$9.02 million proposed to settle APA practice assessment suit

By James Bradshaw, Associate Editor

The American Psychological Association (APA) and the APA Practice Organization (APAPO) are to pay $9.02 million under a proposed settlement to end a class action suit filed by APA practitioner members who contend they were deceived into thinking they had to pay an additional “practice assessment” to maintain APA membership.

The settlement must be approved by the U.S. District Court for the District of Columbia before any claims for payment can be submitted, but the plaintiffs’ acceptance of the terms makes approval likely forthcoming.

As in most negotiated settlements, the agreement means that the defendants, officers of the APA and the APAPO, are not required to admit any guilt in misleading members about the nature of the assessments, which were revealed to be “voluntary” in 2010, prompting the legal actions.

The agreement also calls for renaming the assessment as “APAPO Membership Dues” with accompanying wording on annual dues billings to emphasize that APAPO membership is a recommended option for practicing licensed psychologist members to support APAPO’s advocacy efforts but is not required to keep APA membership.

An APA news release announcing the settlement in January quoted 2015 APA President Barry Anton, Ph.D., as saying, “APA and APAPO were never happy to be in litigation with their members. While we do not concede that there was any wrongdoing on our part, this agreement allows us to end the dispute and return to focusing our full attention on the goals and mission of the APA and the APAPO.”

Once approval is finalized, all licensed psychologists who paid practice assessments for any period from 2001 to the present will be eligible to apply for reimbursement from the settlement fund. Details will be available on the website www.PracticeAssessmentSettlement.com that will be maintained by an independent settlement administrator, the Portland, Ore., offices of Epig Class Action Claims Solutions Inc.

Continued on Page 3

Medicare penalties catch uninformed psychologists off guard

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

Despite repeated announcements and warnings from the Center for Medicare and Medicaid (CMS) of the financial consequences to providers who do not participate in Physician Quality Reporting System (PQRS) in 2013, some psychologists are angry, confused and shocked after receiving letters announcing an across-the-board penalty of 1.5 percent in 2015.

During an informal poll conducted during the February meeting of the Cleveland Psychological Association (CPA), about half had received notices of penalties. Thirty percent reported not knowing what PQRS is. Physicians have been eligible to obtain small bonuses for PQRS participation from 2008 to 2014. Detailed information about how to participate is contained on the government website, CMS.gov.

According to CPA President Nancy Duff-Boehm, Ph.D., “Education from the Center for Medicare and Medicaid Services (CMS) is buried in a sea of information about labs and flu shots. It is very tempting for me to ignore my messages from CMS because so few pertain to my practice. Professional organizations should be doing a lot more to inform and educate their members.”

Peter Kanaris, Ph.D., APA Council Representative for New York, said, “I have been astounded by the number of experienced psychologists who have been unaware of PQRS, paying little attention to the changes going on in healthcare and remaining in their silos until immediately affected. … PQRS is not simple. It requires time and study.”

The New Jersey Psychological Association (NJPA) has been proactive in providing resources and education for its members. Without endorsing any specific courses, Jane Selzer, executive director of NJPA, negotiated discounts for the members in 2014 to purchase privately produced webinars on PQRS basics for psychology. NJPA has also been dispelling misinformation appearing on a listserv about PQRS, encouraging members to contact the APA Practice Organization or the CMS helpdesk for assistance.

Beginning in January all Medicare providers who failed to satisfactorily report one process measure for PQRS participation from 2008 to 2014 will be penalized 1.5 percent payment reduction on their Medicare patients throughout 2015. In an article published in CPA’s February newsletter, Duff-Boehm called the 2013 requirement, “a toe-dabble meant to desensitize providers to the idea that the system is too overwhelming to broach.

The actions recommended in some
COVERAGE FOR ALL

Trust Sponsored Professional Liability Insurance is now available to ALL psychologists!

Coverage at every stage of your career
The Trust has you covered when you’re providing psychological services – as a student, in supervised post-graduate work, in research and education, in professional practice... in every way, you get an entire risk management program.

- No association membership required to apply
- Broad coverage at affordable rates
- Free risk management consultations
- Excellent customer service
- A variety of premium discounts
- Optional Business Office insurance

Move your coverage to The Trust and save 10%
If you’re insured by another carrier, it may be time to switch! It’s easy and affordable, and you can make the transition with no gap in coverage. For details, call us at 1-877-637-9700.

For Psychologists By Psychologists

www.trustinsurance.com • 1-877-637-9700

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and in some jurisdictions, other insurance companies within the ACE Group. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Surplus lines insurance sold only through licensed surplus lines producers. Administered by Trust Risk Management Services, Inc. ACE USA is the U.S.-based retail operating division of the ACE Group, a global leader in insurance and reinsurance, serving a diverse group of clients. Headed by ACE Limited (NYSE: ACE), a component of the S&P 500® stock index, the ACE Group conducts its business on a worldwide basis with operating subsidiaries in more than 50 countries. Additional information can be found at www.acegroup.com/usa.
Settlement pending court approval

Continued from Page 1

The practice assessment began as a $50 annual charge on practicing members in 1985 enacted to fund efforts of the Practice Directorate, a division of APA devoted to advocating for practitioners in such matters as licensing and insurance reimbursements.

But, by 2000 those advocacy efforts involved enough lobbying in Congress and state legislatures that APA’s attorneys said the association’s tax-exempt status could be endangered. As a result, the APAPO was created in 2001 as a legally separate entity (although its board members are the same as those of the APA) with a 501(c)(6) tax status that gives less tax exemption than the 501(c)(3) status of the APA but allows broader lobbying.

It was at that point that the mandatory/voluntary nature of the charge to practitioners came into question. APA could not hinge membership eligibility to charges imposed for the support of a legally separate organization. But the APAPO charge continued to be billed to practitioners annually along with regular APA dues, sometimes including definitions of which members “must pay the Practice Assessment.”

After the legal actions were filed, APA and APAPO officials said the intent was only to indicate that members had to pay the additional charges to be represented by the APAPO and not as a requirement for APA membership.

That intent was not widely known until 2010 when Timothy R. Tumlin, Ph.D., a clinical psychologist in Darien, Ill., began questioning why some APA officers were “encouraging” members to pay the assessment, which most thought was mandatory all along.

In a series of exchanges over APA listservs, Tumlin and others questioned whether members had intentionally been misled to believe the APAPO assessment (which had grown to $137 a year by then) was mandatory.

Kathleen C. Nordal, Ph.D., executive director of the APAPO, finally issued a statement in April 2010 that the assessment was needed to fund the work of the APAPO, it was not required to continue APA membership.

The National Psychologist sought comment from Tumlin, whose dogged pursuit of the mandatory/voluntary question precipitated the legal actions.

“It is no surprise that APA officials who defrauded their colleagues for a decade would spend $9 million of the organization’s money to escape accountability,” Tumlin said. “The settlement saves them from having to tell the truth under oath, so they can now say they did nothing wrong and otherwise continue to stonewall the membership’s questions. Psychologists deserve better than this.”

Once the settlement is approved, the settlement administrator will be given deadlines for notifying members who are eligible for payments from the fund and outlining how to go about making claims.

Eligible members will have four options: file for compensation from the fund, forego filing and seek no compensation, seek to be excluded from the settlement to pursue separate legal action or file objections to the nature of the settlement.

Individual compensation will be prorated according to how much each member paid in APAPO dues. The four individual psychologists who filed court actions representing the class of individuals eligible for reimbursements will be paid an additional $5,000 each for their active participation in bringing the settlement about. (The settlement covers three suits combined for court consideration, two filed in Washington, D.C., and another filed in California.)

The law firms of Tycko and Zavareei LLP of Washington, D.C., and Wexler Wallace LLP of Chicago, which represented the plaintiffs, will receive up to $2.7 million – 30 percent of the settlement – although the court can impose a lower amount if it sees fit.

Any residual in the fund when all claims have been satisfied will be donated to the non-profit corporation Mental Health America. The settlement is one of two areas where APA hopes 2015 will resolve long-standing disputes that have tarnished its reputation.

In December, APA announced it has hired Donald H. Hoffman of the Sidley law firm of Chicago to conduct an independent investigation of the participation of psychologists in developing and implementing torture methods used in questioning at terrorist detention facilities in Guantanamo and Abu Ghraib.

The American Psychiatric Association and the Red Cross issued total bans against their members working at the facilities once the tortures were revealed, but the psychological association did not. APA officials said it could not sanction psychologists involved because they were not APA members and it was felt that ethical psychologists should work at the centers to eliminate abuses that had come to light.

Many APA members were critical that a total ban was not imposed and some even dropped their APA memberships as a result.

Hoffman is to investigate any APA involvement at the facilities and whether APA’s response was improperly influenced by any government-related policy or financial considerations. His report is expected by May 1.

The long-time director of professional affairs for the California Psychological Association (CPA) and leader in the long battle to gain hospital privileges for psychologists in that state died Jan. 19. Chuck Faltz, Ph.D.,76, was a long-time resident of Palo Alto.

Faltz was a passionate advocate for psychology and once served as chief of forensic mental health services with the San Mateo County Courts and Corrections Department. He received numerous accolades during his 20 years with CPA, including the organization’s Silver Psi Award for service, a Lifetime Achievement Award, the American Psychological Association’s prestigious Heiser Award for Advocacy and a Presidential Citation from the APA for his “herculean efforts” on behalf of psychologists across the country.

Contributions may be made in his name to the Multiple Myeloma Research Foundation, 383 Main St., Fifth Floor, Norwalk, Conn. 06851.

Earn 1 CE credit for reading this issue. See Page 22 for details.
Evaluate Attention Disorders and Neurological Functioning Across the Lifespan.

**CONNERS K-CPT 2™**
Conners Kiddie Continuous Performance Test 2nd Edition™

For Ages 4 to 7
7.5 minutes to complete and uses pictures of objects familiar to young children.
MHS.com/KCPT2

**CONNERS CPT 3™**
Conners Continuous Performance Test 3rd Edition™

For Ages 8+
A task-oriented computerized assessment of attention-related problems.
MHS.com/CPT3

**CONNERS CATA®**
Conners Continuous Auditory Test of Attention®

For Ages 8+
Assesses auditory processing and attention-related problems.
MHS.com/CATA

Now available! Develop a comprehensive evaluation using the gold standard in CPT assessment with the Conners CPT 3™, an auditory test of attention with the Conners CATA®, and the Conners K-CPT 2™ now with an expanded age range.

- Easy interpretation with new reports offering clear visuals & summaries.
- Trusted results with the most representative CPT normative samples collected.
- New scores were developed to help pinpoint the exact nature of the child or adult’s attention problems.

It is easy to earn CE credits quickly and online. Just study the manual, pass the online questionnaire, and a certificate is created for you!

Learn more at MHS.com/CE

Multi-Health Systems Inc.
USA Tel: 1.800.456.3003 / CAN Tel: 1.800.268.6011
mhs.com • customerservice@mhs.com
PQRS surprises many
Continued from Page 1

measures were so obviously correct, I felt foolish not doing them and was glad to be reminded to do them. One example last year was to assess depressed patients for suicidality and another required us to ask patients upon assessment whether or not they use tobacco, and if so, advise them to quit and offer help to do so.”

In early February, Pat Bach, Psy.D., president of Psychologists in Longterm Care, organized a national conversation hour with three panelists, Amy Rosett, Ph.D., private practitioner in Los Angeles who teaches seminars on PQRS, Dori Bischmann, Ph.D., APA representative to the Physician Consortium for Performance Improvement (PCPI) and me.

“Medicare is moving away from paying providers a fee based on the time spent with patients. The idea is to focus on the quality, the ‘Q’ in PQRS,” Rosett said.

She said, “People tend to overthink PQRS and make it more complicated. Many of the measures are required only once per reporting period or per calendar year. If using claims-based reporting in 2015, there are only six measures and some can literally take 10 seconds.”

In 2015 there are 240 PQRS process measures, 47 less than in 2014. Because fewer than nine measures are available for psychologists based on allowed current procedural terminology (CPT) codes, data from the claim forms will be analyzed by a process known as the MAV (Measure-Applicability Validation) that determines whether additional measures could be reported.

Panelists agreed the validation process should not prove problematic if the reporting of six measures is done on at least 50 percent of eligible patients. Rosett said if the validation process indicates other measures were available, psychologists have the right to appeal.

Psychologists are eligible to report on more than six measures if they participate through a registry. “Currently claims-based reporting is most popular,” said Bischmann. “CMS’s goal is to phase out claims-based reporting. The big push right now is registry reporting.”

A downside of registry reporting is cost. APA has linked up with PQRS PRO HealthMonix registry that gives psychologists who are APA members a discounted rate of $199 per year per provider, a $100 savings. Paulo Andre, M.D., developer of another CMS vetted registry, MDInteractive, said he will charge the same $199 rate for 2015 for any psychologists. Another option is to use the Dementia Measures group if a psychologist has 20 patients with a dementia diagnosis, and at least 11 are Medicare Part B fee for service patients.

“For 64 patients with 230 sessions, it took me 11 hours to report my data,” said Bischmann, who used a registry for the first time in 2014. “For 2015 as soon as the registry is updated, I will be reporting it little by little.”

Some clinicians think they can wait until the end of the calendar year to do the screens and follow up plans with their patients. Bischmann said the measures are to be conducted at the time of the clinical service. The data can be submitted to the registry at one time.

