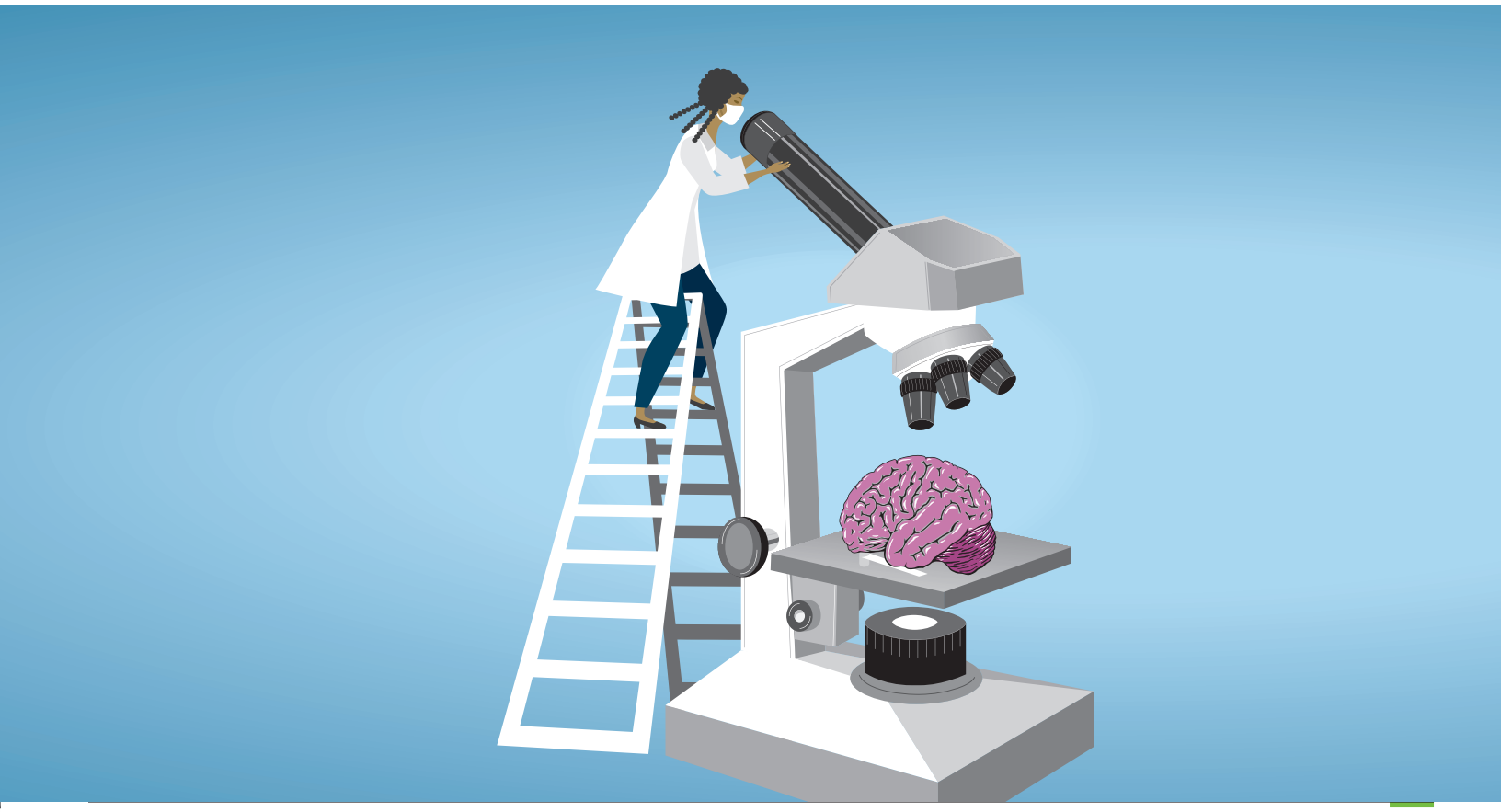
TRUST RESEARCH FINDINGS BUT . . .

DAVID STARKEY, PhD

If psychology is going to consider itself a science, it must follow the scientific method. This method, "to look very, very carefully, and to record exactly" (Feynman, 1971), has evolved over time from the ancient Greeks who used observational methods to measure the circumference of the earth and the movement of the planets around the sun, to the time of Copernicus and Galileo and their conflicts with established doctrines, to the present day, when the notion of "science" itself is questioned by some. The discoveries of science, often made against strongly held beliefs, do not occur by accident, but by the ability to observe natural phenomena carefully and without bias. But this ability has been very hard won. The history of science is the struggle to see the world clearly despite preconceived beliefs and opinions, the self-interest of powerful individuals and groups, and the limitations of human reason.

Out of the simple observational methods used in prior times to understand nature, more sophisticated methods have evolved, meant to remove the individual perspective from observation and to make it more objective still, with development of the experimental method, the double-blind study, replication of results, the transparency in the research process, and sharing data. As graduate students we are taught that research methods have liberated us from distortions and wishful thinking and enable us to pursue knowledge unhindered by all-to-human limitations. We are taught that if the research says so, we have proof that we are onto something real.

In recent years this assumption has been called into question. If the results of research are not valid, the attempt to understand reality through the scientific method is degraded. A few recent headlines indicate a problem that has become a very public concern:



Stanford President Will Resign After Report Found Flaws in His Research (Saul, 2023)

Harvard Professor Who Studies Honesty Is Accused of Falsifying Data (Kim, 2023)

Harvard Calls for Retraction of Dozens of Studies by Noted Cardiac Researcher (Kolata, 2018)

Researchers in psychology and medicine have also questioned current research practices, with some authors indicating that many or most research findings cannot be trusted (Ioannidis, 2005; Schmidt & Oh, 2016).

So, is what we have been told about the reliability and usefulness of research results false? Should we trust the publications in our journals, or has our graduate school education led us astray? The answer is both yes and no.

