Medicare to cut payments for not meeting reporting requirements

By Paula E. Hartman-Stein, Ph.D.

Apathy is turning into urgency as clinicians who bill under Medicare learn that financial penalties are slated for 2015 for non-compliance in the Physicians Quality Reporting System (PQRS) beginning January 2013.

According to the website on PQRS from the Center for Medicare and Medicaid Services (CMS), “Beginning in 2015, if the eligible professional or group practice does not satisfactorily submit data on Physician Quality Reporting System quality measures, a 1.5 percent payment adjustment will apply. To avoid the 2015 adjustment, an eligible professional must satisfactorily report Physician Quality Reporting System quality measures during the 2013 reporting period (Jan. 1-Dec. 31, 2013).”

Anita Somplasky, director of health care quality improvement for the West Virginia Medical Institute, clarified how the sanction will work: “The penalty for non-participation in 2013 will be an automatic 1.5 percent reduction on each payment in 2015.”

Peter Kanaris, Ph.D., coordinator of public education of the APA’s Public Education Campaign in New York and member at large of the executive committee of the New York State Psychological Association (NYSPA), said, “Hearing about the penalties for not participating in PQRS at a recent Medicare workshop sponsored by NYSPA took me and the entire group by complete surprise.”

In a phone interview, Kanaris said he had been aware of PQRS, but he and other psychologists at the workshop lacked sufficient education about the program.

“Knowing there will be a penalty provides sufficient stimulation to get me to move myself and participate in the program,” he said. “I am more responsive to the stick rather than to the carrot.”

PQRS is a reporting program that has been providing a small financial incentive to eligible Medicare providers who submit data on specified screening measures on Medicare claim forms. Psychologists have been eligible to participate since 2008.

In 2012 CMS suggested that clinicians report on at least three screening measures, but as long as at least one measure has been

Continued on Page 4

The New Year will bring new billing codes for all psychotherapists

By Paula E. Hartman-Stein, Ph.D.

Psychotherapists across all disciplines will need to learn a new set of billing codes that go into effect Jan. 1 in order to be reimbursed by insurance companies, including Medicare. The revision of the codes is a result of the five-year review process required by the Centers for Medicare and Medicaid (CMS) and conducted by the American Medical Association (AMA).

“These changes made to the psychotherapy codes are the first revisions made for the first time in most all practitioners’ careers,” according to Tony Puente, Ph.D.

Puente, a professor of psychology at the University of North Carolina who maintains a private practice in clinical neuropsychology in Wilmington, is the only psychologist on the 17-member voting panel of the AMA Current Procedural Terminology (CPT) committee.

In phone interviews, Puente explained the major coding revisions. “The definition of psychotherapy has not changed substantially, but descriptions have been replaced with more modern language that reflects the full range and vibrancy of modern day psychotherapy,” he said.

Diagnostic evaluation for psychotherapy, formerly code 90801, is split into two diagnostic evaluation codes, one with medical management and one without. “The new system represents a different, clearer understanding of what has been occurring under the diagnostic evaluation activity.”

The site where the service is delivered is no longer a criterion for code selection, Puente said. For example, the work value for psychotherapy done in the hospital or nursing home is the same as for office-based work.

Reimbursement is based on three components: work value, liability insurance and practice expense. “CMS has always viewed practice expense as a split entity, separating non-facility (office) and facility (hospital),” said James Georgoulakis, Ph.D., APA representative to the Relative Update Committee of the AMA.

“It is likely that there will be a reimbursement difference between the two locations, with the facility expense being much higher,” he said. “However, it is likely that long-term care facilities will be placed in the non-facility care overhead expense area because they do not meet the CMS definition of a hospital.”

Actual payment amounts for psychotherapy in 2013 will not be known until the Federal Register publishes reimbursement rates for all codes in November.

Puente said introducing significant others to the psychotherapy equation has expanded. “Therapy can be done with the patient alone during the session, with the patient and a significant other or with the patient at one point in the session and with a significant other at a separate point in the session.”

New psychotherapy codes differentiated by time may involve the family member in the session in order to support the treatment plan for the patient, a practice that is common when working with children or with adults

Continued on Page 3
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Billing codes will change in 2013

Continued from Page 1

with memory impairment, for example. In each session there must be some face-to-face contact with the patient.

“The amount of time spent in psychotherapy has increased in granularity or levels,” said Puente. There are codes to indicate 15-, 30- and 60-minute sessions. The standard time rules used by CPT will apply. For example, if the session is longer than 15 minutes, it will be captured by the 30-minute code.

The website of the American Academy of Child and Adolescent Psychiatry provides a chart of time ranges for the new codes. Actual time ranges include codes for 16 to 37 minutes, 38 to 52 minutes and more than 53 minutes. Psychotherapy lasting less than 16 minutes is not reported.

According to Puente, the session begins with face-to-face contact. “When I meet my patient in the waiting room, the clock starts.” Time spent calling referrals and documenting the activity is not captured as psychotherapy, but time spent in these clinical activities is considered in the work valuation of the code.

In the new system there is no separate code for a 90-minute psychotherapy session. “The reason a 90 minute code was not includ-

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Puente also credit Randy Phelps, Ph.D., deputy director of APA’s Practice Directorate, with representing the interests of psychology very well in the lengthy process.

The AMA and APA plan a webinar series to educate professionals on proper coding.

APA Division 20 (Adult Development and Aging) in conjunction with the Society of Clinical Geropsychology is planning a webinar in early 2013 on appropriate coding specifically when using interventions with memory impaired patients, according to Pat Parmelee, Ph.D., Division 20 president.

The AMA’s 2013 Current Procedural Terminology (CPT) was published in mid-October. Copies of the CPT manual can be ordered through Amazon or directly from the AMA online or by calling 800-621-8335. CE

Paula Hartman-Stein, Ph.D., is a consultant, trainer and geropsychologist in Kent, Ohio, and one of the original seven members of the Technical Consulting Group for Clinical Psychology when reimbursement rates for psychology services were first determined by the Resource-Based Relative Value Scale. She is co-editor of Enhancing Cognitive Fitness in Adults (Springer, 2011). Her website is www.centerforhealthyaging.com.
Penalties join incentives in PQRS enactment

Continued from Page 1

reported in 50 percent of the applicable Medicare Part B fee-for-service patients, the health care professional was eligible for a bonus payment of 0.5 percent to be distributed in the fall of the subsequent year. Clinicians who participated in 2011 received their bonus checks in mid-October 2012.

Psychologists had 10 measures available for reporting in 2012 under the individual claims reporting system. Measures can also be reported through a registry system that requires a fee to join. Regardless of which system a health care provider chooses, CMS suggests that clinicians decide that the screening areas they choose fit best with the particular patient population they serve.

According to a recent trends report from CMS, fewer than 200,000 eligible providers out of more than 600,000 participated in PQRS in 2010. Emergency physicians had the largest representation among all specialties and also had a high rate of participation (65 percent). The CMS report said, “Hospital-based practices most likely have processes in place to capture clinical data accurately, therefore allowing quicker uptake of reporting quality measure data.”

Of the 10 specialties listed in the CMS report, psychologists fit into “Other Eligible Professionals.” Only 17 percent of eligible providers participated in 2010.

Alice Randolph, Ed.D., MSCP, owner of Psychological Transitions in Port Clinton, Ohio, a company that provides psychological services in long term care facilities in four states, said, “I have made it a requirement for my 20 employees to participate in PQRS because it is worthwhile to change the way they think by rewarding them. This is very positive on the part of CMS.”

Randolph said after studying the areas that psychologists could screen under PQRS she chose elder abuse, depression and tobacco use. “These are very effective things to ask in a psychological assessment,” she said. “I’m not asking the practitioners to do anything that is alien to a clinical interview.”

According to Randolph, asking questions of nursing home patients about abuse elicited content for psychotherapy and helped to explain why adjustment was not going well or the possible reason for negative reactions of some female patients to male nursing assistants. “There is a whole lot more Post-Traumatic Stress Disorder than we realize. The elder abuse screen has four or five questions that can generate painful memories. That area of screening has been the most surprising and productive.”

Randolph said she was audited on her use of PQRS measures two times by Quality Insights of Pennsylvania, the agency contracted to develop psychological measures, and she had no problems. “I have found that by creating a form you don’t leave it up to a clinician’s memory. If you are organized and have a form for it. It is no big deal.”

Mary Lewis, Ph.D., president of Psychologists in Long-Term Care and psychologist with Senior Life Consultants in Columbus, Ohio, said, “I have not ever officially participated in PQRS but I have been informally documenting measures on my clientele. “I think it has helped me tremendously because it standardized my assessment more than it used to be. It makes me catch things that I might not have asked.”

