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QUARTERLY

Psychology in the Media

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- Advice on compliance plans
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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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Grab an Oar!

Vincent J. Bellwoar, PhD

Dr. Vincent Bellwoar

In our immediate future there are serious challenges facing PPA members, some national, some regional, and some internal to PPA. At the national level the Patient Protection and Affordable Care Act brings substantial change, most of which we still don't understand. Health care reform has many tentacles, such as Medicare reimbursement, electronic health records, CPT billing codes, DSM-5, and ICD-10. While many are overwhelmed by these changes, it is in our best interest to understand them so that we can best serve our clients and also make a decent living! Some say that one reason we pay so much more for health care than any other industrial nation, without better results, is because the incentive structure in our system is wrong. Providers are paid primarily for procedures and tests, not on outcomes. Health care overhaul intends to flip this fee-for-service system to one where insurers or the government pay providers to keep patients healthy. The goal is to have providers reimbursed more for the value of their services than the volume. For psychologists this approach raises the difficult question of how to quantify "value" in a field where outcomes are extremely difficult to measure. Psychologists need more information to make decisions about how to practice in the future. If we expect not only to understand health care reform but also to have a seat at the decision-making table, we must encourage frank dialogue between the provider and the payer. We must understand that the payer is not only the patient, but also the insurer and even sometimes the employer. All of them have a financial interest in containing health care costs. Again, getting a seat at the table is the key to our future.

The second set of challenges are numerous ones at the state level, best described by Sam Knapp in a recent article entitled, "The Perfect Storm." There are numerous events, aside from health care reform, threatening the livelihood of psychologists in Pennsylvania. These include: rate reductions by commercial insurers, increased fraud and abuse initiatives by Medical Assistance, the mounting pressure to use outcome measures, initiatives related to "pay for performance," problems students face in obtaining internships and post-doc positions, spiraling costs of education and the debt that burdens early career psychologists, attempts to change the Child Protective Services Law, the exclusion of psychologists from hospital practice, and the severe budget cuts threatening school psychology positions. With such substantial turbulence before us, one can understand why Sam speaks of a perfect storm. Imagine, for a minute, that PPA is a ship amidst this perfect storm. The challenges that we face act like massive waves threatening the integrity of our ship, our PPA. With these waves of change coming our way, you would think we have our hands full.

But we also face a third wave of change, one within PPA. When there is a storm at sea, the ship needs a good captain and crew to get her to safety. After serving our association for 26 years, Tom DeWall is retiring as PPA's executive director. Tom has been a darn good skipper of our ship and, along with his first mate, they've run a pretty good ship. Most of you already know of Tom's retirement, but 18 months after Tom leaves the helm, Sam Knapp will also retire. Add to that the likely retirement of some additional PPA crew and we have some serious challenges threatening the integrity of our PPA ship. Perhaps the perfect storm metaphor fits. If so, our ship needs to gain momentum to propel itself through the waves of change. The good news is that our ship's momentum comes from its members, from you! With the right momentum we can ride through any storm. Here's how we are going to do it.

Succession development

There are four action steps that will propel our PPA ship through the stormy seas. The first is to address our leadership transition. One year ago we engaged in a national search and received more than 120 résumés. We ranked the top 25 candidates and from that group we conducted 11 video conference interviews. We distilled the top five candidates, gave them a battery of executive assessments, and then brought them to Harrisburg to meet PPA staff and interview with our search team. From this comprehensive search, we have found PPA's next captain: Ms. Krista Paternostro. Please refer to the July/August *Pennsylvania Psychologist* for a full description of her background and to this month's current issue in which Krista writes her first (of many) PPA columns. With her wealth of experience and talent Krista will be an excellent captain as we propel into the future.

Perhaps the perfect storm metaphor fits. If so, our ship needs to gain momentum to propel itself through the waves of change.

With PPA's next captain ready to take the helm, you may wonder, "what about Tom?" As of September Tom will begin his new role as PPA's government relations consultant. Who better than Tom than to advocate for PPA to our legislators? In addition to this role, Tom has graciously agreed to remain readily available to Krista as consultant, just a phone call away.

Succession development doesn't stop here. One of my main duties as PPA president is to support the successful transition of our new executive director.

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Change Brings New Possibilities

Krista Paternostro, CAE


Krista Paternostro

Journalist Linda Ellerbee once said, "What I like most about change is that it's a synonym for "hope." If you are taking a risk, what you are really saying is, "I believe in tomorrow and I will be part of it." I love this quote for so many reasons. Most notably, I love it because I think that it captures the sentiment that may be currently emanating through PPA. The organization is undergoing a lot of change simultaneously. These changes span the uncertainties of the evolving state and federal policy landscape, lingering nationwide economic challenges, as well as our own internal operations. From my perspective, and for purposes of this column, I will focus on the final challenge, the change related to our organization. I am very aware that an organization with a proud 80-year record of accomplishment that is undergoing a leadership change following 26 years of exceptional service by its current executive director, only to be followed by someone relatively unknown and certainly unfamiliar to most, creates a condition of profound uncertainty for everyone involved.

But, with all of this stated, I am more than thrilled to be able to serve as your new executive director! I look forward to taking this journey with you. And, just as the passage above implies, with every change also comes the hope that tomorrow will be even better than today, and that being a part of the change provides an opportunity to be a part of something amazing. Beyond hope, change also brings innovation, ingenuity, and new possibilities. With your help, PPA will continue to flourish and grow in ways that we cannot even predict today. I have always tended to lean toward the optimistic view of change, and I can promise you that this will continue to be my viewpoint as we move forward together.

If you had a chance to hear me speak during the PPA Convention in June, you heard me describe my three initial goals for the organization. For those who were unable to attend, I share them with you below with one caveat: these goals will continue to evolve as the layers of the organization continue to unfold to me. There is much to learn along the way and I consider all of you an important part of our team. We will accomplish these goals together.

LEADERSHIP. My first goal is **to work with the PPA Board of Directors to successfully transition leadership and to build a solid and strategic organizational plan for the future**. I have touched on this goal with my words above. But, I can add that Tom DeWall and I have already successfully begun the transition process. We will continue to work together in the coming months to ensure that this progression is seamless for our members and stakeholders. The organization is also lucky to have a committed, engaged, and energetic Board of Directors, capably led by Dr. Vince Bellwoar. Their collective passion for ensuring that the transition is successful is as evident to me as their passion for the psychology profession as a whole. I am proud to be serving with them on this team.

TECHNOLOGY. Secondly, I want to work **to enhance the organization's effectiveness by creating a technology infrastructure that increases opportunities for collaboration and communication among members, stakeholders, and organizational leaders**. I believe that this goal is critical for us to stay significant and viable in the future. We need to ensure that our technology supports the effective implementation and delivery of all of our products and services. Ever-evolving, technology, and the use of technology, in many aspects have become the distinguishable feature of successful associations. We need to ensure that PPA is on the leading edge in this regard.

MEMBERSHIP/ADVOCACY. And finally, we will continue to **offer relevant, vibrant, and valuable membership programs and services that keep pace with the changing professional environment**. It is crucial for PPA to understand the shifting needs of the membership and to build the mechanisms to bring new services to fruition, while creating opportunities to enhance the effectiveness of existing offerings. We will do all of this with a sound financial strategy to guide our decisions. In regard to advocacy, I could not develop a list of initial goals without mentioning this vital and effective component of our association. We will continue to focus on important policy issues at both the state and federal level to ensure the continued growth and success of the profession.

As I stated during my remarks at the PPA Annual Convention, I would like to salute retiring PPA Executive Director Tom DeWall for his dedication to the organization and for his many, many years of exceptional service to PPA. The organization and membership have benefited tremendously from his knowledge, wisdom, and tireless work ethic. I feel very fortunate to be taking the reins following his tenure, and feel especially lucky that he has built a great staff team that I will have a chance to learn from, grow with, and build upon in the future. I also look forward to engaging with our board leadership team on the path forward for the organization.

I officially begin my tenure as your executive director on September 1 of this year. Please send me an e-mail (krista@PaPsy.org), call me at the office, or even better, please stop by to say hello. I am interested in your ideas and thoughts on how we can continue to provide programs and services of significance to you, our valued members. The wonderful reception I received from all of you during the convention leads me to believe that I have indeed found a professional home away from home! Our association is poised for continued future success. And, just like the opening quotation, it is my sincere hope that you believe in tomorrow and want to continue to be a part of our future.

Record Keeping for Psychologists

Samuel Knapp, EdD, ABPP, Director of Professional Affairs
Rachael L. Baturin, MPH, JD, Professional Affairs Associate


Dr. Samuel Knapp


Rachael L. Baturin

Record keeping is an essential part of professional practice. The functions of records are to assist in collaborating with other professionals; to ensure continuity of care in case of the death, disability, or the inability of psychologists to continue services; to assist psychologists in remembering data and progress; to make or plan treatment; and to justify third-party reimbursement. It is a legal requirement (as determined by regulations of the State Board of Psychology) and a requirement of third-party payers. Good record keeping is also essential for risk-management purposes in difficult situations. Records can also be used to respond to regulatory complaints or inquiries; as sources of archival data for research purposes; as a source of data to share with patients, if clinically indicated; as a means to prove that services were rendered; and as a means to monitor supervisees.

The requirements for records come from a variety of sources including the regulations of the State Board of Psychology (49 PA Code §41.57). However, the State Board of Psychology also requires all psychologists to follow the guidelines and standards of the American Psychological Association including, by inference, the APA guidelines on record keeping (APA, 2007). These sources require that the records of all psychologists must include:

- the name and address of each patient (if the patient is a minor, note the legal custody arrangements and the names of parents or legal guardian; see Tepper, Knapp, & Baturin, 2006, for standards concerning the consent of children[1]);
- the presenting problem or purpose (this may be a diagnosis, although the State Board of Psychology does not require one);
- documentation of informed consent;
- the fee arrangement;
- test results or other evaluative results and the basic test data from which they were derived;
- notation and results of consultations;
- a copy of all tests or other reports prepared as part of the professional relationship;
- authorizations, if any, by the patient for the release of information and any mandated reporting;
- developmental and health history;
- plans for service;
- The substance of each contact should include duration and dates of service, types of service (e.g., assessment, treatment), nature of the intervention, and any formal or informal assessments of the client's status.

In addition, the APA guidelines note that psychologists may, in some circumstances, need to document patient responses to interventions, life-endangering factors, other treatment modalities employed (such as medications), emergency interventions, phone or e-mail interventions, relevant cultural or sociopolitical factors, plans for future interventions, prognosis, or information concerning the psychologist-client relationship.

Although the State Board of Psychology requirements apply to all psychologists, individual psychologists may have additional requirements depending on their third-party contracts. Commercial insurers tend to follow the record keeping standards of the National Committee on Quality Assurance (NCQA). Medical Assistance (MA) and Medicare have their own unique record keeping requirements (see Baturin & Knapp, 2003). Of those, Medical Assistance regulations are the most detailed and burdensome. Also, Medical Assistance is the most proactive in terms of auditing providers. The record keeping requirements of insurers overlap with Board requirements, but some insurers have unique idiosyncratic requirements.

"The profession is not unified concerning how to document the "substance," content, or exact format of treatment notes."

For example, Medicare requires psychologists to document that the patient is cognitively capable of benefiting from the treatment, and NCQA standards, which most commercial insurers follow, require a discharge note.

Here are some other points about record keeping: as has been noted elsewhere in many publications, HIPAA distinguishes between progress notes and process notes. Some psychologists take it upon themselves to create two sets of notes, although nothing in HIPAA requires this, and we leave it up to each individual psychologist to determine whether routinely keeping two sets of notes can be justified from a time-management perspective.