The first and most obvious problem is that some researchers knowingly falsify research data. The fabrication of results by various methods (e.g., data massaging, cherry picking, conscious misrepresentation of the meaning of data, and outright falsification) may be more common than we like to think. The incentives to falsify results are significant. Careers are made, degrees conferred, and monetary rewards allotted to those who produce "positive" results. Falsifying results is an obvious breach of ethics, as noted in the APA ethics code (8.10), and undermines the discipline of psychology, both in terms of public trust and corrupting the knowledge base of the field.

A second problem involves the use of research methods that are more likely to produce positive results, thereby avoiding more rigorous methods that would result in a negative finding.

Schmidt and Oh (2016) describe what they refer to as questionable research practices and gives the following examples:

- Adding subjects one by one until the result is significant
- Conducting multiple significance tests on a relation and reporting only those that show significance (cherry picking)
- Not reporting studies or measures that are not significant
- Deciding whether to include data after looking to see the effect on statistical significance
- Hypothesizing after the results are known
- Running a lab experiment until you get the "right" result

While a brief paper can't examine each individual method and why it may result in false positives, a review of any basic text in statistical methods will show the above to be unacceptable, and a product of "fishing" for p-values that lack validity.

These methods, used to produce positive results, are common, and, according to John et al. (2012), are approved or looked on favorably by as many as 30% of researchers polled. Positive incentives were used to elicit the truth from researchers, but it's possible that the actual use and "approval" of these techniques is even more common. They conclude, "Some questionable practices may constitute the prevailing research norm. "

A third problem with some research involves the use of small samples, or what Tversky and Kahnemann (1971) refer to as an unjustified belief in "the law of small numbers." They argue that using a small random sample as representative of a larger population is unsound. For instance, some studies have a sample size of 20 or so subjects but make generalizations about all human behavior. The problem of choosing a representative sample and controlling for other variables that might influence a small sample are difficult if not impossible to overcome. The larger the sample size, the more likely a positive result will be valid. Some results from small sample sizes may be valid. We just don't know which ones.

Publication bias can affect the field of psychology in dramatic ways (Franco et al., 2014). Negative results tend to not get published even if they contradict major findings because they may be considered less interesting or eye catching than positive results. Research that is of popular interest or related to subjects that are "in the news" also tends to be published more frequently than less high interest subjects. Publication bias narrows the range of available data and reinforces existing knowledge, rather than focusing on novel findings or that which contradicts what is currently known.

Is our belief that scientific research methods provide real answers a myth? We don't know how many researchers fabricate data. Most of those who do are probably not caught, but I think we can assume that they are a small minority. Most people engage in research to find answers, not to fabricate them. However, publication bias and questionable research practices may be common. The age of unthinking confidence in research is over. We learned to trust it, and now we must learn to question it. The scientific method is sound but can be practiced in an unethical or unsound way. Psychologists should read and use research with care, both in the laboratory and in our effort to help our clients to thrive.

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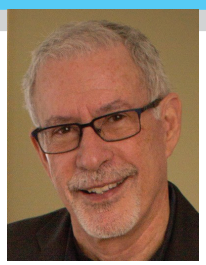

THE MYTH OF THE GOLDWATER RULE FOR PSYCHOLOGISTS

ROBERT M. GORDON, PhD, ABPP

History informs us that the malignant mental illness of autocratic leaders causes the worst avoidable suffering. For example, in just 43 years, from 1933 to 1976, an estimated 120,000,000 people died due to the leaderships of only three men: Hitler, Stalin, and Mao Zedong.

Many psychologists feel that we have a duty to warn about potentially dangerous leaders. Electing well-qualified leaders is essential for the health and welfare of a nation and its citizens. Many people would take a candidate's character into consideration if the assessment were based on scientific standards. "Measuring the Next President's Personality Using an Expert Raters Method" was in the top 2% of all research articles tracked (over 7.2 million of them) regarding the amount of media attention it received (Visser et al., 2018). Since presidential elections are often very close, this information is clearly valued and could make a significant difference.

As important as assessing political candidates is, it is not a good idea to give in-person assessments to political candidates. The findings are not likely to be valid. Candidates for office are often experts in selling a manufactured image. They would certainly be coached in how to fake good. Also, research on the effectiveness of interviews for someone motivated to fake good are often inferior to records reviews and observer ratings. This is especially true for those with psychopathic traits who are naturally skilled at deception.

It is possible to evaluate political candidates' personalities based on their documented statements and recorded observed behaviors, in the same manner that forensic psychologists formulate and offer their evaluations to law enforcement or to the courts, or when the Federal Bureau of Investigation uses personality profiling to help find a criminal.

Scientific research supports the validity of experts rating politicians' personality traits regarding leadership quality. For example, Nai and Toros (2020) compared the Big Five and the D12 inventory for the Dark Triad (i.e., narcissism, psychopathy, and Machiavellianism). They obtained scores of 157 world leaders between June 2016 and July 2019. Using the ratings provided by over 1800 scholars, they found that, "Candidates identified as 'autocrats' score significantly higher than non-autocrats on the three traits of the Dark Triad, and especially psychopathy" (p. 16). Trump had the highest score in extroversion, and the lowest scores on agreeableness, conscientiousness, and emotional stability. On the Dark Triad, both Putin and Trump scored very high on psychopathy, with Trump having the highest scores on narcissism and Machiavellianism and the second-highest score on psychopathy.

However, there is a myth that psychologists cannot offer a professional opinion about a person's mental functioning without having met them. This started with what is known as the "Goldwater Rule," which only applies to psychiatrists and no other mental health professionals.

The Goldwater Rule is Section 7 in the American Psychiatric Association's (APA) Principles of Medical Ethics, which first appeared in 1973, after presidential candidate Barry Goldwater successfully sued a magazine in 1969 for publishing a survey of psychiatrists who considered him unfit for office.

