Vol. 69, No. 6

A PUBLICATION OF THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION • www.PaPsy.org

The Pennsylvania Psychologist

June 2009 • QUARTERLY

ALSO IN THIS ISSUE: AdultBasic expansion proposed • Legal column: Unlearning ethics • Culturally responsive practice in schools • Collaborative process in divorce

Make the right choices in **LIFE**

TRUST ENDORSED TERM LIFE INSURANCE

Sometimes you need a little help making the right choices . . . particularly when your choices may affect those who depend on you for their financial well-being. Whether you want to supplement existing coverage or simply purchase insurance to provide protection for specific life events, Trust endorsed Term Life Insurance from Liberty Life Assurance Company of Boston has the features, flexibility, and affordability to meet your needs.

We can help you choose the right coverage

Just call Liberty Mutual toll-free: For Group Term Life, call 1-800-210-0268 (last names A-G, ext. 36392; H-Q, ext. 38518; R-Z ext. 38026), or for Liberty Series Passport Term call 1-800-341-0603 to be put in touch with a Liberty representative.

THE TRUST

www.apait.org • 1-800-477-1200

Trust-endorsed Group Term Life

State-of-the-art coverage

Trust endorsed Group Term Life Insurance only requires that you provide adequate evidence of insurability at the time you apply. The policy[1] guarantees that you may continue coverage until age 75 without further evidence of insurability. It also has features such as Waiver of Premium for total disability, accelerated death benefits in the event of terminal illness, and Inflation Safeguard[2] to offset erosion of the policy's purchasing power due to inflation. Premiums increase in five year age bands.

Liberty Series Passport Term

Level premiums for the term of the policy

Liberty Series Passport Term insurance[3] provides protection at locked-in premiums for the term period you select. You choose a coverage period that best corresponds to your mortgage, the dependency period of your children, or other important life events. Passport Term is individually owned and is available in 10, 20, or 30 year term periods.

Liberty Mutual

---

[1] Available in amounts up to $1,000,000. Coverage is individually medically underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. Plans have limitations and exclusions, and rates are based upon attained age at issue and increase in 5-year age brackets.

[2] Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.

[3] Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group, issues Liberty Series Passport 10, Passport 20, and Passport 30 term life insurance contracts on policy form TERM 2005057 (TERM 2005057 NY in New York and TERM 2005057 NJ in New Jersey) and state variations identified by state code. Contract availability, terms, conditions, and issue limitations may vary by state. Liberty Life's obligations under its life insurance contracts are guaranteed by Liberty Mutual Insurance Company. Home Office: Boston, MA. Service Center Dover, NH. The Trust has an expense reimbursement/endorsement arrangement with Liberty Life Assurance Company of Boston.

Vol. 69, No. 6

The Pennsylvania Psychologist

Editor: David L. Zehrung, Ph.D.

June 2009 • QUARTERLY

Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102
(717) 232-3817
www.PaPsy.org

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in *The Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance, members or staff of PPA or PPF.

The Pennsylvania Psychologist Quarterly is published in March, June, September and December. The copy deadline is the 15th of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 416 Forster Street, Harrisburg, PA 17102.

Get 1 CE credit for this issue! Page26

REGULAR FEATURES

SPECIAL SECTION
YES WE CAN – BEYOND THE BASICS OF DIVERSITY

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Acknowledging Our Own Diversity

Nancy Chubb, Ph.D., MBA

Colleague, let's get personal. Every one of us has a history – a history that includes commonalities (getting through graduate school) and differences. It is often our shared experiences and goals that bring us together, and we tend to minimize our differences to facilitate this bonding. But our differences matter, and I believe it is a sign of our strength as a group when we can bring them into the open. This makes us better psychologists for our diverse clients and better citizens in this diverse world.

When I was 26, I fell in love with a woman. That experience released my spirit to love without societal constraints. I spent the next quarter century in two long-term partnerships with women – if we had been allowed to get married, I imagine we would have.

My two children have those women as their other parent. My oldest just turned 25, so you can imagine some of the hurdles we faced educating their educators about our "different" family. We chose to live in the city of Pittsburgh because we found more acceptance there than in the suburbs. I was not "out" at work (Mellon Bank) or in graduate school. However, whenever my partner and I were in public together, her "butch" image meant we were "out" and targets for comments by passersby. This was often annoying and occasionally scary.

My community in those days was a dynamic collection of women who supported each other's spirits and love, without a focus on men. We created our own bookstores and social gathering places; we were family to those who were rejected by their birth families. This community is less isolated now that there has been greater acceptance in mainstream America (as marked by the large gay and lesbian section in Borders).

When I got my Ph.D. in psychology in 1993, I went to work for Persad Center, the second oldest counseling agency for GLBT people in the country. One of its founders, Jim Huggins, Ph.D., a long-time PPA member, supervised me for licensure. This was a wonderful experience for several reasons, but above all, I was working in a place in which not only did I not have to hide a significant part of my identity, but my diversity was seen as an asset. It was a freedom to be myself in my work life that I had not experienced since age 26. And yet, when I was considering this job, an Ivy League lesbian psychiatrist and friend said to me, "Don't go to work for a gay agency. It will narrowly define you as a psychologist and ruin your career."

And then I turned 50, was single and open to change, including romance with men. Pete and I met in 2003, married in 2005, and feel blessed by our relationship every day. People who meet me today see a 58-year-old, happily married woman with two kids and a busy downtown private practice and consulting business. What they don't see is the lion's share of my adult life. This has led to some interesting situations:

- Psychologist (someone who knows me well enough to know I had kids): "Congratulations. I heard you are getting married. How long have you been divorced?"
  Me: "Ahhh. Well, I am not divorced. My previous partnerships were with women."
  Psychologist: "Oh. (awkward pause) I didn't know that."
- Clients (lesbian couple in therapy with me for years): "We heard you are getting married to a man. We aren't sure we can keep seeing you as our couple's therapist." We discussed it, and they did.
- Colleague: "Aren't you worried about 'coming out' in an article that will be available online for anyone to read? Don't you think you will lose business customers and therapy clients?"
  Actually, I am worried about that, but how can I ask my clients to authentically be themselves if I am not?

My life experiences have given me unique perspectives. I have lived with the knowledge that not being able to hold hands in public and play in the ocean with my partner diminishes the joy of love. I understand the need to gather away from the critical eye of the majority, to celebrate oneself, to actually discover who one is when one is more than "not them." Heterosexual privilege, like white privilege, class privilege, and male privilege (I have learned a lot about male privilege from a client who grew up female, lived as a male for 20 years, and is once again, reluctantly, identifying as female after falling in love with a guy), is a very real thing. Being married gives me legitimacy and status I feel every day as I move about in both my personal life and professional life. My voice is louder; my fear is less. I hope that some day it will not be so different.

During my involvement with PPA I have been aware that the voices of our GLBT members are rarely heard. I think that is because prejudice still exists (even among ourselves)...

During my involvement with PPA I have been aware that the voices of our GLBT members are rarely heard. I think that is because prejudice still exists (even among ourselves), being quiet is easier, and rejection is painful. One colleague said to me recently, "It will take more

Continued on page 5

Dr. Mark Hogue Elected PPA President

Dr. Hogue

The winner of this year's election for president of PPA was **Mark A. Hogue, Psy.D.** He will serve as president-elect on the Board of Directors for the 2009–10 program year, and as president for 2010–11. He has been chair of the Professional Psychology Board since 2005. Prior to that he served as chair of the Legislative and Governmental Affairs Committee and Hospital Practice Committee. He has been a member of numerous other committees, was a member of the Pennsylvania Psychological Foundation Board for 6 years, and served a term as president of the Northwestern Pennsylvania Psychological Association. Dr. Hogue won the APA Heiser Award for Advocacy in 2005. He is a member of APA's Divisions of Neuropsychology and Exercise/Sport Psychology. He received his Psy.D. degree in Clinical Psychology from the Indiana University of Pennsylvania in 1996. He is in private practice in Erie with Northshore Psychological Associates.

Dr. Bellwoar

Vincent Bellwoar, Ph.D., won re-election as treasurer of PPA. He has been the treasurer for the past 2 years and therefore a member of the Board of Directors, Executive Committee, and Budget and Finance Committee. He is Director and Chief Financial Officer of Associates of Springfield Psychological in Delaware County, a large outpatient psychology practice. He received his Ph.D. in School Psychology in 1996 and an M.Ed. degree in Counseling Psychology in 1988 – both from Temple University.

Dr. Palmiter

Re-elected as the Communications Board chair was **David Palmiter, Ph.D., ABPP**. He is Professor and Director of the Psychological Services Center at Marywood University. He also maintains a private practice in Lackawanna County. He has presented more than 200 public education offerings and over 170 professional workshops. He has also been an active member of the Northeastern Pennsylvania Psychological Association. He received PPA's Psychology in the Media Award in 2006 and Marywood's Distinction in One's Discipline Award in 2008.

Dr. Affsprung

The winner of the election for Internal Affairs Board chair was **Eric H. Affsprung, Ph.D.** He is currently the chair of both the Membership Benefits Committee and the Colleague Assistance Committee. He is past chair of the Membership Recruitment Committee. As Internal Affairs Board chair he will also oversee the committees on Awards, Budget and Finance, Leadership Development, and Nominations. He is Assistant Professor in the Center for Counseling and Human Development at Bloomsburg University. He received his doctorate from the University of Pennsylvania in 1995.

Dr. Karafin

Gail Karafin, Ed.D., was re-elected chair of the School Psychology Board. She is a licensed and certified school psychologist. She maintains a private practice in Doylestown and works as a school psychologist in the Bensalem School District. She earned Ed.D. and M.Ed. degrees from Temple University. She has been a member of the School Psychology Board for 10 years. This service includes recording secretary and past chair of the Outreach Committee. She is a past chair of PPA's Membership Benefits Committee and currently the PPA Board's liaison to PPAGS.

Looking ahead to his year as president, Dr. Hogue stated, "We must continue to add value for all psychologists, including those in academic settings and in practice. We need to expand our influence and ensure continued viability of our profession. As president, I will continue to fight to solidify psychology within health care systems, advocate for reasoned insurance coverage, and strengthen psychology's position as a science and practice."

State AdultBasic Insurance Expansion Is Proposed

Thomas H. DeWall, CAE

Governor Rendell is proposing to expand the health insurance program for uninsured Pennsylvanians between the ages of 19 and 64. The program, called adultBasic, grew out of the tobacco settlement in 2001, when then-Governor Tom Ridge signed into law Act 77. That act directed $11 billion over 25 years from the tobacco settlement to be used for health insurance for the working poor — people who make too much to qualify for Medical Assistance but too little to be able to afford commercial health insurance. The program is administered by the Pennsylvania Insurance Department. It offers basic benefits, including physician visits, preventive care, diagnosis and treatment of illness or injury, inpatient hospitalization, outpatient hospital services, and emergency accident and medical care. It does not, however, cover behavioral health services or prescription drugs.

Participation in the adultBasic program is based on certain eligibility requirements, which include:

- having no other health care coverage;
- lack of prior coverage under any other insurance plan for 90 days prior to enrollment, except for people who have been laid off from their jobs;
- having family income below 200% of the federal poverty level;
- having lived in Pennsylvania for at least 90 days prior to enrollment;
- U.S. citizenship or permanent legal alien status.

The program is free to those whose income is less than 150% of the federal poverty level. For those who make between 150% and 200% of the poverty level there are modest premiums. For all participants there are limited copays.

Governor Rendell's 2009-10 budget, proposed in February, includes a plan to expand the state's efforts to cover the uninsured. The Governor has proposed expanding enrollment in the current adultBasic program to at least 90,000 — approximately doubling the size of the current program. The waiting list for people trying to get into the program has grown from about 90,000 a year ago to more than 200,000, and it grows substantially each month in the current recession.

He has also asked the state legislature to modify and modernize the program. Of primary interest to psychologists, the proposed expansion would include coverage for mental health treatment, although the details of that coverage are not yet available. Current enrollees do not have access to such treatment, nor to prescription drug coverage.

The waiting list for people trying to get into the program has grown from about 90,000 a year ago to more than 200,000...

In an explanation on his Web site, the Governor stated, "Expanding the adultBasic program and offering prescription drug and behavioral health coverage is both the smart and right thing to do. The adultBasic expansion will make a modest impact on the record adultBasic waiting list and the number of uninsured. Of course, the Administration is willing to work with the legislature to expand insurance coverage for more people" (*Rx for PA*, 2009).

Expanding the program in this way will also allow the state to access federal funds to help pay for it. Federal funds will pay for at least 50% of the cost if the law is changed to tie it to Medicaid and reimburse for behavioral health and prescription drugs.

Other avenues for paying for the additional coverage are use of the state's Provider Retention Fund (originally designed to subsidize malpractice insurance) and a proposal to tax chewing tobacco and cigars. Pennsylvania is the only state that does not impose such a tax.

The adultBasic program is only one of several possible initiatives to address the fact that more than 1 million Pennsylvanians are uninsured. However, comprehensive health care reform is unlikely to happen at the state level, or at least in this state, any time soon. State officials are waiting to see what the U.S. Congress and the Obama Administration will be doing to meet the health care needs of the estimated 47 million people without health insurance. The American Psychological Association is working hard to try to ensure that any health system overhaul retain the mental health parity provisions recently enacted at the federal level.

Expansion of adultBasic was one of the subjects that PPA members discussed with their legislators at our annual Advocacy Day in Harrisburg on April 20. Although the actual bill had not been introduced by that date, it is expected to be filed soon and referred to the House Insurance Committee, where quick action is expected. Whether the bill will move

through the state Senate is another matter. The Senate leadership is more skeptical of any new spending initiative. Action by both chambers will be necessary to effect these changes.

The other issue that PPA members addressed during Advocacy Day was that of Problem Solving Courts, in the form of Senate Bill 383, sponsored by Sen. Jane C. Orie (R-Allegheny). This bill, which would encourage the establishment of county-level Problem Solving Courts administered through the Pennsylvania Supreme Court, has been approved by the Senate Judiciary Committee, and action is expected soon in the full Senate.

Reference

Rx for PA. (2009). Retrieved April 17, 2009, from http://www.rxforpa.com/adultbasic.html

PRESIDENTIAL PERSPECTIVE

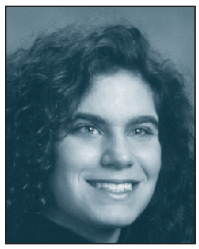
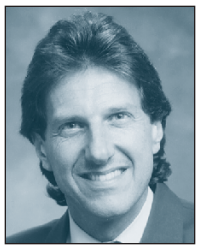
Continued from page 2

than your story and invitation for PPA to feel welcoming to all minorities. Particularly at this point in history, at an organizational as well as an individual level, affirmation needs to be active, inclusive, audible and unwavering. The group, not just a few of its members, has to have some skin in the game." Most of us, like our clients, want acceptance, support, and respect from our colleagues. I know I do.