Randolph said the most challenging part of participating in PQRS is going through the pages of measures and finding those applicable to psychology. “I found the instructional material to be cumbersome, convoluted. I waited till New Year’s Eve to wade through the measures. It took fortitude to figure it out.”

As of press time, the measures available for next year are not yet available. The screening measures are tied to the Current Procedural Terminology (CPT) codes that the AMA published in mid-October. Somplasky said she expects CMS to publish them very soon.

Kanaris thinks psychologists’ participation will increase if information is given in clear terms. “We are educable,” he said.

A webpage dedicated to all the latest news on PQRS is available on the CMS website at http://www.cms.gov/PQRS. Information from APA is also available through http://apapracticecentral.org/reimbursement/improvement/pqri-faq.aspx

Paula E. Hartman-Stein, Ph.D., is a clinical geropsychologist who was chair of the Psychology and Social Work Expert Work Group to develop quality measures for the Physicians Quality Reporting Initiative in 2007 and co-chair of the Psychology Work Group in 2008. She is planning a national webinar on PQRS through her company in early December. It was at a workshop she conducted that NYSPA members learned of the coming penalties. Her website is www.centerforhealthyaging.com.
Conference offers great tips for establishing and growing independent practices

By Jennifer Imig Huffman, Ph.D.

San Diego – Strategies for launching, growing and revitalizing independent practices were featured at the first annual APA Division 42 Fast Forward Conference held here Oct. 5-6.

About 160 attended the sessions at the Rancho Bernardo Inn and Spa.

Headline speakers included Steven Walfish, Ph.D., author of many books on making a practice successful; Keely Kolmes, Psy.D., who specializes in integrating psychology and social media; Katherine Nordal, Ph.D., executive director of the APA Practice Organization; and Peter Sheras, Ph.D., and Phyllis Koch-Sheras, Ph.D., who specialize in couples therapy.

Janet Lapp, Ph.D., gave the opening presentation to begin the conference that included presentations by 32 psychologists and 18 programs offered CE credits.

One of the highlights was a speed mentoring event directed by Heather Wittenberg, Psy.D., of BabyShrink fame. The event matched doctoral, early career and newly established independent practitioners with 20 innovative psychologist mentors who had been selected based on practice interests, career and personal goals.

The organizing committee for the conference included educational, inspirational and practical sessions that emphasized hands-on learning and expert training as well as up-to-the minute ethics seminars on the interface of psychology with technologies.

Programs focused on ethics in the age of Google and Facebook, mindfulness, supporting parents, preparation for court testimony and legal and ethical issues in telepsychology.

Opportunities to network and socialize outside of the presentations were also emphasized. The beautiful weather was the backdrop to happy hour receptions, buffet-style lunches, and evening “Dine Aronuds,” the latter which allowed attendees to sign up for transportation to local restaurants and socialize with other conference attendees.

The reactions to this conference as noted through the list-serve and social media forums have been overwhelmingly positive. Several providers tweeted on Twitter during the conference and a summary of these tweets is on the Division 42 website.

One of the consistent refrains heard from attendees across the board (from ECP to well-established practitioners) was that the Division 42’s Fast Forward Conference was one of the best conferences they had ever attended.

That was this psychologist’s sentiment exactly. Well done Fast Forward conference planning committee, I cannot wait to see what you have in store for us next year!

Jennifer Imig Huffman, Ph.D., is a clinical neuropsychologist specializing in developmental conditions in children and adolescents. She is the owner of Neuropsychology Center for Attention, Behavior and Learning in Lincoln, Ill. She and her husband, Maj. Dennis Huffman, Illinois Army National Guard, are the co-founders of Little Hero Helpers, a non-profit organization designed to support the emotional well-being of military children and families. The Huffmans live in Central Illinois with their three young children. She may be reached by email at: drjennifer@theablecenter.com

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Reports from former players who sustained head injuries throughout their careers express difficulties with memory loss, headaches, vision problems, speech problems, early onset Alzheimer’s disease and other forms of dementia. The players also report psychological symptoms of anxiety, difficulties with impulse control and emotion regulation, depression and suicidality.

There has been increased discussion at all levels of competition about the long-term risks of playing football, the need to implement protocols following a head injury or possible concussion and ways to increase the safety of the sport.

As the number of former and current players who are suffering from psychological issues as a result of their head trauma increases, the number of licensed therapists who are providing treatment to this population will need to increase. There is limited research on the psychological needs of current and former players who present with issues relating to head injury. We know these issues include depression, anxiety, anger management, family conflict, suicide ideation and substance abuse.

The NFL is not the only organization that is under attack because of head injuries. Similar lawsuits at the NCAA and high school levels contend that institutions have a responsibility to protect their athletes.

Licensed clinicians can partner with the NFL (and other organizations) to serve as resources for athletes who have sustained head injuries. As such, there are a few steps that therapists may be able to take in order to help athletes and organizations manage the challenges related to concussions:

* Network and build relationships with NFL team physicians and player development personnel in your market.
* Partner with your NFL franchise to provide comprehensive baseline testing (potentially in conjunction with a neuropsychologist).
* Be mindful of potential brain trauma when working with an athlete in any mental

Helmet-to-helmet contact can cause serious head injuries

Continued on Page 14
Assessment of learning disabilities in adults should be evidence-based

Robert L. Mapou, Ph.D., ABPP

Most clinicians are aware that learning disabilities arise early in development, are presumed to be neurologically based and often run in families. Yet, when reviewing reports I am frequently surprised to see that many clinicians are not aware of the evidence base on these disorders. Statements I have found in reports include:

* Test scatter indicates that Mr. White has a learning disability.
* Mr. Smith’s reading disorder is due to his slow processing speed.
* Ms. Jones’s reading disorder is directly related to her visuospatial difficulties.
* Ms. Adams’s profile indicates a learning disability in processing speed, conceptual thinking and visuospatial skills.

None of these statements is correct. Specifically, research has found that 1) variability in test performance is the rule rather than the exception and is not diagnostic of a learning disability, 2) slow processing speed is associated with dyslexia or ADHD and may reflect their genetic linkage but does not cause either and 3) visuospatial difficulties may accompany reading disorders but do not cause them, as they are rooted in the language system of the brain.

Learning disabilities also cannot be arbitrarily diagnosed based on a cobbling together of weaknesses found on testing. Rather, only learning disabilities for which there is empirical support should be diagnosed, and there should be associated empirically based weaknesses in cognitive functioning.

Research on learning disabilities in children is well established. Over the past 15 years, research on these disorders in adults has grown substantially. Moreover, much of what has been found to be true in children has also been found to be true in adults.

Consequently, much of what we know about children can, in combination with research on adults, be applied to assessment of adults. Clinicians who routinely evaluate adults for learning disabilities should be familiar with this research.

The following applies this research to clinical assessment. References to this work will be provided on request.

Reading disabilities

The largest amount of research is on reading disabilities, including dyslexia, a specific disorder affecting fluent decoding and reading of individual words as well as spelling. A thorough assessment of a reading disability should include measures of:

* Phonological awareness (a deficit in phonological awareness is the core impairment in dyslexia but may be normal in adults who have had early intervention)
* Spoken language comprehension (receptive language; word and sentence level)

General knowledge

* Span for auditory-verbal information and working memory
* Processing speed
* Word retrieval and, especially, rapid visual naming
* Decoding, single-word reading and spelling
* Reading comprehension

Timed measures of decoding, single-word reading and reading comprehension are essential since many adults with reading disabilities, especially if they receive early intervention, can do fine when they have sufficient time to read. They are typically slow and inefficient when reading text for comprehension.

Research on other learning disabilities in adults is less well established. But, there is still sufficient research to guide assessments and to determine if the expected underlying cognitive weaknesses are present.

Mathematics disabilities

Based on research, assessment of math disabilities should include measures of:

* Attention
* Executive functioning (especially planning and problem-solving)
* Visuospatial skills
* General knowledge
* Speed when completing simple math
* Written calculation
* Math word problem solving

Mathematics disabilities frequently co-occur with reading disabilities, often affecting ease of access to math facts. It can be helpful to use timed math measures to examine whether time constraints affect an adult’s ability to demonstrate math skills.

Written language disabilities

Research is still in the early stages of understanding for the cognitive basis for written language disabilities. Spelling difficulties frequently accompany reading disabilities. Problems with expressive writing can occur in association with reading disabilities or ADHD or on their own. Important areas for assessing written language disabilities are:

* Fine motor speed and dexterity
* Handwriting quality
* Fluency when writing words and sentences
* Spelling
* Word retrieval and oral sentence formulation
* Verbal organization
* Essay writing, especially timed

Unfortunately, assessment of essay writing is hampered by a lack of instruments appropriate for expressive writing in adults in post-secondary education. Often, it is necessary to describe the errors on these measures, because they are not adequately reflected by the final score.

