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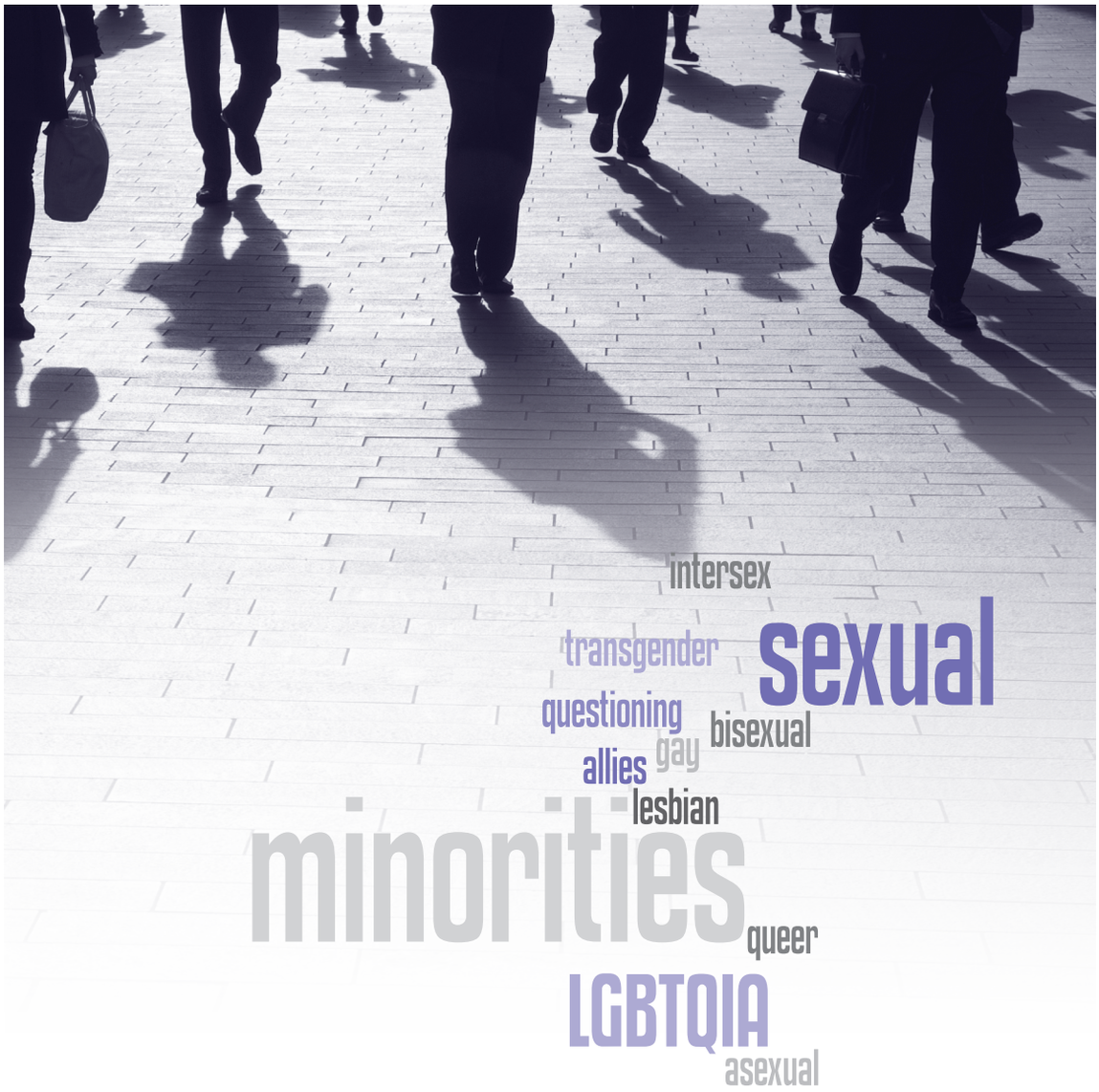
The Pennsylvania Psychologist

June 2012
QUARTERLY



ALSO INSIDE: PPA advocates for psychologists and the public interest • Pitfalls in verifying postdoctoral experience • Adaptations for ADHD students • Apps for psychologists

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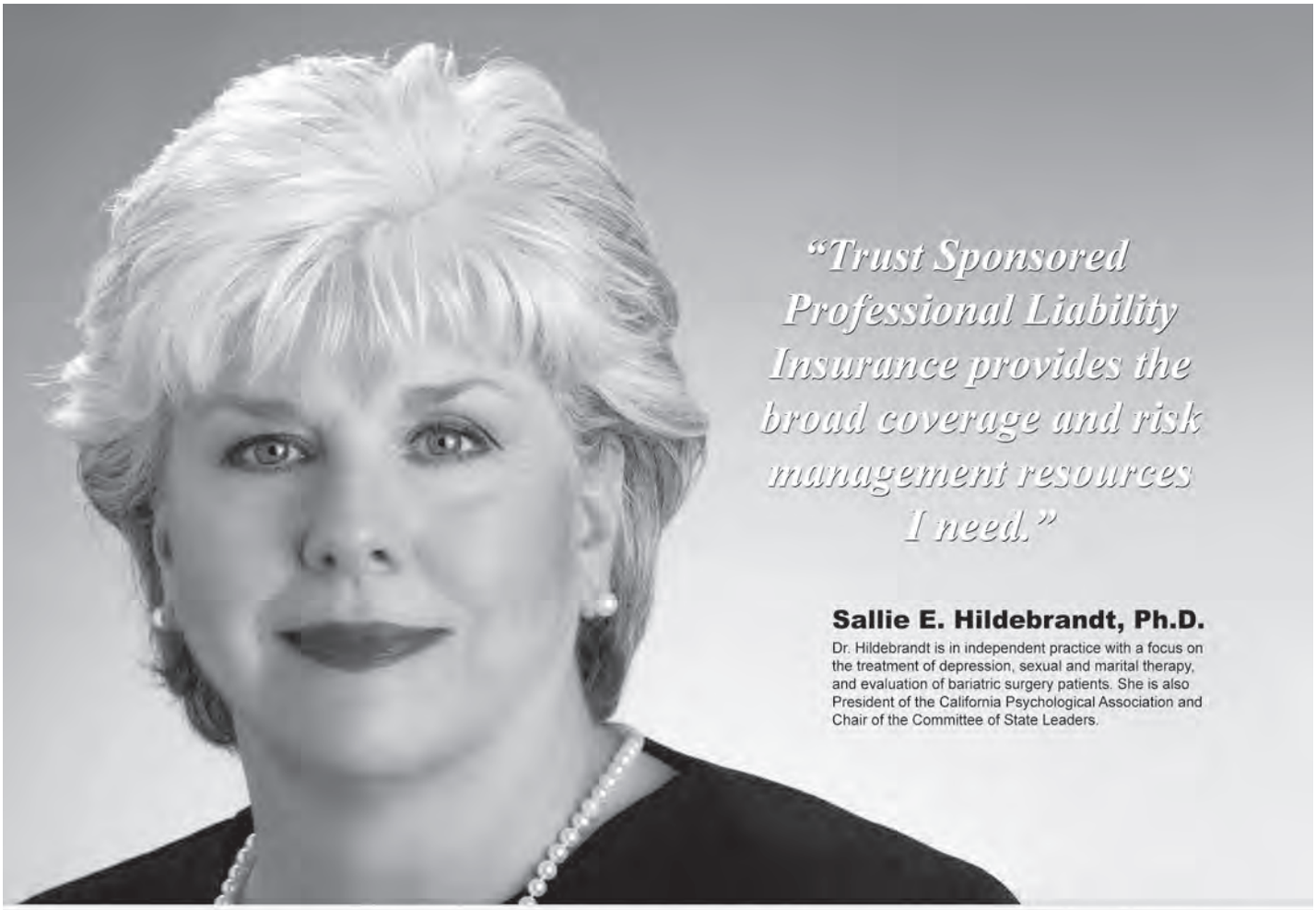

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Editor: Andrea L. Nelken, PsyD

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What a Great Year for Advocacy, Public Education, Volunteerism!

Judith Blau, PhD


Dr. Judith Blau

Welcome to the June edition of the *Pennsylvania Psychologist*. This article will be my last one to you as president of PPA. This year has been a whirlwind of activities and accomplishments for our organization. Our boards and committees continue to be vibrant. The Communications Board is making strides in technology, using social media, wikis, YouTube, and webinars, and continues to update our website, one of the best for state psychological associations in the nation. The Budget and Finance Committee continues to keep us financially shipshape in a storm-tossed economy. We are able to maintain seven staff members, when many states cannot even support one. The Psychologically Healthy Workplace Award winner from Pennsylvania, ReMed Recovery Care Centers, selected by the Business and Psychology Partnership Committee, was honored as a national winner at the APA State Leadership Conference. Our Multiculturalism Committee continues to sensitize and educate us about issues of diversity. Our School Psychology Board has successfully fought to keep positions open in schools amid many cutbacks. There are so many goals and accomplishments that listing them all here is impossible.

I cannot list everyone who has served as board and committee chairs and members, either, but I thank you for all your ideas and energy. Many of you have worked tirelessly for years. We and the public benefit from your dedication. Our PPA staff members, Tom DeWall, Sam Knapp, Iva Brimmer, Marti Evans, Rachael Baturin, Peggie Price, and Katie Boyer, do a phenomenal job of keeping us healthy and productive. They have learned to work together seamlessly, and the fact that they have all been with us for years is a testament to their commitment. When I interact with other states and with APA leaders, they clearly look with great respect to PPA as a role model. The fact that we have about 300 volunteers, an impressive 10% of our membership, speaks volumes about our leadership and the dynamics of our organization.

As this issue comes to us, we can look forward to our upcoming convention: "Moving Forward with the Basics: Advocacy, Public Education, and Volunteerism." I am very excited that the convention will highlight these themes that have been my presidential initiatives. In my past three "Presidential Perspectives," I updated you about the progress of these goals. I will be briefer in this article, and hope that you will come to the Town Hall Plenary Session from 8:00 to 10:00 a.m. Friday morning at the convention to hear more. I wish to inspire you again to be active in our organization and profession, and in educating the public.

> *It is imperative that we all respond to action alerts and contact our legislators to remind them of psychology's critical priorities.*

PPA continues its strong advocacy on the state level. After a two-year effort, the Pennsylvania General Assembly passed Senate Bill 200, the Safety in Youth Sports Act, which aims to ensure proper screening and return-to-play decisions for high school athletes suspected of receiving head concussions. Also on the state level, Pennsylvania is taking a hard look at its child protective services law. The legislature has established a task force designed to make proposals for legislative changes. PPA is an important voice for input into that process.

On the federal level, APA and PPA were successful in staving off the Medicare reimbursement reduction of 27.4% through the end of this year that would have resulted from the Sustainable Growth Rate (SGR) formula. However, the extension of the 5% psychotherapy services add-on was lost as of March 1. PPA continues to lobby to replace the SGR with a system that values cost-effective psychological services, as well as to add psychologists to the definition of "physician" within Medicare. It is imperative that we all respond to action alerts and contact our legislators to remind them of psychology's critical priorities. We have a great track record, but we need to keep it going.

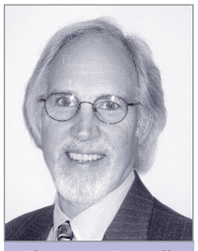
In the realm of public education, more than 50 PPA members continued to actively inform the public and notify us of their activities. We have increased the number of subscribers to our free quarterly e-newsletter, "Psychological News You Can Use," from approximately 3,000 to almost 4,000 since last June. We continue to need your help to invite clients, friends, colleagues, and business associates to subscribe to this informative publication. They can do so easily by logging onto our website and clicking on "Public" at the top.

I initially became involved in PPA leadership through the personal invitation of my dear friend Dr. Linda Knauss. I thank her and a number of other leaders who have especially inspired and encouraged me over the years: Dr. Paul Kettlewell, who provided my first opportunity to be on Executive Committee, the late Dr. Steve Berk, Drs. Paul Delfin, Andrea Delligatti, John Gavazzi, Don McAleer, and Jeff Pincus. Most recently, Dr. Mark Hogue has also been a great role model and mentor as president-elect, president,

Continued on page 5

PPA Advocates for Psychologists and the Public Interest

Thomas H. DeWall, CAE


Thomas H. DeWall

At this writing PPA is gearing up for our annual advocacy day in the state Capitol, scheduled to take place at the end of April. One of the bills we are focusing on in discussions with legislators is House Bill 1405, sponsored by Rep. Glen Grell (R-Cumberland); it passed the House in March and is now in the Senate Judiciary Committee. This bill would permit courts to appoint psychologists to conduct evaluations for determining insanity. To our knowledge this bill has no opponents as long as it is not amended, and we are working to try to make sure that no amendments are added. Nothing in this bill would alter the standards for an insanity defense in Pennsylvania. Insanity determinations are rare and constitute less than 1% of all homicides. Currently, the rules of the Pennsylvania Supreme Court permit psychologists to conduct insanity evaluations (234 Pa. Code §569). Also, Pennsylvania's current insanity statute permits defendants to summon a psychologist to testify on their behalf (50 P.S. §4408 et seq.). However, Pennsylvania's insanity statute does not permit the courts to appoint psychologists to conduct insanity evaluations if they want the report to also address the related issue of competency to stand trial. It makes little sense for the court to allow a psychologist expert to testify for the defense on issues of insanity and competency to stand trial, but prohibit the court the option of appointing a psychologist to do the same.

Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice and legal recognition of psychologists. For example, among many other statutes, psychologists (along with physicians and dentists) are recognized to testify in civil suits according to Pennsylvania's Rules of Civil Procedures (R.C.P. Rule 4010); psychologists (along with physicians) can diagnose children who have been emotionally abused (55 Pa. Code §3490.4); and psychologists may evaluate individuals for purposes of authorizing a permit to carry lethal weapons (22 Pa. C.S.A. §41 et seq.). This bill is one building block in PPA's strategy of getting legislation passed specifically authorizing psychologists to engage in all activities consistent with their scope of practice.

Another issue we are focusing on is the reporting of child abuse. Our education of legislators centers on two main principles: identifying abused children and preventing and stopping child abuse. We argue that Pennsylvania should expand the definitions of child abuse, especially in the areas of neglect, to increase the accurate identification of children who are abused. Dr. Sam Knapp (2012) has described the fact that Pennsylvania has the lowest national rate of identifying child abuse (one-seventh the national average). This is especially true in the area of neglect. For example, in 2010, Ohio identified more than 15,000 cases of neglect; Pennsylvania identified 99. Pennsylvania is near the national average in terms of identifying sexual abuse. But the rate of identifying other forms of abuse, such as neglect, medical neglect, physical abuse, and emotional abuse is one-eighteenth the national average. The rate of substantiating child abuse in Pennsylvania has declined steadily over the last 35 years from 41% of all suspected cases reported in 1976 to 15% in 2010. The national average is now 24%.

The low rates of reporting of abuse in Pennsylvania appear to be influenced by the substantiation rates. As Children and Youth fail to identify abuse in more and more situations, mandated reporters learn that the criteria for abuse is more and more restrictive, thus leading to a decrease in reports. Legislation has been introduced to increase the penalties on mandated reporters; but doing so without changing the criteria by which child abuse reports are substantiated will only result in far lower rates of substantiated reports. Resources will be wasted on investigations that are very unlikely to be substantiated.

> *[HB 300] would amend the Pennsylvania Human Relations Act to prohibit discrimination based on sexual orientation and gender identity or expression...*

In addition to greater identification, the commonwealth needs to increase resources dedicated to preventing and stopping child abuse. Fortunately, several programs have been demonstrated to be effective in preventing or stopping abuse. A comprehensive review by APA showed that a variety of these programs have had sustained success. They include parenting programs that increase positive family relationships and reduce future rates of child maltreatment. Some of these effective approaches include nurse/family partnerships, parent training in positive practices, and multisystemic therapy programs.

The General Assembly has established a Task Force on Child Protection, which is investigating these issues and plans to make a final report by November 30.

There are several other bills on PPA's agenda. One is especially relevant to this issue's theme on sexual minorities. Rep. Dan Frankel (D-Allegheny) introduced House Bill 300 on April 29, 2011, whereupon it was referred to the House State Government Committee, chaired by Rep. Daryl Metcalfe (R-Butler). This bill would amend the Pennsylvania Human Relations Act to prohibit discrimination based on sexual orientation and gender identity or expression in housing, employment,

Continued on page 6

Verification of Postdoctoral Experience: Pitfalls for Students

Rachael L. Baturin, MPH, JD


Rachael L. Baturin

One of the requirements for students interested in becoming licensed in Pennsylvania is to complete one year of postdoctoral experience. It is very important for potential supervisees to review the postdoctoral experience requirements before they start this experience as there are a lot of nuances to the law, and the postdoctoral experience requirements vary from state to state. There have been cases where supervisees did not review the requirements before starting their experience, their experience did not qualify for the postdoctoral year, and they needed to repeat it.

This article will discuss some of the pitfalls that supervisees and supervisors have faced when trying to complete the verification of postdoctoral experience form, which must be sent to the State Board of Psychology upon completion of postdoctoral requirements. If readers would like to review all postdoctoral requirements in Pennsylvania, they can be found in the Pennsylvania State Board of Psychology's regulations, Section 41.32 and Section 41.33, available on the State Board's website: http://www.pacode.com/secure/data/049/chapter41/chap41toc.html.

Practical Issues

First, the supervisee should check to see whether the supervisor has been subject to any disciplinary actions by the State Board of Psychology. If they are currently being disciplined, they may not qualify as a supervisor. After December 1, 2015, postdoctoral supervisors must have completed either a course in supervision or 3 hours of continuing education in supervision.

Second, supervisees are required to have at least half of their training in diagnosis, assessment, therapy, other interventions, consultation, and individual supervision received as a supervisee, and the other half may be in teaching in association with either an organized psychology program preparing practicing psychologists and/or a postdoctoral training program, supervision provided as a supervisor, professional development, or research. For example, if a supervisee is doing 40 hours per week of research and 20 hours per week of direct services, the student should count 20 hours of research and 20 hours of direct services per week because at least half must be in direct services. There have been cases where the supervisee submitted a verification form on which it appeared as though 50% of the time was not in providing direct services because the supervisee was submitting too many research hours.

There have been cases where supervisees did not review the requirements before starting their experience, their experience did not qualify for the postdoctoral year, and they needed to repeat it.

An hour of diagnosis, assessment, or therapy does not necessarily have to be an hour of direct patient contact. For example, a supervisee could spend an hour in therapy with a child and then spend another hour talking to the pediatrician and the school. Both of those hours should be counted toward fulfilling the 1,750-hour requirement for the postdoctoral year.

As another example, if the supervisee is just starting supervision and is seeing clients fewer than 15 hours per week, the supervisee could ask the supervisor for a research project to undertake in order to obtain additional hours, as long as they do not exceed 50% of the postdoctoral hours.

Next, supervisees are required to have 2 hours of face-to-face meetings with their supervisors per week. If you need to complete your experience in two different settings, you are still required to have 2 hours of face-to-face meetings with your supervisor at each site unless the sites are interrelated. For example, if one site is owned by ABC Corporation and the other is owned by XYZ Corporation, then the supervisee is required to get 2 hours of supervision at each site. However, if both sites were owned by ABC Corporation and one was the main office and the other a satellite office then the supervisee would be required to obtain only 2 hours of supervision for both sites. Also, supervisees must be present at each site for at least 6 consecutive months for the experience to count. There have been cases where students failed to meet this requirement and had to repeat the experience.

Last, the supervisor is required to maintain records or notes of the scheduled supervisory sessions, observe client/patient sessions of the supervisee or review verbatim recordings of these sessions on a regular basis and must prepare written evaluations or reports which are discussed with the supervisee. Once again, cases exist in which the supervisor failed to produce the written evaluations and the experience did not count.

Dual Relationships

The supervisor and supervisee must not be in a dual relationship. The supervisor cannot be related to the supervisee by blood or marriage, nor can the supervisor have a therapeutic relationship with the supervisee. In addition, supervisees are not allowed to pay supervisors for supervision (although supervision may be paid by a third party). The supervisor must be free from the supervisee's control or influence and must be allowed to stop the supervisory relationship if necessary.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of April 30, 2012

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 115 HB 58	Provides for involuntary commitment to outpatient treatment - Sen. Stewart J. Greenleaf (R-Montgomery) - Rep. Mario M. Scavello (R-Monroe)	Opposed unless amended	In Public Health & Welfare Committee	In Human Services Committee
SB 850	Provides for the offense of cyberbullying and sexting by minors - Sen. Stewart J. Greenleaf (R-Montgomery)	For	Passed 10/19/11, 50–0	In Judiciary Committee
SB 1019	Provides that managers in Department of Corrections receive salary increases at least as high as civil service employees - Sen. David G. Argall (R-Carbon)	For	Passed 1/24/12, 45–5	In Judiciary Committee
HB 42	Prohibits Pennsylvania from implementing the federal health care mandate - Rep. Matthew E. Baker (R-Tioga)	Opposed	None	Passed by two committees. On tabled calendar
HB 300	Prohibits discrimination based on sexual orientation in housing, employment, and public accommodations - Rep. Dan Frankel (D-Allegheny)	For	None	In State Government Committee
HB 663	Restricts insurance companies' retroactive denial of reimbursement - Rep. Stephen E. Barrar (R-Delaware Co.)	For	None	In Insurance Committee
HB 978	Credentials drug and alcohol counselors based solely on their life experience - Rep. Louise Williams Bishop (D-Philadelphia)	Opposed	None	In Human Services Committee
HB 1405	Authorizes psychologists to testify in court on the determination of insanity and competency to stand trial - Rep. Glen R. Grell (R-Cumberland)	For	In Judiciary Committee	Passed 3/12/12, 193-0

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

PRESIDENTIAL PERSPECTIVE

Continued from page 2

and past president in the cycle starting the year before me. Thank you all so much for your guidance and friendship over the years. And thank you to so many other PPA members from whom I have learned so much and whom I have the pleasure to know.

I also wholeheartedly thank each member of our talented PPA staff for your excellent support of my ideas and activities over the years. It has been a tremendous gift to be able to work with you.

Please be involved in the initiatives I have set forth – and in whatever other area your interests lie. As we move forward, I know we will be in very capable hands under the leadership of our new president, Dr. David Palmiter, and the new president-elect, Dr. Vince Bellwoar.

I hope you will join us at what promises to be a most informative, worthwhile, and enjoyable convention! See you soon!

EXECUTIVE DIRECTOR'S REPORT *Continued from page 3*

higher education, and public accommodations. It would add the same safeguards that the Human Relations Act already recognizes for individuals based on race, color, familial status, religious creed, ancestry, age, sex, national origin, or use of support animals for blindness or deafness. PPA has noted to legislators that it is simply a matter of fairness to create this additional protection. Although PPA and other organizations have urged action on this bill, nothing has happened even though more than a year has passed since its introduction.

Another critical bill on our agenda is Senate Bill 1019, introduced by Sen. David G. Argall (R-Carbon). This bill would provide that managers in the Department of Corrections receive salary increases at least as high as civil service employees. Psychologists and other management-level employees in the Department of Corrections have been subject to pay freezes over the years, so that in many cases unionized employees may make more money than management employees. Many psychology director and psychology manager positions are unfilled because the psychologists would have to take a pay cut in order to accept those positions. This bill has passed the Senate and is in the House Judiciary Committee. We are optimistic about its passage because the funding for it is in the governor's proposed budget.

There are many more issues that the PPA staff and lobbyist are tracking to make sure that we carry out the portion of our strategic plan that calls for promoting public access to psychological services. See the Bill Box in this issue for the list of some of them.

Reference

Knapp, S. (2012, April). The under-identification of child abuse in Pennsylvania: Where does the problem lie? *Pennsylvania Psychologist*, pp. 1, 7-8.

FROM THE EDITOR

LGBTQIA
Breaking the Surface on Alphabet Soup

Andrea Nelken, PsyD

Dr. Andrea Nelken

LGBTQIA: Even among those in the sexual minority community, the letters make little categorical sense. There are the sexual orientations: lesbian, gay, bisexual. There are the gender identities: transgender and queer (although some substitute "questioning" for those who are not yet sure of their identities). There is the biological sex variance, where "I" is for intersex; and finally "A," for "asexual" or "allies," depending on the hour.

Essentially, four spectra overarch this group: gender identity (woman to "gender queer" to man), gender expression (feminine to androgynous to masculine), biological sex (female to intersex to male), and sexual orientation (heterosexual to bisexual to lesbian/gay). To say these categories are non-orthogonal would be to understate.

Beneath the multiplicity of letters is an often-shifting dispersion of individuals. For many, sexual orientation is fixed, but for some it is fluid, and sometimes people slide from one to another identity even late in life. Further, sometimes people enter therapy identifying as lesbian, bisexual, or gay, and their identification later emerges as gender variant, leaving psychologists who believed they were competent to treat sexual orientation scrambling to learn about gender identity. Not infrequently, psychologists working with those spanning the range of gender and sexual identities may also see clients exploring other types of non-normative sexual behaviors and identities – polyamory, swinging, all types of "kink" – who make their way to our offices through word of mouth or social media referrals, looking for nonjudgmental help with their social and psychological stresses.