Most psychologists learned to keep records at their first practicum or internship location. However, the profession is not unified concerning how to document the "substance," content, or exact format of treatment notes. Some psychologists use the SOAP format

[1] *This can be found in the members-only section of the PPA website, www.PaPsy.org*

(Subjective, Objective, Assessment, Plan) or the DAP format (Diagnosis, Assessment, Planning).We have heard mention of the BANJO (Beneficience, Autonomy, Nonmaleficence, Justice, Other moral principle), and the "Who, Why, What, When" formats (Who: identify provider and date; Why: why was patient being seen; What: the content of what the patient said or did). The general rule, however, is that psychologists should link the intervention to the presenting problem of the patient or client and record response to treatment.

Nothing restricts psychologists from relying exclusively on electronic records. Of course, prudent psychologists ensure that they have a backup for these records.

Some psychologists find it prudent to develop a checklist for every chart so they can be certain that the basics of the client record (intake, treatment plan, treatment notes, billing records) are all present. Checklists should supplement, not replace, treatment notes.

Psychologists should, as required by the APA Ethics Code, always document consent. Nothing requires psychologists to have a specific signed consent-to-treatment form (although it is perfectly acceptable and at times very prudent to have one). However, the treatment record should note that the patient consented to treatment.

Finally, most cases are routine and require only routine documentation, but psychologists should take extra care when treating high-risk cases. We will write more about record keeping in future articles.

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PRESIDENT'S MESSAGE

Continued from page 2

I need to facilitate the effective working relationship between the captain and crew. In addition, in six months a new Succession Development Task Force will begin to address the retirement of Sam Knapp. I have asked President-Elect Bruce Mapes to assist me as co-chair of that new task force. Finding the next Sam brings unique challenges; after all, there is only one Sam. Nevertheless, given the terrific job that the current task force performed, I have full confidence that we will be successful!

Recalibrating the compass

As succession development evolves, we turn to action step two. Every ship, especially in turbulent waters, needs a good compass. Our compass is the strategic plan originally completed in March 2008. It's now time to recalibrate it. The plan, which is on the website, describes PPA's vision and mission, and lists the specific strategies we use to get there. Our vision states: "PPA is a member-driven organization dedicated to promoting and advancing psychology in Pennsylvania, advocating for public access to psychological services, and enhancing multiple dimensions of human welfare while supporting the development of competent and ethical psychologists." Because our strategic plan is the compass that guides our ship, its importance can not be overemphasized. The Board of Directors, those persons voted into office by you, will represent you this winter in rewriting the plan.

Fighting back

The third action step involves fighting back, fighting against the threats to psychology. While there are many threats, none has been more insidious, more destructive to the morale of psychologists than the long, slow, painful decline in third party reimbursements. Rate reductions come in two ways. One is the outright slashing of rates as we have recently seen by some payers. The other is the refusal to increase rates at least commensurate with the rate of inflation. Both methods have served to erode our industry. Let me caution you that we cannot talk directly about taking action to influence commercial rates. That would be a violation of antitrust law with regard to every commercial insurer...but not Medicare. Medicare has cut rates for most health care professionals other than primary care physicians. Their complex formula used to determine rates for the various health care professions is called the Resource-Based Relative Value Scale (RBRVS). APA believes that due to an unfair application of this formula to psychological services, psychologists have experienced a 39% reduction in rates over the last 10 years when inflation is taken into account. Although most health care practitioners have experienced Medicare rate cuts, the RBRVS formula creates disproportionately more severe rate decreases for psychologists compared to other health care professionals. We are willing to do our fair share, but we are not willing to take on substantially more of the financial burden than other health care professionals.

Our compass is the strategic plan originally completed in March 2008. It's now time to recalibrate it.

APA is asking psychologists throughout our nation to fight back against these unfair cuts. APA will launch a campaign for federal legislation that will order Medicare and Medicaid to change the formula for reimbursing psychologists to one that more appropriately reflects the value of services we provide. PPA will join this fight and be the state with the most vocal advocates. We will create momentum that will carry Pennsylvania and inspire other states. Such momentum will require a tremendous grassroots effort, not just from those few hundred of you PPA members who routinely respond to legislative alerts. When that call comes, all Pennsylvania psychologists need to create a lot of noise, a lot of momentum!

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Medicare isn't the only area where we can fight back, though it is the most significant. In recent years private insurance companies have modeled themselves after Medicare. In January many of you experienced the severe rate decrease by a Pennsylvania insurer. When asked why they were cutting rates by 21%, they responded that they were now following Medicare rates! If Medicare can cut rates, other insurers feel justified in doing the same. And by the way, for those in academia, you should care too. If rates continue to be cut or not adjusted upward for inflation, you'll see fewer applicants for grad school because ours will quickly become a profession that a young person cannot afford!

In addition to fighting back against Medicare, we can fight back using the teeth of mental health parity. In studying this issue, APA believes it has found some narrow ground within the parity law that suggests parity violations in how mental health services are paid. With APA's guidance and legal expertise, PPA will explore these possible violations of parity and pay on two fronts. First, some CPT codes are defined according to time the provider spends with the patient. If an insurer pays the medical provider a rate differential for the varying lengths of treatment – as defined by the CPT codes – they should do so equally for the mental health provider. Medicare, along with a few insurance companies, already pays a rate differential for these codes; however, most do not. The second area of potential parity violations is the manner with which rate schedules are set on the medical side versus the mental health side. Again, this is an issue of fairness, of parity. It is not an issue of money; rather, it is an issue of confronting and stopping the discrimination toward mental health patients. When insurers provide rate increases on the medical side, but offer no such increases on the mental health side, this seems to constitute a parity violation. While explorations in these areas are relatively young, we hope great things will come of it.

Starting immediately, I will make it a priority that PPA aggressively pursue the potential parity violations by insurers. We are not going to take these threats to our livelihood sitting down; we are going to fight back. To fight back effectively, we need momentum. And that brings us to the fourth step, an action that is absolutely necessary to propel the PPA ship forward. We must create our own force of change!

Creating momentum

In describing the fourth action step, I ask you: Where are you going to be as the waves of the perfect storm hit? Will you be out there alone, trying to navigate the waves on your own? Or will you join us on the PPA ship? There are some pretty big waves forming around us, and we need momentum to push us through the rough seas ahead. Our ship goes nowhere without momentum, without movement, without motivation – and these are created through the passion and commitment of our members. There are many issues out there, many waves to overcome. The power of PPA is in its members' active involvement in advocacy. You see, the most realistic image of our PPA ship is not one with numerous sails or large motors, but one that is propelled by hundreds of oars, each being pulled by the efforts of individuals like you.

I'll be blunt: We need more people pulling on oars for this to work. We are in the race of our lives right now. The winds of change and the challenging waves before us are serious indeed. We need all hands on deck. We need everybody to pull. We need to create momentum unlike ever before, movement that will drive the PPA ship right through the storm. I ask that all psychologists join in this fight. There are three ways each of us can contribute. First, find someone who is not a member and recruit them in to PPA. Membership information is on the website. Bring them aboard the ship. Second, join a PPA committee and/or find some PPA work to do. After all, PPA is not a cruise ship but a working one. Become an active versus passive passenger. Pull an oar, even for a little while. Third, seek a significant role on the ship. We need committee chairs, board chairs, and officers who are inspired to make a change. Let's mentor each other into leadership roles. If you really care about where the PPA ship moves, come on board and grab an oar. I promise you, it'll be one heck of a ride!

PPA Fights Back

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

The last several years have been taxing for professional psychologists. In addition to having to endure the Great Recession, psychologists have had to encounter a number of difficult situations dealing with new CPT codes and declining (or stagnant) reimbursement rates under Medicare and commercial insurers.

However, the PPA Board of Directors has authorized a *"Fight Back"* campaign designed to address the problem of declining reimbursement rates. The articles in this series describe the reasons for the campaign and how it is to be implemented. This article describes what professional associations can and cannot do about declining or stagnant reimbursement rates. As noted below, the most prudent strategy is to focus on addressing the rates of reimbursement under Medicare. The second article (The Medicare Snowball) describes how the decline in reimbursement rates in Medicare has a snowball effect on the levels of income for all psychologists. Although the "Fight Back" campaign is focusing on Medicare, it impacts all psychologists regardless of their source of institutional support. As the subtitle of the article (Why Declining Rates Under Medicare Impact Everyone) suggests, all psychologists, even those who work in institutions or who have a complete fee-for-service practice, are influenced by Medicare rates. The public policy arguments for this initiative are detailed in the third article (Why Congress Should Halt Plummeting Payments Under Medicare), forthcoming next month. The last article, also to be published next month (Alphabet Soup for Professional Associations), explains how the different state and federal associations contribute to this campaign.

Over recent years reimbursements for psychological services have declined considerably, especially when adjusted for the increase in the cost of living. As noted in an accompanying article, these decreases in reimbursement reduce public access to psychological services.

On the surface it would appear that professional associations can do little to influence these reimbursement rates. Professional associations are, as a result of the Sherman Antitrust Act, prohibited from organizing, pressuring, or encouraging commercial insurance companies to increase their reimbursement rates. This law has been enforced against numerous professional organizations although, not to our knowledge, against an organization representing psychology.

However, PPA and APA are pursuing two strategies to influence reimbursement rates. First, associations are permitted to advocate for higher reimbursements under government programs, such as Medicare. After years of trying to work with the Centers for Medicare and Medicaid Services (CMS) without success, APA has decided to seek a sponsor to introduce legislation that would instruct CMS to change the formula by which psychologists are reimbursed, to accurately reflect the work value of what is being provided. We are realistic about this effort. We know that we live in an era of fiscal austerity and that all health care professionals must accept some reductions in reimbursement. But the sacrifices being asked of psychologists far exceed the sacrifices being made of those who provide physical health care. The net result is that more and more psychologists are dropping out of Medicare, older adults are not getting the services they need, and the quality of health care and life is declining for older adults. As we note in a related article, Medicare rates have a ripple effect that influences all psychologists, even those who do not provide services to Medicare beneficiaries.

Second, APA is exploring the possibility that the disparate fee structures could violate the federal parity law if they were to present a barrier to treatment. The regulations for parity are written ambiguously on this issue, but there may be a window of opportunity for this argument to stick at least for the more egregious practices. APA will be exploring this possibility.

PPA is entering this effort with Medicare without illusions. We are aware that we can do everything right in our state and generate broad support among our Congressional delegation. But if other states fail to work on this issue vigorously, our efforts will be futile. Also, we cannot guarantee that an increase in Medicare rates will necessarily mean an increase in commercial rates. As noted in other articles, commercial insurers typically base their rates on a percentage of Medicare fees. However, there is no requirement that they do so. It is possible that we could get an increase in Medicare fees, only to have a commercial insurer drop the Medicare benchmark or otherwise vary their formula to prevent any fee increase. Nonetheless, it represents our best strategy for addressing the decline in reimbursement rates and should be pursued vigorously.

The Medicare Snowball

Why Declining Rates Under Medicare Impact Everyone

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Medicare rates have dropped 39%, when adjusted for inflation, over the last 12 years. On the surface this would appear to be a problem only for psychologists who deal with Medicare patients. (Currently about 15% of the American population is covered by Medicare, but 18% of all Pennsylvanians are.) However, the impact of these rate cuts is more pervasive than it may first appear. The declining rates under Medicare are having a snowball effect across the entire profession and discipline of psychology. They impact psychologists who rely on commercial insurers, students, older psychologists, psychologists working in institutions, and academic and research psychologists. I even argue that they can have an impact on psychology practices that are structured to be completely outside of third-party reimbursements.

Commercial insurance rates

Commercial insurers often base their reimbursement rates on a percentage of Medicare rates. Therefore as Medicare drops its rates, commercial insurers drop their rates as well. For example, when Highmark of Central Pennsylvania dropped its rates in 2013, it explained that its decision was based, in part, on the declining rates for psychologists under Medicare. In addition, several commercial insurers adjusted their rates downward in January 2013 in the exact proportion to the rate reductions that Medicare implemented at the same time.

The decision of commercial insurers to base their rates on Medicare is not surprising. These insurers have to deal with 30 or more different types of health care licensees. Instead of having to argue with and create a reimbursement structure for each of these groups, it is far easier for them simply to defer the decision to Medicare.