Most of us have some sort of minority experience: race, ethnicity, religion, class, differing ability, sexual orientation, family constellation, trauma history. Let's be curious about ourselves and each other and celebrate our commonalities **and** our differences. Let's invite each other into the discussion and learn from our vast experiences.

So "come out, come out, wherever – or whoever – you are." I welcome you and want to hear from you, and PPA needs each and every voice. I think we can handle it.

Unlearning Ethics

Samuel Knapp, Ed.D., Director of Professional Affairs (left); Rachael L. Baturin, MPH, J.D., Professional Affairs Associate; and Allan M. Tepper, J.D., Psy.D., PPA Legal Consultation Plan

It often is more difficult to unlearn false information than it is to learn new information. Based upon our experiences as consultants on ethics, we sometimes encounter psychologists with inaccurate beliefs concerning their legal or ethical obligations, or the manner by which to implement prudent risk-management strategies. Listed below are a number of such beliefs that can be false or misleading if not placed in their proper context. Can you identify what is incorrect, inaccurate, or incomplete about these statements? *The answers are shown on page 6.*

False, Misleading, or Incomplete Statements

1. The duty to report child abuse is triggered when psychologists or other mental health professionals conclude that a child coming before them (or their agency, organization or institution) is an abused child.
2. A psychologist is obligated to release records in response to a subpoena served by an attorney.
3. The Pennsylvania Mental Health Procedures Act allows the involuntary hospitalization of individuals who threaten to harm others.
4. Psychologists and other mental health professionals must warn an identifiable third-party victim whenever a patient voices a verbal intent to harm another person.
5. The APA Ethics Code requires that psychologists utilize a written consent to treatment form.
6. Multiple relationships are unethical.
7. It is permissible to engage in an intimate relationship with a patient 2 years following termination of treatment.
8. When treating a suicidal patient, it is advisable to require that the patient sign a contract for safety.
9. When treating a difficult patient, it is advisable to maintain minimal notes to contain future liability exposure.
10. Treatment notes belong to the psychologist, and the psychologist determines the patient's access to the records.

The answers are shown on page 6

UNLEARNING ETHICS

Continued from page 5

Answers

1. The duty to report child abuse occurs when the mandated reporter *has a reasonable cause to suspect* child abuse. This is a standard below a finding of abuse, and thus the psychologist is not required to conclude definitively that the abuse has occurred *(see Knapp & Tepper, 2007; Tepper, Knapp, & Baturin, 2007)*.

2. In general, psychologists may disclose patient information or turn over patient records if the patient has executed a written release of information. A written release of information is necessary even if the psychologist has been served with a subpoena. A Court Order requiring the release of records negates the need for the written consent of the patient *(see Tepper & Baturin 2005)*.

3. In Pennsylvania, an individual may be subject to a period of involuntary commitment if the person, as the result of a mental illness, threatens harm to self or a third party and engages in an overt act in furtherance of a threat to harm oneself or a third party. The mere presence of a threat, in the absence of an overt act or an act in furtherance of a threat, does not justify an involuntary civil commitment *(see Knapp, VandeCreek, Tepper, & Baturin, 2008, Chapter 11)*.

4. In Pennsylvania, the duty to protect by warning is triggered when a patient has communicated a specific and immediate threat of serious bodily injury against a specifically identified or readily identifiable third party, and when the professional determines or should determine, under the standards of the mental health profession, that the patient presents a serious danger of violence to the third party. The mere verbal threat of harm will not trigger the duty to protect by warning. A determination of potential dangerousness is required. This determination is made, in part, by an analysis of the total context in which the statement was made, as well as the characteristics of the patient *(see Tepper & Knapp, 1999)*.

5. The APA Ethics Code requires that psychologists document informed consent (see APA Code, Standard 310d; American Psychological Association, 2002). There is no requirement that a psychologist utilize a signed consent-to-treatment form. Such a form would fulfill the requirement to document informed consent. Pursuant to the APA Ethics Code, however, it is permissible to convey essential information about treatment in an oral fashion, as long as the discussion is documented in the treatment notes.

6. Nonsexual multiple relationships are not *per se* unethical. Psychologists are advised to avoid multiple relationships with patients that might impair the psychologist's professional judgment or increase the risk of exploitation. From a risk-management perspective, it is advisable to avoid multiple relationships with patients. At times, however, such multiple relationships are unavoidable, such as situations in which psychologists are practicing in small towns or small communities *(see 49 PA Code, Section 41.61, Principle 6, and Bennett, et al., 2007)*.

7. Sexual relationships with former patients are permitted if 2 years have passed since the termination of treatment, and if there has been no exploitation of the patient. The issue of exploitation involves such considerations as the amount of time that has passed since the professional relationship terminated, the nature and duration of therapy, the circumstances of termination, the likelihood of adverse impact on the client/patient and immediate family members, as well as additional factors *(see 49 PA Code Section 41.83)*.

8. Contracts for safety are not considered legal agreements. If they are used in the context of a respectful relationship that helps mobilize a patient's recovery, they can serve a clinical purpose. If they are used in a perfunctory manner purely as a risk-management tool, they may be harmful and clinically contraindicated *(see Knapp, 2003)*.

9. In all situations, and especially in situations involving more difficult patients, it is advisable to document treatment in a complete manner. The records should reflect clearly all steps taken by the psychologist. If a tragedy occurs, the progress notes will provide evidence that treatment decisions were made in a thoughtful and conscientious manner. In any legal proceeding filed against a psychologist, the progress notes will be reviewed as part of a liability determination. No psychologist can guarantee the success of treatment. Comprehensive treatment records, however, can be a powerful defense against an accusation of wrongdoing. The "less is more" standard should not be applied to treatment records *(see Bennett et al., 2007)*.

10. Although psychologists may own the paper upon which the treatment notes are written, they do not have complete control over patient access to records. At a minimum, all patients generally have a right to a treatment summary. In most situations, patients have a right to their complete records if they were treated in a hospital or a facility governed by the Pennsylvania Mental Health Procedures Act. Although there is no controlling Pennsylvania Psychology Board case regarding a patient's access to their voluntary outpatient treatment records, a strong argument can be made that a patient can access these records. The psychologist must exercise caution, therefore, before asserting that the patient has no right to obtain a copy of their records. *(Additional information regarding patient access to records can be found in Knapp, VandeCreek, Tepper, & Baturin (2008, Chapter 3)*.

References

Bennett, B., Bricklin, P., Harris, E., Knapp, S., VandeCreek, L., & Younggren, J. (2007). *Assessing and managing risk in psychological practice: An individualized approach*. Rockville, MD: American Psychological Association Insurance Trust.

Knapp, S. (2003, October). Safety agreements: Good, bad, or indifferent. *The Pennsylvania Psychologist*, 5.

Knapp, S., & Tepper, A. (2007, January). Pennsylvania's mandatory child abuse reporting statute amended. *The Pennsylvania Psychologist*, 1, 4.

Knapp, S., VandeCreek, L., Tepper, A., & Baturin, R. (2008). *Pennsylvania law, ethics, and psychology*, 5th ed. Harrisburg, PA: Pennsylvania Psychological Association.

Tepper, A., & Baturin, R. (2005, November). Release of confidential information: Client authorization and court orders. *The Pennsylvania Psychologist,* 7, 12.

Tepper, A., Knapp, S., & Baturin, R. (2007, June). Mandated reporting of child sexual abuse in Pennsylvania. *The Pennsylvania Psychologist,* 6, 8.

Tepper, A., & Knapp, S. (1999, August). Duty to protect by warning: When does the duty arise? *The Pennsylvania Psychologist*, 15.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of May 12, 2009

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 74	Establishes Criminal Justice and Mental Health Reinvestment Program, proposes grants to counties for diversion from justice system to treatment – Sen. Stewart J. Greenleaf (R-Montgomery)	For	In Judiciary Committee	None
SB 306	Requires all health care providers to wear ID badge – Sen. Edwin B. Erickson (R-Delaware Co.)	Against	In Public Health and Welfare Committee	None
SB 383	Promotes establishment of "problem solving courts," including for mental health – Sen. Jane C. Orie (R-Allegheny)	For	Passed by Judiciary Committee, 3/10/09; on Senate calendar	None
SB 408	Promotes establishment of mental health courts – Sen. Daylin B. Leach (D-Montgomery)	For	In Judiciary Committee	None
SB 442	"Mini-COBRA" – authorizing small group health plan members to access COBRA benefits for up to 9 months after being laid off and to qualify for the 65% federal subsidy – Sen. Donald C. White (R-Indiana Co.)	Under review	Passed, 4/1/09, 50–0	In Insurance Committee
SB 502	Eliminates all health care mandates – Sen. Mike Folmer (R-Lebanon)	Against	In Banking and Insurance Committee	None
HB 215	Restricts insurance companies' retroactive denial of reimbursement – Rep. Stephen E. Barrar (R-Delaware Co.)	For	None	In Insurance Committee
HB 746	Reforms the small group market, limits rate increases, caps administrative expenses at 15%, prohibits medical underwriting, and gives more power to the Insurance Commissioner to regulate premiums – Rep. Tony DeLuca (D-Allegheny)	Under review	None	In Insurance Committee
HB 905	Authorizes employment of persons as drug and alcohol counselors based solely on their previous work or life experience – Rep. Louise W. Bishop (D-Philadelphia)	Against	None	In Health and Human Services Committee
HB 1089	"Mini-COBRA" – authorizing small group health plan members to access COBRA benefits for up to 9 months after being laid off and to qualify for the 65% federal subsidy – Rep. Robert F. Matzie (D-Beaver)	Under review	Passed by Banking and Insurance Committee, 5/5/09; now in Appropriations Committee	Passed 4/22/09, 191–1
HB 1131	Similar to SB 383 – Rep. Craig A. Dally (R-Northampton)	For	None	In Judiciary Committee
HB 1250	Restricts certain titles for social workers, marriage and family therapists, and professional counselors; prohibits provision of any mental health service without a license – Rep. Marc J. Gergely (D-Allegheny)	Under review	None	In Professional Licensure Committee

Information on any bill can be obtained from http://www.legis.state.pa.us/WU01/LI/BI/billroom.htm

Creative Maladjustment: A Call to Advocacy

Eleonora Bartoli, Ph.D., Chair, Committee on Multiculturalism

In 1967, Dr. Martin Luther King Jr. spoke at the American Psychological Association Convention, just a few months before he was assassinated. In his speech, he urged psychologists to consider the social context in which psychological symptoms develop and to avoid making people better adjusted to an unjust society. He called for what he termed "creative maladjustment" (Jackson, 2000). More than 30 years later, we are still struggling to define exactly what those words mean.

Both feminist and multicultural psychology have brought attention to the dynamics of power and oppression in our society, how they manifest in individuals' and groups' behaviors, and how they are often woven into the very fabric of our profession. The path from theory to action, however, has been a slow one, and both feminist and multicultural theories themselves continue to be marginalized within both the academic and clinical professions alike.

So, what *did* Dr. King mean by creative maladjustment? How are we to consider and integrate "context" into our work as psychologists? Aren't we mostly trained to identify and alleviate symptoms in *individuals*, after all? How could we be expected to enter the social arena with little knowledge of social policy or time to spare? In fact, when terms such as advocacy or social justice are evoked in psychological circles, they are usually met with anxiety, skepticism, and irritation by academics or clinicians who feel already overextended and under considerable pressure to make ends meet.

Examples of advocacy, however, can certainly be found in the profession. Many of the same psychologists that oppose adding one more item to their to-do list most likely participate in some form of advocacy, whether knowingly or unknowingly. Have you ever coached a student or client on how to access needed resources? Have you ever written a letter to policy makers about the needs of your research participants or clients? Have you ever

spoken up against a racist, sexist, or other offensive comment? All of those interventions are forms of empowerment or advocacy (Lewis, Arnold, House, & Toporek, 2003). The problem is that these efforts usually go unrewarded both financially and professionally, are performed in isolation, are practically and/or ideologically disconnected from larger social problems, and they are usually spread thinly and inconsistently over a large number of issues.

For the most part, psychology is still stuck in the role of remediation (Vera & Speight, 2003) and largely supports the status quo (Fox, 2003). Once unequal distribution of wealth, racism or unjust social policies manifest as depression, anxiety, or substance abuse, then we are called to act. Such a dynamic puts us in a most difficult moral bind: are we to make our clients who are affected by injustices better adjusted to an oppressive system by reducing their symptoms and providing them with better coping mechanisms? Having been placed in the privileged position of hearing and witnessing the experience of clients or research participants who have been repetitively failed by given policies or ideologies on the one hand, and having the education, connections, and skills to communicate and act on that knowledge on the other, what is our role? If we continue operating as if it were business as usual, are we supporting our clients or an unjust system? These become particularly impossible dilemmas when training programs do not prepare psychologists to do advocacy or promote social justice, when advocacy or preventive efforts are not easily translated into billable hours, when tenure is usually not earned on the basis of forming meaningful community partnerships or using alternative methodologies, and when the process of remediation itself takes all of one's energy and time. The system, as it stands, ensures its own continued survival and makes us complicit in the process (Fox, 2003; Ivey & Collins, 2003).

How do we break this cycle and fully understand the big picture? How can we move from being witnesses of oppression to becoming agents of social change? I will suggest three steps.

How can we move from being witnesses of oppression to becoming agents of social change?

The first requires more soul searching than time or money. You must identify what moves you to action. Social justice work needs the energy and focus given by moral imperatives (Kiselica & Robinson, 2001). It requires long-term and persistent commitment, as change does not come quickly and resistance to change is usually strong. Having a clear direction for one's work and fueling such work with passion are therefore essential. For some of us the moral imperative comes from wanting to dismantle racism, for others of us from wanting to create a more just health care system, for others yet it might come from wanting to end street violence. To truly address any of these issues is to confront deeply rooted oppressive social systems.

Second, don't work alone. Join (or create) the organizations, committees, or task forces that are addressing the concern of your choice, so that your work may build on others'. This is how momentum is generated and advocacy efforts become coordinated enough to gain visibility. For example, PPA regularly focuses on policy issues and sponsors an Advocacy Day. Most communities have non-profit organizations that would welcome on their boards the knowledge and resources of a psychologist. Both PPA and APA have divisions

and committees that focus on diversity and social justice issues.