Add to this the intersection of sexual minorities with other minority statuses – ethnic, racial, religious, age, ability – and the importance of lifelong study becomes more evident: Competent practice with sexual minorities requires a breadth of cultural specializations. While it would be impossible to address the complexities of any one of these cultures in a few 1,000-word articles, let alone their intersections, each of the authors of this special section have broken the surface on more superficial discussions to explore a few aspects of the rich world within. It is a beginning.

Understanding sexual minorities depends upon first understanding the core oppression: sexism. This and its attendant classism explain many differences between gay male and lesbian culture, as well as the extreme and unyielding pressures faced by the gender variant community. For example, gay male couples tend to be the wealthiest, with their two male incomes, and that buys dominant-culture privilege. However, while the privileges of sex and class are great, the penalties for deviating from traditional concepts of male gender are also particularly severe: "flaming" is derided and transwomen are scorned. (Much more subtly, heterosexual people are constrained by sexism as well, which exerts pressure to conform to standards of gender expression and competencies.)

Lesbians, who as couples occupy the opposite end of the sex and class continuum, tend to be devalued. This (and all) devaluing becomes internalized: Historically, lesbians were at the forefront of social activism for every cause *but their own*, from civil rights to reproductive rights to domestic violence to HIV, yet few groups – including women's groups – supported lesbian rights. The dynamics of these internalizations are still expressed in subtle intrapsychic and interpersonal transactions.

Sexual minority oppression remains alive and well in mainstream culture – the term "gay" continues to be used to describe something distasteful, anti-gay and trans jokes abound in comedy, minority members are characterized as "sinners," and basic human rights are still denied. Nonetheless, change is quietly occurring on legal and social fronts, albeit at glacial speed. An exchange between two genuinely affirmative psychologists at a recent PPA conference exemplifies the tensions attending heightened awareness and the search for sensitivity, and an article by one of them describes the challenges of that growth.

Were there an editorial hope attached to this issue – and there is – it is that we all take further steps toward a more sophisticated understanding, daring to consider, to explore, to respect, and to learn – not simply from majority members who claim authority and expertise about sexual minorities, but from minority members themselves, who through experience understand best of all.

What Every Psychologist Should Know About Gender Identity Variance in 1,000 Words (Ha!)

Maureen Osborne, PhD


Dr. Maureen Osborne

As a heterosexual, gender-congruent psychologist trained in the mid-'70s, I was an unlikely candidate for gender identity expert. All that changed in 1992, when a 52-year-old male factory worker entered my office after viewing a Phil Donahue show on transsexuality and stated, "I think I am supposed to be a woman." My graduate studies – even a rotation on human sexuality with Masters and Johnson faculty – had given me no clue as to how to help this client. In the 20 years since, I've found my life's calling within the community of transgender people, their families, and professional allies. It has proven a fascinating and gratifying journey.

Colleagues ask, "How can you build a practice specializing in such a rare condition?" I point out that as popular and scientific knowledge and awareness has grown, the prevalence of gender variant conditions has followed suit. Population estimates initially used "request for surgical reassignment" as an indicator, citing a prevalence of about 1 in 30,000. However, when a recent public health survey (Conron, Scott, Stowell, & Landers, 2012) inquired whether anybody in the household identified as transgender, the results reported an astounding figure of 0.5%, or 1 in 200 (n>28,000). By comparison, the same percentage is currently serving in the military. And yet, I recently negotiated a single-case agreement with an insurance gatekeeper who identified more than 200 LGB specialists within a ten-mile radius, but not one gender identity specialist. This is especially alarming when seen against the backdrop of survey data (Grant, Mottet, & Tanis, 2011) indicating that the percentage of transgender people who have *attempted* – not simply considered – suicide is a whopping 41%. Psychological distress is almost unavoidable in the transgender community, attributable to everything from school bullying to complex family problems as well as legal, employment, medical, and social discrimination.

A good place to start learning about gender variation is the website of the World Professional Association for Transgender Health (Wpath.org) and its "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People." Its revisions represent an evolving blueprint of professional theory and practice, increasingly informed by the voices of transgender consumers. Where the focus was once on assessing the "readiness and eligibility" of individuals to receive "sex reassignment surgery" (now simply "genital surgery"), the Standards now address a host of issues, from the risks and benefits of hormone therapy with or without social transition to the management and treatment of incarcerated transgender prisoners. Any professional working with gender variant clients should be familiar with this document. It includes a comprehensive list of the roles mental health professionals working with gender variant adults, adolescents, and children might be expected to play, ranging from psychotherapy and assessment to interdisciplinary collaboration, to education and advocacy. An invaluable textbook resource is *Transgender Emergence* (Lev, 2004). Julia Serano's *Whipping Girl* is a whipsmart polemic on transgender issues from a feminist perspective. Above all, clinicians working with gender variant clients should attend a transgender conference. In Pennsylvania, there is the annual Keystone Conference in Harrisburg and the Philadelphia TransHealth Conference (May 31-June 2, 2012). The lively engagement between transgender consumers and experienced allied professionals at a national conference is priceless.

The power of our gender assumptions underlies the human drama I witness every day in my office, and these often reluctant explorers are drawing new gender maps.

Human suffering and social injustice are reason enough to improve training of psychologists in this area, but academic psychology can also learn from gender variant people about the essential nature of gender identity, gender roles, sexual orientation, and sexual behavior. Many of us have learned some variant of *"Sex is between your legs, gender is between your ears, and sexual orientation is in your heart."* However, most people, including many psychologists, routinely make heterosexist and cisgender (i.e., gender congruent with body sex) assumptions. Just today, I spoke with an earnest gastric surgeon who repeatedly referred to our mutual transwoman patient as "he," despite my having corrected her several times. Gender pronoun habits are hard to break, even among people with no personal vested interest – just imagine the challenge to a spouse or parents whose entire lives face serious disruption in the wake of their family member's gender transition! The power of our gender assumptions underlies the human drama I witness every day in my office, and these often reluctant explorers are drawing new gender maps.

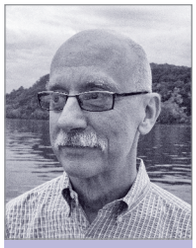
The following points are worth considering:

- Gender Identity Disorder may be in the DSM-IV, but many transgender people resent the assertion that their gender identity is a "disorder" rather than a natural variation: Gender variation has existed throughout time and across cultures. The etiology is not fully understood but appears to have a strong biogenetic component.
- Psychologist Anne Vitale (2010) coined "GEDAD" – Gender

Continued on page 9

Barriers to Intimacy in Gay Male Couples

James Huggins, PhD, jameshug100@hotmail.com



Dr. James Huggins

While common themes may emerge in therapy for both gay and heterosexual couples, fundamental differences exist when two men establish a relationship as opposed to a man and woman or two women. Potential barriers to intimacy and connection are present precisely *because* two members of the same sex seek a union.

Internalized homophobia. While attitudes and prejudices toward sexual minorities are changing, homophobia and heterosexism still exist. One only need listen to the rhetoric surrounding gay marriage to understand the deep-rooted, cultural discomfort with sanctioning the union of two men. Imagine growing up in a culture where hate-filled speech toward gay men is publicly expressed by religious and political leaders, and perhaps even by one's own family members. Thoughts and feelings natural to you become the source of shame and guilt carried with you when you attempt to become intimate with another man. Internalized homophobia may be expressed as disrespect and loathing for one's self, but also for one's partner and the relationship.

Couples therapists need to be sensitive to how internalized homophobia is expressed, because men in relationship may not be conscious of it. They may have a deeply held belief that their relationship is inferior to a heterosexual relationship, failing to give it the respect and energy it needs to grow and thrive. They may also have an unexpressed and mistaken belief that relationships between two men simply do not work because they are rarely exposed to gay relationships that do. Entering and leaving a relationship may be taken less seriously than marriage and divorce might be for a heterosexual couple.

Gender socialization. Most gay boys are socialized to develop a clear understanding that "real men" are heterosexual and "masculine." Some gay boys are able to "pass" as straight, but they know they are somehow different from their peers. They usually keep this knowledge about themselves secret for fear of being ostracized. Gay boys who conform less to gender stereotypes may become the victims of the taunts and violence of male bullies. Some have been killed.

One of the most problematic ironies for gay men is that they desire a loving, intimate, and trusting relationship with another man when men have been the primary source of either direct or feared verbal, emotional, and physical abuse. Gay men, like other men in our culture, are also subject to gender socialization where the expectation is emotional self-sufficiency and independence. Men are not expected to be intimate with other men; they are supposed to be intimate with a woman, which is one of the few culturally sanctioned places where a man may be emotionally vulnerable (Greenan & Tunnel, 2003).

Gay men in couples therapy are most often very clear about their desire to be intimate with another man. Although informed by their strong erotic attractions, they may not be aware of their underlying fears and expectations concerning emotional vulnerability and intimacy with another man. If one has experienced a great deal of emotional pain from other males as a gay boy, why would this man be any different?

Our job as couples therapists is to help these men get past their gender socialization and their internalized homophobia so that they can learn to express and share vulnerability and intimacy with another man. In order to do this, the therapist must understand the coming-out history of each partner, including whether or not he experienced abuse from other men. How out are they now, individually and as a couple? Are they still afraid of men?

Competition. Men in our culture are generally expected and encouraged to be competitive with other men. Because two men are in relationship, easy comparisons by the couple and by others can readily lead to jealousy and competition. Couples therapists can help gay men assess and appreciate each person's unique contributions to the relationship. At the same time, gay men may need particular help in reducing their natural tendency to compete and to gain skill in accommodation and cooperation.

Families. Unlike most other minorities, gay children are almost never born into families that share their minority status. Consequently, they do not develop a positive gay identity (including how to attract, date, and create intimacy with someone of their same sex) within their family system or with their peers. Gay youth often grow up learning that they have only themselves to rely upon. While this belief may be helpful in developing defenses to get through childhood and adolescence, it may interfere with learning to rely on one's partner for emotional support and must be actively challenged during couples therapy.

Couples therapists need to be sensitive to how internalized homophobia is expressed, because men in relationship may not be conscious of it.

In addition, gay men often struggle to garner respect and support from family members. Too often, one or both men feel forced to choose between their family of origin and their partner. Couples therapists can provide invaluable help to gay men as they navigate the complexities of integrating (or not) into each other's family of origin.

Continued on page 9

...GENDER IDENTITY VARIANCE

Continued from page 7

Expression Deprivation Anxiety Disorder – to highlight problems caused by social stigma rather than any inherent disorder.

- There appears to be a spectrum of gender identity variation, including, but not limited to, cross-dressers, transsexuals, dual-gendered, and "gender queer" individuals. Generally, only transsexuals seek surgery, but others may find comfort in hormones, variant forms of gender expression, or simply disclosing and validating their inner gender identity.
- Cross-dressers, often male and heterosexual, resent the term "transvestite" and its association with fetishism. Although cross-dressing frequently begins with an erotic association, it often evolves over time into an activity aimed at non-erotic satisfaction.
- Most transgender people prefer the term "transwoman" for a natal male who has a female gender identity and "transman" for a natal female with a male gender identity.
- *Gender queer* is an emergent identity that challenges traditional binary notions of gender. It encompasses people who identify as a third gender, as both male and female, as non-gendered, or as fluid in gender.
- It is inappropriate to inquire about a trans person's surgical status. It is proper to address transgender persons with the pronouns appropriate to their presentation in public, and in private to address them according to their identification when known.
- Adult gender transition does *not* mean inevitable loss of family relationships. Children adjust reasonably well to a parent's gender transition, and there is no evidence that it disrupts their own gender identity development. Many couples negotiate cross-gender expression in the context of marriage. When a spouse undergoes surgical gender change, some couples remain married, some become friends/roommates, and some go through angry divorces. All need support making the adjustment.
- Sexuality/sexual orientation is a wild card with gender variant folks. Abandon all assumptions/expectations and hold on for the ride!

Finally, among the important roles that a trans-knowledgeable therapist can play, perhaps the most valuable one is to provide a safe and respectful space in which clients can explore the contours of their gender identity. As a contextual therapist, I also work to help my clients identify what they deserve from and owe to significant others on their journey toward gender authenticity. Loved ones are almost always surprised and overwhelmed by this disclosure. Paying attention to *their* transition without abandoning your transgender client can be a tricky balancing act, but it has proven a reliable way to minimize relational losses and resentments with a gender transition.

