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Psychologists With Cancer

Clinical, Ethical, and Practical Challenges

Helen L. Coons, Ph.D., ABPP, and Jana N. Martin, Ph.D.

Psychologists living with cancer face clinical, ethical and practical challenges while coping with their own diagnosis and treatments. This brief article offers several suggestions to psychologists in practice and other professional settings who are coping with an early or advanced diagnosis of cancer.

Dr. Helen L. Coons

Dr. Jana N. Martin

Seek support and supervision. While most individuals are remarkably resilient in coping with cancer and its treatments, a new or recurrent diagnosis and the complex treatment decisions which follow can be highly stressful and frightening. Reaching out to colleagues early for support and supervision is important for psychologists with cancer. Ask colleagues if they know psychologists (or other mental health providers) who have experienced cancer treatment. Practical, informational, and emotional support from someone with an insiders' view is invaluable. The PPA listserv and APA Division listservs may also be helpful in identifying other psychologists with cancer.

Formal supervision from a respected colleague is essential to address clinical, ethical, and practical issues that emerge as psychologists cope with cancer, and to support them in developing a practice management plan during and after treatments.

Develop a practice management plan. A cancer diagnosis will typically be followed by treatment decisions related to surgery, chemotherapy, and/or radiation as well as acute, late, and long-term side effects. At any point in the treatment course, psychologists often face a series of challenging questions related to their practice and other professional roles. Some individuals are too ill, tired, or uncomfortable to work during treatment; some will have to work to maintain their income; and most will likely work part- or full-time with breaks for treatment. Psychologists undergoing cancer treatment are confronted with questions such as: (1) should they continue to see patients, teach, supervise, etc; (2) should they work full- or part-time; (3) if, how, and when to disclose their diagnosis to patients, keeping in the mind their practice focus (e.g., children, teens, adults); (4) how to deal with breaks in treatment resulting from additional surgery or side effects of chemotherapy and/or radiation; (5) whether or not to treat patients who have or had cancer, are "at risk" for cancer, have lost a loved one to cancer, have significant attachment issues, or require a high degree of treatment consistency, etc; and (6) clinical, ethical, and practical issues when closing a practice. Developing a practice management plan in consultation with a supervisor to address these and other questions can be helpful and empowering (Coons, 2010).

A practice management plan during and after cancer treatment may include creating flexibility in the psychologist's schedule. For example,

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PPA Elections to Be Online

Have you voted yet?

Your ballot for the PPA Board of Directors elections arrived via your e-mail address, unless you don't have one, in which case you were sent a paper ballot. If you have not voted, please find your ballot and vote. All candidate statements may be found on the PPA Web site, www.PaPsy.org. If you think PPA has an e-mail address for you that is not current, please e-mail Iva Brimmer at iva@PaPsy.org with a current address. Do it NOW.

As a reminder, for those of you on the listserv, as with all listserv postings, any commentary about the election or candidates must observe the listserv rules and etiquette (http://www.PaPsy.org/membership/rules.html). Not clear about a posting you wish to make? Ask!

We have a terrific slate of candidates who have served PPA well, and we are so pleased that each of them is willing to continue to lead. Support your organization by participating in this election.

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Then and Now: A Contrast Between Early and Senior Practicing Psychologists

Interviewers: Ruth Morelli, Ph.D., ABPP, and Amber B. West, Ph.D.

Dr. Ruth Morelli

Dr. Amber B. West

These two interviews, with a man and a woman at different stages of their careers, show the roles that PPA and PennPsyPAC have played in their lives, and by extension all psychologists in the state. We hope these interviews provide insight and new conclusions about the roles PPA and PennPsyPAC have played in your professional lives.

An interview with
Jeff Pincus, Ph.D.
by Ruth Morelli, Ph.D., ABPP

RM: *What was your terminal graduate degree and when were you licensed?*

JP: I got my Ph.D. in Psychology from Kent State University in 1977, moved to Pennsylvania, and was licensed in the commonwealth in 1980.

RM: *In your graduate curriculum, was there any encouragement or discussion of advocacy for psychology?*

JP: Yes, we had a seminar in Professional Issues including advocacy. One professor, Horace Page, Ph.D., was like our Pat Bricklin. He encouraged us to join the Ohio Psychological Association. He gave us articles to read from the *APA Monitor* and the *American Psychologist,* which we then discussed. He encouraged us to care about ethics, licensure, and insurance reimbursement.