Finally, we must integrate our advocacy efforts into our professional and personal lives. How much so? Thomas Parham, a well-known multicultural psychologist, often ends his presentations by asking participants to "commit to do at least one thing different: I'm not asking you to be 100% better on 50 things, but rather 5% better on one" (personal communication, March 22, 2009) – whatever that translates to in our daily lives, in terms of time, money, emotional resources, or other. The power does lie in the numbers when efforts are coordinated. In my life, integrating advocacy efforts means working with PPA's Committee on Multiculturalism, integrating issues of social justice and anti-racism in the courses I teach, and ensuring that the research I pursue ultimately serves social justice causes.

We can continue to watch train wrecks happen and then support the victims; or we can decide that we are also going to attempt to prevent the train wrecks, since we know many of their causes and have the skills suited to address them. If we don't choose to attempt to stop the train wrecks, we may soon discover that we are enabling the very forces that we are asking our clients to resist. We can either foster creative maladjustment by using our clients' and our own discomfort to question the status quo and create alternatives to it, or we can enable the status quo and ask our clients to adapt to it. Either way, two things are clear: there is no neutrality and the choice is ours.

References

Fox, D. R. (2003). Awareness is good, but action is better. *The Counseling Psychologist, 31,* 299-304.

Ivey, A. E., & Collins, N. M. (2003). Social justice: A long-term challenge for counseling psychology. *The Counseling Psychologist, 31,* 290-298.

Jackson, J. (2000). What ought psychology to do? *American Psychologist, 55,* 328-330.

Kiselica, M. S., & Robinson, M. (2001). Bringing advocacy counseling to life: The history, issues, and human dramas of social justice work in counseling. *Journal of Counseling and Development, 79,* 387–397.

Lewis, J., Arnold, M. S., House, R., & Toporek, R. L. (2003, March 20-22). *Advocacy competencies*. American Counseling Association. Retrieved March 22, 2009, from http://www.counseling.org/Resources/

Vera, E. M., & Speight, S. L. (2003). Multicultural counseling, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31,* 253-272.

Validation

Jeffrey L. Sternlieb, Ph.D.

I have a dream ...

(with apologies and deference to MLK Jr.)

- that one day PPA's Committee on Multiculturalism (COM) will not need to sponsor any workshops on racism, prejudice, privilege, or power;
- that we (members of PPA) no longer have conversations about ***whether*** racism exists in all of us, but that we engage in conversations about how we shall recognize and deal with it;
- that we all recognize that we cannot ethically treat patients of a culture different from our own until we have identified and confronted our own prejudices, and until we have an understanding about the unique nature of our client's culture;
- that we all seek out and actively engage people who are interested in having conversations about race, AND we accept that not all people of color are obligated to be engaged in the challenges of racism, just because they are 'of color;'
- and that white psychologists commit to at least not collude with forces of prejudice by their silence, and hopefully can become prepared to act as allies of people of color in their quest for true equality.

While I'm not convinced that this dream will ever be realized, I would like to suggest that all members of PPA accept it as a BHAG (big hairy audacious goal) in order to set a course or direction that we as an organization can commit to achieving. In order to accomplish such a goal, we need to have a strategy (maybe more than one), anticipate and be prepared for the obstacles we are likely to face, and develop and adopt tools we can all use to achieve success. Because these issues are complex and because we all have different experiences and we have different levels of comfort with varying degrees of confrontation, it seems appropriate that we accept multiple different approaches. My own style is to recognize that this is a journey I am traveling along with others.

This is not primarily an intellectual journey; it is a journey of recognizing and challenging deep seated, and often unconsciously held beliefs that are a product of an upbringing that did not make me (or others?) aware of the injustices surrounding cultural differences (other than my own, of course). My hope is that by sharing insights, experiences, challenges I face myself, and questions I have generated, I may encourage others to consider their own journey and actively challenge themselves as well as others to move closer to these goals (Sternlieb, 2005, 2007). The present article is a product of conversations I participated in during the 2008 PPA annual convention in Harrisburg and my own reflections on these continuing challenges.

Starting Point

One of the first 'rules' I was taught in doing psychotherapy was to "Start where the patient is at." This was very sound and straightforward advice. It required good, empathic listening, reflecting back the feelings that the patient was expressing, and adjusting for any clarifications the patient made after hearing the reflections. "It sounds like you are feeling ..." was the first step to the VALIDATION of the patient's feelings. These feelings get recognized, clarified and named, thus giving them a weight and importance that creates in patients a relief that someone understands how they feel, that these feelings are legitimate, and that they no longer have to justify their emotional reaction to their own experiences. It's no wonder that this is such a powerful process and that attentive and active listening plays such a significant role in establishing a good doctor-patient relationship. Carl Rogers (1965) referred to unconditional positive regard as a way of prescribing for the psychologist a stance that was, for Rogers, the basis of all therapeutic

Continued on page 10

VALIDATION

Continued from page 9

intervention. In fact, research comparing the effectiveness of different psychotherapeutic approaches has identified a good doctor-patient relationship as the one common and necessary component to good therapeutic outcome (Norcross, 2001, 2002).

Active reflective listening helps people feel understood, and it helps them feel that their emotional experience has validity. This includes being taken seriously, not being dismissed, and not having to convince anyone to truly listen. Considering that the 'frame' of this paper is one of embracing multiculturalism by psychologists, there are other implications of VALIDATION relevant to this discussion. To feel valid seems so basic. Consider the opposite – to feel in-valid, as in not having legitimacy or legality or authority or power. It is no wonder that people who have physical disabilities do not want to be referred to as an invalid (an example of an old verbal habit). It took away their personhood, among other things. Is feeling valid or validated something you take for granted? Not everyone does! There are other important implications of validation. Think about getting a parking receipt 'validated.' It is a mark of proof that I actually am entitled to that parking space. No one will take my word for it that my trip was legitimate. I need proof. But in the context of describing personal experience, why would I need proof about my experiences and my feelings related to those experiences?

Another way psychologists in particular understand validity is the context of tests and measurements. Validation is the proof that a test measures what it says it measures. It is an irony that validity in this context emphasizes proof that is measured as a scientific probability statement (e.g., $p < .05$), and it is very different from an individual's unique emotional experience for which no proof should be required to be valid. In the grand scheme of things, all of these observations about validation may seem inconsequential; however, it is not inconsequential when we apply these ideas to issues of race, prejudice and privilege. Once again, I ask: Haven't you taken for granted that you are entitled to be treated like everyone else? Have you taken the time to consider that not everyone can or does?

I wonder why it is so difficult to apply reflective listening skills to a person's description and explanation of experiencing racism (blatant or subtle) and to the impact or toll these experiences take on him or her as a human being. Specifically, this would mean listening without challenging questions, without identifying how things have changed or what kinds of progress have been made, and especially without debating who has had bigger disadvantage. Can we possibly imagine what it is like to be part of a conversation about prejudice or privilege and have to listen to all the many 'buts' that are brought up? "Yes, things were not equal, but, things are changing." Or "...but what about affirmative action?" Or "...but what about all the advances our society is making?" When we qualify a simple descriptive statement about prejudice or privilege, we dilute it, we neutralize it, we minimize it, and in other ways we **IN**VALIDATE the essence of the message. We get defensive and for some reasons *(you fill in your own reason),* we have difficulty acknowledging a sad and shameful reality. Can you imagine listening to a new patient's emotional difficulties and responding with "You think that's a problem? Let me tell you about a real problem!" I wonder why it is so difficult for some of us to listen to and truly **validate** the continuing struggle experienced by people of color just because of their race! I wonder why any of us still have difficulty accepting the reality of an uneven playing field! I wonder why any of us have difficulty acknowledging the reality of white privilege and advantage! It is the equivalent of saying to a patient: "Yes, I see you're depressed about the loss of your spouse, but it's not that bad or you'll get over it in a short while." However, it is actually worse than this example because it is minimizing or denying the cultural institutionalization of racism. The fact that many or most white people have not actively colluded and agreed to be defensive whenever this subject comes up is evidence of how insidious, nearly universal and unconscious this process continues to be – despite all the progress we supposedly have made.

I wonder why it is so difficult for some of us to listen to and truly validate the continuing struggle experienced by people of color just because of their race!

Next Steps

What strategies might any of us use to advance our own personal development and the overall goals of our Committee on Multiculturalism and of the entire membership of PPA? Each one of the parts of my dream can be simply addressed in several ways that I know will make a difference.

We can acknowledge to ourselves that we all judge and prejudge other people, and that often these judgments are based on race (Sternlieb, 2005). We can't address any of our own habits or behaviors until we recognize that they exist. One useful tool to consider applying to this issue is the Johari Window (Luft and Ingram, 1951). The Johari Window is a 2 x 2 grid with the four quadrants describing four different types of personal awareness – what either I or others do or do not know about me. This tool provides a framework for considering the possibility (probability?) that there is much about ourselves and our functioning that are blind spots or even not totally accessible (e.g., unconscious). The goal would be to reduce the size of our 'Blind Spot' quadrant through increased self-awareness and/or feedback from others. Once we accept this proposition, we can seek feedback from others and we can commit to our own self-discovery work. One example would be to attend to our listening habits when the discussion is about race, prejudice or privilege. In what ways are we less than an ideal listener? Ask for feedback from people you trust to be honest and respectful. Randy Mitchell writes about and asks questions about many aspects of listening – a skill that gets little attention (Mitchell, 2001). His way of expressing deeper listening is

reflected in the title of his book – *Listen Very Loudly*.

A second useful tool to consider is Nonviolent Communication (NVC) (Rosenberg, 2003). This is a specific structure of communication designed to separate descriptions of our experiences from the judgments we unknowingly make in the course of normal day-to-day functioning. NVC self-expression includes four elements: observations (distinguished from interpretations/evaluations), feelings (emotions separate from thoughts), needs (deep motives) and requests (clear, present, do-able and without demand). It can be a remedy to the presence of verbal habits we have developed unintentionally, but habits that contribute to significant communication difficulties. If we could begin to identify our feelings (without judgments) and then identify our needs, it would go a long way to improving the quality of our discussions about race and prejudice. An example might sound like: "I feel uncomfortable when I hear you describe how poorly you are treated by some white men." or, "I need to feel like I won't be condemned when I express my thoughts or feelings about prejudice." This is one more technique to increase our awareness of verbal (and unconscious mental?) habits that may be revealing aspects of our own beliefs and behavior. Using NVC could support more productive conversations about emotion-laden topics like racism.

A third tool to consider applying is the concept of emotional intelligence (Goleman, 2006) and all the implications that follow. In particular, we need to realize that the arena of prejudice, racism and discussions about privilege is the arena of emotions. Trying to use logic in the face of views that are emotion-based will be worse than futile. The impact will be a discussion that feels invalidating, and will contribute to a serious disconnect. This is as true about those who deny that racism and disadvantage exists as well as to those who would be allies of people of color. In other words, trying to change people's minds about these issues using logic is doomed for failure, and may further alienate some individuals. I believe it is important to continue the conversation without pressure to change. I have come to this conclusion after falling into the trap of trying to impose change (enlightenment?) on an acquaintance. My effort failed woefully and I ended up frustrated, and my acquaintance became even more defensive. Fortunately, this was an example of one trial learning, and the result did not do irreparable damage to that relationship. In the same vein, it is important to ask for the same effort at understanding each other's position through the most deliberate effort at listening without trying to convert. This would be real progress, and yet, it would be very difficult to accomplish.

A fourth tool to consider is one I use to help health care professionals better understand challenging relationships between doctors and patients – Balint groups (1957), and one of the challenges for the group is to speculate what it is really like to be in a different person's shoes. It may not be necessary to conduct a formal Balint group to develop an exercise where one considers Balint-like questions. For example, "What would it feel like to experience...?" This exercise is a pure empathy exercise designed to elicit a possible understanding of the emotional impact of a wide range of experiences. It would be helpful if it is a structured exercise, and if an experienced facilitator can maintain a safe environment in which to explore others' struggles.

Finally, I would like to suggest using a tool we all have – when the topic relates to race, **listen like you are being paid to listen**! We all do it often; don't stop just because we are not earning money. We might just earn something more valuable – a true multicultural perspective! Also, ask questions, get clarifications, request to be heard yourself, and respond to others' questions as well.

I believe that it is no accident that APA has published a pocket "Guide to Cultural Awareness" (2008) with many helpful suggestions for culturally informed communications as well as a number of helpful resources. In this year when we have an African American man as our president, there will likely be many opportunities to participate in discussions about race and prejudices. Think about which tools may be most helpful to use as a way of participating in a productive manner. How can I listen actively and invite others to listen to me? How can I be successful in validating people's experiences and keep these conversations open? How can I contribute to making this BHAG less of a dream and more of a reality throughout PPA?

References

American Psychological Association. (2008). *Guide to Cultural Awareness*. Washington, DC: Author.

Balint, M. (1957). *The doctor, his patient, and the illness*. New York: International University Press, Inc.

Goleman, D. (2006). *Emotional intelligence: Why it matters more than IQ*. New York: Bantam Books.

Luft, J., & Ingham, H. (1955). *The Johari window, a graphic model of interpersonal awareness*. Proceedings of the Western Training Laboratory In Group Development. Los Angeles: UCLA.

Mitchell, R. (2001). *Listen very loud: Paying attention in the student affairs profession*. Madison, WI: Atwood Publishing.

Norcross, J. C. (Ed.). (2001). Empirically supported therapy relationships: Summary report of the Division 29 Task Force. *Psychotherapy, 38*(4).

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York: Oxford University Press.

Rogers, C. (1965). *Client centered therapy.* Boston: Houghton Mifflin Company.

Rosenberg, M. (2003). *Nonviolent communication: A language of life.* Encinitas, CA: Puddle Dancer Press.

Sternlieb, J. (2005, December). White privilege: How would we know? *The Pennsylvania Psychologist,* 5–6.

Sternlieb, J. (2006, December). Political correctness: A case of privilege, power, and backlash. *The Pennsylvania Psychologist,* 8–9.

Cognitive Strategies & Prison Subcultures: Multicultural Sensitivity Required

Sandra Jenkins, Ph.D., M.Div., CPC

As psychologists continue to wrestle with cultural factors, it appears that treating most clients (incarcerated or not) with one specific treatment model could be considered something of an injustice.