Charlie Cooper, Ph.D., director of professional affairs for the North Carolina Psychological Association, did a cost analysis on registry reporting. In a phone interview, he said, “A psychologist would need to do $9,950 of Medicare billing per year in order to break even with the cost of a registry. If a provider is using the claims-based method with 100 percent effectiveness, then the registry is an unnecessary cost. Providers should work individual analyses to reflect their own circumstances.”

The future of PQRS
According to Bischmann, “The PQRS process is going to change and evolve. It is a relatively new strategy in terms of measuring quality with a lot of work ahead to develop meaningful measures. CMS is moving toward reimbursing in a way that financially rewards providers who show evidence of higher quality and lower cost.” She urges psychologists to participate, be involved and be part of the learning curve to be better positioned when the quality initiatives are more evolved and mandated.

“Quality measures are here to stay.”

----------

Paula Hartman-Stein, Ph.D., is on the technical expert panel for the Elder Maltreatment Screening measure and chaired the first panel to develop measures for psychologists and social workers. She offers tracking templates for claims-based and registry reporting and offers a set of DVF’s: Achieve Success with PQRS: A Psychologists’ Guide for Mastering the 2015 Measures that can provide two CE credits. Her website is: www.centerforhealthyaging.com.

What’s the future of your practice?

Will you work harder and longer for less money? Will you struggle to fill your schedule? Will you enjoy your work or be drained by it?

“Wait and see” can be a risky strategy.

Take charge of your practice now. Learn how to thrive, regardless of economic and political conditions – at this 2-day conference co-sponsored by: The National Psychologist, The Practice Institute and NASW-Ohio Chapter

Building a Private Practice During Uncertain Times June 12 – 13, 2015

Earn 12 CE credits bit.ly/June2015conference

Presenters: Steve Walfish, Ph.D. and Pauline Wallin, Ph.D.

Our goal is to deliver clarity and practical action steps for a profitable business, regardless of political or economic conditions.

Get $50 discount off tuition. Use coupon code: 50off-tnp

Before April 30, 2015


Continuing Education Credits:

#333350— Social Workers - NASW is recognized as a Continuing Education Approver for social work CEUs by the OCSWMFT Board. If you are audited provide the above number. This number does not match the format for other provider’s numbers because NASW is a Continuing Education Approver rather than a provider.

Counselors - NASW Ohio Chapter is an approved Counselor CEU Provider by the OCSWMFT Board - #RCX071201

The Practice Institute, LLC is approved by the American Psychological Association to sponsor continuing education for psychologists. The Practice Institute, LLC maintains responsibility for this program and its content.
Ohio teen’s suicide stirs conversion therapy discussion

By John Thomas, Associate Editor

The suicide of an Ohio transgendered teenager who was forced into conversion therapy treatment has jump-started the discussion about the need for legislative bodies throughout the nation, including Congress, to prohibit the controversial practice for minors.

The Dec. 28 death of Leelah Alcorn, 17, of Kings Mills, a Cincinnati suburb, prompted the Transgender Human Rights Institute of Princeton, N. J., and other groups to start an online petition drive to create a federal law to prohibit conversion therapy for transgender, gay, lesbian and bisexual youth. The petition, which will be sent to President Obama and congressional leaders, has support from more than half a million people.

Alcorn, who was born Joshua, committed suicide by stepping into the path of a semi-trailer truck on Interstate 71 near her home north of Cincinnati.

It appears that legislation banning conversion therapy will be known as “Leelah’s Law” in her memory.

Another national organization, the National Center for Lesbian Rights, recently announced the formation of #BornPerfect: The Campaign to end Conversion Therapy. The San Francisco-based group said its goal is to work with state legislatures to end the practice within five years.

The story went international during the Golden Globe Awards event when Jill Soloway, the creator of the series Transparencies, dedicated the award to Alcorn and the transgendered community. In her acceptance speech, Soloway said she wanted the show to teach its audience about “truth, authenticity and love.”

Efforts by several states to ban conversion therapy during the last four or so years have largely failed after the California Legislature approved the first-in-the-nation law in 2012, followed by the passage of a similar measure in New Jersey in 2013. The U.S. Supreme Court has turned down a request for a hearing from opponents of the California law and a similar appeal has been filed by opponents in New Jersey, following a lower court decision upholding its constitutionality.

More recently, the Washington, D.C., City Council unanimously approved banning conversion therapy for minors in the nation’s capital. Council member Yvette Alexander, chair of the health committee, said the ban would end in the district what nationwide “has been a problem for years.”

The measure was sponsored by Mary M. Cheh. It was opposed by the Family Research Council and Voices of the Voiceless, an organization of ex-gays, which said it will seek to overturn the ban in court action.

The New York Legislature came closest to approving such legislation when the lower house voted 86-28 last year to approve a bill sponsored by State Sen. Brad Hoylman, a Manhattan Democrat. The measure, however, was never considered by the State Senate.

In an editorial, The Journal News, a newspaper that circulates in the lower Hudson River counties of Westchester, Rockland and Putnam, readers were reminded that the state could be the first to enact a “Leelah’s Law.” Hoylman has reintroduced the bill (S121-2015) and the newspaper urged that it be passed. “Children and their families must be protected from this junk science,” the editorial said.

Hoylman’s bill has been referred to the Senate Higher Education Committee.

Among the states that will see legislation seeking the ban on conversion therapy are two where previous attempts met failure by being defeated in committee or not being referred to committee at all, Florida and Virginia. In Virginia, State Rep. Patrick Hope, D-Arlington, has reintroduced the legislation that was defeated in committee last year. The Virginia Senate Education and Health Committee voted 7-8 in January to kill a bill sponsored by State Sen. Louise Lucas, a Portsmouth Democrat, outlawing conversion therapy, but a similar bill in the Virginia House is still under consideration.

In Florida, State Rep. David Richardson, D-Miami Beach, is hoping his bill will at least be assigned to a committee for hearing, which it was denied last year.

In Illinois, State Rep. Kelly Cassidy, a Chicago Democrat, and State Sen. Daniel Bliss, an Evanston Democrat, have introduced legislation in their respective chambers calling for an end to conversion therapy for minors in that state.

Cassidy introduced similar legislation during the last session of the Illinois legislature, but it failed 44-51. She later said that she had sought a vote too early. Equity Illinois said it was creating an education program to inform legislators on the negative aspects of conversion therapy and convince Gov. Bruce Rauner to sign the bill when passed.

In Oregon, House Bill 2307 would outlaw conversion therapy for minors, but has yet to attract any sponsors. The Oregon Democratic Party endorsed such legislation in its platform adopted last year. Basic Rights Oregon is collecting signatures to force a vote on the issue, known as the Youth Mental Health Protection Act.

See related story Page 28

Washington, D.C., City Council approves ban on conversion therapy.

In an editorial, The Journal News, a newspaper that circulates in the lower Hudson River counties of Westchester, Rockland and Putnam, readers were reminded that the state could be the first to enact a “Leelah’s Law.” Hoylman has reintroduced the bill (S121-2015) and the newspaper urged that it be passed. “Children and their families must be protected from this junk science,” the editorial said.

Hoylman’s bill has been referred to the Senate Higher Education Committee.

Among the states that will see legislation seeking the ban on conversion therapy are two where previous attempts met failure by being defeated in committee or not being referred to committee at all, Florida and Virginia. In Virginia, State Rep. Patrick Hope, D-Arlington, has reintroduced the legislation that was defeated in committee last year. The Virginia Senate Education and Health Committee voted 7-8 in January to kill a bill sponsored by State Sen. Louise Lucas, a Portsmouth Democrat, outlawing conversion therapy, but a similar bill in the Virginia House is still under consideration.

In Florida, State Rep. David Richardson, D-Miami Beach, is hoping his bill will at least be assigned to a committee for hearing, which it was denied last year.

In Illinois, State Rep. Kelly Cassidy, a Chicago Democrat, and State Sen. Daniel Bliss, an Evanston Democrat, have introduced legislation in their respective chambers calling for an end to conversion therapy for minors in that state.

Cassidy introduced similar legislation during the last session of the Illinois legislature, but it failed 44-51. She later said that she had sought a vote too early. Equity Illinois said it was creating an education program to inform legislators on the negative aspects of conversion therapy and convince Gov. Bruce Rauner to sign the bill when passed.

In Oregon, House Bill 2307 would outlaw conversion therapy for minors, but has yet to attract any sponsors. The Oregon Democratic Party endorsed such legislation in its platform adopted last year. Basic Rights Oregon is collecting signatures to force a vote on the issue, known as the Youth Mental Health Protection Act.

CE

Achieve Success with PQRS: A Psychologist’s Guide for Mastering the 2015 Measures

2 hour DVD set by Dr. Paula Hartman-Stein, Medicare Correspondent for The National Psychologist, teaching a small group, including Q & A & updated recording forms that cross-reference PQRS measures with CPT codes.

2 CEs available separately

For info: www.centerforhealthyaging.com

Strickland seeks U.S. Senate seat

Ted Strickland, Ph.D., the first psychologist to be elected to Congress and as a state governor, is seeking to become the first psychologist to serve in the U.S. Senate.

In making his announcement to run in the Ohio Democratic primary in May 2016, Strickland stuck to his themes of being a member of a large rural Appalachian family and the product of a working-class background.

“My father was a proud steelworker and my hard-working mother devoted her life to raising our family. I know how difficult it is to move up in this world, and the deck is increasingly stacked against working people.”

Strickland said in his announcement to run against incumbent U.S. Sen. Rob Portman, a Cincinnati Republican, serving his first term.

It appears Strickland and Cincinnati Councilman P.G. Sittenfeld will face each other in the May 2016 Democratic Primary Election.

Continuing, Strickland noted that “we are producing, building, creating and discovering more than ever before, and yet, for the middle-class, getting ahead has never been harder. I believe that if you’re willing to work hard every day and play by the rules, you shouldn’t have to go to bed worrying about tomorrow.”

He said that the country needs to create more living-wage jobs and invest in the kind of infrastructure projects that benefit communities.

Strickland served one term as Ohio governor during the Great Recession in which Ohio lost thousands of jobs and lost by 2 percentage points to Republican John Kasich in 2010.
A Long Island man is suing New York Gov. Andrew Cuomo and other state officials seeking to overturn a portion of the state’s two-year-old SAFE Act that allows the confiscation of firearms on the basis on personal mental health information.

Donald Montgomery, a military veteran and retired police officer, claims that the SAFE Act’s mental health reporting provision resulted in the Suffolk County Sheriff’s office taking four pistols he owns after he sought treatment for a sleep problem at Eastern Long Island Hospital. A portion of the state’s Mental Hygiene Law created under the SAFE Act requires mental health providers to report information on patients who may constitute a threat to themselves or the public.

In his complaint filed in late December in the U.S. District Court for the Western District of New York in Rochester, Montgomery said that he visited the hospital in May 2013 because he was having trouble sleeping. He received a diagnosis of “depression: insomnia” and about two weeks later returned for a 48-hour stay that he claims was labeled “involuntary admission” by the hospital.

The hospital, which is a defendant in the suit, has refused to change the admission to voluntary, which under the SAFE Act would not have triggered the state’s action.

The suit claims that law directly violates residents’ Second Amendment right to bear arms and the Fourth, Fifth and 14th amendments by taking away that right without due process.

Montgomery also said the law discriminates against those coming in contact with mental health professionals in violation of the 14th Amendment’s equal protection clause and could deter those who need mental health services from seeking help.

Montgomery claims his constitutional rights have been violated and is seeking treble damages, a declaratory judgment to strike down the mental health reporting provision of the SAFE Act, a preliminary and permanent injunction on implementation of the provision through the reporting system, an order requiring notification of anyone whose information was reported under the system and an order to purge all electronic and paper records collected under the law.

APA council adopts policy on psychologists in primary care

The discussion arose when the council considered adopting as policy a work group product called “Competencies for Psychology Practice in Primary Care.”

The standards are intended to guide practicing psychologists in training they could pursue to enhance their work in primary care settings, such as the patient-centered medical homes recommended in the federal healthcare reform known as Obamacare.

The standards, under study for three years, cover broad areas, such as the science related to the “Biopsychosocial Approach” for healthcare, interdisciplinary cooperation and building and sustaining interprofessional relationships.

A footnote of the work group report issued in March 2013 and posted on the APA website notes: “This policy describes competencies that serve as aspirational goals for psychologists in primary care settings.”

The problem is that regulators in some jurisdictions – notably Missouri – are interpreting the competencies as minimum requirements for psychologists to practice in primary settings. The Missouri Psychological Association submitted an amendment to the policy in an effort to make it clear the guidelines were intended to encourage continuing education by psychologists working in primary care but are “aspirational” rather than mandatory.

The policy was adopted without amendment.

Past experience shows that regulators vary greatly by jurisdictions in how they interpret ethical and professional standards. Many jurisdictions, for example, adopt the APA Code of Ethics by reference and despite the “aspirational” nature of some sections concerning best practices licensing board investigators may determine any shortcoming to be an ethics violation.

The competency standards was one of the few items to draw much discussion in a largely routine agenda considered by the council at the session held Feb. 20-22.

The first day of the session was devoted to continuing efforts to streamline APA’s decision-making process to allow faster reaction to changing circumstances. The system of requiring council approval for almost all decisive actions has led to great delays as matters wind through the twice yearly council sessions with each tabling or insufficient handling leading to at least six months of inaction.

The intent is to have a 12-member Council Leadership Team make many of the day-to-day, nuts-and-bolts decisions, including some on financial matters, while the council would set overall policy and retain ultimate fiduciary responsibility.

