APA leading the charge against “medicalizing” DSM-5

By James Bradshaw, Senior Editor

The American Psychiatric Association (APA) plans a third – and final – comment period sometime this spring for voicing concerns about the proposed rewrite of the Diagnostic and Statistical Manual, (DSM), but members of the DSM-5 Task Force need not wait that long to learn how outraged thousands of mental health providers are by many of the proposals.

The revised DSM is scheduled to be published in May 2013, and for most of the more than 10 years the mental health “bible” has been under review by the APA the major complaint was the secrecy surrounding the work.

Then as information started becoming available, especially last year after the task force launched an information website – www.DSM5.org – that outlines many revisions being considered, the furor changed from “why are you hiding what you’re doing” to “why in hell would you do that?”

Divisions of the American Psychological Association (APA) are leading the charge to rein in changes they believe will lower the threshold of mental disorders to the point that sadness at the loss of a loved one could be diagnosed as major depressive disorder and all mental disorders could be viewed as biological phenomena calling for prescribing psychoactive drugs.

A petition was launched in October by Division 32, the Society for Humanistic Psychology, with input and backing from several APA practice divisions as a critical point sometime this spring for voicing concerns about the proposed rewrite of the Diagnostic and Statistical Manual, (DSM), but members of the DSM-5 Task Force need not wait that long to learn how outraged thousands of mental health providers are by many of the proposals.

APAPO budget approval saves small state grants

By James Bradshaw, Senior Editor

Small state psychological associations that rely on grants from the APA Practice Organization (APAPO) to remain afloat received good news to begin the New Year – the grants will remain at 2011 levels despite earlier threats of dire cuts.

In a Dec. 15 email, APA’s 2011 president, Melba J.T. Vasquez, Ph.D., told The National Psychologist that the grant fund, including money for legislative and emergency grants, will be $480,000 for 2012.

“The APAPO Board of Directors met this past weekend and approved the 2012 budget as was recommended by CAPP,” Vasquez wrote. CAPP – the Committee for the Advancement of Practice – is the advisory body that sets policy for APAPO. Vasquez said all states are eligible to apply for the 2012 legislative and emergency grants.

APAPO sparked a near revolt among practice members last spring when it announced that a budget shortfall could require a $100,000 cut in grants that would threaten the very existence of administrative offices of state organizations that have memberships too small to support staff workers without help.

The grants dangled precariously between assurances of continuation and threats of cuts until the December budget approval.

At APA’s August convention, CAPP Chairman Sanford M. Portnoy, Ph.D., told members at a joint caucus of practice divisions that CAPP and the APAPO board were who was chairman of the DSM-IV Task Force and is a professor emeritus of the Department of Psychiatry at the Duke University School of Medicine.

In an interview with Psychiatric Times, an independent publication that like The National Psychologist is not affiliated with or beholden to any professional association, Frances recommended the petition as “an extremely detailed, thoughtful and well written statement that deserves your attention and support.”

Continued on Page 3
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The undeniable social causation of many normal individual variation. … We believe but which do not reflect illnesses so much as responses to their experiences; responses by the continued and continuous medical- and the general public are negatively affect- issued a statement saying in part:

Many complaints voiced earlier last year by professional logic, the APA's position echoes on its petition website.

Opposition to such broadening of mental disorder definitions is not limited to those in the health field. The majority of psychologists and often the entire field of psychology are viewed as liberal, but revelations about the proposed revisions are drawing fire across the political spectrum, including the CATO Institute, a conservative think tank headquartered in Washington, D.C.

The opposition has become international. In December, the British Psychological Society with almost 50,000 members endorsed the petition, joining 36 other mental health organizations, including 14 APA divisions. Groups in Europe, South American and Australia also were organizing signers and one group in Barcelona reported gathering more than 5,000 signatures on its petition website.

VA greatly expanding mental health efforts

The number of psychologists working in the Veterans Administration (VA) has more than doubled in the past six years – up from just over 1,200 in 2005 to more than 2,500 in 2011.

That is just one of many expansions of mental health services for veterans noted in a recent press release from the APA based on an interview with Annette M. Zeiss, Ph.D., chief consultant to the Office of Mental Health Services of the U.S. Department of Veterans Affairs.

Zeiss said the primary change in the VA in the past 25 years is the enormous expansion of mental health services. “VA's full spectrum of health care now integrates mental health at every level of care,” Zeiss told the APA.

She said mental health services are integrated into primary care in PACTs (Patient Aligned Care Teams) as well as in teams that serve homebound veterans with physical or mental illnesses and in long-term care settings.

Each VA facility now offers access to intensive outpatient clinics, such as PTSD specialty teams, and access when needed to secure inpatient treatment for veterans in danger of harming themselves or others due to acute mental illness, Zeiss said.

The VA also works with the justice system, she said, including civilian police training for responding to mentally ill individuals and working with the courts to promote diversion rather than incarceration and with incarcerated veterans to support re-entry into the community.

Including the expanded hiring of psychologists, the VA's mental health staff has grown from about 13,500 in 2005 to more than 21,000 in 2011, Zeiss said.

The full press release is available at http://bit.ly/1W74FK.

Lawsuit created budget problems

Continued from Page 1

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Continued from Page 1

from the threat of being put on the budgetary chopping block.

Vasquez did not elaborate on the “new funding streams” either in her November assurance or the December announcement that the grants would be preserved. When the grants were in jeopardy, supporters suggested APAPO should draw on the deeper pockets of the APA to pay for them, but there were concerns among APA officials that intermingling funds could endanger APA’s tax-exempt status.

The APAPO was organized separately in 2000 to give APAPO broader latitude in lobbying for practicing psychologists. APA has a 501(c)(3) tax status that limits lobbying efforts. APAPO was organized as a 501(c)(6) organization that accepts lesser tax exemption in return for a greater voice in lobbying. That technicality indirectly led to APAPO budget problems due to a pending lawsuit in the U.S. District Court for the District of Columbia.

Most practice members of APA believed such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives.”

Many complain that the proposals so pathologize normal human actions that an unruly child’s temper tantrum could be labeled “disruptive mood dysregulation disorder” or a mother’s attempt to turn a child against the father in a custody dispute could be found to be suffering “parental alienation disorder.”

However exaggerated some of that hyperbole might be, the overriding concern is that too many people will be prescribed unnecessary and potentially harmful medications.

Opposition to such broadening of mental disorder definitions is not limited to those in the health field. The majority of psychologists and often the entire field of psychology are viewed as liberal, but revelations about the proposed revisions are drawing fire across the political spectrum, including the CATO Institute, a conservative think tank headquartered in Washington, D.C.

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Most practice members of APA believed they had to pay the practice assessment and regular APA dues to maintain APA memberships. A heated 2010 listerv discussion revealed that despite the fact that the same officials serve on both organizations’ boards of directors, the two are legally separate and membership in APA cannot be made contingent on paying the APAPO assessment.

On learning that, many members who formerly paid the assessment did not in 2011, reducing APAPO’s annual budget – about $5 million in 2010 – by an estimated 15 percent. Some members also engaged lawyers and filed suit seeking recovery of money paid in past years on grounds that they were deceived into believing the assessments were mandatory.

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School curricula following trends of times

By Richard E. Gill, Assistant Editor

According to three professionals in the field of psychological training, most school curricula are up to date and keeping abreast of modern trends and technological advancements, but one says the demands of the American Psychological Association (APA) are cumbersome and detract from teaching specialized courses.

APA accreditation demands schools do things that are not always seen as necessary, especially when compromises are made so students do not have to pay higher rates, said Lenore Walker, Ed.D., professor of psychology at Nova Southeastern University’s Center for Psychological Studies.

“She said that Nova, as most schools, tries to maintain “a balance between past academics and contemporary psychology, rather than being exposed to a variety of things required by APA accreditation.”

There is so much information in the field that students must know a lot, and it is expanding daily, she offered. She believes schools are keeping up with technological advances.

“We use smart classrooms. Everyone has the ability to get on the Internet as you are teaching. Our library uses streaming videos, meaning they take place at the moment.”

Many schools are not keeping abreast of RxP initiatives, although her school, she said, has been a leader in predoctoral students being trained in RxP. The school also offers a masters in RxP.

“No, I don’t think I agree with (Walker’s ridicule of APA accreditation),” said Leon VandeCreek, Ph.D., ABPP, professor at the School of Professional Psychology’s doctoral program at Wright State University.

“The areas APA requires you to cover are quite broad,” he said, agreeing with Walker. “But there is flexibility in what to cover. We might cover the content of psychology differently than Nova does but you have to cover the basic principles. You can have your own local flavor and your own local style of teaching.”

VandeCreek said he believes that schools are keeping up with the trends of the times. He doesn’t see why they wouldn’t unless faculty is stuffy or unwilling to move forward. Curricula should be up to date and he hopes graduate programs do that.

A little bit of history is a good idea for teaching, he said of schools dipping into past psychology teachings. “Here for example, he said, “every three years we do reviews of courses and fine-tune them and make them substantial to curriculum.”

He said he believes the field is divided on RxP. Most states have not given permission to prescribe so why teach it? Not offering RxP is not a problem of the schools. It’s a legislative problem. However, many schools offer RxP as an elective. “Our school offers a course of pharmacology but does not offer a masters,” VandeCreek said.

His school uses technology but he doesn’t know how much practicing psychologists use it in their practices. Hospitals and the VA are using electronic records and students need to learn to use electronic records rather than pencil and paper, he said.

Does curriculum need to be changed for people going into private practice?

“I worry about the business side of a practice. People entering private practice need to be a small business person along with being the psychologist.” They need to learn to operate an office, know laws, understand workers’ compensation, hiring and billing, just to name a few, he said.

VandeCreek said schools are finding a decline in the number of students who want careers as totally independent practitioners. They want to join groups already established.

“Students are not wanting to be solo practitioners.”

Many schools do not teach the business side of psychology, and the business of psychology offices is changing all the time with new ideas and new criteria.

Stanley Berman, Ph.D., dean of Programs of Advanced Graduate Study, University of Massachusetts School of Professional Psychology, agrees with VandeCreek that most schools are keeping up with technological advancement, legal and ethical issues and financial therapy.

All schools take advantage of technology. Many schools use distance learning along with traditional teaching methods.

As with VandeCreek, Berman does not see much movement in the field of RxP.

“If you have a graduate program focus that is preparing practitioners, you must also have a model that doesn’t chip away at the skills of psychology. What new advanced electives do we need to develop? These are in turn the new critical needs in our nation.”