Nonverbal learning disabilities

Although some have questioned the usefulness of this classification, noting that its features overlap with those of mathematics disabilities and ADHD, others believe that there is sufficient data to support it as a separate disability. Unlike language-based learning disabilities, which are attributed to dysfunction in the brain’s left hemisphere, nonverbal learning disabilities are presumed to be due to right hemisphere dysfunction. The core impairments in nonverbal learning disabilities should be the focus of an assessment and include:

* Visuospatial skills
* Attention and executive functioning
* Mathematics (timed tasks are likely to be more sensitive than untimed)
* Interpersonal skills

Adults with nonverbal learning disabilities also are prone to anxiety and mood disorders, often because of the impact of slowness and poor visuospatial skills on effective job functioning and the associated interpersonal difficulties. Consequently, an assessment of emotional functioning is important.

Summary

Our knowledge on learning disabilities has advanced to the point that evaluations should be evidence-based. Clinicians are encouraged to explore the research to insure that their assessments are in keeping with the current state of the art. Diagnoses should reflect those established by research and, when making a diagnosis, the expected cognitive impairments should be present.

Robert L. Mapou, Ph.D., ABPP, is board-certified in clinical neuropsychology. He is in independent practice with The Stixrud Group, in Silver Spring, Md. (www.stixrud.com) where he specializes in assessment of learning disabilities and ADHD in adults and adolescents. He is author of Adult Learning Disabilities and ADHD: Research-Informed Assessment. Portions of this article appear in that book and are reprinted with permission of Oxford University Press. Mapou may be reached at 301-563-0534, ext. 264 or by email at: rmapou@gmail.com.
Risk Management:

Digital age creates new hazards

By Eric C. Marine

During the latter part of the 20th Century and going on into the 21st Century, the pervasive expansion of mental health care has changed the practice of clinical psychology. During the last three decades, the number of people accessing psychological care has grown exponentially. With this expansion has come a change in the way services are perceived and provided. The practice of psychology has maintained its focus on confidentiality and is attempting to adapt to the way our world now communicates and interacts.

The traditional method of recording sessions was with paper and pen. The documents would then be stored in a file in a locked cabinet. This was a change from the use of a notebook that may have contained many notes from multiple patients. The current method is to use some form of electronic media to record and store patient charts.

In our lifetime, the use of computers has become seamlessly integrated into the fabric of everyday life. College students no longer carry notebooks to class to take notes. In the past decade, the use of laptop, notebook or tablet computer has replaced the venerable spiral binder. There is no wonder that students who are now licensed clinicians would continue to use the electronic media that has served them so well, and an entire industry has developed to support all forms of social and electronic media.

Another exciting use of the electronic world is the ability to stream video. This allows a psychologist to have a session with a patient when they are in different locations. Controlled studies in telepsychiatry have shown that this method is effective and that patients embrace this approach. There is no reason to believe that psychology won't see results similar to that in telepsychiatry.

In military parlance, this is a force multiplier. It allows care to be provided to an underserved portion of the population who, for one reason or another, have not been able to get the care they need or want.

Unfortunately, the technology has advanced faster than the regulations that govern it, possibly affecting the standard of care that is the basis of good clinical practice. Electronic record keeping and telemedicine have helped advance patient care but improper use of the current technology can lead to lawsuits, state board sanctions and governmental fines. If the clinician does not take the proper precautions to protect patient privacy there will be legal ramifications.

Since the thrust of this article is managing the risk of these new and expanding technologies, some of the requirements and limitations surrounding these developments are highlighted below:

1. The license(s) that you have are state specific. If a patient is not within those geographical boundaries, you may be practicing without a license, (e.g. Teletherapy).
2. Any transmission of Personal Healthcare Information (PHI) must be encrypted as well as Teletherapy sessions. This is more than password protection. Therefore, be very careful that any information you communicate with a patient is in an encrypted electronic format. Lack of encryption is a violation of federal statute (HIPAA, HITECH) and subject to a heavy fine.
3. If you use your computer to store your patients’ files, that data must be encrypted beyond password protection. If the computer is stolen, you are subject to a fine for every record on the computer. The remediation cost can be staggering. (Recently a physician lost a laptop with unencrypted medical records of 3,600 patients on it. The employer of this physician was fined $1.5 million.)

Distance treatment using non-HIPAA compliant systems is a breach of federal law and an automatic breach of confidentiality. Currently there is no informed consent provision that waives this requirement.

All the major mental health organizations, including the APA, are formulating standards to deal with the way services should be provided in an electronic format. These standards are the first basic step to allow new procedures to occur in a fashion that will benefit patient and provider.

It is a basic tenet of risk management that there are standards, so that the care that is given can be administered, documented and evaluated properly. The current lack of established guidelines leads to an inability to define proper care and puts all practitioners in jeopardy due to a lack of uniform standards approved by governing entities.

Black psychologists oppose death penalty

The Association of Black Psychologists unanimously approved a resolution opposing death penalties at its 44th Annual Conference in Los Angeles earlier this year.

The resolution advocated abolishing death penalties on a variety of grounds, including statistics that show blacks are most vulnerable to wrongful conviction and capital punishment and that there is a risk of executing innocent people regardless of race or ethnicity.
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Ethical and risk-managed telepsychology practice:
a beginner’s guide

By Eric A. Harris, J.D., Ed.D. and Jeffrey N. Younggren, Ph.D.

Telepsychology is exploding, but many psychologists remain in the dark about when and how it makes sense for them to dip their toes into the flowing river that is running rapidly by their office doors.

The American Psychological Association Insurance Trust (The Trust) has been offering workshops on this subject for two years and we have found there is an enormous interest in this area among practitioners seeking guidance about how to proceed.

Further, the consultation calls we get indicate that many psychologists are faced with actual situations where it makes sense to them to continue services to clients making use of some type of telepsychology platform. This article is intended to provide some basic ethical and risk management suggestions about how to proceed when and how to provide these services.

Before starting, we need to clarify that this article will not address the legal and ethical arguments regarding the legitimacy of interjurisdictional practice. The authors have addressed these issues elsewhere. (Harris, E. and Younggren, J. “Risk Management in the Digital World” Professional Psychology: Research and Practice, V 42, #6 2011) Most commentators, including those who represent the interests of states in protecting consumers, believe that this issue will eventually be resolved so that practitioners who are licensed in one jurisdiction will be able to acquire the ability to practice across state lines. Meanwhile, if the suggestions made in this article are followed, the risk of any legal or ethical problems is minimal.

The APA Ethics Committee has opined that it has no problem with remote telepsychology so long as practitioners apply the same standards they would in any emerging area where generally recognized standards for preparatory training do not yet exist. Practitioners should take “reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm.”

Since most of us do not have training or experience with remote treatment, we would be wise to start with cases where an argument can be made that providing the services remotely is superior to, or at least equal to, an in-person referral. Some clear examples of such situations include:

1. Where the services are provided in the context of, and/or in service of, an existing treatment relationship (e.g., if a patient travels regularly, if a college student is going home for the summer, if a patient is moving to a different location or if both parties feel that continuation is better than transfer);

2. Where in-person treatment is either difficult or impossible to access where the patient resides (e.g., where the patient is a resident of a foreign country where English-speaking therapists are rare; where a provider is treating a child of divorced parents and one parent lives in another state; where the provider has a particular specialty or expertise that the client, after appropriate research, has determined is well suited to their particular needs; or where the patient has great difficulty traveling to the provider’s location).

3. Where remote services offer practical advantages over in-person treatment (e.g., where progress is facilitated by short, regular interactions rather than weekly hourly sessions; where clients feel more comfortable communicating remotely than in person; or where clients have very busy lives, making remote sessions more efficient).

4. Where the client desires remote treatment and the psychologist has sufficient information to assess whether this is a rational, informed decision (e.g., where a client feels more comfortable in sharing personal information that is embarrassing or shameful through electronic technology.)

If the case falls into one of the above categories, one can move to the questions that should always be asked before beginning treatment. Do you have enough information about the client and his/her problems, goals and objectives, mental health history and previous treatment to be able to assess whether the client is an appropriate telepsychology candidate? Many experts feel that some in-person assessment is necessary to make this decision. Past records or discussions with previous psychotherapists may be enough in some situations.

The important thing is to discover whether there are risk factors that make the case inappropriate. You don’t want to be treating someone in Denmark and then discover that he/she has a serious untreated bipolar disorder and is in the midst of a serious manic episode with no local psychiatrist involved. Obviously, the more history one has with a patient, the better one will be able to assess these factors.

Client motivation is crucial since you...
Ethics of telepsychology

Continued from prior page

will not be able to control the environment where the client will be receiving the services. The Army and the Department of Veterans Affairs currently require services to be received in a facility with appropriate supervision, a circumstance which will not be possible for most private practitioners.