RM: *Since the Continuity of Care Law was passed, with PPA and PennPsyPAC support, what has changed in your practice?*

JP: The lack of continuity of care was often an obstacle in persuading patients to voluntarily go to the hospital. Because psychologists were not permitted to follow their hospitalized patients, I would not learn that a patient was hospitalized until the hospital called me 12 hours before discharge to schedule an outpatient appointment. Now with this law, there is better patient care. If someone enters the hospital as a medical patient, e.g., for gall bladder surgery, and the treating physician observes the patient is also depressed, anxious, or non-compliant with medication, the physician has called me to come and see the patient. In some cases, I chose to make these interventions by phone using a crisis-oriented approach. That's because though the physician would have been OK with my hospital visit, in some cases the hospital did not extend privileges or I didn't apply for staff privileges.

RM: *In 2007, both PPA and PennPsyPAC helped to pass a law prohibiting licensing board complaints against psychologists during child custody evaluations for up to 60 days after a judge's orders. How has this law affected your practice?*

JP: Two or three psychologists in my practice do custody evaluations. They were in favor of this bill, and it has helped to cut down on needless litigation. I do not do custody evaluations so this law doesn't affect my practice. Many psychologists wonder why they should care about an aspect of treatment they don't specialize in like custody evaluations, hospital continuity of care, or drug/alcohol abuse. One answer is that many significant players in mental health care (legislators, lawyers, judges, hospital administrators, and insurance executives) don't always understand the role of psychology. By having psychology recognized in Pennsylvania statutes, it promotes greater understanding of psychology. When legislators write a bill, they look at other passed bills and use similar language. By including the word "psychologist" in a law, it is more likely to be included in subsequent bills. This greater acceptance of psychology benefits both the consumer and the practitioner.

RM: *Do you have any final thoughts?*

JP: When psychologists are asked to participate in PennPsyPAC, the process is similar to therapy. As psychologists, we don't expect change to occur all at once. Change is incremental. Advocacy happens the same way. It took psychologists more than 20 years to get licensed. All new legislation, including parity, insurance reform, continuity of care, psychologist autonomy in professional practice, is just one piece of a larger mosaic that defines how psychology can benefit society.

An interview with
Tammy Kordes, Ph.D.
by Amber West, Ph.D.

AW: *What was your terminal graduate degree and when were you licensed?*

TK: I received a Ph.D. in 2004 and was licensed in 2006.

AW: *In your graduate curriculum, was there any encouragement or discussion of advocacy for psychology?*

TK: My first class in graduate school was a professional development class and Dr. Don McAleer presented. His presentation had a big impact on me at the time. My program also required that we become members of PPA and APA. I also was impressed with Dr. Mark Hogue, who was my clinical supervisor at the time. He often talked to me about not just our duty to protect our patients and ourselves in practice, but also about our responsibility to protect the field of psychology. Also, in graduate school I attended the legislative day and participated on the student ethics panel during my predoctoral internship.

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THEN AND NOW...

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AW: *What is your area of practice and setting?*

TK: I work in the field of neuropsychology in a private group practice. We work closely with neurologists and primary care physicians as well as providing consultative services for a variety of acute care hospitals, rehabilitation hospitals, and skilled nursing facilities. This type of practice was not available to psychologists before PPA and APA helped get psychologists included in Medicare 20 years ago.

AW: *What role do you see PennPsyPAC and/or PPA in your practice of psychology today?*

TK: I see it as pretty integral. My practice partners are very involved with PPA, as am I. I work with the ECP and Business and Psychology Partnership Committees.

AW: *Since the Continuity of Care Law was passed, with PPA and PennPsyPAC support, what has changed in your practice?*

