The Many Aspects of

ETHICS IN PSYCHOLOGY

Ethical Challenges
Working with the Media

Treating Children
Clinical, Ethical and Legal Issues

Boundaries of Competence
APA Ethical Principles

Considerations of Culture
in Ethical Decision Making

Ethics and the Internet
Security and Managing Boundaries

GPA Member Spotlight
Chris M. Wolf, Ph.D., ABPP
Colleagues and Friends – On behalf of the GPA Ethics Committee, welcome to this special edition of the Georgia Psychologist that is devoted entirely to the topic of professional ethics. The goal of this publication is to feature a sample of issues through a collection of invited articles. With the Committee’s role of focusing on educating GPA members in the area of ethics and promoting ethical practice among its members, the Committee is pleased that the magazine is being utilized as a part of this educative purpose. The breadth of the articles is also a reminder that striving to be an ethical psychologist is an ongoing challenge that requires intentional efforts to stay abreast of developments. Therefore, read, enjoy and be reminded that the Committee is available to you, as members of GPA, for consultation and advisement.

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From the President

by Steven Perlow, Ph.D.

The role that psychology plays in the mental health of our nation is not to be taken lightly.

H is past July, I was asked to participate in an internet based “Help Desk” panel at a local television station to answer questions posed by parents after the shooting massacre in Aurora, Colorado. The help desk was fielded by three psychologists and a psychiatrist. Several of us were also interviewed by the news station to discuss how to answer the questions that children might raise following such a tragedy. In addition to the feelings of shock and sadness, I felt a sense of appreciation for the opportunity associated with being able to provide some service to our community at a time when I felt the desire to do something positive. I also found myself experiencing another feeling. I felt proud that there were three psychologists on this panel. It reminded me that we are consistently perceived as the go-to psychologists in the state of Georgia, for the opportunity associated with helping and meeting people with similar interests and motivations. One thing that has consistently and pleasantly surprised me is the depth of knowledge and variety of skills GPs members possess. Consistent with their diversity of interests and vocations, many have their own set of reasons for participating in GPA activities.

The role that psychology plays in the mental health of our nation is not to be taken lightly.
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MESSAGE

Greetings GPA Members!

Fall has arrived and so has the beginning of a packed schedule at Georgia Psychological Association! We hope you are planning to take advantage of a wide variety of activities that your association is sponsoring to promote psychology as a science and as a profession. Here are a few that I recommend you consider.

Our Continuing Education Committee has been busy recruiting presenters and selecting topics of interest for workshops which will appeal to psychologists across the state in re-licensure year. And, as a GPA member, don’t forget that you will receive a discount to attend the CE workshops of your choice. Don’t delay as workshops are close to capacity. Check out the 2012 workshop schedule at www.gapsychology.org/ceworkshops.

During the month of November, the Psychology in the Workplace Network Committee will be awarding GPA’s Psychologically Healthy Workplace Awards to worthy employers for creating programs that foster employee health and well-being while enhancing organizational performance and productivity. This year, GPA had six nominees for these awards.

Two new initiatives are currently in the planning stages. The first is a luncheon for newly licensed psychologists. This event will introduce these newly licensed professionals to GPA and the benefits of membership in our state association. The second program that is on the drawing board is a Leadership Academy geared toward early and mid-career psychologists which will offer them the opportunity to collaborate, participate, advocate and learn leadership skills through a series of four sessions over a five month period. Applications along with the agenda will be available soon for those who are interested in applying.

GPA is also striving to keep you informed of procedures for re-licensure this year. Please watch our magazine and e-communiques for the latest news from the Board of Examiners of Psychologists.

It is energizing to begin the fall season by greeting members attending these events and activities at GPA! Your association is here to serve you and provide a myriad of opportunities which will promote involvement and pique your interest. Contact me at kgarland@gapsychology.org if you have suggestions or recommendations for programs or activities which would be of interest to you or your colleagues. We appreciate your input and participation!
Lights, Camera, Action

Ethical Challenges in Working with the Media

Psychologists make important contributions to the public’s understanding of mental health issues through working with the media. Reporters ask psychologists for their comments on psychological aspects of issues on which they are reporting. Working with the media can help provide accurate information to the public, enhance the image of the profession, and serve as a practice development strategy for the psychologist. However, working with the media brings with it a number of ethical challenges and dilemmas.

APA Ethical Standards Related to Media Work

Competence

Example: A psychologist is interviewed for a story about addiction, which is one of his areas of expertise. During the interview, the reporter asks questions about the effects of drugs and alcohol use and abuse on children when it is a factor in a divorce. The psychologist does not treat children and does not know this literature. Boundaries of competence (Standard 2.01) is a standard that should be considered when working with the media. Reporters will ask for comments on a wide variety of subjects, for which the psychologists may have no specific expertise. Even if the topic is new to the psychologist, most reporters are basing the interview on some piece of research or a news item. Reporters will usually send the psychologist the data on which they are basing the story. Often, the psychologist is competent to comment after reviewing the data and possibly doing their own literature review. However, if the psychologist then determines that the topic is not in his or her area of expertise, a referral should be made to another psychologist who has the needed relevant expertise. Media training, often offered by the Georgia Psychological Association (GPA), is crucial in developing competence and comfort in the media arena. Mock interviews are helpful in desensitizing psychologists to the process as well as pointing out areas for improvement.