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BARRIERS TO INTIMACY IN GAY MALE COUPLES

Continued from page 8

Monogamy vs. non-monogamy. Many gay male couples choose to be sexually non-monogamous, which defies traditional notions of what it means to be a couple. For some, non-monogamy helps add sexual interest to the relationship and facilitates the "dance of intimacy" between how close and distant one wants to be in a relationship (Firestone & Catlett, 2002). A review of the literature indicates monogamous and non-monogamous gay men report comparable satisfaction with their relationships (LaSala, 2000). Key to each type of relationship is honesty and integrity. Couples therapists need to be self-reflective and decide whether they can be non-judgmental about monogamy vs. non-monogamy. If they have a bias toward monogamy, they shouldn't be working with gay male couples.

Most gay men desire a lasting and loving relationship with another man. They want a life partner who is honest, compassionate, and trustworthy. They want to share a life with him that includes good sex, affection, and companionship. Obviously, these desires are exactly what others in our culture seek in a mate regardless of their sex or orientation (McCarthy & McCarthy, 2004). Couples therapists who understand the unique challenges gay men face in relationships can help these men reach their goal.

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Being "Other" in a This-or-That World

Nancy Chubb, PhD, MBA

Dr. Nancy Chubb

Markedly little research exists on bisexuality (funding is scarce and so are subjects), and most research has focused on younger, easily accessible college students. As a clinician and not a researcher, my perspective is drawn from providing therapy to the GLBTQIA community for 20 years, after training at Persad Center (a mental health center in Pittsburgh for sexual minorities, people with HIV, and their families) under the supervision of founder Dr. Jim Huggins, and from my own life as a bisexual woman.

Bisexuality is defined by the American Psychological Association's *Practice Guidelines for LGB Clients* as the sexual and romantic attraction to members of both sexes (2011, p. 4). These guidelines, adopted in February 2011 by the APA Council of Representatives, are available on APA's website. Guideline 5 states, "Psychologists strive to recognize the unique experiences of bisexual individuals." The purpose of this article is to encourage the reader to think more deeply about the challenges faced by bisexual people.

Bisexuality is *not*: (1) a developmental waypoint for gay men or lesbians unable to fully accept their same-sex attractions, or (2) heterosexuals curious about having a same-sex sexual encounter. A 10-year longitudinal study found that women's bisexuality was a discrete sexual orientation category and not a step on the way to lesbianism (Diamond, 2008). There is much less information on male bisexuality, but recent research suggests a similar discrete bisexual category for men (Rosenthal et al., 2011). Research also indicates that sexual orientation is fluid and can change over a lifetime for women (Peplau & Garnets, 2000).

For most of us, sexual orientation is a central part of our sense of self. If we are heterosexual, we may not think much about it because our orientation is assumed by a culture that has promoted it to the exclusion of other sexual orientations for centuries. This is part of privilege: not having to defend or think about our sexual orientation. If we are gay or lesbian, we have thought about our sexual orientation *a lot*, because it is how we don't fit into mainstream culture, and historically we have had to seek out hidden subcultures as sources of affirmation. But what if we are bisexual? Then we have a foot in both the mainstream culture and gay subculture, but don't entirely belong in either.

> *"Bisexuality immediately doubles your chances for a date on Saturday night."*
>
> *– Woody Allen*

The two challenges I want to address are the effects of not really "fitting in" to either the heterosexual or gay community and, if relationally monogamous, the effects of not expressing one significant part of one's sexuality.

Most people don't think of heterosexual culture as a culture because it is dominant and pervasive, but it is powerful and confers all sorts of advantages to those in it: *We matter, you don't. We tolerate, or don't. We allow images of other relationships for our pleasure, but serious same-sex relationships make us uncomfortable.* In the gay community, there are wonderful, rich cultures – "cultures" because lesbian and gay male culture are vastly different, with distinct art and values. Gay men and lesbians have found acceptance and vitality in their communities. But because their concurrent same-sex attractions are what set bisexuality apart from heterosexual culture, bisexuality becomes lumped with gay and lesbian culture; there is no "bisexual" culture and no "bisexual" community. So what is a bisexual person to do?

Typically, bisexuals will get immersed in the culture that embraces their current expression of their sexuality. If bisexual Betty is in a relationship with a man, she can blend in anywhere – the PTA, gym, office, extended family. If bisexual Betty is in a relationship with a woman, she will usually find refuge and acceptance in the lesbian community.

But what happens if Betty's relationship with the man ends and she starts to date women? Unless she has been "out" as bisexual (not common), she can suddenly find it hard to be honest about her personal life around those with whom she used to casually discuss weekend plans. Betty may now feel alienated, lonely, ashamed, guilty, isolated, or afraid, depending on her ego strength.

Imagine instead that Betty is first with a woman, and after her relationship ends, Betty starts to date men. She has a different experience: Betty finds she can now talk easily with neighbors, colleagues, the person at the checkout counter, and relatives about her plans for the weekend. But where she can't easily talk about her personal life is with her old friends, her lesbian community – friends who may feel betrayed, rejected and hurt. Betty is no longer "one of us" but "one of them," enjoying the heterosexual privilege they lack. How this plays out will depend on Betty's ego strength and that of her lesbian friends, but often she will feel she is no longer entitled to or welcomed into her former community.

Regardless of the sex of Betty's partner, complex relational dynamics will exist. It's the rare heterosexual partner who will be comfortable with a bisexual partner talking about attractions to their own sex, and lesbians and gay men generally do not want to hear about their partner's opposite-sex attractions. Further, while all people have to sublimate some of their sexual feelings, for

Continued on page 13

Clinical Considerations When Working With Lesbian Clients

Jeanne L. Stanley, PhD


Dr. Jeanne L. Stanley

One challenge of working with lesbian clients lies in never assuming *all* concerns relate to sexual identity issues, while also acknowledging the potential impact of sexual identity. Also important is understanding the intersection of our clients' sexual orientation with other socio-cultural identities, including age, citizenship status, ability, ethnicity, gender, race, religion, and socioeconomic status. A client's socio-cultural identities are at times independent, interdependent, and multiplicative, and are best understood individual by individual (Stanley, 2004).

A difference exists between a lesbian's self-identification and behavior. For example a female client married to a man may not be heterosexual. A recent study found that 67% of "exclusively straight" women had questioned or were questioning their sexual orientation (Morgan & Thompson, 2011). Conversely, a client who identifies as lesbian may never have had a same-sex experience. Fifty percent of self-identified lesbian adolescents had not had same-sex contacts (Savin-Williams, 2005). It is therefore better to ask a client, "With what gender or genders are you sexually active, if you are so?" as well as how they identify themselves, rather than to focus solely on labels. For some women, sexual behavior or attraction is not the basis for their identification as lesbian. In this context, Klein, Sepekoff and Wolf (1990) were instrumental in helping psychologists broaden their understanding of sexual identity to include other factors, such as attraction, emotional connection, and community affiliation.

Coming out to oneself about one's sexual identity can happen at any age. Sexual orientation may be static over a lifetime or more fluid (Diamond, 2008). I recently met with a 71-year-old client who described experiencing sexual attraction toward women for the first time. Assuming that sexual identity is static may lead mental health professionals to miss subtle comments by clients who may be reaching out for support regarding their orientation.

As they consider coming out for the first time, clients benefit from thorough exploration of the "why" and "how" of their communication. It is useful for clients to choose carefully whom to tell first, in order to identify those with whom they are likely to have a positive experience. Reviewing how particular people have handled potentially disconcerting information in the past may prepare the client.

Coming out is an ongoing, lifelong process. While clients may focus on the major coming-out events, such as telling parents, spouses, friends, and work colleagues about their sexual identity, the decision of whether to come out and the possible consequences may arise daily. Checking into a hotel as a same-sex couple and assuring the clerk that indeed you would like one queen-sized bed rather than two double beds, or receiving an invitation for one to a cousin's wedding, even though you have been with your spouse for fifteen years, can take a toll on even the most "out" and empowered individuals. A high school reunion full of questions about relationship status may lead an otherwise "out" lesbian to retreat back into the closet for the night. It is especially important for mental health professionals to be able to normalize for clients the process of "recycling" through the coming-out process based upon life circumstances and to give them a place to discuss their present contexts without pathologizing their needs and decisions.

Facing subtle and more overt forms of discrimination leads lesbian, gay, bisexual, and transgender (LGBT) individuals to seek mental health support services on a higher average than their heterosexual counterparts (Israel, Grocheva, Burnes, & Walther, 2008). Lesbian clients are not more emotionally "flawed" than their heterosexual counterparts; rather the chronic, overt discrimination and prejudice they experience can lead to higher rates of depression, anxiety, and substance abuse. The importance of screening for depression, anxiety, addictions, self-harming behaviors, and suicidality is therefore essential in our initial and continued work with lesbian clients.

Support from family of origin and/or family of choice (i.e., friends and mentors) plays a crucial role for many lesbians. Therefore, it may be useful to connect lesbian clients to affinity groups related to their interests and their work, whether through local or national venues. LGBT psychologists may find support and recognition through membership in APA's Division 44. Clients in non-urban areas may benefit from online support groups and other social networking sites. Support for lesbians is often found in their friendships, which may differ in important ways from heterosexual friendships. It is not uncommon for lesbians to work to maintain friendships with their ex-partners (Weinstock & Rothblum, 2004; Stanley, 1996).

Psychologists who see lesbian couples need to consider some of the unique aspects of working with them. If one member of the couple is out to family and friends but the other partner is not because of fear of losing her job or being rejected by her parents or siblings, the disparity may strongly impact their relationship. Domestic violence in lesbian couples may also manifest in unique ways: An angry member of the relationship might threaten to "out" the closeted partner, thereby using the knowledge of her sexual identity to exert control. Working with lesbians who are married to men may involve conflicted feelings about coming out to their husbands and/or children. Their own mixed feelings such as excitement, shame, joy, and fear may interact with the reactions of friends, parents, and neighbors. Support groups are often useful for married or recently divorced lesbians to gain affirmation in their lives.

Unique issues for lesbians considering children range from legal issues (some states do not allow same-sex couple adoptions), to refusals by hospitals to recognize the non-pregnant female partner,

Continued on page 13

A Chance to Walk the Talk at the Ethics Educators Conference

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Dr. Jeffrey L. Sternlieb

During the 2011 annual PPA Ethics Educators Conference, an exchange occurred that could, met with the right attitude, guide our organization in creating safe learning spaces. Here's what happened:

The exchange

The chair of the Ethics Committee began by identifying the content of the program for the day and then introduced the "luminaries" present: past presidents of PPA and significant contributors to ethics education. He ended with a specific request to be respectful of each other in our exchange of ideas and then introduced the morning's presenters.

When the first pair of presenters described their roles, the second made a comment about being a longtime sidekick – Robin to the first one's Batman. Immediately, someone in the audience remarked, "Oh, I guess that means you're gay," chuckling as though it were a joke. A ripple of laughter from the audience quickly subsided as the presenters moved on without any comment about the "joke," even though it occurred minutes after the Ethics chair requested sensitivity.

My thoughts

Immediately I struggled. I wondered whether anyone would respond to the remark. I believed we were all, through our silence, colluding with the "joke" and placing in an unfair position anyone who was gay or simply cognizant of the impact of such comments on any minority member.

I shared my concern with a colleague next to me, who did not seem to consider it nearly as significant. I was considering what I should do, but doing or saying nothing was **not** an option. Two choices occurred to me: say something to the entire group, potentially embarrassing the person who made the remark, or say something to him at the break. The former had the potential to interfere with the ethics program; the latter might determine the speaker's awareness of the remark's impact and intent to address it in the larger group. I chose the latter.

The conversation

When I asked the quipster whether he was aware of the possible impact of his comment, he indicated that not only was he aware, but that he had already addressed it during a small-group discussion. He said he regretted it the minute it came out of his mouth, and that he worked with a number of gay clients in a setting in which his comment would have been heard differently. It struck me as a justification rather than an understanding of its potentially negative impact in the current context. He said he appreciated that I brought the concern to him but made no offer to discuss it with the larger group. He had not heard the term "microaggression" when I used it. Included in his small discussion group had been the Ethics chair, who approached while we were talking and asked whether I would be willing to share my experience with the larger group. I agreed.

The organic process

After the morning break, one psychologist, new to the Ethics Educators Conference, questioned how the earlier comment had impacted the learning, sharing environment. This opened the opportunity to share these issues in a natural way, and the Ethics chair publicly invited me to share what we discussed during break. This person's independent concern supported my belief that such comments have an impact. Save for those who speak out, we cannot know how many others have been affected.

I shared my reaction, thought process, and conversation. I then invited the quipster to share his perspective, and he did, explaining that he worked with a largely gay clientele, apologizing to anyone he might have offended, and repeating that he had regretted his remark immediately after making it.