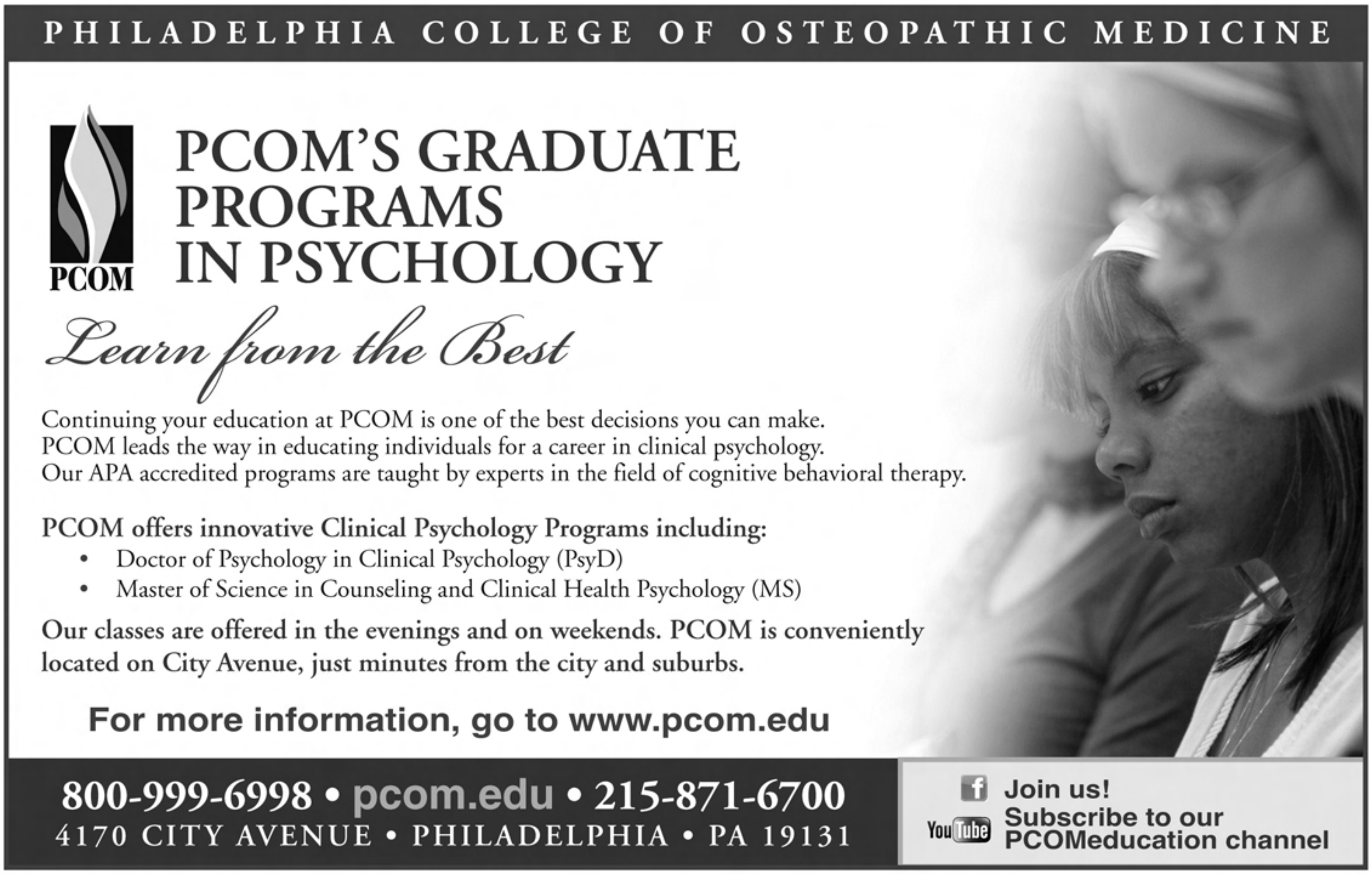
TK: The Continuity of Care Law has unfortunately not affected my practice either, as it is not enforced. I have had numerous patients hospitalized (some are even admissions that I initiated) at facilities where I have privileges and frequently see patients, yet I continue not to be notified or consulted on those particular cases.

ADVOCACY DAY

The PPA leadership has selected **Monday, April 19, 2010**, as our Advocacy Day this year. PPA members are urged to put it on their calendars. It will again be in Room 60 East Wing of the Capitol Building in Harrisburg. The schedule will consist of registration at 9:30 a.m., an issue orientation session from 10:00 to 11:30, and meetings with legislators after that.

We will be providing more information about it by e-mail and on our Web site. We hope to have a good turnout of PPA members. No room for social loafers here!

Please go to www.PaPsy.org to register.



Does (or Why Does) BHRS Work?

Samuel Knapp, Ed.D., Director of Professional Affairs
Robert Reed, Psy.D., Carlow University

Although Pennsylvania's "wraparound," or Behavioral Health Rehabilitation Services (BHRS) program has been in existence for more than 10 years, a question arises as to whether it really works. Although outcome data in wraparound programs conducted in other states can be informative, Pennsylvania's program is so unique in its orientation that it needs to be considered on its own merits. Currently, almost all of the BHRS outcome data comes from the hard-to-retrieve "gray literature" (e.g., newsletters, agency reports, unpublished dissertations) as opposed to peer reviewed journals. This article reviews BHRS outcomes and suggests areas for future research.

Does BHRS Work?