If changes are to be made what has to be changed or eliminated?

“This is a great dilemma for any director of a Ph.D. or Psy.D. program in clinical psychology. So much of the foundation through the test of times is vital for someone to become confident and grounded, so there is always a dilemma of what you can let go,” Berman said.

He said assessment is a very valuable tool in psychology, but many students are not taking as many electives in this area anymore. They are going in other directions.

To refresh courses, Berman recommended looking and deciding what is the core knowledge that is important for psychologists to have a professional identity. “But how do we make new case examples that reflect contemporary life?”

At his school as well as others, he said, discussions to decide what is good and not good are necessary to build a strong school curriculum. Schools need room to renovate and innovate.

Schools fail on the business end of psychology, said Berman. No courses outside of electives are available to learn the business of psychology. He believes schools are slowly beginning to teach this, and he feels they should cover it now.

To address the critical needs of veterans, Berman said his school has a course that trains a veteran to treat a veteran. This is an example, Berman explained, where curriculum is changing with the political demands of the times and needs.

“With traumatic brain injury, PTSD and the disruption to families of these vets, we believe there is a great need to train people beyond what the VA system does to work with veterans and their families.”

Another example of looking beyond, his school has electives in refugee mental health. Students can then offer help to people coming to this country.

The three experts are of one mind in believing that school curriculum is current and that schools are keeping up with trends in psychological advancement. They also agree that schools are failing in other areas, such as practical business training.
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Psychologists in West Virginia – the only state in the nation to continue unrestricted licensing of masters-level providers with the title of psychologist – are embroiled in battle in the state legislature over updating the 35-year-old licensure law. Four previous attempts to modify it meaningfully to conform to national standards have failed due to opposition by the masters community.

Failures principally arose from legislators being swayed by arguments that skies would fall, concerns from state agencies that salary rates would have to be increased, fears from already-licensed masters providers that their reimbursement rates would be cut and lack of consensus among psychologists themselves, primarily the masters licensees.

The last attempt at licensure law revision was in 2005 when conflict existed among members of West Virginia Board of Psychologists Examiners (BOE) with doctoral members being in favor of updating the law and masters members being against, the West Virginia Psychological Association (WVPA) taking no stand and the graduate training programs in the state also lacking a consistent voice on the issue.

The current attempt at licensure law revision is different. For the first time in the history of the state association, WVPA’s elected board of directors is speaking up, and their actions are now reflective of the association’s national affiliate, the American Psychological Association (APA). All of the graduate training programs in the state, from graduate school to internships to post-doctoral fellowships, have publicly voiced their support of the current licensure law revision proposal.

A major stumbling block is the current constellation of the BOE. The current BOE was appointed without vetting from the state psychological association and the majority of the voting members are masters level providers who have publicly expressed opposition to doctoral training requirement for licensure. None of the BOE members work in academic settings and they do not appear to recognize current standards and diverse settings of training.

Indeed, WVPA has received complaints from doctoral-level licensure applicants who describe “hostile” oral exams reflecting lack of BOE understanding of subspecialty area training and a lawsuit was threatened against the BOE for refusing to grant licensure reciprocity for a candidate already licensed in two states and with appropriate post-doctoral training. Another lawsuit was filed against the BOE after they filed an unprecedented “emergency ruling” to block certified behavior analysts from providing services to autistic persons when such services became eligible for insurance reimbursement.

The simmering issue came to a boil in June when the BOE submitted a proposed bill seeking to permanently codify masters training as sufficient for the title, describing it as an attempt to be congruent with Association of State and Provincial Psychology Board (ASPPB) standards. The state association responded with a bill modeled after the actual APA and ASPPB language, specifying doctoral training as necessary for title as well as eligibility for licensure upon completion of doctoral training if two years of supervised pre-doctoral clinical training was documented, plus easier reciprocity provisions for doctoral licensees from other states.

Additionally, the bill included liberal grandfathering of clinicians licensed by 2015 with protected title and reimbursement, two tiers of licensure for masters-level providers with alternative titles, supervision requirements reduced from five years to three years for providers for independent practice and lower EPPP (Examination for Professional Practice of Psychology) pass scores required for supervised providers who would have a more limited scope of practice and would primarily work in state agencies exempt from licensure status.

Benefits of the proposed bill were viewed as protecting patients from being misled by the title of psychologist not currently reflecting the same level of training as in other states, improved access to quality care for West Virginia citizens as national standards of training were phased in for future psychologists, better ability to retain and attract doctorally trained psychologists to a state that was no longer the outlier in licensure law and lower costs to agencies as years of required supervision were decreased.

Further, implementation of health care reform has increased the feasibility of attracting more doctoral psychologists to rural health care clinics, given federal loan repayment in underserved areas and enhanced reimbursements for clinics demonstrating comprehensive (including behavioral) patient care.

Nonetheless, the proposed bill faces stiff opposition. BOE supporters continue to provide misinformation about national standards in public arenas, including stating that APA “regrets” its doctoral model licensing act and asserting that ASPPB is “promoting” West Virginia as innovative in allowing masters level independent practice and its current law. And despite exemption from licensure law that would finally establish all 50 states as requiring doctoral training for the title of Licensed Psychologist. National psychologists with battle strategy to share or who desire to assist with letters of support to legislators, etc. are asked to contact the WVPA via info@wvpsychology.org.

This article was prepared by the West Virginia Psychological Association Board of Directors and other concerned psychologists. Comments may be addressed to C. David Blair, Ph.D., president of the West Virginia Psychological Association. He may be reached at dblair@drdavidblair.com.

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Ethics for psychologists

Running the gauntlet: The treating psychologist in court

By Linda Campbell, Ph.D.

Psychologists who do not identify as forensic psychologists know that they need to be prepared for those occasions when they may find themselves transported to that venue by no choice of their own. Our APA Ethics Code gives us direction on this point in stating, “When assuming forensic roles, psychologists are to become reasonably familiar with the judicial or administrative rules governing their roles.” Let’s take a look at Dr. John Q. Public’s foray into a court appearance and see how he fares.

Dr. Public is a licensed psychologist who primarily does psychotherapy with adults and children and some assessment with children. Dr. Public has been seeing a child for several months for his difficulties in school both in academics and behavior.

The child’s parents divorced several years ago and the boy does see his father occasionally, but the focus in therapy has been on the boy’s life at school and home. Out of the blue, Dr. Public received a notice to appear in court for a proceeding brought by the father to reconsider custody. Dr. Public was well aware that he was a treating psychologist and thought he would be able to enact his role competently in court. The mother was informed of the court notice and agreed to his testimony as the treating psychologist.

When Dr. Public took the stand, he made observations about the boy’s progress as well as difficulties in school. Dr. Public soon found himself thrown rapid fire questions by the opposing counsel about the mother’s fitness for custody and being given challenges to produce reasons the father should not have custody. Dr. Public steadied himself and responded that as the treating psychologist, he could not make custody judgments because he had not done a custody evaluation.

Then, just as he was feeling confident about his answer, the judge asked, “Dr. Public, now surely after seeing this boy for these months, you have some opinion about the parents. You’re not being asked to make a custody evaluation, and I would really value your general opinion here. Think of yourself as just a member of the public, not a psychologist, and tell me your overall viewpoint.”

The rephrasing of the question and the fact that the judge was pressuring him, threw Dr. Public out of the decision tree he had carefully prepared for his response. He thought, in the intensity of the moment, that he not only could but should answer. The judge was sounding as if Dr. Public wasn’t competent if he couldn’t answer these questions. Dr. Public responded that “if he were giving an opinion and not an evaluation and if his comments were to be regarded strictly as a member of the public” that he could give his thoughts about both parents given what the boy had told him.

How did Dr. Public do? We might want to give him an “A” for effort but his report card performance then begins to slip:

* Informed Consent: When Dr. Public began seeing the boy for treatment, he had no idea that custody or any court engagement would be in the picture. He had informed the boy at the outset of therapy that he might have to disclose material to his mother and gave the risk conditions under which he would do so but he did not include this circumstance. He now has to deal with the great potential of a rupture in his relationship with the boy, having revealed what the boy thought was confidential.
* Opinion versus Evaluation: Perhaps in his interest to cooperate, Dr. Public accepted the judge’s distinction between opinion and evaluation. The APA Child Custody Guidelines and the APA Ethics Code treat the terms opinion and evaluation equivalently in that an opinion is an evaluative statement. Further, even though Dr. Public had firsthand knowledge of the mother’s parenting style, insomuch as Dr. Public did consult with and include the mother in quite a few sessions, he had not conducted interviews, administered instruments or sought other critical data that would be necessary to render an opinion on custody.
* Private or Public Conduct versus Professional Conduct: A litmus test that can assist psychologists in making the public versus professional distinction is this. Is it really likely that the judge would ask the bailiff to go outside the courthouse and select the fifth person to walk by, bring that person into court, and ask an opinion that would be utilized in the court’s decision? If the answer is “no” then the psychologist is not acting as a member of the public. As unlikely as this scenario may sound to the reader, there are many cases in which this very trick has been played on psychologists in several venues.

Dr. John Q. Public has had his turn in the proverbial washing machine wringer. On the bright side, the case of a well-meaning psychologist getting caught in the wringer can be educational and corrective more readily than those few cases of intentional unethical conduct of which we hear more often.

Linda Campbell, Ph.D., is a professor at the University of Georgia and director of the Doctoral Training Clinic that serves northeast Georgia. She is past chair of the ethics committees of both the APA and the Georgia Psychological Association. She is an APA Council Representative for Division 29 and vice president of the Georgia Board of Examiners of Psychologists. She may be reached by email at: lcampbel@uga.edu.

Bersoff is 2013 APA president

Donald N. Bersoff, Ph.D., J.D., who is a Drexel University professor and national expert on legal and ethical issues in mental health, has been elected 2013 president of the APA.

Bersoff serves on the faculties of Drexel’s psychology department and Earle Mack School of Law, where he directs the JD/Ph.D. program in law and psychology. He edited Ethical Conflicts in Psychology and has written more than 100 publications and papers on the interaction of law, psychology and public policy.

Bersoff was APA’s first general counsel, from 1979 to 1989, during which he authored 50 briefs filed in the U.S. Supreme Court and lower federal and state courts. His work provided social science evidence relevant to issues such as sex stereotyping, women’s and adolescents’ reproductive rights, hospital privileges for psychologists, admissibility of psychological expertise, jury decision making, privacy rights of the LGBT community, children’s testimony and rights of the severely mentally disabled.