Audience reactions

Some participants thanked the new attendee for her courage in raising this issue, while others commended the quipster for his apology. One asked what the fuss was about, saying she did not recall hearing any offensive remarks. One person rejected the idea that he was collusive, having heard the remark less negatively. Another asked how this had become Jeff Sternlieb's issue. Others expressed discomfort at censoring comments that might be seen as offensive to any one person, resisting "political correctness." One participant noted a significant bias toward calling on male participants to the exclusion of women.

Analysis

All comments struck me as introductory and reactive. No one sought clarification. We did not converse. While no time was scheduled to explore these issues, I was surprised at the lack of informal discussion during lunch or break. These issues seemed too hot to handle and we seemed too uncomfortable to talk about them. Though the exchange introduced the opportunity to learn, our inability to talk effectively stopped us from naming our experience and the concepts involved, including:

- ▸ **Privilege.** Those of us with privilege – especially we who are white, male, heterosexual, and relatively financially secure – tend to minimize the perspectives of those who are marginalized. While none of us want an environment in which we cannot talk about race, sexual orientation, or gender because we are afraid of offending others, we seem to do the opposite: fail to take others seriously when insensitivity is identified. Just because clients or friends are gay does not give us the freedom to make jokes about being gay, particularly among those we may not know well. When any group is singled out, it impacts all groups who have been marginalized.
- ▸ **Collusion** can be active or passive. Active collusion involves direct participation in the offense, and might involve adding to an initial insult or joke, thus amplifying the impact. This "joining in" sanctions the remark, making it easier for others to "pile on" with similar

Continued on page 13

A CHANCE TO WALK THE TALK...

Continued from page 12

comments and more difficult for anyone to object. Passive collusion consists of saying or doing nothing, thereby lending tacit support to an unacceptable statement. To object may be seen as a personal affront, discomfiting, or unnecessarily confrontational.

- ▸ **Microaggressions** are comments that may seem innocent, harmless, or even complimentary but contain demeaning implications or hidden messages. They "...are the brief and everyday slights, insults, indignities and denigrating messages" sent to minorities in subtle, unintended discrimination (Sue, 2010). Sue describes three types: micro-assaults, micro-insults, and micro-invalidations. A useful website, http://microaggressions.com, lists many examples of such comments.
- ▸ **Political correctness.** The primary reason we should not joke about people's race, gender, or sexual orientation is that these characteristics are personal. In the context of a professional exploration of issues, a reference might not be micro-aggressive, but a joke about a minority made as an aside is a personal affront, and to not recognize it as such IS to collude.
- ▸ **Misapplication of Golden Rule.** The Golden Rule, "Do unto others as you would have others do unto you," does not address individual and group preferences; we cannot assume that because a remark might not offend us that it won't offend others. An alternate rule, the "Platinum Rule," can be helpful: "Treat others as they want to be treated," which would require asking rather than assuming.

The fact that one seemingly simple comment raises so many questions, issues, and reactions suggests we in PPA have a lot more to learn. Having a Committee on Multiculturalism and a host of resources (including a CE program) is not a guarantee of progress. Having this experience in vivo can teach more than any didactic exercise.

The comment one person made could have been made by any of us. The real challenge, in my view, is how we respond.

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CLINICAL CONSIDERATIONS...

Continued from page 11

to deciding which partner will be the biological mother. Today's psychologist needs to have at least a basic understanding of fertility, adoption, and donor options for lesbian clients. Lesbian parents may also experience homophobia from teachers, school districts, Boy Scout troops, and others. Psychologists must be aware of local, state, and national laws regarding the protection of LGBT clients in order to best meet their needs. For up-to-date resources for such information in Pennsylvania, see http://www.hrc.org/laws-and-legislation/state/c/pennsylvania.

Lesbian psychologists are also affected by the interconnected nature of the lesbian community (Kessler & Waehler 2005; Brown, 1988). It is not unusual for lesbians to recommend their own mental health provider to friends and colleagues or for a lesbian psychologist to become well known in the community. Given the limited number of lesbian gatherings, a lesbian psychologist may run into clients socially. Consequently, early in therapy a discussion of professional boundaries may be particularly useful.

Finally, all psychologists benefit from ongoing self-introspection and awareness in regard to their own internalized homophobia. None of us, regardless of orientation, are immune from it. Riddle's (1990) scale, which ranges from repulsion to nurturance, is a useful measure to assess one's level of personal comfort regarding sexual orientation. We are ethically bound to recognize our limitations and to refer lesbian clients or consult if our biases or ignorance of a culture may be barriers to treatment. PPA's Multicultural Resource Guide as well as other online resources may assist you in finding LGBT-affirmative therapists in your area for your client and continuing education trainings for yourself. Since we never know whether we may be working with lesbian clients, we must ensure we are providing a supportive and affirming environment for clients of all sexual orientations.

References

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

BEING "OTHER" ...

Continued from page 10

bisexual clients the demand is greater. Therapists working with monogamous bisexual clients can normalize this stress and potential loss for their clients and give them a forum for open discussion. Therapists working with bisexual clients who are maintaining relationships with both a man and a woman can help them negotiate the added complexities introduced by dual relationships.

Over the last 20 years it has gotten easier for clients to tell me about their attractions to men and women. Culturally our country is more open to different sexual orientations, but we still have a long way to go. By considering the challenges our bisexual clients face (even in dating: match.com does not allow a search for men AND women – one is forced to pick one or the other, while eHarmony exclusively serves heterosexual relationships) and by letting clients know you are a safe person with whom to explore sexuality issues, you will be a better psychologist to your bisexual clients. If you haven't read the APA Practice Guidelines for LGB clients and you have LGB clients, take time now to learn more. Listen to your clients, and ask questions of your colleagues and friends – I learn more every day. Our sexuality continues to fascinate, enrich, and challenge many of us and I am grateful for that.

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Who Am I vs. Whom Am I Attracted To

A Crucial Consideration for Working With Sexual Minorities

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Dena M. DiNardo

As a human being, therapist, and student earning a doctorate in professional psychology, I eagerly offered to write about the relationship between gender identity and sexual orientation. In strong support of awareness, I hope to underscore the implication of the concepts as they relate to a controversial but continual evolution of best psychological practice. Specifically, this article seeks to qualify the differences in concrete terms and briefly outline areas for exploration in clinically sound treatment.

Consider this: A first-time client, appearing in age to be mid-20s, walks into your office. About 5 foot 6 and roughly 150 pounds, the client sports short hair, a baseball cap, loose-fitting T-shirt, and baggy jeans. Based on the visual, you are not able to determine whether the client is male or female. Voice and mannerisms offer no further clues. You look at the chart and read "female." What is your next thought?

- If you find yourself wondering whether the client is lesbian, you are questioning the sex of the person to whom the client is sexually attracted. This is *sexual orientation*.
- If you find yourself wondering about the outward expression of this client's physical appearance, you may be questioning *gender identity*.

The first domain: Once upon a time, speculation about a person's sexual orientation ***was*** linked to criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM). If present, the diagnosis was homosexuality. In 1973, that diagnosis was removed.

The second domain: Speculation about the nature of person's gender identity ***is*** linked to criteria in the current edition of the DSM. Criterion-dependent, the diagnosis is gender identity disorder (GID). While these concepts are often considered together, confused as the same, and/or seem to relate only to "the sexual minority population," they have this difference: their relationship to a current DSM diagnosis.

Variance in one's sexual orientation considers the question, "Whom am I attracted to?" The essence of gender identity addresses the question, "Who am I?" We may find that some people choose to express sexual identity as a direct result of whom they are attracted to, in which case, sexual orientation would be considered to have an influence upon one's gender identity. Alternatively, we may find that some people choose to express attraction based upon who they feel they are, in which case gender identity might exert some influence on one's sexual orientation. However, we may also find that in other cases these ideas do not seem correlated at all. Therefore, these concepts serve as the object of analysis both in isolation and in relationship to one another.

Gender identity and sexual orientation are not mutually exclusive. Clients can be oriented to their same sex and clearly represent their physical sex at birth (cisgender), or to the opposite sex and not clearly represent their physical sex at birth, or clients can represent a unique combination that does not seem to follow any socially, biologically, or psychologically constructed formula. This is not to say that the two terms may not be closely related. It is to say that answers about one do not always reveal answers about the other.

Cisgender, or representation of one's physical sex at birth, is not only measured by the degree to which a person seems to dress the part. Understanding gender identity extends outward to all of the ways a person exists in the world. Career choices, peer relationships, preferred recreational activities, role in the context of family, and role in the context of sexual activity serve as relevant, contributing factors to a person's own concept of gender identity. One step further, these factors provide a basis by which others conceptualize a person's gender. Above all, considering any of these components would be useless without acknowledging the impact of even larger forces such as culture, family, religion, and society.

In clinically sound practice, a firm understanding of diagnostic criteria is paramount. So finally, I address the concept of gender identity, given that it is currently linked to a DSM diagnosis. Although it is sometimes tempting, or even easy to judge a book by its cover, we know that an informed review considers all of the chapters. The same goes for people.

The DSM-IV-TR makes a point of distinguishing gender identity disorder from "nonconformity to stereotypical sex-role behavior," pointing out that GID "represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness" (p. 580). However, if someone physically male who enjoys wearing nail polish and presenting other feminine aspects lives in San Francisco, and another does the same thing but is living in Topeka, KS, couldn't we make a very educated guess about how that individual would be received by others in the community? Wouldn't living in one city be more likely than the other to stigmatize in a way that leads to profound disturbance?

If someone physically female who regularly shaves her hair and wears typically masculine clothing enters a dressing room in New York City, and another does the same in Louisville, KY, couldn't we make a very educated guess about how that individual would be received by others in the dressing rooms of each city? Wouldn't clothes shopping in one city be more likely to introduce an experience contributing to profound disturbance in the individual?

The bottom line is that we must consider the phenomenological lives of each client. While we may be acculturated, because of our field, to disregard stereotypes, we still represent a discipline during a time in which some diagnoses may reflect social oppression and not individual disorder. Individually, we are obligated to decide where to draw the line between variance and disorder. I believe we ought to do so from as informed a perspective as humanly possible.

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Apps for Psychologists

Christopher Royer, PsyD; Chair, Committee on Technology Implementation

Dr. Christopher Royer

These days, between iPods, iPhones and iPads, most folks are using apps to stay organized, network, and shop like never before. The question is, how far away is the iPsychologist? This article takes a look at the current state of mobile apps for psychologists.

Apps cost very little. Most are either free or just a few bucks. Apps tend to be simple, giving you access to content from one or multiple websites, or functioning as a standalone program focused on a specific function. Psychology apps are in their infancy, and other general apps can be tailored for use by our field.

The *PAR Assessment Toolkit* (free) gives you a silent stopwatch, a conversion utility for standard scores, z scores, T scores and percentiles, a visual normal curve with conversions, an age calculator and a utility for maintaining compliance with follow-up dates. The *Toolkit* also lets you buy scoring conversions for the BRIEF, the BRIEF-A, BRIEF-P, NEO inventories, the PAI, and the MMSE-2. Each module costs between $4.99 and $7.99.

3D Brain (free) is a fantastic app with just the right level of brain anatomy to help educate clients about brain locations and functions.

Test administration with iDevices has not taken off yet. Tests are expensive. Cost and ensuring user qualifications are still a problem. There's also the issue of personal data stored on a portable device. The touch interface provides a great way to have the subject respond to items.

The Stroop Effect ($ 0.99) asks the test-taker to touch the color that the word is printed in as the stimulus flashes in the screen. The program is very easy to use and the interface is comfortable. We just need some norms!

The *TokenTest* ($2.99) for language disorders is also available. The tokens are reproduced very nicely and a host of test versions can be used. The interface is a bit awkward and needs some work.

The Naming Test and the *Memory Screening Test* ($19.99 each) appear to have some credible press. They are both normed for the iPad, which is important for iTest development, although they have yet to see mainstream use.

On a sad note, for 99¢ you can have your own set of Rorschach plates for the iPad. The images are distorted and stretched lengthwise. The app comes with a "test," which is about as close to the Exner method as Beck is to Freud.

The *Concussion Recognition and Response* app from PAR ($3.99), allows for an on-the-scene assessment of concussion symptoms, as well as follow-up for monitoring of recovery and return-to-play decisions. The app is laid out very well, and the assessment is based on sound clinical standards of care.

HAeval ($2.99) presents a structured interview for headache symptoms, along with assessment of triggers and patterns. The app generates a report based on your findings.

Psychiatry on Call ($1.99) gives the user information on DSM-IV diagnoses and symptoms to use as a companion for a clinical interview.

iCouch CBT ($1.99) gives clients a venue to record and reframe negative thought patterns, and it is very well reviewed by consumers.