At the end of the first day, an optional confidential session was held in which APA’s general counsel, Natalie Gilfoyle, outlined the $9.02 million settlement of a class action lawsuit filed against the APA and the APA Practice Organization (APAPO) over assessments charged practitioner members since 2001. (See story on Page 1.)

Ancillary to the council session, a movement was begun to organize the various caucuses of practicing psychologists into an unofficial “super caucus” to represent their general interests when the need arises.

The caucuses, which may lobby

Continued on page 11
ACAs current beneficiaries: insurance companies

By Dana Beezley-Smith, Ph.D.

Any legislation as lengthy and complex as the Affordable Care Act (ACA) will differentially impact various interest groups. The law, as passed, was an outline of provisions, with details to be determined through thousands of pages of Health and Human Services (HHS) regulations.

Court rulings and congressional modifications mean the law will continually evolve, affecting different stakeholders over time. According to health policy experts, the biggest current ACA beneficiaries are the nation’s largest insurers. The industry’s continued profitability, however, is not guaranteed.

Tom Haynes, president of insurance brokerage TBP Solutions, explains that the five major publicly traded insurance carriers, WellPoint, UnitedHealth, Aetna, Cigna and Humana, are “some of the brightest shining stars of Wall Street — and Obamacare is a major reason.”

Enrollment in the government health insurance exchanges, he says, is “driving the carriers’ increased volume.” Major insurers are bullish in this second year of ACA enrollment, and 2014 earnings reports explain why. In late January, UnitedHealth announced 2014 profits of $10.3 billion and revenues of $130.5 billion, reflecting a gain of seven percent over 2013.

“To put that in perspective,” writes Wendell Potter of the nonpartisan Center for Public Integrity, “United’s share price was $30.40” when the ACA became law. “Since then, the company’s price per share has increased an astonishing 375 percent ... more than either the Dow Jones and Standard and Poors averages has grown during the same period.”

Other major carriers are also experiencing dramatic market gains. Since the law’s enactment, Humana’s shares have risen by 309 percent, Cigna’s by 305 percent and Aetna’s by 290 percent. Anthem saw gains of 238 percent and HealthNet’s share price increased 224 percent.

Since the law’s passage, carriers are also enjoying less competition. The Government Accountability Office reports that from 2010 to 2013, the average dominance of the three largest insurers in states’ individual insurance markets increased from 83 percent to 86 percent, and in 42 states, 75 percent of the 2013 individual market was controlled by three or fewer carriers.

Backstop provisions

One reason for insurer optimism is that the ACA contains mechanisms that offset carrier losses in the exchanges. Through what is collectively known as the “3Rs” – risk adjustment, reinsurance and risk corridors – insurers enrolling expensive individuals receive financial support from more profitable insurers and from federal funds.

However, two of these provisions, risk corridors and reinsurance, expire Jan. 1, 2017, and insurers must then be more fiscally stable. Concerned about insurer losses, the administration

Psychologist killed by Iraq veteran

Timothy Fjordback, Psy.D., who left private practice after the 9/11 attacks because he wanted to help veterans, was fatally shot Jan. 6 by a gunman subsequently identified as an Army veteran who served five months in Iraq in 2007.

The Associated Press and other news agencies reported that Fjordback, 63, was killed on the fourth floor of the El Paso VA clinic at Fort Bliss by 48-year-old Jerry Serrato. Shortly after shooting Fjordback, Serrato used the same .380 handgun to kill himself.

Serrato served in the Ohio National Guard from 1985 to 1993 and joined the Army in 2006. Authorities could find no evidence that Fjordback and Serrato had any work-related connection at the clinic and said Serrato was not a patient there.

But, one of Serrato’s neighbors told KVIA-TV Serrato was let go from his clerk/intern job at the clinic last year and blamed it on Fjordback.

According to The New York Times, Douglas Lindquist, who heads the FBI’s El Paso office, said Fjordback had reported an encounter last year in an El Paso supermarket in which Serrato threatened him, saying something like, “I know what you did and I will take care of it.”

“It was something in public at a grocery store where Mr. Serrato approached Dr. Fjordbak, who did not recognize him, and he made a verbal threat, and that was the extent of the report. As far as we can tell, that was the only connection that they had,” Lindquist said.

Neurofeedback and insomnia

The article on Insomnia clients (Jan/Feb issue) was informative but missed a treatment modality that is extremely effective in the treatment of insomnia.

Neurofeedback as a method of brain training is being utilized by thousands of practitioners all over the world for successfully treating sleep issues. We have specific regions of the brain that are highly successful in resolving insomnia. In my practice, I have had numerous patients who have completely gone off all their sleep medications without further sessions unless we send patients to a psychiatrist for a med. referral?

Metabolic syndrome attached to SSRIs seems to be something that we don’t concern ourselves with as we treat the mind, and not the body.

As an integrative psychologist who has been practicing for almost 30 years, I wish I had been taught about neurofeedback in graduate school. Additionally, there is a ton of research on the effectiveness of this modality.

Divya Kakaiya, Ph.D.
San Diego, Calif.

LETTER

after about 20 to 30 sessions of neurofeedback. Additionally I have a number of patients who have gone off their CPAP (continuous positive airway pressure) machines after neurofeedback.

The reason we do not hear about neurofeedback so much is because Big Pharma runs our airwaves! The United States and New Zealand are the only two countries that allow drug companies to directly market to their consumers. Is it surprising to us as psychologists that many of our insurance companies will not authorize further sessions unless we send patients to a psychiatrist for a med. referral?

should the government lose its case, HHS, recognizing the financial hardship of exchange pools populated with expensive enrollees, recently ruled that carriers may exit federally established exchanges. The court scheduled oral arguments for March 4. A ruling is expected in June.

Dana Beezley-Smith, Ph.D., is a clinical psychologist in private practice serving children, adults and families in Green, Ohio. She may be reached at drdana@me.com.
The ethics of leadership in psychology

By Stephen A. Ragusea, Psy.D.

It is often said that psychologists have the most complex and demanding set of ethics of all the professions. Whether or not that is so, we are clearly obligated to behave ethically in our professional lives, and certainly providing leadership is part of that professional existence.

The essence of leadership may be examined in a variety of ways and the ethics of leadership in the field of psychology may similarly be perceived from different perspectives. Think about the problems caused by ethical mistakes made by leaders that are significant parts of our collective history.

For example, the words Nixon, Enron and Madoff bring forth a flood of memories about ethical breaches of leadership that clearly impacted the recent past. Within psychology, the name Abu Ghiab now has special meaning and the debate within psychology about our leadership role there is ongoing. These are extreme examples provided to emphasize the importance of ethical leadership.

As psychologists, our ethical standards provide us with much general guidance. We are advised by our Ethical Principles that in all our work as psychologists we should act with “Beneficence… Fidelity and Responsibility… Integrity… Justice… and… Respect for People’s Rights and Dignity….”

That’s a significant list of demands. We’re just human, after all. But, we psychologists tend to demand a lot from ourselves.

It is noteworthy and perhaps surprising that nothing in the Ethical Principles of Psychologists and Code of Conduct (2002) specifically addresses our leadership roles. Yet, psychologists function in leadership positions wherever they work and that includes their efforts within psychological organizations. So, we must look to other sources for guidance on leadership ethics.

A literature review quickly reveals that little psychological research has been done on ethics in leadership, despite its importance in our world. In fact, it seems that the subject of ethical leadership is more likely to be considered by business scholars than psychologists. However, there has been some research and scholarly writing done by psychologists, which we can peruse.

On a fundamental level, we psychologists seem to agree that leadership may be described as a “basic tension between altruism and egoism.” That is, some leaders balance the development of themselves and their subordinates, raising the aspirations of both the leaders and the led in the process…. Other leaders wield power to satisfy their own needs and have little regard for either helping the development of their subordinates or behaving in socially constructive ways.”

When considering ethical matters, both psychologists and business professionals tend to embrace models of leadership such as Transformational Leadership. Within that model, leaders provide a vision for change and then endeavor to inspire the other members of the group to pursue that transforming vision. This model is seen as morally superior and stands in contrast to other models of leadership that involve the direct control of others through coercive transactions. Such transactional models are tempting for a variety of reasons. For example they have the advantage of being, at least temporarily, expedient.

Indeed, transactional leadership has been utilized in organizations and nations throughout history and is very often effective for a limited time. Such was the case with Attila, who served as king of the Huns from 433-453. However, as Gandhi pointed out, “all through history…there have been tyrants…and for a time they seem invincible but in the end, they always fall. Think of it, always.” Therefore, from both ethical and effectiveness perspectives, it appears that more altruistic leadership based on inspiration is usually superior to self-centered intimidation in most realms.

For that reason alone, it is would be wise for all of us involved in leadership roles to remember that we are primarily there to serve our profession and our patients, not ourselves. And, research suggests that we lead best by sharing a vision that inspires others to action.

In so doing, we embrace our core ethical principles of “Beneficence… Fidelity and Responsibility… Integrity… Justice… and… Respect for People’s Rights and Dignity….” And, that is our ethical obligation.

References available from author

Editor’s note: This article was originally published as a column for “The Ethics Corner” in The Florida Psychologist. Stephen Ragusea, Psy.D., is in private practice in Key West, Fla. His email is: ragusea@ragusea.com.
Online journals can be predatory

By Judith Schlesinger, Ph.D.

I recently had a dismaying experience with the online journal, Frontiers in Psychology (FIP). I offer it here only as a cautionary tale, since your mileage may differ.

This decade has seen a seismic explosion of new online journals (OJs) in every conceivable area, since they have distinct advantages over print publications. For one thing, instead of requiring expensive subscriptions, they may provide “open access,” material for free. For another, since they vet and publish articles so fast, they help academics pile up those all-important citations.

They also provide a wider presence across cyberspace and often trumpet this “impact factor” when they ask you to participate. Meanwhile, their credibility is enhanced by journalists who enjoy the new convenience and economy of touting for “scientific breakthroughs” with which to regale their readers.

In fact, that research may not be groundbreaking – or even particularly scientific – at all. Growing alongside the legitimate opportunities are vanity presses and scams of various kinds, which we’ll get to later. But to a public eager for such “news,” a snappy sound bite can suffice; many Internet writings exist simply to feed the bottomless content maw, regardless of quality or truth.

OJs claim that their peer review process legitimizes the entire enterprise. Although I once served as a peer reviewer for FIT, and did a careful and responsible job, this is not always the case.

Incessant OJ recruitment is flattering until you realize how many invitations have nothing whatever to do with your specialty – they might as well be addressed to “Dear Occupant.” But FIP was running a “special topic” on genius and pathology, which is my expertise, so I agreed to furnish a 2,000-word opinion piece on the topic. Like most academic writing, no money was involved. What was new was that anything above 2,000 words required me to pay them for the privilege of publishing it.

To be fair, it didn’t help that I have a minority point of view. This made it harder for FIP to recruit people familiar with my work, although anyone can Google my book and professional and popular writing, and even listen to an NPR interview or two, if they care to learn more about it. But these reviewers didn’t. Nor did they recuse themselves, since admitting “I don’t know” is about as rare in psychology as it is in Congress.

The inevitable result was this: Rather than addressing my actual work and the myriad supports I cited, they kept pointing to what they were familiar with, no matter how irrelevant – much like the drunk who hunts his keys under the street lamp, instead of where they fell, because “the light is better there.” Most bizarrely, the reviewers kept complaining that I was opinionated, although an opinion piece is what I agreed to write.

Despite every conciliatory concession I could manage, they only became more intransigent about the “wrongness” of my opinion. After the third round of back-and-forth, I e-mailed the editor to withdraw my article from further consideration. I freely admit I was somewhat less than diplomatic in my assessment of the reviewers’ resistance. But I figured that was okay, since this was a private communication.

Except … that it wasn’t. Suddenly my backstage message appeared on the site, displaying my frustration to the whole interested world, including the reviewers, who were now even less likely to respect my point of view (or me, for that matter). To her credit, the editor phoned me on a Sunday to apologize for her breach of confidentiality.

In what was billed at the nation’s largest-ever mental health workers’ strike, members of the National Union of Healthcare Workers walked off their jobs in mid-January for a week at Kaiser Permanente in California.

The 2,600-member union was protesting the company’s alleged failure to adequately staff mental health clinics and charged that mental health patients had been victims of Kaiser’s “chronic failure to provide its members with timely, quality mental health care.”

Press accounts reported that the union, which has been without a contract for five years since breaking off from the Service Employees International Union, staffed 65 picket lines at 35 Kaiser locations during the walkout. The strikers, which included psychologists, therapists and social workers, were joined at one point by more than 700 other Kaiser workers on the picket lines.

Those employees included medical social workers, speech pathologists, audiologists, health educators and registered dieticians, who also reported problems caused by inadequate staffing, the union’s primary concern.

The union’s action against the healthcare giant follows by a few months Kaiser’s paying a $4 million fine to the California Department of Managed Care for mental health violations. The agency charged that many Kaiser patients seeking mental health care were forced to wait for weeks.

Despite agreeing to drop an appeal of the state’s charges and pay the $4 million fine, Kaiser has not made any improvements in hiring enough staff to handle the increased case load, the union charges.

Under the Affordable Health Care Act, Kaiser added 250,000 new clients last year.

The union claims that Kaiser is shifting resources that allows a shorter wait time for patients to see a mental health counselor, but then have to wait five or six weeks for a follow-up appointment.

April Dembosky, a reporter for the San Francisco NPR station KQED who has been following the story, said part of the problem seems to be that as a result of campaigns that have sought to reduce stigma around mental health, Kaiser is more willing to hire and staff more people with mental health problems are seeking treatment.