Positive outcomes with home-based BHRS services were found by Dixon (2008), Drake (2008), Coleman & Briggs (2009), Cope (2006), Kossor (n.d.), May (2005), Patton (2008), and Slattery & Bean (2008). In a more comprehensive study using a large population, Eyster and Herr (2009) concluded that, in general, the BHRS population is getting better. Rudy (2005), however, did not find additional improvement from wraparound among juveniles in a residential program, although methodological factors may have masked the benefits. None of these studies were randomized studies with control groups and manualized treatments. Instead, these effectiveness studies looked at services being delivered with real clinical populations. Nonetheless, given the variety of agencies, the geographical diversity of the evaluated services, and the variety of instruments used, they suggest a general trend of effectiveness.

Why Does BHRS Work?

This positive trend in outcomes is important from a public policy perspective because it helps justify this program.

Dr. Sam Knapp

Dr. Robert Reed

However, it does not address other outcome questions. For example, why do BHRS clients report improvement? How much of the improvement is due to the common factors associated with psychotherapy? Some researchers have asserted that the therapeutic alliance predicts outcome better than the specific therapeutic modality (Lambert, 2005; Wampold, 2001; & Krupnick et al., 1996). Is BHRS successful, in part, because home- or school-based services increase opportunities for the therapist to form a therapeutic alliance with the client or parents? How much of the improvement is due to regression to the mean, natural recovery, maturation, or placebo effect? How does BHRS relate to other parts of the children's mental health system (e.g., outpatient mental health, residential, partial hospitalization, hospitalization), or other social service programs (e.g., Children and Youth, Juvenile Justice, schools)? Do most clients fail a less restrictive level of care before arriving at BHRS, and/or is BHRS a viable step-down from more restrictive levels of care? How does the cost of BHRS compare to more restrictive levels of care? Do the rates of hospitalization decline for children who receive BHRS?

Finally, what active elements are responsible for success? Does, or when does, therapeutic staff support (TSS) add value beyond mobile therapy? Do the advantages of TSS services justify their costs and do they outweigh the criticisms that they can be misused as surrogate parenting or substitute care for children?

Other Research Issues With BHRS

Unfortunately, the limited space available here prevents a detailed review of all but the most salient findings, and methodological issues have to be ignored or mentioned only briefly. Some of the topics researched deal with treatment integrity, outcomes with subpopulations of children, or research on the practices and problems, including ethical problems, encountered in the delivery of BHRS services.

Treatment integrity means the extent to which treatments are delivered as intended. Toffalo (2000) found that treatment integrity, operationally defined as the match between the quantity of services prescribed and services delivered, was not related to outcome. Kumar (2007) looked at the Wraparound Fidelity Index and found that community-based samples were in the borderline to adequate range with respect to adherence to wraparound fidelity.

Dixon (2008) found that ethnically diverse children who received BHRS services did not differ from non-diverse children in terms of the diagnoses assigned, types of services provided, and likelihood of getting services for special education needs, mental retardation, or drug and alcohol treatment. However, African-American children were more likely to receive services from the juvenile justice system than White American children. Patton (2008) found no differences in the length of stay in BHRS, in hospitalizations, or for legal problems between children living in home and those living in foster care, even when they were matched in terms of age, sex and diagnosis. Drake (2008) found that younger children or children with externalizing disorders were more likely to be successfully discharged from treatment than older children or children with internalizing disorders.

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DOES (OR WHY DOES) BHRS WORK?

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Others have studied the actual implementation of BHRS. For example, Roberts (2008) found that in-home therapists felt confused over confidentiality and boundaries, more than therapists in traditional office settings. Also, in-home therapists reported less individual supervision and less clinical consultation. Nonetheless, Bowden (2007) found that wraparound workers had a good awareness of professional ethics to guide their practice. More research is needed to clarify the apparent disconnect between these two studies, including a review of the samples and operational definitions used. McAllister, Snyder and Reed (2009) looked at the advantages of an "independent prescriber" versus an "in-house" evaluator model of evaluations and found that the independent model did not improve the quality of the recommendations or reduce the levels of prescribed services. Robertson and Husenits (2007) looked at utilization data and found that rural clients were less likely to receive outpatient mental health services than children living in urban areas. However, such discrepancies did not occur for BHRS.

Many other topics related to BHRS outcomes need to be researched. For example, Conlon, Strassle, Vinh, and Trout (2008) used archival data from BHRS clients to study family management styles when a child has ADHD. However, one of the most salient issues appears to be that of maintaining the skill level of the BHRS workforce. Our review of BHRS failed to find any studies on the effectiveness in disseminating outcome research to the wider practitioner community. Unfortunately, mental health, like health care in general, has been dominated by an osmosis theory of information dissemination. That is, researchers are expected to publish their studies in expensive and hard-to-access journals using arcane language, and practitioners are expected to somehow integrate this knowledge and implement it into their practices. More effective and systematic models for information exchange among researchers and practitioners need to be developed and studied. This includes effective ways to remove objections to evidence-supported treatments such as that they are only cognitive-behavioral therapies, that they require clinically contraindicated allegiance to rigid manuals, or that they ignore relationship factors.