PTSD Coach (free) assists clients with assessment and management of PTSD symptoms through education and suggestions for personal behavior change. There is also an extensive set of links to PTSD resources.

There are several self-help modules for AD/HD, adult dyslexia, and autism. Each app costs $4.99. These apps contain the standard checklists to assess how likely a person is to have the diagnosis, and they also give suggestions about interventions and resources.

Breathe2Relax (free) is a great app that presents the user with attractive scenes and sound tracks along with a fully customizable breathing session. The app allows you to set inhale and exhale times, along with the length of the session. The app also asks you to rate your stress at the beginning and end of each session.

For about $25 ($4.99 per module), you can study for the EPPP on your iDevice. I haven't looked at these apps because, well, I don't have to! However, there are some very positive user reviews.

PsycExplorer HD is $2.99 and *Psychology Latest* is free. Both apps give thumbnail sketches of news, videos, and citations that can be followed up for more in-depth information in the app or through links to the Web. Both apps wander into the pop psych arena, although *PsycExplorer* seems less inclined to do so.

iTunes University gives you access to over 500 courses in the field of psychology alone (and thousands in other areas). The courses range from single lectures to complete courses. There are also hundreds of podcasts on iTunes dedicated to psychology and related fields. Like anything else, it's always a good idea to cross check the presenter(s) with reliable sources as to their credentials and areas of competency.

Medline, Pubmed, and APA offer apps for searching for articles and book chapters. Unfortunately, all have been poorly reviewed, mainly for technical issues and crashes.

Popplet ($4.99) offers a nice method of organizing your ideas in a visual manner. It has an easy user interface and many types of files that can be ported into the chart.

APA's *PsycEssentials* ($39.99) provides information about various disorders, assessment, and treatment. APA also released a companion app for the 2011 convention, which was very well reviewed. Access to APA journal abstracts is also available in an app format.

Finally, the recent introduction of interactive textbooks is an amazing opportunity for psychologists. Imagine reading about an intervention and then watching it being performed right on the electronic pages of the same book, or reading about conduction aphasia and then hearing an example of how it sounds at the same time. To see the potential of interactive books, I recommend Al Gore's *Our World* app.

The PPA Committee on Technology Implementation assists PPA members in learning and evaluation of new technologies to improve practice efficiency and patient care.

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

Marti Evans, APA Public Education Campaign Coordinator for Pennsylvania

The vision of the American Psychological Association's current Public Education Campaign focus, *For a Healthy Mind and Body...Talk to a Psychologist*, is to help the public recognize the health benefits of caring for both mind and body. Recent studies and media reports conducted by APA have shown that more people than ever realize that physical health and mental health are intertwined and that psychologists are at the forefront of this public awareness.

More and more PPA members have become active in our Public Education Campaign and have let us know about their outreach activities to the public. We thank them for helping to "make psychology a household word" in Pennsylvania.

The members of the E-Newsletter Committee continue to make psychology a household word by publishing PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." **Rachael Baturin, MPH, JD,** and **Drs. Gail Cabral, Holly Kricher, David R. Leaman, Marolyn Morford, Michelle Reich, James J. Stone, Christie Sworen-Parise,** and **Pauline Wallin** contributed articles for the December 2011 and March 2012 issues. The e-newsletter creative director is **Dorothy Ashman**. The chair of the E-Newsletter Committee is **Dr. Christina Carson-Sacco**.

Dr. Julie Allender, an avid gardener, was interviewed for an article, "Fear Factor Opens a New Market for Seeds," in the April 28, 2011, edition of the *Philadelphia Inquirer*.

On February 22, **Drs. Judith Blau** and **Audrey Ervin** conducted a workshop for 34 people at the Central Bucks Family Y entitled, "Appropriate Responses to Members' Emotional Needs."

Dr. Hazel Brown runs a support group on the first Monday of every month for seriously mentally ill individuals and their families for a local affiliate of the National Alliance on Mental Illness (NAMI) in Camp Hill.

The *New York Times* interviewed **Dr. Alycia A. Chambers** for an article in their March 24 issue, "Sandusky Investigation Drew Psychologist's Alert in 1998, Report Says." She was also interviewed by the *Centre Daily Times* in State College for an article in their March 26 issue, "Timeline of 1998 Investigation of Jerry Sandusky."

Dr. Helen Coons presented "Helping Women with Breast Cancer Talk to Family and Friends" to HelpLine volunteers in December. **Dr. Michael Crabtree** was interviewed by the *Observer-Reporter.com* for an article on November 20, "Lacking Reliable Profile, Pedophiles Hard to Identify."

On October 27, **Dr. Ann Durshaw** presented "Chronic Disease and Mental Health" at the Capital Health Diabetes Education Program in Hamilton, New Jersey. **Dr. Sue Ei** was interviewed for an article, "Bloom Psychological Center Helping Those Affected by Flood," in the February 1 edition of the *Bloomsburg Daily*. The center, owned by **Dorothy Ashman, MA,** and its staff donated space and staff to create a flood support group for community members impacted by the flood in September.

Dr. Audrey Ervin presented "The Invisible Color of Privilege: What It Means to Be White" on October 5 at the Delaware Valley College (50 people), "Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth" on October 7 at the Delaware Valley College Networking for Youth Conference (35 people), "Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth" on December 7 for the Bucks County Children & Youth staff at Doylestown Senior Center (200 people), "Overcoming Procrastination: Practical Strategies for Change" at the Doylestown Health and Wellness Center in Warrington (50 people), and "Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth" on January 23 to 50 teachers and counselors in the Central Bucks School District.

In light of the Penn State child abuse scandal, **Michael Gillum, MA,** was interviewed for an article, "Victim One Triggered Investigation of Jerry Sandysky," in *USA Today* on November 10, and was interviewed by Anderson Cooper on November 11 on CNN's AC360.

Dr. Deborah Derrickson Kossmann was interviewed for an article in the *New York Times* on December 15 on marriage repair.

Dr. Theresa Kovacs has presented several workshops at the YMCA in Dunmore: "Losing the Fear: Living in Recovery from Breast Cancer" in October (14 people), "My Personal Journey: How to Think Healthy" in November (10 people), "ABC's of Letting Go of Negative Thinking" in November (18 people), and "Lessons of Love: Forgiveness and Healing" in November (11 people).

Drs. Marolyn Morford and **Cindy MacNab** were interviewed for an article in the March 28 edition of the *Centre Daily Times* in State College, "Sandusky Case: Man Who Evaluated Alleged Victim Was Not Yet Psychologist." **Pamela G. McCloskey, MEd,** a licensed psychologist in Milesburg, participated in a live call-in program with a panel of experts on November 17 on WPSU-TV and WPSU-FM in State College on "Confronting Child Sexual Abuse."

Dr. David Palmiter was interviewed for an article on October 18 in the *Wall Street Journal*, "Help Wanted: a Good Therapist"

and an article on January 19 in *USA Today*, "Many with Mental Illness Go Without Treatment." He was also interviewed by WNEP-TV in Scranton on February 21 for "Know the Signs of Child Sex Abuse."

The chair of PPA's Public Education Committee, **Dr. Nicole Quinlan**, was interviewed by WVIA on November 15 for a "Call the Doctor" live broadcast on "Sexual Abuse: Healing the Victims." In February she did a radio interview with WPGM on the "Psychological Impact of Overweight." The *Danville News* interviewed her for a December 21 article on child sexual abuse, "Know the Warning Signs."

On November 16, **Dr. Elaine Rodino** and members of the **Central Pennsylvania Psychological Association** provided the *Centre Daily Times* in State College with resources for victims of child abuse.

Dr. David Rogers of Hershey Psychological Services has presented numerous workshops to members of the Pennsylvania State Police Member Assistance Program, including "Healthy Decision Making: Dealing with Stress" on October 5 (100 members). He presented "Cherishing Our Differences" on April 26 to residents at Messiah Village.

Dr. George Schmidt did a presentation on "Self-Esteem and Intimacy" to 24 men in the Prostate Cancer Center's Man to Man Support Group in Camp Hill in January.

Dr. Christie Sworen-Parise participated in "Mental Health Matters," a monthly TV show at Marywood University, in January on the topic of anxiety.

Dr. Ari Tuckman, an international expert and leader in the area of attention deficit/hyperactivity disorders, was the recipient of the Pennsylvania Psychological Association's 2011 Psychology in the Media Award. Dr. Tuckman makes consistent and ongoing contributions to public education by creating podcast episodes of his series, "More Attention, Less Deficit." This two-year-old project includes more than 200,000 downloads.

Dr. Pauline Wallin writes a column, "On Your Mind . . . With Pauline Wallin" for the *Body & Mind* magazine published by the *Patriot-News* in Harrisburg six times each year. Recent topics have included, "Dropping a Bad Habit? Make the Hurdle Easier to Clear," "Yelling Too Much? Reconsider Angry Feelings," "How to Stay in Love with Your Spouse for Decades," "Why Adult Siblings Fight at Family Get-Togethers and What You Can Do About It," and "Dealing with Disappointment in Your Baby's Gender." Dr. Wallin presented "Why You Procrastinate . . . And How to Stop" on January 20 in New Cumberland to 50 members of the Pennsylvania Society of Association Executives. The New Children's Museum of San Diego interviewed her for an article, "Bringing Joy to Your World," on December 1 on managing the stress that is as much a part of the holiday season as anything else. The *Chicago Tribune* interviewed her for an article on December 31, "Resolved: Stop Setting Unreachable New Year's Goals." A recipient of PPA's Psychology in the Media Award in 2002 and 2005, Dr. Wallin continues to actively reach out to the media nationally and internationally to help make psychology and psychologists a household word.

Want *your* name in our next article?

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

- Your name
- Title of your presentation
- Name of the group
- Date of presentation
- Location of presentation (city/state)
- Number of people present

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details!

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

PPA Award Recipients Contribute in Impressive Ways

Paul Kettlewell, PhD, Awards Committee Chair

Dr. Paul Kettlewell

On Friday, June 22, 2012, at our annual convention, a broad range of impressive individuals who have contributed to our society and PPA will receive awards.

- As a pioneer in advocating for mental health services for gay and lesbian individuals, **Dr. James Huggins** co-founded the Persad Center in Pittsburgh, which has provided clinical services to sexual minority populations for almost 40 years. PPA recognizes Dr. Huggins's unique and courageous service with the **Public Service Award**.
- **The Honorable Timothy P. Briggs**, a member of the Pennsylvania House of Representatives, also receives the **Public Service Award** for his leadership in securing passage of the Safety in Youth Sports Act. His persistence in support of this legislation and in support of the role of neuropsychologists in managing concussions led to this legislative victory to protect our youth who participate in sports.

Continued on page 20

The Hate That Lingers: LGBTQ Teens Face Discrimination, High Suicide Risk

Terri Erbacher, PhD, and Charla Curtis, MS, Philadelphia College of Osteopathic Medicine

In a society where bigotry is not tolerated, racism is unacceptable, and prejudice frowned upon, why is such stigma still attached to sexual minority members? Many youth who identify as LGBTQ do not talk about, and often attempt to hide, their "differences," fearing rejection. Consequently, many sexual-minority students feel isolated from those around them.

Schools can be particularly hostile places for many LGBTQ students, who become vulnerable to verbal harassment or bullying by peer groups. Results of the 2009 Gay, Lesbian and Straight Education Network (GLSEN) National School Climate Survey, which surveyed more than 7,200 LGBTQ students, found that more than 70% of respondents hear homophobic remarks frequently at school. Further, more than 18% reported that they had been physically assaulted because of their perceived sexual orientation and 12.5% assaulted for their gender expression. More than 60% of these incidents were never reported because students did not believe any action would be taken by school personnel. When incidents were reported, almost one-third of students surveyed said the school was not responsive (GLSEN, 2010). It seems many school staff members are neither prepared nor motivated to intervene on behalf of LGBTQ youth (Elze, 2006). In one study, only one-fifth of guidance counselors had received training on serving LGBTQ students, and two-thirds had negative feelings toward non-heterosexual youth (Prezbindowski & Prezbindowski, 2001). It seems that while anti-Semitic comments, racial slurs, and gender stereotyping are no longer tolerated, discrimination against those who identify as LGBTQ continues.

Hostile reactions are not restricted to the school. More than half of LGBTQ students surveyed by GLSEN indicated that they were harassed or threatened by peers via electronic media. One study found that victims of cyberbullying had higher levels of depression than victims of face-to-face bullying (Wang, Nansel & Iannotti, 2010). While bullying itself does not lead to suicide, it increases risk for those who are already struggling with internalizing problems (including withdrawal and anxiety/depression), low self-esteem, low assertiveness, and aggressiveness (Arseneault, Bowes, & Shakoor, 2010).