Confidentiality and Public Statements

Example: A reporter heard friends of his talking about how much their psychologist, Dr. Greate, had helped their marital problems. The reporter then calls Dr. Greate and asks for an interview, mentioning how he would like to ask about his work with couples such as his friends. Should Dr. Greate do the interview? If so, should he acknowledge knowing the reporter’s friends? What ground rules should Dr. Greate set up with the reporter before starting the interview?

Maintaining confidentiality (Standard 4.01) will need to be explained to the reporter if the reporter asks to interview a client to make the story more meaningful to the audience. Standard 5, Advertising and Other Public Statements, contains most of the ethical standards that apply to media work. Standard 5.01(a) stipulates that “psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities” (APA, 2002, p. 1069). This includes answers to a reporter’s questions, and questions about the psychologist’s training and credentials. Related to this is Standard 1.01, Misuse of Psychologist’s Work, which states that psychologists must try to correct or minimize misrepresentation of their statements. There is rarely a chance to review an interview prior to publishing or airing, but it is important to review it afterward to make corrections. Standard 5.02, Statements by Others, also relates to correcting other’s statements about a psychologist’s work or one’s own statements that are incorrect. It also states that a psychologist cannot compensate individuals in the media in return for publicity in a news item.

Media Presentations

Example: An experienced child and adolescent psychologist is called by a CNN reporter and asked to comment on the Pennsylvania State University child abuse case. The reporter wants to help viewers understand what motivated the perpetrator.

Standard 5.04, Media Presentations, states that psychologists ensure that their statements are based on “their professional knowledge, training, or experience in accord with appropriate psychological literature and practice… and do not indicate that a professional relationship has been established with the recipient” (APA, 2002, p. 1069). In this author’s experience, this issue most often causes problems for the psychologist. It is important to speak in generalities when making comments in these interviews.

Working with the media can be a rewarding experience, but can be fraught with ethical dilemmas. Seeking an ethics consultation from the GPA or the American Psychological Association Ethics Committee is highly recommended if needed.
Joint Custody Requires Savvy Record Management: CLINICAL, ETHICAL AND LEGAL ISSUES IN CHILD TREATMENT

by Barrie Alexander, Ph.D.,
H. Elizabeth King, Ph.D.,
Elinor H. Hitt, Esq., and Barry B. McGough, Esq.

Psychologists often encounter joint custodians who do not agree about the release of a child’s record. The parent who is not the decision-maker has an equal right to the record as the decision-maker but it is less clear whether the parent without decision-making authority can obtain the records without agreement by the decision-maker absent this being addressed in their Court Order. Such a request places the psychologist in a difficult position since the person requesting the records is likely to view a reluctance to comply as taking the other parent’s side. Without understanding the therapist’s clinical and ethical concerns.

If the parents are involved in custody litigation, there may be a Child Custody Evaluator or a Guardian ad Litem (GAL) appointed by the Court. In the case of the former, the Court Order may specifically state that the CCE have access to the child’s therapy records. If the CCE requires the release of the records, they will likely be obtained by the parents after the report is issued. Alternatively, the

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herapists working with children of divorce face complicated clinical, ethical and legal issues. This is particularly true if the parents share joint legal custody. This article addresses the issues for the clinician who wishes to make choices in the best interests of their clients and from an ethical and legally informed perspective.

Clinical and Ethical Considerations

Psychologists recognize that obtaining information from and providing feedback and recommendations to parents are important part of child treatment. They provide informed consent to the parents (Standards 3.10, 10.01) about the therapeutic process. An immediate issue when a parent brings the child for treatment is whether they have the legal right to do so. If the parent has final decision-making for medical issues, it is assumed they do. The conservative therapist requests a copy of the current parenting plan. Regardless of the information provided by the presenting parent, ethically, the treating psychologist should alert the other parent, preferably in writing, about the child beginning therapy and invite their participation. If a parent solicits treatment and does not wish the other parent to be contacted, this raises an ethical red flag. Children of divorce are often sensitive to whether both parents are supportive of treatment. If a therapist develops a relationship with only one of the parents, the aware child may feel that the therapist is on that parent’s ‘side’ if there is parental conflict. This can impact the therapeutic course for a child who is trying to navigate between two conflicted parents.

Many parents believe their communications with the therapist are privileged; this may not be accurate. The therapist must discuss the Limits of Confidentiality (4.02). In individual therapy, the child is the client and theirs are the only privileged communications. The ethical psychologist should clarify to the parent(s) that they are “collaterals” to the child’s treatment, thus, their communications with the therapist are not privileged and could be accessed by the other parent. This is true unless the parent and child are presenting for family therapy and the clinician is working with both together. In this case, the billing records and clinical notes should reflect that it is family therapy, not individual therapy.

For these reasons most psychologists orally share the child’s feelings and concerns in a reasoned and diplomatic fashion only when therapeutically helpful. Some parents are so concerned about their child’s comments (whether because of fears about accurate reporting, coaching, or for other reasons) that they demand access to the therapist’s notes in spite of the above concerns. This should be addressed clinically with the patient.