Overcrowding in prisons across the United States is one of the most targeted social concerns of the post-modern era. According to the Bureau of Justice Statistics, U.S. prison populations have increased in the last 10 years by as much as 200%, with more than 5 million men and women under the criminal justice system, and the vast majority (about 96%) are male. At least 50% of the offenses involve petty crimes, such as theft of less than $10 or smoking marijuana. This, along with recidivism rates ranging from 50% to 85%, depending on state, area, and facility, overburdens institutions with increased populations.

With 615 incarcerates per 100,000 residents, the U.S. possesses the highest rate of incarceration of any nation. Many prisoners suffer from a mental illness, but debates between groups with treatment, security, budgetary, or political concerns are adversely affecting mental health treatment. Such controversies surrounding treatment make caring for various cultures represented in correctional facilities even more problematic. This article focuses on cognitive cultural considerations for treatment that may be useful for reducing recidivism in the future.

In terms of mental health treatment in prison, cognitive based therapy (CBT), along with behavioral programs, has long been the favored model, since it tends to be an expedient approach to disrupt habituation of negative thinking. Studies have revealed, however, that both CBT and behavior programs yield mixed results. Further, research tends to challenge that improved thinking or behavioral patterns become permanent or generalize.

Applying certain schemas, scripts, assimilation and accommodations used in multicultural psychology, to incarcerated persons may be a way to understand cognitive constructions within an inmate's world. For more information concerning these concepts, see the dissertation link at: www.coachingcorner.spaces.live.com. Cultural competence, as referred to here, is a cognitive construction for maintaining one's solidarity within a group. The phrase "cultural competence identity" refers to maintaining solidarity within that group and its community. For example, let's assume that an inmate assimilates the notion that gang membership is normal to survive (schema). S/he believes that gangs represent a sense of family and belonging, where one gets basic needs met, such as shelter or clothing (script). Further, the "system" (government, prisons, etc.) is really the immoral, corrupt counterculture (assimilation/accommodation).

In exchange for connection to the gang, the person is required to be loyal (cultural competence), even if it involves illegal, dangerous or risky activities because s/he is part of the group (cultural competence identity). When opposing schemas/scripts encounter assimilated/accommodated behavior related to the gang, chances are the person may merely register them as vague competing ideas; however, not necessarily equilibrated enough to change patterns. Thus, treating the person with CBT could be ineffective since behavior, even if illegal, is motivated by cultural competence identity.

This in no way implies that we should condone illegal behavior; rather, such actions may be understood as an inmate's way of maintaining cultural competence identity to survive. As such, any competing information may still be opposed – even if a better solution is offered – since schemas, scripts, assimilations and accommodations are entrenched in cultural competence identity. In short, illegal actions are manifested in ways that seem foreign to non-incarcerates; however, they may also be signs of considerable cognitive sophistication.

While this example is speculative, the ideology of incarcerated persons joining gangs to survive is not. In fact, research indicates that social problems, such as poverty or absentee parents, precipitate gang membership. Thus, joining a gang from such a reality-based perspective is rational and adaptive for survival, but may seem like a serious cognitive cultural error to non-incarcerated individuals.

Variances for such rational adaptive survival behavior may be argued, such as if an inmate even fits cultural competence identity; however, requiring inmates to perform cognitive tasks outlined by non-incarcerate parameters may be analogous to expecting multicultural students to perform well on culturally centric tests outside of the boundaries of their particular culture. Thus, the cognitive development of inmates may be qualitatively different from that of non-incarcerates.

The concept of qualitative differences is not new. That is, current research tends to concur that qualitative differences exist in human development. What is more, studies indicate that inmate cognitive processes may be sophisticated even though many score lower on cognitive, social, and intelligence tests. Lower scores do not necessarily reflect poor cognitive functioning; rather, they may suggest a lack of access to educational opportunities that could lead to greater cognitive functioning.

The conundrum of trying to find appropriate treatment within the prison subculture remains problematic. Though it may not be clear how or when such a cultural identity forms within a prisoner, culture is not always that clear anyway within correctional systems. Still, as Carol Gilligan pointed out that male-centered Freudian approaches could hardly be successful in treating women, treatment approaches based on a non-incarcerated population may be inappropriate for persons in prison.

In light of cognitive developmental differences between incarcerates and non-incarcerates, prison populations could be regarded as a separate subculture. Providing care for inmates in a cultural light, therefore, may be an appropriate strategy, offering new vision for potential treatment. Specifically, treatment specialists should consider and assume that:

1. cognitive errors are not necessarily wrong; rather, they may be inappropriately evaluated, especially if induced by a cultural competence identity norm;
2. cognitive functional expectations of non-incarcerate treatment providers are not necessarily aligned with incarcerates' cognitive functional abilities;
3. an inmate's cognitive processes are not only different from non-incarcerates, they are also quite sophisticated based on survival; and
4. developing treatment plans that reflect cultural considerations may promote more rehabilitative results.

As psychologists continue to wrestle with cultural factors, it appears that treating most clients (incarcerated or not) with one specific treatment model could be considered something of an injustice. For instance, instruments used to "measure" depression, intelligence, or even personality with one culture do not always work consistently with another. Therefore, as the list above suggests, psychologists need to consider infusing additional cultural sensitivity within their practices for their clients.

———

Dr. Jenkins is a counselor and executive life coach in Erie County. Comments concerning this article are welcome at sj@coachingcornersupport.com.

Cultural Conservatism, Racism and Beyond: Who Do We Think We Are?

Takako Suzuki, Ph.D.

During last year's presidential campaign my interest was piqued when I encountered the notion that "cultural conservatism," as reported in a local newspaper article, is a formidable consideration when addressing the economic turmoil from the subprime mortgage crisis and impending recession. Given this national crisis, I wondered, whom shall we blame, and choose as our next president? Why? Who takes responsibility? Do I?

Cultural conservative ideology tends to display preferences for tradition, conformity, order, stability, and hierarchy (Jost, Nosek, & Gosling, 2008), where the ways of the past tend to provide a sense of comfort and security. Cultural conservatism argues for preservation of a nation's domestic culture, holding fast to traditional values and politics especially in the face of monumental change. As a dominant majority, White American values tend to marginalize minority cultures. The Agency for Healthcare Research and Quality (2003) demonstrated that unequal access and care prevails. Individuals who are more culturally conservative tend to be more risk-averse and tolerant of out-group inequalities, whereas those less culturally conservative tend to embrace greater between-group equality, independence and positive out-group relations (Jost, Nosek, & Gosling, 2008; Thornhill & Fincher, 2007).

Racism and other "isms" are, in part, sustained by security needs that we all share in varying degrees. Cultural conservatism falls on a continuum from holding tightly to in-group values and practices toward openness and searching for transcending commonality. In this sense, the more culturally conservative American dominant group ideology correlates with within-group primacy and racism (Berdein, 2008).

Cultural conservatism stimulates group coalescence. Emotional and cognitive defensiveness when experiencing attack is human, as depicted by the turtle-under-shell metaphor. "Fight or flight" examples abound. Following the 9/11 attacks Americans responded by securing boundaries at airports and the Mexican border. Hate crimes, especially against those who appeared to be of Middle Eastern origin, escalated. Civil rights were abused. More restrictive immigration laws were passed and enforced. Nations were invaded. Critics of these governmental practices were marginalized. Rhetorical dissociation, such as stereotyping whole groups or nations as "terrorists" or "rogues" justified exclusion and conflict. Although these are understandable, protective attitudes and behaviors restrict opportunities for communication and empathy as exhibited in our government's "conservative shift" (Bonanno & Jost, 2006). Increasingly extreme forms of fight or flight can Balkanize America's diverse internal groups and its relationships with other nations.

While I glibly critique culturally conservative American group and governmental responses I realize that it is more difficult for me to genuinely examine my professional and personal perspectives, responsibilities, and practices. As a mental health professional I find that I am steeped in traditions that serve me quite well. Might my professional cultural conservatism exhibit results similar to those I observe and often bemoan regarding dominant in-group culturally conservative behavior?

Referring to the question, "Who do we think we are?" I am unable to speak for other mental health professional colleagues, but I can begin with myself. As I reflect on my concerns with the extremes of our culturally conservative dominant domestic mindset I find that I tend to blame "others," distancing myself from what I consider to be their

Continued on page 15

Why Cultural Competency Should Be of Ultimate Concern to Students

William Davis Jr., M.A., and Amanda G. Carr, M.Ed.

Most readers are aware that clinical and counseling psychology training programs are required to emphasize at least *some* aspects of multiculturalism in the curriculum. However, because there is considerable variability in the quantity and quality of our multicultural training, students may need to go the extra mile to ensure their multicultural training is adequate for practice upon degree completion. Depending on one's interest, expanding multicultural training opportunities may be a priority or perhaps just another line item on the graduate school to-do-list. This latter position is understandable given the many competencies that are required of graduate training. Nonetheless, current psychology graduate students might be wise to *maximize* their exposure to multicultural training opportunities prior to graduation. The following is a brief overview of three reasons why multicultural training, specifically training to work with racial/ethnic minorities and older adults, should be of ultimate concern to our generation of graduate students.

The Proverbial Browning and Graying of Our Nation

Foremost, projections from recent census data suggest that minority and older adult populations are increasing rapidly. By the year 2050 the majority of our nation's populace will identify as being minority group members (United States Census Bureau, 2008), and the over-85 group will increase six-fold (Belsky, 1999). Twenty percent of the U.S. population will be 65 years of age or older by the year 2030, (U.S. Bureau of the Census, 2000), which is almost double that of the older adult U.S. population in 2005 (Institute of Medicine, 2008). Given these census projections we should expect an increase in the number of racial/ethnic minorities and older adults utilizing psychological services. If we are to provide psychological services to a more diverse clientele, we are ethically bound to do so in a culturally sensitive manner. This requires awareness, knowledge, and skills beyond the foundational competencies learned in one

course or brief clinical experience. Therefore, maximizing current opportunities may better prepare trainees for inevitable changes in our patient populations.

An Increase in the Demand for Culturally Competent Psychologists

As the number of minorities and older adults increases, so too does the demand for culturally competent practitioners. The increase in demand for psychologists trained to work with racial/ethnic minorities has penetrated current literature in the field (e.g., Carter, 2005; Hall, 2004). Pertaining to older adults, Shea (2003) estimates that an additional 2,800 geropsychologists are currently in need to better serve older adults in America. However, even if every graduate student exiting his or her APPIC internship site this year were to have trained and specialized in geropsychology, we would still fall short of the number of psychologists needed to support the older adult population in our nation. Given this increase in demand for culturally competent psychologists and the current shrinking of the U.S. job market (Gutierrez & Desmond, 2009), it may be advantageous for graduate students to increase their training in multicultural and diversity issues, particularly pertaining to racial/ethnic minorities and older adults.

Multicultural Requirements by Governing Entities and Supporting Organizations

The third reason why cultural competency should be of ultimate concern to clinical and counseling psychology graduate students is because it is of primary interest to our governing bodies, including the American Psychological Association (APA) and other supporting organizations. There have been a number of efforts within APA to actively address older adult issues in the field of psychology including the establishment of the Committee on Aging and publication of Guidelines for Psychological Practice with Older Adults (APA, 2004). Similarly, in 2002 APA released the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, "which reflect knowledge and skills needed for the profession in the midst of dramatic historic sociopolitical changes in U.S. society, as well as needs from new constituencies, markets, and clients" (APA, 2002, pg. 5). These sentiments are echoed at the state level as well, as there now exist cultural competency requirements in licensing laws for certain states, including Pennsylvania.

Even the federal government and other organizations are beginning to emphasize the relevance of multicultural competence. In a recent survey, a number of managed care companies and government officials suggested that cultural competence is related to the bottom line in the health care industry because such interventions are more efficient and patient specific, as opposed to one-size-fits-all interventions that may waste valuable health care dollars (Betancourt, Green, Carillo, & Park, 2005). According to one government official in the study, cultural competency is a primary force in eliminating health disparities for racial/ethnic minorities (Betancourt et al., 2005). As such, federal agencies are offering fellowships for graduate students who possess an interest in developing an expertise in culturally competent assessment and treatment of minority populations (e.g., the American Psychological Association Minority Fellowship Program). Overall, there are compelling forces from both within and outside the field of psychology for practitioners to become more adept at providing services in a more culturally competent manner.

Conclusion

The current generation of graduate students has an opportunity to embrace the initiatives to support growth in cultural competency. However, as stated previously academic training opportunities for graduate students in certain areas are lacking. For instance, fewer than 1% of the 234 APA-accredited clinical programs and 3% of the 72 APA-accredited counseling programs provide specialty tracks in geropsychology (APA, 2008). As graduate students we can expand our cultural competency by attending conferences (e.g., National Multicultural Conference and Summit) and workshops in these areas and complete additional coursework in a specialty area of diversity (e.g., sexual identity, religion and spirituality in counseling). Graduate students are also encouraged to explore PPA's online multicultural resource guide, make regular use of the DSM-IV-TR's cultural formulation in case conceptualizations, ask supervisors to assist us with exploring the use of norms adjusted for pertinent demographic variables, and maintain awareness of the changes in our diverse society. Although we have focused here on race/ethnicity and age, there are many domains of diversity that can impact the provision and outcome of psychological services. Learning the ins and outs of how to navigate these issues in clinical situations seems like a daunting task. However, if our field is to remain relevant in a more diverse and increasingly global society our generation of practitioners may have to go the extra mile to acquire the training opportunities necessary to do so.

References

American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists.* Retrieved April 11, 2009, from: http://www.apa.org/pi/multiculturalguidelines.pdf

American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist, 59,* 236-260.

American Psychological Association. (2008). *Accredited doctoral programs in professional psychology.* Retrieved January 2, 2009, from http://www.apa.org/ed/accreditation/counspsy.html

Belsky, J. (1999). *The psychology of aging: Theory, research, and interventions.* Pacific Grove, CA: Brooks/Cole.

Betancourt, J. R., Green A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and healthcare disparities: Key perspectives and trends. *Health Affairs, 24,* 499-505.

Carter, R. T. (2005). *Handbook of racial-cultural psychology and counseling: Training and practice.* Hoboken, NJ: John Wiley.

Gutierrez, C., & Desmond, M. (2009, February). *The incredible shrinking U.S. job market.* Retrieved April 14, 2009, from http://www.forbes.com/2009/02/08/nonfarm-payrolls-january-markets-econ-0206_unemployment_stimulus_36.html

Hall, L. E. (2004). *Dictionary of multicultural psychology: Issues, terms, and concepts.* Thousand Oaks, CA: SAGE Publications.

Institute of Medicine (2008, April). *Retooling for an aging America: Building the health care workforce.* Washington, DC: The National Academies Press.

