Waivers of Privilege: Intended and Unintended— David Shapiro

Years in Review — Krystal Stanley

Practice Innovations Journal - Interview with editor Jeff Zimmerman
Independent Practitioner

Editor: Eileen A. Kohutis, PhD (2019-2021)
2 W. Northfield Road
Suite 200
Livingston, NJ 07039
(973) 716-0174
email: eileen@d4kohutis.com

Associate Editors: Theresa M. Schultz, PhD (2022-2024)
630-323-1050 x42
email: doctschultz@gmail.com
Lakelta Carter, PsyD (2022-2024)
email: drlcarter@myiheal.com

Bulletin Staff
Patrick DeLeon, PhD, JD, Opinions and Policy Contributing Editor
David Shapiro, PhD, Liability, Malpractice, and Risk Management
Contributor
Krystal Stanley, Ph.D. D. Diversity Editor
Mona Robbins, Ph. D. and Tori Knox-Rice, Ph. D. Early Career Editors
Rick Weiss, Layout Design Editor

Division 42 Central Office
Jack Hutton
2400 Post Road
Warwick, RI 02886
(401) 732-2400
Email: div42apa@gmail.com
www.division42.org

Awards: Judith Patterson, PhD
Paula DeFranco, PhD, MBA

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President’s Column

President’s Message -- January 2022

Peter Oppenheimer

Greetings Everyone,

Division 42 faces a significant transition in 2022: wistful, hopeful, and challenging.

Sadly, it’s time to say so long to Jeanne Beeaff, our executive director, for the past 33 years. We will miss you, Jeannie. Please accept our grateful appreciation and heartfelt best wishes for Sterling and you.

Thank you to President Laney Ducharme and Past-President Judy Patterson for guiding our division through the pandemic during the past two years. They met the challenge of adapting us to an all-virtual environment, kept our division functioning and focused on our mission.

Also, thank you to our departing board members, Krystal Stanley and Lindsey Buckman, and welcome to our newest member, Samantha Slaughter.

New Executive Director

I’d like to welcome Jack Hutson, our new Executive Director. Jack and I have worked together for 20 years at the Rhode Island Psychological Association. In her last presidential column, Laney introduced you to Jack. Over the last few months, I joined Jack and Jeannie for some of their transition meetings and learned a lot from their discussions.

Congratulations!

Two of our board members deserve congratulations for their recent achievements. Our secretary, Derek Phillips, recently became licensed as a prescribing psychologist in Illinois. He’s been working at this for many years, and his persistence has paid off. He is paving the way for a new vision for professional psychologists.

And, Robin McLeod has been elected Chair of the Board of Professional Affairs. Robin will challenge BPA to be more active in engaging with the practice issues that used to be in the domain of the Committee for the Advancement of Professional Practice (CAPP), prior to the “One APA” transformation. Congratulations, Derek and Robin!

National Register and the Trust’s National Practice Conference

Division 42 was the primary sponsor of the National Register and the Trust’s National Practice Conference. Laney, Jack, and I attended to represent the Division. We talked to attendees about the benefits of being a member of this division, as we tackled issues unique to being an independent practitioner. In the process, we gained new members and interested others.

Presentations at the program were geared to independent practitioners. In the domain of our division colleagues in-person; it had been such a long time. Please consider attending the conference next year.

Licensure for Master’s Degrees in Psychology

Members of Division 42’s Advocacy Committee and Board of Directors are active in the groups and meetings APA has organized to promote their interest in creating licensure for professionals with master’s degrees in psychology. Since 2016, APA has been hyper focused on creating a path to master’s licenses, an initiative that was birthed out of the efforts of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to deny those with master’s degrees in psychology licenses as mental health counselors.

APA is actively trying to establish new policies on master’s education and practice. Thus far, the Council of Representatives has only addressed accreditation of master’s programs in health service psychology. The Council has not yet discussed licensure.

APA has held multiple meetings to discuss the development of accreditation standards and licensure for those with master’s degrees in psychology and to explore the “value of the doctoral degree.” As such, APA has formed two task forces. One group is tasked with reviewing the educational competencies for doctoral psychologists. It is unclear how this group will use the existing doctoral competencies or the proposed master’s competencies. In my view, the draft competencies for master’s education do not differ much from existing competencies for doctoral education. The other group is tasked with developing the scope of practice and title for a potential master’s level model license act. This is all being done within the context that the Board of Professional Affairs will seek to revise the Model License Act for doctoral psychologists and create a model act for master’s practitioners.

APA selected the membership of these task forces – and no Division 42 members were selected to serve on the doctoral competency group. Our division will be represented only by liaison Michele McKenny.

Fortunately, we do have division members on the scope and title task force. Past-President Gordon Herz and I are members. President-Elect Robin McLeod will serve as the liaison from BPA, and Diversity Committee Chair Bhum Butaney will serve as our Division’s liaison.