Release of the therapy notes is a complicated issue. The relevant American Psychological Association Ethical Standard is 4.05: “Disclosures (a) Psychologists may disclose confidential information with the appropriate consent of the individual client/patient or another legally authorized person on behalf of the client/patient unless prohibited by law. (b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm…”

Creating a therapeutic environment is dependent upon agreement that communications during therapy will not be divulged to others, including parents. Release of the therapist’s notes often results in the child patient feeling betrayed; the older the child, the more such exposure is likely to negatively impact therapy. Any parent reading the statements and concerns of their child can find them upsetting and confusing. The divorced parent is typically sensitive to any negative impact of their divorce on the child. Therapists, unlike most parents, recognize that children can make extreme statements based on an upsetting event, but this may not reflect their feelings in general. Indeed they may not recall their statements, or deny having made them, if they are inconsistent with their typical feelings and mood. There can be a negative impact on the parent-child relationship if the parent reads these statements.

Sometimes the non-presenting parent sees no need for therapy, does not believe in therapy or believes the presenting parent has ulterior motives. The therapist must determine if the child has difficulties and can benefit from therapy and whether it is likely to be helpful despite the objections of a parent. The psychologist must make the determination they believe is best for the child and document their reasoning. Clinically it is difficult to achieve progress if the child is aware that one parent is voicing opposition.

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Court Order may specifically state that the CCE have access to the child’s therapy records. If the CCE requires the release of the records, they will likely be obtained by the parents after the report is issued. Alternatively, the
privilege extends to communications, such as a

information that originates from a licensed psychologist and their privilege against disclosure of mental illness or substance abuse treatment allow the privilege to be waived by consent of the parent, legal guardian or legal custodian of the minor. There is no other state statutory guidance for psychologists in private practice regarding access to a patient’s mental health record.

Federally, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) establishes national standards for the use and disclosure of individual’s health information (protected health information) by every health care provider who electronically transmits health information in connection with certain transactions (covered entities). Protected health information encompasses all “individually identifiable health information” held or transmitted by a covered entity in any form, including the patient’s mental health condition, provision of health care to the patient, payment and common identifiers such as name, address, birth date and social security number.

Generally, a covered entity may not use or disclose protected health information except as HIPPA permits or requires, or as the individual who is the subject of the information authorizes in writing. As relevant to this article, HIPPA allows disclosure of protected health information in a judicial proceeding pursuant to court order, and disclosure is allowed in response to a subpoena if the individual is provided notice or a protective order is provided. Protected health information, including psychotherapy notes, may also be disclosed upon written authorization from the individual.

When the patient is a child, a person legally authorized to make health care decisions on the child’s behalf (personal representative) can permit the disclosure of the child’s protected health information. In most cases, parents are their child’s personal representatives and can act on behalf of the child’s medical record.

Where the parent is not considered the child’s personal representative, HIPPA defers to State and other law. If State or other law is silent concerning access to the child’s protected health information, then the covered entity has the discretion to provide or deny access to the child’s record, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

Going Forward Considerations

A. If the parents are separated or divorced, review any Parenting Plan or other Court Order regarding custody and the child.

B. Contact the non-presenting parent and attempt to have both parents consent to therapy, though at a minimum, have the parent with final decision making authority regarding health care decisions consent.

C. Know what the Parenting Plan or other Court Order says about access to records.

D. Explain to the parents that their communications are not privileged.

E. In your initial paperwork, include information about your fee, should you be required to testify at a legal proceeding regarding your treatment of the child.

F. Organize your file into three sections, separating privileged from non-privileged materials:

a. Billing and administrative materials.

b. Communications between the therapist and third parties, and materials completed or provided by third parties.

c. Communications between therapist and patient and therapist and other treating professionals.

G. If asked or subpoenaed to release records or testify concerning the child’s mental health, both joint legal custodians should sign a release. If one parent objects or the therapist feels disclosure is not in the child’s best interest, the therapist should refrain from action without a court’s direction.

H. While the legal rules are unclear, the psychologist must use their ethical decision-making skills, document their reasoning and consider obtaining an ethics or legal consultation before proceeding.
The Internet poses challenges for therapists managing boundaries in professional relationships. Therapists who provide web-based services face an evolving myriad of questions as codified ethical standards lag behind increasingly newer forms of technology. Therapists who do not provide services electronically meet prospective clients who typically obtain online information about therapists before the first face-to-face meeting is scheduled (Zur, 2008). Therapist disclosures in the privacy of a psychotherapy session can become unintended public statements that are only a mouse click away from the client yet far beyond the reach of the therapist’s control. Because the Internet is within the public domain, a therapist’s control. Because the Internet is within the public domain, a therapist’s control. Because the Internet is within the public domain, a therapist’s control. Because the Internet is within the public domain, a therapist’s control.

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Managing Boundaries on the Internet

by William F. Dooverspike, Ph.D.

Managing Boundaries on the Internet

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Professional listservs. Professional listservs can compromise the privacy of therapists’ disclosures. Although registration is required to join “invitation only” listservs, the user’s name and email address are usually the only requirements. On many listservs, information is rarely checked for accuracy. Many list members never post at all, less than 10% post with any degree of regularity, and there is often no information regarding the remaining 90% on the list (Zur, 2008). Therapists often request “consultations” with seemingly minimal regard for the complexity and dynamics required in genuine professional consultations (Behnke, 2007). Listserv consultants often seem oblivious to the presence of online “lurkers” monitoring electronic communications (Zur, 2011). Technologically savvy clients, as well as those who deceptively join such lists, have access to information about their own treatment as well as their therapists’ treatment of other clients. Even when therapists disguise the details of a case, clients may recognize themselves or someone else they know is in treatment with the therapist (Zur, 2008). Good risk management requires discretion in posting on professional listservs because clients and others can be harmed by unauthorized disclosures revealing their protected health information.