The Goldwater Rule states that, "It is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."

All other licensed mental health professionals do not have an equivalent "Goldwater Rule," but rather are required to form conclusions based on scientific standards. The APA's (2016) Ethical Principles of Psychologists and Code of Conduct states: "9.01 Bases for assessments (a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings."

The APA guideline 9.01 is consistent with Federal Rule 702 "Testimony by Expert Witnesses." It states that, "(a) The expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine

a fact in issue; (b) The testimony is based on sufficient facts or data; (c) The testimony is the product of reliable principles and methods; and (d) The expert has reliably applied the principles and methods to the facts of the case."

That is, psychology's ethic is based on valid scientific methods, and not necessarily a personal meeting.

Robert F. Bornstein and I developed the Psychodiagnostic Chart (PDC and PDC-2) (Gordon & Bornstein, 2018) to codify the highly complex Psychodynamic Diagnostic Manual. It can be used when the person is not available and assessment is instead based on documents, records, collateral interviews, or other sources of information. Many studies support the clinical utility and validity of the PDC-2 (https://sites.google.com/site/psychodiagnosticchart/). Copies of the PDC-2 are available for free on that website.

I recently tested the utility of the PDC-2 in assessing the mental functioning of political leaders (Gordon, in press). I used three well-known contemporary political leaders (Putin, Trump, and Zelenskyy) using a purposive sample of 50 expert clinicians who responded to an online survey. The PDC-2's 12 mental functioning scales yielded significant differences between Zelenskyy (who scored consistently healthy across all the 12 mental functions), and Putin and Trump, both of whom scored extremely low in all 12 mental functions. Raters' political orientation was not significantly correlated with any of their ratings. This is only one of several instruments that can be used to objectively assess political candidates and leaders.

We psychologists have a duty to warn about dangerousness, but we must use evidence-based methods that are consistent with APA's Ethical Standard 9.01. Do not let the myth that the Goldwater Rule applies to psychologists stop you.

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WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT SUPERVISION

(CONTINUED FROM PAGE 8)

It is important to note that these regulations apply to psychologists in Pennsylvania; when considering providing supervision to trainees in other disciplines such as counseling and social work or to trainees seeking licensure in other jurisdictions, psychologists should familiarize themselves with the appropriate regulations.

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FIVE ETHICS MISASSUMPTIONS ABOUT MARKETING YOUR PRACTICE

PAULINE WALLIN, PhD

Are you overly cautious in marketing your practice? You don't want to do anything unethical, of course. But in your cautiousness, you may unwittingly make it harder to be found by people who need your services.

The APA Code of Ethics (2017) does not prohibit marketing and advertising. However, it does require adherence to basic principles, including benefit to the public, avoidance of harm and exploitation, and accurate representation of your training and competence.

From these and other aspects of the Ethics Code, psychologists sometimes draw erroneous conclusions about what is and what is not ethical when it comes to marketing. Here are a few myths and misassumptions, along with clarifications.

1. MYTH: IT IS UNETHICAL TO "TOOT MY OWN HORN" ABOUT MY PRACTICE.

Fact: Self-promotion per se is not considered unethical. What is unethical is making false or misleading claims about your training, expertise, or experience. Thus, for example, if you have a doctorate in a field other than psychology—say, a PhD in history—and you also have an MSW and are licensed as a clinical social worker, you cannot ethically represent yourself as "Dr." when referring to your mental health work. Furthermore, in Pennsylvania, you cannot legally call yourself a psychologist unless you are licensed as such.

That said, self-promotion is ethical when advertising your services or introducing yourself to new referral sources. You can also ethically emphasize your expertise through writing, videos, audios, and presentations to community groups and professional groups.

2. MYTH: IT IS UNETHICAL TO PUBLISH MY FEES ON MY WEBSITE OR IN MY BROCHURE.

Fact: It is not unethical to publish your fees on your website or in other promotional material. However, certain aspects of fees may be subject to laws in your jurisdiction. For example, in the United States, discussing fees with colleagues and competitors could give the impression of price fixing among the members of your group (Federal Trade Commission, n.d.), which is illegal. For this reason, our professional listservs, forums, and social media have strict rules banning any discussion of fees other than Medicare fees, which are set by the government.

3. MYTH: IT IS UNETHICAL TO ASK FOR TESTIMONIALS FROM NON-CLIENTS.

Fact: It is unethical to request a testimonial or positive review from current individual clients, as well as from people who are vulnerable to undue influence, which often includes former clients. That's because they may agree to provide a testimonial to please you, even when it is not in their best interest.

For instance, by posting a positive review, they are publicly revealing that they have had mental health treatment. "No big deal," a client might think. However, they may not have considered ways that such information could affect how they are perceived by future employers, dating partners, and others who Google their name. This is just one of the reasons that it is ethically prudent to avoid asking current or former clients for testimonials or ratings.

On the other hand, it is ethically permissible to ask for testimonials from people who are not clients or patients: referral sources, colleagues, or readers of your books and other materials. Thus, it does not violate ethics if you ask a physician or attorney who has received positive feedback about you, to write a supportive blurb. Similarly, it does not violate ethics if you request a written or video testimonial from a colleague who is familiar with your work.

4. MYTH: IT IS UNETHICAL TO APPROACH BUSINESSES AND ORGANIZATIONS, OFFERING MY SERVICES.

Fact: It is unethical to solicit individuals for clinical services, due to their potential vulnerability to undue influence. However, for organizations and corporations, it is not unethical for you to solicit their business. In fact, direct solicitation may be the only way that they can learn about you and how you can help them. If you do not misrepresent your skills, credentials, or fees, you are in the clear, ethically speaking.

5. MYTH: IF AN INDIVIDUAL ASKS IF I KNOW OF A MENTAL HEALTH PROFESSIONAL WHO CAN HELP THEM, IT IS UNETHICAL FOR ME TO OFFER MY OWN SERVICES, EVEN THOUGH I HAVE EXPERTISE IN TREATING THAT TYPE OF PROBLEM.

