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President’s Column

Pat DeLeon

Independent Practice Under the Affordable Care Act

Trends in Malpractice Litigation


Growing and Sustaining a Private Practice

Moms in Independent Practice: One Mom’s Story

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President’s Column
Promoting a Culture of Inspiration and Innovation in Practice
— June W. J. Ching

I am truly honored and blessed with the opportunity to serve as the first Asian-American woman president of Division 42. As a diversity leader, this is particularly meaningful to me, as it reflects an integral characteristic of our division that not only values differences, but fosters inclusiveness and recognizes the strength and richness diversity brings to the composition of 42. My overarching mission this year is to expound upon key values from my diversity background to promote and build upon the unique culture which makes 42 a great division. As you can imagine, being born and raised in Hawaii as a second generation Chinese-American makes culture huge for me.

Why did I join Division 42? Because I was invited. Why have I remained active in Division 42, making it my primary home? Because the core cultural values and visions in our division closely parallel that of my own. It is meaningful to me that members come first. The Division perpetuates a supportive community which enables us to work towards a common goal of thriving in professional practice. We are also invested in the future generation of psychologists. These salient underlying principles are in concert with my personal cultural norms -- living with “Aloha,” which embodies sharing in the breath of life and denotes a way of treating each other with care and respect; the importance of “Ohana” in which family, relationships, and the extended community are paramount; and the paradigm of “collectivism,” which addresses the needs of the group taking precedence over that of an individual, while working towards goals through active collaborations and joint efforts.

Culture of Division 42
During the wrap up session at our third annual Fast Forward Innovative Conference, I was touched by a statement expressed by a first time early career psychologist (ECP) member. He noted that private practice can be isolating and what he appreciated the most about our conference was the sense of caring and support which was generated by the 42 community. This indeed depicts an essential aspect of Division 42’s culture; one in which ECPs are provided avenues in which they can network and connect within a community that encourages and sustains them.

It’s exciting to be advancing a culture in 42 which engages in the collective talents of our members, fosters a staunch advocacy agenda, promotes innovative models of practice, addresses business of practice concerns for members, facilitates diversity initiatives, provides opportunities for clinical learning, and mentors ECPs in the leadership pipeline.

Some of my presidential initiatives are focused on activities that translate new visions into actions. However, many of my additional goals are direct outgrowths of the initial building blocks that were developed by an exceptional series of Division 42 Presidents. Going forward, I am therefore standing on the shoulders of dedicated and remarkable prior Presidents - Lisa Grossman, Nancy Molitor, Jeff Younggren, Steve Walfish, and Gordon Herz. They have set a high bar for continued achievement and progress in our collective undertakings.

Culture of Innovation and Sustainability for the Future of Practice
This is undoubtedly both a galvanizing and challenging time for the practice of psychology, as the shifting landscape in healthcare has directly affected the practitioner community and the delivery of service. Members have been stepping up to the plate by generously sharing information and resources on alternative practice models, options for developing unique niches, ways to think out of the box for untapped markets, approaches to integrated healthcare, models of reimbursement, and formulating business plans that may help members not only survive but thrive in the new tomorrow.

Our members are interested in understanding and keeping
abreast of the quickly evolving field. They are also asking for useful practice tools to utilize in their practices. In responding to practitioner needs and in an effort to expand value to our members, these are updates on some of our innovative programs and developing projects:

- New Division Journal – “Practice Innovation.” At the August 2014 APA Council Meeting, Council approved our proposal to create a new Division journal. Perseverance triumphs as we will be moving this project forward! We are absolutely thrilled to have put out a call for RFP’s. The RFP review process is being chaired by our Division 42 Treasurer and APA Past President Gerry Koocher. Assisting him on the review committee will be Lisa Grossman, Linda Campbell and Jeff Zimmerman. This will be followed by the selection of our journal editor. I firmly believe that our Practice Innovation Journal will fill a much needed gap for practitioners yearning for timely and relevant information on evolving practice models and innovative practice developments in assessment, treatment, ethical issues and supervision.

- Forensic Conference. Our second Forensic Conference “Forensic Psychological Assessment and Testimony” held in May 2014, in Chicago, was a huge success with nationally recognized expert faculty, recruitment of new members, and a healthy profitability. Under the very capable leadership of Bruce Frumkin, Division 42 will be delivering its third Forensic Conference in 2015 with new programming planned.

- Fast Forward Conference. Likewise, the “Fast Forward Innovative Conference” in October 2014, in Long Beach California, was a tremendous success (based in part on extremely high participant ratings). Nancy and her hardworking FF committee are already planning the venue for 2015. This is a prime example of being on the cutting edge of practice innovations with 3 full days packed with CEU programming featuring intensive skills training and entrepreneurial workshops.

- Webinar Learning Series. Division 42 is comprised of a large national network base of knowledgeable and skilled psychologists. One of my goals for the upcoming year is to develop a Webinar Learning Series, drawing upon the expertise and talents of members and creating a library of continuing education training made accessible to members.

- Nuts & Bolts of Digital Communication and Social Media. Social Media and Digital Platforms continue to evolve with an everyday presence in professional practice. While digital technology and social media are automatic modes of operation for early career folks, mid-career and senior career psychologists may not be as adept in their usage. Nevertheless, keeping abreast in the field means learning how to adapt to these changes. With that in mind, I have been working on putting together a team which will develop a hands-on series focusing on the Nuts and Bolts of Digital Technology and Social Media. Possible topic areas being considered are the development of effective websites, twitter, blogs, and Linkedin.

**Culture of Collaboration on Behalf of Practice**

Our mission to advance the practice of psychology requires that we work collectively to address and stay on top of a multitude of robust practice issues. These include scope of practice, compensation and reimbursement matters, licensure mobility, telepsychology, inter-jurisdictional practice, implementation and abuse to parity legislation, integrated health care, and barriers to Medicare/Medicaid. Rather than operating in silos, it is imperative that we identify and collaborate with other stakeholders and practice constituents to work as a unified force in many of these endeavors.

- At last year’s Division 42 Board Meeting, Immediate Past-President Gordon Herz reached out to APAPO’s Executive Director Katherine Nordal. She provided an enlightened discussion about major overlapping areas of interest in professional practice. We have subsequently worked in close collaboration with the Committee for the Advancement of Professional Practice (CAPP) and the APAPO for structural changes to enable CAPP to function more effectively in addressing the needs of professional psychologists. The plan is to continue forging forward with these alliances.

- On behalf of our Division, our six Council Representatives are engaged in bi-annual APA Council meetings. They are charged with representing our Division’s practice interests in the midst of changes in the structure and function of Council along with understanding and monitoring the APA Council’s Good Governance Project. Our CoRs consist of Doug Haldelman, Nancy Molitor, Robert Resnick, Lenore Walker, Robert Woody, and Jeffrey Younggren. We look forward to their representation and updates.

- The plan is well underway for APA Convention to continue shifting towards a Collaborative Programming model in the allocation of convention hours. I have appointed Stephanie Mihalas, our incoming ECP Member-at-Large, and Luis Morales Knight to co-chair the Program Committee. They have been working diligently in guiding members towards the
development of proposals with other divisions, committees and boards. Division 42 will undoubtedly have a fabulous schedule of collaborative programs in Toronto.

- I will be exploring opportunities for appointing additional liaisons with other committees, boards and division practice constituencies, as well as outside entities such as ASPPB.

**Promoting a Culture of Advocacy**

Sally Hildebrandt, our Federal Advocacy Coordinator and Advocacy chair, along with the advocacy committee (Gordon Herz, June Ching, Peter Oppenheimer, Dianne Polowczyk, Lindsey Buckman, Lisa Grossman), will be implementing a strategic plan for the Division’s Advocacy efforts to meet the challenges of professional practice. Throughout the year, we will be working with membership to embrace a call to action. Primary activities entail the following:

- Promoting activities which foster a culture of advocacy in our Division
- Updating, distribution and implementation of the Division 42 Advocacy Training Manual
- Designation of Elena Eisman as APAPO Division Liaison
- Re-appointment and funding of Lisa Grossman as our CAPP liaison
- Appointing a State Provincial Territorial Psychological Association (SPTPA) liaison to Division 31 and to the Board of Professional Affairs (BPA)
- Providing for greater collaboration at the APAPO State Leadership Conference

**Culture of Diversity and Mentoring**

In tandem with my initiative to promote a culture which advances the practice agenda, the implementation of diversity initiatives is also front and center for me. I am passionate about building a Division 42 community with a culture that is inclusive of diversity in the broadest sense – ethnicity, race, gender, sexual orientation, age, religion and disability.

- I have asked two dynamic members, Michi Fu and Doug Haldelman, to co-chair the Diversity Committee. They will be working on initiatives that increase diversity membership in our Division, develop leadership roles and training for diversity members to participate on various Boards and committees, and provide information on increasing our cultural competence in working with the changing demographics of our country and profession.
- I am establishing a diversity mentoring component to be added to the recently revitalized Mentorshoppe Program, which now mentors ECPs and those seeking ABPPs. Mentorshoppe has proven to be one of the highly valued benefits of Division 42.
- I intend to continue building on the initiative of our immediate Past-President Gordon Herz, which involves the development of a leadership pipeline for our future generation. With that objective, we will strive to ensure that students and ECPs are included on committees, programs, and task forces.

**Culture of Marketing and Public Education**

Focus groups have shown that the public has trouble differentiating psychologists from other psychotherapists. Part of the difficulty is that Psychologists stay within the comfort zone of their private offices and shy away from having more of a public presence. Additionally, psychologists also have trouble translating our psychological principles to the public in the manner that the public understands. Similar to how lawyers talk in legalese, psychologists have a tendency to talk in “psychologyese” about their work.

This is where Marketing and Public Education (MPEC) becomes relevant. I have asked Pauline Wallin, our current MPEC guru to continue chairing the committee. She has done a superb job in delivering Virtual Learning Hours with CEUs for our members and will be generating a repertoire of marketing and public education topics for 2015.

- A logical area to expand our efforts is to develop training for our members on the Do’s and Don’ts in MPEC, geared at what is most effective in reaching the public.
- I have also asked Laney Ducharme, a well experienced APA Public Education Coordinator, and radio personality extraordinaire, to develop monthly blogs focused on timely public education topics that our membership can utilize as a springboard in their own practices.

In closing, I want to acknowledge all of the members who comprise our wonderful Ohana (community). You are our breath of life. Please let me know if you are interested in participating on any of our committees or programs. My gratitude goes to our dedicated Board and committee members as we move forward in building a culture of inspiration and innovation in practice. Warm Aloha --
Opinions and Policy

A Long Distance Run

—Pat DeLeon

Hills and Valleys:
During the exciting 2013 APA State Leadership Conference (SLC), Katherine Nordal noted: “The clock is ticking toward full implementation of the law and January 1, 2014 is coming quickly. But January 1st is really just a mile marker in this marathon we call health care reform.... We can’t hope to finish the marathon called health care reform if we’re not at the starting line. Fortunately, many psychology leaders have embraced our call to action.” With the steady implementation of President Obama’s Patient Protection and Affordable Care Act (ACA), our nation’s mental and behavioral health providers (regardless of professional discipline) are increasingly being held to the standards and nuances of the overall healthcare system. For over two and a half decades, Jim Georgoulakis has represented psychology’s voice on the American Medical Association’s (AMA’s) Resource Value Update Committee, which is responsible for advising the Centers for Medicare and Medicaid Services (CMS) on payment policy for services contained in the Current Procedural Terminology (CPT) reimbursement system. His visionary perspective on the considerable challenges facing our practitioners as they face the inevitable integration of federal, state, and private sector requirements:

“Psychologists and Compliance Plans: Recently various lit-serves and publications have raised the issue of compliance plans which have unfortunately left a number of psychologists confused as to whether they should develop compliance plans for their practices. The answer is clearly an unequivocal ‘Yes’ and there should be no further debate on this matter. This fall, in an AntiFraud newsletter, the former Department of Health and Human Services (HHS) Inspector General (IG) Richard Kusserow made a number of statements regarding Medicare and Medicaid mental health fraud to the effect that mental health benefits have been ‘a special enforcement problem that stretches back decades.’ ‘Many healthcare fraud investigators believe mental health caregivers such as psychiatrists and psychologists have the worst fraud record of all medical disciplines.’ Support for this assertion comes from Assistant U.S. Attorney Ted Radway, who stated that in Medicaid there has been ‘an explosion of fraud in community-based mental health treatments, including billing for services not rendered.’