Kaiser mental health workers hold one-week strike
Practice caucuses coming together
Continued from Page 7

for or against specific council actions, generally represent the specific interests of a particular APA division or group of council members. That means in the case of practitioner members, the efforts are often splintered into diverse areas, such as psychoanalysis, independent practice, clinical psychology, military psychology, etc.

Representatives of the practice caucuses began collecting contact information so that practice as a whole could be informed and called together for united action whenever needed.

One “splinter” was eliminated entirely in a caucus meeting the night before the council session. Belt-tightening of the APAPO budget in 2011 threatened to reduce funds available for “organizational grants” to smaller states to $150,000 – a 40 percent cut.

For states with fewer than 200 psychologists because of small geographic size, such as Rhode Island, or sparse population, such as Montana, those grants are needed to keep the doors open at state association offices. As a result, a “very small states” caucus split off from the caucus of State/Provincial/Territorial Psychological Representatives to lobby against the grant cuts.

Those efforts, with the support of many other members, successfully staved off the cuts and allowed those states to maintain local offices.

In a session of the “very small states” representatives before the full state, provincial and territorial caucus session, it was noted that no efforts have been made since to cut the organizational grants, meaning there is no need to continue the very small states caucus. It was disbanded by a unanimous vote with the note that it could always be revived if the need arose.

A few benefits of subscribing:
* Earn 1 CE credit for reading each issue
* Reduced fees for TNP sponsored workshops and conferences

Terrific Teaching Tools

**Emotions Chart**

Our brightly colored emotions chart and flashcards help children learn and express emotions in therapy, at school and at home. Create your own games with these flexible therapy & teaching tools.

- 11 cards, (8-1/2 x 11)
- $9.95 + $2.95 p&h

To order go to:
[www.terrificteachingtools.com](http://www.terrificteachingtools.com)
click on “Health and Science” then click on “Emotions”
or call: 1-614-861-8000

Over 100 other teaching tools for all ages available on our website
Achievement

The Academic Achievement Battery™ (AAB™) gives you exactly what you need to confidently evaluate achievement.

A complete assessment of an individual’s academic skills, the AAB Comprehensive Form can be administered throughout the life span. Bright, modern stimuli are available in print and digital formats. Scoring is simple and straightforward.
Purchase the Comprehensive Kit for $495.

Offering four subtests, the AAB Screening Form can be administered quickly for a snapshot of an individual’s performance.
Purchase the Screening Kit for $195.

Get on-demand, free training on the AAB. Visit the PAR Training Portal at www4.parinc.com/trainingportal.
Risk Management

Sorting through professional liability insurance

By Rachel Brusstar

Professional liability insurance: the difference between claims-made and occurrence coverage, limits of liability, extended reporting period ... the list goes on when you’re looking at professional liability insurance, and you may not fully understand what it is that you’re purchasing.

The prospect of purchasing insurance can be daunting, and you don’t always know where to begin, what coverage options to look for or which company to choose.

The one thing you do know is that you’re required to carry professional liability insurance.

Professional liability insurance provides coverage for the professional services you can legally provide as a psychologist. This means that you’ll be covered in the event of a claim or suit that arises as a result of the treatment you provided to a client.

In today’s litigious society, you can’t guarantee that you’re immune from a liability claim, no matter how good your intentions as a clinician.

While there are many coverage options included in a professional liability insurance policy, there are just two main options for types of policies: Occurrence Form Coverage and Claims Made Coverage.

An occurrence form policy provides lifetime coverage for the period the policy is in effect. This means that you’ll still have coverage for any treatments or incidents that occurred while your occurrence policy was in place, even if you allow the policy to lapse.

For example, if a client you saw while your policy was in place files a complaint with your state licensing board after your policy expiration date, you can still seek coverage under your occurrence policy. The same limits of liability that you had in place during the treatment dates will still apply, and you don’t have to pay an additional fee to ensure that you’ll be covered.

A claims-made policy provides coverage for claims while the policy is in effect. If you want to have coverage for the policy period after the expiration date, you would need to purchase an extended reporting period endorsement or “tail coverage.”

Price is also certainly an important determination when purchasing insurance. Occurrence form policies tend to start at a higher base premium, but the price will stay the same from year to year. A claims-made policy will typically start at a lower premium than an occurrence policy for the first year of coverage. However, the premium will increase each year until you reach the “mature” rate. It’s also important to keep in mind the premium that might be owed for a “tail.”

We know there are many factors that go into selecting professional liability insurance to protect your practice. You’ve worked too hard to go without the appropriate coverage. Before making a decision, there are many factors to consider, and you want to be sure that you’re making the correct choice for your business.

Occurrence policies tend to be recommended by insurance professionals if there is an option, as you’re truly getting coverage for a lifetime, when you purchase an occurrence policy.

---------------

Psychologist imprisoned for fraud

Keenan R. Farrell, Psy.D., of Chicago, has been sentenced to 88 months in federal prison for billing Medicaid for psychotherapy services to skilled nursing home patients that he never performed.

As part of the scheme, Farrell, 55, submitted more than 31,000 Medicare claims over several years for psychotherapy services for nursing home patients he never saw, including many who were deceased at the time he supposedly saw them.

In addition, Farrell will serve two years on probation and be required to pay $1,525,496 in restitution.

Rachel Brusstar is a licensed insurance agent and the marketing manager for CPH and Associates, a leader in providing professional liability insurance for the mental health and social service fields. Her email is: rbrusstar@cpphins.com.
By Paula E. Hartman-Stein, Ph.D.

The hue and cry among many psychologists notified of a 1.5 percent reduction in payments from the Centers for Medicare and Medicaid (CMS) this year as a penalty for not participating in a government quality assurance program is perhaps understandable given the tight finances of most practices.

But there have been ample warnings that changes connected to the Physician Quality Reporting System (PQRS) were coming, including the penalties that will grow to 2 percent next year for non-participants.

Some psychologists who knew about the penalties chose not to participate, criticizing its relevance and viewing it as a conspiracy against mental health practitioners. A brief history might give some perspective.

Crossing the Quality Chasm: A New Health System for the 21st Century, published in 2001, is an early publication that aligned incentives in healthcare payments to accountability and called to close the quality gap between research evidence and practices of care.

In 2004 the Ambulatory Care Quality Alliance (AQA), a national coalition of more than 135 organizations, formed to improve healthcare quality.

In December 2006, health economist Jim Hahn informed Congress for the need to align payment with quality rather than quantity of services due to the projected growth in Medicare over the next 40 years. Also in 2006 the Institute of Medicine (IOM) called for variable physician payments based on quality. At that time there was no infrastructure for clinicians to report what they did and no measures of quality of care.

On Dec. 20, 2006 President George W. Bush signed the Tax Relief and Health Care Act that authorized a quality reporting system by CMS to reward clinicians if they met reporting requirements, giving birth to PQRS, initially called the Physician Quality Reporting Initiative (PQRI).

An article in the Journal of the American Medical Association (Oct. 17, 2007) gave momentum to quality reporting by noting the public’s interest in healthcare quality but still no standardized or consistently accurate quality measurements existed. CMS then hired contractors such as Quality Insights of Pennsylvania that formed panels of professionals to create and modify “measures” that are similar to best practices.

The number of measures has grown from 73 in 2007 to 287 in 2014, with 40 measures retired in 2015. The rules change over time, but in 2015 providers must report on nine across at least three public health domains (if there are nine available based on CPT codes).

PQRS initially offered small financial incentives to encourage buy-in. The highest bonus was 2 percent for reporting three quality measures on 80 percent of eligible patients in 2009 and 2010.

In March 2007 CMS convened a panel for Psychology and Social Work to develop three “best practices.” I became chair, appointed by APA Division 12, Clinical psychology, because of my work in 1990 on the Resource-Based Relative Value Scale study at Harvard that determined reimbursement.

The committee consisted of two other mental health practitioners and a nurse with a master’s in public health. The initial measures were screens for depression and cognitive impairment and the motivational interview technique of getting the patient’s acceptance of a treatment plan.

At a historic meeting of the AQA in October 2007, representatives from commercial insurance companies and the AMA engaged in a vociferous debate. The AMA stance was that “best practice” measures should reflect basic competencies of healthcare that fill gaps of care based on research.

Commercial payers advocated for “aspirational measures” that would supposedly raise quality a few notches. The AMA and non-MD providers were allies on this point and the AMA stance prevailed. At the meeting all specialties were created equal and voted on 73 proposed measures. Because of the vote at that meeting, psychologists, social workers and physical therapists were included in the bonus system in 2008.

In the past seven years, measures have come and gone, more expert panels have appeared with financial penalties arriving in 2015. Besides the financial carrot and stick process, pressure to participate began in another way in 2014 with the creation of the Physician Compare website. All providers who accept Medicare payments can find their name on this public site in addition to address, gender, year of graduation from a doctoral program, and notice of PQRS participation in 2013. In the near future quality ratings will be published for individuals and group practices.

Who’s to blame for so many not anticipating the penalties or the website data? Is it the individual practitioners for not staying abreast of the growing quality movement in healthcare? Is it their professional associations for not alerting them sufficiently? Or is it CMS itself for burying PQRS notices in a mountain of other bureaucratic notices?

Who gets the blame really doesn’t matter. Those who didn’t get an early start in PQRS should begin catching up immediately because PQRS or another iteration is here to stay.

Some psychologists who have been aware of the carrot-stick system chose to forego participation in PQRS because the money involved was small potatoes in the grand scheme. But is that all that counts?

Whether we think participating in PQRS improves the quality of care of our patients or not, the government and third-party payers think so. The Department of Health and Human Services announced in January 2015 the goal of tying 85 percent of all fee-for-service payments to quality and cost measures by 2016 and 90 percent by 2018.

The question of participation in the quality movement in U.S. healthcare has principles similar to those found in the vaccination debate. We vaccinate our children not only to protect their health but also for the health of the children around them. Some PQRS measures have been created to increase the safety and health of the population as well as lower costs. Screening for and educating about weight, smoking, elder abuse, pain, what meds a person is taking and mood are aspects of health patterns that keep people healthy, out of hospitals and maybe even needing less meds. What a concept! Aren’t psychologists supposed to help their patients have healthier life styles, not just deliver protocols to treat mental health symptoms?

If neither financial penalties nor performance ratings are sufficiently motivating to participate in PQRS, consider whether you have any responsibility to improve the overall health of your patients and prevent medical problems via lifestyle changes, similar to an immunization but without chemicals. If the answer is yes, then participate in PQRS, a flawed system that is bound to improve and someday may even come close to measuring quality of care.

Paula Hartman-Stein, Ph.D., is a practitioner, consultant and Medicare correspondent for The National Psychologist, who teaches others how to navigate PQRS. Her website is: www.centerforhealthyaging.com.
The focus of traditional sex addiction-compulsivity treatment models tends to be on diagnosing and stopping specific sexual behaviors, termed “sexual sobriety.” From a treatment perspective, it is correct and necessary to implement behavioral containment and stop destructive or problematic behaviors.

However, this is where most treatment ends, rather than also treating the other patterns of abuse of human beings and violations of human rights, termed “sex addiction-induced perpetrations” (SAIP).

The model proposes clinical management and treatment of both sexual behaviors and SAIP. According to the model, sex addiction-compulsivity disorders are defined as “a complex system of sexual, personality and masculinity pathology, which may include the maintenance of a deceptive, compartmentalized sexual-relational reality, sexual-relational acting out behaviors and other patterns of perpetration, abuse and violation that causes serious PTSD and C-PTSD (SAIT) in victims.”

The reality here is that the pre-occupation with diagnosing and treating these complex pathologies as simply “compulsive” or impulse control disorders and focusing on treating sexual behaviors, while avoiding and omitting the proper diagnosis of abuse and covert violence, leaves dynamics of serious pathology untreated.

A disorder of chronic lying in a family system is pathology and requires treatment, regardless of sexual acting out or not. Chronic patterns of establishing and maintaining a deceptive, compartmentalized sexual-relational system in an intimate relationship or family system, is pathology and harmful, which is more accurate in description then simply “compulsive pornography use.”

The process of gaslighting an intimate partner – the intentional psychological manipulation of victim’s reality over time – is a form of emotional and psychological abuse and torture, eroding and damaging the victim’s survival instincts and intuition, regardless of sexual behaviors. Clearly, there exist many symptoms of pathology, beyond the single symptom of “lack of control of specific sexual behaviors” or “compulsivity.” Sexual sobriety alone is an inadequate treatment model.

Sex addiction-induced perpetration (SAIP) is clinical pathology. However, within traditional treatment models there exist no established diagnostic or clinical formulation for SAIP and no treatment, methodology or clinical paradigm that accounts for and treats SAIP. This is a serious omission in the field and in clinical practice.

Perpetration requires treatment and appropriate clinical intervention, not defensive denial, silence and professional avoidance. Clinical pathology that contributes to serious harm and violation of others and human rights requires an organized clinical methodology and direct clinical management, not undefined, underdeveloped or squeamish clinical approaches.

After all and in fact, it is these dynamics of sex addiction-induced perpetrations that often “induce trauma,” do more human damage and accrue more human cost than sexual acting out behaviors alone ever possibly could.

By Omar Minwalla, Psy.D.

‘Sexual sobriety’ leaves victims untreated

Omar Minwalla, Psy.D., is a licensed psychologist and clinical sexologist. He is clinical director of The Institute for Sexual Health. His website is: www.theinstituteforsexualhealth.com and his email address is: dromarinwalla@gmail.com.