Dr. Terri Erbacher

Charla Curtis

The nature of the suicide problem

LGBTQ youth contemplate and attempt suicide at a rate 2–4 times higher than that of their heterosexual peers (Suicide Prevention Resource Center [SPRC], 2008); more than 20% of LGBTQ youth report having attempted suicide in the past year (Hatzenbuehler, 2011). Of particular concern is that Safren and Heimberg (1999) found that 58% of LGBTQ individuals who had attempted suicide reported that they had really hoped to die, in contrast to 33% of heterosexuals. LGBTQ youth even face prejudice from their own families, with those experiencing severe family rejection being 8 times more likely to have attempted suicide (Ryan, Huebner, Diaz, & Sanchez, 2009).

What schools can do

While comprehensive school-based programs can help prevent suicidal behavior, SPRC (2008) identified only one program with a primary focus on preventing LGBTQ suicide. The Trevor Project operates the nation's only 24-hour, toll-free suicide prevention helpline for LGBTQ youth (1-866-4-U-TREVOR).

Because the risk of attempting suicide is 20% greater in unsupportive environments (Hatzenbuehler, 2011), supporting the development of Parents and Friends of Lesbians and Gays (PFLAG) groups, LGBTQ support groups, and Gay-Straight Alliances (GSAs) may help to reduce the isolation of LGBTQ youth and create the social supports intended to protect against suicidal behavior. Students in schools with GSAs report hearing biased or homophobic language less frequently, are more likely to feel safe, and can identify with adults and peers at school who are supportive of them (GLSEN, 2007).

Further, gatekeeper training is important to teach staff to recognize youth at risk for suicide and refer them for help. Peer gatekeeping programs may also be effective, because LGBTQ students often first confide their problems to peers before adults. Gatekeeper training can include education on warning signs for suicide, the risk and protective factors for suicidal behavior in LGBTQ youth (SPRC, 2008), and steps to take when concerned that someone may be suicidal, such as referrals to mental health services.

The following are also suggested (SPRC, 2008):

- Institute and enforce anti-bullying and non-harassment policies for LGBTQ youth.
- Start prevention early, because children often realize their sexual orientation at an early age.
- Include material on LGBTQ youth in health curricula and education.
- Make accurate information about LGBTQ issues and resources readily available. Diversify library and media holdings.
- Do not assume heterosexuality. Simple questions such as "Do you have a girlfriend?" to a male student may alienate him.
- Ensure adult supervision, especially on playgrounds and in labs.
- Keep up with technology; bullying often takes place in areas hidden from adult supervision.

Continued on next page

504 Adaptations for ADHD Students – A Different Era?

Timothy L. King, PhD, drztlk@aol.com

Dr. Timothy L. King

About a decade ago, a counselor at a private high school in the area shared with me that she had just received a two-sentence statement from a psychologist requesting extra test-taking time for one of his ADHD clients. She said she knew she had to get a notice to faculty right away to put the accommodation in effect. Not these days.

Not too long after the above incident, an elementary-school principal said she would accept my recommendation for a 504 accommodation plan for a student in her public school and simply have her secretary retype all of my recommendations and re-label them "Accommodation Plan." Not these days.

So, exit the era of simple accommodation access for ADHD students and enter the era of Student Assistance Teams, 504 planning committees and even "pre-accommodation" plans (i.e., venues that must be explored and utilized before an accommodation plan can be established) – all of which could potentially be the first hurdle a psychologist must guide parents over before a student's eligibility for accommodations can be determined. Access to accommodations for the ACTs, SATs, LSATs and GREs now has become a more complex road for a psychologist to guide parents down, as well. Guidelines related to performance-competence discrepancies have been replaced, according to McKethan (2012), by the Office of Civil Rights's (OCR) guideline of "typical person" (i.e., a disability is not a disability unless it impairs one's functioning to a level below that which is acceptable/average for an individual of one's age). Recent achievement tests such as the Wechsler Individual Achievement Test III (NCS Pearson, 2009) now define "the average range" as extending down to a standard score of 85 (approximately 16th percentile).

ADHD expert Russell Barkley (2008) continues to assert that students with this disorder do not need extra time, they need "breaks." Other clinicians/researchers argue that extra time interferes with identifying students who are academically competent and allows students to use strategies other than cognitive sophistication to attain entrance into advanced coursework and programming. This latter group believes the accommodation should be eliminated altogether and that slow-producing students should simply be trained to utilize more efficient test-taking strategies.

Further, in recent years, even at a collegiate level, some institutions have insisted, "Don't send a report; just send the numbers [computer-generated test scores]. If the numbers don't show a disability, the student is not eligible for any accommodations." Other colleges require clinicians to complete a detailed accommodation application justifying a student's disability, even if a report has been prepared. Students themselves are now being required to complete "impact statements" to display their awareness of how their disability impacts their educational functioning.

Confused yet? As though the above elements of the accommodation application process were not challenging enough, consider that private schools at both high school and collegiate levels can sometimes be more flexible than their public institution peers in permitting students access to a variety of accommodations such as separate, reduced-distraction environments for test-taking and backup notes for classes with more extensive note-taking requirements.

While some, like Barkley (2008), insist that new, more stringent 504 eligibility guidelines offer clinical clarity to the disability-judgment process, other clinicians

Continued on page 20

Continued from previous page

Institute protocols for appropriate response if a student is identified as at risk of self-harm.

What school psychologists can do

One way in which psychologists can better serve LGBTQ youth is by using a cultural competence model; school psychologists need to make their sensitivity to LGBTQ issues clear. Morrow (2004) suggests the following:

- Assess the degree of LGBTQ identity development.
- Assess the level of disclosure of sexual orientation to others; help young people carefully explore the advisability and consequences of disclosure.
- Assess safety. LGBTQ youth can be at risk of violence, suicidal ideation, substance abuse, self-harm, and depression.
- Provide accurate educational information on sexual orientation and gender identity, given that such material is often excluded (or presented inaccurately) in health classes.
- Display LGBTQ-supportive literature and signs.
- Advocate for enhanced social services, a more supportive school environment, civil rights, and social change.

References are available from the first author at terbacher@dciu.org or on the PPA website, www.PaPsy.org.

504 ADAPTATIONS FOR ADHD STUDENTS – A DIFFERENT ERA?

Continued from page 19

wonder whether the changes are, at least in part, financially or politically motivated. Put simply, they suspect institutions may be creating obstacles to the development of 504 plans because more knowledgeable parents and students are challenging schools to update as well as enforce them, thereby drawing funding from already shrinking school budgets.

The intent of this article is not to propose a solution to this debate but rather to aid psychologists in supporting their ADHD clients in need of 504 interventions by offering guidance about the complexity that now surrounds their creation and continuance. In the service of the latter goal, psychologists are encouraged to keep in mind the following:

1. A diagnosis of ADHD (or even a previously existing accommodation plan generated by a school a client previously attended) does not automatically provide students with entitlements or guarantees. Federal guidelines require that schools complete their own evaluation of a student's eligibility and need for accommodation. These are separate: The school may agree that a student is eligible for accommodations but not believe there is a need. For example, a second grade student with ADHD and slow processing/production speed may be eligible for extra time or supports such as reduced board copying but not have a need for such interventions in the second grade. Consequently, a psychologist working with parents of an ADHD student should make them aware that schools must do their own assessment of a student's needs and eligibility even if they have already been tested.

2. Be aware that ADHD is rarely a "lone ranger." Barkley's (2008) research has identified that fewer than 25% of individuals with ADHD have only attention/impulse regulation problems. Encourage parents to seek further testing through their local school district or privately if an ADHD student is having significant/substantial academic problems to rule out the possibility of underlying learning or information processing/retrieval issues. However, not all ADHD students will meet the eligibility criteria for accommodations. Sometimes, even in high school and college, students' needs may be stronger for tutorial support that focuses on "re-processing," test preparation and aiding assignment completion rather than on extra time.

3. Keep in mind that ADHD students may not always need extra time to finish a test, but they may need extra time to finish it accurately. Many ADHD students offered the accommodation of "extra time" refuse it, claiming they don't need it. Helping them to address their problems in test-taking accuracy by, for example, utilizing "re-do's" in math testing (re-doing as many math problems as possible on a separate sheet of paper and comparing them with their original productions) may be the only way they can reliably discern their errors.

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PPA AWARD RECIPIENTS...

Continued from page 17

- **Dr. Andrea Delligatti** will receive the **Distinguished Service Award** for her outstanding service to the Pennsylvania Psychological Association. She has been a tireless contributor to PPA in many roles including chair of the Program and Education Board and president. She has been a powerful advocate for leadership development in PPA and has been a mentor to many of us.
- The **Distinguished Service Award (Posthumous)** will be presented to **Dr. Stephen N. Berk**, who died in February 2012. Dr. Berk was widely respected and loved and served gracefully and effectively in many roles in PPA for 25 years, including president. He was an outstanding force for psychology and his fellow citizens.
- For his vision and professional accomplishments **Dr. Edward O'Brien** receives the **Award for Distinguished Contributions to the Science and Profession of Psychology**. As chair of the Department of Psychology and Counseling at Marywood University he has led many noteworthy initiatives and advances including the development of their PsyD program. He has been a prolific researcher and developed a widely used self-esteem assessment tool.
- **Maiken Scott**, the Scattergood Foundation Behavioral Health Reporter for WHYY public radio in Philadelphia, and the executive producer of "Voices in the Family" with Dr. Dan Gottlieb, will receive the **Psychology in the Media Award**. She researches and reports on a wide range of psychology-related topics of interest to the general public.
- For exemplifying an excellent professional presence in the media both locally and nationally, **Michael Gillum, MA**, will also be a recipient of the **Psychology in the Media Award**. Mr. Gillum was instrumental in launching the investigation into the alleged Jerry Sandusky child sex abuse scandal which has garnered national media attention.
- The **Award for Distinguished Contributions to School Psychology** will be presented to **Dr. Gail R. Karafin** for being a voice advocating for school psychologists in Pennsylvania and for making significant contributions to the Pennsylvania Psychological Association. From 2007 to 2011, Dr. Karafin served as chair of PPA's School Psychology Board.

Come to the award ceremony at the PPA Convention and celebrate the work of these outstanding individuals.

Internet Resources for Sexual Minorities

Edward Zuckerman, PhD


Dr. Ed Zuckerman

The social advantage of the Internet is that it allows relationships to develop regardless of the usual barriers of distance, cost, time, social class, ethnicity, and age. For minority populations, this is particularly important, because it allows individuals from groups who are a fraction of the population to find each other with fewer constraints, breaking a long history of relative isolation.

In addition to the direct connections through dating and chat sites for sexual minorities, a number of resources providing accurate, relevant, and helpful information exist. Some of these are:

Resources from the American Psychological Association

- A "Fact Sheet" on sexual orientation and youth designed as a "Primer for Principals, Educators, & School Personnel" at http://www.apa.org/pi/lgbt/resources/just-the-facts.aspx. It is designed to counter, using facts and the best professional opinions, "... the promotion of therapies and ministries to change sexual orientation (attraction to the other sex, to one's own sex, or to both)."

  Its eight pages address the development of sexual orientation, efforts to change sexual orientation through therapy (with position statements from the major organizations), efforts to change sexual orientation through religious ministries (briefly noting that their emphasis on sin and redemption would increase marginalization and likely harassment, harm, and fear of minority students), relevant legal principles, citations, and a long list of links to relevant organizations.
- A seven-page guide at "Selected Healthy LGB Resources" (http://www.apa.org/pi/lgbt/programs/hlgbsp/sites.aspx) includes links to dozens of quality resources for schools, teachers, pupil services professionals, families, and community organizations.
- "Transgender Identity Issues in Psychology" (http://www.apa.org/pi/lgbt/programs/transgender/index.aspx) is a brief but rich meta-site from which to explore gender variance.
- "The Healthy LGB Students Project" (http://www.apa.org/pi/lgbt/programs/hlgbsp/health.aspx) is an extensive site that offers data and citations on health risks, school climate and policies, and workshop materials for school staff development.

For Schools

Additional materials and supportive guidance for school settings are available from other sites, such as:

- The National School Boards Association (www.nsba.org) provides legal guidance for school personnel. A hard-hitting Q&A available at http://www.nsba.org/DealingwithLegalMattersSurroundingSexualOrientation.
- A page at the Safe School Network (http://www.safeschoolscoalition.org/RG-law_policy_guidance.html) links to most of the best resources for coping with school discrimination, bullying, and laws and legal decisions.