A native of New York, Bersoff received his Ph.D. in 1965 from New York University and his J.D. in 1976 from Yale Law School. He was an Air Force clinical psychologist from 1965 to 1968.

Bersoff will serve as president-elect under the 2012 president, Suzanne Bennett Johnson, Ph.D., ABPP. Johnson is a research professor at Florida State University College of Medicine.
Risk Management

But the Judge ordered me to do it

By Jeffrey N. Younggren, Ph.D. and Elizabeth Ann Younggren, J.D.

During a recent risk management consultation a psychologist reported how a judge had ordered him to render a forensic recommendation regarding a family that he had been treating. This psychologist had been treating the family in question for more than a year, but eventually the parents decided to divorce. As a consequence of the decision to divorce, they began to battle over which parent should have what amount of time with their respective children.

The psychologist found himself in the middle of their legal dispute and, without input from the psychologist, the judge ordered him to provide a custody recommendation to the court. It was the judge’s opinion that the psychologist in question was most qualified because he had been treating the family for more than a year and, to quote the judge, “He knew the family the best.”

While fully aware of the role conflicts that exist between providing therapy to clients and concurrently providing forensic opinions in a legal matter, the psychologist thought that since the judge had ordered it, he had no choice but to comply. So, he went ahead and rendered a custody recommendation to the court, an act that resulted in a complaint being filed about his conduct with the state licensing board.

In another consult, a judge ordered a psychologist to turn all the psychotherapy records of a client over to the attorneys involved in a legal matter. The psychologist was very concerned that the information contained in the records was private and violated the confidentiality rights of his client. Consequently, she simply refused to comply with the court order. Because of this refusal, the judge sanctioned her and ordered her to pay a significant fine along with the costs incurred by the attorneys in trying to obtain these materials.

The words “court ordered” can be quite daunting and confusing to practicing psychologists, most of whom are unfamiliar with the power and respective authority of those who are involved in the legal system. In addition, most psychologists do not understand what their rights are when they find themselves working in the forensic arena in one fashion or another.

The courtroom is a confusing arena of decision-making to be sure, but the seriousness of this level of confusion is only enhanced by the reality that it is also “foreign turf” to most practicing clinicians. This confusion frequently involves a misunderstanding of the concept of judicial authority within the legal system.

When something is “court ordered” the order generally establishes the courts authority over the matter at hand. While in some circumstances it will require compliance, in others it does not. For example, should a psychologist be ordered to provide a professional service under the auspices of the court, it does not necessarily mean that the psychologist must provide those services.

What it does mean is that the judge has given the request the judicial stamp of approval, if you will. What it does not mean is that psychologists who are so ordered by the court are required to comply with the order even if the request violates the standards of professional practice. Simply put a court cannot order a psychologist to violate professional standards.

While psychologists who have been ordered to do something for the court must take some type of action when so ordered, they do not necessarily have to provide the service identified in the order. What they should do is notify the court of why the order cannot be complied with and the ethical and professional standards foundation for this.

What is important to remember is that while psychologists can educate the court on professional matters, such as what service a psychologist can or cannot provide, they cannot educate the court on legal matters. That is simply out of their area of expertise. The two examples that appear at the outset of this article are great examples of these types of differences.

While in the first example, the psychologist had a professional responsibility and duty to educate the court on how the order violated the standard of care and of ethical practice, the second dealt with a legal determination made by the court. While a psychologist surely should feel free to contact the court regarding these issues, a lack of compliance with a legal determination, is truly risky.

To make matters more serious, an inability to understand the differences between these two issues could expose treating psychologists to potential civil lawsuits and licensing board complaints. For example, if a treating psychologist is ordered to render an opinion as to the best suited parent to have custody of a child, the disgruntled parent could argue that such a decision constituted malpractice because the psychologist had a conflict of interest in the matter. The argument for the psychologist would be that such a recommendation was court ordered. While this would likely constitute a successful defense, the psychologist would still be faced with potential hefty legal costs and time spent defending against the allegations.

So, what is the psychologist supposed to do when these types of things occur?

First, if you do not know what to do, do not do anything until you get guidance. This is very important. Most psychologists are not lawyers and until you are able to get legal advice, decisions about what to do in legal matters can be quite dangerous. So, seeking out answers from an attorney, an ethics committee or another type of legal resource is in order.

Second, psychologists should not be afraid to communicate with the court regarding questions and concerns they have about court orders. If a professional believes an order is a violation of the standards of professional practice, this should be expressed in correspondence to the court and/or to the attorneys involved in the matter. Remember, judges and lawyers are usually not psychologists and may be unfamiliar with the significant role conflicts that exist when a treating psychotherapist is required to render a forensic opinion to the court.

If neither of these provides a solution to the dilemma at hand, then it is in the best interests of the psychologist dealing with this dilemma to retain legal representation in the matter. When this is necessary, contacting your malpractice carrier is in order since such representation might be covered by your professional liability policy.

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Arnold Dahlke, Ph.D., has been appointed program director and professor for Touro University Worldwide’s online program in organizational and leadership psychology that will soon launch an Ed.D. program.

Dahlke is a former consulting psychologist with several Fortune 500 companies. Touro is headquartered in Westlake Village, Calif.

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By James Bradshaw, Senior Editor

The National Psychologist was born 20 years ago after a six-month gestation period that allowed the infant newspaper to test the waters before diving headlong into the journalistic fray as the nation’s first – and to date only – independent chronicle for psychology.

The paper was founded by Henry Saeman, who was born in Regensburg, Germany, and migrated to the United States alone to escape the Nazi regime in 1941 at age 14 with only $3.90 in his pocket. Henry’s father had died years earlier and his mother, who was unable to gain a visa, later died in a concentration camp during the Holocaust.

In the following years, the orphan adolescent worked at various jobs, attended night school courses and, when old enough, enlisted in the U.S. Army, which later allowed him to go to college under the G.I. Bill.

Henry studied printing and journalism and in time became an Ohio Statehouse correspondent and editor for newspapers in Springfield and Dayton. He gained his knowledge of psychology on the job after joining the staff of the Ohio Psychological Association (OPA) as a part-time lobbyist in 1973. Henry soon became OPA’s full-time executive director – the first-ever executive director of a state psychological association.

He stayed with the OPA until 1991, helping it become one of the premier state associations, and he was recognized with several “firsts” – the first non-psychologist to receive OPA’s Distinguished Service Award, the first state association administrator to receive the Outstanding Executive Director Award from APA Division 31 and the first non-psychologist to be inducted into the Psychology Academy of the National Academies of Practice.

The heart of a newspaper man still beat within his breast and after leaving OPA in 1991 at the age of 63, Henry set about filling a void he saw in the field of psychology: There was no independent, unaffiliated voice to sort facts and news from image-conscious articles in the house organs of the APA or the state psychological associations.

The National Psychologist debuted with a July/August 1991 demo edition to test the market and, on proving its viability, began full publication of six issues a year with the January/February 1992 edition.

Saeman stated the newspaper’s credo clearly in the inaugural edition:

“The National Psychologist will grant the opportunity for conflicting views and will avoid serving as a mouthpiece for any individual or cause, realizing there are two or more sides to most stories, relying on experience and good sense to decide what constitutes news and information. We will seek to flush out important issues affecting practitioners and, if articles contradict their convictions, readers will find a publication which is receptive, subject to space limitations, to present opposing, legitimate viewpoints with civility.”

At first the newspaper was very much a family operation. Henry was publisher and managing editor; his wife, Mitzi, was the office manager and his son, Marty, was advertising director. The staff soon expanded to include John Thomas, a former newspaperman and public relations officer for the Ohio AFL-CIO.

Henry died at age 76 on May 13, 2003 of complications from a rare blood disorder that afflicted him for about six years. Marty and his mother took over the newspaper’s operation and Thomas stayed on as associate editor. In time, Mitzi retired to become a snowbird enjoying winters in Florida while maintaining her home in Ohio and Thomas also reduced his schedule, becoming an editor emeritus to assist in proofreading and offer an occasional story for the paper.

On the current staff, Marty is managing editor and marketing director, his stepdaughter, Renee Reisinger, is office assistant, helped by his wife, Barbara. Mark Flewellen is the computer consultant.

Reporting is handled by James Bradshaw, senior editor, and Richard E. Gill, assistant editor. Like Henry, Bradshaw is a former member of the Ohio Legislative Correspondents Association, having covered the Ohio Statehouse for The Columbus Dispatch. Gill also learned the newspaper business as a reporter with The Dispatch, covering several beats including many years as a police reporter.

Many psychologists are also regular contributors on topics such as ethics, technology and risk management, but the longest relationship has been with Paula Hartman-Stein, Ph.D., who writes regular updates on Medicare reimbursements and often acts as a correspondent at various conferences and conventions.
Facts are facts; like it or not

By James Bradshaw, Senior Editor

The National Psychologist’s mission is to assure practitioners that they can get all the news, including information officialdom may find embarrassing or inconvenient.

In an interview on his retirement as chief of staff for U.S. Sen. Daniel K. Inouye, D-Hawaii, Patrick H. DeLeon, Ph.D., J.D., a past president of the APA and “father of the RxP movement,” said the newspaper fulfills that role admirably.

In a comment carried in the September/October edition, DeLeon said, “It’s an outside voice that has to be heard.” Not included was an expansion he added. DeLeon noted that because the newspaper acts as a watchdog, APA publications are forced to acknowledge developments adverse to the organization’s image or desires.

“You keep them honest,” DeLeon said.

For a more complete wrap-up of the 20-year history of The National Psychologist, see The First Decade and The Second Decade on our website at: www.nationalpsychologist.com

Honest reporting is always the goal, even in covering DeLeon’s pet cause, RxP. The newspaper has reported many achievements of the movement, such as gaining prescription authority in New Mexico and Louisiana, but also has reported many failures as other state legislatures or governors rejected RxP.

A pending lawsuit is another area where the independent voice of The National Psychologist kept psychologists abreast of the full story. In 2010, a controversy developed over assessments charged APA’s practicing members to support advocacy by the APA Practice Organization (APAPO).

Many practitioners believed paying the assessment was mandatory to retain APA membership. After some double-speak, APA officials conceded that the two organizations are legally separate and APA membership could not be contingent on whether a member supports the APAPO.

The National Psychologist gave front page coverage to the dispute, and many practitioners quit paying the assessments and some filed suit last year seeking repayment of assessments paid since the APAPO was created in 2000, saying they were deceived into thinking the assessments were mandatory. The suit is pending in the U.S. District Court for the District of Columbia.