Be sure to see our website at: www.nationalpsychologist.com

Review by Susan D. Rego, Ph.D.

“What do I do? I just got a subpoena.”

“How do I handle confidentiality when the parents of a teenager I’m seeing want to talk to me?”

“A longtime client wants to invite me to lunch. Do I say ‘yes’?”

These are but a few of the ethical dilemmas psychologists in private practice face on a regular basis. The Ethics of Private Practice answers these and many more ethical questions in well-organized, concise manner. The book offers a useful, accessible and comprehensive reference guide to the ethical challenges of psychology private practice.

The multitude of ethical dilemmas that psychologists face in private practice are explored, from starting a practice to retirement. The authors include chapters on general clinical practice, documentation, dealing with third parties and confidentiality, financial issues, staff training, advertising and professional development. The sections on informed consent and how to ethically handle cases with legal involvement are particularly helpful.

The organization of the book is also commendable, in large part because of the summary at the end of each chapter. These summaries include a list of “Ethical Challenges,” “Key Points to Keep in Mind,” “Practical Recommendations,” “ Pitfalls to Avoid” and “Relevant Ethics Code Standards.”

They are succinct and practical, providing psychologists and other mental health professionals with a quick reference for a multitude of ethical questions and concerns; particularly helpful when a practitioner needs answers quickly and doesn’t have the time to scour the text for the relevant information. The text too is reasonably accessible.

The chapter on multiple roles and boundaries is especially thought-provoking. The authors freely acknowledge that this area is not black and white, as some practitioners may believe, but is nuanced and situationally specific. Having multiple relationships with one client may be fine, but with others, harmful.

Sometimes multiple relationships are unavoidable or even therapeutically helpful, especially for practitioners in a rural environment where contact with clients outside of the therapy sessions is highly probable. The authors include a couple ethical decision-making models to help determine if a multiple relationship is ethical, i.e., does no harm to the client. They also repeatedly stress that when in doubt about any ethical issue, consult a trusted colleague or mentor.

The importance of having a network of trusted colleagues to consult with is a key point in the book and bears repeating. The authors make the point that practitioners tend to overestimate their capabilities and need input from colleagues in order to practice ethically and competently.

They suggest that clinicians who don’t regularly consult with their peers tend to rationalize problematic behavior and are more at risk of sliding down the “slippery slope” into unethical behavior.

Throughout the book, Barnett, Zimmerman and Walfish make a number of helpful suggestions, including the recommendation that a practitioner create a “professional will” which names a colleague who would be responsible for communicating with clients should the practitioner be unable to practice for an extended period of time. This individual would assist patients with continuity of care issues. Clients would be informed of this arrangement as part of informed consent.

They also suggest that practitioners who offer sliding fee scales have patients sign an agreement to inform the clinician if their financial situation should change, and they offer some excellent suggestions and an invaluable reference for developing a social media policy, a cutting edge issue which deserves more of our ethical attention.

My criticisms of the book are few, but worth mentioning. For one thing, while they include some sample documents (such as a client termination letter), they fail to include a sample of one of the most important documents, The Consent to Treatment Form. Given the technological changes in our world and the advent of social media, such a document would be very useful, especially for professionals who have practiced for many years and are not well versed in how to use email and other technological advances as ethically as possible.

My other complaint is that the index is incomplete. For example, it was difficult to find “Telepsychology” in the index although it was discussed in some detail in the text.

Overall, though, these are minor criticisms. The Ethical Practice of Psychology is an excellent addition to any mental health practitioners’ reference library. Even though the list price of $45 for the paperback is rather steep, it is well worth the price.

Psychologist Robert Wicks, Psy.D., says it best in his endorsement of this book, “Reading the chapters is like having a series of sessions with a wise mentor who is helping you raise and weigh the most important options at hand before making a professional decision.”

References available from author

Susan D. Rego, Ph.D., is a licensed psychologist in private practice in Bethlehem, Pa. She specializes in treating adults with depression, anxiety and eating disorders and offers clinical consultation to mental health professionals. She serves as chair of the Ethics and Continuing Education Committees for The Lehigh Valley Psychological and Counseling Association. She may be reached by email at: sdrego@ptd.net.

Review by Thomas S. Greenspon, Ph.D.

Intellectual giftedness is a personal quality which arouses both admiration and enmity. We stand in awe of people who bring us stunning advances in medicine or technology, yet the same individuals may have endured teasing and bullying as “nerds” early in life.

Many children we call gifted and talented (GT) grow up with a sense of estrangement and aloneness. When combined with the nuanced awareness common to giftedness, existential concerns about such things as meaninglessness and personal finitude arise, accompanied by feelings of anxiety and depression. Jim Webb, a preeminent psychologist in the GT realm, addresses his readable (if lengthy) treatment of such issues directly to a GT audience.

For the practicing psychologist, this book provides a profound insight into the GT world, a compelling description of giftedness as a critical contextual treatment variable, and a valuable bibliotherapy tool for GT clients.

To understand existential depression, Webb makes extensive use of Kazimierz Dabrowski’s Theory of Positive Disintegration (TPD) and of the positive psychology and existential therapy literature.

Dabrowski observed that intellectual prowess frequently comes with super-stimulatabilities, commonly referred to as overexcitabilities (OE). Children exhibiting OEs can easily be misdiagnosed with ADHD or anxiety-related disorders (see Webb, et. al, The National Psychologist, July/August 2012).

If I have a difference with Webb, it is over Dabrowski’s larger theoretical view. While TPD includes consideration of the social context of human development, it is still a primarily intrapsychic theory, relying on concretized metaphors such as dynamisms and developmental potentials, describing emotions as autonomous inner forces which direct development.

There is also an implied maturity morality, in which individuals are ranked on a scale of human emotional levels. Since well before Dabrowski’s death in 1980, realms of inquiry from contemporary psychoanalysis to attachment theory and even developmental neurobiology have shifted away from innate drives to affect regulation as a prime source of motivation, and from intrapsychic mechanisms to relational, intersubjective systems views of affective development.

Although profound hopelessness and depression can certainly lead to reassessment and renewed sense of purpose, such episodes are not commonly viewed as representing intrapsychic positive disintegrations. The antidote to existential emotional estrangement, a disconnection, is the renewed hope of connection engendered by the emotional attunement of an empathic other.

Webb argues additionally that as humans we invent ideals – “the illusions around which we organize our lives” (p. 29). Awareness of a discrepancy between these ideals, or what ought to be, and what is, can open the door to existential depression.

He offers exercises with which to challenge these ideals and their origins, as he himself acknowledges having done in response to conservative stric-

tures in his own upbringing.

Rather than attempting to distinguish reality from illusion, more contemporary theory privileges a phenomenological focus on the differing ways we might make sense of our experience, as shaped by our particular relationship matrix. Ongoing themes in our developmental relationships result in emotional convictions that form our sense of reality, which is not easily altered by decisions on a purely rational level.

Progressing, as Webb suggests we do, from what we have been told we are to what we “really” are is in contemporary terms a process, in dialogue, of arriving at a differently-organized experience of ourselves. Webb’s exercises are poignant, but may perhaps be most effectively done in conversation with a trusted friend (or therapist).

Although the way Webb makes personal sense of the phenomena associated with giftedness may be debatable, the basic issues he brings into focus are not, and they are worth being aware of in clinical settings. Giftedness entails a minority status for gifted individuals, who are hence vulnerable to feelings of alienation and differentness. Academic environments which do not adequately challenge gifted students can have serious effects on their sense of agency or personal empowerment.

The resulting anxiety can be paralyzing; it is crucial that psychotherapists be aware of this. A major context for effective relief is the experience of a safe, understanding relational home for the profound emotional states that occur.

Webb’s book itself provides such an empathic connection for his gifted readers, and it can help interested clinicians provide it for their gifted clients as well. Definitely recommended reading.

----------

Thomas S. Greenspon, Ph.D., is a psychologist, marriage and family therapist and author in private practice in Minneapolis with his wife, Barbara. They work with gifted and talented individuals, couples and families and are former co-presidents of the Minnesota Council for the Gifted and Talented. Tom teaches a course on intimacy and couple therapy at the Minnesota Institute for Contemporary Psychotherapy and Psychoanalysis. His email is: tsg@greensponassociates.com.
NEW FROM APA BOOKS®
Resources for Practicing Psychologists

NEW EDITION!
APA Dictionary of Psychology
SECOND EDITION
2015, 1,200 pages. Hardcover.
List: $49.95 | APA Member/Affiliate: $39.95

A Concise Guide to Personality Disorders
Joel Paris
2015, 224 pages. Hardcover.
List: $59.95 | APA Member/Affiliate: $49.95

Personality Disorders
Toward Theoretical and Empirical Integration in Diagnosis and Assessment
Edited by Steven K. Huprich
List: $79.95 | APA Member/Affiliate: $59.95

Premature Termination in Psychotherapy
Strategies for Engaging Clients and Improving Outcomes
Joshua K. Swift and Roger P. Greenberg
List: $69.95 | APA Member/Affiliate: $49.95

Complementary and Alternative Medicine for Psychologists
An Essential Resource
Jeffrey E. Barnett, Allison Shale, Gary R. Elkins, and William Ira Fisher
2014, 386 pages. Hardcover.
List: $79.95 | APA Member/Affiliate: $49.95

Forgiveness Therapy
An Empirical Guide for Resolving Anger and Restoring Hope
Second Edition
Robert D. Enright and Richard P. Fitzgibbons
List: $69.95 | APA Member/Affiliate: $49.95
ISBN 978-1-4338-1837-0

On Becoming a Better Therapist
Evidence-Based Practice
One Client at a Time
SECOND EDITION
Barry L. Duncan
List: $59.95 | APA Member/Affiliate: $49.95

Spiritually Oriented Psychotherapy for Trauma
Edited by Donald F. Walker, Christine A. Courtis, and Jamie D. Aten
List: $59.95 | APA Member/Affiliate: $49.95

Handbook of Psychotherapy and Religious Diversity
SECOND EDITION
Edited by P. Scott Richards and Allen E. Bergin
List: $89.95 | APA Member/Affiliate: $59.95

Multiculturalism and Diversity in Clinical Supervision
A Competency-Based Approach
Edited by Carol A. Falender, Edward P. Shafranske, and Celia J. Falicov
List: $69.95 | APA Member/Affiliate: $49.95

Case Formulation in Emotion-Focused Therapy
Co-Creating Clinical Maps for Change
Rhonda N. Goldman and Leslie S. Greenberg
List: $59.95 | APA Member/Affiliate: $49.95

A Practical Guide to PTSD Treatment
Pharmacological and Psychotherapeutic Approaches
Edited by Nancy C. Bernardo and Matthew J. Friedman
List: $29.95 | APA Member/Affiliate: $29.95

Treatment of Late-Life Depression, Anxiety, Trauma, and Substance Abuse
Edited by Patricia A. Areán
List: $59.95 | APA Member/Affiliate: $49.95
ISBN 978-1-4338-1839-4

Psychological Practice With Women
Guidelines, Diversity, Empowerment
Edited by Carolyn Zehr Enns, Joy K. Rice, and Roberta L. Nutt
List: $69.95 | APA Member/Affiliate: $49.95

Biopsychosocial Practice
A Science-Based Framework for Behavioral Health Care
Timothy P. Melchart
List: $69.95 | APA Member/Affiliate: $49.95
ISBN 978-1-4338-1761-8
Valuable tips on building a practice


Review by William C. Wester II, Ed.D.

This book brought back many wonderful memories of when I built my “dream practice.” I was in a small group owned by the psychology chairpersons of Xavier University, Miami University and the University of Cincinnati. We had a pretty impressive letterhead.

As these individuals aged they became interested in selling the practice. Two of us bought it and moved offices several times. My partner became ill and I bought her shares. We had always been known as Behavioral Sciences Associates. I changed the name to Behavioral Science Center Inc. and began to sell shares – the split was 70/30.

My dream was to build our own building to house about 30 psychologists and two psychiatrists. We did just that, complete with play therapy rooms, rooms with two-way mirrors and a special kitchen for ourselves and staff.

In addition to my business and marketing experience, I was vice president for academic affairs and dean of a local college for several years, giving me a well-rounded background for evaluating this book. It is divided into four sections with 10 chapters: Build the Foundation, Create a Culture, Think Abundance, Niche Down, Connect with Your Community, Market Relationally, Present Powerfully, Lead Well, Innovate Constantly and Build It and They Will Come.

The authors base their practice on FIRE – Fun, Innovation, Relationship and Excellence – and all 30 clinicians work outside managed care. They clearly discuss ideas for running a practice and how to hire the right people. They market in a variety of ways: free talks to the community and special divisions and programs within their practice.

They go on to say that you need to let the practice flow from your dreams, from your unique calling and mission and from your personal and professional values. They seem to have lots of fun in their practice and have made their waiting room just as fun and comfortable.

The authors stress the importance of finding your niche and being willing to say no to a referral if the issue is outside your field of practice. Having such a large group has the advantage of referring within the practice.

They don’t get distracted if something does not work for them. They stress presenting powerfully when giving free talks to the community. Their leadership team needs to lead well and continue to develop skills and ideas.

The last chapter is Build It and They Will Come, which stresses taking risks, being bold and dreaming big. The authors reference many sources.

Some references from the business community could have also been included, such as Revolutionary Retailing: The Complete “Wise Guys” Guide to Small Business Management and Marketing by Robert Kramer.