Summary and recommendations. If you are concerned about better boundary management on the Internet, consider these recommendations. First, assume that everything you post online will be read by your clients or their significant others. As Zur (2010, p. 1) cautions therapists, “Consider anything you post on Facebook (and online in general) to be written on your forehead.” In other words, assume that clients have access to your personal emails, private blogs, social networks, and professional listservs. While posting on your personal computer or texting on your smartphone, think of the Internet being like the front page of the New York Times. Be cautious about consulting with colleagues through listservs, because information posted on listservs may be forwarded by unauthorized individuals to unintended destinations. If you request online consultations, obtain the client’s prior authorization, use authentication procedures, and use an online platform with secure encryption (Younggren, 2012). If you provide online consultations, be aware that anyone (including clients) may intercept, carefully read, personalize, and draw conclusions about advice that you provide to other clients (including clients) may intercept, carefully read, personalize, and draw conclusions about advice that you provide to other clients.

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Ethical Concerns in Working with Veterans Across the Generations

A
s of 2010, there were more than 22 million Veterans in the United States (US) representing service spanning from World War II (WW-II) to Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), with 36% enrolled in the Veterans Health Administration (VHA, Department of Veterans Affairs, 2012a). It was estimated that there were 773,900 Veterans living in Georgia in 2010 with more than 74% having served during war time (Department of Veterans Affairs, 2012a). Much attention has been paid in recent years to OIF/OEF Veterans and the importance of providing education and treatment for mental health conditions, yet the majority of Veterans being treated are not OIF/OEF Veterans. This article will provide an overview of the psychological impact of war and recovery from war, it is common to hear of risk of suicide in OIF/OEF Veterans. Several studies show that OIF/OEF Veterans are at elevated risk for suicide compared to the general public (Bruce, 2010; Guerra & Callamoun, 2011; Kang & Bullman, 2008; Pietrzak et al., 2010). However, among those using VHA services, OIF/OEF Veterans were not at greater risk for suicide than other veterans using VHA services (Ilgen et al., 2012). It is notable that OIF/OEF Veterans receiving care in the VHA are more likely to have received mental health services following a new mental health diagnosis than were Vietnam Veterans (Seal et al., 2010). A report on risk for suicide in Vietnam Veterans revealed that they also had an elevated risk for suicide during the first five years after discharge from active duty (Boocher, Flanders, McGeehan, Boyle, & Barrett, 2014). Veterans as a whole who used VHA services have been found to have an elevated risk for suicide relative to the general US population (McCarthy et al., 2009). Among the Veteran population, active duty Veterans and those with post-traumatic stress disorder (PTSD) or physical injuries from combat were found to be at a greater risk for suicide (Bruce, 2010), as well as Veterans with accessible firearms (Kaplan, Huguet, McFarland, Benton, & Newsom, 2007). While slightly less common, homicidal ideation is another salient expression of psychological distress in Veterans. A chart review of 425 soldiers deployed during OIF found that 67 (nearly 16%) had considered killing someone else (not the enemy) within the past month and more than half of them had formed a plan to harm someone else (Hill, Johnson, & Barton, 2006). Related to homicidal ideation is IPV. Studies have found that rates of IPV across these military and Veteran populations ranged from 13.5% to 58% (Marshall, Panuzio, & Taff, 2005). For Veterans as a whole, PTSD was found to be an important correlate that largely accounted for the relationship between combat exposure and IPV (Marshall et al., 2005). Other studies (Jordan et al., 1992) found that Vietnam Veterans with and without PTSD have higher rates of IPV than the general population. A study of former prisoners of war from WW-II found that PTSD negatively affected marital satisfaction with the numbing symptoms of PTSD being the most harmful to the marriage (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004). With society paying close attention to the psychological impact of war and recovery from war, it is common to hear of risk of suicide in OIF/OEF Veterans. Several studies show that OIF/OEF Veterans are at elevated risk for suicide compared to the general public (Bruce, 2010; Guerra & Callamoun, 2011; Kang & Bullman, 2008; Pietrzak et al., 2010). However, among those using VHA services, OIF/OEF Veterans were not at greater risk for suicide than other veterans using VHA services (Ilgen et al., 2012). It is notable that OIF/OEF Veterans receiving care in the VHA are more likely to have received mental health services following a new mental health diagnosis than were Vietnam Veterans (Seal et al., 2010). A report on risk for suicide in Vietnam Veterans revealed that they also had an elevated risk for suicide during the first five years after discharge from active duty (Boocher, Flanders, McGeehan, Boyle, & Barrett, 2014). Veterans as a whole who used VHA services have been found to have an elevated risk for suicide relative to the general US population (McCarthy et al., 2009). 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There are countless other initiatives, including screening primary care patients for depression, PTSD, and problematic substance use, the implementation of primary care-mental health integration psychologists, and the distribution of gun locks in medical and mental health clinics, to name a few. Given that almost two-thirds of Veterans are not enrolled in the VHA (Department of Veterans Affairs, 2012a), mental health providers in the general population also play an important role in helping to address and treat suicidal and homicidal ideation and IPV. In addition to assessing for and treating suicidal and homicidal ideation, mental health providers should recognize that combat Veterans with PTSD and depression are at higher rates of perpetrating IPV and recommend that clinical assessments of couples consider IPV, especially in couples seeking couples therapy, and that proper treatment and/or referral to specialized treatment programs for perpetrators and victims/survivors be a part of the treatment plan (Sherman, Sautter, Jackson, Lyons, & Han, 2006). “The person identified herein is an employee of the Department of Veterans Affairs however, the views expressed in this article do not necessarily represent the views of that Department or of the United States.”
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Sallie E. Hildebrandt, Ph.D.
Chair of the Committee of State Leaders.
President of the California Psychological Association and evaluation of bariatric surgery patients. She is also of the treatment of depression, sexual and marital therapy, Dr. Hildebrandt is in independent practice with a focus on Sallie E. Hildebrandt, Ph.D.