Such instances should not, however, be construed as meaning The National Psychologist is an adversary of the APA. Balanced coverage is just that: reporting the good and the bad.

The newspaper has carried many stories on APA’s good works, most recently in a front page article in the November/December edition on 20 years of service by the Disaster Response Network that focused particularly on help psychologist volunteers provided following last year’s devastating tornado that struck Joplin, Mo.

As stated in the founding credo for the newspaper, its job is to give fair and balanced news and not become the mouthpiece for any organization or individual. Carrying out that mission was evident in another recent news article.

In 2006, a group of practicing psychologists including many APA past presidents and other distinguished psychologists organized the National Alliance of Professional Psychology Providers (NAPPP), which they felt was needed because APA’s advocacy for practitioners was insufficient.

The relationship between APA and NAPPP has been largely acrimonious, causing some APA officials to complain that The National Psychologist’s reports on NAPPP have been unduly promotional.

Last August, Nicholas Cummings, Ph.D., Sc.D., a long-time friend of the newspaper and an organizing member of NAPPP, suggested the paper should give more publicity to the “Truth in Drugs” campaign NAPPP has launched.

The September/October edition carried a front page story noting that many psychologists viewed the tone of the campaign as so demeaning to general practitioners that RxP psychologists in Louisiana resigned “en masse” from the Academy of Medical Psychologists because of its endorsement of the campaign—probably not the kind of publicity Cummings wanted.

But, fairness demands factual rather than friendly reporting.
What is the power of group psychotherapy?

Robert H. Klein, Ph.D.

To treat individuals not groups who are seeking help, some group leaders, especially those who are psychodynamically oriented, pay careful attention to the process of the group, while others make only limited use of group process and dynamics.

Among those who advocate for the importance of examining the group process, some emphasize an examination of the intrapsychic level of the group process, that is, individual members’ internal lives, their character formations, typical defenses, internal objects, etc. Others prefer to focus more on the interpersonal level of the process, exploring relational styles of members and how their internalized conflicts are reenacted in the interpersonal field of the group. Still others systematically examine the group-as-a-whole level of the process, attempting to highlight developmentally early relationships of members with persons in positions of authority.

Since no single form of group psychotherapy has been proven to be more effective than any other, what common ingredients might underscore the efficacy of all these different group approaches? This question has led to a body of research that has attempted to identify the “therapeutic factors” in group therapy. Among those identified have been: the instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors (Yalom and Leszcz, 2008). Of these, high levels of cohesiveness and interpersonal learning have been consistently linked with successful outcome (Burlingame and Fuhriman, 2003).

One recent application of group psychotherapy has involved the use of group interventions in the treatment of trauma. A growing body of empirical data supports their effectiveness (Schein, 2006). Several aspects of groups appear to make them particularly well suited to working with trauma and disaster victims.

To begin with, groups can provide a safe, nurturing, non-judgmental environment where participants can feel accepted and emotionally supported. Relief from the aloneness, isolation and disconnectedness that trauma survivors frequently feel can be especially valuable. Meeting together with others who have endured similar frightening, overwhelming and deeply disturbing experiences provides an opportunity for group members to put into words those very experiences that have been so difficult to talk about with others.

Establishing a holding container enables group members to find their voices, share their experiences, disclose painful feelings and begin to speak the unspeakable. The dreadful nature of such experiences, along with the accompanying feelings of shame, loss, rage and anguish, often are kept secret. Frequently, these reactions interfere with and sometimes preclude survivors from broaching their concerns with others. Participating in a group with other survivors rather than seeking individual attention can relieve the social stigma and cultural barriers that often impede help-seeking and enable emotionally isolated survivors to recognize that they are not alone.

Furthermore, the presence of other people in the group generates opportunities to reveal, validate and to bear witness to what has happened. In the process of so doing, members begin to restore their disrupted external connections with others as well as begin to repair the often profound rifts in their internal assumptive worlds about themselves, relationships, life and the way the world usually works.

The very act of sharing information about what happened can quell misinformation and upsetting rumors. The group can provide a context for education and the proper dispersal of information, especially with regard to needed available resources and how to secure them. The courage, strength, compassion and resilience displayed by group members often serve to inspire participants and to stimulate a renewed sense of hope about the future. By helping other group members, individual participants can both augment their own damaged sense of self-esteem and relieve the collective sense of helplessness survivors experience.

In addition, groups enable members to share and learn new ways of self-care and new strategies for coping. The acquisition of such tools can promote healing and restore more effective levels of functioning.

Finally, by providing opportunities for sharing, emotional support and new learning in a safe environment, groups can help disaster survivors to begin to repair their disrupted sense of trust in their leaders, the world around them and other people (Klein and Schermer, 2000; Klein and Phillips, 2008; Buchele & Spitz, 2005).

References available from author

By Robert H. Klein, Ph.D., ABPP

Man is a social animal who remains group-oriented to ensure survival, connection and belonging. Our lives begin in family groups and we function thereafter as members of groups at school, work and in communities. The origin of the power of the group as an agent of change to promote healing lies buried in antiquity. But, as noted by Rutan and Alonso (1979), group psychotherapy, where one’s family and community are represented in the room, provides unique opportunities to work on issues of intimacy and individuation.

The first modern systematic use of groups to promote healing is generally credited to Joseph Pratt who, at the turn of the 20th Century, incorporated groups into his efforts to treat patients with tuberculosis. Evidence of the effectiveness and efficacy of group psychotherapy has continued to accumulate since then and is well documented.

A summary of the relevant literature can be found in the brochure published by the American Group Psychotherapy Association aptly entitled, “Group Works!” Group psychotherapy with adults, adolescents and children when used alone or in combination with other treatment interventions (e.g., psychotropic medications) has been found to be useful in treating a broad variety of problems, including depression, anxiety, serious medical illness, loss and addictive disorders (AGPA, 2003).

Just as there is no single form of individual psychotherapy, there is no single form of group psychotherapy. Groups come in different sizes and shapes. Different purposes and goals lead to the articulation of different group contracts.

Thus, the size of the group may vary, as well as the length of time and number of sessions, whether the group membership is open or closed, its composition, the format that is followed, the ground rules that are adopted and how leader and member roles and responsibilities are defined and developed. Similarly, different theoretical orientations guide the group psychotherapy that is practiced, including psychodynamic, general systems, interpersonal and cognitive/behavioral approaches.

Since it is the job of the psychotherapist to treat individuals not groups who are seeking help, some group leaders, especially those who are psychodynamically oriented, pay careful attention to the process of the group, while others make only limited use of group process and dynamics.

Among those who advocate for the importance of examining the group process, some emphasize an examination of the intrapsychic level of the group process, that is, individual members’ internal lives, their character formations, typical defenses, internal objects, etc. Others prefer to focus more on the interpersonal level of the process, exploring relational styles of members and how their internalized conflicts are reenacted in the interpersonal field of the group. Still others systematically examine the group-as-a-whole level of the process, attempting to highlight developmentally early relationships of members with persons in positions of authority.

Since no single form of group psychotherapy has been proven to be more effective than any other, what common ingredients might underscore the efficacy of all these different group approaches? This question has led to a body of research that has attempted to identify the “therapeutic factors” in group therapy. Among those identified have been: the instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors (Yalom and Leszcz, 2008). Of these, high levels of cohesiveness and interpersonal learning have been consistently linked with successful outcome (Burlingame and Fuhriman, 2003).

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References available from author

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ADHD coaching: An important tool for therapists

By Ari Tuckman, Psy.D., MBA

One study found that 10 percent to 20 percent of adults seen in outpatient mental health settings have ADHD. Too often, they are being treated for comorbid anxiety, depression, addictions, etc. while the ADHD goes undiagnosed and untreated.

When it is treated, it is usually with traditional therapy models that don’t address practical matters where adults with ADHD need help the most. Therapists have not sufficiently addressed these needs and the field of ADHD coaching was born and people without clinical training are providing these services. Some therapists have responded by adding coaching to their repertoire.

I have written extensively about a four-part treatment model for adults with ADHD that includes education, medication, coaching and therapy (Integrative Treatment for Adult ADHD: A Practical, Easy-to-Use Guide for Clinicians, 2007).

Because ADHD is fundamentally a disorder of information-processing and self-regulation, these clients need practical strategies to help them manage responsibilities and therapy to address the fallout from a lifetime of struggle and setbacks. Therapy alone will not suffice if clients continue to have the same struggles that drive their low self-esteem, anxiety, depression, maladaptive coping mechanisms, etc. I liken it to trying to fill a bucket with a hole in the bottom.

Therapy vs. coaching

Coaching, like therapy, has no single definition of what it entails or how it differs from therapy. One distinction often made is that coaching addresses the present and future whereas therapy focuses on the past, but this mostly seems to apply to psychoanalytic therapy. Others say coaching focuses on strengths whereas therapy focuses on diagnosable pathologies, but positive psychology would disagree.

“There is a great deal of overlap between coaching and some types of therapy,” says Michelle Novotni, Ph.D., of Wayne, Pa. “Cognitive behavioral therapy and behavioral therapy are most closely aligned with coaching. There are elements of a number of other counseling theories.” When asked about the differences, Alan Graham, Ph.D., of Park Ridge, Ill., said, “This may be heretical to say but the answer is, not much.”

I make a rather over-simplified distinction that coaching involves helping clients more effectively manage practical matters that adults with ADHD invariably struggle with, such as time management, organization, priorities, etc. Therapy helps with the commonly comorbid anxiety and depression, etc.

Coaching and therapy can achieve similar goals from opposite directions, as Deborah Rowley, MSW, of Madison, Wisc., knows. “Therapy involves working on the ‘stuff’ on the inside to gain strength, insight and awareness in preparation for participating more fully and effectively when interacting with the outside environment. And at the same time, effective coaching efforts usually result in desired and improved internal experiences (relief, pride, etc.).”

David Giwerc, MCC, has trained more ADHD coaches than anyone else through his ADD Coach Academy. He says coaches “empower adults with ADHD to look at their strengths and successes first and then notice what is getting in the way of their ability to create consistent progress in their lives.”

Some logistics may be different. “Therapy is almost always done face to face,” says Marjorie Johnson, LCSW, of West Chester, Pa. “Coaching can be done either face to face or virtually on the phone or through Skype. The fees are different, the frequency of sessions may be different.”

Coaches will also often have more contact with clients between sessions. For example, Novotni recently had a client call her every morning for a week to ensure the client got out of bed on time – a common problem for adults with ADHD and one that almost cost this client her job. Few therapists would make such an arrangement and many might interpret it as dependent.