While APA is concerned for the welfare of master’s students and the people who teach them, they have been short-sighted about the potential impact these changes could have on practicing doctoral psychologists and the future of our profession, and psychological science. At least as long as I have been involved in this issue, APA has never addressed what should be, in my opinion, two fundamental questions:

For what roles/skills in professional psychology is a doctoral degree not required?

Is it alternatively preferable to have a person with a master’s degree perform those functions?

The workforce of mental health practitioners is flooded with professionals with master’s degrees in psychology. Of course, there is potential value in having some of these professionals better trained in the field of psychology with some exposure to our science and standards of practice. There is also value to creating educational standards through accreditation and regulating the practice of master’s clinicians in a more consistent way. Currently, 17 states recognize some form of master’s level practice in psychology. The scope of practice and titles vary greatly among the states. It is possible that regulation could be successfully expanded if it is carefully thought out and implemented.

The key to APA’s success in licensing at the master’s level is if the plan creates a regulatory scheme that will be adopted widely among the 65 jurisdictions of Canada and the United States. To do that, there needs to be a model acceptable to the State Provincial and Territorial Associations (SPTAs), regulatory bodies (licensing boards and often the governmental departments that are bureaucratically intertwined), and the state legislatures and governors (provincial parliaments and premiers in Canada) whose votes are needed to support the plan. Make no mistake, this is a tall order.

Also, we must consider another potential hazard. If APA endorses licenses for people with less training and experience, then that could be used as an excuse by some state legislators to undermine professional regulation or eliminate it altogether. It’s important that we recognize the existence of political and business interests across the country who want to undermine...
government regulation. Professional regulation is an easy target for these interests. Unless the professions stand firm and support criteria that demonstrate to the public that licensure requirements do protect them as consumers – the anti-regulatory interests could succeed in destroying effective regulation. That would be harmful to consumers and reduce the value of having a professional degree, training, and experience.

In Rhode Island, I am addressing a desire by licensed mental health counselors to create a trainee license that could potentially license someone who has not yet finished a master’s degree and their supervised experience. As a regulator, I want to be confident that the people I credential are indeed competent to do what they are enabled to do through their license.

I recognize that part of the effort to license master’s level people with psychology degrees is to create more practitioners to serve underserved populations and areas. Everyone should have access to quality services from well-trained and genuinely-competent professionals. A properly conceived regulatory plan will support that.

We must also encourage and support people from diverse communities to enter the psychology field, support their training, and empower them to become leaders in our professional community. In the long run, people will only enter the profession if they believe that their training will enable them to have a meaningful career where they are able to do the work they want to do and be appropriately compensated for it. APA has an ethical duty to ensure that education and training in their accredited programs enables people to do that.

It is not lost on me that, while APA is putting so much focus on enabling master’s level practitioners, they are paying scant attention to what could be done to support existing practitioners to better serve diverse communities. Here’s a list of ideas that I generated in the context of my work in Rhode Island that could help psychologists to reduce disparities to accessible quality mental healthcare:

- Create income opportunities for psychologists that are congruent with the level of training, expertise and professionalism that are required to serve the public.
- Require payers to adapt their reimbursement rates to keep pace with inflation and the costs of providing services (such as the added costs of EMR and telehealth platforms).
- Enable health care professionals to meaningfully negotiate the terms of their contracts with payers.
- Offer state subsidies for the cost of practicing in underserved areas and with underserved populations.
- Offer free or low-cost cultural humility and sensitivity training to increase knowledge and skills in practitioners.
- Offer free or low-cost language classes to help more clinicians develop additional language skills so that they can work with people from communities who speak languages other than English (including American Sign Language).
- Provide support for interpreters at the expense of states or payers.
- Create more mental health programs and services in the schools to support normal development, prevention, clinical services; expose students to the science of psychology; and encourage them to consider careers in our field.
- Make the mechanics of getting licensed less arduous.
- Make education more affordable by supporting in-state graduate students with scholarships and loan forgiveness.
- Create financial incentives for in-state residents and trainees who complete their training in-state to stay in-state.
- Offer state subsidies for clinical supervision.
- Allow access to E&M and other consultation codes in state.
- Provide subsidies and enhanced reimbursement for integrated care by paying for integrated care activities for which there are no codes or for codes that psychologists cannot use.
- I am sure that there are ideas I am missing. If you have ideas, please share them and add them to this list. Please let me know if you are interested in creating a task force to work on what APA, payers, and state governments could do to support professional psychologists and the science of psychology to meet the needs of underserved communities and groups.

Venture Capitalized Corporations

Lastly, I am sharing with you my growing concern over the manner in which venture capitalized corporations (e.g., Better Help, Talk Space, etc.) are not only threatening the future of community-based and locally-owned practices, but also the professional independence of practicing psychologists. They are infiltrating our local communities by buying out independent community-based practices and by expanding their stake in the telehealth app market.