Those of us who have owned a practice or are just starting out need to realize that in addition to our professional skills and calling, we are running a business and need to think in those terms while always remaining ethical in what we do.

I wish I had the idea of publishing this book based on my 43 years of business and clinical experience. I do not hesitate in recommending How We Built Our Dream Practice, especially for those new to our field. Those who have been around for a while may be able to use some of the suggestions to “jump start” practices in these difficult times.

Book on DSM is lively reading


Review by Roger Peele, M.D. and Marilou Tablang-Jimenez, M.D.

In 1850, the diagnosis of drapetomania was proposed to describe a behavior of “Negroes running away from their plantations.” After providing us with this history and reminding us that homosexuality was a mental disorder until 1973, the reader is made aware that medical diagnosing can, at times, be appallingly wrong. Gary Greenberg, a journalist and psychotherapist, reviews the development of DSM-5, including its important tributaries. His interviews with the DSM-5 developers provide quotes DSM historians will find useful, as they cannot be found elsewhere.

While most writings on the development of DSM-5 will cure insomnia, not Greenberg’s, especially for those who like to read about conflicts. His lively writing style, his ear for irony and his sense of humor make for an interesting read. Some will also welcome his negative slant on the motivations and credibility of DSM developers, if not on psychiatrists more generally.

A key theme of the book is not new: DSMs are not valid. What will not be clear to readers is that the American Psychiatric Association has never claimed the DSMs are valid. DSM-I’s (1952) goal was reliability, not validity. The reliability goal of the DSMs became even clearer with DSM-III (1980). Moreover, no one has claimed that DSM-5 has an increase in validity over the prior DSMs.

The key issue in Greenberg’s book is the degree to which DSM-5 expands the concept of mental disorder. While he captures these conflicts well, he and other reviewers overlook the fact that none of the DSMs provide boundaries to “mental disorder.” So there has been nothing to expand. The “Not Otherwise Specified” category of DSM-IV and the “Unspecified” category, of DSM-IV and DSM-5 respectively, provide clinicians a diagnosis for anyone who is mentally distressed or disabled. So long as we have no adequate definition of the “normal mind,” there is not going to be an adequate definition of “mental disorder.”

DSMs’ foundations were determined largely by consensus and less frequently by votes, not by science. For many, that consensus organizes psychopathology, an organization upon which empirical results of treatment are based. Greenberg exposes cracks in the foundation, none of which, however, reach the dangers of drapetomania.

Furthermore, while Greenberg questions many aspects of the development of DSM-5, he is quite unclear as to what he would prefer. Retain DSM-IV-TR? An alternative to the DSMs? This book pervades a negative critique of the process that went into the development of DSM-5, but suggests no alternative.

Near the end we are told that Allan Francis, editor of DSM-IV, asked Greenberg, “Why do you hate psychiatrists so much? Is it because I pinched your cheek?” Readers will raise the same question, but Greenberg provides no answer.

Closing a practice: practical, ethical and clinical dimensions

By Janet T. Thomas, Psy.D.

Opening a psychology practice is a monumental endeavor requiring energy, drive and determination. The skills required for clinical work are necessary, but not sufficient for initiating and sustaining such an entrepreneurial endeavor. In addition to attending to the practicalities, independent practice demands continual marketing and self-promotion to remain in the forefront for referral sources and accessibility to prospective clients.

Terminating a practice requires a complete reversal of the momentum cultivated. This phase requires knowledge of tasks and challenges associated with the practical, ethical, clinical and personal dimensions of discontinuation. Closing a practice, like opening one, requires careful planning, diligent effort and emotional preparation.

Practical Considerations

Once the decision to close is made, the process begins with setting an end date and working backward to determine the timing of other steps. Notification of clients is among the first considerations. The amount of notice depends on circumstances precipitating the closing. Serious illness or acceptance of a new position, for example, may necessitate minimal notice. When the departure is planned, psychologists can establish a timeline taking into account the types of treatment they provide and client needs. That timeline may range from six weeks to six months, and may be more protracted with longer-term clients, as in a psychoanalytic practice. How far to go in notifying former clients also will vary.

Other notifications include referral sources, liability insurance companies and licensing boards. NPI numbers must be deactivated and provider agreements terminated according to contractual requirements.

Many authors offer suggestions about managing the emotional (McGurk, 2005) and practical aspects of closing a practice (Blakelee, 2014; Heller, 2007; Holloway, 2003). The NASW Center for Workforce Studies provides a helpful checklist for private practitioners (2012).

Ethical Considerations

Ethical responsibilities to clients continue through closing a practice and the termination of therapeutic relationships. For example, APA Ethical Standard 10.10 states that, “prior to termination, psychologists provide preretirement counseling and suggest alternative service providers” (2010, p. 14). Ethical Standard 3.12 requires psychologists to “plan for facilitating services in the event that psychological services are interrupted” (APA, 2010, p. 7).

Notification includes providing information about plans for maintenance, storage and access to records (Standard 6.02). Likewise, the termination process has implications for confidentiality and informed consent.

Clients must authorize communication with future treatment providers (Standard 4.05) and be informed about factors that may influence decisions about participating in current treatment, such as the psychologist’s plan to close.

Clinical and Personal Challenges

Client needs, including those related to therapist self-disclosure, session content and time of termination, are generally paramount in psychologists’ clinical decisions. A decision to close a practice, however, is based on the psychologist’s needs, a significant departure from normal practice. Additionally, psychologists have their own emotional responses. They may experience anxiety, guilt, ambivalence, excitement and sadness.

Psychologists must manage these feelings, distilling out what would be helpful to share with each client. Clients may experience anger, disappointment, indebtedness and gratitude, all with potential to stir emotions in the psychologist. One retiring psychologist commented, “It’s really hard when you are grieving yourself, and you have to listen to your professional eulogy hour after hour.” (P. L. Layton, personal communication, Sept. 19, 2014).

Another challenge involves the potential for accelerated clinical work. Impending termination may awaken past losses or clients may talk about issues that they had put off, feeling that this will be their last opportunity. Former clients who receive notification letters may request another session to say goodbye or to resume treatment.

One psychologist described her work during the weeks preceding her retirement as “some of the most emotionally intense work I have ever done.” (C. O. Geiger, Oct. 3, 2014). Consultation with colleagues at this stage is helpful, if not imperative. Psychologists approaching their final sessions may experience impulses to transgress normal boundaries in an unconscious effort to avoid facing clients’ disappointment or their own feelings.

Holding the therapeutic frame with every client through the very last session is critical. Failure to do so risks undoing the positive impact of work done. After closing their practices with careful thought and planning, psychologists can begin the transition into the next phase of their lives.

Full references available from author

Janet T. Thomas, Psy.D., licensed psychologist, has been in independent practice in Saint Paul, Minn., since 1991. She provides clinical and ethics consultation to mental health professionals, including those in the process of closing practices. She may be contacted through her website located at: www.janettthomas.com.

Special offer:

2015 Appointment Calendar for Mental Health Professionals

This 8 1/2 by 11 inches calendar book has a durable cover. Unique features: appointment times in 15-minute intervals from 7 am to 8 pm; DSM-5/ICD-9-CM/ICD-10-CM; Licensing Board Do’s & Don’ts (new); How to Use the ICD-10-CM (new); mental health legal terms; CE record form; more.

Special price: $27.00 (includes p&h)
Ohio residents add 7.50% per book sales tax

Please send me ________ copies of the 2015 Appointment Calendar.

Name ___________________________________________________________

Address ___________________________________________________________

City ______________________________ State ________ Zip _____________

Gry ____________________________ State __________ Zip _____________

Phone ___________ Email ___________

PAYMENT: _____ Visa  _____ MasterCard  _____ Discover  _____ Check enclosed

Acct # __________________________ Exp. Date ___________ CVV Code ______

Signature __________________________

Order online: www.nationalpsychologist.com

Mail: OPP, 620-A Taylor Station Rd., Gahanna, OH 43230 or Phone: 1-800-486-1985
GET COVERED WITH PROFESSIONAL LIABILITY FROM CPH & ASSOCIATES.

Your practice is too important to leave unprotected.

A++ PROFESSIONAL LIABILITY INSURANCE FOR PSYCHOLOGISTS

- Occurrence Form “Lifetime” Coverage
- Up to 50% Discount for Newly Licensed Professionals
- 10% Risk Management Discount
- 5% Online Discount
- Online applications processed in minutes: receive your proof of coverage immediately!
- 2 Free Hours of Attorney Consultations per year HIPAA Coverage
- Unlimited Defense Coverage
- State Licensing Board Coverage: $35,000 automatically and option to increase up to $100,000
How medical psychology really works in Louisiana

By Darlyne G. Nemeth, Ph.D., M.P., M.P.A.P.
and Joseph Tramontana, Ph.D.

In the November/December, 2014 edition of The National Psychologist, an article, written by Julie Nelson, Ph.D., entitled, “Be careful what you ask for: RxP and psychology in Louisiana,” was highlighted. As a follow-up, we wish to offer our personal and professional experiences of the collaborative nature of Act 251.

Statement of Darlyne G. Nemeth, Ph.D., M.P., M.P.A.P., clinical, medical and neuropsychologist and Louisiana’s Representative to APA Council:

As a member of the Louisiana Psychological Association, currently serving as the APA Council Representative, and as a member of the Louisiana Academy of Medical Psychologists (LAMP), I am in a unique position to offer updated practice information. My current practice at the Neuropsychology Center of Louisiana focuses on clinical, medical and neuropsychological issues. Having been in the first graduating psychopharmacology class of the California School of Professional Psychologists (CSPP), I am in a unique position to offer perspective.

Becoming a medical psychologist was not easy. First of all, there was the arduous three-plus years of post-doctoral master’s training (M.S.C.P.) and two practicums, one with a neurologist and another with an internist. It was a multi-year commitment. After graduating in 1999, I continued my full-time practice, while studying for the PEP exam. Upon successful completion of the PEP exam, I practiced with introductory supervision and restriction for several years. Eventually, with enough experience, I was granted the advanced practice designation (M.P.A.P.).

One of my best experiences was the collegiality I shared with so many other psychologists. For me, graduate school was a competitive experience. Although I survived, there were many scars. The most healing process occurred during the years that I participated in the master’s degree program in clinical psychopharmacology. There, I experienced a collaborative model, which was truly remarkable. Even to this day, my friendships with my classmates have endured. I know that I can call on any of them for assistance and guidance.

This collaborative model needs to be the basis for all graduate training in psychology at all levels. I now know how to gracefully interact with medical and other healthcare professionals in a very collaborative way. Integrated healthcare is the model of the future. Having gone through the M.S.C.P. program, I can say that it provided an excellent precursor for what will soon be the national standard.

To this day, I continue to consult and collaborate with medical practitioners for the benefit of my patients. One absolutely marvelous result is the ease of sharing information. For example, many physicians have told me that, after referring to a psychiatrist, they never heard from that practitioner again. This lack of feedback to the attending physician was one of the reasons why so many neurologists and neurosurgeons supported our Louisiana law.

Now, most physicians are very pleased with the information I provide and feel comfortable picking up the phone and calling me when the need arises. Oftentimes, for example, the attending physicians and dentists will ask me to run drug/drug interaction profiles to make sure that there will be no problems with medications that they choose to add. This level of collaboration is truly remarkable.

As remarkable is the level of collaboration I experience with my clinical psychology colleagues. Now, they are free to consult a medical psychologist, rather than a psychiatrist or non-psychiatric medical practitioner. We work together to develop a treatment program that is in the best interest of the patient. The attending physician, however, is never left out of the loop, so to speak.

Such collaboration is truly a model for integrated healthcare. As one can expect, there were many unfortunate difficulties that led to this current state of equilibrium. Any form of change is usually fraught with resistance and misunderstanding. When change occurs, there are always unintended consequences. There are now more than 60 medical psychologists serving the mental health needs of Louisiana citizens. I look forward to a very positive future for medical psychology and healthcare psychology in our state and beyond.

Statement of Joseph Tramontana, Ph.D., clinical psychologist and president of the Louisiana Psychological Association:

Many years ago, I subscribed to the Prescribing Psychologists’ Register and took the first course or two of their corresponding curriculum, hoping that one day clinical psychologists would get privileges to prescribe psychotropic medications to our patients. At some point, I lost interest, believing that it would never happen. All along, however, I believed that, with appropriate psychopharmacology training, psychologists would be the ideal providers for this treatment. After all, I doubt any psychologist would disagree that we are the most highly trained mental health discipline.

When the prescription law passed in Louisiana, I was pleasantly surprised. When I evacuated to Baton Rouge after Hurricane Katrina, the CSPP was providing psychopharmacology classes in Baton Rouge. When I learned that they were offering the first semester (biochemistry and neurochemistry), which could count as 30 CEU hours without any commitment to complete the entire program, I enrolled.

At the time, I was writing the first of my published books on hypnosis, and realized that I did not write one word that whole semester because I was always studying. I decided that because of my age and other interests (writing), I did not want to further pursue privileges. Since, I was sharing office space with two psychologists and did not feel the need for me to prescribe to be so great. Perhaps if I were in my 30s, 40s, or even 50s, I might have viewed it differently.