L istservs are powerful tools with the ability to provide support and information across a staggering range of issues and professional challenges. Our discussion of ethics must be placed in the context of how the Internet has the capacity to change our professional lives for the better. What are the ethical aspects of requesting a clinical consultation over a listserv? Two points seem important to consider in thinking about this question. First, a consultation is a dynamic process. A consultation involves two or more professionals engaging around a particular matter where questions, concerns and issues emerge that are addressed and discussed as recommendations are formulated. A consultation is a professional activity that requires competence in the areas consulted upon, as well as the ability to define the boundaries of the question posed and the opinions or recommendations offered. Both the consultant and the consultee should be aware that they are engaged in a professional activity; that is, the process of obtaining and providing a consultation, with that fact explicitly acknowledged by the psychologists involved. Second, communications made during clinical consultations are governed by confidentiality, as set forth in Ethical Standard 4.06. 4.06 Consultations When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. Psychologists treat the relationship between consultant and consultee as a confidential relationship, and disclose information in the consultative process “that could reasonably lead to the identification of the client/patient” only if necessary and then only to the extent required for the consultation. Several issues arise in thinking through the degree to which listservs allow the kind of dynamic process that is central to a clinical consultation. Consider, for example, whether the psychologist requesting the consultation is aware of the competence of those listserv members who choose to respond. Generally, psychologists choose consultants for their expertise and would hesitate to act on a recommendation of a consultant whose qualifications to address the relevant issues were uncertain. Consider as well the degree to which exchanges on a listserv lend themselves to discussing details of a specific patient, whether the psychologist identifying important clinical considerations for a given condition or disorder, and in calling attention to unique complexities and important competencies in certain treatments. When postings on listservs move the focus from more general issues to discussing details of a specific individual’s clinical situation, the ethical issues become significantly more complex. Our ethical scrutiny of how we use the Internet therefore rises correspondingly. 

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Ethics and the Internet: Requesting Clinical Consultations Over Listservs

by Stephen Behnke, J.D., Ph.D., APA Ethics Director

With so much to do and so much at stake, it’s good to know The Trust has me covered. I can spend more time focusing on what matters—helping others to help themselves. Call The Trust at 1-877-637-9700 or visit www.apait.org to learn what they can do for you.
Integrating Considerations of Culture into Ethical Decision Making in Psychotherapy Practice

by Elaine Thomas, Psy.D. and Zahida Kassam, M.Ed.

Most practicing psychologists are conscious of the ethical issues related to treating someone of a different background or culture as explicitly stated in the APA Ethics Code (2002) standard 2.01 (b), Boundaries of Competence. The code also enumerates cultural diversity variables, such as gender, identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and considers these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on these factors, and they do not knowingly participate in or condone activities of others based on such prejudices (p. 1063).

Culture has been defined in many ways. For the purposes of this discussion, the parsimonious, yet potent description of Parham (2009) will be used: “Culture…is a complex constellation of mores, values, customs, and traditions that provides a general design for living and a pattern for interpreting reality” (p. 433). Additionally, other fundamental assumptions about culture guide this discussion. These are that: any culture continually evolves, each individual possesses multiple identities arising from multiple cultures and, culture mostly operates outside our awareness until there is an obvious clash in values or expectations arising from the intersection of two or more cultures, or there is an explicit attempt to bring aspects of culture to awareness. Rarely do we explicitly acknowledge that our APA Ethics code itself reflects a cultural perspective and that interpretation of the enforceable standards in the code is subjective. It will also vary depending on the culture of the interpreter and the larger sociopolitical context within which the interpreter resides.

There is little research indicating the types of ethical dilemmas related to culture encountered in clinical practice. A study of 256 counselors by Sadeghi, Fischer & House (2003) aimed to determine the multicultural ethical dilemmas rated most frequently and significant in their treatment of ethnoracial minority clients. The study found that the five dilemmas encountered most frequently (at least once a month to once a year), by about 60% of clinicians surveyed were:

1. A conflict between the client’s cultural expectations that solutions are given and fostering the clients independence to solve the problem(s).
2. A conflict between helping the client leave the family of origin for his/her own individual growth and helping the client stay and cope with conforming to the expectations of the culture within the family.
3. A conflict between the clinician compartmentalizing counseling values to achieve credibility with the client and maintaining counseling values at the cost of losing credibility with the client.
4. A conflict between working on alleviating symptoms and negative consequences related to discrimination the client faced and working toward helping the client assert their civil rights and the resulting negative consequences resulting from such an assertion.
5. A conflict between helping a client leave an abusive marriage that would result in social exclusion and staying in the marriage and coping.