In addition, some reimbursement programs, such as Workers Compensation or automobile insurance in Pennsylvania are linked directly to Medicare rates. For example, Workers Compensation fees are based, according to Pennsylvania law, on 110% of Medicare rates.

The decline in reimbursement rates has an impact across the entire field of psychology. Data from PPA surveys and other surveys show that, on the whole, the income for psychologists has remained steady for the last 20 years (since PPA started gathering data). The exact reasons for the stability in income is not clear given the reductions in fees from Medicare and commercial insurers, at least when adjusted for inflation. Perhaps psychologists are working longer hours or are finding more income streams outside of third-party payments (or both). However, there is a limit to the number of hours that a psychologist can work and a limit to the number of services that a psychologist can provide outside of third-party reimbursement. I do not know this for certain, but it is possible that psychologists have reached or are approaching the limit to which they can continue to compensate for declining insurance fees.

Impact on psychologists practicing outside of third-party reimbursements

A minority of psychologists have developed independent practices that are free from any third-party reimbursement (although even in these practices some patients may submit for partial insurance reimbursement on their own). It is possible that the level of insurance fees can impact practices that are entirely free of third-party reimbursement. For example, a patient may feel few qualms at paying $150 for a service where the insurance company pays (and appears to value at) $100. However, the same patients may have more qualms about paying $150 for a service where the insurance company pays (and appears to value at) $50 an hour, especially if the patients were expecting to collect some money by submitting claims to the insurer.

Psychologists working in institutions

About 20% of PPA members work in institutions, such as a college counseling center, public school, state hospital, prison, or other facility where they receive a fixed salary. Sometimes these salaries are determined by union contracts or faculty fee schedules. Nonetheless, the salaries in these settings are influenced by the income levels of psychologists in independent practices. Most of these facilities try to establish salary ranges that allow them to compete for qualified psychologists. If the incomes of psychologists in independent practice are high, they will be forced to raise their salaries to ensure that they can recruit and retain employees. If the incomes of psychologists in independent practice are low, they can afford to reduce the salaries of their employees.

Older psychologists

Psychologists tend to like their work. Data from PPA showed that 90% or more of PPA members liked or strongly liked their work. In fact, most psychologists continue to practice well after the traditional retirement age of 65. However, the decision to keep practicing depends, in part, on the extent to which the income offsets practice expenses. Unless there is some kind of reasonable return on their time, however, those psychologists will be more likely to discontinue practice entirely, thus depriving the community (and the profession) of the benefits of their experience and wisdom.

Students and early career psychologists

The impact of declining fees may be especially difficult on students and early career psychologists, particularly considering the increasing debt load for recent graduates. This huge increase in student debt could lead to a de facto decline in the quality of life for new psychologists, especially if Medicare and commercial insurance rates continue to decline. A

Novitas Solutions, Inc., the Pennsylvania Medicare Carrier, Changes Mailing Addresses

Effective Monday, July 29, 2013, Novitas Solutions, Inc., began using new street and PO mailbox addresses resulting from a Post Office change and the move of its mailroom to a new facility. Forwarding of mail addressed to the Camp Hill address will occur, but it may delay delivery of mail.

New Zip Codes

Mechanicsburg Street Address	17050
All PO Boxes	17055

Example of how to address mail for the new PO boxes:

Novitas Solutions, Inc.
PO Box xxxx
Mechanicsburg, PA 17055-18xx

Description	New Address
Use for mail that cannot be sent through a PO Box (Attn: name or department on the envelope)	2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050

Here is a chart containing all of the new PO Boxes:

Description	New PO Box #	City	Zip Code
Accounts Payable	3104	Mechanicsburg	17055-1820
Accounts Receivable Part B	3063	Mechanicsburg	17055-1806
All EDI JL Part A and B Documents	3011	Mechanicsburg	17055-1801
All Part A and Part B FOIA	3700	Mechanicsburg	17055-1856
All Part B ADR/Medical Records	3065	Mechanicsburg	17055-1807
All Part B Medical Review/Manual Development	3007	Mechanicsburg	17055-1800
All Pennsylvania, DCMA, Maryland, New Jersey Part A Documents (attention: name or department on the envelope)	3385	Mechanicsburg	17055-1840
JL (Part A & B) Provider Enrollment Services	3157	Mechanicsburg	17055-1836
PA Part B Appeals/Provider Inquiries	3413	Mechanicsburg	17055-1852
PA Part B Checks	3304	Mechanicsburg	17055-1838
PA Part B Claim Submissions	3418	Mechanicsburg	17055-1854
PA Part B Hearings/Reconsideration/CAP Submissions	3326	Mechanicsburg	17055-1839

THE MEDICARE SNOWBALL

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psychologist who enters the field with $100,000 in debt might have to pay $1,000 a month for the next 15 years to repay that.[1] Many psychologists will still be paying down this debt at a time when they should be saving money for the education for their own children or their own retirement.

Currently, the average psychologist earns $85,000 to $90,000 per year. The actual disposable income needs to be reduced to accommodate the increased debt load. In the example above, it would be reduced $12,000 per year for the first 15 years of professional life. Fortunately, many psychologists of my generation were able to complete most of our doctoral education with graduate assistantships or other sources of income that minimized our debts when we graduated. Nonetheless, plummeting incomes and huge debts will dissuade many qualified individuals from choosing psychology as a career.

[1] *Of course, the actual debt load would vary depending on interest rates.*

Research

Psychology departments across the United States and other countries have been responsible for most of the research that has led to advancements in psychotherapy, behavioral health, social, and other experimental fields of psychology. The vitality of these departments will be jeopardized if the profession of psychology is no longer able to attract qualified members into the field, enrollments decline, and faculty positions have to be eliminated.

Summary

Increasing reimbursement under Medicare is an important issue in its own right. Data from PPA shows that the number of older adults in Pennsylvania who are having trouble finding a psychologist has doubled in the last two years. In addition, the decline in Medicare reimbursement rates is having a "snowball effect" across the entire profession and discipline of psychology making the effort to increase reimbursement rates under Medicare an imperative for all psychologists.

How to Talk to a Reporter and Live to Tell About It

Bradley C. Norford, PhD, Communications Board Chair, bradnor4@gmail.com

Dr. Bradley C. Norford

Nine out of ten psychologists I know would prefer to walk across hot coals than to talk live with a reporter. Usually I'm one of the nine. Yet connecting psychology to the public is vital to our profession and a great form of community service. Through access to the media, psychologists are able to inform the public how psychological research and clinical experience can impact family life, health, safety, and the workplace, as well as inform public policy, and identify implications of current events. PPA aptly calls this "Making Psychology a Household Word."

Why do psychologists run the other way?

This past March I attended APA's State Leadership Conference in Washington, DC, as a representative for PPA. In a meeting with Public Education Campaign (PEC) chairs from around the country this question was asked. Fears of being misquoted, of stumbling on words and not looking professional, and of not being "expert" enough on the topic were high on the list. Often psychologists I have spoken with about this topic just hoped that someone else would do it. However, Maiken Scott, WHYY's behavioral health reporter for the Health and Science Desk, told me simply, "If psychologists don't take the call, someone else will."

What if a reporter contacts you?

Media and APA panelists at the State Leadership Conference offered considerable information and a variety of worthwhile suggestions. We learned of the demand on reporters to become informed about the subject of their story in just a day and how much they rely on the quick help of experts to shape their product and provide relevant quotes. Reporters clearly appreciate experts who respond to them rapidly and who are willing to be heard on the radio or go live on television. Ms. Scott explained that if contacted it is fine to ask to get back to the reporter within the hour so that you have an opportunity to quickly gather your facts and thoughts, and to even research the background of the reporter.

Admittedly, such circumstances are not ideal. But, if more psychologists do not take that chance, the risk of psychology becoming less relevant is greater. Not to take the call due to any of the aforementioned fears leaves our profession at risk. And why have someone in another profession fill the gap?

Reporters value experts who are accurate, succinct, and who do not have the compunction to qualify everything they say (as psychologists are prone to do). Despite their bad name, there is a preference for good sound bites. Ms. Scott, who received the 2012 PPA Psychology in the Media Award, advised that if an expert feels that his or her main point might be lost in the discussion with the reporter, it is fine to succinctly restate or clarify the essential message.

Dr. Frank Farley, a professor in the Department of Psychological, Organizational, and Leadership Studies in Education at Temple University, cautions that the media can be insatiable in its need for rapid content. If the reporter has a story angle that is different from your position, he suggests being cautious and clear in the points that you make.

In general though, Dr. Farley relates that contacts with the media are rewarding. As a veteran of 150 interviews last year, he is not afraid to put himself out there. His best advice when engaging the media stems from his favorite dictum of Larry King, "Keep it short, keep it simple, and make it funny." For psychologists, Dr. Farley suggests changing the last clause to "keep it engaging," with a focus on connecting their message to people's lives.

What if you want to initiate contact with a reporter?

Dr. Farley recommended that interested psychologists register with APA's Media Referral Service. This resource is used by APA's public affairs staffers to direct the nation's news media to APA psychologists with predetermined areas of expertise.

"You can even choose your outlet and your reporter if you have information you would like to share," suggests Ms. Scott. It is acceptable to send an e-mail or a tweet if you are doing some interesting work, have a new study, or have something to contribute about a hot topic in the news. Another opportunity mentioned by Ms. Scott is to offer respectful feedback after the fact to a reporter when it is felt that they may have missed something in their story. This might be a way of introducing yourself as a potential source for a future story.

At the State Leadership Conference we were reminded that reporters have a challenging job and welcome appreciation for their work – so that is a good place to start when looking to establish a relationship with a reporter.

Another avenue to connect with the media is to subscribe to HARO, which stands for "Help a Reporter Out." This service, which costs $19 a month, provides subscribers with three e-mails a day of targeted real-time media opportunities from journalists on a deadline needing a source.

How can PPA better connect our members with the media?

Media outlets prefer local sources. The public is thought to relate more readily to a local expert who also has firsthand experience with the story, the populace, and the culture.

PPA's Public Education Campaign (PEC) chaired by Dr. Nicole Quinlan, is aware of this preference. The PEC worked this summer with staffer Marti Evans to update and expand the resource list of PPA members who are willing to be contacted by members of the media looking for the voice of a local psychologist. We are working on making the resource list easier for the media to access. Psychologists willing to help "Make Psychology a Household Word" are encouraged to e-mail Marti (mevans@PaPsy.org) with their areas of interest/expertise.

Adventures of a Reluctant Media Psychologist

Michael Gillum, MS

Michael Gillum

Many psychologists feel ill-equipped to deal with the media. I never expected to become a media-savvy psychologist, but was drawn in by circumstances outside my control. With only a handful of interviews under my belt, I experienced my first media storm.

First media storm: The crash of TWA Flight 800

In July 1996, TWA Flight 800 went down off the coast of Long Island. The jet was carrying the Montoursville High School French Club and their chaperones from New York City to Paris. Montoursville is where I live and where my children attended school. My work as a psychologist-volunteer following this event brought me to the attention of the media, including the *New York Times* and CNN. Despite my initial trepidation, I spoke with a number of reporters. The resulting media pieces were thoughtful and accurate. They helped our community heal and provided valuable support and feedback to many around the world.

This experience made me more confident about interacting with the media. It also taught me the importance of setting ground rules with reporters before granting an interview. Once you have spoken with a reporter, it is too late to discuss what will and will not be included. But nothing could fully prepare me for dealing with a more complicated and protracted situation.

Second media storm: The Jerry Sandusky scandal

In November 2008, Aaron Fisher (later known as Victim 1) and his mother, Dawn Daniels, came to the Clinton County CYS office, where I was the clinical supervisor. Aaron, then 15 years old, became my client and we worked together during the three years it took before Jerry Sandusky was arrested. I worked hard during those years to protect Aaron's confidentiality, but this became increasingly difficult as media scrutiny intensified. There were rumors that Sandusky was under investigation and information was leaked about my patient. Eventually a reporter showed up at the family's door and demanded an interview. Dawn followed our plan and denied any knowledge about the investigation. The reporter wrote an article anyway, although fortunately she did not reveal anything about Aaron's identity.