If the client is paying for the treatment, that will provide some incentive but the psychologist will have to discuss with the client the need to minimize distractions and interruptions. It is also very important to know how to provide technologically based services or, better said, to be technologically competent. Sadly, at this point, finding information and training in remote service provision will require some effort.

There are good continuing education courses and books on telepsychology available and there will be more available soon. Also, you should check the telehealth guidelines that are available. (For example, Division 29 of APA has a published set of telepsychology guidelines and APA is under way in developing its own.)

Consultation with colleagues will help identify issues you have not thought about and will also provide backup for your judgments in the event that some type of legal or administrative action is taken against you. Choose a technology that you have or can develop some familiarity with. Technology that most approximates an in-person visit with the maximum amount of privacy protection and reliability would be ideal.

At this point, perfect choices are very expensive but they can be expected to become cheaper. You can find a lot of valuable information by using Google to research what is available or by using list serves to which you belong or which are set up to discuss telepsychology. As previously noted, competence with the technology you are using is vital. Obviously your first experience with Skype or Facetime should not involve a remote patient.

All of the existing telehealth guidelines put particular focus on informed consent. The client will need to have an adequate understanding of the technologies that will be used, potential problems, reliability and privacy and security problems. This will allow the client to decide whether the benefits of proceeding outweigh the risks.

In addition, the psychologist’s and client’s lack of experience should lead to an agreement that if the treatment is not working other arrangements will have to be made.

Agreements will have to be made about other issues as well: For example, how and if contact can be made between sessions and what will happen if the technology fails in the middle of a session. It is very important that specific arrangements be made for an emergency, should that occur. In that spirit, requiring an emergency contact where the client is located is highly recommended.

Finally, realize that if there is a problem that leads to a licensing board complaint, board members, who are conservative by nature, are likely to be skeptical about telepsychology practices. If this turns out to be the case, good documentation of your thinking process, comprehensive informed consent, consultations with other professionals, discussions with clients and assessment of the effectiveness of your work will be crucial. It is only in this fashion that you will be able to argue that your conduct was consistent with the standard of care.

CE

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APA touts psychotherapy over drugs

The APA has launched an initiative to educate the public on the benefits of psychotherapy compared to drugs with animated shorts that feature the fictitious drug “Fixitol.” Each animation begins as a spoof ad for Fixitol (Fix It All) that purports to cure depression, anxiety and almost any other mental disorder. After noting that “Fixitol is not available in North America, South America … (or the rest of the world),” the message suggests patients ask their physicians about seeking help from a psychologist as a treatment option.

The animations may be viewed at www.apa.org/psychotherapy.

The hope is to provide some balance from the barrage of information about drug therapy consumers are exposed to from commercials and pop culture.

“While medication can be an appropriate part of treatment, people should know that psychotherapy works,” said Katherine Nordal, APA’s executive director for professional practice. “Hundreds of studies have found that psychotherapy is an effective way to help people make positive changes in their lives. Compared with medication, psychotherapy has fewer side effects and lower instances of relapse when discontinued,” Nordal said.

Federal estimates are that one in 10 adults in America report having depression and between 1996 and 2008, the number of prescriptions for antidepressants more than doubled from 55.9 million to 154.7 million.
Rip Van Winkle’ looks in on psychology today

By V. Edwin Bixenstine, Ph.D., ABPP

Revising a long neglected manuscript on psychotherapy led me to a catch-up review of the literature covering about 30 years. The exercise caused me to feel a bit like Rip Van Winkle down from the mountains. The state of psychology today, as regards its clinical applications, is not at all as I expected. Instead of convergence of theory, agreement on treatment procedures and a more confident base in empirical knowledge, I found divergence, contradiction and uncertainty.

Fomenting this state of affairs are recurrent meta-analytic studies launched to wrest clarifying generalities from thousands of diverse researches on psychotherapy. What has emerged, however, while reliable, is a perplexing if not confounding conclusion. No theory-based approach has been found more effective than any other.

Psychotherapy in general does show modest benefits over no therapy at all, although there is a downside risk that some persons (5 percent to 10 percent) will fare less well than had they not received therapy at all. This is about where we were 76 years ago when Saul Rosenzweig introduced his wry “Dodo Bird Hypothesis” that different therapy approaches, like contestants in Alice in Wonderland’s foot race, are all winners “and all must have prizes.”

Yet, in spite of the substantial empirical support for the Dodo Bird Hypothesis, many if not most psychologists reject the idea that some therapy approach will not be found to excel over all others. Inventive explorers continue searching afield for new approaches, such as “mindfulness” (borrowed from Buddhists thinking) or “narrative therapy,” all adding to the burgeoning numbers of divergent approaches (estimated at 400 or more).

Many psychologists act, however, as if these meta-analyses results did not exist. For example, there is a strong professional (APA backed) movement to emulate medicine and sanction only EST (Evidence Supported Treatment), which sounds good but on its face simply denies the relevancy of meta-analytic results. We do not have reliable evidence supportive of this-over-that procedure.

In addition, imposing an EST restriction would discourage clinical exploration of new (untested) and possibly more effective treatment approaches. Another problem is that psychotherapy of whatever approach utilizes a human relationship rather than a pill to carry the active ingredient to the distressed person. This makes psychotherapy research far more challenging than drug research. For example, how does a blind control (placebo) therapist not know the facts and knowing, how to participate in an authentic helping relationship?

There are those seeking to calm insecurities of professionals who are doing therapy or teaching it by assuring them that psychotherapy in general works, if not always well, at least better than no therapy. They advise dispensing with endless and futile efforts to confirm some superior therapy theory. Even if the benefit of therapies we consider boils down to a placebo effect, as long as those effects over all are positive and the therapy is construed in psychological terminology, then it remains a legitimate application and province of our discipline.

Unfortunately, this position simply surrenders to the Dodo Bird Hypothesis. Yes, it may give some succor to beleaguered practitioners, but such aid comes at the cost of abandoning psychology the science. Theory in science is more than mere suasion, more than a convincing narrative. Theory, sufficiently undergirded in empirical evidence, is what we call knowledge. However, the Dodo Bird essentially says theory is irrelevant.

But why would all these therapy theories, so varied in terms and concepts, be alike in bringing indistinguishable results? I would argue that there is a fundamental way all researched approaches are indeed the same. They all advance, often implicitly, the same starting premise – that the basic cause of human psychological distress is negative emotions that inspire various obsessive, ameliorative efforts (symptoms) and which have been seared into our psyches by both distant and current traumas. The goal, then, of psychotherapy is to annul these negative, victimizing emotions.

This premise, moreover, is so prevalent and unquestioned that you may well find its rendering here merely a statement of the obvious, a fact rather than an assumption. Unless you are nearly as old as I am, you might not recognize that 60 years ago O. Hobart Mowrer explicitly challenged this assumption and advanced a critically contrasting premise – that the basic cause of human distress is not “negative” emotions but “negative” behaviors, behaviors incompatible with troubled persons’ values.

These behaviors represent departures from personal integrity and prompt those painful emotions (such as guilt) and subsequent efforts to deny and minimize them. It follows that the goal of psychotherapy is not to dismiss emotions but, instead, to attend to them, be instructed by them and to discover from them what behaviors troubled people may be well advised to change.

If Mowrer’s integrity theory focusing on changing behavior is right and the trauma theory focusing on changing emotions is wrong, then no matter how therapy is terminologically construed as it endeavors to annul negative emotions, it will be less useful than it could be and perhaps even harmful – precisely the results of the meta-analyses.

We do not need research on yet another “new” therapy based on the same underlying premise. We should be fairly confident now that the results will be unremarkable. What we do need is a wide-gauged research effort to examine an “old” therapy, now all but forgotten, but grounded in a truly different premise about the nature of human psychic misery and the focus of psychological intervention.

The arguments I have presented here are elaborated and referenced in a manuscript, yet unpublished, titled “Integrity Therapy, How Do It and Why Do It: O. H. Mowrer’s Theories Revisited.”

Email me should you have an interest in examining these matters in greater detail.

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Many credentials in mental health are questionable

By Jerrold Pollak, Ph.D.

Consumers of behavioral health care services are confronted with a bewildering array of practitioners with a multitude of graduate degrees, certifications/licensure and titles. This includes so-called “vanity” credentials too often conferred based on a resume, a “work sample” and payment of a fee.

The proliferation of credentials has been driven by the dissemination of information afforded by the Internet, the heightened competition for jobs and private practice opportunities resulting from restrictive managed care practices and the increasing graduation rates in graduate programs in behavioral health care since the start of the new century.

The pursuit of credentials is likely to intensify in view of the growing number of “fast track” masters and doctoral level programs in behavioral health care that offer the allure of completing nearly all degree requirements on line. The “tipping point” appears to be rapidly approaching when a bachelor’s degree from just about anywhere awarded in nearly any area of study, together with the ability to pay tuition and related costs “up front,” may suffice to initiate the matriculation process when it comes to many of these graduate programs.