These data, though limited, highlight that value differences between therapist and client are amongst the most commonly encountered and significant ethics related dilemmas in multicultural practice (Sadeghi, et al., 2003).

In everyday practice, we do not often explicitly consider or articulate the fundamental values that are rooted in professional culture. These may be described as valuing the following: characteristics: autonomy and individualism, ways of knowing rooted in empiricism and logical positivism, explicit identification and honest expression of feelings, the pursuit of pervasive happiness, as well as the experience of positive emotion. Hoop, DiPasquale, Hernandez and Roberts (2008) name the existence of such values as arising from “health care culture.”

Examination of The Universal Declaration of Ethical Principles for Psychologists (2008), adopted by the International Union of Psychological Science in 2008 is instructive in our explicit examination of values. It describes aspirational principles and the values following from these principles that are believed to be relevant to the provision of psychological services globally. Four principles are described: I. Respect for the dignity of persons and peoples, II. Competent caring for the well-being of persons and peoples, III. Integrity and IV. Professional and scientific responsibilities to society. Most notably, it includes language describing that certain values (and by extrapolation standards for application to the APA ethics code) are ‘culturally defined’ and that they must be considered at not only the individual, but other contextual levels. For example, it states that psychologists accept the values of “free and informed consent, as culturally defined and relevant for individuals families, groups, and communities” (p. 2), and similarly “protection of confidentiality of personal information, as culturally defined and relevant for individuals, families, groups, and communities” (p. 2). In the values associated with Principle II, it states “self-knowledge regarding how their own values, attitudes, experiences, and social contexts influence their actions, interpretations, choices, and recommendations” (p. 3).

There are also values from which a psychologist operates that are rooted in each or a combination of the multiple identities s/he holds. In upholding ethical mandates to maintain multicultural competence, identifying and articulating the values is essential. Recognizing and navigating conflicts related to values is probably one of the most complex tasks in psychotherapy practice. That is, how can psychologists approach integrating culture (that of the client and one’s own) into ethical decision making? There are several ethical decision-making models that explicitly take culture and other diversity variables, such as gender or culture, specifically into account. Describing the details of these models

Culture isn’t just what other people do. (Rogoff, 2003, p. 11)
is beyond the scope of this article, however, features distinguishing these models from those that do not discuss culture are worth mentioning. Intuitively, multicultural decision-making models encourage psychologists to maintain a high level of cultural sensitivity and awareness (Garcia, Cartwright, Winston & Breunichowska, 2003). Practitioners can demonstrate an appropriate level of competence by seeking consultation and practicing regular self-reflection, specifically in relation to cultural values and norms (Frame & Williams, 2005; Hill, Glasser & Harden, 1998). Explicit examination of the psychologist’s personal characteristics or values that may affect framing the problem and any solution is a crucial step in the model of Hill et al. (1998). There is also a clear shift toward a more collaborative decision-making style, particularly with consideration of the inherent power differential between client and therapist (Gauntier, Pettifor & Ferrero, 2010; Hill et al., 1998; Frame et al., 2005), which is influenced not only by the very nature of psychotherapy, but by contextual and systemic factors e.g., institutional oppression and marginalization of specific groups. Frame et al. (2005), explicitly include assessment of the acculturation and racial identity development of the client. This is a useful and practical base from which to begin hypothesizing the extent of the potential gap between client values and the Eurocentric values inherent in our profession, as well as the values of a psychologist educated and raised within that tradition.

For example, let us imagine that we are faced with a dilemma similar to that described in Sadeghi et al. (2003), i.e., #2. A young adult female immigrant client from a collectivist culture is brought to treatment by her parents because she is sleeping excessively, not eating regularly, fatigued and isolating from family. Previously, she had been a good student while attending college and had been developing a circle of friends who did not share her culture and whose families had lived in the United States for several generations. The family states that they would like the daughter individually and help her to reestablish her cultural values. Additionally, with whom will you work? Will you work primarily with the daughter, the family or both? One’s answer to these questions will depend on many factors and we suggest that without awareness and critical evaluation of one’s values, one may be inclined to work with the daughter individually and help her to separate and develop independently of her family. This example is overly simplified, but was introduced to highlight the need to examine the values inherent in developing treatment goals. To elucidate the nature of the value conflicts inherent in developing treatment goals, the psychologist may begin to ask the following questions:

1. To what extent are the goals a reflection of values held by the client and family?
2. To what cultures’ (psychology, mental health care, client, psychologist-culture, psychologist-gender, psychologist-ethnicity etc.) assumptions about optimal functioning and well-being can I attribute these goals?
3. How would I describe the client’s beliefs and expectations about optimal functioning and well-being? And, who is the client?
4. Who are the others with whom the client is interdependent that may impact the client’s optimal functioning and well-being, and that may need to be considered in treatment with respect to goal setting and/or inclusion in treatment?
5. What do I understand and not understand about the client’s multiple identities, culture and level of acculturation?

