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Welcome to this edition of the Georgia Psychologist focused on issues related to diversity. To quote from the Merriman-Webster dictionary, diversity is the condition of having or being composed of differing elements…the inclusion of different types of people in a group or organization.

It is a pleasure to be part of such a diverse group of psychologists and psychologists in training. We work as a team through our shared identity as advocates of psychology. I want to focus on advocacy, mentoring, and working as a team.

Let me take you back 20 years to my first local area psychological association meeting in which county psychologists were meeting with a state representative, sharing their thoughts about the practice of psychology in the area, and listening to the representative’s ideas. There was a group of psychologists ready to have me join their team, mentor me along the way, and provide a fantastic example of grass roots efforts in action, all as we worked together to promote psychology.

Think about the importance of making connections at any and every level to help move psychology forward.

So, why should you care about where the practice of psychology is going?

We need to be our own best advocates and help shape the future of psychology instead of letting external demands fully shape us. We need to reach out and mentor in both directions, guiding our newer professionals as well as learning from them. It is about adapting and changing to meet the changing environment. Speaking up as a profession and having our voices be heard. Finding like-minded colleagues and pooling knowledge to be a stronger group.

Or, if you disagree, get involved and change things. It is not who is right but what is right.

So how does GPA fit into all this?

Trouble with testing authorizations? We’re on that.
Are you concerned about parity violations? We’re on that.
Scope of practice issues? We’re on that.
Want training on new and innovative techniques and practice styles? We’re on that.
Concerned about legal and legislative issues? We’re on that.
Want to find a mentor? Join our mentoring program.
Want a leadership training program? We have that too.
What about the psychological testing bill? We’re on that.
Want web-based trainings and meetings? Come join us this fall for webinars on hot topics of interest.

We need you to speak with legislators, help testify at the Georgia Legislature when called upon, volunteer for committees, do lots of grunt work, get paid nothing and keep a smile.

We need your money (there….I said it... someone had to say it.) Protecting you from incursions into our practice statues is hard work. We seek to coordinate efforts to limit the sometime abuses of care organizations, and seek fair compensation for our long years of training, flexible schedules, requirements of a fully functional office space and services we provide.

We have psychologists who are working to maintain, grow and adapt their practices as the world changes with them. One psychologist alone is a single voice. A group of psychologists together is power.

Why did I do it? If I don’t who will? I was taught to always advocate for my profession and make this a part of everything I do. Be that message for those who need it, including yourself. Mentor in both directions.

Be an advocate for the practice of psychology. Together we are a stronger voice.

“We need to be our own best advocates and help shape the future of psychology...”
During the June 1 GPA Board of Directors meeting, the Leadership Training Program class presented their class project which was a "Membership Ambassador Program." The program encouraged meaningful participation in GPA's programs by placing existing members in roles to welcome new members, promote GPA sponsored events and facilitate personal connections. Certificates for completion of the inaugural program were awarded to: Robin Casey, Psy.D., Nan Cooley, Psy.D., Laura Dilly, Ph.D., Decia Dixon, Ph.D., Mesha Ellis, Ph.D., Nadya Hollahan, Ph.D., Carli Reis, Ph.D., Brian Smith, Psy.D. Congratulations and best wishes are extended to each graduate from GPA!

Click here to visit www.gapsychology.org/ceworkshops for more information and to register.
In January 2013, the Georgia Psychological Association (GPA) Board of Directors assigned a Quick Action Team to review the mission, values and governance of GPA, and to find ways in which the organizational plan could be streamlined and made more accountable. As a result of the hard work of this team, a new organizational chart and new organizational goals for the coming year was approved for GPA at the March 23, 2013 Board of Directors meeting. The Board is very excited about the positive direction in which these goals will move GPA, and the collaborative efforts they will allow at all levels of the organization.

One of the major steps that was proposed, initially by Council leadership, and then by the Quick Action Team, was to combine the existing Council on Gender and Sexual Identity, the Committee on Ethnic and Minority Affairs, and the Task Force on Diversity Training. The functional result of this action is one combined council, the new Council on Diversity, which would have a vote on the Board of Directors, and a collaborative voice on other councils and committees within GPA. Our hope is that by combining the efforts of leaders from what were three distinct groups, we can avoid the possibility of duplicating efforts and more effectively advocate for diversity across domains. The new Council will be led in the coming year by multiple Executive Committee representatives, each of whom will retain an emphasis in some area of diversity. The vision of the Quick Action Team was that these areas may change over the years depending on assessed needs in the area of diversity, as well as the areas of interest of the Council leaders.