What if, in the near future, your only employment options are to work for local institutions (e.g., hospitals, prisons), state or federal government service providers (e.g., CMHCs or the VA), corporate-owned practices, or do telehealth for an app? It does not bode well. Your ability to practice as you feel best serves your professional commitment and your commitment to your community may be limited.

I am looking to you for help in organizing a task force of independent practitioners whose focus will be marketing the value of independent community based professional services and expertise to our communities. Now’s the time to step up and take a stand for independence and, what I believe to be, the best options for our community. Please let me know if you have an interest in working with this task force or other groups within Division 42.

I am looking forward to working with you all this coming year, as we support our practice and our professional community in Division 42.

Thank you!

Peter

Opinions and Policy

“If You Miss the Train I’m On, You will Know that I am Gone”

Pat DeLeon

Bushmaster: Several exciting aspects of the educational environment at the Uniformed Services University (USU) are its emphasis upon military readiness, interprofessional education (IPE) and teamwork, and providing unique clinical experiences – such as serving in American Samoa and other isolated and austere environments. USAF Maj. Abby Diehl: “Reflections on Behavioral Health at Bushmaster Exercise – We invest so much time in designing the experience of learning and rarely allow for time to critically reflect on what happened after. Instead, our cultural tendency is to jump to the next meeting, event, or task at hand. There is great power in putting our energy into the process of reflection. Slowing down and stopping to reflect after experiences is key to solidifying learning as well as recharging and rebooting. My hope is that my personal reflection on my experience at Behavioral Health at Bushmaster will accomplish two goals. Primarily, through reading my reflection to encourage and allow others to engage in their own personal reflection. Secondly, to induce excitement about the amazing opportunity that this simulated real world learning experience affords learners at all stages of their development as military psychologists.

“Talking about something is not equal to experiencing it. In the months leading up to the two iterations of Behavioral Health at Bushmaster, I attended many meetings where the experi-
ence for students was crafted by instructors. As well as many pre-briefings and lectures for the students where information was presented to aid in pre-exercise preparation for PMHNPs (Psychiatric Mental Health Nurse Practitioner) DNP and MPS (Medical and Clinical Psychology) PhD graduate students. The experience was crafted and designed with experiential learning in mind. Yet, I could not really ‘see’ it. Even though I had no less than eight different individuals spend a good amount of time and energy to help me ‘see.’

“Going in with an open mind to listen and to learn on the first iteration, I was not prepared for my own emotional reaction. It was as if I was watching all my most challenging days as Clinical Psychologist in the military over the course of my entire career play out in front of me. However, it was not mine to fix, change, or help. It was my job to observe and to assist in crafting the experience. For instance, coaching first year medical students to role play a patient with severe psychotic symptoms or as a member who had witnessed the death of their team member. It was for our students to decide what energy they would put into the experience and what they would do.

“It was not mine this time to stand up a mental health clinic in an austere environment with almost no resources from scratch. Then, to learn that you did not bring the items you needed to. And by the way that you need to spin up pretty fast on some clinical aspects you did not know that you did not need. To be completely outside of your comfort zone and to know you had to accomplish this mission. I completed my graduate training in Counseling Psychology at Texas Tech University, which some might say is an austere environment if you have been to far west Texas.

“However, I never had the opportunity in my graduate training to really experience what it meant to build a clinical system under these simulated combat conditions. Living out everyone’s most difficult challenges in clinical care, command consultation (i.e., fired up commanders), and psychological first aid AND having regular feedback, supportive coaching, and backup from those who have been in these scenarios was not a grant afforded. The type of critical, creative, and flexible thinking that is required in these scenarios is a skill that must be practiced — it cannot be read about. Our USU students have the uniquely brilliant opportunity to learn how to think critically in this way — mostly by making mistakes at first — in a crafted and supported learning environment. I learned — as most of us do — the harder way (or more painful way) — by making the mistakes in the ‘real world’ after internship is completed on our first assignment as military mental health providers.

“It was not mine to feel the uncertainty of being on the spot to brief a commander regarding how you as a mental health provider can support their mission. It was not mine to figure out how to negotiate building a team. It was not mine to figure out how to communicate clearly expectations when pressed for time and being pulled in multiple directions. It was not mine to feel unsure of the best way to build new relationships with colleagues — especially in an era of the world where we have been ‘socially distanced’ from each other for so long.

“It was only mine to point out what I saw and to provide feedback. I noticed that we often focus on the ‘process’ and lose sight of the fact that we are working with humans. And humans are inherently unpredictable — despite our scientific efforts to quantify and categorize human behavior. It was mine to point out relationships and connections are everything. We cannot lose and common humanity in difficult situations. We cannot lose the light and the hope. Mental health providers need to remember that we are present to listen, support, offer recommendations, and make difficult decisions. What we as mental health providers have to offer in operational environments is not a secondary piece. It is arguably the most important piece of a mission. To enhance performance, to care for, to listen to, and to support those who are engaged in executing their mission.