Shea, D. G. (2003). Swimming upstream: Geriatric mental health workforce. *Public Policy and Aging Report, 13*(2), 3-7.

U.S. Bureau of the Census. (2000). *Projections of the total resident population by 5-year age groups, race, and Hispanic origin with special age categories: Middle series, 1999-2000 and 2050-2070.* Retrieved December 22, 2008, from www.census.gov/population/projections/nation/summary/np-t4.a-g.txt

U.S. Bureau of the Census. (2008). United States Census Bureau News: *An older and more diverse nation by midcentury.* Retrieved April 11, 2009, from: http://www.census.gov/Press-Release/www/releases/archives/population/ 012496.html

CULTURAL CONSERVATISM

Continued from page 13

undesirable maliciousness or blindness, and practices. Upon reflection, I believe I am, and I wonder if we as psychologists are also "guilty" of culturally conservative practices in varying degrees. Our capacity to serve "others" effectively requires risk and full engagement rather than separation. As mental health professionals we have opportunities not only to assist those culturally most like us but to bridge socio-cultural gaps among clients and psychologists. To minimize the damaging effects of segregating those with the disease of "otherness," can we find ways to enhance our collective cultural health and wholeness? Are we, perhaps, promoting culturally conservative stances by serving certain populations based on access or capacity to pay," especially during times of economic crisis? Are we less than comfortable and conversant with the verbal or cultural lifestyles, locations, and languages of "others?" How, perhaps as a result of our social and professional subcultures, do we collectively and individually contribute unconsciously or insensitively to racism and other "isms?"

I find that it is relatively comfortable to critique social issues that, although of genuine concern, are beyond our professionally designated roles, for we can deny responsibility. I suspect my, and our, effectiveness is constrained, however, unless we humbly address our collusion with undesirable conditions and commit personally to modify these. Perhaps we too readily avoid risking innovative approaches as we rely on traditional roles, models, and training. As culturally responsive mental health providers we may contribute profoundly by reexamining our assumptions and opportunities. How culturally compassionate, proactive, and adaptive are we/am I as a psychologist, and as a person?

We have the responsibility and capacity to create means for dialogic engagement across cultural boundaries. We can redirect and accelerate understanding, together exploring changes with our clients, peers, and communities. It depends on who we think we are, and what we do. Yes...we can!

References

Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2003.* Rockville, MD: Author. Retrieved April 28, 2009, from http://www.ahrq.gov/qual/nhdr03/nhdr03.htm

Berdein, I. (2008). Principled conservatives or covert racists: Disentangling racism and ideology through implicit measures. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 69,* 728.

Bonanno, G. A., & Jost, J. T. (2006). Conservative shift among high-exposure survivors of the September 11th terrorist attacks. *Basic and Applied Social Psychology, 28,* 311-323.

Jost, J. T., Nosek, B. A., & Gosling, S. D. (2008). Ideology: Its resurgence in social, personality, and political psychology. *Perspectives on Psychological Science. 3*(2), 126-136.

Thornhill, R., & Fincher, C. L. (2007, July). What is the relevance of attachment and life history to political values? *Evolution and Human Behavior, 28*, 215-222.

An Alternative to the Adversarial Divorce and Custody Process: Collaborative Attorneys and Psychologists

David F. Tamanini, Esq., and Samuel Knapp, Ed.D.

Psychologists who treat families going through a divorce see the great pain and turmoil that can occur. Parents may feel anger at each other, and children may respond with anxiety and depression or defiant and aggressive behaviors. Many attorneys and psychologists drawn into the litigation process would rather find other ways of dealing with these high-conflict disputes. And now, a new alternative to litigation is being used by specially trained attorneys. Originally just lawyers, but increasingly with consultants as team members, these professionals minimize a focus on the past, and show how to maximize the possibility of realizing future goals in a win-win process for the divorcing couple.

Many times, before and after divorce, parents are able to set aside their disappointments and frustrations and work together to develop a parenting plan in the best interest of the child. Indeed it has been stated that the greatest gift that divorcing parents can give their children is a sense of respect and courtesy for the other parent.

However, when divorcing parents are unable to agree to a parenting plan, they usually turn to the courts to determine the child care arrangements. On the other hand, therapists know that the court's custody determination process itself can be expensive and iatrogenic. As part of the adversarial process both parties must

David F. Tamnini Esq.

Samuel Knapp, Ed.D.

highlight their parenting strengths and disparage the skills of the other parent. At times the process is brutal. The ill feelings existing at the time the divorce decision is made can increase as the other party becomes more defensive and hostile. Embarrassing actions may become public, minor parenting errors may be presented as indications of major character flaws, and motives of revenge may get intermingled with sincere interests to consider the welfare of the children. Friends and extended family members may be asked to take sides and testify on behalf of one party or the other, thus damaging their relationships with the other spouse. The ability to communicate may become impaired as a consequence of the courtroom-centered custody determination process. It is hard for parents to work cooperatively with each other after the opposing attorney tries to rake them over the coals in court. Sometimes the intensity of anger that the litigation process can generate tempts one or both parents to inflict as much damage as possible on the other party.

Alternative dispute resolution (ADR) mechanisms have been advanced to minimize the harm to the families in the litigation process. As a prelude to a court hearing, most counties in Pennsylvania will mandate a conciliation conference, mediation, or some other ADR.

Today in many Pennsylvania counties there is a new alternative to the court-centered divorce process itself. The collaborative process is a settlement-oriented arrangement that avoids the courts completely. In the collaborative process, the couple, along with the attorneys who represent each of them, meet and resolve differences in the divorce including financial and parenting decisions. The process is structured to reinforce cooperation and respect among the parties. For example, the parties and their specially trained collaborative attorneys and professional consultants, such as mental health experts, child experts, accountants, and financial planners, work as a team. Both spouses have their own attorney to advise them, but the couple and the attorneys agree ahead of time that the attorneys will not represent either party if the collaborative process terminates at an impasse. In other words, the attorneys have no incentives to prolong the divorce process, to needlessly antagonize the other party, or to act as a tool of revenge for their clients. If the

process breaks down and the parties eventually litigate, the attorneys and consultants will be disqualified as witnesses and their work product will be inadmissible unless otherwise agreed. The collaborative divorce process appeals to many divorcing couples who desire to keep or regain adequate relationships with each other to ensure future harmony between and among the entire family.

The time spent in the collaborative process varies depending on the number and complexity of the issues, the degree of conflict riding below the surface, and ability of the participants to stay focused (either with or without the use of coaches, see below). The cost is generally less than the expense that would be generated by an adversarial divorce and custody battle stretching over years. Finally, the process appeals to many participants because they, not the court, determine the pace of the process and the outcome. Data reported to the International Academy of Collaborative Professionals in 2008 shows that approximately 87% of the cases are able to reach mutually acceptable agreements in divorce (and about 3% of couples actually reconcile).

Psychologists and the Collaborative Process

Psychologists who treat patients of divorcing families and see the "carnage" can inform divorcing families of the option of using the collaborative process and explain the ways that the children and both parties can benefit when restraint and cooperation are the model. A list of Web sites of collaborative process practice groups originally founded by attorneys in Allegheny County, Central Pennsylvania, and Bucks County, as well as the International Academy of Collaborative Professionals, can be found at the end of this article.

Also, psychologists or other mental health professionals are needed as neutral non-therapeutic team members in collaborative process cases. For example, many attorneys working through the collaborative process desire psychologists to act as "process coaches" whose goal is to help the parties get through the collaborative process. There are single-coach and two-coach models to choose from. The process coaches help clients to articulate thoughts, clarify and act on their intentions, or listen more carefully to each other. Other psychologists can serve as neutral "parenting coaches" and give parents general as well as specific information and guidance about the emotional impact of divorce on the children, explain events to the children, teach parents how to reassure them, and when a referral to a mental health professional may be indicated, make a referral.

...many attorneys working through the collaborative process desire psychologists to act as "process coaches" whose goal is to help the parties get through the collaborative process.

Typically the coaches are paid directly by the parties under a fee agreement. They will not appear in court because as part of the collaborative process as consultants, their opinions, advice, and knowledge of the collaborative process discussions may not be entered into court at a later date. Psychologists who participate in the collaborative process need to have basic psychological skills and relationship management "for process coaches" or child developmental experience to serve as "child specialists." Participating consultants need to have training in the collaborative process. This training gives them knowledge of the skills, the focus of the attorneys, and a deeper understanding of the collaborative process itself.

At the June 2009 Annual Convention, the Pennsylvania Psychological Association will present a program sponsored by the Independent Collaborative Attorneys of Central Pennsylvania (ICACP) on the Collaborative Process. The ICACP is developing an in-depth consultant/coaching training program in November 2009 to give interested psychological professionals and others the opportunity to present themselves as collaborative-process trained. The ICACP's most expansive goal to date is to create a new multidisciplinary practice group this year where attorneys and consultants will be equal members giving greater depth to the evolution and growth of the collaborative practice in Central Pennsylvania. To add your name to a list of e-mail recipients of ICACP's e-mail news and training newsletter, send your contact information to dft@TamaniniLaw.com.

David F. Tamanini, Esq., practices family law and is a member of the South Central Pennsylvania Independent Collaborative Attorneys of Central Pennsylvania (ICACP) and the International Academy of Collaborative Professionals.

Web sites and contacts of practice groups:

Alleghenies Region Collaborative Caucus **in Cambria County. Contact Linda Rovder Fleming at (814) 262-2123 in Johnstown, PA.**

Collaborative Family Law Affiliates: **www.nocourtfamilylaw.com. Contact Maribeth Blessing, Rockledge, PA, (215) 392-0849, or Ellen Fischer, Willow Grove, PA 19090, (215) 346-4296.**

Collaborative Law Association of Southwest PA: **www.clasplaw.org. Contact Paula Hopkins.**

ICACP: **www.collaborativelawpa.com**

International Academy of Collaborative Professionals: **www.collaborativepractice.com**

PA Collaborative Practice (Berks/Schuylkill): **www.pacollaborativepractice.com Contact Diane Hitzemann or Linda Pellish.**

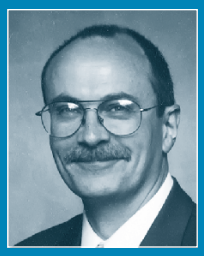
Convention 2009

PPA TO HONOR

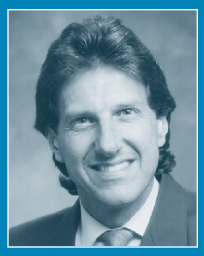
Drs. Efran, McAleer, Meyers, and Tepper

Stephen N. Berk, Ph.D., Awards Committee Chair

On Friday, June 19, we all will gather to honor Pennsylvania psychologists who are being recognized for the contributions they have made to our profession, our organization, and the public in general. Please come and join us as we celebrate the accomplishments of these individuals.

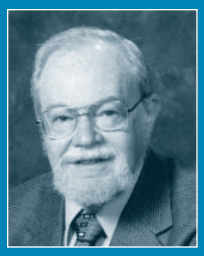


Dr. Don McAleer will receive the Distinguished Service Award for the many years of service he has given to PPA. Dr. McAleer is a past president of PPA, chaired numerous committees, and worked on a number of task forces. He is currently one of Pennsylvania's representatives to the APA Council of Representatives. Our organization has benefitted and will continue to benefit from Dr. McAleer's efforts.



Dr. Allan Tepper will also receive the Distinguished Service Award. He is both an attorney and psychologist, and has been a legal resource for PPA for years. Dr. Tepper was founder of PPA's legal consultation plan, and has written almost 60 articles for *The Pennsylvania Psychologist*. Dr. Tepper's years of professional support and contributions to our organization, as well as to many psychologists throughout the state, have been significant.

Dr. Lillian Meyers will receive the Public Service Award for her 20-plus years of providing bereavement programs in the Pittsburgh area. Dr. Meyers is the program chair for the Pittsburgh chapter for the Compassionate Friends. This group provides self-help support groups for parents, grandparents and siblings who are grieving the death of a child. Dr. Meyers is an educator as well as a clinician, and has touched the lives of numerous individuals, families, and students.



Dr. Jay Efran will receive the Award for Distinguished Contributions to the Science and Profession of Psychology for his years of research, teaching, and clinical work. Dr. Efran is a nationally known psychologist and is Professor Emeritus of Psychology at Temple University. He has won teaching awards at both Temple University and the University of Rochester. His list of research publications, books, and invited lectures is long. The scope of Dr. Efran's work is remarkable. He has served as a role model for many.

State Board of Psychology Update

The State Board of Psychology (Board) has been busy this year working on updating many regulations. One of the primary regulations that the Board rewrote this past year was the Code of Ethics. After many months, the Board has just adopted a final version of the Code that will be moving through the cumbersome regulatory review process in Pennsylvania which means, among other things, being circulated within the Bureau of Professional and Occupational Affairs for comments and eventually being published in the *Pennsylvania Bulletin*, the official publication of Pennsylvania government, where it will receive public comments and further review.

Another regulation that was updated was 49 Pa. Code 41.32 dealing with qualifications for taking the licensing exam. As readers may recall, 2 years ago, the Board updated this regulation by requiring that all applicants for licensing who have enrolled after July 1, 2008, must have attended an APA-accredited, CPA-accredited, or ASPPB/National Register designated school or a foreign college or university whose standards are equivalent to the ASPPB/National Register Designation Project.

One of the unintended consequences of changing this regulation is that if an applicant who applied to the Board to become licensed before the regulation change sat for the licensing exam and failed the exam twice, that applicant would have to reapply under the new requirements (i.e. administrative, education and experience). Therefore, if the applicant came from a school that was not APA-accredited, CPA-accredited or ASPPB/National Register designated school or a foreign college or university whose standards are equivalent to the ASPPB/National Register Designation Project, the applicant would have to repeat their education and go to a program that was APA-accredited, CPA-accredited or ASPPB/National Register designated school or a foreign college or university whose standards are equivalent to the ASPPB/National Register Designation Project.

State Board of Psychology Newsletter Goes Electronic

The State Board of Psychology will no longer be providing a yearly paper newsletter to licensees. Instead, the State Board of Psychology will be communicating to licensees through electronic newsletters. The newsletters will be briefer – only about two pages long – but will be out on approximately a quarterly basis. Licensees will be able to access the State Board of Psychology's Newsletter on its Web site at http://www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&q=433051.