Jerry Sandusky finally was arrested in November 2011 on multiple charges of indecent sexual assault in part due to continued pressure by Aaron's family and me. At the news conference, the state police and Attorney General's Office indicated that there was more than one victim. That was the first time Aaron was referred to as Victim 1. The *Patriot-News* reporter again approached the family and me stating she was doing a series of articles. We agreed to cooperate if she did not use Aaron's name. Although she kept the family's identity hidden, the articles included my name. This started a flood of media attention that was beyond anything I could have anticipated.

Only one day after the article was published my Williamsport office was overrun with TV crews and reporters. The location of my private practice was easy to find, but the media did not realize I saw Aaron at my office in Clinton County CYS. The press was unbelievably aggressive at my private office. They sat in my waiting area even after my office manager said she would give me their business cards and messages if they would leave. In between appointments with patients, I also insisted that the reporters leave. They did, only to gather outside the building where they covered every exit in an attempt to film or interview me. They surprised me in my office parking lot late in the evening, and even tracked me down at my home.

This recurred day after day, and then I began receiving messages from talk show hosts (or their producers) and TV show anchors. It seemed that I was contacted by every morning show, talk show, and news show, even those I didn't know existed. Eventually I met the producers of "Good Morning America" and began lengthy negotiations about under what circumstances I would agree to an interview. Meanwhile, the Internet was wild with speculations about who Victim 1 was. In addition, information was leaked by a staff member at Aaron's school to parents who were upset about Sandusky's forced resignation as guest football coach for the local high school. Thus, rather than there being a lot of support in the school and community for Sandusky's victims, the opposite occurred. Many people believed this was a scam to collect money and that there was no way Sandusky or Penn State could possibly be involved in child abuse. Aaron and his family received threats of bodily harm and worse. I received a threat on my life. Now reporters from other news organizations began knocking on doors in the small community of Lock Haven to try to find out who the locals believed Victim 1 was.

This experience made me more confident about interacting with the media. It also taught me the importance of setting ground rules with reporters before granting an interview.

Aaron, his mother, and I decided that Aaron's mother would be interviewed in shadow with her identity withheld. We wanted to get out information about how difficult it is for victims of sexual abuse to come forward and proceed with prosecution, especially given these particular circumstances. I believe this interview helped turn things around. After hearing

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ADVENTURES OF A RELUCTANT MEDIA PSYCHOLOGIST

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from Victim 1's mother, there was greater public support for Sandusky's victims.

Shortly after Dawn's interview, I was asked by Anderson Cooper to do an interview via telephone. Once again, Aaron, his mother, and I discussed the risks and benefits. We came up with guidelines that were followed, and the interview went very well. I was confident, after speaking to him before the show, that Anderson Cooper was a compassionate man who was looking for the truth and for ways to help the public understand sexual abuse. Following the success of that show, we also agreed I would do an interview with *USA Today*. Once again, I negotiated with the reporter concerning how important it was that the public understand the validity of Victim 1's allegations and what he had suffered in terms of the abuse and in terms of the negative reaction from those who blindly supported Mr. Sandusky and/or officials at Penn State. This interview went particularly well and became a front page story. The paper quoted me as referring to Aaron as a hero with the courage to reveal what Mr. Sandusky had done.

Aaron, his mother, and I began receiving (through my office) hundreds of letters praising Aaron and offering words of support and comfort. Many were sexual abuse victims themselves, some of whom had never revealed it previously. Dozens of calls came in requesting assistance for victims and families throughout the country. After these initial interviews I also saw a change in the media's reporting of this affair. They were more concerned about the children who had been abused. They included articles on the effects of child abuse, its prevalence and widespread impacts throughout the world, and what people can do to get assistance.

Although Dawn and I made appearances on "Good Morning America" and "20/20," Aaron was not interviewed until the criminal trial was over. Since the trial's conclusion, all three of us have done several interviews including a radio show with the BBC while the UK was dealing with a similar scandal involving a well-known children's television personality. We also have done interviews, and Aaron did a public service announcement, about the non-profit organization, "Let Go Let Peace Come In." This organization, of which I am a board member, is based in Philadelphia. It provides funding for victims of child sexual abuse who cannot afford treatment and is involved in a variety of research and prevention programs.

There continued to be offers to do print interviews as well as TV and radio shows. We accepted some, but turned down many more to limit the stress on Aaron. It was very difficult to turn down these opportunities; however, I had to keep in mind my patient's well-being. Sometimes I made counter-proposals that would exclude Aaron. Unfortunately, some programs insisted that Aaron be present. It was disheartening to hear the responses of these program producers who were looking for sensational or salacious details rather than providing a useful public service. Still, Aaron does selective speaking engagements, often for organizations involved in law enforcement, child protective services, prosecutor's offices, and agencies that advocate for children.

Aaron, Dawn, and I eventually decided to write a book. We believed this could increase public awareness about the causes and prevention of child sexual abuse. We also wanted to reduce the stigma for victims in the hopes that others might receive the mental health services and other support they desperately need. I thought we would have more discretion over what was included when we wrote the book, but there were lengthy negotiations with the publisher much as there had been in our earlier media outings. In particular, I had to forgo adding chapters about sexual abuse in general, how to navigate the criminal justice system, and how to find appropriate treatment. This was extremely frustrating, but overall we were pleased with the book.

Silent No More: Victim 1's Fight for Justice Against Jerry Sandusky was published by Ballantine Books in October 2012. It achieved the goal of increasing public awareness. It also prompted more media coverage, requests for speaking engagements, and support for the foundation we're affiliated with.

Writing a book with a patient was an interesting experience. It was important to maintain boundaries, and we wanted to tell the story from each of our perspectives. We accomplished both of these goals with the help of a professional writer. She interviewed each of us separately and then helped organize the writing each of us did to make the book flow.

Lessons learned

One thing I have learned is that the media often predetermines what type of story they want to do about newsworthy events. Consequently psychologists must be careful when agreeing to do interviews. Make sure the reporter includes certain information, such as how to obtain help for similar problems. Remember that reporters are under terrific time constraints and must fashion articles to fit a particular theme.

Other advice to psychologists who are interviewed by news media:

- You do not have to answer the question that is asked, especially if the question is inappropriate. Use the opportunity to provide information you want the public to know.
- Use the terms "psychology" and "psychologists" repeatedly.
- Use language a lay audience will understand.
- Do not speculate about how a particular individual feels, but make statements about how people often feel in such situations.
- If you don't know the answer to a question, say so, or say you'll get back to the reporter. (And then get back to him/her in a timely manner.)
- Include specific ways (e.g., telephone number or website) for people to get more information.

Media is a powerful tool to educate the public about psychological issues. I recommend all psychologists receive media training either through a formal workshop and/or with the assistance of a colleague who is experienced in dealing with the media. As my example shows, you never know when you might find yourself in the middle of a media storm.

Some Problems Between Psychology and the Mass Media

Edward L. Zuckerman, PhD

Dr.Edward L. Zuckerman

Our relationship with the mass media is often problematic. We complain of their distorting our ideas and findings but we may collude with their needs. We may do research that produces poor quality results and communicate it poorly with our peers. However, we and journalists can improve how we share knowledge with the public.

The media distort our findings

Novelty attracts attention and attention sells products. Media ignore valuable information and seek the "sexy" both literally as in this from *Breast Size Preferences May Reveal Men's Attitudes Toward Women* by Christine Hsu (2013a), "Sexist men are more likely to prefer women with bigger breasts, according to a new study." She even notes that this was not the first study "to link male ideals of female beauty with oppressive, sexist beliefs. Past studies revealed that men who were more sexist were also more likely to feel like it was important for women to be thin, wear make-up and be shorter than their male partners."

However, by reading the original article, Swami and Tovée (2012), we learn they were trying to clarify "... equivocal findings, with studies variously indicating a preference for small, medium, or large breasts," and found that "... men's preferences for larger female breasts were significantly associated with a greater tendency to be benevolently sexist, to objectify women, and to be hostile towards women. These results were discussed in relation to feminist theories, which postulate that beauty ideals and practices in contemporary societies serve to maintain the domination of one sex over the other." Re-read the headline and see if it represents the results accurately.

"Karate experts are psychic: research," says the headline in an Australian publication ("Karate Experts," 2013). The research on which it is based is not about psychic research or research on psychics or psychic karate experts. It concerns reaction times in anticipating a move by a karate opponent. This is pure attention-mongering and factual distortion. It reflects badly on the journal and on the research and cheapens both in the public's view.

Usually, when research is reported in the popular press it is reduced to news-snippets and sound bites that eliminate the cautions, qualifications, and contexts that are provided in professional publications. But our Code of Ethics holds us, not the journalist, responsible for misrepresentations.

Sometimes, in the name of "journalistic balance" media create or present two sides as if they were of equal import. It is parallel to the efforts of the Institute for Creation Research (www.icr.org) to argue for a "creation science" and to pressure schools to "teach the controversy" with evolution. I believe it is only recently that the press has taken notice of the work of Big Pharma to create disorders, fake journals (see "Elsevier") and conferences (Kolata, 2013). The parallel with "tobacco research" is clear and shameful. Those concerned and wanting more evidence are directed to the writings of David Healy and Ben Goldacre.

Further, journalists usually report correlations as if they were causative. As a result, early studies often find relationships that follow-up studies reverse.

> In both the above examples, earlier studies had shown a *correlation* but not a *causal connection*. They had not shown that, for example, taking vitamin D was the *only relevant difference* between those whose pain decreased and those whose pain did not decrease. Perhaps, for example, those taking vitamin D also exercised more, and this was the cause of the pain decrease. Typically, the best way to establish a cause rather than a correlation is to perform a randomized controlled trial (RCT), where we know that only one possibly relevant factor distinguishes the two groups. In both the vitamin D and the niacin cases, there was an RCT that showed that the earlier results had been merely correlations. (Gutting, 2013)

We sometimes collude with the media

We usually think this is impossible but a British psychologist reported this successful use of hypnosis:

> Felix Economakis, a British counseling psychologist and hypnotherapist, claims that he can help women enlarge their breasts by up to three cup sizes through hypnosis. "Using hypnosis, I can work directly with the mind. I speak to the part that controls hormones to encourage growth," he told the *Daily Mail*. Economakis explained that the mind often creates obstacles to stop women's breasts from growing. "The mind basically controls the body and if you know how to work with the mind you can get it to make changes in the body," he said. "We know emotions affect the body. When people get stressed they get headaches, for example" (Hsu, 2013b).

On a more worrisome note the media have publicized wrong results with real consequences. Andrew Wakefield's faked data is justifiably notorious, but the role of the media in promulgating his falsified findings linking autism and vaccines is shameful as well. I think the *Lancet*, among other sources, should be held responsible for its publication of his data, despite recent retractions. There are real consequences to these lies, such as the recent measles epidemics. (See http://www.bbc.co.uk/news/health-22277186 for current data in the United Kingdom and http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1022280/ for data in California.)

Much of our research is of low quality

Many studies use sample sizes too small to yield real world results even if they meet the customary standard of ≥ .05. In

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fact, this level guarantees that almost one out of twenty findings is by chance and very likely to be wrong.

Even the use of randomized controlled trials can be deeply flawed. In a crucial and very widely cited paper, "Why most published research findings are false," John Ioannidis (2005) explains exactly what factors contribute to false conclusions and how to increase the power of findings:

> There is increasing concern that most current published research findings are false. The probability that a research claim is true may depend on study power and bias, the number of other studies on the same question, and, importantly, the ratio of true to no relationships among the relationships probed in each scientific field. In this framework, a research finding is less likely to be true when the studies conducted in a field are smaller; when effect sizes are smaller; when there is a greater number and lesser preselection of tested relationships; where there is greater flexibility in designs, definitions, outcomes, and analytical modes; when there is greater financial and other interest and prejudice; and when more teams are involved in a scientific field in chase of statistical significance. Simulations show that *for most study designs and settings, it is more likely for a research claim to be false than true*. Moreover, for many current scientific fields, claimed research findings may often be simply accurate measures of the prevailing bias. In this essay, I discuss the implications of these problems for the conduct and interpretation of research. (Italics added)

This paper is clear and not long. I consider it required reading for all science-consuming professionals. For a more popular but longer article on this and other relevant materials see Freedman (2010).