“After being present, listening, and learning from two iterations of students experiencing Bushmaster, now I ‘see.’ I believe this is an exercise in something all military mental health providers must complete before their first assignment. Reflecting back, there is no substitute for experience. And we have a vehicle to deliver this experience to mental health provid- er graduate students to set them up for learning a process of thinking, which will enhance not only their future but the future of the lives of those they serve.”

**Competition Fosters Change:** Over the years, we have come to appreciate that especially within our nation’s health policy context, competition is extraordinarily important in providing consumers with reasonable choices and in fostering new avenues of exploration which are often never considered within comfortable isolated professional silos. Since 1988 the Association for Psychological Science (APS) has been the professional home for now 35,000 of our science colleagues who may/or may not also belong to APA. Founding Executive Director Alan Kraut left APS some six years ago to direct the Psychological Clinical Science Accreditation System (PCSAS). PCSAS now has been fully vested by relevant federal agencies in the same way that APA has, including the Department of Veterans Affairs, the nation’s largest employer and trainer of clinical psychologists. This year PCSAS accredited programs became eligible to apply for grants from the Graduate Psychology Education (GPE) program of HSRSA for graduate student training and faculty development — the vision of former APA acting CEO Cynthia Belar. PCSAS also was recognized this year by the U.S. Public Health Service.

Alan will soon be retiring from his position as Executive Director of PCSAS to be replaced by Joe Steinmetz. Joe was on the founding Board of PCSAS and recently retired as Chancellor of the University of Arkansas. He also has been Provost of Ohio State University, Dean at the University of California at San Diego, and Adjunct Professor at India’s University’s Department of Psychology. During his tenure, Alan was successful in having graduates of PCSAS programs recognized by eight states, which represent more than 30 percent of the nation’s population, and many federal agencies, with the exception of the Department of Defense (DOD). Not surprisingly, in this year’s DOD appropriations bill, the House of Representa- tives expressed their concern regarding the shortage of current and prospective mental health care professionals and requested an assessment which “should include a review of related regulations to determine what impact a change in regulations to allow the employment of clinical psychologists who graduate from schools accredited by the Psychological Clinical Science Accreditation System may have on the Military Health System.” Once again, substantive change always takes time, especially within the health policy arena.

**Remembering Those Who Stand in Harm’s Way:** For colleagues fortunate to engage with Rod Baker regarding the history of VA psychology and/or Division 18 (Public Service), perhaps on Tiffanie Fennell’s introduction to his Division 18 webinar, in the corner behind his desk is an impressive American flag. Ten days after 9/11, Rod brought that flag to his VA Director’s morning meeting. “Where were you on March 4, 2001? We are already telling ourselves that we will always remember where we were and what we were doing the morning of September, 11, 2001. For me, I will remember my abode meeting in Washington, DC where I watched the smoke rising from the Pentagon from the top of the parking garage at the VA hospital and where that evening the smell of smoke from the Pentagon fire started seeping into the lobby and elevators of our hotel. I will remember those of you who expressed concern for my safety, and I will remember a group of friends I was with who provided each other emotional support for those days we were stranded in Washington. Others will better chronicle the horrors and dis-
belief of that day, and each of us will have our own personal memories.

“But today I want to ask: ‘Where were you on March 4, 2001?’ For most of us it was an unremarkable Sunday. On that day, however, there was a U.S. soldier in Kosovo helping keep the peace in a war-torn country. On that day, there was a U.S. Marine stationed outside one of our embassies overseas remembering the embassy bombing in which fellow Marines were killed. And on that day, there was a U.S. sailor on board the USN Cole performing his duties remembering a shipmate that had died 3 months previously in a terrorist attack on his ship.

“On that day, my son-in-law was on a combat mission in a F-16 fighter jet enforcing the no-fly zone over Iraq. Sometimes when I describe my son-in-law’s missions over Iraq as a combat mission, people are surprised by the designation of these flights as combat missions. And yet he was surely tracked by Iraqi radar that day, as on previous missions, and maybe that was a day a missile was aimed at his plane. He came home safely that day and finished out that assigned tour without harm.

“On March 4, 2001, my son-in-law carried a U.S. flag with him on that mission over Iraq that he later sent to me and my wife. I have that flag with me today as you can see. We associate our flag with many things – freedom, honor, pride. Our flag provides us with inspiration and comfort in times of crisis. For me... the flag, and this flag in particular, reminds me of the many military personnel around the world in harm’s way each day of the year. We need to thank, honor, and appreciate them.

“As our nation considers military options in the weeks and months ahead.”