Another issue that the Board has been addressing is that of training in multiculturalism. Given the multicultural make-up of Pennsylvania, the Board has been looking into the types of training that doctoral degree students receive in multiculturalism. The Board has discussed whether a CE requirement is warranted, but to date has not voted to include multiculturalism as a required topic. The Board is studying this issue. On the one hand, the Board members feel that it is important for psychologists to have training in multiculturalism. On the other hand, however, the Board does not want to mandate three continuing education credits in multiculturalism. The Board is encouraging psychologists who treat diverse populations to take continuing education classes in multiculturalism.

Lastly, the Board has been addressing issues related to professional records. The Board has had a couple of cases dealing with records that have been lost due to computers crashing. (See Commonwealth of Pennsylvania Department of State Bureau of Professional and Occupational Affairs v. Howell, Docket No. 2084-63-07, File No. 07-63-010837). It is the Board's position that psychologists have the responsibility to assure that records be maintained for 5 years after the last date of treatment. If psychologists keep electronic records, they should have a back-up of these records.

Thanks to Our Members Who Help to Make *Psychology* a Household Word

Marti Evans, APA Public Education Campaign Coordinator for Pennsylvania

Recent studies and media reports conducted by the American Psychological Association have shown that more people than ever realize that physical health and mental health are intertwined and that psychologists are at the forefront of this public awareness.

In the last 6 months many PPA members have been active in our Public Education Campaign and have let us know about their outreach activities to the public. We thank them for helping to "make *psychology* a household word" in Pennsylvania.

The members of the E-Newsletter Committee continue to make *psychology* a household word by publishing PPA's free quarterly electronic public information newsletter, "Psychological News You Can Use." Pennsylvania is the only state psychological association with an e-newsletter for the public. **Drs. Marolyn Morford, Vincent Morello, Charles LaJeunesse, Marnie Hiester, Richard Johnson, Pauline Wallin, Sybil Holloway,** and **Judith Blau** contributed articles for the September and December 2008 issues. The e-newsletter editor is **Dorothy Ashman.**

Dr. Eric Affsprung, an assistant professor at Bloomsburg University, spoke on "Stress Management and Self-Care for New Teachers" in November.

Dorothy Ashman spoke to the Kiwanis in Bloomsburg on "Mindfulness" in September.

Drs. Nancy Chubb and **Douglas Ramm** were interviewed for an article in the *Pittsburgh Business Times* in November on "Economy a Worry, but Not the Biggest, as Holidays Approach."

Dr. Helen Coons, clinical health psychologist at Women's Mental Health Associates in Philadelphia, has done more than 70 media presentations, interviews and presentations to corporate and community audiences in the past 4 years.

Lynne DiCaprio, director of Delaware County Professional Services, was interviewed for an article in the *Philadelphia Inquirer* in October on "Economic Turmoil is Real, and It Feeds Fear Among Us."

Dr. Joe Dreiss was interviewed for three articles in *The Patriot News* (Harrisburg) in December: "Some Kids Ask Santa to Help Parents," "Bridging the Gap: Talking, Planning Enables Interaction with Grandfolks," and "A Leaner Christmas List: Families Cut Back in Less Cheery Economy."

Since 1985, **Dr. Christine Ganis** has run a free weekly eating disorders support group through the WomanCare Resource Center, a part of the Pinnacle Health System in Harrisburg. The support group reaches over 200 members of the community each year. She also was interviewed for an extensive article in *The Patriot News* in September on "Anorexia, Bulimia Not Just for Teen Girls."

Dr. Rex Gatto has been interviewed for several articles in October and November about stress and the economy in *The New York Times* and *The Pittsburgh Business Times*.

Chris Gipe presented a "Stress, Aging and Memory" workshop for more than 50 Susquehanna University faculty, staff and students in October.

Dr. Jonathan Grayson, co-director of the Anxiety and Agoraphobia Treatment Center in Bala Cynwyd, was a guest on the May 21, 2008, edition of CBS's Oprah Winfrey Show to discuss obsessive-compulsive disorder.

Dr. Sybil Holloway, an assistant professor at Bloomsburg University, writes a monthly column, "Stressbusters," for *The Allentown Morning Call*. Her column contains practical stress management tips and supplemental resources.

Dr. Andrew Koffmann, director of the University of Pittsburgh Clinical Psychology Center, was interviewed for an article in *The Pittsburgh Post-Gazette* on September 24 about "Stock Tip for Health: Stay Calm."

KidsPeace Director of Psychology, **Dr. Peter Langman**, appeared on several radio stations in the fall on suicide prevention and school shootings.

Dr. Bruce Mapes spoke on "Assessing and Prosecuting Emotional Abuse" on September 10 to the Pennsylvania Chapter of the American Academy of Pediatrics.

Dr. Donald McAleer spoke to a bariatric support group in Erie on December 17 on stress management related to post weight-loss surgery.

Dr. John Norcross was interviewed by *The Pittsburgh Post-Gazette* for an article about New Year's resolutions.

We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and the services psychologists offer.

Dr. Michele Novotni, the recipient of PPA's Psychology in the Media Award for 2009, has had several articles printed in *ADDitude Magazine* and has presented numerous community workshops on ADHD.

Dr. David Palmiter, chair of PPA's Communications Board, has been interviewed by many newspapers and magazines about stress and the economy and talking finances with kids including *Forbes Magazine, The Philadelphia Inquirer, O Magazine* and *U.S. News and World Report*. He and his students coordinated free mental health screenings for more than 200 community members in the Scranton area to mark National Depression Screening Day on October 9.

Twenty-two people heard **Dr. Steven Pashko** speak on "Psychological Awakening" at the Mind Body Spirit Expo in Valley Forge on October 24.

Brother Bernard Seif spoke to 35 people in Saylorsburg on "Moving, Breathing & Meditating for Wellness" on September 20.

Dr. Pauline Wallin writes a column, "on your mind . . . with Pauline Wallin" for the Body & Mind magazine published by *The Patriot-News* six times each year. Recent topics have included "Stay Flexible by Tapping into Your Creative Mind," "Visibly Pregnant? How to Deal with Intrusive Questions & Comments," and "Divorced Dad? Make the Most of Time with Your Kids." A recipient of PPA's Psychology in the Media Award in 2002 and 2005, Dr. Wallin continues to actively reach out to the media to help make psychology and psychologists a household word.

Marie Weil, chair-elect of PPAGS, spoke to 50 people on "Mental Health in the Latino Community" on September 20. She also distributed the Spanish versions of our public education campaign brochures.

Submissions

If you have done a presentation about psychology and mind-body health to a community or business group, please let us know about it so your activities can be recognized in our next "Thanks to Our Members" article for the December issue of *The Pennsylvania Psychologist*. Kindly send the following information about your presentation(s) to Marti Evans at mevans@PaPsy.org:

- Your Name
- Title of Your Presentation
- Name of the Group
- Date of Presentation
- Location of Presentation (city/state)
- Number of People Present

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details! We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and the services psychologists offer. And, we hope to see your name in our next article.

Sustaining Members

Special thanks to our Sustaining Members as of May 19! PPA appreciates your additional support! For more information and to join the cohort of Sustaining Members, please visit the PPA Web site, www.PaPsy.org/. We have raised $7,300 so far this fiscal year with this effort.

Eric H. Affsprung, Ph.D.
Elaine Axelman Broudy, M.A.
Thomas G. Baker, Ph.D.
Vincent J. Bellwoar, Ph.D.
Stephen N. Berk, Ph.D.
Marcie A. Berman, Ph.D.
Richard E. Carlson, Ph.D.
Nancy Chubb, Ph.D., MBA
Steven R. Cohen, Ph.D.
Lynne DiCaprio, M.A.
David W. Durka, Ph.D.
Janet L. Etzi, Psy.D.
Russell A. Fairlie, Ph.D.
Joe French, Ed.D.
Rebecca A. Gillelan, M.S.
Beverly J. Goodwin, Ph.D.
Robert M. Gordon, Ph.D.
Ruth L. Greenberg, Ph.D.
Irvin P. R. Guyett, Ph.D.
Mark A. Hogue, Psy.D.
Katherine M. Holtz, Psy.D.
Jane E. Iannuzzelli, M.Ed.
Douglas A. Jones, Ph.D.
Gail R. Karafin, Ed.D.
Charles J. Kennedy, M.Div., Ph.D.
Jane H. Knapp, Psy.D.
Samuel J. Knapp, Ed.D.
Jeffrey Knauss, Ed.D.
Linda K. Knauss, Ph.D.
Bruce E. Mapes, Ph.D.
Susan Mathes, Ph.D.
Donald McAleer, Psy.D.
Judson W. McCune, D.Ed.
Arthur S. McHenry, M.A.
Jerry McMullen, Ph.D.
Marolyn Morford, Ph.D.
Larry J. Nulton, Ph.D.
David J. Palmiter Jr., Ph.D.
Roberta R. Penn, M.A.
Joanne P. Perilstein, Ph.D.
Katherine R. Powers, Ph.D.
Michael E. Remshard, Ph.D.
Vincent Rinella Jr, M.A., J.D.
Shelley L. Roisen, Ph.D.
Rose Mary Rosella, M.A.
Stephanie Russo, Psy.D.
Karyn L. Scher, Ph.D.
Michael H. Schuman, Ph.D.
Arnold T. Shienvold, Ph.D.
Dea Silbertrust, Ph.D., J.D.
Amber B. West, Ph.D.
Mary O'Leary Wiley, Ph.D.
Charles L. Zeiders, Psy.D.

Bullying of Diverse Students: It May Not Be What You Think

G. Ronald Bell, Jessica L. Blasik, Laura M. Crothers, Heather M. Schwickrath, Duquesne University; John Lipinski, Robert Morris University


G. Ronald Bell


Jessica L. Blasik


Laura M. Crothers


Heather M. Schwickrath


John Lipinski

Bullying, a form of repetitive instrumental aggression that results in an imbalance of power between perpetrator and victim (Smith & Brain, 2000), has increasingly been recognized as one of the most common and widespread forms of school violence occurring not only in the United States, but also in countries around the world. Evidence has been provided establishing the normative (routinely occurring) nature of bully-victim relationships in schools (Smith & Brain, 2000), as well as the negative effects of bullying behavior upon both perpetrators and victims (Olweus, 1993). Although many dimensions of bullying behavior have been studied, relatively few research investigations have examined issues of diversity pertaining to peer victimization in schools. Of those that have been conducted, results have been inconsistent regarding whether differences exist between minority and majority groups' experience of bullying.

For example, a study of seventh and eighth grade American students found no statistical difference in the frequency of bullying that occurred in samples of White and Black children (Seals & Young, 2003). Similar results were found in a study from the United Kingdom (Siann, Callaghan, Glissov, Lockhart, & Rawson, 1994) that investigated actual and perceived physical and psychological bullying among secondary school students. Although students *believed* that the bullying of minority students was more common, there was no significant difference in the number of bullying incidents that were actually reported by majority and minority students. In an investigation of bullying of Indian Muslim, Pakistani, and Bangladeshi students in Britain, each minority group was found to experience similar levels of bullying, with minority children the perpetrators of bullying just as often as were majority White children (Eslea & Mukhtar, 2000). Mouttapa and colleagues (2004) investigated bullying among ethnic minority sixth grade children who represented ethnic majorities in their individual schools. While Asian students were more likely to be bullied overall, the researchers found no statistical difference between rates of perpetration and victimization among majority and minority students in these schools. However, other studies suggest that race is a significant factor of bullying. Within racial groups, one study found bullying to be most prevalent among Caucasians (Finkelhor, Ormrod, Turner, & Hamby, 2005), while two others (Peskin & Markham, 2006; Fitzpatrick, Dulin, & Piko, 2007) found that peer victimization appeared to be more common in the experience of African American children than among other groups. Yet another study indicated that physical and relational bullying was occurring at higher levels for Hispanic youth than for other racial/ethnic groups (Storch, Nock, Masia-Warner, & Barlas, 2003).

How can we account for the contradictions that typify the research literature? Perhaps they can be explained by the numerous methodological issues (e.g., lack of clear operational definitions of bullying and racism, failure of questionnaires to fully address issues of racial bullying) associated with research on racial bullying, or by the potentially divergent ways that different forms of victimization are perceived by victims (Eslea & Mukhtar, 2000). A related problem is the imprecise use of racial terminology that reflects an underlying lack of accuracy or depth of understanding by researchers investigating these issues. Moreover, the use of skin color alone as a criterion for identifying and describing behaviors that occur among ethnic groups also appears to be very one-dimensional. As Rogers and colleagues (1997) argue, many other factors figure into the equation of ethnic behaviors, including socioeconomic status, religion and religious observance, and parental control. Finally, an individual's perception of racial bullying might be very different from his or her experience of more general kinds of bullying, which could help explain why many minorities have reported levels of victimization similar to those in the majority. Some researchers (Eslea & Mukhtar, 2000; Siann et al., 1994) have argued that general bullying is an assault upon the individual person, which is very specific and distressing; on the other hand, racial bullying – while being extremely painful – is an attack not just upon an individual but an entire race with whom a person shares solidarity. Thus, in racial bullying, a person is being attacked as a member of a group rather than as an individual, which has fewer personal implications and therefore may not be seen by him or her as bullying per se.

Another group of students who may be particularly vulnerable to peer victimization are sexually diverse youth. Among those at greatest risk for being bullied by peers are children and adolescents whose gender nonconformity or sexual orientation places them in the minority. These include those who identify as lesbian, gay, bisexual, or transgender (LGBT) and perhaps also those questioning (Q) their

Continued on page 24

Culturally Responsive Practice

Amelia Lopez, Ph.D.

In today's school psychology practice it is not uncommon to encounter a child who speaks a different language or does not speak the language of instruction. Limited English proficiency (LEP) enrollment has increased by almost 60% in Pennsylvania. While 53% of these students are from Spanish speaking backgrounds, many other languages are also represented. As numbers increase, unique challenges are presented to school-based professionals and those involved in the assessment and treatment of learning and behavior disorders. Regardless of competent functioning in their culture of origin, these children and their families are at risk for being judged as deficient relative to the new culture (Maital, 2000). Because of cultural differences and limited English proficiency, these children may be at risk for academic underachievement.

In the field of school psychology fewer than 6% of practitioners are members of a minority population (Rhodes, Ochoa, & Ortiz, 2005). Many educational professionals involved in the assessment of children are unfamiliar with the unique cultural and linguistic characteristics of their clientele (Rhodes, et al., 2005). This situation has resulted in two divergent and problematic outcomes: (a) over-representation in special education and (b) under-identification and misdiagnosis of children needing special assistance. Over-representation occurs when existing majority norms rule and tools are utilized and applied to English language learners (ELL) without full consideration of experiential variables and language differences. Under-identification and misdiagnosis occurs when all learning difficulties, regardless of source, are attributed to cultural differences or LEP where true cognitive deficits may exist. Research regarding the best instructional and assessment methods have failed to provide clear direction.