> We apparently fudge our data with high frequency. In a survey (with incentives for telling the truth) a "majority admitted being guilty of selectively reporting studies that "worked" (67%), failing to report all dependent measures (74%), continuing to collect data to reach a significant result (71%), reporting unexpected findings as expected (54%), and excluding data post-hoc (58%). Remarkably, 35% indicated that they had doubts about the integrity of their own research on at least one occasion and 1.7% admitted to having faked their data (Laws, 2013, citing John, Lowenstein, & Prelec, 2012).

We are just beginning to face up to the faking of data in our publications. We don't have to go back to Sir Cyril Burt's apparently fraudulent data when we have the contemporary social psychologist Diederik Stapel admitting to faking his data to support now widely popular ideas (Bhattacharjee, 2013). The consequences for our field's knowledge through his dozens of papers, his more than 20 PhDs, and our public image are continuing to play out.

I leave it to others to explore the roles of confirmatory bias and the experimenter bias effects in our current research climate although such research would be embarrassingly unpopular. True science is slow. It accumulates findings, it corrects wrong turnings, and it is based on replication, not just statistical support. But too much of our work now is fast science. Samples of convenience, samples just large enough to allow (low) confidence, the answering of simpler but less useful questions, quick and multiple publication, data dredging, post hoc analyses, reports and conferences without peer review, etc.

Some of our ways of presenting our research are unethical and misleading

Among print journals the "junk journals" are segregated by the Library of Congress's refusal to keep them. But now there are thousands of online, open-access journals. While the National Library of Medicine's PubMed selects for quality the public and journalists are not so savvy.

In the *New York Times* Gina Kolata noted that:

> Jeffrey Beall, a research librarian at the University of Colorado in Denver, has developed his own blacklist of what he calls "predatory open-access journals." There were 20 publishers on his list in 2010, and now there are more than 300. He estimates that there are as many as 4,000 predatory journals today, at least 25 percent of the total number of open-access journals. "It's almost like the word is out," he said. "This is easy money, very little work, a low barrier start-up."

Incidentally Beall's List is online at: http://scholarlyoa.com/individual-journals/.

In the same article she describes fake conferences set up to enhance the résumés of the presenters who have made substantial cash payments. How are university hiring committees able to decide on the quality of a candidate's presentations?

It is widely recognized that journals are reluctant to publish negative results (for some good reasons). In fact, negative results – where a stated hypothesis is not supported by the results – appear to be disappearing across the world (Fanelli, 2012). This failure to publish failures to replicate means that that earlier inaccuracies remain unchallenged. The situation appears to be worse in psychology than other disciplines (Greenwald, 1975).

What we might do about this state of affairs

First, journalists could get smarter. They could avoid just rewriting press releases or each other's articles and seek other views, especially on the validity of research results. They could endeavor to include the thoughtful limitations on our findings that we usually include in the discussion sections of our publications. They could speak about failures to replicate and how later and better research can and should replace earlier misleading reports. They could learn to distinguish junk journals from quality, understand peer reviews' value, and refuse to play up the flashy but shallow. They could try to educate the public, and reinforce the "Chinese wall" between editorial and advertising contents. They could be much more skeptical and demonstrate their critical facilities.

There also are things we can do as psychologists. While there will never be a "Journal of Negative Results," there is at least one new effort. The American Psychological Society, through its journal *Perspectives on Psychological Science* will host a series, the Registered Replication Reports project, which will recruit research groups to conduct exact replications of previously published studies. They promise to publish all the results and all at the same time. The effect would be unbiased estimates of the true effect size and so certifying the chance or reality of the effect. (For more see http://www.psychologicalscience.org/index.php/replication.)

References are available on the PPA website, www.PaPsy.org, or from the author at edzuckerman@mac.com.

The Fine Line Between Normal and Abnormal: A New Movie Trend?

Brooke J. Cannon, PhD

Dr. Brooke J. Cannon

Over the last 60 years, films have included characters with identifiable mental illnesses. Initially, the behavior of characters with mental disorders was clearly "abnormal" and significantly different from the "normal" behavior of others. In the past few decades, there is less distinction between normal and abnormal behavior.

The classic portrayal of psychopathology

Psychopathology is a major plot feature in many films. The symptoms of psychotic disorders, including hallucinations and bizarre behavior, provide great opportunities for drama in both classic and modern films, such as: *I Never Promised You a Rose Garden* (1977), *Shine* (1996), *A Beautiful Mind* (2001), *Revolution #9* (2001), and *Canvas* (2006).

Similarly, mood disorders, particularly major depression, have been dramatically portrayed in films over the years. A good early film, *Don't Bother to Knock* (1952), stars Marilyn Monroe in an effective performance as a woman with psychotic depression. More recent films, such as *Ordinary People* (1980), *The Hours* (2002), and *Revolutionary Road* (2012), also vividly bring to life the painful world of people struggling with depression.

Among anxiety disorders, post-traumatic stress disorder (typically combat-related) has most frequently appeared in the movies, e.g., *The Deer Hunter* (1978), *Coming Home* (1978), and *Born on the Fourth of July* (1989). Other anxiety disorders also are featured in films, including acrophobia in Hitchcock's *Vertigo* (1958) and the obsessive-compulsive disorder of Jack Nicholson's character in *As Good As It Gets* (1997).

A favorite plot device in soap operas, dissociative identity disorder (DID), also appears often on the movie screen, most famously in *The Three Faces of Eve* (1957). The made-for-television movie, *Sybil* (1976), launched a multiple personality disorder diagnosing frenzy, with 200 cases of DID reported prior to *Sybil* and 40,000 cases diagnosed within a few years of the book and movie release (Nathan, 2011). Dissociative amnesia, along with post-traumatic stress disorder, is seen in Hitchcock's *Spellbound* (1945) and dissociative fugue is featured in *Nurse Betty* (2000).

The fine line

More recently, movies have blurred the distinction between abnormal and normal behavior. "Quirky" behavior is more socially acceptable. As Thomas Szasz said, "Why don't you have a right to say you are Jesus? And why isn't the proper response to that 'congratulations'?" (Sullum, 2000).

Two recent movies bring some of these issues to light. The first, *Lars and the Real Girl* (2007), stars Ryan Gosling as the socially withdrawn main character. Lars lives in a garage apartment behind the family's home occupied by his older brother and his pregnant wife.

Lars is gainfully employed in an office. One day a coworker shows him a website from which one can order life-sized sex dolls. Lars orders a doll and presents her to his family and the community as Bianca, his foreign girlfriend, who is in a wheelchair and can speak softly only to him. Unlike his co-worker, Lars does not use the doll for sex, but instead for love and companionship. Lars buys clothes for her, feeds her, and talks to her. The community supports Lars and treats Bianca as real. She has her hair done in a beauty shop, "reads" to the children in school, and is hired at a boutique. As Lars deals with the issues fueling his delusions and finds an emotional connection with a "real girl," Bianca dies. The community mourns her loss in a most heartfelt way.

The movie explores what behaviors are socially acceptable (e.g., using a doll for sex) and what behaviors are considered abnormal (e.g., using a doll for companionship). It challenges audience members' judgments about Lars's behavior through comparisons with the behavior of others. One co-worker, for example, prizes his collection of super hero figurines and frequently plays with them. Another co-worker becomes upset when her stuffed bear is hanged as a prank. How different is their behavior from that of Lars?

In the second film, the academy award winning *Silver Linings Playbook* (2012), Pat (Bradley Cooper), returns to his parents' home after spending eight months in a state psychiatric facility. He was sent there following an apparent psychotic episode when he assaulted his wife's lover upon discovering them together. He has been diagnosed with bipolar disorder and is initially resistant to taking his medications. He also experiences paranoia, falsely believing that his wife and a fellow teacher are embezzling money. Pat looks for signs that he is going to be able to reunite with his estranged wife. His mantra is "Excelsior," Latin for "ever upward."

Pat Sr. (Robert De Niro), his father, is a rabid Philadelphia Eagles fan, but is banned from the stadium because he got into a fight at a game. A bookmaker who manages bets on the Eagles, he becomes paranoid when an empty envelope (that he uses to organize bets) is taken from his room. Pat Sr. has other "quirky" behaviors. He needs to have the TV remote in certain positions, must wear particular clothing and hold a special handkerchief, and have others engage in certain activities in order to superstitiously engineer an Eagles' win. Pat Sr. believes his son is a good luck charm because the Eagles began winning when he comes back home. He makes a bet on a game, certain they will win because he has sent his son to see the game live. The Eagles lose. Pat Sr. blames his son for losing his "mojo." When it is pointed out that the Eagles were playing the New York Giants and the motto of New York State is "Excelsior," Pat Sr. concludes that the Eagles lost because his son was present.

Both Pat and his father exhibit similar behaviors. They act aggressively, believe in signs that predict the future,

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Mental Health Clinicians in Film

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Allison Otto

The film industry has been present in our culture for more than 100 years. Despite its recent arrival in history, film has become a worldwide phenomenon, with international box office sales grossing approximately $34.7 billion in 2012, and box office sales in the U.S. and Canada grossing $10.8 billion. On average, moviegoers attend six movies per year. Despite other popular forms of entertainment, more people are drawn to the movies than to professional sports and theme parks combined (MPAA, 2013).

There have been several hundred films to date that have featured a mental health clinician as a main character. The frequent portrayal of mental health clinicians in the media has the power to influence both public and professional preconceptions about clinicians as well as the process of therapy (Orchowski, Spickard, & McNamara, 2006; Diefenbach & West, 2007). Entertainment media has been found to be a more powerful influence on attitudes towards mental illness than real-world experiences, news media, or print media (Pirkis, Blood, Francis, & McCallum, 2005). Unfortunately, when clinicians are portrayed in film, they tend to be depicted as overly sexual, often psychotic, typically malevolent, or, at best, eccentric (Gabbard & Gabbard, 1999). The typical practices and education of different types of mental health clinicians are often incorrect in film. This confusion regarding the roles and duties of different mental health professionals as understood by the American film industry is a reflection of the confusion of the general public (Schultz, 2005). Although the portrayal of these fictional characters may be appealing to a general audience, these stereotypes conflict with the ethical principles that real life clinicians strive towards, such as fidelity, integrity, justice, and beneficence (APA, 2002).

It is critical that clinicians be familiar with the way their profession is portrayed in film so that they are able to understand the expectations that their clients might have regarding therapy and the behavior of their therapist. It has been demonstrated over the past 50 years that client expectations about mental health clinicians and the process of therapy have the potential to influence not only the willingness of clients to engage in treatment, but the outcome of treatment as well (Glass, Arnkoff, & Shapiro, 2001). Fewer than one-third of people who could potentially benefit from psychotherapy actually seek out those services (Andrews, Issakidis, & Carter, 2001). The anticipated risks and benefits that clients perceive about psychotherapy directly affect their attitudes towards seeking professional help (Vogel, Wester, Wei, & Boysen, 2005; Gharaibeh, 2005). The persistent fictional negative stereotypes of mental health clinicians continue to contribute not only to the development of negative attitudes, but to the persistence of them as well (Sieff, 2003).

People often base their expectations of the practice and goals of psychotherapy on the stereotypical portrayal of clinicians in television and film (Jorm, 2000). These messages portrayed in the media are not always subliminal. In a national survey with 3,479 respondents in 2005, 67% of regular daytime drama viewers and 58% of primetime drama or comedy viewers report to have learned something new about a health issue or disease from a television show in the past six months (HealthStyles, 2005).