Implications for Future Research

Fortunately the large databases of BHRS agencies or managed care companies allow for research into outcomes for specific diagnoses (or co-occurring diagnoses), demographic factors, or the relationship between outcomes and the use of certain treatments and outcomes. Archival data from agency or insurer records could provide a series of single subject (N=1) studies where a clearer connection between treatment and outcome could be made. This research, combined with what is known about effective outcomes treatment for children in general (Hoover, Kettlewell, & Morford, 2009) and sound clinical judgment, should help improve the quality of BHRS services.

References

Bowden, J. A. (2007). Ethical issues in the provision of wraparound services. *Dissertation Abstracts International, 68*(2-B), p. 1295.

Bradley, J. R. (2005). The deinstitutionalization of children: An evaluation of the efficacy of wraparound services. *Dissertation Abstracts International, 66*(6-B), p. 3398.

Coleman, A. R., & Briggs, E. (2009). *Assessment of clinical outcomes in wraparound using two statistical methods: Meta-analysis and analysis of variance.* Poster presented at the Annual Meeting of the Pennsylvania Psychological Association, Harrisburg, PA.

Conlon, K., Strassle, C., Vinh, D., & Trout, G. (2008). Family management style and ADHD: Utilization and treatment implications. *Journal of Family Nursing, 14,* 1-20.

Cope, J. M. (2006). Which client and treatment variables influence the efficacy of wraparound services? *Dissertation Abstracts International, 67*(3-B), p. 1695.

Dixon, A. (2008). Wraparound services with ethnic majority and ethnic minority children. *Dissertation Abstracts International: 69*(2-B), p. 1949.

Eyster, S., & Herr, S. (2009, November 13). CBHNP children's outcomes monitoring program. Presentation: Harrisburg, PA.

Hoover, H., Kettlewell, P., & Morford, M. (2005). *Evidence-based treatment: What it is and how it will help children.* Harrisburg, PA: Pennsylvania CASSP.

Krupnick, J., Stotsky, S., Simmens, S., Moyer, J., Watkins, J., Elkin, I., & Pilkonis, P. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64,* 532-539.

Kumar, N. (2007). A descriptive study of treatment integrity in community-based wraparound. *Dissertation Abstracts International, 67*(8-B), p. 4714.

Lambert, M. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects." *Journal of Clinical Psychology, 61*, 855-869.

May, R. (2005). Strengths-based: Measurement and outcome. Unpublished data.

McAllister, J., Snyder, D., & Reed, R. (2009). Unpublished data.

Patton, R. A. (2008). Efficacy of wraparound services for in-home and foster children. *Dissertation Abstracts International, 69*(3-B), p. 1988.

Robertson, D., & Husenits, K. (2007, March). The impact of mandatory managed care for Medicaid clients on the delivery of mental health services to children and adolescents in rural Pennsylvania. *The Center for Rural Pennsylvania,* 1-4.

Roberts, J. (2008). Navigating the ethical quandaries of wraparound multi-systemic treatment (MST): A comparative study between in-home and outpatient therapies. *Dissertation Abstracts International, 68*(7-B), p. 4844.

Rudy, E. (2005). Outcome of wraparound services in a juvenile residential program. *Dissertation Abstracts International.*

Slattery, J., & Bean, T. (2008, November). In-home family therapy outcome research: Messy, but part of competent and ethical practice. *The Pennsylvania Psychologist,* 3-4.

Toffalo, D. (2000). An investigation of treatment integrity and outcomes in wraparound services. *Journal of Child and Family Studies, 9,* 351-361.

Wampold, B. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Check out PPA's Career Center

The Membership Benefits Committee would like to remind all PPA members that the new online Career Center is up and running! Simply click on the green box labeled "Career Opportunities" on the right hand side of the PPA home page (www.PaPsy.org). This is a resource for both job seekers and employers/recruiters.

Dr. Cohen Testifies Before House Judiciary Committee on Child Custody Issues

PPA President Dr. Steven Cohen testifying before the House Judiciary Committee

Representing PPA, Dr. Steven Cohen testified before the state House Judiciary Committee in Harrisburg on several bills dealing with child custody in February. Dr. Cohen focused on the proposals to amend Pennsylvania's statutes so that the courts would have a presumption of joint custody, and plaintiffs would have the burden of showing why joint custody was not in the best interests of the child.