“Gilding the lily” with regard to credentials for professional practice extends to all the behavioral care professions. However, the biggest offenders come from the fields of mental health counseling, clinical social work and professional psychology.

Clinical psychiatry is clearly not lacking in critics and skeptics, including many from within its own ranks. Still, it has done a better job at adhering to standardized education, training and credentialing than the non-physician/M.D. behavioral health care professions. In contrast to clinical psychiatry, there is considerably more heterogeneity in the non-medical behavioral health care fields with respect to education, training and credentialing.

In tandem with the “Zeitgeist” of “life long” learning and the growing popularity of on-line education, there has been a rise in the number of mid- and late-career masters degree level professionals in mental health counseling and clinical social work who have been awarded doctorates in professional psychology and related fields.

Some of these graduates do not qualify to take the psychology licensure examination. Others decide against taking this examination or are unsuccessful at passing it. These clinicians continue to bill for their services under their masters level license while referring to themselves as “doctor so-and-so” and, at times, “sinning by omission” as to the precise nature of their additional education/training and licensure status.

Within professional psychology, controversy continues as to who can legitimately use the title of “psychologist.” While a doctoral degree in psychology and a state license are needed for entry level practice in nearly all states, West Virginia and Vermont recognize master’s level practitioners. School psychologists, most of whom hold masters degrees, routinely refer to themselves as psychologists.

There is also the problem of licensed psychologists who arrogate titles that fall outside the parameters of their license. This includes practitioners who refer to themselves as a “licensed clinical psychologists” or “licensed clinical neuropsychologists” when their state license (which, in most states, are generic licenses as is true in medicine) only permits the title of “licensed psychologist.”

As well, there are psychologists who conduct evaluations of patients with benign medical/neurological histories with questions of attention deficit disorder and/or one or more learning disabilities. To establish this niche practice, some of these clinicians market themselves as neuropsychologists despite limited, if any, formal training in clinical neuropsychology.

This is akin to primary care physicians, who may treat patients with migraine headache, referring to themselves as neurologists or dermatologists, who offer botox wrinkle reduction treatment, advertising as cosmetic surgeons. Worse still, are those psychologists who broaden the scope of their practice from assessment of attention and learning difficulties to evaluation of persons with known or suspected acquired neurobehavioral impairment.

There are many dubious titles to go around – behavioral coach, medical psyc-therapist, forensic examiner, disability consultant etc. These are not titles regulated by state law, recognized as legitimate specialties by the APA or credentialing boards like the American Board of Professional Psychology or conferred on the basis of rigorous examination and peer review.

The burnishing of questionable credentials/titles is enabled by the historic failure of the behavioral health care professions, including clinical psychiatry, to develop any good competency-based tests for entry level or advanced clinical practice.

Unfortunately, state licensure and even board certification/diplomate status, conferred by well regarded credentialing organizations like the American Board of Professional Psychology/ABPP, American Board of Professional Neuropsychology/ABN and the American Board of Psychiatry and Neurology does not insure competent and ethical practice.

There are excellent resources available that review the licensure/certification and board examination process in professional psychology. It is far from clear, however, whether graduate students in behavioral health care programs, including professional psychology, are being taught about legitimate and ersatz credentials.

Recommended for reform

Consumers of behavioral health services should be better informed about the education/training of practitioners from the ranks of all the behavioral health care professions. Caveat emptor should prevail when it comes to website advertisements of credentials claimed by practitioners in behavioral health care.

Graduate programs in behavioral health care need to do a better job of educating students about legitimate and faux credentials.

Licensing examinations have to become much more competency-based. Despite its 35-year-plus history, the content/format of the Examination of Professional Practice of Psychology has not substantially changed.

Furthermore, this entry level examination has never demonstrated a clear relationship with competent or ethical practice.

Academic/research psychologists with no clinical training, but some prior study of the APA ethics code and state licensing laws, are probably still in as good, if not a better position, to pass this examination than many graduates of doctoral training programs in professional psychology.

Data are needed on the opinions of behavioral health clinicians regarding vanity credentials, the numbers of clinicians who have obtained or are considering seeking such credentials and the ways these credentials are marketed to the public and to prospective employers.

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health capacity, as brain injury can manifest itself in a multitude of ways.

* Consider providing (and marketing) a post-concussion protocol (possibly in conjunction with a neuropsychologist) for current and former players.

* Encourage athletes to obtain MRIs or brain studies to assess possible brain injury.

* Provide psycho-educational information about the connection between physical injury/head trauma and mental health challenges as a means of helping athletes and organization understand and possibly prepare for such challenges.

* Provide counseling focusing on impulse control, substance abuse, grief and loss and anger management.

* When working with current or former players consider integrating strategies to increase memory and slow down potential side effects of brain injury.

* Help educate former players about health benefits they are eligible for and assist them in accessing those resources.

* Encourage honest communication between athletes, coaches and trainers around sports-related injuries, particularly head injuries.

* Help increase awareness related to physical health and increase ability to assess readiness to return to play realistically following injuries.

Shaun Tyrance, Ph.D., is a licensed therapist who specializes in sport psychology. Shaun earned his Ph.D. in counseling from the University of North Carolina at Charlotte, and his masters in sport psychology from the University of North Carolina at Greensboro. He was a four-year varsity letter winner in football at Davidson College where he played quarterback. He may be reached at shaun.tyrance@gmail.com

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Symptoms vary in head injuries

Continued from Page 6
Appreciating the sparkle

By Emily Moore, MFT

A sweet piece of terminology that I picked up from my studies of narrative therapy is “sparkling moment.” The idea is to search for what shines in a positive way by contrast to the predominantly dark problemsaturated stories our clients can be stuck in.

The challenge in this situation is to locate a moment that sparkles in the eyes of the client. Regardless of how brilliantly something stands out in our minds, it’s dull as a coal smudge if the client is not on board with acknowledging it as an exception to the rule, or a “unique outcome,” as the Australian family therapist Michael White would say.

In simple terms, narrative therapy posits the idea that we make meaning out of our lives by stringing together moments in our lives of which a story can be made. Because there is no such thing as an “objective reality” according to the post-moderns, the story we construct from moment to moment is only one of an almost infinite number of choices.

However, once we have created a story for ourselves, our minds immediately begin to filter out experiences, thoughts, feelings, relationships and pieces of our history that do not make sense within our pre-existing story. Because this happens, whatever story we have adopted tends to grow bigger and stronger over time as we collect more and more instances that appear to support it.

In the process, other possibilities and other realities that might provide the structure for a very different story are left unseen, their value unacknowledged. The hopeful, liberating idea is that if we pay attention to moments, experiences etc. that we acknowledge cannot be made sense of within the problematic story to which we have become so attached, other stories will emerge and meanings and identities we thought were permanent fixtures start to make room for new realities about ourselves.

As therapists, it is sometimes hard to maintain a sense of freshness about our work. It can be challenging to sustain an attitude of hopeful curiosity about what might be coming next. This can be true under various circumstances: if we feel tired and unappreciated or if difficult problems with no easy solutions seem to fly at us relentlessly or if we have had a big disappointment in our professional or personal lives, as a few examples.

At times like these, we need to look for sparkling moments that may have been hidden under a thick layer of frustration and discouragement, moments that simply will not conform to our temporarily dreary perception of ourselves as not-very-good therapists and the world as tired, old, predictable and boring.

A client of mine came in who has been seeing me for more than two years on a weekly basis. Together we have gone through days of despair, self-loathing and hopelessness that have appeared to her to be certainly interminable. The person she was two years ago would not have believed that she could ever be the person she is today: she would have tossed that person off as fiction.

Today, however, she is able to see herself as happy, capable of being alone as well as in relationships with others, clear about what she wants and what she will accept in life and much more in control of her life and its direction than she was in the past.

Today she sparkles and serves as a reminder that life, as a therapist or otherwise, will produce moments of delight and that they may be waiting just around the corner.

Emily Moore, MFT, is a licensed family therapist who practices in Pasadena, Calif. Her email is: emily@emilymooremft.com.

USC fosters technology advances

An article in the July/August edition of The National Psychologist on virtual reality treatment for PTSD incorrectly said the Institute for Creative Technologies (ICT) is affiliated with the University of California. It is actually affiliated with the University of Southern California.
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Learning from a master:

My experience with Carl Whitaker

By Len Bergantino, Ed.D., Ph.D.

Carl A. Whitaker, M.D., was a pioneer in psychotherapy as well as family therapy. He co-authored the master classic, The Roots of Psychotherapy, with Thomas P. Malone, M.D., Ph.D. Whitaker’s major contribution was freeing up the use of self to shoot from the hip concerning such unconscious materials as suicide, homicide, incest etc. that therapists and patients customarily do not deal with.