“The current IG of HHS Daniel Levinson is also very clear on the need for a compliance plan. In his keynote address to the Health Care Compliance Association 2014 meeting, he stated that every provider should have a compliance plan. He noted that a one or two person practice will have a different compliance plan than a large organization. He also emphasized that each compliance plan should be unique to the practice – he cautioned against an off the shelf program. The IG also discussed the training materials (written, audio, and video) that his office has produced to assist providers. These materials can be located on the OIG web site which includes a section titled Compliance 101. In this package it is important to note specific videos on compliance program basics, documentation, and operating an effective compliance program. Additionally, there is a caption that states ‘ultimate responsibility for complying with federal fraud and abuse laws lies with the provider of the service.’

“In the main psychologists were very supportive of the passage of the ACA. However, the ACA included a new section [Section 6401 (a)] which established a new Section 1866 (j) (8) which reads that a provider of medical or other items or services or a supplier shall, as a condition of enrollment in Medicare, Medicaid, or CHIP, establish a compliance program that contains certain ‘core elements’ of a Federal Compliance Program. The core elements of such a compliance program have been available on the OIG web site since 1999. As to be expected when reviewing the compliance plan requirements of the 50 states, there is considerable variability among the states with New York having the most comprehensive and the oldest requirements (i.e., mandatory plans since 2009).
“The AMA provides CE credit for participating in the OIG training on compliance. This training is web based and is included in the OIG’s web site. Similar to physicians, I would hope at some time in the near future psychologists would stop debating on whether compliance plans are necessary, develop similar training CE programs, and move forward and improve our standing in the health care compliance community.”

Exciting New Faces and New Agendas: The Illinois Psychological Association, with the guidance and leadership of Beth Rom-Rymer, in particular, succeeded this year in passing prescriptive authority legislation, which is the first RxP bill to be signed into public law since Louisiana’s on May 6, 2004. “With the passage of our prescriptive authority bill, that gives opportunity for graduate students to take the core component of their training in Clinical Psychopharmacology pre-doctorally, close observers have wondered if only the young students will take the training. Others have asked, ‘Will access to care issues really be addressed?’ Still others have questioned, ‘In what ways will the identity of the clinical psychologist change as (s)he also takes on the identity of the prescribing psychologist?’ As we are only at the beginning of our prescriptive authority journey, I will, today, address the question of ‘Who wants to prescribe’ by drawing some portraits of just a few psychologists who have expressed their intention to prescribe in Illinois and/or who are already in the process of gaining their eligibility to prescribe. These examples are in no way exhaustive but represent the diverse spectrum of psychologists, in Illinois, who will be prescribing.

“* Karla is an early career psychologist, is Director of Behavioral Health and Pastoral Care at a Federally Qualified Healthcare Center (FQHC) that serves a largely Hispanic and African American population on the west side of Chicago. She has almost completed her training in clinical psychopharmacology from Fairleigh Dickinson University and is looking forward to soon completing the other components of her training. * Jane has wanted to be a prescribing psychologist since she was a teenager and she is now 62 years old! A practicing clinical psychologist, she is currently taking the core training in clinical psychopharmacology from Fairleigh Dickinson University. She is looking forward to taking the undergraduate science courses on-line and/or at a nearby community college. * Dick is a mid-career clinical psychologist who had been in a joint practice with his pediatrician father for 25 years. He had been a pre-med major as an undergraduate and has completed all of the undergraduate sciences courses; the core training in clinical psychopharmacology from NOVA Southeastern University; and has taken and passed the PEP. These dedicated colleagues are leading the way to our future.

“Since the passage of our legislation, I have been in contact with leaders in more than 10 states in which prescriptive authority initiatives have been reinvigorated. Indiana is one of those states, where, although never implemented, their original effort became public law back in 1993. Other states include Hawaii, California, Idaho, Arizona, Texas, Nebraska, Missouri, Michigan, Ohio, Florida, Virginia, and Maryland. It was a particular pleasure to be able to speak at the convocation of the most recent graduating class of the New Mexico State Psychopharmacology training program where we honored Elaine LeVine for the monumental pioneering work that she has done for all of us in the RxP arena. The enthusiasm at the grass roots level is contagious!” (Beth Rom-Rymer). A journey of a thousand miles begins with a single step. Aloha, Pat DeLeon, former APA President – Division 42 – November, 2014
Independent Practice Under the Affordable Care Act: Legal Strategies
— Robert Henley Woody

In this article, legal strategies are presented, defined, and discussed that will complement psychological services, and create a protective framework for promoting quality care, with special consideration of the implications for independent practice under the Affordable Care Act. An emphasis is placed on warding off any negative consequences for the psychologist, service user, or society.

Like it or not, the Affordable Care Act ("the Act) is law and must be obeyed fully (see Congressional Act: the Health Care and Education Reconciliation Act of 2010, Pub.L. 111–152, 124 Stat. 1029), amending the Patient Protection and Affordable Care Act (Pub.L. 111–148; and signed into law by President Barack Obama on March 30, 2010). In considering possible legal strategies for accommodating the Act, study of the legislative documents and their history is an essential starting point. In a nutshell, the Act is intended to: (1) expand insurance coverage to low-income people and improve Medicaid; (2) regulate insurance companies; (3) specify health care costs; (4) guarantee choice of service-providers; and (5) enhance the quality of American health care (http://www.medicaid.gov/). Note that the Act does, of course, go beyond Medicaid per se, and will potentially encompasses all health care policies and services.

Current Status of Independent Practice of Psychology

Throughout its existence, psychological services were primarily defined, monitored, and regulated by the profession. The entry of health insurance coverage introduced a degree of control by third-party payment sources, but the Act commands primary control by the government. The Act redefines the “reality” for psychological services, especially in independent practice.

Necessary Professional Framework

It is human nature to cling to the established and known, and according to social psychology research, people are prone to rely on heuristics—taking the east route to a particular decision. On the other hand, “professionalism” requires that reality be constantly assessed, modern, and authoritative, with evidence-based decisions. To accommodate the shift from professional to governmental control, psychologists must be open-minded and well-informed. There can be no presumed acceptance of what was possible previously, and there must be adoption of what is acceptable presently.

Applying legal principles to any conflictual situation calls for people to be “level headed” and cognitively objective. Allowing emotionality, whether in support or opposition to the Act can lessen objective and logical strategic calculations. For example, dwelling on the Act’s seeming movement into socialism, without a cost-benefit analysis, may allow emotionality to jeopardize objective and wise decision-making.

Quoting an old song, one approach is to “accentuate the positive and eliminate the negative,” which means identifying and assessing positive opportunities and avoiding a focus on barriers or detriments (the latter being the antithesis of opportunities). From this launching pad, the tenets of professionalism should be used to explore the expectations and demands of governmental and financial sources that, because of the Act, are now impacting upon psychological services. The implicit goal is to integrate optimally the tenets of professionalism into governmental control.

Needed Changes in Competency

The training of psychologists does not commonly include knowledge of the sort of management factors that will be dictated and applied by governmental accountants and other “bean counters” (including the minions of third-party payment sources). There is a current deficit in many (most?) training programs, namely a lack of preparation for the array of legal and business management issues that practitioners need to know and address. If formal training programs for psychologists unwisely ignore the relevance of the Act, practitioners must undertake independent professional develop-
ment to gain understanding of this issue. Without input from informed psychologists, like it or not, the future of clinically-oriented psychological practices will be heavily shaped, monitored, and controlled by non-professional and, moreover, non-psychological determinants.

The Vicissitudes of Practice

Fundamentally, politically oriented analyses support reducing the cost of health care that has consistently elevated over the past few decades (Starr, 1994). There seem to be three reasons why practicing psychologists do not receive higher status under the Act.

First, thankfully there is no widespread disciplinary fault attributed to poor training. Unfortunately, there are some doctoral training sources that have spewed out a deluge of graduates who nominally meet accreditation and licensing standards, but do not assuredly achieve the level of behavioral science knowledge and clinical skills that would provide competitive strength.

Second, there is a public perception that psychologists are not distinctively superior to other sources for psychological help. There is contemporary reliance on obtaining psychological information outside of the traditional service delivery models, such as through the mass media. Some sources have alleged that psychologists have become “arrogant” or “defensive,” to the point that disfavor is triggered (such as within governmental and third-party sources); this attribution may, however, be rooted in dislike for the financial expectations of many psychologists.

Third and aside from socialistic governmental efforts, the primary reason for the Act is market competition. Despite attempts to obtain accurate numbers relevant to the various mental health disciplines, overlapping titles and categories make specificity impossible. That said, it seems, that the proliferation of non-psychologists offering clinical services and the previously mentioned negativity about psychology in public perception have reduced substantially the social power of psychology to claim a superior level of service and revenues that match this level (as due to the requirement of a doctoral degree for independent practice).

As a concrete example (with a reminder of the earlier caveat about ambiguity for “head counts”), the APA center for Workforce Studies (2014, apa.org) indicates there are about 93,000 licensed practicing psychologists in the United States, as compared to about 85,000 in 2004. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that there are over 200,000 clinical social workers, a number greater than psychiatrists, psychologists, and psychiatric nurses combined (2014, see http://en.wikipedia.org/wiki/Social_work).

In my “home state” of Florida, there are 25,605 fully licensed mental health practitioners, constituted by psychologists (18.5%), school psychologists (2.8%), clinical social workers (34.2%), marriage and family therapists (7.2%), and mental health counselors (37.4%) (L. Lobinske, personal communication, July 8, 2014). [Due to having multiple licenses (e.g., a psychologist also holding licensure as, say, a marriage and family therapist), there may be some overlap.] It is apparent that (1) there will be competition between service providers, and (2) psychologists are greatly outnumbered by the other mental health professions (i.e., 4,736 compared to 20,869).

Nationwide, it seems noteworthy that the fees expected by non-psychologists are commonly lower than those sought by psychologists, which may well be a major incentive for service users and governmental/third-party payment sources to reduce their reliance on psychologists. There is no reason to believe that the foregoing numbers and proportions will change dramatically.

The supply-and-demand math is simple. The market demand for psychologists has been diluted or reduced by the increasing number of psychologists and other types of mental health providers, with the latter having lower financial expectations.

Suggested Strategies

As a realist about selecting and adopting coping strategies that are legal under the Act, I wish to posit eight concrete strategies for the clinician to adopt at this time--now, not later. Unfortunately, each suggested strategy will be subject to mandates from governmental and third-party payment sources that will be time-consuming and require expertise, which means, in a sense, there will be more work and expenditures for less income. In other words, the “cost of doing business” will increase.

Strategy One: Accept (but try to influence) Governmental Definitions, Monitoring, and Regulations (i.e., Control) of Practice Standards and Management.