Fact: There is no general ethical prohibition against offering your services in response to a request. And, contrary to popular belief, there is no ethical requirement to provide names of three professionals.

However, in some cases, where your objectivity could be compromised—such as when the request is made by someone you know well (e.g., family member or close friend)—it would be in their best interest to be referred to a professional who is less apt to be influenced by personal relationship biases. The same applies to people with whom you have a professional relationship, such as referral sources or your hairdresser.

On the other hand, if an audience member at one of your presentations comes up to you or contacts you later about getting a referral, you can ethically offer your own services, if you have the required competency, and that your objectivity would not be compromised by a social or working relationship with that person.

READ YOUR PROFESSIONAL ETHICS CODE!

When in doubt, check *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017), particularly General Principal A (Beneficence and Nonmaleficence), Standard 2 (Competence), Standard 4 (Privacy and Confidentiality), and Standard 5 (Advertising and Other Public Statements). You won't find comprehensive dos and don'ts for specific aspects of marketing but by understanding the rationale and aspirations of your ethics code, you can become more confident in your marketing efforts.

For additional personal guidance in making specific, ethical marketing decisions, talk with the risk management consultant affiliated with your malpractice insurer.

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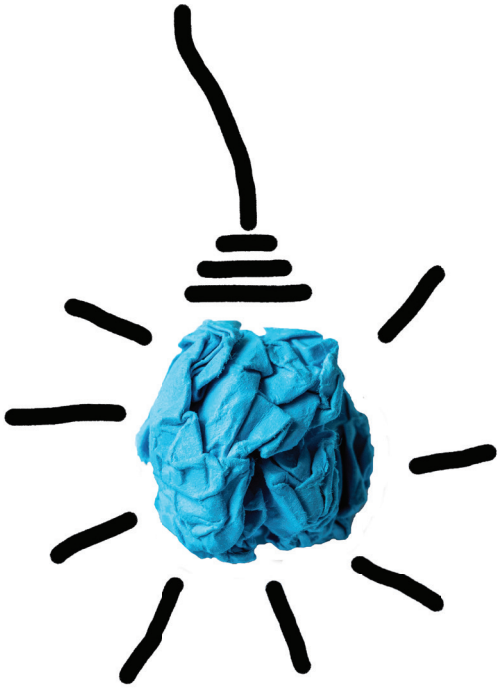

MYTH: Only U.S. Citizens Are Entitled to a Free, Public Education

SHIRLEY A. WOIKA, PhD

FACT: Undocumented children and youth are guaranteed the right to an education. This right was first guaranteed in the Equal Protection Clause of the Fourteenth Amendment in 1868. This Clause mandates that no state shall deny to any person within its jurisdiction the equal protection of the laws.

Whether the Fourteenth Amendment applied to undocumented immigrants was at issue in the 1982 Supreme Court case of *Plyler v. Doe* (457 U.S. 202). This case was in response to a 1975 Texas state law that allowed Texas to withhold state funds from local school districts for educating children of illegal aliens. Although not citizens of either the United States or Texas, the Supreme Court reasoned that undocumented immigrants and their children were people "in any ordinary sense of the term" and were therefore afforded Fourteenth Amendment protections. Because Texas was unable to prove that the regulation served a compelling state interest, the practice was found to be unconstitutional. The Supreme Court ruled that the Constitution guarantees equal protection under the law for undocumented children and reasoned that denying undocumented students their right to an education would "deny them the ability to live within the structure of our civic institutions and foreclose any realistic possibility that they will contribute in even the smallest way to the progress of our nation."

Although the *Plyler* decision did not specifically address issues of enrollment procedures for students, it is generally viewed as prohibiting any district actions that might "chill" or discourage undocumented students from receiving a free public education.

Clear guidance was provided by the U.S. Department of Justice and the U.S. Department of Education via a joint Dear Colleague letter to schools dated May 8, 2014. This letter clearly stated that "the undocumented or non-citizen status of a student (or his or her parent or guardian) is irrelevant to that student's entitlement to an elementary and secondary public education." The letter goes on to state that districts may not request information with the purpose or result of denying access to public schools. More recent, the Secretary of Education provided an updated letter to Chief State School Officers dated September 6, 2023. This letter was written for the purpose of affirming "school district's responsibilities to serve immigrant students."

States were ranked in 2021 based on their share of students from immigrant households. California, New Jersey, New York, Florida, and Texas topped the list, while Pennsylvania was ranked at 27. In 1980, 4% of students in PA spoke a language other than English at home. In 2021, this tripled to 12%.

The PA Department of Education outlines enrollment procedures in a Basic Education Circular (BEC) entitled Enrollment of Students that was issued on June 1, 2023. It states that a school-age child may be presented for enrollment by a parent, school district resident, or any other person having charge or care of the child. There are exceptions for children who are homeless or in foster care. Required documentation is limited to proof of the child's age, immunizations required by law, proof of residency, and a parent registration statement. A Home Language Survey is also required for all students seeking first time enrollment.

There is flexibility in what documents may meet these requirements. For example, proof of age could include a birth certificate, notarized copy of a birth certificate, baptismal certificate, copy of the record of baptism that is notarized or duly certified showing the date of birth, a notarized statement from the parents or another relative indicating date of birth, a valid passport, or a prior school record indicating the date of birth. Similarly, proof of residency could include a deed, lease, current utility bill, property tax bill, vehicle registration, driver's license, or a Department of Transportation identification card.

The required parent registration statement is a sworn statement attesting to whether the student was suspended or expelled for offenses involving drugs, alcohol, weapons, or infliction of injury or violence on school property. A school district may not deny or delay a child's school enrollment based on the information contained in a disciplinary record or sworn statement.

The BEC also states that a child should be permitted to attend school on the next school day after the day on which the child is presented for enrollment, and in all cases, within 5 business days of the school district's receipt of the required documentation (22 PA Code §11.11(b)).