Other ethics related issues that arise in psychotherapy practice for which the clinician may reference the literature for guidance include expectations of privacy and confidentiality (Meer & VandeCreek, 2002), boundaries and dual relationship (Hoop, et al. 2008), informed consent (Hoop, et al., 2008), different levels of acculturation in a family (Schwebel & Hodari, 2005), and among other issues the potential harm to clients resulting from use of outdated theoretical ideas and treatment strategies (Cole, 2008; Gallardo, Parham, Johnson & Carter, 2009). Further, multicultural competence, a broad ethical imperative may be, enhanced with maintaining familiarity with APA guidelines regarding working with specific groups (those with disabilities, LGB, girls and women). There are a multitude of other ethics-related issues that may come up and the points raised here could be elaborated more extensively; however it is hoped that this article will begin psychologists’ awareness and reflection of, and consultation about culturally sensitive ethical decision making.

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Secure Deletion and Encryption of Sensitive Files

by Andrew Burkley, MS, Member of the Pennsylvania Psychological Association

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lient confidentiality is of the utmost importance for psychologists. Unfortunately, the technicalities of computers often make it difficult for therapists to securely store and delete sensitive information. A new piece of legislation that amended HIPAA, called the Health Information Technology for Economic and Clinical Health (HITECH) Act, created additional regulations and penalties regarding the secure storage of protected health information (PHI). The following article seeks to inform psychologists on procedures for secure deletion, protection, and encryption of their files.

Secure deletion
It is essential that sensitive information be deleted off of any drive in ways that prevent its ever being recovered. Any malicious individual with an easily obtainable program can recover all types of deleted information from a computer’s hard drive. Secure deletion is necessary for deleting old contact notes from a hard drive, removing sensitive files from a USB flash drive or floppy disk, or wiping the hard drive before the computer is sold, recycled, or thrown away.

Macintosh
Macintosh users are at an advantage over Windows users on this front. Macintosh users have an option to securely delete their trash bins. This process takes longer, but actually overwrites the file with random data, making the file unrecoverable. The secure delete option can be found under the Finder menu.

Windows
Although Windows does include a program to securely erase files and free space, it is not user-friendly. A more user-friendly, and free, program is called Eraser. Eraser will write over the fragments of the file with random 1’s and 0’s so that the data is not recoverable by any program.

Removal of old/crashed hard drives
Old and crashed hard drives can present a dilemma when sensitive information is stored on them. An old hard drive, however, presents a slightly different issue than a crashed hard drive. Presumably, old hard drives still run and can be wiped and reformatted. Several programs, such as the aforementioned Eraser, will totally wipe a hard drive. The difficulty is that you cannot wipe a hard drive that you are currently using. However, accessing a preloaded program (Command Prompt) before Windows boots will allow the user to reformat the drive without removing it from the computer. After formatting the drive, it would take a computer specialist to recover any of the data. In consideration of crashed hard drives, you may rest in comfort in that if the hard drive is not booting or loading at all, chances are the data is unrecoverable anyway. The circuitry on the board can also be physically damaged to prevent access, but is not 100% foolproof.

Encryption
Encryption is a form of protection that prevents files from being accessed without the correct password or key. The HITECH act does not require that files be encrypted; it only requires that they are stored securely. However, if a data breach occurs, and the data was not secured, the offender must make a public announcement regarding the breach to those affected, and have their name listed on a government website of offenders. If the data was found to be securely stored, a public announcement of a breach is not necessary. According to the HITECH act, encryption is considered a method of securely storing data. Luckily, both Macintosh and Windows software (with some exceptions) natively support encryption standards. Encryption can be used to conform to HIPAA/HITECH standards, prevent unauthorized access to data, and prevent access to USB drive data if lost or stolen.

Third-party programs
There is a variety of third-party programs that offer to encrypt your data for use on USB drives and portable hard drives. One program in particular, which complements Dropbox, is called SecretSync. SecretSync will encrypt your files automatically before syncing them to Dropbox, which means that the files stored in your Dropbox folder on your hard drive are encrypted before they are sent to Dropbox. Another great program, appropriately named TrueCrypt, can encrypt an entire USB drive or hard disk. Therefore, if the USB drive is lost or the computer stolen, it would be impossible to access the data without the correct password. This article was reproduced with permission from the Pennsylvania Psychological Association. No further reproduction or distribution is permitted without written permission from the Pennsylvania Psychological Association.

Ethics
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Reflecting on Boundaries of Competence

by Linda L. Hoopes, Ph.D.

Standard 2.01 of the APA Ethical Principles of Psychologists, Boundaries of Competence, includes the following guidance:

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

In recent years, we have seen increases in “crossover” activity, including clinical psychologists working in organizational settings and organizational psychologists building deep one-on-one advisory relationships. Even within a given area of psychology, there is a potentially wide range of services, some of which we are better prepared to deliver than others.

Nagy (1989) reminds us that one option is to refuse to treat clients to whom we cannot deliver competent service. However, another option is to expand our capabilities. This raises the important question of how one appropriately cross-trains in a new area of psychology. How might a clinician prepare to effectively work with organizations? How might an organizational psychologist develop deeper therapeutic skills? How might anyone whose training and experience is in one aspect of psychology prepare themselves to move into a new arena?

I would suggest that the first step in developing a new competency (or strengthening an existing one) is to recognize when you are moving beyond your competence. Research summarized by DeAngelis (2003) suggests that we often overestimate our abilities, and may therefore fail to accurately perceive our limitations. It is critically important to seek feedback from experts and peers to gain an unbiased view of yourself.