Shortly thereafter, I was asked to participate on a panel at the 2008 APA’s annual convention. The topic was “Impact of Prescription Privileges on Psychological Practice” and the panel was comprised of three Louisiana prescribing psychologists, one undergraduate assistant who was researching psychopharmacology and me as the non-prescriber. After telling the audience how great I believed it was having psychologists to whom I could refer my clients if I believed they needed psychotropics, I told the following story:

During my clinical internship year, a psychiatrist on the interdisciplinary faculty admitted something to me at “Happy Hour.” He said: “Joe, I am so impressed with the training film you made with that autistic boy. You know so much more about behavior than me. I’m going to tell you something that if you repeat, I will deny: Psychiatrists study medicine which they don’t practice – in order to practice psychology, which they don’t study.”

This psychiatrist later became chief of psychiatry at a state medical school. The audience loved the quote and one of the panel members asked me to repeat it.

In September 2012, prior to Illinois passing its RxP law, I was invited by Beth Rom-Rymer, Ph.D., to participate in two workshops in Illinois (Chicago and Springfield) to help in their efforts. More specifically, one presenter was a Louisiana prescriber (who was moving to Illinois) and the other was me as a non-prescriber to talk about prescribing in Louisiana.

Rom-Rymer primarily wanted me to show psychologists who were leery about the movement that non-prescribers are NOT “second class citizens” in the psychology community. I shared all of the above information about why I chose not to pursue RxP privileges and let them know how effectively I work with prescribers on a cross-referral basis, not just within my office but throughout the state. The workshop attendees also enjoyed the above story.

While I agree with Dr. Nelson’s concerns about many Medical Psychologists (MPs) being regulated under the medical board, not the psychology board, along with a number of psychologists’ concerns about Act 251, I disagree with some of her interpretations about the chronology that led to that outcome.

I serve now as president of LPA, last year was president-elect and for two years before that was on the LPA Continued on next page
STUDENT VOICES

Concussions complicate doctoral studies

By Samantha Sanderson

One month before starting my doctoral program at Wright State University in Dayton, Ohio, I was rear-ended by a double tractor semi on my way home from work. The next day, which was a Saturday, I experienced a headache, nausea, fatigue and soreness.

My mom wanted me to go to the doctor due to her concern that I may have suffered another concussion. As a former Division I soccer player, I suffered multiple concussions, which resulted in a lengthy recovery and the end of my soccer career. Although I didn’t share her concern, I promised her that if I didn’t feel better by Monday I would go to the doctor. Sure enough, I went to the doctor and was diagnosed with a concussion.

Unfortunately, one month was not long enough for me to fully recover so I started my doctoral program while I was still symptomatic. Between classes, meetings, appointments and driving the 150-mile roundtrip to Columbus for treatment, the first semester was not exactly what I had in mind.

I experienced anxiety and acute stress for which I received therapy and I had difficulty with attention and memory. I developed a tremor in my hands that affected my writing, and I had vision problems that made my ability to read and my ability to switch from looking up during class to looking down to take notes very difficult. Fortunately, I spoke with my professors and they were all understanding and supportive of my situation and my recovery.

After one year, I started to feel much better. I was determined not to let my concussion steal my higher education as it stole my sports career. My best friend/roommate is in my program and she was a tremendous support. She helped me study, complete assignments and remember important dates. In addition, my dad bought me a LiveScribe smartpen, which helped me with lectures during my first year.

Finally, I found support online and started a website with another athlete who has a history of concussions in order to bring awareness to the psychological effects of concussions (www.concussionconnection.com).

Being in a doctoral program with a concussion is far from ideal, but I have learned a lot about myself through this process. If you find yourself in a similar situation, my advice is to seek out services, advocate for yourself, know that you are not alone and believe that you will get better.

Samantha Sanderson is a third year doctoral student in clinical psychology at the Wright State University School of Professional Psychology in Dayton, Ohio. She is passionate about working with collegiate student-athletes. As co-founder of Concussion Connection, she strives to raise awareness of the psychological impact of concussions. She may be reached at: samantha@concussionconnection.com.

Why you cannot afford to practice without an office assistant

By Larry Waldman, Ph.D.

For the past 20 years that I have presented to mental health providers on how to develop, manage and market a private practice, I have always asked members of the audience to raise their hand if they practice without an assistant. Depending on the group and location, typically half or even more of the providers acknowledge practicing solo.

When I question why this is the case, the most common reason is cost. My response is always: “You cannot afford to practice without an assistant.”

On my three busiest days I see eight to 10 patients. If I had to pull charts, refile them, answer the phone, collect, reschedule clients, schedule new clients, return “shopping calls,” make new files, type letters, etc. I could see only half of what patients need. Thus, I cannot afford to be without an assistant.

Aside from the cost issue there are several other reasons why working with an assistant is necessary.

If you are running a one-person shop, I believe you are sending a message you are “small potatoes,” as my Dad used to say. To me it suggests a lack of professionalism. I would think twice before using any service professional – attorney, financial consultant, CPA, etc. who worked alone.

When that prospective new client decides to call your office that morning, did they decide to call just that day or had they been thinking about calling for some time? Obviously, the latter. When that prospective new client calls, what do they want? They want to speak with a knowledgeable person and schedule their first appointment quickly. What they don’t want is to get a recording telling them to leave a message.

When that prospective client finally makes that initial call and gets a recording what are they likely to do? Many will leave a message but many of them will make another call – to the next therapist on their list. Again, one cannot afford to be without an assistant. When new patients call my office they get a live person who can answer all their questions and schedule them promptly.

The first question I ask every new client is, “How did you find me?” (Every mental health provider should ask this question.) I cannot tell you how many times they answer “Your office was the first to answer my call.” (Strangely, many new clients have reported they never receive a return call from other therapists. Those other therapists are busy filing and making charts.)

When the solo provider finds the time to call back the prospective new client, assuming the client has not made an appointment with another provider, the conversation is likely not to be brief. Once the client realizes they are speaking directly with the therapist they will be tempted to “tell their story.” This presents a difficult situation, as the therapist is reluctant to cut off the conversation. Thus, the solo therapist is spending more time without compensation, not to mention teaching the client they are willing to work for free. Moreover, if during the “free scheduling phone session,” the client implies they might be suicidal, the therapist is now faced with the duty to protect a client they have never seen.

Providers seeing only a few clients per day might get by working solo. But, they are likely to remain small because they will have insufficient time to market their practice to make it a larger thriving one.

Larry F. Waldman, Ph.D., ABPP, is a licensed Arizona psychologist who has practiced in the Paradise Valley area of Phoenix for the last 35 years. He is author of several books on treating adolescents, marital issues and marketing a private practice. His website is: http://topphoenixpsychologist.com.

This excerpted article originally was published in the November 2014 issue of The Clinical Practitioner, the online newsletter of the National Alliance of Professional Psychology Providers.
Things I learned in 7 years as an ECP

Previously I wrote about the first three things that I’ve learned in my seven years of being an ECP: the importance of getting involved, how it’s not about the location and the value of consulting. Here are three more things I learned.

Expand Your Horizons

This may mean joining a state association and getting involved in leadership – which has been the most rewarding for me – joining a consultation group, your local chamber of commerce, finding a group of diverse professionals or a newcomers’ club in your home town (if you’ve never heard of a newcomers’ club I highly recommend you look it up online. These can be a great way to meet people in the same boat as you who plan fun activities).

Regardless of what you choose, get your face out there. Meet people. It does not have to be purely on a professional level, it can be social (though I Second of a 3-part series suggest you conduct yourself professionally). When you start to get more fully integrated in your neighborhood or in the town where you work it will eventually result in an enhanced working experience.

I used to hate “networking.” It was so difficult “advertising” myself and what I do. Elevator speeches – blech! I avoided it, thinking I could get by just by doing good work. I found out the hard way that that takes a lot longer than the alternative.

When you put effort into getting to know others they get to know you. They will actually think of you when their friend or colleague needs a therapist. A personal referral goes very far. And, of course like most things, it gets easier over time. Now I actually enjoy it. Meeting new colleagues for lunch gets me out of the office and some turn into friends. I just wish I would have started doing it sooner.

Get a mid-career buddy or mentor

I joined the council of my state association and volunteered for a couple of projects and several mid-career psychologists made themselves available to me. It’s been really amazing. I had been feeling so isolated and with just a little effort on my part I was rewarded incredibly.

I cannot thank these people enough as they’ve been tremendous mentors, consultants and friends. They’ve helped me with difficult

The power of ‘Like’ on Facebook

By Larry D. Rosen, Ph.D.

Michael, a young high school student I am mentoring, celebrated his seventeenth birthday recently. I saw him a day or two later and wished him a belated congratulations and made arrangements to take him out to dinner to celebrate. I asked how his birthday was and he grabbed his smartphone and excitedly showed me a long string of Facebook posts on his wall.

As I was reading them he said, “Did you see that I got 129 ‘likes’? That’s the most ever! Wow! What a birthday!” When I mentioned that everyone was alerted that it was his birthday on the right side of their Facebook pages he shrugged and said, “I know that, but it still feels great.”

Michael demonstrated an interesting phenomenon that appears to have amazing strong power: The power of “Like” (with apologies to Huey Lewis).

According to Facebook’s Help Center, “Like” is a way to give positive feedback or to connect with things you care about on Facebook. You can like content that your friends post to give them feedback or like a page that you want to connect with on Facebook.

So, what is it about having so many people click “Like” on my friend’s birthday that made Michael feel so excited and so happy? Victor Pineiro of the website Big Spaceship sees it this way:

“ ‘Like’ is a vast expanse, covering things I feel lukewarm about, things

I’m fond of and objects toward which I exhibit a smoldering passion. But give me a sunny day and some good music and there are few things I don’t like – which makes the button a notoriously easy impulse click.”

From his excitement, it is clear that “Like” meant a lot more to Michael than just a 127 impulse clicks by his Facebook friends. It meant much more. I am sure that he would not voice this aloud, but it made Michael feel more than liked; it made him feel loved.

First, as you might guess, being better at dispensing real-world empathy makes you feel more supported by your real-world friends. However, so does being better at dispensing virtual empathy. Is it the same? Not really. Real-world empathy is six times more important than virtual empathy in making someone feel supported BUT virtual empathy DOES make you feel supported – even when you know a social media birthday “Like” most likely came from being announced to all your Facebook friends.

Further, using a path analytic model, we were able to show two important results: (1) spending more time using social networks (Facebook) and engaging in instant message chats predicted more ability to be virtually empathic and (2) being better at dispensing virtual empathy was the best predictor of being able to express real-world empathy followed by spending more time communicating face-to-face with others, less time using email and less time playing video games. You get the best empathy from your friends who are actively doing it out online but are not big gamers or big emailers.

The next time you are alerted by Facebook that it is someone’s birthday, don’t just shrug and pass it by. Post a happy birthday message on their wall, and don’t forget to click “Like” as well. It does feel good and that’s really what life is about, isn’t it? Having friends and knowing that they care and want the best for you.

The best birthdays may simply include a lot of well wishes (and “Likes”) on Facebook followed up by gathering your all-important bonding social capital from your real life friends in the real world. It’s all about feeling better and gathering those feelings wherever you can. They are real and they are important.

Larry Rosen, Ph.D., is a professor at California State University, Dominican Hills and the author of five books on the psychology of technological social media. He may be reached by email at lrosen@csudh.edu and his website is www.DrLarryRosen.com. He is currently writing a book entitled, The Distracted Mind with neuroscientist, Adam Gazzaley, MD, Ph.D., of the University of California, San Francisco.

----------
ECPs need mentors, consultants and friends

Continued from prior page

clients and they’ve supported me in my professional growth. They have introduced me to others and opportunities I would not have been able to get so early on in my career on my own. Now I am very integrated in the profession. I have gained a lot of confidence. And the cherry on this fine sundae is that they refer patients to me.

Go to analysis

I know, I know. This one is going to ruffle a few feathers. I cannot emphasize enough the value of doing your own intensive insight-oriented therapy early on in your career. You learn about your psychological strengths and weaknesses, your blind spots.

I walked into analysis during grad school thinking I was only following a professor’s recommendation to us all and that I would walk out a week later with a stamp of approval. It was mind-blowing how much I learned about myself in those few years (and even after I had left analysis). It will help to keep you out of a lot of trouble if you have first figured out who you are and your true unconscious motivations for becoming a psychologist.

If you don’t think you can afford it ask if you can afford the alternative – getting into a heap of trouble with a patient. A cheaper alternative would be to read Freud, starting with page 1 of Volume 1 and going through to the last page of Volume 23. It will take you some time and it may not always be palatable but you will learn about human behavior, human psychology and yourself in the process in a way that is absolutely priceless. And if you’re squeamish about the terminology of ‘oral,’ ‘anal,’ ‘phallic’ and ‘oedipal’ – well I suggest you rush off to therapy.

To be continued …

Karla Steingraber, Psy.D., is a licensed clinical psychologist with Aprioris Psychological Health Services in Skokie, Ill. She may be reached at: keasme@mac.com.

Florida’s ‘Baker Act’

Sheriff wants more spent for mental illnesses

Florida’s “Baker Act” that has been in effect since 2005 allows judges, law enforcement officers, physicians or mental health professionals to seek up to 72 hours of involuntary institutionalization of persons who evidence signs of mental illness and pose harm to themselves or others or self-neglect.

The law was named for a Florida state representative, Maxine Baker, who had a strong interest in serving the mentally ill and sponsored the bill.

The sheriff of Pinellas County, Bob Gualtieri, testified in February to a State Senate subcommittee that what is needed to make the law protect the general public and those with mental illness is more money to hire mental health case managers to follow up on Baker Act evaluations and see that the mentally ill get the services they need.

Gualtieri said more mentally troubled people need to be sent to hospitals instead of jails and law officers need better training on dealing with those who have mental problems. About 5,000 persons booked into the Pinellas County Jail between 2011 and 2014 had been evaluated under the Baker Act the same year.