The vision of the new Council on Diversity is to take a “Bronfenbrenner-esque” approach, which fosters an emphasis on diversity at all levels of GPA, ranging from the composition of our membership to the content of our programming. Certainly the demographic categories that have been traditionally considered relevant to the study of “diversity” continue and will continue to require care and attention in the profession of psychology and in the larger world. Yet the notion of what constitutes “diversity” has changed across the decades, continues to evolve and mirrors our increasingly diverse society--as individuals from marginalized groups move into gatekeeping roles and expand our vision. Our hope is that with the evolution of the Council on Diversity, we can continue to advocate for ethnic and minority affairs, diversity training, and gender and sexual diversity. However we also hope to be able to advocate for the inclusion of areas of identity outside the usual categorizations of gender, race, class, ethnicity, etc. as individuals continue to explore and embrace neglected, invisible or seemingly disparate aspects of themselves in their “multiple identities.”

(Continued on page 6)
The Council on Diversity will have a dedicated representative to the GPA Board of Directors. In addition, Dr. Tiffiny Hughes-Troutman (former chair of the Committee on Ethnic and Minority Affairs) will represent the Council on Diversity on the Membership committee in 2013-2014. Dr. Rachel Anne Kieran and Dr. Lori Muskat will continue to work with the Continuing Education committee to ensure that diversity is represented in the CE efforts of GPA, and Dr. Kieran will also perform this function on the 2014 Annual Meeting committee. Infusing diversity into all areas of continuing education is one of the immediate goals of the Council leadership, and we hope to work closely with CE and the Annual Meeting committee to make Georgia a leader in this area.

The other immediate goal of the new Council on Diversity is to host a networking event for members and interested others in the coming months. We are looking forward to providing GPA members with an opportunity to meet one another, to learn about the exciting work our members are doing in the community, and to share with the Council leadership needs in areas of diversity. Those interested in helping to plan or host this event, are encouraged to join the Council on Diversity Executive Committee.

All current members of the existing Council on Gender and Sexual Identity, the Committee on Ethnic and Minority Affairs, and the Task Force on Diversity Training have been automatically transitioned into membership on the new Council on Diversity, and should have received a notification from Amy Dietrich about the initiation of the new Council on Diversity Google Group to manage the Council listserv. We hope that this listserv will become a useful point of connection for members around these topics. If you are interested in taking the next step to leadership, please consider becoming a part of the Council on Diversity Executive Committee. In the spirit of multiple identities and the importance of all voices being represented, we welcome everyone to participate in making this new Council greater than the sum of its parts.

We hope that the new Council on Diversity can become an active, thriving part of GPA in the coming year, and fully embody the GPA vision of being the preeminent advocate and resource for Georgia psychologists.

If you are currently not on the Council on Diversity listserv, click here for more information on joining.

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Mental health is an area that has not been at our nation’s forefront, despite the fact that more and more individuals are suffering from mental illness and need services. Furthermore, the mental health field is challenged by disparities in the availability of and access to services. Unfortunately, not all United States citizens share equally in the hope of recovery from mental illness, especially those individuals from racial and ethnic minority groups (U.S. Department of Health and Human Services, 1999, 2001). Mental health care for minority populations is less available, and the services that are available are of poorer quality. Thus, members of these populations are frequently left to suffer in silence and bear the burden of unmet mental health needs. According to former Surgeon General David Satcher, M.D., Ph.D., eliminating disparities in the accessibility, availability, and quality of mental health care for racial and ethnic minorities is imperative.

In today’s multicultural society, mental health professionals, along with federal, state and county governments must work together to eliminate the disparities in mental health care for racial and ethnic minorities—as well as for other diverse groups. Psychologists have much to offer in this regard. However, in order to do so, we must ensure that we follow recent best practices in mental health services for the diverse client groups with which we work. The following list is by no means exhaustive; however, it contains links to landmark governmental reports—as well as to a number of guidelines compiled by the American Psychological Association for working with various diverse groups. Unlike ethics, guidelines are aspirational and reflect best practices, which are evidence-based. Familiarizing oneself with the resources on this list is one step in the lifelong journey of achieving multicultural competence.