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**Practice Innovations Interview with Journal Editor, Dr. Jeff Zimmerman**

La Keita D. Carter

With so many APA Journal options available for psychologists, it can be difficult to determine which journal will help you take your clinical work to the next level in your private practice. Additionally, there is much overlap between journals, which is a good “problem” to have. However, there’s only one division that has a mission of speaking directly to the needs of psychologists in independent practice. This is a much needed voice in a field where professionals trained in similar ways can engage in completely different professional tasks.

In September 2021, I sat down with Dr. Jeff Zimmerman, the editor-in-chief of Practice Innovations (PI), which is Division 42’s research journal. We talked about the work that is currently being published in the journal, his goals for the publication, and his experience at its helm. As we renew our membership and commitment to APA throughout the year, consider PI as a must-have journal for your practice needs.

All journals have a focus or major theme. What is the specific focus of Practice Innovations? What can readers expect to get when they crack open PI?

Practice Innovations serves practitioners by publishing clinical, practical, and research articles on current and evolving standards, practices, and methods in professional mental health practice. It is a cross-disciplinary publication with a multi-theoretical scope. The journal supports innovation and the highest standards of care in mental health practice. Coverage areas include population-based practice issues, procedure or technique-based practice issues, diagnosis-based practice issues, and service delivery models.

APA boosts dozens of journals. What sets Practice Innovations apart from other journals?

We specifically look to publish manuscripts that are pertinent to the mental health clinician who is engaged in clinical practice. We want the reader to say, “Wow. That’s something I can use in my office.” Manuscripts don’t have to be a formal study. They can be, but we also encourage scholarly manuscripts about ethical and multicultural issues, best practices and other relevant topics as they relate to practice.

Every editor has a slightly different focus or bend when they lead a publication. What do you hope your leadership is known for during your tenure as the editor of PI?

I hope my leadership is known for having built a strong foundation for the journal, which was in its infancy when I became the editor (1 year old). I also hope I will be known for having the journal’s content span a wide range of content from authors from diverse backgrounds both in the United States and internationally.

What’s been your most rewarding experience working as an editor or with the editorial board of PI?

There have been so many. In short, I would say it is all about the people. Gerry Koocher and Linda Campbell are outstanding Associate Editors. They have volunteered their services since the journal’s inception. APA Publications...
Waivers of Privilege: Intended and Unintended

Focus on Ethics

David Shapiro

In an earlier paper (in 2015), I described the dilemma encountered by therapists in some states that have a criminal defense exception to privilege, but I did not describe the reasoning behind such exceptions to privilege. When most psychologists hear about an attorney attempting to obtain their records for an individual who may be a victim of a crime, the understandable response is one of outrage: how dare an attorney try to get confidential records of a patient to attack the credibility of that patient on the witness stand? In representing a criminal defendant, the defense attorney is allowed to pursue vigorously whatever strategies she/he feels may be effective; attacking the credibility of a witness is one of the most frequent. If a trier of fact (i.e., judge or jury) does not believe a witness, they may not give much weight to the testimony, and it may well raise “reasonable doubt” about the accuracy of the testimony; the trier of fact needs to be convinced that the defendant committed the criminal act “beyond a reasonable doubt.” A therapist may perceive the attack on his/her patient as using the patient’s psycho-pathology, the very reason the patient sought treatment, against them. This exception to privilege also may apply to a witness, wherein the defense attorney may use evidence of their psychopathology to question the accuracy of their recollection (e.g., “Ladies and gentlemen of the jury, would you believe the accuracy of the perceptions of someone who has a serious mental illness?”). The defense attorney, in other words, is capitalizing on a lay juror’s misperception of what mental illness is. It needs to be made clear to the patient, that, if the treatment is being provided in a state that recognizes exception to psychotherapist-patient privilege, the therapist will make all possible efforts to protect the confidentiality of those records. There also are some legal safeguards that will assist in this attempt to protect patient records.

The reason behind this criminal defense exception to privilege is that there is, within the United States Constitution, a right that a criminal defendant has to confront their accusers; the controversial question, for our purposes as psychotherapists, is whether that right to confrontation overrides psychotherapist-patient privilege. This situation arises frequently in sexual assault or child abuse cases because complainants in such cases are often referred to therapists or counselors to help them process the trauma of the assault or abuse. A variation on this criminal defense exception also may happen in some criminal cases in which a key witness, for instance in a homicide case, may have had a lengthy record of treatment for various mental or emotional problems or for drug or alcohol abuse. Thus, there is a conflict between various privileges recognized in the law and the defendant’s right to confront and cross examine accusers, and to assert what is called “compulsory process” to call adverse witnesses. All these exceptions to privilege deal with the victim or witness; the mental state of the defendant is something quite different, having to do with such issues as competency to stand trial or mental state at the time of the offense. This paper deals only with the former situation and does not have anything to do with the mental state of the defendant.