The second step is planning and executing a course of preparation to help you reach the desired level of competence. This does not necessarily mean becoming a world-class expert; Handelsman (2011) argues that a minimum level of competence is often adequate to meet the ethical criterion, especially in cases where failing to provide aid could lead to harm.

The planning process should involve consulting expert sources to accurately understand what foundational and functional competencies you need to develop. This may involve expanding your network of peers/professional resources to include those with expertise in the new area. Your plan could include one or more of the following options:

• Returning to school to gain an additional advanced degree
• Postdoctoral work in a new specialization
• A structured course of continuing education study
• Attending a different group or division’s meetings
• A formal supervision or mentoring relationship
• Apprenticeship: observing and then being observed by experts in the area of competence
• On-the-job training

A critically important element of learning a new specialty is putting oneself into “beginner’s mind,” fully opening up to what can be learned rather than trying to move too quickly into practicing in the new area. One of my colleagues cites the inability or unwillingness to adopt this mindset as the biggest challenge in developing new hires.

Once you have achieved a level of mastery in the new area, it is important to monitor, evaluate, and refine your effectiveness by measuring the outcomes of your work, identifying strengths and weaknesses in your performance, and staying up to date with new developments.

Our desire to learn and grow does not end when we finish our graduate work. By taking appropriate steps, we can continue to shift and expand our capabilities throughout our careers.
Jennifer makes Georgia and GPA proud!
Breaking Anger's Embrace: and Other Insights on the Human Condition
by Thomas Schneider, Ph.D. (Smyrna, Georgia: SouthForce International)
100 pages with glossary, references and index. $14.95.

Based on 40 years of clinical experience, this book is a treasure chest of homegrown wisdom on coping with anger, anxiety and other personal issues, such as dealing with parenting, marital, and communication challenges in general. This is a fairly brief book, and quite straightforward in its approach. Why use more words when getting to the point, directly, is so refreshing?

As the title says, the main thrust is Breaking Anger’s Embrace—how to overcome the primal urge to fight back when feeling threatened. If there are three basic emotions—anger, fear and sadness—Dr. Schneider is able to dig deeper into each one. Anger, for example, can range from mildly annoyance through violent rage to a psychotic-like meltdown. Anger, maintains the author, can cover a host of more vulnerable emotions, such as loneliness, shame, and guilt. When left to simmer, anger can transform love to hate, humor to sarcasm, and open-hearted. We welcome this small book with a big embrace.

In his chapter on persuasive communication, Dr. Schneider recommends we stick to specifics, ask for feedback and, above all, do not monopolize the conversation. His suggestion for successful premarital counseling is to ask each client what they like and dislike about one another, what they resent, what are their expectations; basic questions we need to remember.

A chapter on parenting reminds us that our best role as parents is that of benevolent dictator. Control change but do so by offering choices and maintaining consistency. Among his “nurvers” are: Never give an order more than once, never allow a television set in a child’s room, never fail to set limits, whether on television time, computer use, video games or cell phone use. “Are we in danger of rearing a new generation of cyborgs?” he asks. When teens ask for a solution to a problem, invite them to take on all suggestions and then sleep on it. Their “under-conscious” will help provide the right answer.

What is the solution to the obesity epidemic? Just “eat less; exercise more.”

These are all great insights with “stickiness” in that they make so much common sense once we hear them. Dr. Schneider, a Fellow of the Georgia Psychological Association, has let his own genie come out of his own under-conscious and shares his unique contributions, including the concept of Inventive Alternative Method, in which both parties in a conflict situation contribute equally until both are satisfied without compromising their basic values. He takes his place alongside Jung, with his concept of Ancestral Unconscious where we might find our potential talents and inspirations. Not only does Dr. Schneider help us break anger’s embrace—he also helps us find our unique selves by becoming more compassionate and open-hearted. We welcome this small book with a big embrace.

Dr. David Ryback (David@EQassociates.com) is the author of ConnectAbility (McGraw-Hill) and The Anxious City (Well hello, NY). His first novel, Birthroot in Love (Tiger Ivan Press).

\**Review**

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October 5, 2012; 9:00am-12:00pm
Presenter: Bethany Davis, M.D.
CE Hours: 3 hours (Psychopharmacology)

Untangling Ethical Knots: A Common Sense Approach to Ethical and Legal Considerations
October 5, 2012; 1:00pm-4:00pm
Presenter: Andrew M. Gothard, Psy.D.
CE Hours: 3 hours (Ethics)

Mindfulness Mini-Conference (Atlanta, GA; Crowne Plaza Atlanta Perimeter NW)
October 12, 2012; 8:00am-5:00pm
Presenters: Susan Barrett, Ph.D., Jeanette Sawyer-Cohen, Ph.D., Nzinga Harrison, M.D., Mickyta Daugherty, Ph.D., & Thaddeus W.W. Pace, Ph.D.
CE Hours: Up to 6 hours (Psychopharmacology & Ethics)

TMS Therapy—An Overview
October 26, 2012; 9:00am-12:00pm
Presenter: Brian Teliho, M.D.
CE Hours: 3 hours (Psychopharmacology)

Ethical and Legal Challenges in Working with Families in 2012
October 26, 2012; 1:00pm-4:00pm
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2012 Rural Health Conference (Coastal Georgia Center, Savannah, Georgia)
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Contact: Marie Williams; marianwilliams@georgiasouthern.edu/ (912) 478-2260
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