Every independent practitioner must read, understand, and adhere to the voluminous documentary edicts that will constantly emerge from the governmental and payment-source bureaucracies. Acceptance that the cost of “Doing Business” must include services from a knowledgeable attorney and accountant in the jurisdiction in which the psychologist practices--not a “tennis court” buddy or generic “hot-line” source.

Incidentally, if the cost of doing business reduces the attractiveness of clinical health services, other income-producing activities should be identified. That is, there
may be good reason for some independent practitioners to move into other career tracks.

**Strategy Two: Establish Personally Preferred Conditions for Practice.**

With patience and persistence, the practitioner should object to any semblance of diminished quality for professional services promulgated by any review source, be it governmental, third-party payment, or another practitioner--professionalism does not allow silence on quality because of concern about negative backlash.

**Strategy Three: Adopt Acceptable Marketing Tools.**

Psychologists can no longer rely on only “word of mouth” or “yellow-pages advertisements.” There must be a carefully planned marketing approach, particularly employing web-based and inter-professional promotions of practice distinctions and possible positive outcomes. Psychology training programs seldom address marketing, and may even denounce it. Again, the cost of doing business will have to include payment for expertise from a marketing professional.

**Strategy Four: Be Selective in Accepting Service Users (clients/patients).**

There is already a seeming trend to “opt-out” of third-party payment plans, and to give preference to “self-pays.” Although this option may seem desirable, there is the downside is that this option may apply more readily to well-established practitioners than to early career psychologists.

From a risk-management point of view, the practitioner should not succumb to accepting service users who might have clinical needs that are outside the scope of one’s competency. Careful screening is essential.

**Strategy Five: Maintain Detailed Computer-Based Records (with reliable backup).**

The legal aspects of the Act will require increased documentation for “medical necessity,” treatment planning, and clinical outcomes. Every psychological service must pass successfully through a regulatory law filter.

**Strategy Six: Assiduously Pursue Contemporary, Evidence-Based Professional Development (with emphasis on law and ethics).**

Due to its underlying governmental nature, it is clear that professional health care with undergo constant revision, as will provide support for the idea that non-professional regulation, monitoring, and control is preferable to professional determinations. In practical terms, this means that past psychological theories and interventions will be subject to being declared outdated, and the practitioner will be required to provide documentation of possessing contemporary knowledge. Professional ethics and standards will be honored only to a degree; legal tenets will be the sine qua non of acceptance under the Act.

**Strategy Seven: Justify Every Service in a Detailed Treatment Plan.**

Much like the implicit aspects of the other strategies, treatment planning must be astutely accomplished (Woody, 2013). Treatment planning will allow the practitioner to optimize influence on the impositions from governmental and third-party payment sources. There will also be the concomitant benefit of risk management.

**Strategy Eight: Be Persuasive and Authoritative, and Avoid Uncertainty in Decision-Making.**

Although high quality training of psychologists commonly emphasizes evidence-based decision-making that will facilitate scholarly authority, practitioners may decline to be persuasive or determinative, that is, to give credence or accommodation to a contradictory viewpoint. One practitioner jokingly said that the principle was “It’s nice to be nice.” The Act will always expect compliance by and deference from the practitioner. To effectively counter this attempted dominance, the practitioner should, along with open-mindedness, commit to having a solid rationale for clinical services, as buttressed by behavioral science. On a personal level, it will be essential to cultivate personal characteristics to communicate a justifiably powerful opinion.

The currently ill-defined Act imposes uncertainty on psychological services. The practicing independent psychologist will need to become as strong an influence as possible, such as via the eight strategies suggested. Pассивivity will be detrimental; professional assertions will be worthwhile.

**REFERENCES**


Robert Henley Woody is Professor of Psychology, University of Nebraska Omaha. He a Licensed Psychologist in Michigan, and a member of the Florida, Michigan, and Nebraska Bar Associations. He serves as a Division 42 Representative on the APA Council of Representatives. He has authored thirty-seven books, including: Legal Self Defense for Mental Health Practitioners (Springer, 2013). An appreciated version of this paper was presented at the APA Annual Convention, Washington, DC, August 7, 2014.
Accuracy of data regarding malpractice claims is complicated by several difficulties in finding complete claims records. There are multiple insurance carriers and some do not provide clear claims information. Especially difficult is obtaining reliable data on such claims as sexual misconduct. Also, practitioners who work for State and Federal agencies may not have claims against them reported, since many of these agencies are self-insured. In addition, it is often difficult to delineate these categories precisely and obtain exact percentages for each type of malpractice case. The premiums psychologists pay, of course, reflect the cost of insurance companies defending not only legitimate claims but, on occasion, spurious ones.

As a result, while there is some agreement on the major categories in which malpractice occurs, people writing about it may combine them in different ways. The following list, then, is not intended to be exhaustive, nor does it account for all of the categories in which malpractice actions are noted.

**Negligent Diagnosis**

Negligent diagnosis occurs not when there is merely a misdiagnosis, for anyone can misdiagnose a client or patient. It occurs when the diagnosis is missed because of a serious departure from accepted diagnostic techniques. For example, if a patient presents to a therapist complaining about severe headaches and that therapist fails to do a diagnostic workup which includes referral to a medical provider or to a neurologist, and the client subsequently becomes ill due to some neurologically-based illness.

While this scenario is not that frequent, psychologists often put themselves in a position of negligently diagnosing, by attempting to “cut corners”, failing to administer a psychological test completely, doing rather slipshod scoring, no scoring at all, or interpreting test results in a manner inconsistent with the test manual. Were this to lead to some harm, this could be the basis for a lawsuit based on negligent diagnosis.

**Wrongful Involuntary Commitment**

While most therapists would take the concept of involuntarily committing an individual very seriously, there are some cases in which a client asserts that they were committed for a less than adequate reason. In light of the over-concern about violent patients, there was a period of time, especially in the 1970’s and early 1980’s, when there were large numbers of unnecessary involuntary commitments because therapists were over-reacting to clients when the clients would share angry or violent fantasies. Nevertheless, the wrongful involuntary commitment constitutes a relatively small number of malpractice claims.

**Negligent Release**

These cases seem to occur more frequently, especially in an era of managed care, when hospitals and therapists are not able to provide the extent of care which they believe clinically is necessary. Were a client to act out, for instance, in a violent manner, and review of the record reveals that there was inadequate treatment or that the individual was not, according to the standards of the profession, ready for release, then such a lawsuit could ensue. It is very important, therefore, especially for clinicians working in a hospital setting, to cover within their discharge planning all of the issues that were raised in the initial treatment recommendation, such as, violent acting out based on delusional thinking. A classic example of this occurred in the State of New York many years ago when an individual ultimately killed his wife following lengthy documentation of a delusional system in which he believed that his wife was a witch. The individual had merely learned to “keep his mouth shut” while he was hospitalized, was transferred from a maximum security to a minimum security facility, and was given a weekend pass, during which time he killed his wife.

**Breach of Confidentiality**

The actual issue here is a breach of confidentiality when there is no compelling need for such a breach of confidential communications. The typical cases involve a breach of confidentiality when a review of the clinical records...
reveals no evidence of violent or self-destructive tendencies, and it appears that the therapist was over-reacting to something which the patient may have said. This, of course, underlies and highlights the need for very careful assessment procedures when and if such statements are made.

Sexual Misconduct

Sexual relationships with current clients is, of course, prohibited by the A.P.A. Ethics Code. However, more problematic are the sexual relationships which involve former clients. Earlier versions of the A.P.A. Ethics Code did not make a distinction between current and former clients, but since 1992 there has been a careful discussion of this. Cases in which psychologists had sexual relationships with former clients, prior to the 1992 Ethics Code, at times resulted in difficulties pursuing them and several psychologists, in fact, sued their own Boards of Psychology successfully because of the lack of clarity in the definitions. In response, several states have, in fact, defined the therapeutic relationship as existing “in perpetuity” and therefore sexual relationships with any client, current or former, are prohibited. Other approaches, for instance in those states that merely adopt the A.P.A. Ethics Code, endorse the so-called “two-year rule” in which there is no intimate contact with a former client for at least two years following the termination of therapy. Even then, it is not a license to engage in such activities, for the therapist must bear the burden of proving seven points enumerated in the A.P.A. Ethics Code, which basically show that there is absolutely no exploitation of the client whatsoever. This becomes, of course, virtually impossible, since the client will be alleging that there was exploitation. In short, this two-year rule is really a prohibition without being called a prohibition.

Injuries Resulting From Non-Traditional Therapies

These cases are relatively rare but do involve claims by individuals who have been involved in what may be called “cutting edge”, innovative or out of the mainstream kinds of therapies. This would include such areas as the hot tub therapies, immersion tanks, primal scream therapies and bioenergetic treatments. While many traditional therapists would frown at the use of such treatments, if a therapist decides to use them, there must be an exceedingly careful and well thought out informed consent, indicating the lack of scientific basis to the treatment and the fact that the treatment is basically experimental.

Failure to Obtain Informed Consent

While therapists have become more sensitive to the issues of informed consent in recent years, it has been observed that many practitioners still do not really think through what the issues in an informed consent must be. The Ethics Code certainly addresses this but practitioners are well-advised to also consult relevant legal documents. Essentially, the concept of informed consent is made up of three areas: competence, voluntariness and sufficiency of information. The therapist must determine and document first that the client is competent to understand the parameters of treatment; secondly, that they consent to the treatment or diagnostic procedure voluntarily; and third, that sufficient information is provided to them so that they can make an informed choice. The information provided must include who the practitioner was, what the nature of the referral was, what the nature of the intervention will be and any limits to the confidentiality that might be involved. Further dimensions, such as fee arrangements and other financial matters, such as whether or not an individual will be charged for missed sessions, should also go within the informed consent document. Of course, the document must be clearly written, such that a client would be able to understand it. Unfortunately, many practitioners have an attorney develop their informed consent form and it becomes very complex, involved and unable to be understood by most people. Therefore, it needs to be comprehensive, yet understandable, and the therapist or diagnostician needs to take time to discuss the matters in the consent form in an adequate manner.

Failure to Take Precautions Against Suicide

It is an unfortunate observation that some clients or patients do, in fact, make suicide attempts, some of which are successful. However, the mere fact that a client commits suicide does not automatically make the therapist negligent or liable. The suicide has to have been “reasonably foreseeable” and reasonable foreseeability is determined by the totality of circumstances and whether or not the therapist did a careful enough evaluation to make a decision whether or not self-destructive behavior was reasonably foreseeable. Therefore, a great deal of this litigation has to do with the adequacy of the clinician’s assessment for suicidality. If there is a comprehensive assessment and nothing in that assessment would suggest the potential for suicidal behavior, then it cannot be asserted that the practitioner deviated from any established standard of care. The standard of care refers to the adequacy of the assessment, not to whether or not it was ultimately accurate in predicting behavior.

Abandonment

While this area is quite straightforward, in that we should not abandon clients, there arise situations in which the
issues are very complex. For instance, if a therapist has a severely disturbed, borderline individual, who is constantly acting out, and demanding 100% attention from the therapist, and perhaps even threatening the therapist, the therapist can certainly withdraw from the treatment, but there has to be evidence that the therapist attempted to work with the individual and when it was determined that such work was not feasible, there be a careful termination and/or transfer plan in effect. Unfortunately, some therapists merely refuse to see an individual when a bill is in arrears. There should, of course, be a carefully worked out fee arrangement as part of the informed consent to avoid claims of abandonment.