In his testimony against the presumption of any particular custody arrangement, Dr. Cohen noted that each family is unique and that parenting arrangements need to match the abilities of the parents with the developmental needs of the children. Many children do well in shared custody arrangements, and they often do better than children living in sole legal custody arrangements. However, Dr. Cohen cautioned against assuming that shared custody arrangements necessarily create better conditions for children. Instead, Dr. Cohen stated,

> *Shared custody is most effective when parents communicate respectfully with each other for the welfare of their children, and when they do not expose the children to ongoing hostility, conflict or violence. Most likely it is this ability to communicate respectfully and the willingness to shield their children from conflict that gives judges the confidence to order shared custody with a particular family.*

Therefore, Dr. Cohen concluded, we should not assume that shared custody automatically makes parents better parents. Dr. Cohen is president of the Pennsylvania Psychological Association, a member of PPA's Child Custody Committee, and a frequent presenter on child custody issues. He has an independent practice in Southampton.

Pennsylvania's Supreme Court Chief Justice, the Honorable Max Baer, also testified against the presumption of joint legal custody, noting that "the real goal of custody arrangements should be child-focused and to reduce high levels of conflict." Justice Baer noted that courts can reduce conflict by requiring parents to develop specific parenting plans and, if appropriate, directing them into specialized services, such as parent education programs. Other witnesses opposing a presumption of joint legal custody included representatives of the Family Law Section of the Pennsylvania Bar Association, and the Pennsylvania Coalition Against Domestic Violence. Nonetheless, several fathers' rights groups have been promoting the presumption of joint legal custody, and their supporters enthusiastically applauded proponents who testified at these hearings when they claimed, among other things, that many custody arrangements marginalize fathers and are responsible for high rates of crime, drug abuse, and incarcerations.

Member News

Boiling Springs psychologist, dog trainer, and author, **Dr. Risë VanFleet**, received the 2009 Maxwell Award from the Dog Writers Association of America for best magazine series. Her series, "Engaging Owners Fully in Dog Training," appeared in the Association of Pet Dog Owners' *Chronicle of the Dog*, to which Dr. VanFleet contributes regularly.

Dr. VanFleet has developed the Playful Pooch Program in Boiling Springs and Carlisle, a service offering canine-assisted play therapy as well as positive dog training for children, teens, and families. The award recognized the quality of her writing and her work with dogs and their human families. To read this year's winning series and other articles, visit her Web site at www.playfulpooch.org.

PSYCHOLOGISTS WITH CANCER

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some psychologists reduce their patient and teaching load, and/or block their schedule after each chemotherapy cycle when side effects (e.g., nausea, fatigue, pain, low blood counts, etc.) are more likely to emerge and may adversely affect one's ability to work. Some individuals undergoing chemotherapy have also shifted the focus of their clinical work to more testing or consultation so that they can schedule evaluations between cycles when they have more energy. Others have found that the familiarity of work is a healthy break from cancer treatment. A management plan should include finding colleagues to be on standby to call and re-schedule clients (who have provided informed consent) so that psychologists do not have to explain to patients how they are feeling.

Pace yourself during and after treatment. Throughout and after cancer treatment, psychologists need to be mindful of their physical, emotional and cognitive well-being. Psychologists have an ethical obligation to ensure that their own physical and psychological well-being is healthy enough to care for patients, teach, supervise, etc. Fatigue, pain, nausea, and vomiting and the medications used to treat these symptoms or side effects may compromise some individuals' ability to meet the demands of clinical practice. Chemotherapy and other medications used in cancer treatment, for example, can diminish cognitive functioning. While changes in concentration, memory, processing speed, and the ability to multitask are likely to be mild and time-limited, high level clinical decision-making is essential for differential diagnosis and treatment. Psychologists undergoing cancer treatment must evaluate if they are healthy enough to meet the demands of practice and other professional responsibilities.

Designate a clinical power of attorney. Consistent with the APA Ethical Principles of Psychologists and Code of Conduct (2002), psychologists are obligated to ensure that patients will be taken care of if they are not able to meet professional responsibilities because of personal problems or when there are interruptions in therapy or termination. While many psychologists with cancer will continue to practice during and after treatment, it is important to designate a clinical power of attorney in the event that the psychologist is unable to take care of patients. This colleague should be able to access the psychologist's office (i.e., they have door and file keys), patient lists, appointment schedules, and records; will contact patients and can either reschedule or provide care to patients, or refer them to other colleagues with the appropriate clinical expertise. See Pope and Vasquez, (2007); Spayd & O'Leary Wiley (2009); and www.apapracticecentral.org for more detailed discussions on closing a practice.