I first met him when he came to the Bonaventure Hotel in Los Angeles and presented to 700 licensed psychiatrists, psychologists and social workers. He began by telling a story about a farmer and his son:

Father: “All right, son. I will see you in a couple of days.”

Son: “Well, dad, I found her but she was a virgin.”

Father: “Son, you did the right thing. If she wasn’t good enough for her own family, she isn’t good enough for us!”

Two days later the son came back.

Father: “Well, son, where is she?”
Son: “Well, dad, I found her but she was a virgin.”

Father: “Son, you did the right thing. If she wasn’t good enough for her own family, she isn’t good enough for us!”

The 700 clinicians in the room were in disbelief.

Later, I went up to him and said, “Dr. Whitaker, I spent a week at the Atlanta Psychiatric Clinic getting to know Tom Malone but I never got a sense of his style of work. You were very good at demonstrating your style. I wonder if you could give me an example of how Tom Malone actually worked.”

Whitaker pensive looked up in the air for a moment and then said, “Tom Malone was catatonic, but you ought to look him up. I think he has something to offer you.”

He subsequently wrote the foreword to my book, Psychotherapy, Insight and Style: The Existential Moment. (Allen and Bacon Inc., Boston.)

I saw Whitaker at The Evolution of Psychotherapy Conference after Milton Erickson’s death on March 3, 1980. He said he and Erickson met only once. Erickson picked him up at the airport when he was invited to be a guest speaker at Wayne State Hospital.


Whitaker said they never spoke another word to each other.

I asked Whitaker to supervise me and he agreed to do so by speakerphone, as he was at the University of Wisconsin Medical School and I was in Los Angeles. He kept throwing down the gauntlet, realizing I was dedicated. He kept saying, “How can I take you seriously that you want to learn family therapy when you don’t have your own family in family therapy?”

So I mobilized my parents in Connecticut, my wife and her parents and her brother and his girlfriend with a speakerphone in Los Angeles and Whitaker worked 26 weeks with all of us once a week by speakerphone coast to coast.

My parents had been considering moving to Los Angeles near me for years and brought it up in one session. Whitaker raised every fear they had not voiced:

“You have to be crazy to uproot at your ages and move close to that one-way son-of-a-bitch son of yours who is so involved in his practice that he will never make time to see you. You will be giving up all your lifetime friends and family.”

And then, in the last seconds of the session, he said, “Take a chance,” and hung up.

I did not think much about it, but I got a phone call from my father two days later, saying, “Len, your mother and I are moving to California. We will be there in two months.”

So, Whitaker gave me something of value: my parents for the last few years of their lives.

The other thing I learned from him is that in doing family therapy it is imperative to have the battle for control right in the beginning and win it in terms of getting all the family members present, such as mother, father, children and grandparents on both sides and, where applicable, the lover of one or both spouses. A paranoid situation will be set up if you only bring one spouse in later.

Whitaker worked with me only long enough for me to set the dynamite necessary to get all family members involved. He refused to work with a family if only some were present. “I have enough blood spilled,” he said. “I don’t need another failure. I have already failed enough times. Are you sure you want to do this? I am not a good as you heard.”

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Len Bergantino, Ed.D., Ph.D., is a licensed psychologist in California, Arizona and Hawaii with an ABPP diplomate in family psychology. He is the author of Psychotherapy, Insight and Style: The Existential Movement. He may be reached at Dr.LenBergantino@gmail.com or 310-207-9397.

MMSE screener available for mobile devices

PAR Inc. announced that the MMSE/MMSE-2 screen for cognitive impairment is now available as an app for smartphones and tablets.

“Like the paper-and-pencil version, the app can be used to screen for cognitive impairment, to select patients for clinical trials research in dementia treatment, or to track patients’ progress over time,” the company’s press release said.

The app includes an instructional video to walk users through its features and is available in the original, standard and brief versions of the MMSE.

Scoring is done automatically, and patient records can be uploaded directly to an electronic medical records (EMR) system or emailed to appropriate personnel. Equivalent, alternate forms of the MMSE-2 decrease the possibility of practice effects that can occur over serial examinations. The app also includes norms for both versions by age and education level.

The app is available to qualified health care professionals from the Apple® App StoreSM (for the iPhone® or iPad®) and from Google Play (for Android™ devices).
In their July/August 2012 Viewpoint, “Practice opportunities with gifted children and their families,” Webb, Gallagher and Kuzujanakis make a number of erroneous statements about gifted children. Based on extensive literature searches of three databases, the following were found:

1. Traits listed as “often misdiagnosed as psychopathology” are not characteristic of gifted children, such as delayed speech/language and reading difficulties. Gifted children are advanced in talking and reading.

2. Symptoms characteristic of ADHD are listed as traits of giftedness. Research studies of executive functions, self-regulation, attention, distractibility and cognitive inhibition of gifted children without ADHD show superior ability compared to average children without ADHD. Gifted children without ADHD do not show the deficits in attention, inhibition, distractibility and performance speed shown by children with ADHD. These are not traits of giftedness.

3. Webb et al. state that gifted children are at risk for misdiagnosis for ADHD, Asperger Syndrome and Oppositional Defiant Disorder without any research evidence that this is so. No studies have been done. The literature shows supposition and opinion that gifted children are being misdiagnosed, without any clinical basis.

4. Webb et al. stated that there is strong clinical support that gifted children are at increased risk for anorexia, obsessive-compulsive disorders and depression. Far from strong clinical support, there are no clinical or research studies that show increased prevalence of any mental health disorder for gifted children. The few studies that exist show similar levels of anxiety and depression as in the general population.

Gifted children do have special academic, social and emotional needs, and clinicians working with them need education about how best to serve this population; however, information needs to be checked to determine its validity.

Deirdre V. Lovecky, Ph.D., Director
Gifted Resource Center of New England
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Lovecky is the author of Different Minds: Gifted Children with AD/HD, Asperger Syndrome and Other Learning Deficits. She may be reached by email at: GRCNE02940@aol.com.

Editor’s note: James T. Webb, Ph.D., Rosina M. Gallagher, Ph.D. and Marianne Kuzujanakis, MD, submitted this response. Webb is lead author of Misdiagnosis and Dual Diagnoses of Gifted Children and Adults. Gallagher is president of the Illinois Association for Gifted Children and Kuzujanakis is on the board of SENG (Supporting Emotional Needs of Gifted).

Their response: We agree that 1) clinician education requires training in giftedness, and 2) there is need for further research in this area.

To clarify our basic premise, we acknowledge that some gifted children do suffer certain disorders, but many, in our experience, are being misdiagnosed for lacking understanding of asynchronous development (brain studies report prefrontal cortical delays) and the effects of educational mismatch and/or environmental stress.

Most of the research is summarized in Misdiagnosis and Dual Diagnoses of Gifted Children and Adults, and in dissertation studies suggesting gifted individuals are more at risk for certain disorders (bulimia, cutting, etc.). Further research is under way.

The rise in ADHD and Autism Spectrum, among other diagnoses, is alarming. This may be due to increased awareness, but also arbitrary treatment before confirming diagnoses. Learning disabilities are not always properly identified. Yet there is no training available to help pediatric clinicians understand giftedness and complex multi-exceptionalities. Giftedness may mask a disorder or a disorder may mask giftedness.

Roger T. Strachan Ph.D.
Director, Center for Creative Choice
Prescott, Ariz.

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Cancer.
It’s a very scary word, one most of us have had to deal with and one we associate with many different things. Whether it has affected us personally, a family member, a friend or a friend of a friend, we have all endured cancer in some way. While it is never easy, it affects each person differently, each coping in his or her individual style.

I did not personally suffer from cancer, but had to experience my father enduring the illness, as well as the residual effects it had on my entire family. As a result, I understand how challenging it can be, the influence it has on a person’s mental health and the obstacles it creates in reaching one’s goals. Just as I was embarking on my academic goals and adjusting to the grueling nature of graduate studies, I was overwhelmed by the effects of cancer.

My story begins as I was about to start student orientation of my Ph.D. program in clinical psychology. Unfortunately, my graduate academic career did not start off as I had anticipated. My excitement quickly dissipated and my nervousness about the long, arduous academic path ahead was replaced with the guilt of leaving my sick father at home.

The subsequent semesters of my first year of graduate school are a blur. I learned a lot from my classes, but learned more from my own life experiences in those first months. I worried incessantly about writing top-notch papers, doing endless research and perfecting assignments all in tandem with the incessant worry for my father’s comfort, safety and well-being.

This steady focus on my school work aided in dealing with cancer. I knew that being preoccupied and solely focused on negativity was not a healthy way to function and my studies were just the distraction I needed. Even so, there needs to be balance and harmony in what preoccupies our thoughts.