Duty to Protect Third Parties

This discussion comes at the very end of this paper because, in fact, it occurs very infrequently. Despite the media hype around such cases, they are quite rare and it is only because of the sensational nature of some of the violent behavior that there is a great deal of public misperception about it. In fact, such cases constitute less than 2% of the cases seen by malpractice insurance carriers. Once again, as in suicide, the key is doing a careful assessment and basing the treatment plan on the results of that assessment. Psychologists are not expected to be prophets, nor are they expected to accurately predict the future. However, what will be closely scrutinized is the adequacy of the assessment and whether or not assessment instruments that have been validated for evaluation of the potential for future violence have been used.

In this brief summary, I have attempted to cover some of the major areas of malpractice litigation. As noted above, authors will divide the topics in different ways. For instance, Bennett, et al. (2006) presented data indicating that the most frequent area of malpractice litigation is “ineffective treatment, failure to consult and failure to refer, about 29% of cases.” Clearly, there are many sub-areas included within this broad area. Another one which is listed specifically in Bennett’s analysis is child custody evaluations, which are sometimes included in negligent diagnosis and sometimes in a category called “loss from evaluation”. Inadequate supervision also appears on this list and may well come under other categories, depending on the way the cases are divided.

One final issue is worthy of note. While these figures used to list sexual misconduct as the single highest area of malpractice litigation, it is now down to only about 9%, according to Bennett’s analysis. The reasons for this drop from the former figure, which had been approximately 23%, is unclear. There has not been any careful analysis to determine the reasons but some authors have spoken about the fact that in several states patient-therapist sexual relationship has been criminalized, and others point to the greater number of women in the workplace since women are far less likely to engage in sexual relationships with male clients than the other way around.

References


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Among the general population, criminal justice-involvement occurs at about the same rate as Panic Disorder and Generalized Anxiety Disorder (National Institute of Mental Health [NIMH], 2014). Approximately 1 in 33 adults are under some type of justice-related supervision in the United States. The vast majority of this large population is serving their sentence in the community: Almost 5 million are supervised in the country’s parole and probation systems (Bureau of Justice Statistics, 2014b). Of the 2 million people incarcerated in the United States (Bureau of Justice Statistics, 2014a), 90% will be released and returned to the community.

Community settings that specialize in services for justice-involved clients (JICs) include day reporting centers, drug courts, halfway houses, and transitional housing programs. Although such court mandated or correctional environments are the most common settings for treatment and intervention for JICs, such individuals are also routinely encountered at substance abuse rehabilitation centers, and appear in general outpatient psychotherapy or counseling for help with collateral issues (e.g., relationship & vocational difficulties). JICs supervised in the community include probationers (who are typically serving their entire sentence in the community), parolees (who are released from prison early and serving the remainder of their sentence in the community), and pretrial defendants (arrestees who are permitted to reside in the community on bond/bail while awaiting trial).

What's Different About Working with JICs?

(1) The primary goal is reducing future criminality, not symptoms. Mental health counselors and psychotherapists usually focus on diagnosable disorders, and it is the symptoms associated with those disorders that are viewed as problems to be resolved. In contrast, the primary emphasis of forensic treatment is the prevention of future criminality. Therefore criminal behavior and reoffending are the outcomes of most concern.

(2) Coercive referral mechanisms. As a client group, JICs do not typically show up for treatment voluntarily. Referrals involve some form of external coercion: pretrial clients are advised (“Go to counseling and your charges will be dismissed.”), while those already convicted and on probation are warned (“Complete a program, otherwise face incarceration.”), and prisoners are compelled to participate in treatment activities (“Attend a treatment program and securing early release will be more likely.”). Although such mechanisms do not technically force the JIC into treatment against their will (even the probationer, after all, can refuse treatment and serve his sentence in prison rather than in the community), from the client’s perspective, they have been “forced to come here.” In many ways, JICs can be strikingly similar to unmotivated mental health clients. In our forensic CBT model, a significant amount of time is devoted to engaging clients and fostering internal motivation for making life changes.

(3) Practitioner empathy. Practitioners working with traditional mental health clients may have little difficulty empathizing with their clients. JICs, on the other hand, have committed some type of criminal act that may have caused harm and suffering for someone else. Some JICs may readily acknowledge engaging in physical assault, sexual abuse, drug selling, conning, and theft. They may justify their actions, express no remorse for their behavior, minimize its consequences to others, or even blame those who have been victimized. Add to that, the low levels of motivation to change noted earlier, and it may be no surprise that developing and maintaining empathy for such clients can be an ongoing challenge. Yet, as with traditional mental health clients, effective treatment with JICs is related to empathy and the establishment of an effective working alliance.

(4) Limitations of confidentiality. Written reports documenting JIC attendance, participation, and progress are often required by the referring court or criminal justice agency. Practitioners may also be expected to be in regular telephone contact with a probation or parole officer, and provide information on a JIC’s employment status, violations of protective and non-contact orders, and drug test results. For this reason, working in the community with JICs involves a complex practitioner role, blending

Focus on Clinical Practice

Featured Expert Review

Forensic CBT: An Integrated Approach for Working With Justice-Involved Clients

— Raymond Chip Tafrate and Damon Mitchell
the goals of behavior change, monitoring, and community safety.

(5) Difficulties identifying treatment goals. A common complaint among practitioners is that JICs entering treatment have difficulty identifying or acknowledging areas in need of change; often presenting at intake with minimal symptoms and a lack of subjective distress. In some cases JICs may even find their current destructive patterns enjoyable, largely harmless to themselves, and worth continuing (e.g., “Smoking weed is what I like to do. It doesn’t get in the way of anything so why should I have to stop?”). Even when awareness of negative consequences exists, some JICs see the cause of their difficulties as a function of other people or external circumstances rather than their own behavior (e.g., “Of course I’ve got problems with the police. My parents are screwed up. I had no one guide me growing up.”). They may view themselves as victims rather than perpetrators, and argue that any change ought to lie in other people and institutions, rather than themselves (e.g., “It’s not my fault I’m in this program. Every time my girlfriend and I get in an argument, the neighbors get freaked out and call the police. My neighbors just need to calm down when they hear normal people arguing.”). Because of these reasons, it is the presence of specific risk-relevant factors that are statistically linked to criminal behavior, and not subjective symptoms, that will most often dictate the goals of treatment. These risk-relevant factors (described later) become the focus of intervention.

(6) Atypical thinking patterns. For practitioners new to the forensic area, JICs may seem somewhat bewildering in terms of their beliefs and cognitions. In some cases the cognitive profiles of JICs are a mirror image of clients suffering from anxiety and depression (Kroner & Morgan, 2014; Mitchell, Tafrate, & Freeman, 2015; Seeler, Freeman, DiGiuseppe, & Mitchell, 2014; Walters, 2014). For example, while clients suffering from anxiety and depression often overestimate and exaggerate potential dangers, are overly concerned about others’ opinions, and harshly blame and judge themselves when things do not go well, JICs have a tendency to underestimate danger, challenges, or difficulties in favor of overly optimistic and self-serving predictions, and have a lack of concern for the opinions of others and how their actions negatively affect others.

(7) Consequences of treatment failure. Another difference between clinical work with traditional mental health clients and JICs is the ramification of unsuccessful treatment. If treatment with a depressed or anxious client is unsuccessful, the impact of that treatment failure is going to be felt most acutely by the client through continuation of their symptoms. In contrast, the costs of treatment failure with JICs may result in an unchanged criminal risk profile, the consequences of which are future criminality and victimization that can ripple out and create suffering for others and the larger community (Mitchell, Simourd, & Tafrate, 2014).

Proposed Core Components of a Forensic CBT Model

We recommend 3 foundational components for working with JICs: (1) focus treatment on reducing criminal risk-relevant factors, (2) enhance motivation to adopt more prosocial lifestyle patterns, and (3) address thinking patterns that facilitate criminality. These components are applicable to a variety of offense types and problem areas (e.g., antisocial personality patterns, dysregulated anger, aggression, interpersonal violence, substance use). They are also applicable across a range of treatment environments (e.g., community, custody).

Focus on Risk-Relevant Factors

Practitioners will be more effective by adopting a risk-reduction perspective rather than a symptom reduction mind-set. The good news is that most practitioners are already familiar with the philosophy of the risk reduction approach as it applies to other areas such as heart disease (e.g., Risk factors: family history of heart disease, high cholesterol, smoking, diabetes, hypertension, obesity, poor diet, increased age, lack of physical activity) (Centers for Disease Control and Prevention, 2014). The risk approach is somewhat like going through life with a shopping cart -- the more factors in the cart -- the more risk. In terms of intervention, the goal is to reduce a person’s risk profile as much as possible.

A similar model has emerged around the identification and treatment of risk factors specifically linked with continued criminal behavior. Much of this work has been advanced through the risk-need-responsivity (RNR) model of offender assessment and rehabilitation developed by Andrews, Bonta, and Hoge (1990). Although the RNR model may be unfamiliar to many practitioners, it has been increasingly influential in forensic assessment and treatment (Andrews & Bonta, 2010). Table 1 lists two levels of risk-relevant factors that are known as the central eight (Andrews, Bonta, & Wormith, 2006). The Big Four are somewhat more strongly linked with reoffending than the Moderate Four.
Table 1. Risk-Relevant Factors for Criminal Behavior

<table>
<thead>
<tr>
<th>Big Four</th>
<th>Description</th>
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<tbody>
<tr>
<td>History of antisocial/criminal behavior</td>
<td>Patterns of antisocial/criminal behavior beginning in childhood and continuing into adulthood</td>
</tr>
<tr>
<td>Antisocial personality characteristics</td>
<td>Signs and symptoms of antisocial personality, dissocial personality, and psychopathy</td>
</tr>
<tr>
<td>Antisocial cognition/criminal thinking patterns</td>
<td>Beliefs and attitudes that facilitate antisocial, criminal, and destructive behavior</td>
</tr>
<tr>
<td>Antisocial companions</td>
<td>Close association with, and approval seeking from, criminal companions; absence of prosocial friends</td>
</tr>
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<table>
<thead>
<tr>
<th>Moderate Four</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Family/marital dysfunction</td>
<td>Marital or family relationships that ignore, reinforce, or model antisocial behavior; lack of positive family bonds</td>
</tr>
<tr>
<td>Lack of connection with school/work</td>
<td>Negative attitudes and low levels of performance and satisfaction in school/work</td>
</tr>
<tr>
<td>Antisocial leisure/recreational pursuits</td>
<td>Enjoyment of antisocial and risky activities; low levels of connection and enjoyment related to prosocial pursuits</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Abuse of alcohol/drugs; positive attitude toward substance use</td>
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The changeable nature of these risk factors (with the exception of criminal history) means that their improvement reduces the risk of criminal behavior and reoffending while their worsening increases risk for future criminality. One important implication of the risk perspective is that treatment, which fails to address risk-relevant factors, is likely to fail in spite of the best intentions of the practitioner. In fact, interventions that target risk-relevant factors produce larger reductions in reoffending than interventions that target factors that are not strongly related to reoffending (Smith, Gendreau, & Swartz, 2009).

Noticeably absent from the list of risk-relevant factors are traditional mental health symptoms such as depression, anxiety, schizophrenia, and bipolar disorder. Contrary to common wisdom, mental health symptoms do not improve the prediction of future criminality over the risk-relevant factors described in Table 1 (Bonta, Law, & Hanson, 1998; Morgan et al., 2012; Phillips et al., 2005; Skeem, Winter, Kennealy, Eno Louden, & Tatar, 2014).

Consider a JIC with moderate antisocial personality features, prominent criminal thinking, and a large number of active criminal companions -- who is also severely depressed. Targeting only his depression may help him feel better but will not reduce his likelihood to reoffend (and could possibly increase it). Addressing his criminal thinking and criminal companions will reduce his likelihood of reoffending, but such an approach will be difficult to implement if he is too depressed to engage in activities designed to restructure criminal thinking patterns, break ties with criminal companions, and develop new prosocial connections and routines. In this case, addressing the depressive symptoms would be an essential first step so he can later work on improving the risk-relevant areas of his life.