Personal experience with cancer and expertise in psychosocial oncology. Psychologists who undergo their own cancer treatment will have a special understanding of the experience faced by so many adults across the life span. After treatment, they may even consider taking care of patients with cancer. While well meaning, the psychologist's own treatment experience is very different from having the expertise in psychosocial oncology necessary to provide evidence-based assessment and treatment to adults with early and advanced cancers. Treating patients with cancer requires a highly specialized fund of knowledge and clinical competencies to ensure quality care and outcomes. While psychologists may want to help others deal with this challenge, they still have the ethical obligation to practice within their scope of expertise. Again, supervision from a respected colleague can be invaluable to sort out if and when a psychologist should treat others with or affected by cancer.

References

American Psychological Association (2002). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author.

Coons, H. L. (2010). Psychologists with early and advanced breast cancer: Clinical, ethical and practical challenges. Manuscript submitted for publication.

Pope, K. S., & Vasquez, M. J. T. (2007). *Ethics in psychotherapy and counseling: A practical guide.* San Francisco: John Wiley.

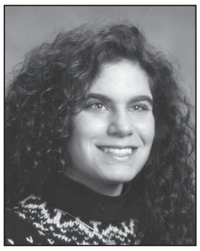
Spayd, C. S., & O'Leary Wiley, M. (2009, December). Closing a professional practice: Clinical and practical considerations. *The Pennsylvania Psychologist, 69*(11), 15-17.

Helen L. Coons, Ph.D., ABPP, *is a board certified clinical health psychologist who is president and clinical director of Women's Mental Health Associates in Philadelphia. She has specialized in psychosocial oncology for 30 years, mentors psychologists and other health care providers with cancer, and underwent treatment for breast cancer. Dr. Coons may be reached at hcoons@verizon.net or 215-732-5590.*

Jana N. Martin, Ph.D., *is a licensed psychologist in independent practice in Long Beach, CA. Some of her work with children, adults, and families has focused on coping with chronic diseases such as cancer, and she is in remission from lymphoma. She may be reached at drjanamartin@verizon.net.*

Using Electronic Media to Supplement Face-to-Face Therapy

Rachael L. Baturin, MPH, J.D., Professional Affairs Associate



As electronic media is becoming more prevalent among patients, psychologists are starting to incorporate it more and more in their practices. Some psychologists use e-mail and texting as legitimate ways to communicate with their patients between face-to-face therapy sessions. For example, a psychologist working with a child having school problems may benefit from between-session feedback as to how the child is responding to particular stressors. Nonetheless, psychologists should set up a policy on if or how they are going to use these means to communicate with their patients, and psychologists should communicate this policy to their patients. Of course, nothing requires a psychologist to use e-mail to communicate with patients, and individual psychologists may decide never to do so. However, for psychologists who do use e-mail or texting, here are some practical tips that psychologists should consider when adopting a policy on the use of electronic media with patients:

❶ Psychologists should clarify to patients what, if any, kinds of e-mails or texts they will accept and the general nature of how they will respond. Generally, e-mails should be professional in nature and should not take on the appearance of a social message. If e-mails are becoming too lengthy or prolonged, psychologists should notify patients to come in or call to discuss the issue. Psychologists should remember that patients can keep e-mails and texts, forward them, edit them, or otherwise use them in ways that the psychologist did not intend.

❷ Psychologists should anticipate and be prepared to respond to patients who abuse the use of e-mailing or texting.

❸ E-mails or texts should not be used in emergencies. Patients should be advised to contact psychologists by phone if an emergency arises.

❹ Psychologists should advise their patients on headings that they will use in the subject line of the e-mail (e.g., billing question, appointment).

❺ Psychologists should establish a turnaround time for their response to patients' e-mails or texts. For example, psychologists may establish a policy that they will check e-mails at least once every 24 hours, thus notifying patients that they should not be surprised if a day or so elapses before a response is received.

❻ Psychologists should inform their patients about privacy issues, including the limitations on the confidentiality of e-mail or texts. Patients should know who besides the psychologist processes e-mails during normal business hours, during vacations, and when the psychologist is out sick. Also, patients should be advised that even though psychologists will take precautions to secure privacy, privacy cannot be guaranteed.

❼ Except for routine scheduling or billing, psychologists should maintain a copy of all messages sent to/from their patients in their records and document in these e-mails what took place in the psychologists' case notes. This is important because e-mails can be edited. Psychologists who receive texts from patients should summarize them in the case notes or, if especially important, should transcribe them verbatim, including date and time the message was received.

❽ Psychologists should include a standard block of text to the end of the e-mail message to patients containing the psychologist's full name, contact information and reminders about security and the importance of alternative forms of communication for emergencies.