Everything around me began to be about cancer; everything I read, everything I heard, everything I did. In an attempt to ground myself, I began practicing yoga as a way to de-stress and detoxify my mind. While knowledge is power, so is making the right healthy choices and staying on track.

While going through all of this, a friend read me a very powerful and insightful email from her friend’s brother who was also suffering from cancer. He wrote how in coping with his cancer, he had no expectations. He couldn’t have prevented it from occurring so now he would just deal with it as it came. He said his “decisions appear so clear. It is as if there is only one option in the world; to get better ... whatever the prognosis … it was always 100 percent.”

To know that such a young person was suffering with what I was watching with my own eyes and had such a clear outlook on life was incredibly refreshing. I looked at my father and saw before me a hero. It changed my perspective on life and gave me the strength to carry on.

I would never wish to have a friend going through the same thing I did, but the mutual understanding helped immensely. Friends and family who provide loving and caring support is crucial. My extensive support system helped me air my worries and maintain a clear, focused mind. My mental health was vital in caring for my father, as well as my mother. With the help of my support system, I was able to mentally and emotionally be there for my mother at her most vulnerable moments.

All the while I felt that I had to be the strong one. I had to keep reminding myself that it’s O.K. to show weakness and cry; in fact, it’s human. Even now that my father’s health has returned, worry is still prevalent. When a disease like cancer strikes, it takes the immune system with it for a while. Therefore, practicing healthy living is key.

Even though there is no cancer to worry about, the stress and anxiety of being in graduate school suddenly caught up with me. My distraction from cancer was school, but my preoccupation with cancer ended up distracting me from school.

It seemed to hit really hard how heavy a work load graduate school can be. So maintaining that balance, support system and focused mind is still essential. Take on the burdens that others cannot carry, but remember to show compassion and love – and receive it back.

If there’s one thing I’ve learned it’s to never be afraid to ask for help and never be afraid to show emotion. You’re human. And people will be there for you; they are human too.

Amy Todey is a doctoral student at the University of Georgia in the Division of Counseling Psychology. She is the American Psychological Association of Graduate Students’ state advocacy coordinator for Georgia and campus representative to Student Affiliates of Seventeen, the student affiliate group for Division 17 of APA. Avocationally, Amy works as a collegiate women’s basketball official in the NCAA. Her research interests include private practice issues and the experiences of female sports officials. Her email address is: amytodey@uga.edu.

By Lisa Bolshin

Learning the business of practice in grad school

There were two equally important motives that attracted me to the field of psychology. First, I had a natural desire to help others and felt that I possessed the intrinsic qualities of empathy, altruism and intuition that I envisioned to be a necessary part of the profession. Second, I wanted to be a small-business owner, to utilize my creativity and ingenuity to grow a psychological practice from scratch, knowing that this would afford me the freedom and autonomy that are at the core of my personal values.

While therapeutic qualities of warmth, compassion and charity are germane to my personality, the assertiveness, pragmatism and profit-mindedness requisite of successful business people are intrinsically foreign. Similarly, my doctoral training successfully reinforces my natural therapeutic abilities while neglecting the entrepreneurial skills that I need most help developing.

I am discouraged by messages from psychology-educators and practice professionals that financial ambition and psychological healing are incompatible goals, that I will be unable to have a lucrative career as a psychologist and that the complications of private practice outweigh its benefits. Taken together, these perceived obstacles have made my dream of becoming a successful independent psychologist-practitioner seem daunting and elusive.

With 34 percent of psychologists choosing careers in private practice, I know that I am not alone in my concern that my graduate training does not sufficiently prepare me for independent practice. As students, it is incumbent upon us to hone fundamental entrepreneurial skills to complement our clinical expertise.

There are several things that have made this business learning possible for me. First, through networking I have formed relationships with several successful independent practitioners who serve as mentors to me, offering career-related advice, sharing important private practice issues and presenting me with future job opportunities. I am a member of divisions of the American Psychological Association such as Division 42 (Independent Practice) that offer leadership and professional growth opportunities specific to private practice.

Second, I have gained professional business skills through financial classes, private practice workshops and practicum training in a private practice setting. These experiences have offered clear strategies for developing a business plan, finding a niche and marketing my future practice.

Third, as much as possible, I have taken advantage of open-ended course projects to research and write about my practice goals. While the learning of small business skills is difficult in graduate school in light of all of our other educational demands, my initiative to connect to the private practice world has made my doctoral training more focused and meaningful and has restored my hope that a successful independent practice career is possible.

Amy Todey is a doctoral student at the University of Georgia in the Division of Counseling Psychology. She is the American Psychological Association of Graduate Students’ state advocacy coordinator for Georgia and campus representative to Student Affiliates of Seventeen, the student affiliate group for Division 17 of APA. Avocationally, Amy works as a collegiate women’s basketball official in the NCAA. Her research interests include private practice issues and the experiences of female sports officials. Her email address is: amytodey@uga.edu.

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National Psychologist Quiz
Vol 21 No 6 Nov - Dec 2012

New billing codes…
1. Which of the following is one of the major revisions in the new CPT psychotherapy codes for 2013?
a. The definition of psychotherapy has not changed substantially, but descriptions have been replaced with more modern language
b. Descriptions of therapeutic tasks have not changed, but the definition of psychotherapy has been replaced with more modern language
c. Diagnostic evaluation for psychotherapy, formerly code 90801, is now split into three diagnostic evaluation codes
d. The work value for psychotherapy done in a hospital or nursing home is different from office-based work

2. In the new system there is no separate code for a 90-minute psychotherapy session. The work group’s reason for this is:
a. long engagements with patients that exceed 75 minutes tend to be crisis situations, which have new codes
b. long sessions tend to be those that include significant others, which have separate billing codes
c. long sessions sometimes include time spent documenting the activity, which is not billed as psychotherapy
d. the session begins when it is formally started by the therapist, not at the start of face-to-face contact

Assessment of learning disabilities…
3. Which of the following statements about learning disabilities is true?
a. Reading disorders are due to slow processing speed
b. Variability in test performance is diagnostic of a learning disability
c. Reading disorders are directly related to visuospatial difficulties
d. Slow processing speed is associated with dyslexia or ADHD and may reflect their genetic linkage but does not cause either

4. Mapou says the largest amount of research on learning disabilities is in the area of:
a. mathematics disabilities
b. nonverbal learning disabilities
c. reading disabilities
d. written language disabilities

Risk management: digital age…
5. Which of the following statements about electronic record-keeping and teletherapy is true?
a. Most state licenses are valid across geographical boundaries for purposes of treating underserved populations
b. Lack of encryption is a violation of federal statute (HIPAA, HITECH) and subject to a heavy fine
c. Any transmission of Personal Healthcare Information (PHI) must be password protected
d. The regulations that govern technology have advanced at the same pace as technology itself

Ethics of telepsychology…
6. Which of the following is an example of a situation in which a case can be made that providing the services remotely is superior to, or at least equal to, an in-person referral?
a. There is an existing treatment relationship, and the client is moving elsewhere
b. The client has difficulty traveling to the provider’s location
c. The client feels more comfortable communicating remotely than in person
d. Any of the above, but with the added condition that the therapist has sufficient information to assess whether this is an appropriate choice

7. From a risk management perspective, which of the following is an important consideration in deciding whether or not to engage in teletherapy?
a. If a problem leads to a licensing board complaint, board members are likely to be sympathetic to the licensee
b. If there is a complaint, the current state of the evidence on teletherapy is likely to provide a solid defense
c. If there is a complaint, it is important to have very detailed documentation of informed consent discussions

d. If technology fails in the middle of a session, the client must understand that it is beyond the psychologist’s control

Rip van Winkle…
8. Bixenstine suggests that the concept of EST (Evidence Supported Treatments) has some complications, among them:
a. imposing an EST restriction encourages clinical exploration of new and possibly more effective treatments
b. emulating medicine will likely serve to enhance the practice of psychology
c. psychotherapy research is far more challenging than drug research
d. once we have reliable evidence supportive of this procedure over that one, some approaches will fall into disuse

Mental health credentials…
9. What do titles such as “behavioral coach,” “medical psychotherapist,” “forensic examiner,” and “disability consultant” have in common?
a. They represent a variety of valid specialties in the field of clinical psychology
b. They are not titles regulated by state law or recognized as legitimate specialties by the APA or credentialing boards
c. They are descriptors that can help consumers be better informed about the education/training of practitioners
d. They depict professionals who have passed competency-based tests for advanced clinical practice

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Miscellaneous

iCope: Stress Management for Teens and Young Adults by Anthony Cimino, Ph.D. This easy to read cognitive-behavioral self-help book teaches the four core stress management skills, and can be used within individual and group treatment formats. The book is ideal for 17-30 year olds. The paperback version (127 pgs.) is available from Amazon while ebook versions are on Apple or at www.smashwords.com for other digital formats.