It is important to appreciate the complex interrelationship between risk factors. Consider another JIC who is unemployed and spends the better part of her free time with friends who drink heavily and use drugs. Her friends reinforce her unproductive beliefs about work, her drug use diminishes the likelihood of passing pre-employment drug screens, and her substance use and criminal companions further distances her from prosocial family members. Thus, the various risk factors specific to this case impact each other in an interrelated destructive system. On the optimistic side, a positive change in one of these areas could facilitate positive changes in the others. For example, full-time employment would result in less time with her antisocial friends, less time to engage in substance use, and expose her to new peers who express prosocial thoughts and who model more productive lifestyles.

Enhance Motivation to Change Risk-Relevant Life Areas

Since few people react well to being pressured into getting help, it is not surprising that JICs often present with a lack of interest, if not outright hostility, toward intervention programs and practitioners. A recent meta-analysis reached the stark conclusion that mandated forensic programs were generally ineffective, whereas voluntary treatment activities in both institutional and community
settings were associated with positive effects (Parhar, Wormith, Derkzen, & Beauregard, 2008). An important implication of this finding is that in order to be effective, coerced clients must develop an interest in treatment and change akin to that of their voluntary counterparts. In essence, practitioners will need to create an atmosphere where JICs who say they are “forced to be here,” are willing to look at themselves and come to say they “want to make changes anyway.”

One increasingly common recommendation for working with JICs is to integrate motivational interviewing (MI), or adaptations of MI, into interventions (Tafrate, Mitchell, & Novaco, 2014). MI (Miller & Rollnick, 2013) has immediate practical advantages in the early stages of treatment; moving JICs toward greater engagement and collaboration and moving practitioners away from confrontation, advice-giving, and practical steps for which the client is not yet ready. Instead of practitioners telling the client what to do, JICs and practitioners collaboratively discuss reasons why change would be important as well as how the client might go about it. The main objective in using MI is to elicit and explore JICs’ own motivations for changing the risk-relevant areas discussed above (Tafrate & Luther, 2014).

Address Thinking Patterns That Promote Criminality

Conceptualizing cognitions that are relevant for JICs can be approached effectively by taking into consideration the empirical literature that has developed around the assessment of criminal thinking patterns (thinking patterns that facilitate criminal and self-destructive behavior). At the core of this literature are seven criminal thinking assessment instruments that have been developed for adult JICs: the Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995), Criminal Sentiments Scale-Modified (CSS-M; Simourd, 1997), Measure of Criminal Attitudes and Associates (MCAA; Mills, Kroner, & Forth, 2002), Texas Christian University Criminal Thinking Scales (TCU CTS; Knight, Garner, Simpson, Morey, & Flynn, 2006), Measure of Offender Thinking Styles (MOTS; Mandracchia, Morgan, Garos, & Garland, 2007), Criminogenic Thinking Profile (CTP; Mitchell & Tafrate, 2012), and Criminal Cognitions Scale (Tangney et al., 2012). Each instrument measures multiple thinking patterns (ranging from 3 to 8). The total number of thinking patterns measured across all the instruments adds up to an unmanageable 32, however, taking into account overlapping content reduces the number of distinct thinking patterns to a more clinically practical 13. A comprehensive listing of criminal thinking patterns has been presented elsewhere (Mitchell, Tafrate, Freeman, 2015; Seeler, Freeman, DiGuisepppe, & Mitchell, 2014) and some examples include:

- Disregard for others, lack of empathy, lack of remorse, and callousness (e.g., “I don’t have time to care about anyone else. My life’s about me and only me. Only the strong survive.”).
- Avoiding intimacy and vulnerability (e.g., “Why should I open up to you? You’re just going to leave anyway.”).
- Justifying, minimizing, and excuse making related to harmful behaviors (e.g., “The store has insurance. What I stole isn’t going to put them out of business.”).
- Underestimating negative consequences (e.g., “I can time my drug use so that it’ll be out of my system by the time my probation officer tests me. I won’t get violated.”).

Criminal thinking instruments are readily available, free to use, and easily administered and scored. As recommended by Kroner and Morgan (2014), administering more than one criminal thinking instrument will provide a useful range of potentially relevant thinking targets for intervention.

Concluding Comments

Practitioners across many settings are likely to encounter clients who are justice-involved. Understanding the key differences between forensic and traditional mental health treatment is an important first step in working effectively with this challenging client group. Given our current state of knowledge, integrating risk-reduction, motivation building, and criminal thinking components are most promising in changing the life trajectories of individuals who are involved with the justice-system.

References


Raymond Chip Tafrate and Damon Mitchell are clinical psychologists and Professors in the Criminology and Criminal Justice Department at Central Connecticut State University. They frequently consult with state criminal justice agencies on the application of interventions for adolescents and adults with justice-related problems. Their most recent book is Forensic CBT: A Handbook for Clinical Practice (Wiley).
**Challenges and Opportunities: Religion and Spirituality in Clinical Psychology**

—David Zuniga

“You are better equipped to lecture on psychology than I.”  
(William James speaking to Anagarika Dharmapala, a Buddhist monk, Fields, 1992, p. 135)

There are no easy answers regarding the place of religious and spiritual beliefs and practices in clinical psychology. Religion and spirituality are ancient, vast, complex and at times self-contradictory endeavors. Given the great numbers of individuals who draw upon some form of religion or spirituality, it is worth considering how to integrate these arenas with clinical psychology as they all explore the transformation of the human condition.

Collaboration between religion, spirituality and clinical psychology has the potential to yield great benefits as long as ethical boundaries are respected and academic rigor is maintained. Theoretical orientations, and sound ethics inform best practices in clinical work. Thus, this first article, of a two-part series, will focus on established professional guidelines, ethics, and research related to potential integrations of religion in psychology. Opportunities and challenges in this emerging integrative work will also be discussed. Most contemporary clinical methodologies in mental health seeking to integrate Buddhist-derived ideas are conceptualized in relation to cognitive and behavioral approaches (Eifert & Forsyth, 2005; Hayes, Strosahl, & Wilson, 1999; Kabat-Zinn, 1990, 1994; Linehan, 1993; Segal, Williams, & Teasdale, 2002). The second article for this series will specifically explore a more existential-humanistic clinical methodology that is congruent with Buddhist texts and the academic research of Buddhism.

The American Psychological Association’s (APA, 2002) “Ethical Principles of Psychologists and Code of Conduct” (Ethics Code) delineates clear guidelines for when and how religion, and hence spirituality, should be incorporated into professional psychological services. In the Ethics Code it states that psychologists are cognizant and respectful of cultural, individual, and role differences based on religion and eliminate related biases accordingly (APA, 2002, p. 1063). Similarly, the Ethics Code states that when scientific or clinical knowledge in the discipline of psychology requires an understanding of religion, psychologists must either have or acquire the necessary training, experience, consultation, or supervision to guarantee their professional competence or make appropriate referrals (pp. 1063-1064). The Ethics Code further states that psychologists do not knowingly engage in actions that are harassing or demeaning to people with whom they interact based on religion (p. 1064).

Division 36 of the APA, Psychology of Religion, formally encourages the study of religion and spirituality, advocates for the integration of research into clinical and other applied environments, and facilitates dialogue between these disciplines. Similarly, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (DSM-5; APA 2013) specifically classifies “Religious and Spiritual Problems” as a V-code (V62.89) meaning that they are a legitimate focus of clinical intervention. This DSM-5 V-code states, “This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution” (p. 725). Further, V-code V65.40, “Other Counseling or Consultation” states, “This category should be used when counseling is provided or advice/consultation is sought for a problem that is not specified above or elsewhere in this chapter. Examples include spiritual or religious counseling, dietary counseling, and counseling on nicotine use” (p. 725). These V-codes suggest spiritual or religious counseling can be a recognized service that is provided by mental health professionals. While beneficial avenues of intersection exist between religion, spirituality, and clinical psychology, caution must be employed and ethical parameters closely followed when seeking integration or collaboration among them.

**A Brief Overview of Psychology and Religion**

For most of human history, religion, spirituality and clinical psychology were understood as complementary disciplines (Nelson, 2006). Psychology and other scientific disciplines initially arose as an outgrowth of philosophy and religion (Reber, 2006). Psychology, religion and spirituality share a multiplicity of important concerns such as ethics, human relationships, sexuality and mortality.
However, the 1800s ushered in a new era in the relationship of science and religion; thinkers such as Auguste Comte and John Stewart Mill and philosophical movements such as positivism called for a clear separation of these previously allied fields due to the perception of religion as unscientific discipline (Nelson, 2006). Yet over the last thirty years, a veritable explosion of publications and studies investigating the relationship of psychology to religion and spirituality indicates a new trend in clinical psychology of integrating the discipline with religious systems of belief and ritual practice (Powers, 2005).

The Value of Clinical Integration of Religion in Psychology

This modern trend towards integration is not surprising because most people participate in some form of religion or spirituality. In the United States, by a wide margin, most people express a belief in God or some form of a higher power, cite a personal association with a formal religious organization, and claim that religion or spirituality is a significant dimension of their lives (Delaney, Miller, & Bisonó, 2007). Similarly, 83% of the world population practices some type of formal religion (Brown, 2005). For better or for worse, formal religious systems make their presence felt in virtually every aspect of human society and culture. Religious and spiritual beliefs and practices may affect people's actions, cognition, and ethical reasoning (Reber, 2006). Since clinical psychology is the empirical inquiry into human nature and behavior, this scientific discipline may seek to understand religion and spirituality, which can impact the human condition.

Religion and spirituality are some of the hallmark definers of multiculturalism. Thus, it is important that clinicians be open and skilled at intervening in this dimension of their clients’ lives. One qualitative study at the University of Iowa uncovered multifaceted relationships between feminist principles, roles of gender, culture and religiosity for Muslim and Christian women (Ali, Mahmood, Moel, Hudson, & Leathers, 2008). African American participants felt traditional feminism did not reflect the needs of minority women. Instead, they felt their formal religious communities were a place of concrete activism. The majority of Muslim women self identified as being feminist (which may be counter to how Muslim women are often viewed in the U.S.). While many Christian women identified with some of the foundational issues of feminism, they were actually less likely to refer to themselves as feminists.

Another recent study of 215 African Americans examined how they coped with common everyday stressful occurrences and stress caused by prejudice (Utsey, Giesbrecht, Hook, & Stanard, 2008). The study concluded that African Americans often form passionate and deep-seated connections to traditional religious communities and they see a benefit in integrating religious and spiritual methods into clinical interventions. The U.S. is rapidly becoming a minority majority country; hence this trend towards religious diversity is highly likely to continue to increase. Consequently, the importance of psychologists being professionally competent in religion and spirituality is likely to be increasingly important as well.

Attitudes and Some Attempts at Integration

In an investigation of APA psychologists’ attitudes regarding religion, 489 clinicians were randomly selected and assessed by researchers (Delaney, Miller, & Bisonó, 2007). While most were not personally religious, 82% viewed religion as positively impacting mental health while only 7% understood it to be harmful. One review suggests many health benefits attributable to religious participation, including decreases in mortality, suicide, divorce, and depression (Hill & Pargament, 2003). Therefore it is not surprising to see a trend towards integration and collaboration between clinical psychology and the disciplines of religion and spirituality. One way cross-discipline partnerships have evolved is through psychologists seeking to utilize specific religious beliefs and ritualistic techniques as targeted interventions for their clients.