Explaining her rationale, Rowley says, “The foundational component in coaching is accountability. Traditional therapy does not go outside the treatment hour unless there is an emergency, so any accountability strategy utilized between sessions wouldn’t be used. With a pure therapy client, there might be homework to report something back during the next session. With coaching, the same client might email me a few sentences about her experience between sessions.”

Integrating coaching into therapy

About half of those interviewed said they don’t mix therapy and coaching with the same client – it’s one or the other. The other half feel comfortable doing a combination. Johnson keeps them separate based on the client. “In general, if a client is new to ADHD (recently diagnosed) or under the age of 16 or so I will use a counseling model to help them understand and cope with their diagnosis and learn how it affects their whole functioning. Once the client has been diagnosed for a while and is older they often have specific goals they want to pursue (e.g., college or a job advancement or career change.) Then, coaching is the model I use.”

In my integrative model, I go both ways. I have therapy clients who also see an ADHD coach. But I also tend to mix in some coaching with my therapy clients, especially those with ADHD. Any therapy model that can tolerate an active and sometimes directive therapist can be adapted to more fully meet the unique needs of ADHD clients.

One reason I like to blend the two is that coaching often reveals important matters for therapy when coaching strategies that “should” work, don’t. When working with a client on getting to work on time, you may discover that the problem involves practical matters like getting to bed too late and getting distracted by having the TV on when getting ready. You may find that the client feels trapped in a hopeless job and avoids the pain temporarily by showing up late, even though it contributes to job problems.

Coach training

Because coaches are not licensed by the states – yet, there are no formal training requirements. If you want to get into coaching, Alan Graham recommends, “Complete coach training. There is a different mindset that a coach uses.” However, there is a lot of variability in the quality and intensity of the programs. The International Coach Federation (ICF) accredits coaching programs of all sorts, whereas the Institute for the Advancement of ADHD Coaching (IAAC) and the Professional Association of ADHD Coaches (PAAC) focus on ADHD coaching. These accreditations aren’t required, but they are preferred.

You can include elements of coaching in your practice without making it official. Some clients may not need this, but clients with ADHD most likely will – and they will likely terminate prematurely if you don’t provide it.

Final thoughts

It’s worth noting that although you may distinguish between coaching and therapy, if you are a licensed mental health practitioner, your licensing board probably won’t – coaching services will likely be seen as falling within the purview of your license. For example, coaching is often done by phone, making it easy to work with clients who live out of state. This puts licensed clinicians at risk if the licensing board from a client’s state believes they are practicing in that state without a license. This is a relatively small risk, but some caution is warranted.

That said, coaching can be a helpful addition to your practice.

References available from the author

Ari Tuckman, Psy.D., MBA, is the author of three books: Integrative Treatment for Adult ADHD; More Attention, Less Deficit; and Understand Your Brain, Get More Done. Information about his books and podcast can be found at adultADHDbook.com. His email address is: Ari@TuckmanPsych.com
Peace of mind:

Keeping medical records safe

By Kim Holmes and Barry Fonarow

How secure are your patients’ data? Storing patient health records electronically may be an efficient solution to the antiquated paper filing system of the past, but despite the many upside perks (including financial incentives from the government to adopt electronic health records), a failure in your system that results in breached data may come at a hefty price.

As a psychologist, you understand that maintaining confidentiality between patient and therapist is core to your ability to practice. Suffering a data breach could not only cost you time and resources but could cost your professional reputation.

While federal and state laws vary, generally a data breach can occur when sensitive protected health information (PHI), including mental health records and personally identifiable information (PII), is accessed without authorization, which can occur through intentional or unintentional means. According to a recent U.S. Department of Health and Human Services report, roughly 7.9 million people’s medical records have been exposed in 30,750 cases of health care-related data breaches since 2009 – a trend that is expected to continue.

The U.S. Congress first addressed individual privacy infringements in 1996 when they enacted the Health Insurance Portability and Accountability Act’s (HIPAA) Privacy and Security Rules, which sought to set a national legislative standard for protecting electronic individual health information. The issue was revisited in 2009 with the signing into law of the Health Information Technology for Economic and Clinical Health Act (HITECH) – a piece of legislation that was introduced as part of the Patient Protection and Affordable Care Act (the “health reform” law) that amended HIPAA – giving it “teeth” for the first time in the form of potential civil monetary fines and penalties.

While HIPAA/HITECH now provides that fines and penalties may be incurred by a health care organization in the event of a breach (on a sliding scale ranging from $50,000 up to $1.5 million per violation for the most egregious breaches), whether and to what extent these fines and penalties may be levied is always a subjective assessment by the government. An organization’s preparedness to prevent a data breach and its timely and appropriate response to a breach are factors taken into account by the federal government in determining whether and to what extent fines and penalties will be assessed under HITECH.

In addition to lost and/or stolen laptops and other portable electronic devices, one of the largest causes of health care-related data breaches is employee negligence. For instance, in 2010 NewYork-Presbyterian Hospital at Columbia University Medical Center reported a data breach which resulted in 6,800 patients’ PHI, including 10 social security numbers, being accidentally posted on the internet by an employee.

Additionally, allowing access to information by third party vendors and service providers may add another layer of vulnerability that is often overlooked when identifying cyber security weak spots. From 2010 to 2011, the personal PHI pertaining to 20,000 patients who visited the emergency room at Stanford Hospital in Palo Alto, Calif., remained publicly accessible on an online homework help site following an incident with the hospital’s third party billing contractor.

In the event that a cyber-related data breach occurs, there are often far-reaching repercussions including reputational harm and financial burdens due to potential fines and penalties and civil and class action lawsuits. There may also be expenses related to privacy notification, credit monitoring, health records resolution services, crisis management and forensic investigation.

The first step to protecting against a cyber-related data breach is through education. Learn about the federal and state laws that could apply to your organization and understand the reporting and notification requirements that may apply in the event of a data breach. Utilizing best practices both in advance of and at the point of discovering a data breach may also position your organization to be viewed more favorably by a federal or state reviewing authority post breach.

With most health care organizations only allocating 2 percent to 3 percent of their IT budgets to cyber security, an all-inclusive plan will probably be a distant reality at first for most practices. However, being caught unaware and unprepared when a breach occurs could have catastrophic consequences that an organization may not be able to weather. Therefore, in addition to consulting with a trusted advisor such as a specialized privacy/data breach attorney or risk management consultant, following these few simple guidelines may help reduce the impact of a cyber-related data breach:

* All portable/mobile electronic devices should be encrypted with data encryption software.

* When outsourcing work, do your due diligence by researching the third party vendor or service provider’s data breach policies, whether and to what extent they have errors and omissions liability and/or cyber liability insurance in place, and seek to put in place a written indemnification agreement with all vendors and service providers.

* Draft an internal incident response plan for data breaches and make it part of your organization’s culture. A clear plan outlining how to respond to a data breach within your internal organizational structure should help reduce the time between when a breach occurs and when it is appropriately responded to – all of which may place your organization in a more favorable light with an after-the-fact government audit or review of the data breach.

* Consider the purchase of a cyber liability insurance policy to help weather the financial burden of the “when” not “if” of a data breach occurring.

Complete peace of mind concerning the subject of data breaches and cyber security is not something most organizations can enjoy these days. But, you may be more confident regarding the safeguarding of your patients’ protected health information against a data breach if you have put an appropriate response plan in place to help mitigate the potentially devastating financial and reputational impact a data breach can bring upon your organization.

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Barry Fonarow, a senior vice president for the insurance agency of Haughn and Associates Inc. He may be reached at bfonarow@haughn.com.
Enhancing therapy with ‘Energy Psychology’

By Robert Schwartz, Psy.D.

In my 27 years of practice as a clinical psychologist, I have been guided by a continuous curiosity to study and implement the most effective tools for helping my clients experience relief and healing. Whether the techniques are firmly rooted in the psychotherapeutic establishment or newly emerging, the main question for me has always been, “Do they work?” And like most scientist clinicians, I start off in a skeptical, yet open place.

My toolkit at this stage is rather expansive – including hypnosis, solution-oriented therapy and systems approaches to name a few. Central to my work in the past decade, however, is the practice of Energy Psychology (EP), a psychotherapeutic strategy that integrates established clinical principles with methods derived from various healing traditions of Eastern cultures (acupuncture, yoga, etc.).

The most prominent EP modalities being practiced today (Emotional Freedom Techniques (EFT), Thought Field Therapy (TFT) and Tapas Acupressure Technique (TAT)) combine brief psychological exposure with the manual stimulation of acupuncture points (acupoints) in the treatment of a variety of emotional conditions.

Though the field of EP is only 30 years old, it is fast growing due to its ability to provide swift results with no abreaction in most cases – particularly with trauma patients. For instance, in the spring of 2006, 50 orphans of the Rwandan genocide (many of whom witnessed their parents die by machete) were treated with a single TFT session.

Following this session, scores on a PTSD checklist completed by caretakers and on a self-rated PTSD checklist had significantly decreased. The number of participants exceeding the PTSD cutoffs decreased from 100 percent to 6 percent. Retesting a year later showed that the improvements held.

There have been many other outcome studies describing the effectiveness of EP methods in quickly and permanently reducing maladaptive fear responses to traumatic memories and related cues.

Even so, the approach has been controversial. Some consider EP to fall under the rubric of pseudoscience. This is, in part, because the mechanisms by which EP works have not been established.

In his 2010 “Rapid Treatment of PTSD” article in Psychotherapy: Theory, Research, Practice, Training, psychologist David Feinstein, Ph.D., speculates that adding acupoint stimulation to psychological exposure is unusually effective in its speed and power because deactivating signals are sent directly to the amygdala, resulting in reciprocal inhibition and the rapid attenuation of maladaptive fear.

Another possibility is that Energy Psychology techniques share certain characteristics with EMDR (Eye Movement Desensitization and Reprocessing), hypnosis and other therapies that use highly focused patterns of treatment. First the client is asked to pick a specific target and rate how distressing it is with a SUDs (Subjective Units of Distress) number between 0-10. What proceeds next is some sort of therapeutic operation, which could be tapping on meridian points, bilateral stimulation or the use of imagery.

The client is then asked to report on his/her experience as well as the current SUDs level. If the SUDs is zero, the therapy is essentially done for this target issue. If it is not zero, whatever remains becomes the new target of the intervention. The therapeutic operation is performed again and a new SUDs assessment is taken. This continues until the SUDs is zero or close to zero.