According to the Pennsylvania Department of Education (DOE), there are items that may NOT be requested or required during the enrollment process. These include a social security number, the reason for a child's placement if not living with natural parents, a child's or parent's visa, immigration status, or agency records. Except in limited circumstances, the district may not require a court order or records relating to a dependency proceeding or the legal address for families enrolled in the Address Confidentiality Program. The PA DOE clearly states "a child's right to be admitted to school may not be conditioned on the child's immigration status. A school may not inquire regarding the immigration status of a student as part of the admissions process."

The Department of Health and Human Services (HHS) operates about 150 shelters to care for unaccompanied children until they are released to sponsors. These children are in the temporary custody of HHS. They do not enroll in public schools while living in these shelters. Instead, they are provided with basic education services by HHS. Once released to a sponsor, students are entitled to enroll in the local school districts of the sponsor's residence.

Unaccompanied youth, including undocumented individuals, may qualify for services under the McKinney-Vento Homeless Act. This federal law provides educational rights and support to children and youth experiencing homelessness to include immediate access to a free, public education. The broad definition of *homelessness* under McKinney-Vento is any individual who lacks a fixed, regular, and adequate nighttime residence. Any students qualifying under this Act have the right to immediately enroll in school.

It is important that schools remove enrollment barriers. For example, remove arbitrary requirements such as custody papers, lease agreements, and social security numbers. Allow for alternative methods to demonstrate residency. Remove any registration requirements that are likely to "chill" enrollment. Provide English language programs. Offer therapeutic support to immigrant children given that they express concern about immigration enforcement issues at school. Provide families with resources to obtain additional information. Such resources might include Fact Sheet: Information on the Rights of All Children to Enroll in School and Educational Resources for New Arrivals & Deferred Action for Childhood Arrivals (DACA) Students available at https://healthinschools.org/issue-areas/immigrant-and-refugee-children/.

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MYTH BUSTERS: Five Common Myths About School-aged Children

KAYLA BROOKS, MEd; CELINE KRISTOFF, MEd; JESSICA MAGNESS, MEd; MEGAN RIEKER, MEd; LAUREN SULLIVAN, MEd; SHIRLEY WOIKA, PhD

Myth: Talking about suicide and suicidal thoughts will encourage suicide.

Fact: Initiating a conversation with students who are experiencing suicidal thoughts will not make it more likely that they will act on those thoughts. Talking about suicide and addressing any noticeable warning signs directly helps those who may be considering suicide feel heard and potentially seek professional help. Nearly 23% of high school students in Pennsylvania seriously considered attempting suicide with 10% attempting suicide one or more times within the last year (Centers for Disease Control and Prevention [CDC], 2021). Direct discussion of suicide can provide an immediate safe space for youth in crisis who need support. There are often warning signs present before someone dies by suicide, including talking about the act and reaching out for help. Suicide can be prevented by listening and talking to those who reach out for help. Approaching the topic of suicide may seem awkward or intimidating, but breaking the stigma and opening discussions of topics like suicide can be effective in saving lives of those struggling with suicidal thoughts. In Pennsylvania alone, approximately 2,000 deaths related to suicide will occur yearly (CDC, 2023). If you or someone you know is in need of support text "PA" to 741741 for crisis services.

Myth: Children in foster care have experienced trauma leading to mental health disorders that are beyond repair.

Fact: Foster children face numerous barriers that other children may not have to overcome. They are often underserved, placed in the wrong classes, and lack access to the services needed to succeed (Education Law Center, 2022). A meta-analysis found that children in foster care demonstrate higher rates of oppositional defiant disorder/conduct disorder, posttraumatic stress disorder, reactive attachment disorder, major depressive disorder, and suicidality (Engler et al., 2022). Furthermore, children in foster care are more likely to be diagnosed with a mental disorder by three to four times (Greiner & Beal, 2017). However, just because foster care children experience higher rates of difficulties with mental health does not mean they are beyond repair. Service providers should consider mental health screeners and assessments and participate in trauma-informed training. Schools can work toward supporting children in foster care by communicating with previous schools to obtain records and make sure the child's Individualized Education Program is up to date and appropriate. There are 15,000 children in foster care in Pennsylvania (Department of Human Services, 2023). Many effective treatments are available and working to support children in schools while collaborating with outside providers is important.

Myth: Children can outgrow attention-deficit/hyperactivity disorder (ADHD).

Fact: Most children do not outgrow ADHD. As children develop into adolescents and adulthood, the symptoms of ADHD may present differently. ADHD is a neurodevelopmental disorder that impacts attention and can lead to increased hyperactivity and impulsivity

(American Psychiatric Association, 2013). In early childhood, ADHD may present as difficulty sitting still, a shorter attention span, excessive talking, and struggles with emotion regulation and following directions. Over the years, these symptoms can begin to appear more as forgetfulness, impulsive behavior, procrastination, distractibility, and restlessness. When diagnosing adults with ADHD, the DSM-5 criteria require symptoms to have been present before the age of 12, thus indicating ADHD is not typically outgrown (American Psychiatric Association, 2013). A longitudinal study found that 60% of people diagnosed with ADHD as children still had symptoms as an adult, and 41% had symptoms that met impairment criteria (Sibley et al., 2016). The symptoms may be less visible in adults, but they can still significantly impact a person's functioning. It is important for psychologists to recognize that ADHD symptoms are likely to continue into adulthood; however, the presentation of symptoms may differ. Remember that treatments may need to be adjusted over time to support individuals as their symptoms change.

Myth: Children see things backwards if they have dyslexia.