One example is a study investigating the value of cultivating spiritually “sacred moments” for counseling clients. Goldstein (2007) defined sacred moments has having two key dimensions. The first is “they inherently possess spiritual qualities… such as feeling of connection with and support from the transcendent (e.g., God, higher power, all of life), connection with others, purpose, gratefulness, awe, compassion, mercy, and/or a deep sense of inner peace” (p. 1002). The second is “they are imbued with descriptive qualities such as precious, dear, blessed, cherished, and/or holy” (p. 1002). In this study 73 participants were assigned randomly to one of two groups. The first group did a three-week program aimed at creating sacred moments. The second group followed a three-week journaling regimen. Cultivating sacred moments was therapeutically as effective as journal writing for subjective wellbeing, psychological wellbeing and stress management (2007).

An alternative method for collaboration between these disciplines is to have clinical psychologists serve as expert consultants and advisors to ordained clergy and religious communities. The Congregational Development Program (CDP) seeks to help religious communities assess their assets and limitations and plan for the future (Pargament, Falgout, Ensing, Reilly, Silverman, Van Haitsma, et al.,
There is also collaboration between psychology and non-theistic (non-God based) forms of religiousness. The largest and oldest forms of non-theistic religions are the various lineages (denominations) of Buddhism. From the time when western-based psychology first arrived in East Asia, Buddhism was understood by many Asians to be a skillful cultural receptor and transmitter for this new form of scientific inquiry (Muramoto & Hoffman, 2005).

One historical challenge in these integrative attempts is that most religions tend to operate via belief in things that are unseen and cannot be demonstrably proven. Science historically has sought to obtain empirical data that can be verified through repeatable experiments. Buddhism avoids this dichotomy, to some extent, because it does not require a belief in either God/s or the afterlife (Batchelor, 1997). Interestingly, many leading Buddhist thinkers such as Phra Prayudh Payutto echo some modern scientists who argue against a belief in God because it cannot be proven (1995). It is important to note that this non-belief based approach to religion is not a modern notion in Buddhism but actually dates back to the Pali canon, the oldest Buddhist scriptures written over 2,000 years ago.

Unlike most forms of religion, Buddhism consistently extols people not to believe dogma or other religious ideas until it is proven to be true (Gotama, trans. 2001, 2011). Buddhism philosophy is a disciplinary precursor, and yet remarkably similar, to western notions of empiricism (Batchelor, 1997; Payutto, 1995). It is for this reason that there was never an unhappy divorce between Buddhist philosophy and science in Asia as opposed to western cultures where there was a much sharper break between the disciplines of religion and science that has yet to be rectified (Hubbard & Swanson, 1997; Muramoto & Hoffman, 2005). Because of its kinship with empirical methods, Buddhism could be a logical and ready partner for dialogue with clinical psychology.

Impediments to Integration

As there are literally thousands of world religions, most of which have roots in antiquity, and as the United States is such a diverse nation religiously, it is incredibly hard for a psychologist to be conversant in all the various world religions and spiritual movements. This difficulty in understanding the vastness of religion and spirituality is reflected in recent conflicting studies from within the field of psychology. A study of 1,000 members of the APA concluded that a majority of psychologists felt professionally competent to help clients with their religious and spiritual issues in counseling (Delaney, Miller, & Bisno, 2007). Yet another study concluded the opposite, two thirds of psychologists stated that they did not have the professional ability to provide counseling to people with religious or spiritual needs (2007). This ambiguity about clinical competence is reflected in the training of psychologists. For example, in reviewing graduate psychology programs internationally Kenneth Brown found very few academic classes exclusively focused on the psychology of religion (2005). While there are many psychology textbooks and journals that focus on religion, few academics report feeling capable of teaching psychology of religion courses (Hage, 2006; Reber, 2006). Although religiously integrative voices that are more culturally sensitive are emerging (Pargament, 2007), additional work in the field of psychology is needed.

Conclusion

Fortunately the APA Ethics Code provides many practical guidelines for clinicians seeking to integrate these disciplines (2002). Like much of the Ethics Code, the three sections that discuss the relationship of psychology to religion seek to empower the client in the therapeutic setting and promote a healthy environment where multicultural dimensions and professional boundaries are recognized and honored. Thus the Ethics Code requires that “Psychologists are cognizant of and respect unique cultural differences, including religion” (Principle E: Respect for People’s Rights and Dignity). In a similar vein the Ethics Code dictates that “Psychologists do not engage in discrimination based upon religion” and therefore “Psychologists actively avoid insulting and denigrating behavior based on religion” (3.01 Unfair Discrimination; 3.03 Other Harassment). As previously discussed, many clinicians do not feel competent to serve clients’ religious and spiritual needs. Recognizing this problem the Ethics Code states, “When an understanding of religion is essential for providing professional services, a psychologist will acquire the necessary competence or make a referral as needed” (2.01 Boundaries of Competence [b]).

It is important therefore to note that despite the clear guidelines in the Ethics Code, none of the psychologists reviewed in this article called for referring clients to other professionals when their clients’ religious and spiritual problems could not be addressed in therapy. When they cannot address the religious and spiritual needs of the people in their care, psychologists rarely make referrals to ordained ministers (Hill & Pargament, 2003). However, the needs of clients should always be the hallmark concern of the clinician. Not referring to a qualified professional when clients’ religious and spiritual needs cannot be addressed in therapy could be at odds with the Ethics Code.

While it is certainly true that psychologists would be well served professionally to be better versed in the complexities of the ancient fields of religion and spirituality, this is an extremely daunting task. While it would certainly be bene-
cial for clinical psychologists to have some degree of formal knowledge of religion and spirituality, the educational integration of these varied and vast disciplines remains elusive (Johnson & McMinn, 2003; Russell & Yarhouse, 2006). Of all the psychologists calling for integration, few call for dialogue with academic scholars of religion. The emphasis for integration from within psychology seems to be largely focused on partnerships with ordained clergy. Religion and spirituality can, on occasion, be skillfully integrated with clinical psychology in a therapeutic setting as long as clear and objective ethical parameters and guidelines are followed and academic rigor is preserved.

References
Focus on the Business of Practice

Growing and Sustaining a Private Practice: Opportunities Are Where You Find Them and Where You Make Them

— Steven Walfish

In their book, *Built to Last: Successful Habits of Visionary Companies*, Collins and Porass (2004) point out that successful companies are aware that market conditions are always changing and therefore it is necessary for companies to change. Not to do so, according to Collins and Porass, is a recipe for extinction for the company. Companies are constantly experimenting and investing in research and development. They realize that some of these experiments will be failures, but some indeed will be successful and profitable.

Are we doing research and development and experimenting with new services in our own clinical and consulting practices? Or are we doing the same type of work, with the same types of clients that we did 5-10-15 or 20+ years ago? If that strategy is working for you, then it may make sense to “keep on, keeping on.” However, I believe that it is more likely that due to changes in culture, market demand, and social policy changes, this will be a successful strategy for only a select few private practitioners, in a few select markets. In an *IP* editorial (Walfish, 2008) I described Johnson’s best-selling business book, *Somebody Moved My Cheese* and how concepts from the parable apply to our private practices. Our cheese is always being moved and it is up to us to evolve and adapt to the changes elsewise our practices may become extinct. Further, the ride to the end will be unpleasant fraught with anger, frustration, learned helplessness, burnout and the opposite of a thriving private practice.

Some shout about the doom and gloom that is the current state and future of private practice. This may be primarily due to low reimbursement rates, competition from other mental health professionals and life coaches, and the infringement of our independence by managed care companies. Contrary to the prediction of these naysayers, my partners and I at The Practice Institute, LLC believe (minus a few geographical markets that are either rural in nature or have extreme poverty) that this is indeed a great time to be in private practice!

Concepts from Creative Thinking

I recently purchased one of the Great Courses video set, *The Creative Thinker’s Toolkit* by Gerald Puccio (Undated), a Professor of Psychology at Buffalo State University. In this course he discussed several topics that I believe relate to the development of a successful sustained private practice. He described the work of J.P. Guilford on divergent thinking as having the ability to draw on different ideas across several disciplines. When faced with a problem that seems unsolvable, “vertical thinkers” just dig deeper holes. On the other hand “lateral thinkers” simply dig other holes. If your practice is not doing well, do you simply do more of the same “hoping” things will improve? Or, do you attempt to create new service lines and revenue streams that may bring income into your practice? Puccio notes that divergent or creative thinking is a better predictor of success than IQ.

Everyone is familiar with the concept of “brainstorming.” In his video series Puccio presents the concept of “reverse brainstorming.” As it applies to us in Division 42, imagine that you have a successful and rewarding practice in 2014. In reverse brainstorming, the question to ask is, “How can I ensure that my practice will be extinct in 2016? 2018? 2020? 2024? or in 2030? The answer to this question could lead you to prepare yourself to adapt and evolve to whatever local market conditions and social policy changes you will inevitably face over the lifetime of your practice (i.e., small business).

Effectuation

Saras Sarasvathy is a University of Virginia Professor of Business who has now become a mini-hero of mine, as her writings feed my entrepreneurial soul. *Effectuation: Elements of Entrepreneurial Expertise* (Sarasvathy, 2008) is a page-turner for those interested in creating practice opportunities. A complete presentation of her work is beyond the scope of this article, but these are a few important concepts. Effectuation assumes that opportunities are not waiting to be discovered, but rather it refers to opportunities that emerge when created by an entrepreneur and his/her partners. According to Sarasvathy, opportunities are co-created by the entrepreneur and committed stakeholders. Effectuators see the world as open, still in the making. Further, effectuators rarely see opportunities as given or outside of their control. For the most part they work to “fabricate” (e.g., create), as well as...
recognize and discover opportunities.

As a small business owner, I find Sarasvathy’s rhetoric both exciting and empowering. If I can find committed stakeholders, I can create a new service line or revenue stream in my practice. I can do this work with partners who have a vision of creating something new, and we can all reap the benefits. To fabricate opportunities, we can use our entire skillsets of psychotherapy, assessment, teaching, research, supervision, and writing, all the tools we developed in the course of years of graduate training and later professional practice. We also have available to us practice opportunities, products and revenue streams that we can create based on the work of others, or can borrow based on what others are already doing.

**Opportunities Are Where You Make Them – Reading Data-Based Research**

I believe that most private practitioners stop reading professional journals shortly after leaving graduate school. There are many reasons for this which are summarized elsewhere (Grossman and Walfish, 2014). While private practitioners may believe that published clinical research is not relevant to their everyday practice I believe ignoring this body of data is turning a blind’s eye to a tremendous resource for developing clinical services that clients will pay for in your practice, if one takes an effectuating and entrepreneurial stance towards one’s business.

Let’s take a few examples. Blanchard, Hickling, Taylor et al (1994) studied the psychological effects of being involved in a motor vehicle accident (MVA). They found that individuals in an MVA who also sought out any type of medical attention (emergency room, primary care physician, chiropractor) within one week of the accident, when evaluated 1-4 months later, 46% could be diagnosed as having PTSD. What is the potential market for services and who might the stakeholders be that would be interested in such data? The market is obviously huge given the ubiquity of MVAs each year in our country. The stakeholders may be the physicians who treat these individuals (we know that undiagnosed and untreated PTSD complicates medical recovery), chiropractors (who commonly see accident victims for pain following an accident), and personal injury attorneys who advocate for the injured. Based on these data, when I previously practiced in Washington State, I developed a service for attorneys, physicians, and chiropractors to evaluate their clients and patients who had been in accidents. It became a stable service line and revenue stream for my practice.