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Three Question and Answer brochures: “Questions and Answers about ADHD” “Questions and Answers about Clinical Hypnosis” and “Questions and Answers about Clinical Psychology and Psychological Healthcare” Written in layman’s terms so clients can easily learn about these aspects of psychological treatment. Cost: $27/100; $50/200. P&H add $4.50 (1st 100 and $1.50 for each addl 100 (max. $15). (Ohio residents add 6.75% tax.) Samples .25 each + SASE with .65 postage. Send orders to: OPP, Inc., 620-A Taylor Station Rd., Gahanna, OH 43230, Fax: 614-861-1996, or 800-486-1985

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Revised ‘Bible’ of forensic testimony is excellent


Review by Martin H. Williams, Ph.D.

This is the sixth edition of a classic work in the field of psychology and law. It is a compendium of ways that psychological testimony or expertise can be employed in criminal, civil or administrative courts, along with an expose of the procedures, strengths and weaknesses of each. In this sense, it is an invaluable resource for attorneys seeking to find the flaws underlying expert testimony.

Even more important, it is a reference for any psychologist who plans on offering testimony, as it advises the psychologist on the choice of measures and procedures to employ, as well as what cross-examination questions to expect. It is an excellent and comprehensive book. Indeed, it has become The Bible of forensic psychology.

The book has evolved from the original intent and vision of Dr. Jay Ziskin, who passed away in 1997. Ziskin was the co-founder and first president of the American Psychology-Law Society, which later became Division 41 of the APA.

Back in the late 1960s and early 1970s, psychological testimony was heavily psychoanalytically informed. Thus, a psychologist might testify regarding some psychoanalytic “truth” that was completely unproven, unscientific and, quite possibly, was a bone of contention even within psychoanalytic circles. This expert might consider it appropriate to conceal from the court that some other psychoanalytic thinkers disagreed with him or her because that expert might hold those who disagreed in utter contempt.

BOOK REVIEW

Along similar lines, perhaps a Rorschach result, based on some impressionistic scoring system, would “prove” that a defendant was a psychopathic killer, and the psychiatric expert would explain this “fact” to the jury.

Ziskin looked at this state of affairs, along with other forms of psychological “knowledge” that were unproven and of unknown validity and was appalled. How could the courts rely on psychological “evidence,” how could juries be swayed by such evidence when it was not evidence at all? It was merely opinion, conjecture and belief masquerading as some sort of science.

Ziskin’s first edition predated the Daubert rulings of the Supreme Court that attempted to set new standards for scientific testimony. When Ziskin first published, the field of psychological testimony basically existed without standards. The original purpose of his book was to assist attorneys in demonstrating the often weak foundation of psychological testimony. No expert witness could withstand a cross examination guided by Ziskin’s book (being “Ziskinized”) unless that expert’s testimony was scientifically supported, valid and objective.

This sixth edition is brilliantly authored by David Faust, Ph.D., (co-author with Ziskin of the fourth edition). The series takes a different slant as the field of forensic psychology has changed. No longer is unfounded psychological opinion likely to be accepted unchallenged. Forensic psychology has evolved, largely in reaction to what Ziskin started, into a field with a solid scientific basis.

Today, testimony is often supported by valid, peer-reviewed findings. Nevertheless, data can be argued, bias can be introduced and the scientific basis can be stretched. Explanations can be offered as to why this particular set of findings, regarding this particular individual, should be interpreted using a modified set of standards – even unpublished and unproven ones. Experts can venture into the realm of unscientific conjecture where plausibility is taken as proof. Any attorney who reviews the relevant portions of this book will be prepared to punch holes in the testimony of any expert who oversteps the limits of scientific evidence.

The book contains 47 chapters, written by Faust along with other contributors who constitute a who’s who of leading forensic psychologists, attorneys, and psychiatrists. It is massive, over one thousand pages, and exhaustive. Although it retains Ziskin’s original title, Coping with Psychiatric and Psychological Testimony, and although it was originally directed to attorneys, who were the ones who needed to “cope” with said testimony, it is probably of greater use today to the psychologists and psychiatrists who might testify, rather than the attorneys who might employ or cross-examine them.

This is not to say attorneys will not benefit from reviewing the relevant chapters prior to cross-examining a psychological witness, but the book is steeped in the language of psychology and psychological research. If anyone needs to read this book it is psychologists!

Regardless of whether the question is testamentary capacity, competence to stand trial, insanity defense, a civil suit over a brain injury or psychological trauma, prediction of violent or sexual re-offense, matters of intelligence or substance abuse, this book will provide guidance. Its final section, on practical applications, is useful for attorneys and psychologists seeking assistance on the nuts and bolts of preparing psychological testimony and making it effective.

Ziskin would be proud of the latest edition of his classic work. Not only because the book is as authoritative as the editions prepared by Ziskin himself but because, thanks to Ziskin’s original challenge, he would have seen that forensic psychology has become a credible and useful scientific endeavor.

This is one book that every forensic psychologist must own and that every psychologist must consult should he or she ever be facing an interaction with the legal system.

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Martin H. Williams, Ph.D., is a forensic psychologist in San Jose and Los Angeles, Calif. He is on the Forensic Panel of the Superior Court of California. He is an approved evaluator for Immigration and Customs Enforcement, Enforcement and Removal Operations, San Francisco Region, and was formerly with the Forensic Assessment Division, Board of Parole Hearings, California Department of Corrections and Rehabilitation. He can be reached through www.drmwilliams.com.
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What’s happening across the USA

**California** – In September, California became the first state in the country to ban controversial therapy practices that attempt to change the sexual orientation of minors. The law bars mental health practitioners from performing so-called reparative therapy, labeled by professional psychological organizations as potentially harmful and by gay rights groups as dangerous and abusive.

**Connecticut** – Research at Yale University continues to support the promise of ketamine as a treatment for depression. A study released in the Oct. 5 issue of *Science* said that administering small amounts of the drug regenerates synaptic connections, bringing patients almost immediate relief. Psychotherapy still is recommended from depression’s most debilitating symptoms. Ketamine is used illegally as a “party drug” known in street lingo as “Special K.”

**Florida** – A federal suit filed two years ago by forensic psychologist Michael Brannon after his yearly income from the Broward County Public Defender’s Office fell from $608,757 in 2007 to $390,000 in 2008 then to $170,162 in 2009 and $12,800 in 2010 has been dismissed. Brannon contended Public Defender Howard Finklestein reduced his assignments in retaliation because Finklestein disagreed with testimony Brannon gave concerning a judicial misconduct complaint. U.S. District Judge Donald Graham dismissed the suit, saying the reductions paralleled budget reductions in the public defender’s office.

**Kentucky** – Blue Cross/Blue Shield (BC/BS) and the Kentucky Psychological Association have been in talks to resolve issues related to BC/BS not wanting to credential autonomously functioning master’s-level psychological providers in the state. Those providers have long been grandfathered in under previous rules. BC/BS says they have “created a mechanism by which (the master’s level providers) may provide psychological services to Anthem policy holders.”

**Louisiana** – Marie Leiner, a research associate professor at Texas Tech University Health Sciences, presented research at an October conference of the American Academy of Pediatrics in New Orleans showing that border violence in the El Paso/Juarez region is creating mental health problems among poor children. Her research shows that between 2007 and 2010 children living in poverty in El Paso showed significant but not increasing levels of psychosocial problems. On the Mexican side of the border children in poverty showed significant increases in social problems, rule-breaking and aggressive behavior.

**Maryland** – On Oct. 1 Maryland became the 13th state to require private sector insurance companies to pay for telehealth services considered medically necessary that would be covered when provided face-to-face. The law defines telehealth as “interactive audio, video or other telecommunications or electronic technology... to deliver a health care service.”

**New Jersey** – Princeton alumni Nancy Peretsman and Robert Scully have donated $20 million to name a new psychology building Peretsman-Scully Hall being built on the Princeton University campus. Peretsman, a trustee of the university, co-chaired a campaign that raised $1.88 billion for Princeton, and her husband Scully is on the board of dean’s advisors. Neither is a psychologist, although Scully has a bachelor’s degree in psychology from Princeton.

**Oregon** – The Portland Police Bureau is creating a mental health unit of officers specifically trained to handle mental health related calls. The department is also reinstating crisis intervention training for all officers. The actions are in response to a scathing U.S. Justice Department report in September that showed “a pattern and practice” of excessive force in handling those in mental health crises.

**Pennsylvania** – Thomas H. DeWall, CAE, executive director of the Pennsylvania Psychological Association announced that he will retire in August 2013 after 25 years at the helm of the association. He plans to continue consulting with association leadership and his successor.

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