Cognitive psychologists Miller, Galanter and Pribram refer to this therapeutic strategy as a TOTE (Test – Operate – Test – Exit). Psychotherapy approaches incorporating the TOTE pattern are distinguished from the standard Rogerian or psychoanalytic talk therapy in many ways – most notably by the swift nature of the healing reported in outcome studies, peer-reviewed articles, randomized controlled trials and case studies.

Could it be that this very pattern is the source of the effectiveness rather than the specific intervention (e.g. tapping on meridian points) in the “Operate” section of the TOTE? It is a fascinating question.

Nevertheless, a recent randomized controlled trial (soon to be published in the Journal of Nervous and Mental Disease) has shown EFT to significantly lower cortisol-related stress levels and self-reported psychological symptoms after a single treatment session. It’s exciting to see more robust research validating years of anecdotal positive outcomes with EP – many of which, as in the case of the Rwandan orphan study or the rapid relief of PTSD symptoms experienced by U.S. combat veterans treated with EFT, have seemed incredible from a talk therapy perspective. While more sophisticated (and more expensive) studies need to be done, the data continue to stack up in favor of EP.

I cannot help but think that Energy Psychology is following the path described by Williams James a century ago: “A new idea is first condemned as ridiculous and then dismissed as trivial, until finally it becomes what everybody knows.”

References available from author

Robert Schwartz, Psy.D., DCEP, is a licensed psychologist and a diplomate in Energy Psychology who has been practicing psychotherapy for more than 27 years. He is also executive director of the non-profit Association for Comprehensive Energy Psychology (ACEP). For more information, visit www.energypsych.org. He may be reached by email at: acepoffice@gmail.com.
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Authored By Maria Kovacs, Ph.D.

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Multiple relationships not always bad

By Ofer Zur, Ph.D.

I was surprised to read the statement of my esteemed colleague, Ed Zuckerman, Ph.D., in the last issue of The National Psychologist (Nov/Dec, 2011), where as part of an article on “The Fiduciary Heart of Ethics” he stated, “We have an ethical obligation to avoid multiple relationships.”

This statement is in contrast to the APA’s code of ethics, (Section 3.05), which clearly states that:

“A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence or effectiveness in performing his or her functions as a psychologist or otherwise risks exploitation or harm to the person with whom the professional relationship exists.”

Multiple relationships not reasonably expected to cause impairment or risk exploitation or harm are not unethical.

Zuckerman’s statement and discussion of multiple relationships are not only incorrect, unsupported and outdated, but also are in clear contrast to the standard of care of psychotherapy and counseling. For example, multiple relationships are mandated in military settings where psychologists often have primary loyalty to the Department of Defense and only a secondary loyalty to the person they are treating in the consulting room. Multiple relationships are inherent in some correctional settings, such as prisons, where psychologists have a responsibility to the security of the institution, as well as to the mental health of actual patients.

Zuckerman, who to the best of my knowledge, lives in Pennsylvania, should be aware that multiple relationships are unavoidable in small communities and rural areas, which are quiet prevalent in his state. In fact they are a normal and healthy part of such interconnected communities (Zur, 2007). Familiarity and multiple relationships between all members of small communities, including health care providers, is how such communities survive and thrive.

Not all multiple relationships are created equal.

There are different types of multiple relationships (Zur, 2007):

* A social multiple relationship is one in which a therapist and client are also friends, acquaintances or have some other type of social relationship within their community.
* A professional multiple relationship is where a psychotherapist/counselor and client, are also professional colleagues in colleges or training institutions, presenters in professional conferences, co-authors of a book, or other situations that create professional multiple relationships.
* Institutional multiple relationships take place in the military, prisons, some police departments and mental hospitals where multiple relationships are an inherent part of the institutional settings.
* Forensic multiple relationships involve clinicians who serve as treating therapists, evaluators and witnesses in trials or hearings.
* Supervisory relationships inherently involve multiple relationships and multiple loyalties. A supervisor has a professional relationship and duty to the supervisee and to the client, as well as to the profession.
* A sexual multiple relationship is where a therapist and client are also involved in a sexual relationship.
* Sexual multiple relationships with current clients are always unethical.

Multiple relationships can be ethical or unethical, legal or illegal, and can be avoidable, unavoidable or mandated. They can also be planned and anticipated or unexpected.

Multiple relationships not necessarily lead to exploitation, sex or harm. The opposite can be true. Multiple relationships can reduce isolation and prevent exploitation rather than lead to it. Almost all professional association codes of ethics do not mandate a blanket avoidance of multiple relationships.

In summary:

* Non-sexual multiple relationships are not necessarily unethical or illegal.
* Multiple relationships can’t be avoided in many settings and are mandated in others.
* Multiple relationships are a healthy part of small and rural communities.
* Sexual multiple relationships with current clients are always unethical.

Multiple relationships do not necessarily lead to exploitation, sex or harm. The opposite can be true. Multiple relationships can reduce isolation and prevent exploitation rather than lead to it. Almost all professional association codes of ethics do not mandate a blanket avoidance of multiple relationships.

References available from author

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Ofer Zur, Ph.D., is a fellow of APA (Division 42). He is co-author of Multiple Relationship-ships in Psychotherapy, author of Boundaries in Psychotherapy, and director of the Zur Institute, LLC, which offers numerous free resources and online CE courses on multiple relationships, boundaries and other topics at www.zurinstitute.com. He may be reached at droferzur@zurinstitute.com.

Letters to the Editor

Divergent view of ADHD far off-base

Astonishment and disappointment don’t begin to express my reaction to “A divergent view on ADHD” in your Nov/Dec. 2011 edition. This “divergent view” defies volumes of research on brain differences in ADHD individuals. It defies the 2002 International Consensus on ADHD endorsed by over 80 international researchers and scientists who validated this disorder on multiple continents. The Consensus “cannot overemphasize the point that, as a matter of science, the notion that ADHD does not exist is simply wrong ... because the scientific evidence ... is so overwhelming.”

Even worse, the psychologist author of the “divergent view” blames parents for the problem we call ADHD. I’ve lived with two family members with Attention Deficit Disorder. I’ve worked with thousands of children and adults who’ve struggled with this disorder. So on a personal level, this article makes me angry. Is the author living in 2011? His viewpoint smacks of the era where schizophrenia was blamed on refrigerator mothers.

There is no evidence that parents of ADHD children are different from a representative group of non-ADHD parents so that they might be considered the cause of the problem. Cause-effect actually works the other way around. There’s considerable evidence that ADHD children cause anxiety and depression, particularly in mothers.

If you were striving to create shock and awe, you’ve succeeded. You’ve also succeeded, in this psychologist’s opinion, to the loss of your editorial board and publication’s credibility.

Myles Cooley, Ph.D.
Palm Beach, Fla.

Denying ADHD shows dangerous bias

I was astounded that any legitimate professional newspaper would run commentary such as that published under the title, “A Divergent View on ADHD” which ran in the last issue. The evidence that ADHD is neurochemical disorder is overwhelming and includes the identification of no fewer than five genetic markers all related to dopaminergic functioning.

The assertion that ADHD is caused by poor parenting is grossly inaccurate and potentially as damaging as telling the parents of a child with schizophrenia that they are the cause of their child’s disorder. Dr. Paterno’s “diagnostic guidelines” are at best misguided, but without question they reflect a degree of ignorance and personal bias that has no place in ethical practice. Shaming parents into compliance by convincing them that they are the cause of their child’s disorder is demeaning and potentially quite damaging to them and their child.

The publishing of such grossly inaccurate, narcissistic, self-promoting commentary left me wondering if I can trust The National Psychologist as a source of information and useful commentary. This article never should have made it to press, and since Dr. Paterno’s book is self-published, I assume that his ideas failed to pass muster with publishers who actually expect a professional book to meet ethical standards for accuracy and efficacy.

I understand that there are limits to the editorial process, but an article promoting unethical, damaging notions should never make it through the screening process. And when it does, then I believe the paper has an obligation to correct what clearly is a serious error in the choice of material to publish.

Jan L. Nix, Ph.D.
Olympia, Wash.
Organizations gear up to treat veterans

By Richard E. Gill, Assistant Editor

If the troops that came home last month are to receive required mental health treatment, private psychological groups, the Veterans Administration (VA) and the Department of Defense (DoD) will need to work together or else some of these veterans will fall through the cracks.

It’s believed that as many as one-third of these troops will need some kind of help for depression, PTSD or traumatic brain injury and other illnesses, said Barbara VanDahlen, Ph.D., formerly Barbara Romberg, founder and president of Give an Hour, which began in 2005 with about 500 volunteers and now has more than 6,000 professionals that volunteer an hour each week to treat veterans.

The troops are a concern to many, she said. There are more programs with the VA and DoD, which has increased its staff for the returned troops by 21,000 professionals. “We know all veterans continue to struggle and we have not gotten in front of the train, yet” said VanDahlen.

“We will have a large influx of people coming home the next few months. So the need is going to continue to be significant in the foreseeable future. As they return home there will be no more deployments for them and you will see more people experiencing the stress of being deployed four, five or six times. Now that they are home they are dealing with life without that; trying to find a job as they separate from the military, trying to live life that is not combat focused. This is a big transition for these people,” said VanDahlen.

The country needs to make certain the families of veterans get the help they need.

The other two-thirds who do not have mental health concerns could have other problems, such as getting a job or going back to school, she said. No one agency can do it all. That is why the country has to use all the resources available to get everyone help, VanDahlen said.

Give an Hour’s volunteers help when they give one hour a week, and this, she said, “is a huge help. The number of hours weekly is a pretty good response to this surge. Plus we are very well established with our good friends in mental health associations.”

When Give an Hour finds a need for help in an area where there are no providers, the network will contact volunteers and find someone that would provide assistance and help to the veteran.

She acknowledged that many of these veterans do not have private insurance and there are only so many groups to help the troops. “This is a problem and there has to be a collaborative effort with all areas and all groups to help these people. If veterans can’t find a job their mental health problems increase. And if they have mental health struggles they will have trouble keeping a job. People will fall through the cracks if we don’t all work together,” VanDahlen said.

Her program works with mental health organizations to help train civilian mental health professionals. “We have to make sure they step up to help. We all need to work together, the APA, VA and DoD.”

She said suicides are likely to increase, especially among reservists, National Guard members and people living in rural areas who are not connected with established networks.

“We are working to help these people who are not near any professional in-person help. We have to think outside the box for these people on how we can better serve them.”

It might not always be mental health professionals who touch a veteran. It may be a faith-based leader who identifies a veteran that is struggling and can help by referring the veteran to someone who can help. “We see it as a community and nationwide response.”