Other questions raised in legal opinions revolve around what kind of allegation the defendant needs to make to trigger a record review. In other words, defense counsel cannot merely go on a “fishing expedition” to obtain records but must demonstrate to the presiding judge why that material would be essential to the defense and could not be obtained in a manner different from getting access to the records. Here again, we are dealing with the mental state of the victim or witness, and not that of the defendant. Still another issue that has been litigated in courts when this exception to privilege issue arises has to do with whether the defense attorney themselves can get the records or whether the records need to be reviewed “in camera” (i.e., in chambers by the presiding judge). This is the model followed in most states that allows for criminal defense exception to privilege. In performing this “in camera” review, the judge is guided by whether the release is more probative or more prejudicial. This refers to whether the revealing of the records would be important enough to the defense of the case (probative) to overcome the harm that may be done to the victim or witness by having their records revealed (prejudicial). As noted above, if this exception to privilege applies in their state, the therapist should inform the patient of the steps they will take to protect the records, such as the preparation of an argument to protect the records or having an attorney file a motion to oppose the production of the records (sometimes called a “motion to quash” or a “motion for a protective order”). Under no circumstances should the therapist reveal the patient records without a good faith effort to protect them. In other words, the therapist’s ethical obligation to protect the confidentiality of the records must override, from the therapist’s point of view, any attempt to obtain them by the defense attorney. Below are cases that may provide additional means of understanding the reasoning described herein. This is not an exhaustive list, as the Law Review articles dealing with this topic are relatively limited. That is, there are few published cases dealing with this topic.

Cases in Which Discovery of Records was Permitted:

1. Iowa v. Cashen (2010). Discovery of records permitted if there is a “balancing
Cases in Which Discovery not Permitted:

2. Larsen v. State (2021): Appellate Court

3. Burns v. State (2009): “In-camera review” allowed; defendant’s motion for personal review (by defense counsel) was denied.

4. State v. Nederback (2013): Trial court denied request for “in-camera review” of psychotherapy records; Appellate Court ruled that the record contradicted psychological injury and trauma. – Please explain for the reader what is meant by “upward departure from sentencing guidelines.” An upward departure from the sentencing guidelines is allowed based on the discretion of the trial judge. There may also be a downward departure. An upward departure may be certain factors that the judge decides should increase the sentence such as obstruction of justice or lying under oath. A downward departure may be considered if the judge believes that factors such as mental illness, the age of the offender, or the fact that the defendant was only an accessory to the crime, influenced the defendant’s criminal behavior.

Case Law References

3. Burns v. State. 968 A.2d.1012(Delaware 2009)
6. Hawaii v. Pesetti (2003): Trial court ordered release of records of child protective services records; Appellate Court ruled that this was not judicial error.

Cases in Which Discovery not Permitted:

1. State v. Garcia (2021): Court denied motion for “in-camera” inspection of records because defendant Garcia provided no rationale that the records might contain exculpatory material (i.e., no “fishing expedition” allowed as described above).
2. Larsen v. State (2021): Appellate Court ruled that there was no evidence of ineffective assistance of counsel. Motion was denied because, while attorney did not ask for mental health records of victim, there was no evidence of exculpatory material in those records.
3. State v. Fay (2017): Sixth amendment right of confrontation overrules psychotherapist-patient privilege only when the material was relevant to the defense; in this case, it was found to be not relevant.
4. U. S. V. Doyle (2012). Court rejected defense request for records of traumatized victim. Government wanted upward departure from sentencing guidelines, contending that the record contradicted psychological injury and trauma. – Please explain for the reader what is meant by “upward departure from sentencing guidelines.” An upward departure from the sentencing guidelines is allowed based on the discretion of the trial judge. There may also be a downward departure. An upward departure may be certain factors that the judge decides should increase the sentence such as obstruction of justice or lying under oath. A downward departure may be considered if the judge believes that factors such as mental illness, the age of the offender, or the fact that the defendant was only an accessory to the crime, influenced the defendant’s criminal behavior.

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Focus on Diversity

Years in Review

Krystal Stanley

Just over two years ago I wrote my first article for the Independent Practitioner (IP), and this will be the last one that I write (for now). Writing for the IP has been such an enriching experience; doing so allowed me to dig deeper into learning more about my own areas of interest and to re-engage with scholarly literature in a way that I had not since graduating from my doctoral program in 2009. I’ve spent the last few months reflecting on what I’ve written and how I want to wrap up. I will start with a review of what I have written and will finish with some thoughts about the American Psychological Association’s (APA) recent publication of their historical chronology of psychology’s contributions to racial hierarchies and perpetuation of BIPOC (Black, Indigenous, People of Color) people in the US and their apology for these contributions.