Fact: With an increasing number of states recently passing legislation emphasizing screening for and remediation of dyslexia, many misconceptions have formed regarding the meaning of this term (Eide, 2016). One common myth surrounding dyslexia relates to it being a visual problem. Psychologists may interact with individuals who suspect a student has dyslexia as evidenced by the student "seeing words backwards." Comments such as this perpetuate the myth that dyslexia relates to a deficit in a student's ability to perceive objects in space. In reality, a label of dyslexia does not refer to an issue with vision at all. According to the International Dyslexia Association of Pennsylvania, *dyslexia* is defined as "a language-based learning disability," or "a cluster of symptoms which results in people having difficulties with specific language skills, particularly reading." If a student truly had a problem seeing words as backwards, this would likely not be an isolated issue related to reading. They would likely have difficulty with other activities related to vision, such as depth perception when reaching for an object. When answering questions about what dyslexia means, psychologists should attempt to provide an accurate definition of the term to decrease misconceptions, while also considering the unique needs of each student when planning for dyslexia-related interventions and accommodations.

Myth: Children with autism are intellectually disabled.

Fact: autism spectrum disorder (ASD) and intellectual disability (ID) can co-occur and have some overlapping features, but the cognitive profiles among individuals with autism vary greatly. ID is marked by deficits in intellectual and adaptive functioning, while ASD can be characterized as a developmental disability that affects communication and social interaction (Individuals With Disabilities Education Act, 2004). Studies evaluating the comorbidity of autism and ID have produced mixed results, likely due to the variation in sampling procedures and study design. One study comparing ASD students to their neurotypical counterparts found that scores on a measure of cognitive ability were more widely distributed across the ASD sample, indicating greater variation in ability (Billeiter & Froiland, 2023). This variability has contributed to the lack of consensus among researchers who have attempted to measure rates of comorbidity. Reported values have ranged from 20% (Khachadourian et al., 2023) to as high as 80% (Mpaka et al., 2016). It is important for professionals to assess across the areas of cognitive, academic, adaptive, and social functioning to best understand where the child's strengths and weaknesses lie. Additionally, educators should avoid making assumptions about a child's intellectual functioning, especially when children are nonverbal.

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ETHICS IN ACTION: Perceived Power and Effective Cross-disciplinary Collaborations

JEANNE M. SLATTERY, PhD; LINDA K. KNAUSS, PhD; JOHN GAVAZZI, PsyD; AND SAM KNAPP, EdD

This discussion is part of a series examining clinical dilemmas from an ethical perspective. In addition to the three of us, we were joined by Drs. Brooke Cannon, Deb Kossmann, Valerie Lemmon, and Ed Zuckerman. Rather than immediately reading our responses, consider carefully working through the vignette first.

Dr. Integrate is a psychologist working in a mixed practice with psychiatrists, nurses, and social workers. For the most part, this has been a very positive experience for her, but she often finds that there are cultural differences between her and her colleagues in other disciplines. Her colleagues tend to emphasize client autonomy to a lesser degree than she does, often wanting her to "tell" her adolescent clients or their parents what to do, informing clients only of their desired treatment approach, and "putting" their shared clients on medication if they do not change as rapidly as her colleagues believe their clients should change. Dr. Integrate believes that psychological pain is a normal aspect of life, while her colleagues have a relatively lower tolerance for their patients' pain. Her clients often enter with significant trauma, while her more medically oriented colleagues often ignore adverse childhood events and other negative life events in their assessments.

Dr. Integrate often feels incompetent during these interactions because she cannot advocate for her clients in the ways that she would like. Sometimes she believes that this is a clinical issue, but at other points she wonders if it is an ethical one. Suggestions?

Clinical or Ethical?

Many dilemmas in psychological work are often initially conceptualized with a false dichotomy as either a clinical or ethical issue. Nonetheless, all our work has an ethical dimension. Although it may be natural for Dr. Integrate to think of ethical issues when her clients are not receiving the care she thinks is best, it may be more beneficial to both her clients and to her interpersonally to conceptualize the situation as a clinical issue with ethical underpinnings. This is a less confrontational communication and is likely to lead to better outcomes for her clients and for her relationships with her colleagues.

A Different Kind of Cultural Competence

Several of us have had close experiences with the medical system in the last year and noted how difficult it can be to feel heard by medical professionals who are often rushed and hurrying from one patient to another. It can require significant assertiveness to advocate for our clients effectively. Prescribers operate within a culture that is often quite disparate from that of psychology, one in which newer or less confident and assertive professionals, as Dr. Integrate appears to be, often struggle. Prescribing mental health professionals often hold a position of authority due to their ability to prescribe medication. This perceived or real authority can create power dynamics within a group practice that may also be based on or reinforced by reimbursement rates and salaries. Practitioners with greater perceived power may tend to assume a more dominant position when planning treatment and identifying intervention strategies, even when others might offer significant contributions. Such a power imbalance can interfere with collaboration, communication, and decision-making processes, although they may also recognize psychologists' greater expertise with "challenging" clients, including those who are treatment noncompliant. In general, however, younger physicians are more likely to have been trained to collaborate, while older physicians were trained to assert their authority and be "captains of their ship," who denigrate people who disagree with them.

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

In addition, prescribing professionals and psychologists often have different treatment approaches and philosophies. Prescribing professionals may view medication as crucial in addressing mental health issues. Some may have never been adequately trained in the biopsychosocial model, which is now a dominant theme in psychiatric training. They may perceive psychologists as limited in their ability to contribute to patient outcomes. Because psychologists are often trained in the biopsychosocial approach to assessing, treating, and managing mental health conditions, we can advocate for a comprehensive and holistic approach to mental health care. These differing beliefs about treatment can create tensions and conflicts when developing comprehensive care plans. To provide truly collaborative and high-quality care, the team must recognize and minimize potentially harmful power dynamics, while valuing and incorporating different perspectives.