Many groups and organizations are working with a sense of urgency to see how to harness all the resources available. “We must partner with all communities to get it done for all those who have served our country. Thank goodness we are doing that. We have the tools and bodies; we just need to utilize them all to get the job done.”

RXP guidelines available


The guidelines were developed by the division’s Task Force on Practice Guidelines chaired by Robert E. McGrath, Ph.D. Others on the task force were Stanley Berman, Ph.D.; Elaine LeVine, Ph.D.; Elaine Mantell, Ph.D.; Beth Rom-Rymer, Ph.D.; Morgan Sammons, Ph.D., and James Quillin, Ph.D. Robert Ax, Ph.D., representing Division 18 (Psychologists in Public Service) also provided input.

The guidelines are also available in the December 2011 issue of The American Psychologist.

Two new works explore Narrative Therapy


Review by Melissa Perrin, Psy.D.

Innovations in Narrative Therapy, Connecting Practice, Training and Research is a new offering for clinicians beginning to explore narrative therapy or seeking a deeper understanding of the paradigm. The book is organized around teaching principles: historical and social context followed by discussing the significance of language in treatment. That is followed with research discussions exploring the validity of theoretical application of the work. The best chapters are in the second section, focusing on applying strategies to specific populations.

This work is resolute in embracing and sharing the traditions of narrative therapy while adding to the canon. The inside flap states that the book is intended “for readers with little previous knowledge about narrative therapy.” I have a great deal of awareness of narrative therapy but struggled with comprehending or remembering much of what I read in the first section. I found myself reviewing other texts on narrative therapy, thinking I had missed something or didn’t know enough to review this book. Eventually I realized that Section I on “Innovations in Narrative Therapy” is not as accessible to the clinician new to narrative therapy as it should be, nor as accessible to the seasoned clinician as it could be.

“Storied Therapy as a Three Act Play” is the innovation referred to in the title. The authors put forward an “organizing concept” of the three act play. This is a terrific metaphor and structural hub to use with clients. As I read the chapter and studied the diagrams, I found myself wishing that I could attend a class or seminar with the authors to see and hear how the diagrams built upon themselves.

Section 2, addressing specific populations and clinical work, is well written and flows nicely. The authors offer good examples of application and client interaction. Movement away from pathologizing language when working with clients who have used substances addictively or violence is well modeled in the later section of the book.

Narrative Practice: Continuing the Conversations edited by David Denborough flows with wisdom and clarity from beginning to end. Michael White, a founder of narrative therapy, died in 2008. Denborough sorted through White’s papers, interviews and essays and compiled gems into this book. I empathize with how difficult it must have been to cull through these papers and choose which to use. Each chapter is full of gold nuggets and refreshing admonitions to clinicians. White’s humor, wisdom and heartfelt exhortations for professional clarity and judgment shine through.

The book is organized around White’s specific messages to clinicians as well as questions and on-going dialogues presented to White during his career. Denborough does this by combining letters and conference presentations into a chapter. Other chapters hold papers written by White that were not published or interviews given to Denborough that were discussed but not published. There are in-depth explorations of important topics such as the clinician’s responsibility to bring the world into therapy and be aware of how power from the world can impact therapy. Juicy suggestions for working with couples are given and we are invited to explore anorexia and approach abuse in invigorating ways with clients.

As a clinician and teacher I was thrilled to read White’s exhortations to observe ourselves in the therapeutic setting. He encourages us to remain ethical, to push against sitting comfortably in the therapy room without questioning ourselves and our responses. We are urged to remain accountable and observe ourselves keenly as we listen to clients.

White’s passion and urgent need to share his awareness of the individuality of each narrative hold great resonance. Clinicians from every paradigm will learn, feel challenged and gain insight from Narrative Practice: Continuing the Conversations.

Melissa Perrin, Psy.D., is a licensed clinical psychologist in private practice in Evanston, Ill. She works primarily with teens and adults dealing with addiction or life transitions. She may be reached by email at psydperrin@aol.com.
By Susan Jarmuz-Smith

Ten years ago I was a happy engineer who was pursuing the dream of a doctorate and a career in academia. Then, life threw a curve ball in the form of a tiny 2 pound baby boy and soon I found myself where I am now: a happy school psychology doctoral student aiming to assist families of children with special needs. Each and every day I try to find the balance between my technology-centered training.

As all graduate students in school psychology know, we are student-centered but our focus is never far from the data and effectiveness of our interventions. When I first entered this field, I personally shunned my engineering past but I have found that doing so was a disservice. In fact, a critical eye for scientific outcomes is a profound challenge.

Since that eye-opening conversation with a colleague about a certain anxiety program I wanted to try. She said, “Should you really do that?” Again, I needed to reassess for balance.

One day I asked myself, “When can he just be a kid?” The balance was lost and I didn’t have the appropriate knowledge to restore it. I didn’t know how to choose which interventions were effective and which were wasting his time.

So, I went to graduate school. During the first few years of learning, I found I wanted to test out every concept I learned or every program I experienced in my practical work on my son. I was excited by the evidence-based results they each offered.

But, what hit me next was an ‘ah-hah’ moment. It happened when speaking with a colleague about a certain anxiety program I wanted to try. She said, “Should you really do that?” Again, I needed to reassess for balance.

Since that eye-opening conversation with a colleague over a year ago, I have looked at everything through a different lens, one that blends my role as mother with my role as future school psychologist. I have friends who also have children with special needs and I see that I am not alone in struggling with this dilemma. The balance between services and allowing a child to develop naturally is a tricky thing to find.

In my current work, I research, explore and interact with families of children with special needs. My goal is to work with families who are struggling with this balance and use my personal experiences to support their journey.

Susan Jarmuz-Smith is a third-year doctoral student in the School Psychology Program at the University of Southern Maine. She is on the adjunct faculty in psychology, a behavioral consultant for local public schools and volunteers in local and national professional organizations. Her research focuses on families of children with special needs and family-school partnerships. She is always looking for kindred spirits to collaborate with and can be reached at ssmonthusmainede.edu.

Student subscriptions to The National Psychologist are available. See page 24 for details.

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Be yourself, not an imposter

By Dave K. Jean

Have you ever felt like an imposter? Despite excelling in your previous endeavors, you can’t seem to shake that feeling, can you? That feeling one gets when they are imperfect in a seemingly perfect school, department or hospital. What graduate student hasn’t felt the sting of self-doubt? Or maybe you have never heard of it?

The imposter phenomenon (IP) or impostor syndrome is an insecurity of sorts. It occurs when a person is unable to believe or internalize their own achievements. They are likely to believe that their accomplishments are more attributable to dishonesty or luck, maybe even timing. With every mistake, shortcoming or set back they lower themselves deeper and deeper into a hole of uncertainty. Does this description fit you or anyone you know? Fortunately, this phenomenon has never been an accepted psychological disorder. At least it has yet to be recognized as such. You may find the history a bit surprising.

The term IP was first coined by clinical psychologists (shocking) Pauline Clance, Ph.D., and Suzanne Imes, Ph.D. In their first paper, they described women who despite significant accomplishments could not convince themselves they were deserving of such success. Later research suggests that men feel it too. People of color have also reported IP within the Ivory towers.

Although various groups have demonstrated the IP, graduate students may have a much more difficult time coping.

As graduate students, we are uniquely susceptible to these insecurities. The reasons vary from one student to the next, but we are just starting out. To varying degrees, we are unseasoned in a world surrounded by… well, the best. We do not yet have the volumes of work, publications and experiences that our more seasoned advisers do. So almost naturally, we compare ourselves to our peers, who are likely doing the same thing. From grades to internships, the self-criticisms and comparisons at times are incessant.

Fortunately, there are advanced graduate students and, wow, can they give advice.

In every program or site, no two people are on the same path. From where we originate to the relationships we have within our labs or with our advisers, to our research interests or even our populations of interest, no two paths are the same. Why bother comparing and indulging in self-doubt or the IP? Your graduate education is your fingerprint: Make it your own without the insecurity. I think I can do that. Can you?

Dave K. Jean is a student in the George Washington University Department of Psychology. He may be reached by email at davejean@gwmail.gwu.edu.
There are many reasons to add a forensic sub-specialty in your practice. Maybe you are becoming burned out by the demands of HIPAA and managed care; wouldn’t be? Perhaps you have excellent assessment skills and would like to use them in a different and more challenging arena. Maybe you could use a new revenue stream.

In any case, you have been thinking about trying forensics but are unsure how to go about preparing yourself and then marketing your skills once you are ready. It can be done, but let’s be clear, it will take considerable effort and it is not for everyone.

How can you know if forensic practice is for you? Based on my experience, there are a number of prerequisites:

* You need a solid basis in psychological assessment. Not only do you need excellent testing and interviewing skills, you have to know some of the science behind the tests. You don’t need to be Wechsler, Catell or Reynolds, but you will need to be able to field questions about what the tests measure and how.

* You should be comfortable speaking in public in an adversarial setting. Unlike case conferences and presentations, there is likely to be a highly trained attorney asking questions designed to raise questions about your training, your methodology and your conclusions. Forensic psychology is no place for the thin-skinned.

* You have to be willing to put in the hours of preparation to allow you to do your assessments knowledgably, professionally and ethically. This includes reading the authoritative text, articles (on an ongoing basis) and attending high quality workshops. You’ll need some supervision as well.

Assuming you have these qualities and you have prepared properly, your first forays into forensic work should be closely related to the kind of psychology practice you already know. For example, child clinicians can start with child custody, parenting assessments and educational due process cases. Geropsychologists might consider assessments for guardianship and testamentary capacity. Those in correctional settings may want to start with sentencing evaluations and competency to stand trial.

Again, be very sure you are properly prepared. Lack of knowledge and slipshod methods will quickly be discovered in the courtroom. The importance of receiving guidance and consultation from an experienced forensic psychologist initially cannot be overstated.

Perhaps the biggest problem for those trying to enter this area of practice is letting the people who might hire you know that you do this kind of work. In my experience and my research with my colleagues, a number of methods of breaking into the forensic field seem to be the most effective:

1. Present some papers and publish some articles. You may not be in a position to do hard research, but your reading and preparation are bound to get you thinking about some of the issues in the field. Topics for review articles and “think pieces” are bound to occur to you. You can start by presenting at regional conferences and publishing in the local bar newsletter. You already wrote a dissertation; 10 pages on a topic of forensic interest shouldn’t be too difficult.