When I first began writing for the IP, I wanted to cover a diversity topic that I believed was less discussed: discrimination based on body size. At the time I had been going through my own process of unlearning internalized body shame and moving towards weight and body acceptance. My plan was to do a series of articles about this topic for various groups (e.g., intersecting identities, children and adolescents, etc.) but my focus, and the world, shifted over time. In my first article, Weight Bias in Therapy: Are You Culturally Competent (Stanley, 2019), I provided a brief overview of the literature exploring weight-based discrimination and stigma among a variety of health professionals (e.g., doctors, therapists, nutritionists, trainers, etc.), the internalization of weight stigma by folks in fat bodies, and the measures taken by many people in fat bodies to avoid stigma. In revisiting this article, I was struck by this section: “Bergen and Mollen (2019) are critical of APA’s adoption of fatness as a medical condition that can be treated with diet and exercise, and state that placing the roots of obesity in individual and alterable factors, rather than attending to the cultural constructions of size and health, is akin to prescribing ‘conversion therapy’ (e.g., a therapy focused on changing a client from what is considered ‘deviant’ to what is assumed to be ‘normal’ – in this case from ‘fat’ to ‘thin’) to fat clients. The authors notes that this individualized view of fatness enforces and upholds harmful hierarchical systems such as meritocracy (e.g., blaming an individual for ‘personal failings’ - in this case, fatness) and healthism (e.g., assigning a social value on health such that health equates to worthiness).” (Stanley, 2019; pp 27-28)

As previously mentioned, I plan to end this current article with a brief discussion about APA’s recent apology to BIPOC for the organization’s contributions to systemic racism, and rereading the above section made me wonder if/when there would come a time when APA would apologize for not speaking up about and contributing to systemic fatphobia. My hope is that, at the very least, on an individual basis, Psychologists will continue to explore their own weight-based biases and any ways in which they may be upholding fatphobia. At the end of my first article, I provided a few useful resources for understanding and supporting body diversity...
that I will share again here:

- **Health At Every Size® (HAES;** [https://haescommunity.com/])
- **The Association for Size Diversity and Health (ASDAH;** [https://www.sizediversityandhealth.org/index.asp])
- **The Body is Not an Apology** ([https://thebodyismnotanapology.com/])

I attended a seminar at the APA Annual Convention in August 2019 after writing my first article and learned new information about the Body Mass Index (BMI) that challenged what I thought I knew about the BMI. I, like many others, believed the BMI to be based in science, and although I knew that it was biased and inaccurate for non-white bodies, I had no idea that it was actually not all science based. In the Winter 2020 IP I explored my new findings in my article *The Body Mass Index: Our Shaky Foundation.* Through research I learned that the BMI was based on a project by a statistician named Adolphe Quetelet (1796-1874). Quetelet sought to create a composite of “the average man” based on population averages of height and weight, and he believed that physical variance would exist on a normal curve, but his research did not support this belief (Quetelet, 2019). In 1972, Ancel Keys and his colleagues created the BMI based on Quetelet’s work (Eknoyan, 2008). The BMI was designed to be based on population averages of height and weight, and he believed that physical variance would exist on a normal curve, but his research did not support this belief (Quetelet, 2019). In 1972, Ancel Keys and his colleagues created the BMI based on Quetelet’s work (Eknoyan, 2008), and it has been used as a standard for height and weight since then. The problem is that many assumptions are made about an individual’s health based on where they fall on the BMI chart, but there is no way to know someone’s health based on this information. For instance, metabolically healthy individuals (i.e., free from risk of disease) exist at all points of the BMI, as do metabolically unhealthy individuals (Ortega et al, 2012). Additionally, research consistently demonstrates that the BMI is not culturally sound, as it was based on data solely from individuals of European descent, and the consequence in using the BMI to predict health risk is that it may overpredict risk in some BIPOC populations while underpredicting risk in others. At the end of the article, I posed three questions that I believe are useful to revisit:

1. What if we accept that there are both fat and thin bodies, and we don’t assign any meaning or value to either?
2. Knowing what we know about the development of the BMI and its limitations, how can we continue to accept it as a valid measure of health?
3. How can we as psychologists, for the benefit of our patients and ourselves, continue to challenge our assumptions about weight and health, and share what we know with our clients?

A final question that comes to mind that I didn’t write in the original article is: Are you willing to challenge the notion that your concerns about another person’s health may actually be based in fatphobia?