As mental health clinicians as portrayed in film have been explored, certain stereotypes have emerged. These stereotypes include "The Faceless Clinician," who either cures by presence or is ineffectual, the "Active Clinician," who may be effective or manipulative, the "Oracular Clinician," who many be omniscient but arrogant, the "Societal Agent Clinician," who is reconciling but malevolent, the "Eccentric Clinician," who is human but neurotic, the "Emotional Clinician," who is compassionate or psychotic, and the "Sexual Clinician," who is either a healing lover or exploitative (Gabbard & Gabbard, 1999).

Another commonly referenced set of stereotypes that have emerged include "Dr. Dippy," who is comedic and incompetent (although sometimes sanctimonious), "Dr. Evil," who is a sinister scientist, "Dr. Wonderful," who is attractive, extraordinarily skillful, and always available (to the extent of transgressing boundaries), "Dr. Sexy," who is female and whose positive outcomes in therapy are a result of her sexual relationship with the client, and the "Rationalist Foil," who often presents with formulations to explain supernatural phenomena in the film, only to be proven wrong in the end (Schneider, 1987; Gabbard, 2001; Pirkis et al., 2006).

Given the demonstrated inaccuracy of the public's knowledge about mental health issues, it is important to consider the impact of inaccurate knowledge on a client's potential success in therapy. Multiple researchers have identified a positive correlation between the inaccuracy of expectations about clinicians with attrition rates in treatment (Dew, 2005; Aubuchon-Endsley & Callahan, 2009). In addition to addressing the existing lack of public knowledge about mental health disorders and treatments, mental health professionals should also incorporate psychoeducation into their work with clients in order to clarify the gap between evidence-based treatments and the existing preconceptions of the public (Riedel-Heller, Matschinger, & Angermeyer, 2005). When people receive information about mental health services that is accurate, they demonstrate improved attitudes towards seeking professional help. If someone reads a realistic example of a therapeutic intervention or accurate information about mental illness, they may demonstrate a more personal commitment to therapy (Gonzalez, Tinsley, & Kruder, 2002).

References

References are available on the PPA website, www.PaPsy.org, or from the author at allisonpsych@gmail.com.

Annual Convention Highlights

APA President Dr. Don Bersoff was the speaker at the Psychology in Pennsylvania Luncheon.

The Honorable Judge Jeannine Turgeon was presented the Public Service Award by Dr. Arnold Shienvold.

Dr. Brad Norford presented the Psychology in the Media Award to Dorothy Ashman.

Outgoing President Dr. David Palmiter (l) passed the gavel to incoming President Dr. Vince Bellwoar.

(Right) Nationally renowned association management expert Mary Byers was the keynote speaker addressing the topic of using a mission statement to accomplish meaning and productivity.

(Left) Dr. Sam Knapp presented the Award for Distinguished Contributions to the Science and Profession of Psychology to Dr. Risë VanFleet.

Two Pennsylvania companies were winners of this year's Psychologically Healthy Workplace Awards. Pictured above are Rachael Baturin, PPA staff; Michael Peluso and Jeff Cypher of Duquesne Light, Pittsburgh; Cyndi Grim and Jim Grim, owners of the Ultimate Image Salon of Exton; and Dr. Rex Gatto, chair of the Business and Psychology Partnership Committee.

Dr. Rex Gatto (r) was presented the Distinguished Service Award by Dr. Don McAleer.

Amy Smith (l) was the recipient of the Award for Distinguished Contributions to School Psychology, presented by Dr. Marie McGrath.

(Right) Marti Evans was saluted by Dr. Palmiter for her 20 years as PPA's conference and communications manager.

PPA secretary Katie Boyer celebrated her 10th anniversary on the PPA staff and was duly recognized for her service by outgoing President Dr. David Palmiter.

Dr. Palmiter acknowledged Iva Brimmer's 20 years as PPA's business and membership manager.

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Compliance Plans for Psychologists, Part Two: Addressing Billing Errors

Samuel Knapp, EdD, ABPP, Director of Professional Affairs
Renee Martin, MSN, JD, Tsoules, Sweeney, Martin & Orr, LLC


Dr. Sam Knapp


Renee Martin

As noted in a previous article (Knapp & Martin, 2013), both the Affordable Care Act and insurance companies require psychologists to adopt compliance plans, or documents designed to ensure adherence to state and federal law. At least one Medicaid HMO is now including such a requirement in its contracts with psychologists and other health care professionals. Developing such a compliance plan on one's own would likely cost a psychologist several thousand dollars. However, working with the law firm of Tsoules, Sweeney, Martin & Orr, PPA is making a template for compliance plans available to its members on its website (www.PaPsy.org) at no cost. The PPA website will include a template for psychologists with solo or small group practices and a second template for psychologists with larger or more complex practices. The compliance plans will also include sample policies and procedures for implementing the plan. Tsoules, Sweeney, Martin & Orr has tried to develop these compliance plans (and associated policies) with the goal of helping psychologists fulfill their goals of running an ethical and efficient practice – not just adhere to a legal requirement.

Our previous article (Knapp & Martin, 2013) gave an overview of the required elements of compliance plans. This article will discuss the one practice feature where we believe psychologists run the greatest risk of compliance exposure with state or federal law. Our experience has been that psychologists will sometimes run into problems by inadvertently violating anti-kickback statute provisions or hiring an employee who has been excluded from Medicaid or Medicare. Other psychologists may run into difficulty if they bill for the services of supervisees in a manner that does not conform to state law or their insurance company contracts. However, problems with billing and documentation occur more frequently for the average psychologist than any of the other problems addressed by compliance plans. This article mentions a few of the more common billing and documentation problems that psychologists may encounter.

Perhaps the most important billing problem facing psychologists is ensuring that the documentation supports the procedure code used. All insurers have some basic elements required for documentation. Most commercial insurers follow the documentation standards of the National Committee on Quality Assurance (NCQA), although some commercial insurers may add unique or idiosyncratic record keeping requirements. Medicaid and Medicare have other elements that must be included in the treatment plan and notes, although sometimes individual Medicaid HMOs may also have some additional requirements. Some of the documentation errors noted by Pennsylvania's Office of Program Integrity (which oversees Pennsylvania's Medical Assistance Program) include using a signature stamp to sign progress notes, failing to have the patient sign the treatment plans, or having treatment notes that are almost identical to previous treatment notes, so-called "parrot charting." Among insurers, Medical Assistance is unique in that it requires a separate document called a treatment plan and requires that the patients sign such a plan. Medicare is also unique in that it requires documentation that the patient has the cognitive ability to benefit from treatment.

The procedures section of the compliance plan offered through PPA by Tsoules, Sweeney, Martin & Orr will contain a checklist that psychologists can use to achieve compliance with these record keeping requirements. This checklist will include the essential documentation requirements of NCQA, Medicare, and Medicaid. Of course, psychologists need to individualize their compliance plan and policies and check their insurer contracts to determine if the insurers include additional documentation requirements beyond the NCQA, Medicare, or Medicaid requirements found in the sample policies. These compliance documents will not guarantee that a psychologist will not encounter program audits or potential claims of abusive practices, but they provide an important defense against such claims.

Good documentation can help reduce problems that may be created by the new psychotherapy codes. For example, psychologists need to use 90834 and 90837 psychotherapy codes with deliberation. Psychologists who bill for a 90837 (psychotherapy for a minimum of 53 minutes) should ensure that they actually spent a minimum of 53 minutes with the patient. (This can usually be done by noting the start and stop times in the chart.) Billing for a 90837 when the documentation supports a 90834 (psychotherapy for a minimum of 35 minutes) could be interpreted as an example of "upcoding." Also, care must be taken when using intensity codes to ensure that the documentation justifies their use. Finally, psychologists should ensure that the date on the medical record corresponds to the date billed for services.

In its compliance guidance to small physician groups of individual physician practices, the Office of Inspector General (OIG) recommended "that periodic audits be conducted at least once each year." 65 Fed. Reg. §59437. Although there is no absolute or fixed formula to determine the number of records to audit, the OIG recommends that the physician review 5 or more medical records per federal payer or 5 to 10 medical records per physician.

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If an error is found, then the corrective action plan should include the cause of the identified error, how it will be corrected, and how and when the correction will be monitored. Psychologists who follow such procedures will develop confidence in their billing procedures.

Reference

Knapp, S., & Martin, R. (2013, July/August). Compliance plans for psychologists, part one: The good news and the bad news. *Pennsylvania Psychologist*, 1.

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THE FINE LINE...
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and believe that certain actions can cause seemingly unrelated events to occur. Both behave impulsively, show poor judgment, and exhibit obsessive thinking and paranoia. Yet, Pat is diagnosed with a mental illness and his father is not. Like *Lars and the Real Girl*, this movie challenges the notion that there is more than a fine line between normal and abnormal behavior.

Time will tell if the movie industry continues to normalize mental illness and if this evolution continues. Have we gone from movies depicting ordinary people with extraordinary problems (e.g., *Three Faces of Eve*), to films of extraordinary people with extraordinary problems (e.g., *A Beautiful Mind*), to ordinary people experiencing what may now be considered ordinary problems (e.g., *Silver Linings Playbook*)? Perhaps abnormal is the new normal, if art is imitating life.

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Nathan, D. (2011). *Sybil exposed: The extraordinary story behind the famous multiple personality case.* New York, NY: Free Press.

Sullum, J. (2000). Curing the therapeutic state: Thomas Szasz interviewed by Jacob Sullum. Retrieved from http://reason.com/archives/2000/07/01/curing-the-therapeutic-state-t

Pennsylvania Psychological Association
2014 Award Nominations Sought

For each nomination you would like to make for the categories below, please prepare a one-page narrative describing the person's contributions and his/her vitae with contact information, and send the information to Marti Evans, mevans@PaPsy.org, or to the following address by the deadline listed.

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

Award for Distinguished Contributions to the Science and/or Profession of Psychology to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications. Deadline for entries is **October 20, 2013.**

Distinguished Service Award to be given to a member of the association for outstanding service to the Pennsylvania Psychological Association. Deadline for entries is **October 20, 2013**.

Public Service Award to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the association. Deadline for entries is **October 20, 2013**.

Award for Distinguished Contributions to School Psychology: The School Psychology Board of the Pennsylvania Psychological Association nominates a candidate annually for this award. Criteria for nominations include persons who have contributed significant research in the field of child, adolescent, school, or educational psychology; have contributed significant public service to children, families or schools; have made major contributions to the field of assessment; have made significant contributions in the media; have advocated politically for children, families or schools; have been a voice advocating for school psychologists in Pennsylvania; and/or have made significant contributions to the Pennsylvania Psychological Association. Deadline for entries is **December 31, 2013**.

Psychology in the Media Award: Deadline for entries is **December 31, 2013**. Members of the Pennsylvania Psychological Association and members of the media in Pennsylvania who have presented psychology and psychological issues to the public are encouraged to apply for the 2014 Psychology in the Media Award. Members who have written newspaper or magazine articles or books, have hosted, reported or produced radio or television shows or commercials about psychology or psychological issues, or have designed psychologically oriented websites are eligible for the award. We are seeking candidates who have had a depth and breadth of involvement in these areas with the media over a period of time. Some of the work must have been published or broadcast during 2013. An application form, which is available at www.PaPsy.org, must accompany all entries for this award. Applicants who have received this award in the past are not eligible.

Early Career Psychologist of the Year Award to be given to a Pennsylvania early career psychologist (ECP) who, in his or her practice as an early career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2014**.

Student Multiculturalism Award to be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology-related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2014**.