Issues pertaining to multicultural assessment have received attention in the professional literature in school psychology. Although many questions remain unanswered, several recommendations for "best practices" have been made (Ortiz, 2008; Rhodes, Ochoa, & Ortiz, 2005; Hernandez, 2005).

A multi-culturally sensitive psychologist:

- **Is aware of the various limitations involved in the assessment process.** Non-discriminatory evaluators caution against the search for the "ideal" or unbiased test. Best practices and non-discriminatory assessment are not defined as a single test but as a wide range of approaches that collectively seek to uncover data upon which decisions can be fairly made (Ortiz, 2008).

- **Engages in hypothesis testing and avoids confirmatory biases.** Critical to non-biased assessment is a process of generating hypotheses rather than looking to confirm preconceived notions about what the data will show. Confirmatory bias is avoided by not anticipating the diagnosis for which data is sought. For example, avoid focusing assessment on assumed attention problems and failing to examine possible learning issues related to LEP (Ortiz, 2008). The culturally responsive psychologist seeks to determine the conditions under which student learning occurs.

- **Recognizes that the evaluator's linguistic competence is not enough.** Though language is often seen as the single variable that makes certain tests inappropriate, the reality is that cultural differences may also weaken their validity (Hernandez, 2005). Culture influences how we define problems, the behaviors we teach and expect of our children, whether or not we consider certain behaviors problematic, and our willingness to address or change the behaviors. Cultural competence is neither a discrete skill nor a set of learned facts about culture; it is reflected by the ability to recognize when and where cultural issues may be operating. In non-biased assessment evaluators seek to understand and attend to the salient cultural variables. Resources for focusing interviews on cultural and ecological variables are available (Suzuki, Ponterotto & Meller, 2001; Rhodes, et al., 2005).

- **Considers the influence of ecological variables** and compares the child to his or her native cultural norms. It is possible that reported behaviors are expected and valued at home. Within the child's home culture, eye contact, independent functioning, and assertiveness may not be taught, yet the school may expect these of the child. See Sheridan (2000) for a discussion of the application of behavioral consultation within a multicultural paradigm. Setting Events, or conditions that are temporarily or contextually distal to a target behavior may include variables mediated by culture. For example, rigid sex role definition in some cultures may affect the unwillingness of a male student in a life skills class to clean the dishes after cooking instruction. It is better to identify problems from the perspective of a mismatch between the child and the requirements of the environment (Sheridan, 2000).

- **Attends to issues of language proficiency.** Second-language acquisition takes several years to develop and is affected by a family's socio-economic status, acculturation and the quality and consistency of instruction. Children acquire a basic interpersonal language within 2 to 3 years, and academic language proficiency within 5 to 7 years. Throughout this process several things are evident. First, gaps between the language development of ELL and monolingual children are normal. Second, silent periods are expected as language comprehension precedes production. Third, some loss of the native language is normal. Indicators of potential problems, however, may exist when there appears to be difficulty in learning a language at a normal rate compared to learners of similar backgrounds, even with assistance. Other red flags include short mean-length utterances (in both languages); auditory processing problems; poor sequencing skills whereby communication is disorganized, incoherent, or leaves the listener confused; and

Continued on page 24

CULTURALLY RESPONSIVE PRACTICE

Continued from page 23

difficulty conveying thoughts (Gopaul-McNicol &Thomas-Presswood, 1998; Mattes & Omark, 1991), and learning difficulties across both languages.

- **Solicits parental participation in the assessment process and recognizes it as a critical component for culturally and linguistically diverse children.** Parent/home information may be the only source of historical information. Such information should detail parental concerns, the child's competence and progress as seen by the parent, and the child's medical, educational, health, and social/emotional development. Parent and family interviews should also reveal attitudes and behaviors that influence the student's achievement.

- **Evaluates in the spirit of RTI.** Response to intervention offers a promising alternative for assessment and education of culturally and linguistically diverse students by identifying at-risk students early and providing preventive instruction. In RTI programs, children enter the assessment-classification process with systematic and scientific data documenting response to well designed evidence-based interventions.

References

Gopaul-McNicol, S., & Thomas-Presswood, T. (1998). *Working with linguistically and culturally different children.* Boston: Allyn & Bacon.

Hernandez, L. (2005). Becoming a cross-culturally intelligent evaluator. *In Sight, 25.*

Maital, S. H. (1999). Reciprocal distancing: A systems model of interpersonal process in cross-cultural consultation. *School Psychology Review, 29,* 389-400.

Martinez, D. (2004). Multicultural assessment: Training suggestions. *Trainer's Forum, 24.*

Mattes, L. J., & Omark, D. R. (1991). *Speech and language assessment for the bilingual handicapped.* Oceanside, CA: Academic Communication Associates.

Ortiz, S. H. (2002). Best practices in non-discriminatory assessment. In A. Thomas & J. Grimes (Eds.). *Best Practices in School Psychology IV, 2* (1321-1336). Bethesda MD: National Association of School Psychologists.

Rhodes, R. L., Ochoa, S. H., & Ortiz, S. O. (2005). *Assessing Culturally and Linguistically Diverse Students: A Practical Guide.* New York: Guilford Press.

Sheridan, S. M. (1999). Considerations of multiculturalism and diversity in behavioral consultation with parents and teachers. *School Psychology Review, 29,* 344-353.

Other references are available from the author. E-mail amelia.lopez@millersville.edu.

BULLYING OF DIVERSE STUDENTS

Continued from page 22

sexual orientation (GLSEN, 2005). For as many as 2 million school-age children and adolescents, victimization at school, including verbal and physical harassment, threats, intimidation, prejudice, and discrimination, may be related to their perceived sexual orientation and/or development of a non-heterosexual identity (Adams, Cox, & Dunstan, 2004; Browman, 2001; Horowitz & Loehnig, 2005).

As a consequence of being bullied at school, many LGBTQ children and adolescents may perceive that school is unsafe, and focus more upon their survival rather than their educational progress, placing these students at heightened risk for a variety of academic difficulties and underachievement, including frequent absences and dropping out before graduation (National Association of School Psychologists, 2004; National Mental Health Association, 2004; Weiler, 2004). Additional negative outcomes for sexual minority youth include low self-esteem, depression, suicidal ideation or completion, alcohol and other substance abuse, sexual acting out, exposure to sexually transmitted diseases, and subjection to violence at rates higher than their heterosexual counterparts (Callahan, 2001; NASP, 2004).

Although research is not consistent regarding whether non-majority students are more likely to be bullied than their non-diverse peers, it appears that peer victimization is a problem for many ethnically, culturally, racially and sexually diverse children and adolescents. Thus, in order to improve the educational experience of diverse students, it is vitally important that psychologists, educators, and health care providers develop an increased awareness of the issues faced by these students, and learn effective strategies for preventing and intervening in instances of bullying of non-majority children and adolescents.

References

Adams, N., Cox, T., & Dunstan, L. (2004). "I am the hate that dare not speak its name:" Dealing with homophobia in secondary schools. *Educational Psychology in Practice, 20,* 259-269.

Browman, D. H. (2001). Report says schools often ignore harassment of gay students. *Education Week, 20,* 5.

Callahan, C. J. (2001). Protecting and counseling gay and lesbian students. *Journal of Humanistic Counseling, Education, and Development, 40,* 5–10.

Eslea, M., & Mukhtar, K. (2000). Bullying and racism among Asian schoolchildren in Britain. *Educational Research, 42,* 207-217.

Finkelhor, D., Ormrod, R., Turner, H. & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10,* 5-25.

Fitzpatrick, K. M., Dulin, A. J., & Piko, B. F. (2007). Not just pushing and shoving: School bullying among African American adolescents. *Journal of School Health, 77,* 17-22.

GLSEN (2005). From teasing to torment: School climate in America – a national report on school bullying. Washington, DC: Author. Retrieved April 1, 2009, from: http://www.glsen.org/cgi-bin/iowa/all/library/record/1859.html?state=research.

Horowitz, A., & Loehnig, G. (Eds.). (2005). *Safe schools manual.* Saint Paul, MN: Out for Equity.

Mouttapa, M., Valente, T., Gallaher, P., Rohrbach, L.A., & Unger, J. B. (2004). Social network predictors of bullying and victimization. *Adolescence, 39,* 315-336.

National Association of School Psychologists. (2004). Position statement on gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth. Bethesda, MD: Author. Retrieved September 2, 2006, from http://www.nasponline.org/about_nasp/pospaper_glb.aspx.

National Mental Health Association (2004). Back to school — bullying at school: Harassment puts gay youth at risk. Alexandria, VA: Author. Retrieved October 6, 2006, from http://www.nmha.org/pbedu/backtoschool/bullyingGayYouth.cfm.

Olweus, D. (1993). *Bullying at school: What we know and what we can do.* Malden, MA: Blackwell.

Peskin, M. F., & Markham, C. M. (2006). Bullying and victimization among Black and Hispanic adolescents. *Adolescence, 41,* 467-485.

Rogers, A., Adamson, J. E., & McCarthy, M. (1997). *Ethnicity and Health, 2,* 309-317.

Seals, D., & Young, J. (2003). Bullying and victimization: Prevalence and relationship to gender, grade level, ethnicity, self-esteem, and depression. *Adolescence, 38,* 735-748.

Siann, G., Callaghan, M., Glissov, P., Lockhart, R., & Rawson, L. (1994). Who gets bullied? The effect of school, gender, and ethnic group. *Educational Research, 36,* 123-134.

Smith, P. K., & Brain, P. (2000). Bullying in schools: Lessons from two decades of research. *Aggressive Behavior, 26,* 1-9.

Storch, E. A., Nock, M. K., Masia-Warner, C., & Barlas, M. E. (2003). Peer victimization and social-psychological adjustment in Hispanic and African American children. *Journal of Child and Family Studies, 12,* 439-452.

Weiler, E. M. (2004). Legally and morally, what our gay students must be given. *The Education Digest, 69,* 38–43.

The Power of Stereotypes

Ed Zuckerman, Ph.D.

Academic performance differences between Blacks and Whites have been documented in a variety of settings and with a variety of measures. Why? You can easily think of several reasons but there is a less well known but well documented cause which (good news!) can be changed fairly easily.

Consider the "Obama Effect" on scores by a variety of people on a set of verbal questions drawn from the GRE (Friedman, Marx, and Ko as cited by Dillon, 2009). The large performance gap (8.5 vs. 12 correct answers) between Blacks and Whites appearing on this test before the nomination of Mr. Obama became non-significant after his nomination and again after his election. Why? What had changed?

Over the last 20 years psychologists have documented this social cognitive force and called it "stereotype threat:" When a situation reminds people of their membership in a stereotype they conform their behavior to that stereotype. For example, Black people asked to define vocabulary words when questioned by a White interviewer scored lower than Whites but at the same level as Whites when the interviewer was Black (Min-Hsuing Huang, as cited by Vedantam, 2009).

It turns out that the threat does not have to be conscious and applies to other differences. "Reminding women about their gender or telling them that men generally outperform women on math tests invariably depresses the women's scores. Similarly, telling test-takers that people of Asian descent score better than other students depresses the performance of White men" (Vedantam, 2009).

Claude Steele's well reasoned and well written programmatic research documenting the discovery and power of this phenomenon can be read at http://www.dushkin.com/olc/genarticle.mhtml?article=27042. Because this ends in 1999 it offers only one way in which the threat can be overcome – a "racially integrated 'living and learning' community in a 250-student wing of a large dormitory."

Joshua Aronson has shown that teaching "Black and Hispanic junior high school students how the brain works, (and) explaining that the students possessed the ability, if they worked hard, to make themselves smarter. ... erased up to half of the difference between minority and White achievement levels" (Nisbett, 2009).

It turns out that the threat does not have to be conscious and applies to other differences.

Daphna Oyserman "asked inner-city junior-high children in Detroit what kind of future they would like to have, what difficulties they anticipated along the way, how they might deal with them and which of their friends would be most helpful in coping. After only a few such exercises in life planning, the children improved their performance on standardized academic tests, and the number who were required to repeat a grade dropped by more than half" (Nisbett, 2009).

Geoffrey Cohen "asked teachers at a suburban middle school, at the beginning of a school year, to give their seventh graders a series of assignments to write about their most important values. Afterward, the Black students did well enough in all their courses to obliterate 30 percent of the difference that had existed between Black and White students' grades in previous years" (Vedantam, 2009).

Such interventions give people a sense of belonging which can counter some of the self-fulfilling stereotypes. All of the above is not to suggest that these brief or simple interventions will erase all or even most differences due to race in this country but they do offer hope and a starting place.

Federal Money to Implement an Electronic Medical Record

Part of the economic "stimulus" package includes $17 billion for electronic medical records, and to encourage their adoption there is about $20,000 a year available to practices. Before you consider sharing in this wealth, here are some details.

1. There is no cash to go out and buy a system. The payments are in the form of extra money to current Medicare providers after they implement an EMR.
2. Payment will be up to 75% of last year's Medicare payments to the provider. If a system will cost $7,500 the provider will have to have received $10,000 from Medicare last year to get the maximum recovery.
3. It is not yet clear which costs and which "meaningful uses" will be covered and which developers' systems will be approved.
4. Psychologists are not currently included, only physicians, but the regulations are under development.

References

Dillon, S. (2009, January 23). Study sees an Obama effect as lifting black test-takers, *The New York Times,* A15.

Nisbett, R. E. (2009, February 8). Education is all in your mind. *The New York Times.*

Steele, C. M. (1999, August). Thin ice: "Stereotype threat" and black college students. *The Atlantic Monthly,* 44-47, 50-54.

Vedantam, S. (2009, February 2). How a self-fulfilling stereotype can drag down performance. *The Washington Post,* A5.

CE Questions for This Issue

The articles selected for one CE credit in this issue of *The Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this offering. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, then you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the test at home and return the answer sheet to the PPA office. Passing the test requires a score of at least 70%. If you fail, you may complete the quiz again at no additional cost. We do not allow more than two attempts at the test.

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before November 30, 2009 — the end of the current renewal period.