We might conceptualize what's happening here in terms of different models of helping (Brickman et al., 1982). The medical model implies that patients are not responsible for the problem or the solution; patients just need the solution—direct advice or medication—to resolve issues (prioritizing beneficence). Psychologists, on the other hand, tend to emphasize the "compensatory model," a participatory model where clients are seen as holding a significantly greater responsibility for the solution. Clients are believed to have the power and resources to solve their problems or should be empowered to access such power and resources (prioritizing autonomy). Addressing client preferences is seen as necessary for positive outcomes in treatment (American Psychological Association [APA], 2006).

Framing these issues in terms of apparently conflicting models of helping (Brickman et al., 1982) can help us recognize and talk to different professionals holding different perspectives, just as understanding individual perspectives and cultural biases can facilitate what might otherwise be difficult interactions.

Rubber Hits the Road

How might we put these ideas into practice? One of us suggested that Dr. Integrate needs to "learn to stand up to her medical colleagues." All of us agreed that it can take significant assertiveness to work in a medical setting and that not all practitioners will work well in all settings. Psychologists need to know more about disease states, medications, drug interactions, and side effects to be effective in medical settings. They need more than technical competency to be effective; they also need self-confidence and assertiveness (emotional competency). Finally, as discussed above, they need a type of "cultural competency" when working in an interdisciplinary agency.

All team members—both more and less powerful—are responsible for co-creating a treatment culture that listens to and values other perspectives to serve their clients most effectively (APA, 2017, Standard 3.09). Effective teams may be characterized by good communication, mutual education, role differentiation, a culture of "speaking up" when a problem appears, and valuing client feedback. During brown bag discussions, they can discuss research issues that bear on the cases they share. Psychologists might educate other team members about other ways of conceptualizing a case. Attending to adverse childhood events means that the team might approach apparent attention-deficit/hyperactivity disorder symptoms first from a trauma lens (e.g., Johnstone & Boyle, 2018). They can discuss the advantages of empowering clients in treatment so they can continue using these newly built skills independently, even after they are no longer seen in therapy or taking medication. Empowering clients in this way also increases the likelihood of compliance with the recommendations of medical professionals. They may also help them recognize how psychologists can inquire about medication, side effects, and responses to treatment and determine whether clients are making progress toward shared, collaboratively generated goals (between clients, psychologists, and the rest of the team). Such collaborations are associated with fewer malpractice claims and, perhaps, better patient outcomes (Napier et al., 2014; Neily et al., 2010).

Thoughts on Practice

One might be an excellent psychologist in some settings and work less effectively in another setting with different colleagues, a different client population, or different expectations. Getting training or supervision to develop more confidence and competence in different settings can be helpful, but sometimes moving to a different environment can make sense. Nonetheless, values shared by many "master therapists" set them up for success across many settings. These values include alliance building, humility, facilitative interpersonal skills, and deliberate practice (Wampold et al., 2017). Acting on these four values might serve Dr. Integrate well in this challenging situation, but the team would also profit by fostering these throughout its culture.

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PPA MEMBERSHIP SURVEYED ON LICENSURE FOR MASTER-LEVEL PROVIDERS

SUSAN EDGAR-SMITH, PhD; JEANNE SLATTERY, PhD; AND HELENA TULEYA-PAYNE, DEd

In the December 2022 edition of *The Pennsylvania Psychologist*, Dr. Paul Kettlewell discussed the American Psychological Association's (APA) consideration for allowing individuals with master's degrees in psychology to seek licensure. Dr. Kettlewell reviewed critical issues and challenges for allowing individuals without doctoral degrees to pursue licensure.

According to Dr. Kettlewell, APA leaders have been examining this issue for the last 5 years. Even if APA makes a recommendation to expand who is eligible for licensure, states are responsible for developing their own regulations. As the organization that represents psychologists in Pennsylvania, leaders in PPA endorsed gaining input from its members about any changes to licensure . A Master's Level Licensure Task Force was formed and in June 2024, PPA emailed a survey to serve the dual purpose of engaging membership in considering this issue and to obtain member's guidance, suggestions and concerns on this topic.

The task force was gratified with the robust response from the membership; 420 surveys were returned. The survey was divided into questions answered through a Likert scale and an open-ended comment opportunity.

Perceived Concerns

We asked survey respondents about nine concerns that we imagined PPA members might have. Several of these were shared by almost half of our respondents. They rated the following as of High Importance (5 on a scale from 1-5): possible confusion by the public about what a psychologist is

and the requirements for becoming one (58.17%); decreased value for the doctoral standard for the practice of psychology (57.49%); increased public confusion related to the difficulty in differentiating among master's-level psychologists, certified school psychologists, and other master's-level practitioners (54.09%); decreased reimbursement from insurance companies for doctoral-level providers (48.88%); and difficulty in differentiating the required training and the specific skills set for Doctoral psychologists, as opposed to master's-level practitioners (42.75%). On the other hand, there was much less consensus about the following issues: increased competition among psychology providers, resulting in a decrease in income (29.8%); decrease in applicant pool for psychology graduate programs leading to a decrease in the quality of psychology training (29.63%); the legislative effort for master's-level licensure might interfere with other legislative priorities for PPA (26.3%); and requirements for supervising master's-level practitioners might become a burden for practicing psychologists (14.89%).

Perceived Benefits

Respondents had less shared consensus on perceived benefits. Almost one-third believed that improving access to care was a benefit was of high importance (5 on a scale from 1-5, 32.17%). Of high importance to some respondents was that licensure might make the path to become a doctoral-level psychologist less burdensome.

This does not mean that respondents saw no benefits. Responses were fairly evenly distributed across possible average ratings of benefits. One hundred twenty respondents (29.6%) perceived all benefits as being important (an average of 4 or more on a scale from 1-5); however, 133 (32.68%) perceived almost no benefit to the proposed changes (an average of 2 or less on a scale from 1-5), with 37.72% between these two extremes. An additional 13 respondents did not respond to the quantitative questions in this part of the survey; they held generally very poor views of this proposal.

Other Issues to Consider

This section of the survey asked a variety of questions related to master's-level licensure.