January 1, 2020 was the first January in almost 30 years that I did not start the year on a diet; I briefly discussed this in my next article *The Weight of Fat Phobia* (Stanley, 2020). I discussed how the internalization of fatphobia is often reinforced by a society that does not accommodate large bodies, and I referenced the work of Virgie Tovar, a prominent fat activist, who identified three dimensions of fatphobia: intrapersonal, interpersonal and institutional (Tovar, 2017). Tovar noted that individuals in larger bodies may seek to shrink their bodies in order to meet the standards of the world “easier”, and I certainly had this feeling recently while taking a flight; is it just me or are the seats getting smaller? In the Spring 2020 article I discussed how the roots of fatphobia are based on population averages of height and weight, and he believed that physical variance would exist on a normal curve, but his research did not support this belief (Quetelet, 2019). In 1972, Ancel Keys and his colleagues created the BMI based on Quetelet’s work (Eknoyan, 2008), and it has been used as a standard for height and weight since then. The problem is that many assumptions are made about an individual’s health based on where they fall on the BMI chart, but there is no way to know someone’s health based on this information. For instance, metabolically healthy individuals (i.e., free from risk of disease) exist at all points of the BMI, as do metabolically unhealthy individuals (Ortega et al, 2012). Additionally, research consistently demonstrates that the BMI is not culturally sound, as it was based on data solely from individuals of European descent, and the consequence in using the BMI to predict health risk is that it may overpredict risk in some BIPOC populations while underpredicting risk in others. At the end of the article, I posed three questions that I believe are useful to revisit:

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Your black employees are crying in between meetings.
Your black employees have mentally checked out.
Your black employees are putting on a performance.

Forgive us if our work isn’t up to par, we just saw a lynching. Pardon us if we’re quiet in the Zoom meetings, we’re wondering if we’ll be the next hashtag. Spare some grace if we’re not at the company office because the hour of joy that most adults look forward to has been stolen from us due to the recent string of black death.

We’re biting our tongues, swallowing our rage and fighting back tears to remain professional because expressing that hurt caused by witness black death is considered more unprofessional, than black men and women actually being killed.” (Golding, 2020)

A beacon of hope at the end of 2020 was the initial phases of the administration of the COVID-19 vaccine; I wrote Public Trust and the COVID-19 vaccine; I wrote about various ways that BIPOC communities through research, that researchers found that the Black Lives Matters protests were largely nonviolent, but that when there was violence it was due to either police or counter-protesters acting violently towards the protestors (Chenoweth & Pressman, 2020).

The focus of my writing shifted after my Spring 2021 article; I was experiencing quite a bit of hatred and fear of a winter of being a therapist during COVID-19 so I asked the IP Editors for topics of interest for the upcoming edition. Out of this question came Gender Identity: A Primer (Stanley, 2021). You may have noticed that your clients, particularly if you work with adolescents or young adults, are engaging with gender identity in ways that are vastly different than even 10 years ago. Additionally, you may be engaging with your own gender identity differently than you had in the past; this has been a process for me over the past year or so. My article provided an overview of the difference between sex, which is assigned by doctors at the time that a baby is born (i.e., assigned/ female at birth; AMAB/AEAB respectively; also, intersex individuals; New York Presbyterian Hospital) and gender, which is socially constructed. Zimmerman (2009) stated: “Gender means creating differences between girls and boys, women and men, differences that are neither natural nor essential or even biological. Once the differences have been produced, they are mobilized in return to promote the “naturalness” of the genre.” I discussed the relationship between sex and gender, noting that the sex assigned at birth can be aligned with one’s gender identity (i.e., cisgender) and/or that a person might not identify with one gender at all (i.e., nonbinary, agender, bigender). I ended the article with an overview of pronouns and made suggestions for how Psychologists could be more affirming in their practice.

My idea for my last article was inspired by watching the Netflix documentary called Pray Away; this film discusses the history of ex-gay movements in Christian churches. In Integrating LGBTQQ+ and Spiritual Identities: A Brief Review of Recent Literature (Stanley, 2021) I provided an overview of the film and reviewed related research that has been published in recent editions of two APA journals (Spirituality in Clinical Practice and Psychology of Religion and Spirituality). The research that I reviewed explored the emotional impact of religious/spiritual beliefs and practices of some LGBTQQ+ folks and the ways in which some have been able to integrate their identities as LGBTQQ+ and religious/spiritual individuals. I ended the article with recommendations based on the literature for Psychologists to aid clients who may be engaging in a process of integrating their identities.

I will end this article with a brief discussion of APA’s Apology to People of Color for APA’s Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S. (https://www.apa.org/about/apa/addressing-racism/historical-chronology; October 2021). It was interesting to read these two documents at the same time that I was reviewing my articles in which I wrote about various ways that BIPOC communities have experienced harm, both historically and in the present in the U.S. As APA noted, Psychologists have “historically perpetuated harm to these communities through research, that influenced policy and the public view of these...
I sincerely hope that APA will consider the added professional, psychological and financial toll of the EPPP on BIPOC ECPs and will consider eliminating the requirement for licensure. I believe that this would be a step towards their mission to open pathways for BIPOC Psychologists. References


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Thank you for your consideration.

Rachel Anne Kieran, Psy.D.
Kennesaw State University (IRB: IRB-FY22-20)
rkieran@kennesaw.edu - 404-695-1100

Jennifer Rafacz, Ph.D.
The Family Institute at Northwestern University (IRB: STU00215802)
jrafacz@family-institute.org
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