A Continuum of Reflective Practices: What, How, and Why – Part 1

Jeffrey L. Sternlieb, PhD, Chair, Colleague Assistance Committee, jsternlieb@comcast.net


Dr. Jeffrey L. Sternlieb

The Colleague Assistance Committee has two primary roles. One is very private and involves helping psychologists who might be impaired, burned out, or are just looking for help. This function is managed through the PPA office and is coordinated by Sam Knapp, director of professional affairs, who tries to find a therapist with experience in this sensitive area of helping colleagues. The other role is more public – we encourage all of our PPA colleagues to recognize the importance of self-awareness and self-care to practice ethically, to prevent burnout, and to reduce the stress from our work. This is accomplished by writing articles for the *Pennsylvania Psychologist* and presenting CE programs; both are designed to increase psychologists' attention to this task and to provide opportunities for self-care.

Most group discussions among psychologists tend to focus on patient care with an emphasis on diagnosis and/or treatment. They often take the form of a consultation group (Aboyoun, 2008; Knapp, Baturin, & Tepper, 2004), which may have open membership, and usually meets at some regular time and at some regular interval. Leadership may be shared. Another type of reflective group is a support group (Gold et al., 1993). Often these groups have closed membership and are less formally structured. The content may include issues of diagnosis or treatment, and may also include discussion of many other aspects of practice.

Possibly the least common type of reflective practice may be the most relevant to reducing stress and burnout. What may be the most significant element in psychotherapy and the largest contributor to stress and burnout is the relationship between therapist and patient. Psychologists often do not discuss situations when we have problematic relationships with patients. Yet, we all have or have had patients we have allergies to, patients who weigh on our minds, patients who frustrate us, or even patients to whom we find ourselves very attracted. Gordon (1997), in a paper on transference and countertransference, has written facetiously about items on a hypothetical MMPI Lie scale for psychologists, which would include items about being angry at a patient or being sexually attracted to a patient.

With this in mind, I would like to describe and discuss three discrete levels of exploration of all personal reflections about our relationships with our patients. In a subsequent paper, I will describe a taxonomy of specific reflective practices along with a description of these practices.

Reflection about our relationship with our patients must begin by recognizing that we are having an emotional experience. I describe this first step with the phrase *"You have to be it to see it."* It may start with a sensation. We may notice that we feel differently anticipating one patient's appointment vs. another. Typically, much of our energy is expended in our head, thinking about what we hear and see. We are also working to develop a formulation of this case and deciding on a strategy to begin psychotherapy. We are heavily invested in 'doing.' Much less time is spent intentionally attending to our emotional experience while we are with our patients. How do I feel about (patient's name)? We typically spend less intentional energy aware of our 'being.' In fact, it is possible that the failure to recognize our emotional reactions may contribute to future dilemmas.

A second step in reflecting about our relationships with patients is to acknowledge and identify our emotional experiences. My phrase for this part of the process is *"You have to name it to tame it."* Until we are able to name the emotional experience, we are limited in the options we have to process or just be aware of having this emotion. Language is a substitute for action. It allows us to consider an event or experience without having to re-experience it. Psychodrama or role-plays can bring us back to the experience and can help us to recognize the full nature of that experience. Instead of re-enacting the event, we can name the emotion or describe the full experience – if we have a sufficient emotional vocabulary. Finally, thinking about the emotion without naming it is not sufficient in order to fully process it. We need to either say it out loud or write it down so that we can hear it or read it. Externalizing the 'naming' gives it a status it does not have when it is only in our head. This is obvious when we are working with our patients; it seems elusive when it is about ourselves.

The third step is to share the reflection with trusted colleagues. My phrase for this third step is *"You have to share it to bear it."* This is another qualitative leap, and the evidence of this is our own emotional reaction to the thought of telling a few colleagues that I have 'the hots' for a patient, or that I think a patient is a stud, or that a patient is a pain in the rear, or that another patient creeps me out. It might feel shameful or embarrassing because it is unprofessional to talk about patients in that manner. It is evidence that our humanness has leaked out through our professional facade. However, if we are honest with ourselves (remember Gordon's Lie scale!), we have had those feelings on one occasion or another.

Now what? I would like to suggest that if we are able to recognize the emotional reactions we have, name them, and share them with trusted colleagues, that we will be better therapists, be less burdened, feel more supported, learn to manage feelings we formerly kept private,

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Teen Sleep Issues and School Start Times, Part II

Gail R. Karafin, EdD, Public Policy Chair, School Psychology Board, gkarafin@verizon.net

Dr. Gail R. Karafin

Part I of this article, presented in the June *Pennsylvania Psychologist* (Karafin, 2013), summarized the research about adolescent circadian rhythms, and the importance of sufficient sleep for physical and mental health and cognitive functioning. Sleep deprivation and shortened sleep often lead to significant consequences for students' learning and comfort. This article will focus on positive sleep hygiene and the progressive moves by three school districts to establish school start times that were developmentally appropriate for their students.

Positive sleep hygiene

Fixing sleep problems may be as simple as repairing sleep hygiene or pre-bed habits. Major habits to reinforce are as simple as:

1. Promote a consistent bedtime and bedtime routines.
2. Avoid caffeine in the late afternoon and evening.
3. Avoid books, games, or television programs that are emotionally charged at night.
4. Get regular exercise but avoid exercise/horseplay before bed.
5. Do not take naps. Naps interfere with the circadian rhythm.
6. Turn off the electronic lights of laptops, computers, iPads, cell phones, etc., at bedtime. Electronic light promotes wakefulness.
7. Wake up with bright light.

Experiences of schools with delayed start times

In 1997, the Minneapolis Public School District changed its school start and dismissal times from 7:15 to 8:40 a.m. and from 1:45 to 3:20 p.m., respectively. The results suggested clear statistical evidence that students who do not experience a sleep lag syndrome report higher grades, less depression, fewer at-risk behaviors and fewer drop outs (Wahlstrom, 2002). Positive change in attendance rate and a reduction in school lateness due to oversleeping were statistically significant. A three-year study of grade trends did not show statistically significant improvement; however, there was a gradual trend noted indicating an increase in grades. Contrary to expectation, changing the morning start times did not encourage students to stay up an hour later on school nights; the statistics showed that students continued to go to bed at the same times, reinforcing that the circadian rhythm causes feelings of sleepiness regardless of the wake-up time.

The Wilton, Connecticut, schools delayed their start time for secondary students by 40 minutes to 8:15 a.m. The Wilton League of Women Voters prepared a report of their study group (2002) recommending that the Wilton Board of Education delay the start time for instruction at the Wilton High School and Middlebrook Middle School in order to provide the best opportunity for student learning and to promote adolescent health and safety. Specifically they recommended that the school district set a high priority on the health and safety of its adolescent students and offer them the opportunity to learn when they are most alert and receptive. In addition, as part of its plan they included a thorough review of the strategies to minimize costs associated with later school start and to maintain participation in extracurricular activities. Teachers reported that students were more awake, had better attitudes, and were overall more pleasant. There was a trend toward higher grades. Athletic coaches who had been worried about holding practices because of the time change reported that their teams had the best athletic season, winning several state championships (The Impact of School Start Times, 2012).

Early high school start times run contradictory to a teen's normal developmental patterns.

In 2009 in Middletown, Rhode Island, the St. George's School changed its start time from 8:00 to 8:30 a.m. Their research (Owens, Belon, & Moss, 2010) suggested fewer reports of depressive symptoms. Students reported feeling more motivated to participate in a variety of activities and were less likely to seek medical attention for fatigue-related concerns. Students surveyed reported going to bed 15 minutes earlier following the change and increased their sleep nightly by an average of 45 minutes. Teachers reported alertness increased, and daytime sleepiness and fatigue were reduced. Absences and lateness decreased by 45 percent. Grades rose slightly, but the differences were not statistically significant. At the end of the experimental period, no faculty member, student, or administrator wanted to return to the old start time (The Impact of School Start Times, 2012).

Implications for psychologists and educators

There are no simple solutions to this complex issue. Circadian rhythms play a major role in the development of sleep patterns. As psychologists and educators we need to promote opportunities for healthy lifestyles. Teens are faced with hormonal shifts creating delays in the circadian rhythms for sleep. Educators need to be mindful about the developmental needs of students and consider the effects of early school start times on the physical and mental systems of teens. Early high school start times run contradictory to a teen's normal developmental patterns.

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Joining Forces: Collaboration Between Private Practitioners and School Psychologists

Shirley A. Woika, PhD, NCSP, The Pennsylvania State University
Carissa M. Bowersox, PhD, Juniata County School District


Dr. Shirley A. Woika


Dr. Carissa M. Bowersox

As a licensed psychologist, you diagnose a 4th grade boy with ADHD–Combined Type based on a clinical interview with the parents, standardized ADHD-specific parent checklists, a review of his report cards and work samples, and direct observations of his behavior in your office. The parents take the report to the school with the request that their son's needs be addressed in the school setting. They contact you to inform you that the district has considered your report but will need to complete additional testing. Parents are frustrated. They thought your evaluation would result in a faster route to services for their child. Now, they feel that working through you first may have actually lengthened the time to services.

As a district school psychologist, you are presented with an outside provider's diagnosis of ADHD by parents who want immediate services for their child. Although the diagnosis seems appropriate, you explain to parents that the determination of eligibility for special education services or other accommodations is made by a school-based team. In order to start the process, an evaluation will need to be completed. You assure the parents that the outside evaluator's report will be considered by the team in making a determination, but additional information will also be needed. Parents are frustrated and don't understand why you are "dragging your feet."

From the scenario above, meeting the student's needs in a timely manner seems unlikely. To promote effective collaboration between private practitioners and school personnel, we will review common misconceptions about ADHD in the schools, summarize the legal mandates governing school-based eligibility and service delivery, and discuss the benefits of collaborative efforts.

One misconception involves school districts' obligation upon receiving recommendations from private practitioners. If a private practitioner recommends an Individualized Education Program (IEP) or a 504 Service Agreement, for example, a school district's obligation is limited to consideration of the recommendation (see Section 300.502 of the IDEIA). There are very specific eligibility requirements and evaluation procedures associated with IEP and 504 processes that are governed by federal and state statutes. A written recommendation from a licensed psychologist cannot be used to bypass these processes nor does it obligate a district to begin the evaluation procedure. The Pennsylvania Department of Education has developed required forms for securing permission to conduct an evaluation/reevaluation that are intended for use by parents or school districts. These are the only parties who can initiate an evaluation/reevaluation. Professionals outside of the school setting cannot initiate the evaluation process directly.

A related misconception is that all students with a diagnosis of ADHD will qualify for either an IEP or a 504 Plan. This is simply not true. Having a diagnosis of ADHD does not automatically qualify a student for school-based services. A student with ADHD could be functioning well in the school environment and require no individualized supports. For students with ADHD, there are three potential options for service delivery through the school: (1) specially designed instruction through an IEP, (2) accommodations via a 504 Service Agreement, or (3) regular education without an IEP or a 504 Plan. As a private practitioner, it is important to be familiar with the federal and state regulations governing school-based practices for students with disabilities such as ADHD. A review of the standard procedures associated with IEPs and 504 Plans follows.

Under the Individuals with Disabilities Education Improvement Act and Chapter 14 of the Pennsylvania School Code, it is possible that students with a diagnosis of ADHD could be eligible for special

As a private practitioner, it is important to be familiar with the federal and state regulations governing school-based practices for students with disabilities such as ADHD.

education services under the category of Other Health Impairment (OHI). "Other health impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that (i) is due to chronic or acute health problems such as asthma, **attention deficit disorder or attention deficit hyperactivity disorder**, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and (ii) adversely affects a child's educational performance" (U.S. Department of Education, 2013, "Regulations: Part 300/A/300.8/c/9"). This two-pronged approach to eligibility for an IEP involves meeting definitional criteria and evidencing a need for specially designed instruction. A student with ADHD could technically meet definitional criteria by having a diagnosis of ADHD but not evidence a need and therefore be ineligible for special education services. If he/she had needs as evidenced through below age- or grade-level performance on standardized

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JOINING FORCES...

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assessments, curriculum-based assessment, and/or classroom performance, he/she might then meet the second prong and be eligible for an IEP. Additional information on evaluation procedures and eligibility requirements is available online through the U.S. Department of Education at http://idea.ed.gov/ and through the Pennsylvania Department of Education at http://www.portal.state.pa.us/portal/server.pt/community/special_education/7465.