- A large majority (83.06%) agreed that PPA should continue to support certification of the Master's Plus preparation programs for school psychologists.
- Respondents selected three possible titles for the master's-level licensure position: (1) Licensed Psychological Associate (20.83%), (2) Licensed Psychological Practitioner (20.59%), (3) Master's Limited License (20.83%) with only a few selecting other titles: Licensed Psychological Assistant (1.23%), Psychological Assistant (7.6%), and Psychological Examiner (.074%).
- The majority of respondents (92.57%) endorsed required supervision hours after obtaining the master's degree (e.g., 2 years, 3000 hours) before licensure and practicing independently.
- When asked if APA/PPA needs to develop practice and ethical standards for master's-prepared individuals in addition to expecting adherence to professional psychology's practice and ethical standards, 62.69% endorsed the idea while another 37.31% disagreed.

The last question, prior to allowing respondents to offer open-ended comments, explained that APA is working on "model licensing guidelines for master's level licensure." APA indicates that the details of those guidelines will likely be developed by key committees by June and approved by the end of 2024. If PPA offers a proposal for master's licensure, should PPA include APA's specific recommended language in the proposal? The majority, 81.41%, responded affirmatively while 18.59% answered negatively.

Conclusions

Membership responses suggested strong feelings about the the master's-level licensure issue. More than half of the respondents indicated concern about confusion to the public about what a psychologist is as well as potential decreased value for the doctoral standard. A third of the respondents saw many benefits for this expansion while another third indicated seeing almost no benefits. The task force recognizes that it is difficult to make conclusions about membership beliefs without a clear proposal of APA recommended changes.

The task force will continue to monitor the work of APA committees as they work toward their final recommendations and to contribute additional articles to *The Pennsylvania Psychologist* as updates occur.

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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. You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of **$25 for members ($50 for nonmembers) and mail to:**

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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.

Five Psychological Myths

1. Not having a desired medical abortion:
- a. Results in long-term social and financial problems
- b. Results in long-term regret
- c. Has been well studied in the Turnaway Project
- d. All the above

Myths in Psychological Practice: I Must Keep My Suicidal Patient Alive

2. According to Jobes (2016), the obligations of psychotherapists are to:
- a. Guarantee that they can prevent all suicide attempts
- b. Promise that their patients will not die from suicide
- c. Deliver high-quality mental health services
- d. All the above

3. According to the author, which of the following is TRUE?
- a. Safety planning-type interventions can reduce suicide attempts.
- b. Lethal means counseling can reduce suicide attempts.
- c. Evidence-supported interventions for suicidal patients are better at reducing attempts than treatment-as-usual approaches.
- d. All the above

Myths Keeping the United State Mired in Addiction

4. Individuals with a substance use disorder are always best treated in an inpatient or residential setting.
TRUE
FALSE

5. Which treatment is the most effective for working with individuals with addiction?
- a. Group therapy
- b. Motivational interviewing
- c. Mindfulness-based relapse prevention
- d. No one treatment has been shown to be superior to another, rather the display of genuine empathy and a nonjudgmental spirit is associated with the best outcomes.

Trust Research Findings But…

6. What are the two most common factors resulting in lack of trust in published research?
- a. Publication bias and questionable research practices
- b. Running a lab experiment until you get the "right" result and publication bias
- c. Data fabrication and questionable research practices
- d. Publication bias and data fabrication

7. The basis of the scientific method is:
- a. Experimentation
- b. Questionable research practices
- c. Double blind studies
- d. Careful observation

The Myth of the Goldwater Rule for Psychologists

8. The Goldwater Rule forbids psychologists from offering a professional opinion about a political candidate that was not personally interviewed by the psychologist.
TRUE
FALSE

Five Ethics Misassumptions About Marketing Your Practice

9. Self-promotion is inherently unethical.

TRUE
FALSE

10. Which of the following is NOT an example of ethical marketing?

a. Posting a long list of your credentials and professional experiences on your website
b. Asking colleagues on the PPA listerv what they charge, so that you can set your fees to be competitive
c. Approaching your local women's shelter to offer training of their staff
d. Asking a physician to write an endorsement of your services on your Facebook page

MYTH: Only U.S. Citizens Are Entitled to a Free, Public Education

11. Which of the following items may be required for school enrollment?

a. Birth certificate
b. Social security number
c. Immigration status
d. Visa

12. What key issue did the *Plyler v. Doe* case resolve?

a. Non-citizens were not entitled to an education.
b. Tax dollars cannot be used to provide education services to non-citizens.
c. The 14th Amendment applies to undocumented immigrants.
d. Immigration status must be revealed when enrolling in a public school.

Myth Busters: Five Common Myths About School-Aged Children

13. The term *dyslexia* is primarily characterized by:

a. Difficulties perceiving objects in space
b. Deficits in language skills and reading
c. Visual deficits and difficulty reading
d. Difficulty writing sentences legibly

14. Approaching the topic of suicide with someone who is considering suicide could:

a. Encourage the act
b. Get you in trouble at your job
c. Save the life of the person struggling
d. Discourage others from reaching out

Ethics in Action: Perceived Power and Effective Cross-Disciplinary Collaborations

15. To work effectively in integrated care settings, psychologists need to:

a. Recognize power dynamics
b. Value different perspectives
c. Interact assertively
d. All the above

16. Which values are commonly shared by master therapists?

a. Autonomy, professional growth, organization, a search for "rightness"
b. Alliance building, humility, facilitative interpersonal skills, deliberate practice
c. Family, organizational quality, community, beneficence
d. Professional success, perfectionism, organization, individualism

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, December 2023

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

1. a b c d	5. a b c d	9. T F	13. a b c d
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3. a b c d	7. a b c d	11. a b c d	15. a b c d
4. T F	8. T F	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
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Act 74 CE programs

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Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE
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The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

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Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

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Telepsychology Q&A (Webinar)—1 CE
Why the World is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

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