Psychologists should remember that e-mail has inherent limitations in that the lack of non-verbal cues (facial expressions, voice tone) may cause the intent of the communication to fail. For example, an attempt at humor may come off as being sarcastic even though it was not meant to be. As new technologies emerge, they will continue to present new opportunities and challenges for the practice of psychology.

Classifieds

POSITIONS AVAILABLE

PA LICENSED DOCTORAL-LEVEL PSYCHOLOGIST – Children's Behavioral Health Services, Inc. provides quality mental health services to children in Northeastern Pennsylvania. Full-time position and part-time contract positions available. Salary is negotiable depending upon experience. Excellent benefits! To apply for a position: e-mail, send or fax resume and cover letter to: Children's Behavioral Health Services, Inc, Attn: Susan Hurd, 104 Woodward Hill Road, Edwardsville, PA 18704; Fax 570-714-7231; shurd@cbhsinc.com

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EXPERIENCED PA LICENSED PSYCHOLOGIST is needed for thriving Delaware Valley psychology practice. Multi discipline practice serving diverse patient populations for over 25 years. Candidate will possess experience and competence in working with adults, adolescents, marital and family counseling. Excellent opportunity for highly motivated individual with ownership aspirations.Reply in confidence to papsycopp@verizon.net

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Continued on page 10

CLASSIFIEDS

Continued from page 9

FREE CE HOME STUDY SLIDES on ethics, personality disorders, psychotherapy, MMPI-2, PDM, love relations and more at www.mmpi-info.com

FREE CONSULTATION IN COGNITIVE & BEHAVIORAL PSYCHOLOGY: I am a Pennsylvania licensed psychologist who is board certified by ABPP in cognitive & behavioral psychology and am offering free clinical consultation to other psychologists who may be in need of this type of assistance. This would be focused on helping psychologists better understand how to use cognitive & behavioral approaches in their clinical work. If you have interest in this type of consultation please feel free to contact me at 412-380-2695 or by email at drdanmarston@comcast.net

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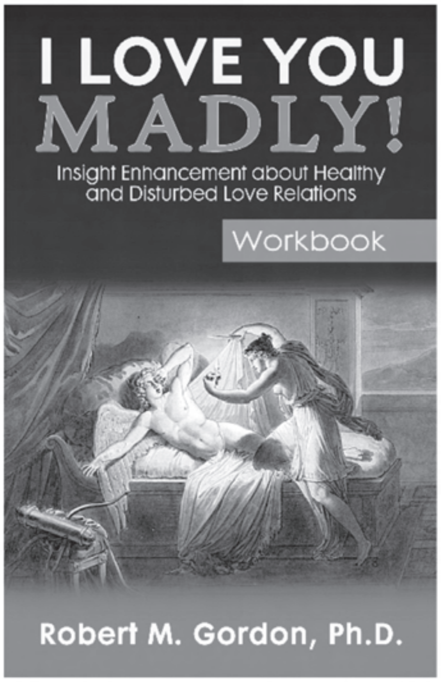

"We commend Dr. Gordon for his attempts to simplify complicated matters and to make them available in a scientific form which can be easily understood by most people." Gerd Fenchel, PhD, in Issues in Psychoanalytic Psychology. 2007 Vol 29(2) 143-147.

USI Affinity

offers Vision Program to improve PPA members' health

USI Affinity, the PPA's recommended health insurance broker, sees the connection between a member's eye health and overall health.

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- Eighty percent of all learning takes place visually for children under 12
- One out of four children between ages 5 and 12 have impaired vision that affects their school performance
- Baby boomers, with aging eyes, are staying in the workforce longer
- Cataract, glaucoma and diabetic retinopathy account for 75% of all blindness.

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2010 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

April 8–9, 2010
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

April 10, 2010
PPAGS Workshop: Congratulations! You Have a Doctorate: Now What? Pursuing a Successful Career in Psychology
Lancaster, PA
Marti Evans (717) 232-3817

May 14, 2010
Parenting Coordination Training: Understanding High Conflict Families and Resolving Their Disputes
Philadelphia, Allentown, Pittsburgh, Mechanicsburg, and Wilkes-Barre
Rachael Baturin, MPH, J.D.
(717) 232-3817

June 16–19, 2010
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

September 24, 2010
APA Insurance Trust Risk Management Workshop
Harrisburg, PA
Marti Evans (717) 232-3817

November 4–5, 2010
Fall Continuing Education and Ethics Conference
Exton, PA
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For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

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If you have additional questions, please contact Marti Evans at the PPA office.

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

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.