2. Speak to local bar sections (matrimonial, elder law, early career etc.) child protection agencies, probation and parole departments and schools. They all need training hours and are all looking for speakers. Speak to any group however small that might be a potential market for your services. Word of mouth works best of any marketing strategy.

3. Get a web page and provide content of interest to your market such as links to important new articles and other sites. A word of caution: if you are not very good at designing web pages, have it done professionally. An amateurish webpage is off-putting to prospective clients.

If you research your market carefully, you will probably find that there are areas in which the forensic field is underpopulated or underpaid. For example, in some of the jurisdictions in which I practice, courts and child protection agencies are having difficulty finding psychologists to evaluate court-referred juveniles, because the reimbursement is so low. You might want to consider taking some of these cases. The benefits include the fact that you will meet potential referral sources for other types of cases, you will have a high volume of cases on which to hone your skills and you will begin to establish your bona fides.

Less effective methods of marketing are print ads in bar journals, elaborate listings in phone books and mass mailings. They are expensive and don’t seem to garner much attention.

All of this is easier to write about than to accomplish. I cannot emphasize too strongly that it is absolutely essential to be sure you have developed the requisite skills. Slipshod work will be quickly discovered and revealed very publicly. An in-depth knowledge of the ethical standards of forensic psychology is the base on which a successful practice is built.

Important issues are informed by forensic assessments and the work must be taken very seriously. But if you are willing to work hard, research your market and do quality work, you are bound to have some degree of success in forensic practice.

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Eric G. Mart, Ph.D., ABPP, is a forensic psychologist based in Manchester, N.H. He is author of Getting Started in Forensic Psychology and may be contacted via his webpage at www.psychology-law.com. He recommends that those wishing to work in forensics follow the General Guidelines adopted by the APA Board of Professional Affairs, stated briefly as “Before offering professional services beyond the range of their experience and usual practice ... psychologists strive to obtain pertinent knowledge through such means as education, training, reading, and appropriate professional consultation.”

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James Bradshaw, Senior Editor
Richard E. Gill, Assistant Editor

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Jackman awarded Order of Canada

My dear friend and beloved colleague, Frederic (Eric) Jackman, Ph.D., of Toronto, has been awarded the Order of Canada, that country’s highest civilian honor. It ranks with the U.S. Medal of Honor and with the Nobel Peace Prize as the ultimate recognition of one’s contribution and dedication to the community and service to the nation. The Order of Canada is bestowed upon distinguished people who have enriched the lives of others locally, provincially and internationally.

Dr. Jackman was awarded the Order in Ottawa, Ontario, by Canada’s governor general, the queen’s representative in Canada.

This is the latest and highest among many honors bestowed upon Eric for his influence and philanthropy in every conceivable area. A significant example is his recent donation of $5 million to the Dr. Eric Jackman Institute of Child Study at the University of Toronto, the largest gift ever in Canada for the study of early childhood development and education.

I acknowledge an enormous debt of gratitude to Eric, who was a mentor and role model to me. Without his encouragement, support and suggestion 40 years ago that I join him in his downtown Chicago office for my psychotherapy practice, I might never have become a group psychotherapist.

Leon J. Hoffman, Ph.D., ABPP
Chicago, Ill.

Letters to the editor are encouraged.

Email them to: Natlpsych@aol.com
C.E. Quiz  (earn one CE credit)

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Vol. 20 No. 1 January/February 2012

DSM5...
1. According to the article on “medicalizing” the DSM5, broadening the mental disorder definitions may have the effect of:
   a. increasing the precision of mental illness diagnosis
   b. too many people being prescribed unnecessary medications for normal human reactions to their experiences
   c. more individuals being identified and treated for newly defined categories
   d. providing increased scientific rigor and independent review for diagnostic categories

Organizations gear up...
2. According to Gill, large numbers of troops returning from multiple combat deployments will require assistance in a number of areas. Which of the following describe the statistics quoted in the article?
   a. About a third may need help with jobs or school; the other two-thirds will need help for depression, PTSD, or TBI
   b. About half will need help adjusting back to home and family; the other half will do well without any assistance
   c. About three-quarters will have difficulties finding employment; the rest will

Ethics: running the gauntlet...
3. In rating the courtroom performance of her fictitious Dr. Public, Campbell suggests that he might have avoided some of the perils by:
   a. refusing to testify
   b. using a more inclusive informed consent process
   c. performing a formal child custody evaluation
   d. insisting that his opinion should be treated as if he were just a member of the general public

Risk management...
4. When something is “court ordered” the order generally:
   a. requires compliance in some circumstance but not in others
   b. requires immediate compliance by the involved parties
   c. does not require compliance if professional confidentiality is at stake
   d. does not require compliance unless a judge specifically orders it

5. When a psychologist is presented with a legal court order and does not know what to do, the Younggrens recommend:
   a. retain legal representation immediately
   b. avoid expressing dissenting opinions to the court
   c. do not do anything until you get guidance
   d. appeal to both attorneys to discharge you from further involvement

Group psychotherapy...
6. Which of the following dynamics in group therapy have been consistently linked with successful outcome?
   a. The instillation of hope and universality
   b. The corrective recapitulation of the primary family
   c. Catharsis and existential factors
   d. High levels of cohesiveness and interpersonal learning

ADHD coaching…..
7. Tuckman’s simple distinction between therapy and coaching for ADHD holds that:
   a. coaching offers help with practical matters and therapy helps with comorbid conditions
   b. coaching addresses the present and future whereas therapy focuses on the past
   c. coaching focuses on strengths whereas therapy focuses on diagnosable pathologies
   d. coaching and therapy are essentially the same

8. Tuckman suggests that therapy and coaching:
   a. can be combined in an integrative model
   b. should always be done by a trained psychotherapist
   c. are best done by two different professionals
   d. can interfere with each other if they are not coordinated

Keeping Medicare records safe....
9. According to Holmes and Fonarow, the first step to protecting against a cyber-related data breach is:
   a. encrypt all portable/mobile electronic devices with data encryption software
   b. obtain education about federal and state laws and notification requirements in the event of a data breach
   c. research the data breach policies of third party vendors and service providers
   d. draft an internal incident response plan for data breaches

Multiple relationships...
10. According to Zur, multiple relationships:
   a. should be avoided
   b. are an inevitable fact of life in professional practice
   c. are patently prohibited by various sections of the APA code of ethics
   d. that are not reasonably expected to cause impairment or risk exploitation or harm are not unethical

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Prison psychologist has license suspended
The California Board of Psychology has suspended the license of a prison psychologist who is charged with falsely telling police she was sexually assaulted, the Associated Press reported in December. The board said an administrative law judge approved the suspension Dec. 15. Officials seek to revoke Laurie Ann Martinez’s license permanently.

Martinez, formerly a supervising psychologist at Sacramento’s California State Prison, is accused of conspiring with a friend to fake that she was raped in order to persuade her husband to move to a different neighborhood in Sacramento.

She has been assigned to the corrections department’s administrative offices pending resolution of the charges.
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Connecticut – A new brain imaging study led by researchers at Yale University shows how people who regularly practice meditation are able to switch off areas of the brain linked to daydreaming and anxiety, as well as schizophrenia and other psychiatric disorders. The brains of experienced meditators appear to show less activity in an area known as the “default mode network,” which is linked to largely self-centered thinking. The researchers suggest through monitoring and suppressing or “tuning out” the “me” thoughts, meditators develop a new default mode, which is more present-centered.

California – A psychology professor at UCLA can explain the “brain freeze” experiences of Rick Perry’s debate flub and Herman Cain’s floundering on a question about Libya. A moment like this can happen to the best of us, said Robert A. Bjork, Ph.D. “The human memory system is characterized by a virtually unlimited storage capacity that is coupled with retrieval processes that are fallible and probabilistic; in fact, most of what is stored in our memories is not retrievable at any given time in any given situation,” Bjork explained. This is usually a good thing, he noted, because we need to be able to keep our memories current. “There is an adaptive side to our retrieval limitations, but retrieval failures can nonetheless be very embarrassing,” Bjork said.

Indiana – New research suggests the mere act of walking through a doorway helps people forget, which could explain many millions of confusing moments that happen each day around the world. A person enters a room and then thinks, “What was I coming in here for?” A study published recently in The Quarterly Journal of Experimental Psychology found that participants who walked through doorways in a virtual reality environment were significantly more likely to forget memories formed in another room, compared with those who traveled the same distance but crossed no thresholds; Notre Dame University psychologist Gabriel Radvansky, Ph.D., says doorways serve as an “event boundary” that the brain uses to separate and store memories.

Kentucky – The Carnegie Foundation has recognized Jonathan Golding, Ph.D., psychology professor at the University of Kentucky, as professor of the year for the Advancement of Teaching and the Council for Advancement and Support of Education. Golding, who joined the university in 1988, was selected particularly for his teaching skills in undergraduate education.

New York – The New York State Psychological Association Foundation is conducting a fund-raising “gadget drive.” Members are encouraged to recycle old computer devices – laptops, cell phones, MP3 players, digital cameras, etc. – by going to the drive website which is located at, www.NYSPAFoundation.gazelle.com, where instructions for valuing the item and how to arrange free shipping is provided. The drive ends Jan. 31.

Michigan – Judith Kovach, Ph.D., retired as executive director of the Michigan Psychological Association effective Dec. 31. Kovach served in a variety of positions with the MPA for more than 25 years and for the last five years was the association’s sole staff member. Kovach is succeeded by Cheval Breggins, experienced executive of non-profit organizations with an MBA in business administration and marketing.

Ohio – The Clark County Mental Health and Recovery Board has $2 million less to operate than it did in 2008 due to a 44 percent reduction in state funding included in an austere state budget. Rep. Bob Hackett, a conservative Republican, told the Springfield News-Sun that mental health cuts have gone too far and will be counterproductive due to the increased expenses when untreated mental patients, alcoholics and addicts wind up in other systems, such as jails and prisons.

Pennsylvania – The Pennsylvania General Assembly has passed a bill requiring all athletic coaches to complete a concussion management training certification training course prior to coaching any athletic event. During an athletic event, coaches will be required to remove from competition any athlete that shows signs of a concussion or TBI. At press time the governor was expected to sign the bill which goes into effect on July 1. This bill only affects public schools in the state. Passage of this bill was one of the top legislative priorities of the Pennsylvania Psychological Association.

Washington, D.C. – Garett Jones, an economist at George Mason University, contends the nation’s intelligence level is associated with a number of important economic outcomes. Jones stressed that “policymakers should include measures of national average IQ when reporting a nation’s level of human development” as at present no nation appears to do so.