Return the completed form with your CE registration fee (made payable to PPA) for $15 for members ($25 for nonmembers) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1748

Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Chubb

1. For the sake of the organization, Chubb recommends that PPA members minimize our discussion of our differences so that we can focus on our commonalities.
   True
   False

DeWall

2. The expansion of adultBasic:
   a) will cover behavioral health and prescription medication
   b) will be free to everyone in the program
   c) will cover most of the uninsured in Pennsylvania
   d) now needs only Senate approval to become law

Legal Column: Unlearning Ethics

3. According to the authors, all of the following statements are true EXCEPT:
   a) It often is more difficult to unlearn false information than it is to learn new information.
   b) Psychologists sometimes have inaccurate beliefs concerning their legal or ethical obligations or the manner by which to implement prudent risk-management strategies.
   c) Psychologists' beliefs about ethics need to be placed in the proper context so that they are not false or misleading.
   d) All of the above are true.

Bartoli

4. Creative maladjustment:
   a) means assisting clients to develop better coping mechanisms to accommodate oppressive social forces
   b) is the diagnosis given to members of minority groups as they develop significant psychological symptoms in reaction to the oppression they experience
   c) calls for all psychologists to join the fight to end street violence
   d) is necessary to promote social change

Sternlieb

5. Validation in the context of multiculturalism is
   a) a form of proving the accuracy of a person's feelings
   b) a product of effective listening
   c) a psychologist's stamp of approval
   d) different when applied to feelings about race

6. Some of the reasons we have difficulty in conversations about racism are
   a) our own defensiveness
   b) we miss the emotional tone of the conversation
   c) we fail to identify our own feelings and needs in these conversations
   d) all of the above

Jenkins

7. Cultural Competence Identity (CCI) is a survival concept that certain clients have acquired. Which of the following best describes cultural competence identity and cognitive strategies that can assist a treatment specialist in caring for this type of client?
   a) CCI is a way that some clients can work through trauma. Several ways that a treatment specialist can help is to be a good listener, employ treatment for PTSD, test for depression and employ a treatment plan consisting of at least 6 months.
   b) CCI pertains to special populations, such as prisoners, who have cognitively developed survival skills through certain schemas, scripts, and accommodation. The treatment specialist does well to assume that such cognitive constructions are culturally different, and regardless of how seemingly inappropriate, are not necessarily wrong when understood in this context.
   c) CCI creates a specific mode for survival, and a counselor might do well to apply carefully constructed, cognitive functioning measurement instruments.
   d) CCI allows for survival and social development. For that reason, the treatment specialist might consider developing a treatment plan that reflects more social considerations.

Suzuki

8. Mental health professionals must monitor how their own culturally conservative beliefs and practices affect access and treatment methods for culturally different populations.
   True
   False

PPAGS – Davis & Carr

9. Reasons why graduate students may want to maximize training in multiculturalism include:
   a) changing demographics
   b) unique health needs of the diverse populace
   c) pressures from governing and supporting organizations
   d) all of the above

Bell et al.

10. Why have there been discrepancies in the research literature regarding whether there are racial/ethnic differences in the likelihood of children and adolescents being bullied?
   a) methodological issues (e.g., lack of clear operational definitions of bullying and racism) associated with these research studies
   b) imprecise use of racial terminology in these research studies
   c) the use of skin color alone as a criterion for identifying and describing behaviors that occur among ethnic groups in these research studies
   d) all of the above

Lopez

11. Regarding second language acquisition, an indicator of a potential problem which the multiculturally sensitive psychologist takes into consideration is that the child:
   a) takes longer than 4 years to develop English proficiency
   b) exhibits "silent periods"
   c) exhibits poor sequencing and disorganized communication in both languages
   d) exhibits gaps in his/her communication as compared to monolingual children

PsychTech – Zuckerman

12. Stereotype threat:
   a) leads test takers to conform their behavior to the expectations of a stereotype they accept
   b) is largely unconscious
   c) reduces White test takers' math scores when they are reminded that Asians do better than Whites on math tests
   d) can be substantially reduced by reducing the saliency of racial and other stereotype-related differences before testing
   e) all of the above ☑

Continuing Education Answer Sheet
The Pennsylvania Psychologist, June 2009

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

1.	T	F			**7.**	a	b	c	d
2.	a	b	c	d	**8.**	T	F		
3.	a	b	c	d	**9.**	a	b	c	d
4.	a	b	c	d	**10.**	a	b	c	d
5.	a	b	c	d	**10.**	a	b	c	d
6.	a	b	c	d	**11.**	a	b	c	d
					12.	a	b	c	d e

Satisfaction Rating

Overall, I found this issue of *The Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

Please print clearly.

Name _____

Address _____

City, State _____ ZIP _____ Phone ( ) _____

I verify that I personally completed the above CE test.

Signature _____ Date _____

A check or money order for $15 for members of PPA ($25 for non-members of PPA) must accompany this form.
Mail to Continuing Education Programs, PPA, 416 Forster Street, Harrisburg, PA 17102-1748.

Welcome New Members

We offer a hearty welcome to the following new members who joined the association between February 1 and April 30, 2009!

NEW FELLOWS

Richard S. Citrin, Ph.D.
Pittsburgh, PA
Holly E. Evans-Schaeffer, Ph.D.
Lafayette Hill, PA
Michelle M. Goldberg, Ph.D.
Philadelphia, PA
Barbara C. Knickerbocker, Ph.D.
West Chester, PA
Thomas W. Lane, Ph.D.
Allentown, PA
Lori D. Lindley, Ph.D.
Erie, PA
Katherine Martin, M.Ed.
Philadelphia, PA
Matthew L. McDonald, Psy.D.
Erie, PA
Patrick J. McHugh, Ph.D.
Media, PA
Rosemary Mennuti, Ed.D.
Wenonah, NJ
Deborah A. Miller, Ph.D.
Havertown, PA
Patricia E. Piper, Ph.D.
Lewisburg, PA
Brendali F. Reis, Ph.D.
Wayne, PA
Elaine Rodino, Ph.D.
Pacific Palisades, CA
William S. Rybicki, Ph.D.
Blue Bell, PA
Shilpa Saroop, Ph.D.
Philadelphia, PA

NEW MEMBERS

Sandra H. Banks, Ph.D.
Pittsburgh, PA
Daniel G. Byer, Psy.D.
Spring Grove, PA
Kaila Dickstein, Psy.D.
Philadelphia, PA
Mary K. Dougherty, M.A.
Clifton Heights, PA
Nicole Gabriel, Psy.D.
Malvern, PA
Kathleen F. Gallagher, Ph.D.
Annville, PA
Lauren E. Hazzouri, Psy.D.
Scranton, PA
Wendy Heberlein, Ph.D.
Collegeville, PA
Melissa Jenkins-Fernandez, Psy.D.
Oakdale, PA
Theresa Ann Kovacs, Psy.D.
Swoyersville, PA
Tammy A. Lazicki, Ph.D.
Annville, PA
Jerri Maroney, Psy.D.
Harrisburg, PA
Yahaira I. Márquez, Ph.D.
Pennsauken, NJ
Constance M. Mesiarik, Ph.D.
King of Prussia, PA
Katherine Michos, Psy.D.
Sewell, NJ
Jennifer I. Minkin, Psy.D.
Philadelphia, PA
Robert J. Palladino, M.Ed.
Upper Darby, PA
George Panrock, Ed.M.
Philadelphia, PA
Christopher Patrone, Psy.D.
Philadelphia, PA
Bradley M. Rosenfield, Psy.D.
Narberth, PA
Robert W. Shambaugh, Psy.D.
Marietta, PA
James A. Welsh, Ph.D.
State College, PA
Andrew Yake, Ph.D.
Pittsburgh, PA

STUDENTS TO MEMBERS

Joseph Altobelli, M.S.
Drexel Hill, PA
Stephanie Binter, Psy.D.
York, PA
Lori L. Cangilla, Ph.D.
Pittsburgh, PA
Lisa Collins, M.S.
Conestoga, PA
Ann E. Fisher, Psy.D.
Elverson, PA
Tammy A. Fronzaglia, Ph.D.
York, PA
Rachel A. Glatfelter, Psy.D.
York, PA
Anna N. Hiatt, Psy.D.
Philadelphia, PA
Monica Malone, Psy.D.
Brigantine, NJ
April L. Myslivy, Ed.S., M.S.
Northern Cambria, PA
Samuel K. Schachner, Ph.D.
Pittsburgh, PA
Margaret H. Swartz, Psy.D.
Gettysburg, PA
Cindy N. Takacs, Psy.D.
Bryn Mawr, PA

NEW STUDENTS

Nichole Berman, B.A.
Philadelphia, PA
David Y. Brownstein, M.A.
Kingston, PA
Jennifer L. Buhler, B.A.
Newark, DE
Renee Cahill, M.A.
Newtown Square, PA
Bethany Ann Conn, M.S.
Pittsburgh, PA
Anna M. Czipri, M.A.
Wyomissing, PA
John J. Donahue, B.A.
Philadelphia, PA
Tanisha E. Drummond, B.A.
Scranton, PA
Matthew L. Eisenhard, B.S.
Whitehall, PA
Shanon Randall Harmon, B.A.
Bolivar, NY
Sean J. Henley, M.A.
Pittsburgh, PA
Emily A. Herber
Mohnton, PA
Kimberly N. Jefferson, B.A.
Philadelphia, PA
Kate Keller
Philadelphia, PA
Kimberly R. Lieber, M.A.
Scranton, PA
Lucas D. Malishchak, B.A.
Hazelton, PA
Michelle N. Morgan, B.A.
Millersville, PA
Kevin P. Newgren, M.A.
Mount Joy, PA
Kathleen Shinko, M.A.
Kingsley, PA
Joe W. Spause, B.A.
Plymouth Meeting, PA
Mendy L. Viel, M.A.
Philadelphia, PA
Wendy E. Wild, M.A.
Middletown, PA
Jared L. Young, MSW
Elizabethtown, PA

Classifieds

POSITIONS AVAILABLE

PSYCHOLOGIST – Established practice in Central PA with solid reputation seeking a PA-licensed Psychologist as a full- or part-time Associate, using an Independent Contractor model. Furnished office, billing and receptionist services, and referral assistance provided. Our community is in clear need of additional providers: We turned away 20 viable psychotherapy referrals this month alone, due to lack of available time! Duncansville is a small town near Altoona in beautiful sub-rural Central PA, located one hour from State College and Johnstown. Contact Catherine Spayd, Ph.D. at 814-693-0617, or drspayd@aol.com, to further discuss this opportunity.

OTHER

PRIVATE PRACTICE SUCCESSION AVAILABLE IN HARRISBURG, PA AREA. Twenty- four year specialization in eating disorders and/or women's issues. Substantial potential for growth. Terms negotiable. Owner will provide optional 1-2 years consultation during transition to new ownership. Contact Christine Ganis, PsyD @chrisganis@aol.com.

PROFESSIONAL OFFICE SPACE FOR RENT IN EXTON COMMONS Contemporary style offices for rent in Exton psychology practice. Central, familiar location in lovely medical/professional office park with landscaping. Shared, furnished waiting room, use of kitchenette (fridge, microwave), large private bathroom. Wood trimming, large windows. $575/month-full-time, unfurnished. Includes all utilities and cleaning. Call Dr. Janet Edgette (610-363-8717 ext. 2, leave message).

RECESSION OFFICE SPACE SPECIAL! Share quiet, professional suite near suburban Philadelphia area (Bala Cynwyd), furnished, conference room, fax/copier, etc. Flexible hours. 610-664-3442.

INSUR SERVICES INC – THE CURE FOR YOUR BILLING PROBLEMS! We offer a complete billing service customized to your practice, large or small, allowing you more time to do the kind of work you were trained to do. With 15 years experience exclusively in the mental health field, working with all insurance types including traditional managed care, HMO, auto accidents and Workers' Comp. Also specializing in provide application preparation, compliance books, confidential client contact and electronic billing without the use of a clearing house. A Member of the Better Business Bureau in good standing. Please contact Ronda White at 800-608-7298, insusvci1@msn.com.

THERAPY OFFICE SPACE W/ WAITING ROOM (ARDMORE) – Single office or suite, rent monthly. Or rent beautifully furnished office for one-or-two days of the week time slot. "Day of Week" includes the evening of that day. Saturday/Sunday rental, too. Prime location. 1½ blocks from train and SEPTA bus. Sunny windows, Wi/Fi enabled, central AC. 610-649- 9964 or carole@mstherapist.com.

ADVERTISING RATES

Display Advertisements *(electronic black & white only)*

Back Cover (¾ Page)	$480	7.25 x 7″
Inside Cover	$465	7.25 x 10″
Full Page	$415	7.25 x 10″
½ Page	$235	7.25 x 4.75″
¼ Page	$125	3.5 x 4.75″

A 25% additional production fee will be added for display ads that require type-setting and/or composition. The preferred file format is a high resolution with all graphics and fonts embedded.

Classified Advertisements
$.45/word *(minimum order: $30)*

PPA member and multiple insertion discounts are available. Acceptance of advertising does not imply endorsement by PPA or PPF. For further information, contact Marti Evans at the association.

CO-MEDIATION PLUS

Divorce & Business Mediation
Expert Witness

Robert M. Schwartz, Esquire
610-212-7344
robertm.schwartz@gmail.com

Karen L. Schwartz, Ph.D.
Licensed Psychologist
610-687-6768

Fax: 610-527-1216

FREE EXAMINATION COPIES of psychology Ebooks and free CE slides, by Robert M. Gordon, go to IAPTpress.com. Go to RewardingLove.com for online dating!

OFFICE TO SUBLET IN MEDIA, PA – Bright, spacious corner office to sublet in Media, PA. Up to three full days available. Located on 3rd floor of professional building four blocks from central commercial area. Comfortably furnished. Perfect for individual tx and can accommodate families and small groups. In four office suite with shared waiting room and common area with fridge, fax, copier, and scanner. Ample off-street parking. Easy access by public transportation from Philadelphia, Main Line and surrounding DE County. Photos can be viewed at www.BodySoulWorks.com/Office. If interested, contact Renée Balthrop, PhD: (Office) 610-590-1965, (Cell) 215-840-1587, DrBalthrop@BodySoulWorks.com.

Vol. 69, No. 6

The Pennsylvania Psychologist

June 2009 • QUARTERLY

The Pennsylvania Psychologist
416 Forster Street
Harrisburg, PA 17102-1748

Join PPA's Listserv!

The listserv provides an online forum for immediate consultation with hundreds of your peers. Sign up for FREE by contacting:

iva@PaPsy.org.

2009/10 CE Calendar

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

June 17–20, 2009
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

October 9, 2009
Western Fall Continuing Education and Ethics Conference
Mars, PA
Marti Evans (717) 232-3817

November 5–6, 2009
Eastern Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

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

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

Registration materials and further conference information will be mailed to all members.

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

HOME STUDY CE COURSES

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

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

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