For friends and family

The organization Parents, Families, and Friends of Lesbians and Gays (at www.pflag.org) has a long history, extensive connections, and rich resources. Under the link "Education and Programs" are detailed and complete guides for making schools safer. Local chapters can offer direct support for those concerned about any sexual minority issue (including bisexual and gender variant, not just lesbians and gay men and their families, as the name might suggest). The *FAQ* and *Terminology* pages have solid and pertinent information. Under the tab "Transgender" at the top of the pages is TNET, a major project and resource pool with legal resources, book reviews, handbooks, and newsletters. The downloadable, 58-page *Welcoming our Trans Family and Friends* is a particularly fine introduction.

Focusing on the legal aspects of discrimination, the ACLU has many resources and is available to help (see http://www.aclu.org/lgbt-rights/lgbt-youth-schools). Their guides direct users to the relevant laws and provide a list of rights, a way to change schools, and specific legal supports for counteracting discrimination and harassment. The ACLU project "Lesbian Gay Bisexual Transgender Project: Schools and Youth" offers tips for schools and community, statistics on gay youth, and how to contact the ACLU for help and information.

Similar and equally effective but smaller and more focused is the National Center for Lesbian Rights (www.nclrights.org), whose materials focus on legality, including current news and legal cases regarding marriage, elder law, parenting, and sports. Legal consultation is also available. Somewhat similar is GLSEN, the Gay Lesbian Straight Education Network (at www.glsen.org).

For professionals

From a more clinical perspective, The World Professional Association for Transgender Health (at www.wpath.org) offers journals, members who may help, and a formal document: *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*.

From a medical perspective, there are those diagnosed with disorders of sex development (DSDs), involving congenital anatomical, chromosomal, and gonadal development (http://www.dsdguidelines.org/htdocs/clinical/index.html), information about which can be found in the handbook *Clinical Guidelines for the Management of Disorders of Sex Development in Childhood*. Also available is a handbook for talking to parents about these issues.

For individuals

- The most publicized therapeutic intervention is Dan Savage's It Gets Better Project (at www.itgetsbetter.org), whose hundreds of autobiographical videos, along with book versions,

Continued on page 24

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 June 30, 2014.

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.

DeWall

1. The rate of reporting suspected child abuse in Pennsylvania since 1976:
   a. has fallen steadily
   b. has increased steadily
   c. has stayed about the same
   d. is unknown, since the data is not available

Baturin

2. Which of the following statements is FALSE:
   a. The supervisor and supervisee must not be in a dual relationship.
   b. The supervisee can pay the supervisor for supervision.
   c. Supervisees can complete their training in two different sites as long as they are at each site for 6 consecutive months.
   d. The supervisee should check to see whether the supervisor has been subject to any disciplinary actions by the State Board of Psychology.

Nelken

3. The core issue that can be seen as underpinning sexual minority stigmatization is:
   a. the refusal of sexual minority members to adopt a more conventional presentation
   b. sexism, which leads to a particular devaluation of gay men who "flame," transwomen, and lesbians
   c. fear of a rapid decline in population
   d. ageism
   e. internalized homophobia

Osborne

4. In a recent study, what percentage of transgender respondents had attempted suicide?
   a. 41%
   b. 34%
   c. 18%
   d. 50%

5. "Gender Queer" identity describes individuals who are:
   a. gender fluid
   b. a third gender
   c. non-gendered
   d. all of the above

Huggins

6. Because gay relationships comprise two men, competition similar to that between heterosexual men is rarely present.
   True
   False

7. Gay men in non-monogamous relationships report less satisfaction with the relationship than do gay men in monogamous relationships.
   True
   False

Chubb

8. APA Practice Guidelines for LGB Clients state that:
   a. all people are basically bisexual
   b. bisexuality is a stage of early to mid-psychosexual development
   c. bisexuals have unique experiences
   d. bisexuality is an effective means of avoiding homophobia

DiNardo

9. Gender identity disorder is differentiated in the DSM-IV TR from:
   a. homosexuality
   b. conformity to sex-role behavior as influenced by culture
   c. nonconformity to stereotypical gender-role behavior
   d. nonconformity to stereotypical sex-role behavior

Stanley

10. Which of the following is NOT the case for lesbian clients:
    a. Many lesbians remain friends with their ex-partners.
    b. A lesbian psychologist should discuss with her lesbian client early in their work the possibility of running into each other at social events.
    c. Research suggests most lesbians feel disdain for heterosexual or gay men.
    d. Lesbians in non-urban areas can benefit from finding support from other LGBT individuals online and through professional networks.
    e. It is important to understand the difference between self-identification and behavior for lesbians.

King

11. A student diagnosed with ADHD:
    a. is automatically eligible for some test-taking accommodations
    b. is not eligible even if tested privately
    c. is eligible if their local school district assesses them and finds that they meet eligibility requirements
    d. is eligible only if their local school district finds they meet eligibility requirements and have a need for accommodations

Zuckerman

12. One good online source of support for a despondent, bullied, and/or isolated gay teen mentioned in the article might be:
    a. Colage
    b. the DSD handbook
    c. the Matthew Shepard blog
    d. the It Gets Better Project
    e. none of the above

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, June 2012

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

1.	a	b	c	d		**7.**	T	F			
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	e
5.	a	b	c	d		**11.**	a	b	c	d	
6.	T	F				**12.**	a	b	c	d	e

Satisfaction Rating

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

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

Comments or suggestions for future issues _____

_____

Please print clearly.

Name _____

Address _____

City _____ State ____ ZIP _____ Phone ( ) _____

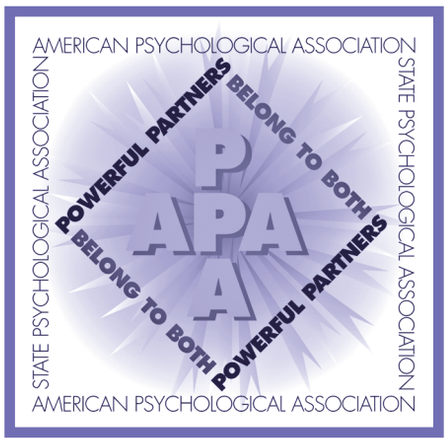
I verify that I personally completed the above CE test.

Signature_____ Date_____

A check or money order for $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.

Welcome New Members

We offer a massive, monumental, mighty welcome to the following new members who joined the association between February 1 and April 30, 2012!



NEW FELLOWS

Joseph Bene Jr., PsyD
Lebanon, PA

Jo-Ann Cohn, PsyD
State College, PA

Adrienne Garro, PhD
Chalfont, PA

Harold J. Miller, EdD
Fayetteville, PA

Rose C. Murr, PsyD
Wynnewood, PA

Maureen L. Osborne, PhD
Malvern, PA

Laurie Roehrich, PhD
Indiana, PA

Kurrie Wells, PhD
Collegeville, PA

NEW MEMBERS

John W. Beiter, PhD
Mount Washington, PA

Sheryl Berardinelli, PsyD
Mount Laurel, NJ

Jyothsna S. Bhat, PsyD
Lawrenceville, NJ

Mitra Y. Gilbert, PsyD
Philadelphia, PA

Suzanne G. Goldstein, PhD
Ft. Washington, PA

Johanna R. Isaacs, PsyD
Philadelphia, PA

Kristina P. Lloyd, PsyD
Harrisburg, PA

Roger K. McFillin, PsyD
Macungie, PA

Laurane S. McGlynn, PsyD
Easton, PA

Iris Paltin, PhD
Philadelphia, PA

Edmund L. Riccio, PsyD
Lafayette Hill, PA

Barbara A. Thompson, MS
Pittsburgh, PA

Kristie L. Zoller, PsyD
Cranberry Township, PA

STUDENT TO MEMBER

Ciarán J. Dalton, PsyD
Wallingford, PA

Diane C. Shaffer, PsyD
Swarthmore, PA

Marie C. Weil, PsyD
Big Spring, TX

Jared L. Young, PsyD
Elizabethtown, PA

NEW STUDENTS

Marykate Burke, BA
Philadelphia, PA

Elizabeth G. Conlin, MS
West Chester, PA

Melissa Coppola, MA
Hazlet, NJ

Tiffany L. Gillie, MSEd
Pittsburgh, PA

Jennifer A. Greiner, MA
Reading, PA

Katie Herbster, BA
Scranton, PA

George Herrity, MSW
Pittsburgh, PA

Adam Kaluzshner, BA
Philadelphia, PA

Jennifer A. Kehoe, MA
Tannersville, PA

Shari R. Kim, MS
Jacobus, PA

Vanessa S. Kim, MS
Blue Bell, PA

Scott I. Levson, MA
Bensalem, PA

Sara A. Mix, BA
Philadelphia, PA

Christian H. Monson, MS
Temple, PA

Myra K. Ortega, BA
Bensalem, PA

Natalie A. Rahm, BA
Collegeville, PA

Melissa D. Scotch, MS
Union Dale, PA

Amanda L. Sellers, MS
Slatington, PA

Christine Wojnicz, MA
Philadelphia, PA

INTERNET RESOURCES FOR SEXUAL MINORITIES

Continued from page 17

have reached thousands with the message of hope. The videos can be viewed through the website. If you are touched, you can contribute, join, or organize.

- Colage's (http://www.colage.org/) mission is distinct from most: supporting those with a LGBTQ parent. The site offers first-person stories, political commentary, and humor.
- Lyric (at http://lyric.org/home.html) is a very rich meta-site for young people and their friends. For example, there are hundreds of links under its resources that provide community-building support for inspiring social change for LGBTQ youth.
- The Trevor project (http://www.thetrevorproject.org/) strives to prevent suicide among LGBT youth through testimonials, help lines, and educational resources. Support crosses every format, from chat to "Ask Trevor" to the social networking Trevorspace.
- And finally, a fascinating blog (http://jamespatemd.com/) by an OB/GYN resident offers many lively issues and information you definitely did not know.

Classifieds

POSITION AVAILABLE

SEEKING PART-TIME LICENSED DOCTORAL PSYCHOLOGISTS, who are Medicare providers or Medicare eligible, to do consultations and provide follow-up treatment to geriatric residents in rehabilitation facilities and skilled nursing homes in Montgomery, Bucks, and Chester counties. Training is available. If interested in working in a highly rewarding setting, please contact: LMF Psychological Services, LLC, PO Box 237, Hatfield, PA 19440; Ronda White at 215-362-1420 or e-mail at lmfpsych@hotmail.com

OTHER

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

MMPI-2 OR MMPI-RF? BIG-5? PAI? Why not all in one report with 187 scales? Request a sample report at rmgordonphd@rcn.com or www.mmpi-info.com.

BHRS EVALUATION PRACTICE (WRAP AROUND) FOR SALE. Evaluations of children and teens one day a week with current appointments scheduled into the future. This is a turn key operation in a commercial area on the first floor facing a major shopping area in Hermitage, PA, Mercer County Premises have been remodeled to suit and are leased to include two clinical offices, reception, rest room, and waiting area. Included are furnishings, four years of electronic records and a competent associate who may chose to continue if desired. Associate needs only your presence for supervision and review of completed evaluations one day a week. Current practice involves between 8 and 16 evaluations weekly, with excellent growth potential the remainder of the week. Please call Shannon at 724 630 3978 for information.

MOTIVATION CARDS by Dr. Julie Ann Allender; they are designed to help motivate everyone to have a better day. Each card is created with a photo chosen from an extensive photo library & includes a motivational saying. The deck of 54 cards comes with a purple collapsible desk holder for portability. $15 per set. Quantity discounts available. Cards can be viewed & ordered from www.pettherapyparadisepark.com or office: 215-799-2220.

FURNISHED OFFICE FOR RENT – Available 3 days per week in small group practice location. Access/use of facilities including waiting room, restrooms, conference room and kitchen as well as office equipment. Prefer psychologist or LCSW. Rates negotiable. Contact Lou Poloni, Ph.D. at DrPoloni@ptd.net or 717-741-4071.

OFFICE SPACE CENTER CITY, NEAR RITTENHOUSE SQUARE. Share with other mental health professionals. Bright well-appointed offices with waiting room in secure, hi-rise building. Near parking, shops, dining, transportation. Available by day, evening or weekend. Reasonable rates. Contact: Joanne Buzzetta, 215-636-0336.

Vol. 72, No. 6

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2012 CE Calendar

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

June 20 – 23, 2012
Annual Convention
Hilton Harrisburg
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

November 1 and 2, 2012
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

April 4 and 5, 2013
Spring Continuing Education and Ethics Conference
Monroeville, PA
Marti Evans (717) 232-3817

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.

also available at www.PaPsy.org – HOME STUDY CE COURSES

*Ethical Practice Is Multicultural Practice** – NEW!
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

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

*Ethics and Professional Growth**
3 CE Credits

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

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

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

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

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