In a more recent study Garland, Manusov, Frieleger, Kelly et al. (2014) developed an 8-week program for patients with chronic pain that targeted both pain reduction and decreasing the likelihood of opioid abuse. This was a multimodal intervention that focused on the training of mindfulness skills. After eight weeks of the intervention chronic pain patients reported less pain and reduced desire to use opioids, and these findings were maintained at three-month follow-up. What is the potential market for services based on such an intervention and who might the stakeholders be that would be interested in such data? Pain management physicians often come under fire for addicting and maintaining the addiction of their patients. Some medical licensing boards have developed specific guidelines for physicians who prescribe to this patient population. Physicians might welcome having a psychologist (who could be a consultant to the program or function as an independent contractor doing their own billing for services) in their practice who could implement such an 8-week intervention. In this way, patients learn to reduce their pain levels and physicians reduce their liability exposure. Might Workers Compensation or Rehabilitation Case Managers be interested in offering such a program for their clients who do not appear to be improving from traditional pain management interventions? I would bet the answer to this question is “yes” given that improvement in functioning and reduced medication usage may reduce costs and more optimize clinical outcomes.

In another paper published during the past year Ter, Kulie, Moniek, M. Melles, R., de Groot, E. et al. (2013) examined the effectiveness of a brief treatment program for women who experienced lifelong vaginismus. This was an exposure-based treatment approach that consisted of three 2-hour sessions conducted over a 3-month period. After this brief intervention, 89% of the women reported having sexual intercourse at post-treatment, with improvement within 2 weeks of beginning the treatment. There was also a concomitant reduction in coital fear, coital pain, and sexual distress. What is the potential market for services based on such an intervention and who might the stakeholders be that would be interested in such data? First, we have the women who are experiencing this disorder. Second, the partners of the women experiencing this disorder would have significant interest in this data. Third, Ob-Gyn physicians are likely the first health care professional to hear that this disorder is present in their patient. Some might welcome having a Psychologist (who rents space from them) in their office to deliver such an effective data-based intervention. This would be a value-added service to the Ob-Gyn practice and enhance the credibility of the physician’s clinic.

These are just three examples, one from a paper published in the 1990’s and two published within the past year, of how I believe that data-based research is a great friend...
Opportunities Are Where You Find Them: APA CE

Most states have a Continuing Education (CE) requirement for psychologists in order to renew their licenses. Why not use this requirement as an incentive to develop a new service or product line in your practice?

Of course CE offerings are plentiful. But perhaps there is no more centralized location to obtain CE credits and begin to develop a new practice opportunity than through the offerings at APA. These may be found on their website at http://www.apa.org/education/ce/topic/index.aspx

Let’s take a look at a few possibilities. The medical conditions of chronic fatigue syndrome and fibromyalgia can be debilitating for patients and ones that physicians find difficult to treat. APA offers an 8-credit CE program titled, “Chronic Fatigue Syndrome and Fibromyalgia: Theory, Assessment and Treatment” presented by the premier researcher in this area, Leonard Jason, Ph.D. This CE program presents a 7-Step cognitive-behavioral improvement approach to the treatment of these conditions. There is clearly a market from both treating physicians and patients and their families who endure these conditions, where there is no readily available medical intervention to address the symptoms being presented.

With the media highlighting the incidence of concussion in sports injuries there is clearly a market for psychologists, especially neuropsychologists, to apply their services skills. APA offers an 3-credit CE program titled, “Concussion on the Cutting Edge: Evidence-Based Comprehensive Approach from Assessment to Treatment” presented by Anthony Kontos, Ph.D. Neurologists, Sport Medicine Physicians and Rehabilitation Physicians might be interested referral partners if an entrepreneurial psychologist could set up a service in their practice that focusses on this problem area. In my local vicinity, much attention is being given to the incidence of concussion in youth sports and those with pediatric neuropsychology skills may find a significant market opportunity in this area.

As a final example there is a growing literature on the role of emotional factors in heart disease and the reoccurrence of heart disease. APA offers a 3-credit CE program titled, “Evidence-Based Psychosocial Interventions for Cardiac Patients” by Robert Allan, Ph.D. Imagine approaching a Cardiologist and presenting them with a proposal to rent space in their office and provide psychological services. This is a “win-win” situation for all as the physician would be earning income from rent from the psychologist, his/her patients would be taken care of from a holistic perspective, and the patients might be more likely to take advantage of the services because they are offered in their doctor’s office rather than being referred to “an unknown Shrink.”

These are but three examples of ways psychologists can take advantage of CE requirements and begin to develop a new service area. Of course one does not take a 3-credit CE course and then begin delivering the service. However, it can be a good start, followed-up with further training and consultation from an expert in the content area.

Opportunities Are Where You Find Them: Books

There is no shortage of books published in psychology. The subject areas of a portion of these books provide opportunities for the entrepreneurial and effectuating private practitioner to develop service lines in their practice not previously considered.

One area that psychologists hold the primary market share is in psychological assessment. With the greater integration of health care and mental health care, there are opportunities to provide services because physicians and health care teams want our expertise and input. One interesting recent book that describes a multitude of opportunities for private practitioners in this area is Presurgical Psychological Screening: Understanding Patient, Improving Outcomes, edited by Andrew Block and David Sarwer (2013). In this book there are chapters related to transplant recipients and organ donors, spine surgery, bariatric surgery, pain control stimulators and pumps, bone marrow and stem cell transplant, deep brain stimulation for Parkinson’s Disease, Temporomandibular Disorder–related oral surgery, breast cancer surgery, gynecologic surgery, carpel tunnel surgery and cosmetic surgery. There is a role for psychology in the assessment and treatment of psychosocial issues each of these health conditions. These opportunities are waiting for us to take advantage of them.

One remarkable series of books published by Oxford University Press is the Treatments That Work library edited by Division 42 Fellow David Barlow. These clinical guidebooks are based on evidence-based practice in which there is both a therapist’s guide and a client guide available for purchase. Many of the books outline treatment protocols that can easily be adapted in private practice.
by an entrepreneurial and effectuating psychologist who wants to develop and offer a new service line. These are just a few of these titles:

- A CBT Program for Overcoming Alcohol Problems
- Enhancing Sexuality
- Stopping Anxiety Medication
- Obsessive Compulsive Disorder
- Managing Tourette Syndrome
- Coping Effectively with Spinal Cord Injuries
- CBT Treatment for Coping with Prostate Cancer
- Coping with Breast Cancer
- Cognitive-Behavioral Stress Management
- Compulsive Hoarding and Acquiring
- A CBT-Approach to the Beginning of the End of Life
- Coping with Chronic Illness
- Mastering Your Adult ADHD
- Mastery of Your Anxiety and Panic

One can easily see how there would be a market and demand (e.g., people willing to pay for services) for evidence-based treatment in such a wide variety of clinical problem areas. As noted above, if your practice is stagnating don’t be a vertical thinker and “dig more of the same hole” but rather consider being a lateral thinker and finds some other holes. Barlow’s series can easily facilitate finding other holes.

**Opportunities Are Where You Find Them: What Your Colleagues Are Doing Nationally**

I have previously conducted two studies with psychologists (Walfish, 2001; Le & Walfish, 2007) and one with social workers (Walfish, 2011) on ways private practitioners are earning a living that falls outside of the purview of managed care (complimentary copies of these papers are available by writing to me at stevewalfishphd@thepracticeinstitute.com). Private practitioners are always wanting to find ways to get away from “the big, bad insurance company.”

In the first study I was able to identify 180 specific practice activities that fell outside of managed care that could be grouped into ten separate categories. These practice opportunities can be found in (a) Business Psychology; (b) Consultation To Organizations; (c) Fee-for-Service; (d) Forensic Psychology; (e) Group Therapy; (f) Health Psychology; (g) Psychoeducational Services; (h) Services to Government; (i) Teaching and Supervision, and (j) a category we labeled Miscellaneous that did not fit into any of the other categories. In the follow-up study, Jane Le and I were able to identify a total of 158 separate practice strategies that fell outside the purview of managed care in which private practitioners received income for their efforts. In the 2011 study with MSWs I presented a list of 71 such strategies.

Find out what your colleagues are doing nationally. Liberally borrow from other clinician’s success experiences if they can be applied in your local area.

**Opportunities are Where You Find Them: What Your Colleagues are Doing Locally**

This past summer I was fortunate enough to be invited to do a workshop at the Annual Meeting of the Florida Psychological Association on the very topic of this article. In preparing for the workshop I viewed the website of every psychologist in Florida who advertised on Psychology Today. This was both an exhaustive and exhausting experience but yielded a tremendous amount of data on what services psychologists in Florida were providing that fell outside of the purview of managed care. After completing the exercise, I concluded there are psychologists in Florida who are entrepreneurial, recognize or fabricate a need, and are providing services in their communities. I was able to identify over 100 psychologists doing interesting work that is not financially supported by managed care companies. Presenting the entire list is beyond the scope of this article (if anyone would like a complimentary copy write to me at stevewalfishphd@thepracticeinstitute.com and I will forward it via email attachment) but below I will present ten I thought especially creative:

- Karina Oppenheimer, PsyD. – Melbourne
  Evidence-based treatment for weight loss and eating disorders
- Michael Simpson, Ph.D.
  Auto accident treatment
- Suchuithra Hirode, Ph.D. - Tampa
  Job interview preparedness for young adults and adults
- Kellie French, Ph.D. – Winter Park
  Five-session interfaith/intercultural premarital counseling program
- Justin D’Arienzo, PsyD. - Jacksonville
  Dating coaching
- Lori Ben-Ezra, Ph.D.  – Hollywood
  Emotional support animal evaluations
- Helen Schwartz Cohen PsyD, - Plantation
Immigration evaluations
• Kerri Bresnan, PsyD – Fort Lauderdale
  Evaluation with Egg Donors
• Karla Aguilu, PsyD. - Tampa
  Hands on Parenting: (at least 2 hrs) at home sessions for parent(s) and child after at least sessions in the office.
• Benmeleh Roditi, Ph.D. – Miami Shores
  Group: Girl Talk is an innovative group specifically for girls ages 11-18. Being a girl can be a lot of fun, but at times there can be bumps in the road.

Exploring your colleagues websites, both locally and nationally is a form of divergent thinking. It helps to expand your horizons to consider ways to utilize your entire skill set to provide needed services in your local community.

Conclusion
Verhaagen and Gaskill (2014) describe the development of their group practice in Charlotte, North Carolina in which 35 clinicians practice, all have full caseloads and consultation opportunities, and they participate in no insurance plans. They trace their success to building the practice that emerges out of their core values of FIRE: fun, innovation, relationships, and excellence. It is clear from reading this book and exploring their website (www.southeastpsych.com) that they have mastered innovation. They have done so by not resting on their laurels, but are always looking to adapt and evolve. Through entrepreneurial and effectuating behaviors they have demonstrated what is possible for all of us in private practice or who want to be in private practice. As mentioned above, my partners and I this is a great time to be in private practice.

References

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Moms in Independent Practice: One Mom’s Story

— Lauren Behrman

It was 1999 and I was sitting on the floor in my home office working with Sandy, a feisty 4 year old girl with gleaming deep brown eyes. We were ‘playing’ with my dollhouse, and she was weaving an intricate family drama with my Playmobil dolls, playing out her struggles and worries in her story. On the other side of the double doors, my three children, aged 2, 4, and 6 were home from school, and even though they knew to be quiet when mommy was working, I could imagine the sound of their voices. They were playing and doing homework with their nanny, and I began to question myself: “Here I am, sitting on the floor and giving my undivided attention to other people’s children, while my own children are with a nanny inches from where I sit. What is wrong with this picture?” It was at that moment that I realized that the practice model that had worked for me for the past 14 years was no longer workable, and I needed to shift my practice paradigm.