“Preventing the next bad act is monitoring them, case managing them and at the same time also respecting their rights,” Gualtieri said in an interview with WFTS ABC Action News of Tampa, Fla.

Gualtieri has been leading a move for mental health reform following the arrest of Christian Gomez for the New Year’s Eve beheading of his mother. The sheriff said Gomez was off his medication despite a mental illness diagnosis and had not been checked on by any case managers.

Scheduling & To Do Lists

Streamline your practice management and workflow. Past appointments are automatically added to your To Do List. Sync your calendar to your iPhone. Great multi-clinician scheduling features.

Patient Notes & EMR

Our form-based system makes it easy to keep up with your notes. Templates were designed specifically for mental health and therapists. Also upload any files to your patient records.

Electronic Billing

Easily submit claims electronically with TherapyNotes EDI. Track balances, view revenue reports, and generate CMS forms, superbills, and patient statements all from within TherapyNotes.

Appointment Reminders

• Automatic text, phone, and email reminders
• Reduce no shows and decrease expenses

Fully Integrated Credit Card Processing

Swipe or enter patient credit cards

...AND MANY MORE FEATURES!
C.E. Quiz (earn one CE credit)

You can earn one (1) continuing education (CE) credit for studying each issue of The National Psychologist (TNP). This offer is made possible in collaboration with Professional Development Resources, a provider approved by the American Psychological Association to sponsor continuing education credits for psychologists. Under this agreement, Professional Development Resources reviews TNP content in advance, selects substantive articles, formulates the CE quiz and maintains responsibility for the CE program.

After reading the articles marked with a “CE” symbol in this issue, complete the quiz by going to www.pdresources.org/tnp and select the issue for which you wish to take the CE test. There will be a $10 fee for each quiz you take. Once you successfully pass the test (requires 80% correct), you will be able to print your certificate of credit instantly. Professional Development Resources maintains secure records of your credits.

National Psychologist Quiz
Quiz Vol. 24 No. 2
March/April 2015

Medicare penalties catch uninformed psychologists off guard
1. Beginning in January 2015, all Medicare providers who failed to satisfactorily report one process measure on one patient in 2013 began to receive a _______ payment reduction on their Medicare patients throughout 2015.
   a. 1%
   b. 1.5%
   c. 0.5%
   d. 2%

Ohio teen’s suicide stirs conversion therapy discussion
2. Which of the following states were the first in the nation to successfully pass laws banning conversion therapy?
   a. Florida and Virginia
   b. Illinois and Oregon
   c. Connecticut and Pennsylvania
   d. California and New Jersey

The ethics of leadership in psychology
   a. leadership roles
   b. respect for people’s rights
   c. justice
   d. fidelity

4. Within the ________ leadership model, leaders provide a vision for change and then endeavor to inspire the other members of the group to pursue that transforming vision.
   a. transactional
   b. tyrannical
   c. transformational
   d. transitory

Sorting through professional liability insurance for needed coverage
5. Which one of the following statements about professional liability insurance is accurate?
   a. You can only guarantee that you’re immune from a liability claim if your intentions as a clinician are good
   b. An occurrence form policy provides life-time coverage regardless of the time the policy was in effect
   c. A claims-made policy provides coverage only for claims that occur while the policy is in effect
   d. There is no way to have liability coverage after you allow a policy to lapse

PQRS: a quality vaccination for behavioral healthcare
6. According to Hartman-Stein, the question of participation in the quality movement in U.S. healthcare has principles similar to those found in the
   a. DSM-5 debate
   b. vaccination debate
   c. carrot and stick process
   d. morass of CMS beureaucratic notices

‘Sexual sobriety’ leaves victims untreated
7. The ______________________ proposes clinical management that includes assessing and diagnosing sexual addiction-induced perpetuations and providing appropriate safety, stabilization and clinical de-escalation for victims.
   a. Sex Addiction-Induced Trauma
   b. Sexual Sobriety Model
   c. Sexual Compulsivity Model
   d. Compartmentalized Sexual-Relational System

(Ethics) Closing a practice: practical, ethical and clinical dimensions
8. Which one of the following considerations concerning the process of closing a practice represents a significant departure from normal practice?
   a. Closing a practice, like opening one, requires careful planning, diligent effort and emotional preparation
   b. The timeline for giving notice to clients can be shortened to suit the convenience of the psychologist
   c. It is not necessary to notify referral sources, liability insurance companies and licensing boards
   d. A decision to close a practice is based on the psychologist’s needs, rather than those of the client

Arizona seeks return of court-appointed psychologists to board
The Arizona State Legislature is considering a bill to change the way complaints about psychologists appointed by family courts are handled.

Under legislation enacted in 2009, when a judge in a family court appoints a psychologist to work with contending parties, any complaints about poor performance, ethical violations and other problems go to the judge rather than the Arizona Board of Psychologist Examiners. That law prevents the board from considering complaints against court-ordered psychologists unless a court finds a “substantial basis” to refer the complaint.

State Sen. Steve Smith, a Maricopa Republican, sponsor of SB 1439, said he introduced legislation to make all complaints referred to the psychologist licensing board because “many families, particularly those in divorce cases, feel that their complaints aren’t being handled properly because a judge may not have the background to evaluate their concerns properly.”

Submit Online & Save!

Save time & money by submitting your CE quiz online.
Online test fee $10 (versus $15-$25 if mailed). Instant results.

Learn how @ www.pdresources.org/tnp

OR Use Form Below to Submit by Mail

Name: ________________________________
Address: ________________________________
City: ____________ State: _______ Zip: _______
Phone: _______________ Email: _______________
Profession: ________________
State(s) of Licensure: ________ License #: ______

Mail quiz and payment ($15 TNP Subscriber/$25 Non-Subscriber) to:

Professional Development Resources
PO Box 550659 | Jacksonville, FL 32255
Make checks payable to Professional Development Resources.
Please allow 3-4 weeks for processing.
Albany, & NYC licensed psychologists to perform evaluations in our busy offices throughout NYS. Contact jobs@ima-us.com, apply to: http://jobs.medcruiter.com/Company/IMA/JobSearch. Call 914-323-0312. View our website at www ima-us.com follow us on twitter @IMArecruiting.

Question and Answer brochures: "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 7% tax.) Samples .25 each + SASE with .65 postage. Order at: OPP, Inc., 620-A Taylor Station Rd., Gahanna, OH 43230, Fax: 614-861-1996, or 800-486-1985

Lily Billing Medical: Specializing in mental health medical billing. Instead of a costly in-house hire, my reasonable fees will save you headaches and money. I provide the highest quality service and maintain an exemplary reputation for my clients and myself. Contact: Lily Azizi, Medical Biller, call: 310.701.8049 email: lilybillingmedical@gmail.com. References upon request.

Whitey Bulger, the Boston mobster serving two life sentences for racketeering, including direct involvement in 11 murders, traded autographed mugshots with a prison psychologist in exchange for favors, including transfer to a private cell and privileges to write letters to his girlfriend who is serving time in another lockup, the DailyMail.com reported.

The mobster and the shrink

The online newspaper based in the United Kingdom said the 85-year-old mobster persuaded the woman psychologist, who has not been identified, to lobby for the cell change and to let him write to Catherine Grieg, who is serving time in a Minnesota prison for harboring a fugitive – Bulger.

Bulger and Grieg were arrested in Santa Monica, Calif., in 2011 after the relationship with the 30-something prison psychologist came to light, Bulger was transferred from a high-security federal penitentiary in Tuscon, Ariz., to an unnamed facility in Florida. The psychologist was removed from the prison but reportedly is still on the payroll.

Authorities are investigating whether she attempted to make money from the photos and whether she will face any employment discipline or criminal charges. Bulger’s notoriety has made his likenesses valuable. A portrait of him as a young inmate at Alcatraz, reportedly drawn by a fellow inmate there, has been posted on eBay for bids.

Johnny Depp will play Bulger in an upcoming movie.
What’s happening across the USA

Alabama — The Alabama Department of Mental Health is closing the North Alabama Regional Hospital mental health facility near Decatur in June, but state officials told The Tuscaloosa News that positions are available at three state facilities in the Tuscaloosa area for the 150 employees whose jobs are affected. About 40 are eligible for retirement, and the department’s commissioner, Jim Reddoch, said the state will work to find private sector jobs for those who don’t want to move from Decatur to Tuscaloosa.

California — Steven E. Clark, director of the University of California, Riverside’s Presley Center for Crime and Justice Studies, has been awarded a two-year $300,000 grant to create the UC Consortium on Social Science and the Law. Members of the consortium are international experts in a range of topics in the intersection of law and social science, including inequality and diversity, crime, juvenile justice and legal decision-making, according to a university news release. Among topics to be studied are how witnesses make decisions about reporting crime, how jurors make decisions in criminal and civil trials and how judges make decisions and exercise judicial discretion.

Delaware — The Christina Care Health System closed the Herman Rosenblum Child and Adolescent Center in Wilmington on Feb. 20 and is progressively shutting down its other outpatient psychiatric services in an overhaul of its behavioral health services. Christina officials say the plan is to move psychologists, social workers and therapists who work in the outpatient programs to primary care practices for earlier diagnosis of mental illnesses.

Iowa — The Iowa Psychological Association has received a $50,000 grant from the Tellenig Community Initiative to help fund its psychologist internship training program, which brings postdoctoral psychologists to Iowa for one year of supervised clinical work. The grant will allow one postdoctoral psychologist to be placed in Ames under the supervision of Warren Phillips, Ph.D., a clinical psychologist at Central Iowa Psychological Services. Phillips said one of the goals of the training program is to lure young psychologists to the state, which is losing many of its older psychologists to retirement.

Michigan — Two “limited-license” masters-level psychologists in Ann Arbor have filed suit in Detroit’s federal court seeking unnamed compensatory damages and attorney fees after they were forced by state regulation to remove advertisements from Psychology Today. Judy Seldin and Karen Gottschalk claim their free-speech rights were breached by a state regulation that forbids so-called “limited-license” psychologists to advertise under certain circumstances. State regulation requires master-level psychologists to practice under supervision of already certified psychologists before striking out on their own and before gaining the right to advertise.

New Hampshire — The New Hampshire Psychological Association has hired Robert P. Blaisdell as executive director. Blaisdell, a professional lobbyist since 1998, was formerly senior vice president of Demers and Blaisdell Inc., a consulting company.

New York— The New York State Psychological Association has created a Division of Cognitive Behavior Therapy, bringing to 17 the number of divisions in the organization. To fully implement the new division, 50 NYSPA members need to join. On-line registration for joining the new division ends Sept. 1.

Pennsylvania — Susan Schecter-Cornbluth, Ph.D., a Temple University psychology professor, has been ordered to cease practicing psychology in Pennsylvania following an investigation that alleges she lied under oath in a in Bucks County court saying she was licensed to practice in the Keystone state and New Jersey. She was charged with felony perjury and released on bond in early February. She allegedly told a Bucks County court that she was licensed to practice in New Jersey and therefore didn’t need a license to practice in Pennsylvania. She has entered into a consent agreement and order with the Pennsylvania Bureau of Professional and Occupational Affairs admitting to never being authorized to practice psychology anywhere as a profession or occupation, according to an affidavit.

New Jersey judge rules group cannot claim homosexuality is a disorder

A New Jersey Superior Court judge has ruled misrepresenting homosexuality as a disorder in marketing conversion therapy services violates the state’s consumer protection act, a significant development made in advance of a scheduled June civil trial involving a Jersey City group promoting a cure for same sex attractions.

In a suit filed by the Southern Poverty Law Center (SPLC) against Jews Offering New Alternatives for Healing (JONAH), Superior Court Judge Peter F. Barsio, Jr. found that it is a “misrepresentation in violation of New Jersey’s Consumer Fraud Act” in advertising or selling conversion therapy services to describe homosexuality, not as being a normal variation of human sexuality, but as being a mental illness, disease, disorder, or equivalent thereof.”

The judge also ruled that JONAH is in violation of the consumer fraud act if it offers specific success statistics for its services when “client outcomes are not tracked and no records of client outcomes are maintained” because “there is no factual basis for calculating such statistics.” Part of the evidence in the June trial will claim that JONAH has misrepresented that their conversion therapy works based on bogus statistics.

In an earlier ruling in February, the judge ordered that several of JONAH’s witnesses – some of the country’s most prominent conversion proponents, including widely known supporter Joseph Nicolosi, Ph.D., of the National Association for Research and Therapy of Homosexuality (NARTH) – will not be permitted to testify as defense experts in the upcoming trial. The judge also excluded key conversion therapy supporter Christopher Doyle, a therapist associated with the International Healing Foundation and Voice of the Voiceless; James Phelan, MSW, a frequent NARTH spokesperson, and John Diggs, M.D.

Judge Barsio said they were being excluded because their research is unscientific and rests on the false premise that homosexuality is a disorder.

The Southern Poverty Law Center filed the suit against JONAH in November 2012 on behalf of two former JONAH clients, Benjamin Unger and Chaim Levin, and two parents of former clients. The suit also names JONAH’s founder Arthur Goldberg and counselor Alan Downing as defendants.

The suit claims that the group used deceptive practices to lure plaintiffs into their costly services for gay-to-straight therapy that can cost in excess of $10,000 a year. The SPLC said the judge’s ruling marked the first time a court has ruled that it is fraudulent as a matter of law for conversion therapists to tell clients that they have a mental disorder that can be cured.