Students diagnosed with ADHD who do not qualify for an IEP do not automatically qualify for a 504 Service Agreement. Section 504 of the Americans with Disabilities Act (ADA) of 1973 was amended by the Americans with Disabilities Act Amendments Act (ADAAA) of 2008, which went into effect on January 1, 2009. Although the primary focus was on employment, eligibility of K-12 students under Section 504 was also expanded. Section 504 refers to the federal mandate. In Pennsylvania, provisions of 504 are addressed under Chapter 15 of the School Code. Thus, the terms 504 Service Agreement and Chapter 15 Service Plan are often used interchangeably. Under Section 504, a person is considered to have a disability if that person:

(1) Has a physical or mental impairment which substantially limits one or more of such person's major life activities,
(2) has a record of such an impairment, or
(3) is regarded as having such an impairment.

The ADAAA expanded the list of major life activities to include activities such as reading, concentrating, thinking, and various major bodily functions. Note that eligibility is not limited to impairments concerned with learning. Learning is just one of many major life activities that need to be considered.

A medical diagnosis in and of itself does not mean a student is disabled under 504. The district should determine if there is reason to believe the child may need services, and therefore, needs to be evaluated. The opinion of the parent, a physician, or another outside professional need only be considered in the decision-making process. To determine eligibility, an evaluation must be conducted. If the evaluation determines that services are not needed, the district is not required to provide services the student does not need. If a student is found to be eligible, a service plan is developed that specifies accommodations. For example, the student with ADHD may need assistance with organizing homework materials at the end of the school day. As a general rule, students who need accommodations rather than specially designed instruction are serviced with 504 Plans. Additional information about 504 can be found at www.ed.gov/ocr/504faq.html.

Contacting the school psychologist might help determine the methods to be used in the private practitioner's evaluation.

If a private practitioner believes that a student might benefit from either an IEP or a 504 Plan, it may be beneficial to consult with the school psychologist in the student's district early in the process. It is possible that the student is already in the process of an evaluation, that he/she was recently evaluated and found ineligible, that the school recently made a request for an evaluation and the parent declined consent, or that the parent recently made a request and the school district determined that an evaluation was not warranted based on a review of available data.

Contacting the school psychologist might help determine the methods to be used in the private practitioner's evaluation. School psychologists can also offer assistance with collecting and analyzing data. They can be a valuable resource in maintaining a multi-method, multi-rater assessment of behaviors associated with ADHD. With parental consent, they may be able to assist with time-sampling observations of on-task behaviors in multiple school-based environments (e.g., different teachers, times of the day, types of instructional activities). This could lead to a comprehensive assessment of student behaviors across two or more environments, which aligns with the best practice methods of diagnosing ADHD. Although school psychologists are qualified to make a diagnosis of ADHD for the purposes of determining eligibility under OHI, it is important to note that a small number of districts limit their role and require medical documentation. Therefore, referring to a district's policy or practice regarding OHI may be beneficial in determining how to proceed. With effective collaboration, there can be timely service delivery and strong parent buy-in.

The following is a replay of the introductory scenario in the context of effective communication and collaboration:

As a parent, you are concerned with how your child is doing in school. He has below basic scores on the PSSAs, has failing grades in most subjects, and has been getting in trouble for making poor decisions. You are also worried about his restlessness, lack of sleep, difficulty paying attention, and impulsivity. You call a wraparound agency and are referred to a local psychologist for an evaluation. The psychologist requests a release to speak with the school and in doing so, the school district initiates an evaluation of your son at the same time as the psychologist. Over a 2-month period, your son is evaluated by both the private practitioner and the school psychologist. You receive many phone calls from each party and it seems that they are working together. You feel great about this process. In the end, the practitioner diagnoses your son with ADHD and begins a referral to the wraparound agency, and the school-based team determines that your son is also eligible for special education services. Within a month after the evaluation meeting, he will receive behavioral specialist supports in the home and school environments as well as specially designed instruction in both reading and math. You are extremely impressed with the efficiency of this process and feel like an important and active member of your child's educational team.

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TEEN SLEEP ISSUES...

Continued from page 22

Despite the aforementioned benefits of later school start times for teens, there are areas of concern that would need to be addressed sensitively before implementing change. Psychologists and educators need to be mindful that reversing elementary and high school start times may create controversy in the following areas:

1. School transportation schedules and costs.
2. Athletics and after-school activities.
3. Darkness at bus stops for elementary school children.
4. Needs for elementary child care would shift.
5. Changing contractual needs for staff.
6. Afterschool jobs for students.

School districts planning start-time reversals would clearly need to consult with the school community in a collaborative effort before implementing such changes. It should be noted that in review of all the research on teen sleep issues, there has been no study that contradicted the benefits of later start times for adolescents. As advocates for human welfare, psychologists and educators need to bring the research-based knowledge to the community and to advocate for developmentally appropriate environments for children.

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A CONTINUUM OF REFLECTIVE PRACTICES

Continued from page 21

understand our patients in more productive ways, and ultimately be practicing more ethically. Emotional leaks are normal; we are, after all, human. When they are recognized, named and shared, we can learn to manage them. When they are ignored or repressed, we run the risk of acting on them.

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Welcome, New Members

We offer a hearty, humongous welcome to the following new members who joined the association between May 1 and July 31, 2013.

NEW FELLOWS

Jennifer A. Fernandez, PhD
Pottstown, PA

Melissa M. Sumner, PhD
Fort Washington, PA

NEW MEMBERS

Robin L. Carosella, PsyD
Allentown, PA

Deborah J. Gregg, MA
Conneaut Lake, PA

Cheryl A. Henkel, MS, EdS
Greensburg, PA

Amy S. Langsam, PsyD
Philadelphia, PA

Rosemarie Manfredi, PsyD
Philadelphia, PA

Tjitske Milks Sprang, PsyD
Clarksboro, NJ

STUDENT TO MEMBER

Amy Andre McNamee, PsyD
Horsham, PA

N. Diny Capland, PsyD
Havertown, PA

Shannon Wilson Cribbs, PsyD
Pittsburgh, PA

David Haynes-Weller, PsyD
Red Lion, PA

Lauren Lane Herman, PsyD
Stroudsburg, PA

Michele L. Mattis, PsyD
Rector, PA

Jaime L. Moldovan Friedman, PsyD
Southampton, PA

Jennifer Pravlik, PhD
Uniontown, PA

Jacqueline R. Weaver, PsyD
York, PA

NEW STUDENTS

Brittany M. Lebretore, MS
Malvern, PA

Megan E. Narad, MA
Bloomsburg, PA

Rebecca P. Newland, MA
Bloomsburg, PA

Heather L. Pelletier, MA
Danville, PA

Amy M. Williams, MA
Danville, PA

Rebecca E. Wilson, MA
Bloomsburg, PA

Christine C. Wineberg, MA
Philadelphia, PA

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 program and its content. 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 test 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 September 30, 2015.

Return the completed form with your CE registration fee (made payable to PPA) for $20 for members ($35 for non members) 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.

Bellwoar

1. The author describes four actions to propel PPA through stormy seas. They include all of the following except:
   a. addressing the leadership transition
   b. updating the strategic plan
   c. increasing the budget and size of the staff
   d. encouraging more members to get actively involved
   e. fighting back against third-party rate decreases

Knapp & Baturin

2. When it comes to keeping records, the practices of psychologists may be guided by
   a. regulations of the State Board of Psychology
   b. standards of the American Psychological Association
   c. standards of insurance companies with whom psychologists have contracts
   d. all of the above

Norford

3. HARO stands for:
   a. Histrionic Argumentative Reporters Organization
   b. Hide A Reporter Outside
   c. Hopeless Author Resistance Optimization
   d. Help A Reporter Out
   e. none of the above

Gillum

4. Reporters or media producers typically:
   a. include most of the information psychologists provide in an interview
   b. allow you to dictate what information they will include in their piece
   c. significantly edit interviews depending on limits of space, time, and interest
   d. will allow you to write your own copy

5. If patients or clients are asked to give an interview, the psychologist should:
   a. not interfere and leave it up to them
   b. discuss the possible negative consequences, including having their identity revealed
   c. always encourage them
   d. always discourage them

Zuckerman

6. The author states that the media distort research findings:
   a. to choose "sexy" topics and headlines
   b. by uncritically accepting press releases
   c. by confusing correlation and causation
   d. all of the above

Cannon

7. Which of the following movies contributed to a "multiple personality disorder diagnosing frenzy?"
   a. *Three Faces of Eve*
   b. *Me, Myself, and Irene*
   c. *Sybil*
   d. *Primal Fear*

8. How are *Lars and the Real Girl* and *Silver Linings Playbook* similar?
   a. Both movies demonstrate parallels between "abnormal" and "normal" behavior.
   b. Both movies portray unethical use of electroconvulsive therapy.
   c. The main characters in both movies fail to improve.
   d. The families in both movies are uninvolved with the main characters.

Otto

9. Which of the following is true regarding the impact of media portrayals of psychotherapy and mental health clinicians on the public?

a. There is a positive correlation between inaccuracy of expectations about clinicians with attrition rates in treatment.
b. The anticipated risks and benefits that clients perceive about psychotherapy directly affect their attitudes towards seeking professional help.
c. People often base their expectations of the practice and goals of psychotherapy on the stereotypical portrayal of clinicians in television and film.
d. all of the above

Knapp & Martin

10. When it comes to compliance plans, the authors claim that psychologists need to pay special attention to:
    a. billing and documentation
    b. the moral character of their employees
    c. false, deceptive, or misleading advertising
    d. the difference between supervision and consultation

Karafin

11. Which finding was not reported?
    a. The Minneapolis Public School District found that changing to later start times did not delay teens' bedtime.
    b. All schools reported improved grades and standardized test scores as a result of a later school start time.
    c. The Wilton, CT, schools reported that their athletic teams had the best athletic season when they instituted later school start times.
    d. The Saint George School reported a 45% decrease in absences and lateness after they instituted later school start times.
    e. All three schools noted improvements in student well-being (e.g., less fatigue and depression) after changing to later start times.

Woika & Bowersox

12. When a school district receives an evaluation completed by a private practitioner, the school is required to:
    a. implement recommendations made by the private practitioner
    b. begin the 60-day multidisciplinary evaluation process
    c. implement an Individualized Education Program and Behavior Intervention Plan
    d. consider the results of the outside evaluation
    e. develop a 504 Service Agreement

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, September 2013

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

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

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I verify that I personally completed the above CE test.

Signature_____ Date_____

A check or money order for $20 for members of PPA ($35 for non-members of PPA) must accompany this form.
Mail to Continuing Education Programs, PPA, 416 Forster Street, Harrisburg, PA 17102-1748.

Classifieds

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Licensure Renewal Deadline

PPA urges all psychologists to make sure that they have completed the mandatory continuing education requirements before the current biennial licensure period ends on **November 30**. The State Board of Psychology has disciplined psychologists for failing to get the necessary continuing education or for falsely stating that they had completed their CE requirements. Psychologists who need more hours of CE for this renewal period may want to attend PPA's Fall CE and Ethics Conference, October 31 and November 1, at the Holiday Inn Harrisburg East. In addition, psychologists can order home studies from PPA by calling 717-232-3817 or by downloading them from www.PaPsy.org.

2013 CE/14 Calendar

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

September 13, 2013
A Day of Ethics Education with Dr. Samuel Knapp
Monroeville, PA
Marti Evans (717) 232-3817

October 31 – November 1, 2013
Fall Continuing Education and Ethics Conference
Harrisburg, PA
Marti Evans (717) 232-3817

November 2, 2013
Introduction to the WPPSI-IV
Harrisburg, PA
Marti Evans (717) 232-3817

April 11, 2014
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

June 18 – 21, 2014
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@PaPsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/index.php/collaboration-communication/.

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 – *also available at www.PaPsy.org*

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*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.