I had been in practice for close to 9 years prior to becoming a mother, and had a well-established referral base in two different locations. At the time I became a mother, my practice was over 80 percent testing and therapy with preschool and school aged children, as well as parent guidance sessions. Much of my work took place from 3:00-8:00 or 9:00 PM. That model worked for the years my three children were infants and preschoolers. As I closed my two locations and worked solely out of a home office, I was home with my children much of the day to take them to Mommy and Me, Gymboree, Musical Munchkins, the playground, playdates and their doctors appointments, and was then able to work while my children napped and after they went to bed. With some childcare in the late afternoons, I could take time off for dinner and then see a few clients after the children were asleep. However, once they entered elementary school, the landscape completely changed.

When my oldest son went to elementary school, and was out from 8 AM to 4 PM, seeing the bulk of my clients in the afternoon and evening was akin to working in Chicago. If I didn’t change things quickly, I was about to miss my children’s childhood.

My Solution

I realized that the hours I had carved out for my practice were no longer feasible with school-aged children. I needed to find a population that could be seen primarily during daytime hours. I went to an APA convention, ‘shopping’ for ideas for a practice niche that would interest me, match my skillset, and would primarily be limited to the hours that my children were in school. I attended seminars in anger management groups for children, couples therapy, therapy with women undergoing infertility treatment, and co-parent counseling for divorced parents to name a few. By the end of the convention, I came away with many ideas for shifting my practice, so it would fit into daytime hours.

After much thought, I decided that the co-parent counseling would best meet my skillset, areas of interest, and hours that I wanted to devote to practice. Co-parent counseling was more of a time-limited intervention, and often court-ordered, and as a result, my clients were willing to come in to see me during daytime hours. What began as a niche practice in co-parent counseling evolved into a divorce-services niche that included mediation and parent coordination which supplemented my therapy practice.

Lessons Learned in the Trenches

Looking back to my own professional journey, I wish I had recognized that I was a small business owner early on in my career, and that there were business skills that I could have learned to make that part of the practice more efficient and less stressful. Somehow, flying by the seat of my pants, I figured out how to make it work, and was able to shift my work as my family evolved and grew. However, I didn’t have the consciousness that would have allowed me to strategize, anticipate and plan for the necessary shifts that my practice would require as my children grew.

An Opportunity to Pay it Forward

One of my greatest professional pleasures in ‘paying it forward’, is sharing experiences, resources, frustrations and satisfactions with moms in practice from around the country once a month in an open conference call I facilitate through The Practice Institute. Women practitioners at all stages of parenthood and practice have joined together and brought their questions and concerns to our call. From pregnant first-time mothers-to-be, to mother’s of teens, adoptive moms, stepmoms, gay moms, moms of special needs children, college age and adult children, all have been represented on our calls. The calls
are a mixture of practice consultation and support group, and are open to both members of The Practice Institute, as well as the general public.

The most common concern among these mothers in independent practice has to do with finding balance - being able to juggle the demands of motherhood with being a clinician and small business owner. Independent practice lends itself perfectly to blending with parenthood at all developmental stages, although burn out from taking care of dependent children and needy patients while neglecting oneself is a huge occupational hazard. Attending to self care, and consciously and intentionally setting up one’s practice so that there is a balance, is critical. The flexibility and autonomy of independent practice allows for one to choose a niche population that is available when you want to work, and during the times that work best for the needs of your family. It is the intentionality and planning that are so critical. Rather than allow the practice to take over your life, and seep into all the available moments, planning the hours you want to work, and then matching your interests and skills with a population available during those times, allows one to work smarter and not shortchange either your family or your practice. There are so many different options available for niche practices that can suit any practitioner’s availability and interests. With independent practice, it is also possible to shift and change as the developmental needs of your family evolve. Anticipating those transitions, and actively researching your options in advance, allows you to find that optimal balance, and avoid burnout.

1 An organization, founded by psychologists, devoted to improving the professional life and professional services for mental health practitioners.

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Focus on Diversity

Diversity Narrative Project

— Michi Fu and Doug Haldeman, Diversity Committee Co-Chairs

What do you do for a living? What led you to your line of work? What diversity improvements you like to see happen in the future? How will you be a part of this change? These are a few of the questions that we are most curious to introduce in this latest Diversity Column.

Meet Michi Fu

Growing up, my parents would intentionally speak to me in Taiwanese so that I would be able to communicate with them. Saturday Chinese schools helped me to learn Mandarin. Many of my private practice clients seek my services because I have the language capacity or cultural sensitivity to work with Asian immigrants and their families. My private practice clients help to remind me why I teach diversity issues to doctoral students of clinical psychology at the California School of Professional Psychology at Alliant International University. I am also the Statewide Prevention Projects Director at Pacific Clinics, working to reduce mental health disparities and stigma & discrimination reduction projects.

My immigrant family spent much of our time between two worlds. Though I was born and raised in Southern California, summers were spent in Taiwan visiting with relatives. Years later, my work involves helping families to bridge the bicultural divide that oftentimes leads to family conflicts.

Jennifer was an American of Japanese descent. She studied engineering because her father demanded that she pursue a “respectable” profession. Nearly every day, she dreamt about flinging herself out of her apartment window. It took all of her concentration for her to ignore her passion for pursuing the arts out of fear that her family would disown her. Much of our work would focus on how to remain true to herself and not disgrace her family by making them “lose face.”

Stephanie recently emigrated from China and married an African American partner who was outraged when he perceived that she had been hiding crucial information from him. Couples counseling helped them to understand the difference between cultural expectations, personal values and the impact on communication styles.

These are a couple of examples of the cases that allow me to explore my clients’ worlds with cultural humility. As incoming co-chair of Division 42’s Diversity Committee, it’s my hope that our members have an opportunity to learn from one another’s experiences that makes us more culturally responsive to those that we work with. I am grateful to Dr. June Ching for appointing me as Diversity Committee Co-Chair and am looking forward to working with Doug Haldeman who has been our champion for diversity issues as our Diversity Representative to APA Council. More importantly, I’m eager to hearing from YOU in regards to how to further our diversity initiative in a way that’s most relevant to our membership.

Meet Doug Haldeman

After 30 years in private practice, I now chair the Doctoral program in Clinical Psychology at john F. Kennedy University in Pleasant Hill, CA. Our program integrates multicultural competence and service to a diverse community into every aspect of our curriculum, and I am proud to be a part of this institution. I’ve also had the privilege of serving Division 42 as Diversity Representative to APA Council for the past five years, in addition to numerous other roles in APA governance.

I spent my early years growing up with a single mom; we lived in an extended, multi-generational family of Swedish immigrants. Imagine, if you will, what it might have been like to grow up in an Ingmar Bergman movie – that
was my early childhood. In all sincerity, I learned at an early age about cultural and generational differences – not to mention the Swedish language, which brings me to the present. I would like to continue with my brief story, but first let me tell you about some of the men I worked with this summer.

Mohammed (not his real name) took a job as a war photographer in his hometown of Damascus, hoping to be killed in street fighting instead of having to tell his family that he is gay. Abdul, a male-to-female transgender Palestinian, was arrested, beaten and raped by local police numerous times until an American friend intervened. Her face is a road map of scars; I shudder to think what the rest of her body looks like. Philip was thrown out of his family’s home in Kampala, Uganda, when it was discovered that he had a male lover. The couple moved to a shanty where, after having been tipped off by the family, local “authorities” barged in one night and started to beat them. Philip’s lover shouted at him to run for his life – which he did, fleeing with nothing, not knowing if his lover survived the attack. His family still hangs up when he calls. These are just a few of the men with whom I have had the privilege of working recently.

I am telling you a bit about them because every year I volunteer at a summer camp in Sweden sponsored by an organization that assists gay men seeking asylum in the country. These men are refugees from countries in which homosexuality is criminalized: they may face imprisonment, torture or death – not to mention rejection from their families, loss of employment, and so on. The lucky ones escape. Still, they must deal with the residual trauma they have suffered, navigate an unfamiliar culture, re-establish themselves professionally, make new friends and redefine family, and all the other issues of asylum seekers. It is an extraordinary transition.

It is also an international humanitarian crisis, about which we hear little in this country – owing, I suspect, in part to our own country’s hostility to refugees, as well as a lack of concern about what happens to gay men in Uganda, or Syria, or Palestine. I seek to continue this work, and to identify ways in which people in my community (LGBT and allies) can become more aware of serious human rights abuses in a global context.

I have another, more immediate goal, however: that is to continue working toward a more diverse and inclusive Division 42, and to be a better resource for practitioners seeking to be more multiculturally competent. For us, this is a personal endeavor: very often, personal experience is the most transformative force in creating an interest in cultural competence. I appreciate the opportunity to share a bit of my story.

How do we collectively move the diversity agenda forward in Division 42?

You have had an opportunity to hear a bit from both of us regarding the work that we are currently engaged in and how we might have been shaped by our prior experiences. Now, we’d be interested in hearing from you. We would like to get started by inviting you to share your stories with us.

Please join us as we launch the Diversity Narrative Project. This endeavor helps us to understand a little about how members see themselves contributing to the division and the field in the general from the perspective of culture. Please send us a statement that describes (1) the culturally sensitive work you engage in, (2) what diversity issues interest you and (3) ideas for how to make Division 42 more culturally responsive. Statements forwarded to either of the co-chairs may be shared with the rest of the membership.

We hope that Division 42 will be considered a welcoming professional organization to people of diverse backgrounds. We foresee that Division 42 be more oriented in its agenda to diversity issues and concerns. How do we go about doing so? We are currently recruiting for new members to join the Diversity Committee. If you are interested, please don’t hesitate to contact either Michi Fu, Ph.D. at drmichifu@gmail.com or Doug Haldeman, Ph.D. at Doughaldeman@aol.com.

Michi Fu and Doug Haldeman are Diversity Committee Co-Chairs.
Announcement Concerning Division Continuing Education

Due to a change in APA’s process for reviewing and approving sponsors of continuing education for psychologists, Division 42 will not be offering CE for home study activities (IP, Virtual Learning Hours) until our application is approved in the Spring of 2015. We apologize for any inconvenience caused by this hiatus. Please contact our central office for updates about when the Division’s application has been approved, and watch for further announcements in the IP and on our website at www.Division42.org.

Mark Your Calendars!

Division 42’s Fast Forward 2015
Join us at the fabulous Hard Rock Hotel Chicago October 2-4, 2015
Details to follow on the Division 42 website www.division42.org

Need a Mentor? Come join Mentorshoppe!

Mentorshoppe is Division 42’s home for two separate mentoring programs:

1) A Student/ECP Program where students and early career psychologists are able to find guidance, consultation, and information that will help them navigate through the labyrinths of training and early career issues under the guidance of a psychologist who’s been there! For more information about the program, please visit the Division 42 website at http://division42.org/content/secp-mentorshoppe-introduction-and-goals or you can contact Dr. Lori Thomas (drthomasloric@gmail.com), the Student/ECP Mentoring Coordinator, will help match you with a mentor.

2) An ABPP Clinical Psychology Program where those psychologists interested in obtaining the ABPP in Clinical Psychology will be able to find help in traversing the road from application to examination from a psychologist who has already gone through the process. For more information about this program, please visit the Division 42 website at http://division42.org/content/abpp-introduction-and-goals or contact Dr. Fred Alberts (fred@dralberts.com), the Clinical Psychology Mentoring Coordinator, who will help match you with a mentor.

It is our hope that you will find these programs valuable to your careers as professional psychologists.
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