- Achieving the Promise: Transforming Mental Health Care in America (President’s New Freedom Commission)
- APA Task Force on Resilience and Strength in Black Children and Adolescents: Resilience in African-American Children and Adolescents: A Vision for Optimal Development
- Guidelines for Assessment of and Intervention with Persons with Disabilities
- Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations
- Guidelines for Psychological Practice with Girls and Women
- Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
- Guidelines for Psychological Practice with Older Adults
- Guidelines for Research in Ethnic Minority Communities
- Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change
- Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists
- Mental Health: A Report of the Surgeon General
- Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General
- National Healthcare Disparities Report (Agency for Healthcare Research and Quality)
- Report of the APA Presidential Task Force on Immigration
- The Task Force on Psychology’s Agenda for Child and Adolescent Mental Health
- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Institute of Medicine)
The Georgia Psychological Association invites psychologists to submit program proposals for three-hour continuing education workshops for the 2014 Annual Meeting to be held May 1-4, 2014 at the Classic Center in Athens, Georgia. Psychologists have high levels of expertise in a broad range of specialties, and the Annual Meeting is an opportunity to share your knowledge with colleagues.

GPA’s Annual Meeting Committee strives to offer a variety of workshops and equal consideration is given to all submissions. The committee is especially seeking advanced level programming. Programs for the 2014 Annual Meeting are expected to align with the theme, the “Changing Face of Psychology.” Programs related to this theme may include the following areas: Diverse Treatment Modalities and Settings, Telepsychology, Individual/Couples/Group/Family Therapy, Psychology and Social Media, Assessment, Medical Psychology, Evidence Based Best Practices, Preventative and Community Psychology, Psychology in the New Insurance Era, the Changing Face of Diversity in Psychology, Mindfulness, and Working with Challenging Populations.

Programs will be reviewed for appropriateness and quality by the GPA Continuing Education Committee, GPA Annual Meeting Committee and, when relevant, a representative from the Academic community. Please prepare the information as specified below and return to GPA. Early submissions will help greatly in the planning. Check items as you complete them to be sure your proposal includes all requested elements.

Submission options:
Fax: (404) 634-8230
Mail: 2200 Century Parkway, Suite 660, Atlanta, GA, 30345
E-mail: amydietrich@gapsychology.org
Contact: Amy Dietrich; (404) 634-6272, ext. 208

The Georgia Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. The Georgia Psychological Association maintains responsibility for this program and its content.

PROPOSAL SUBMISSION DEADLINE: October 15, 2013
(Proposals will not be considered if received after this date).
IMPORTANT: Workshops will be peer-reviewed.

Click here to download or print the Call for Programs.

*The Call for Programs is also located on the homepage of the GPA website.
The newly-formed Council on Diversity recognizes the importance of dedicated membership initiatives in furthering our mission and goals. It is critical that we retain existing members of GPA who align with us in valuing diversity and inclusiveness as well as attract new members who embody diverse perspectives and share fresh and inspiring ideas. In order for the Council to thrive, it is essential that we join with psychologists who embrace leadership opportunities through the Council on Diversity and who are active in the association.

The Council has a number of goals and plans aimed at engagement with potential members. First, we will collaborate with the Membership Committee to focus on member recruitment and to ensure that GPA works to establish a membership body that represents diversity at all levels. The Council realizes that potential members who hold and value diverse perspectives are seeking an association that values and embraces diversity not only in theory but in practice. In that respect, we will work to ensure that GPA is highly transparent in communicating our diversity mission, values in action, and practices to our potential members.

We will be very intentional in developing and maintaining liaison relationships so that potential members can learn about the work that GPA is accomplishing for psychologists in the state and for our communities. The Council will collaborate with psychologists who are champions for ethnic and minority affairs, diversity training, and gender and sexual diversity who may be reluctant to join but are interested in collaborating with the Council on projects to promote diversity awareness and benefit underserved people in the diverse communities. It is our hope that these relationships may serve as a bridge to more formal relationships within GPA. Further, we recognize that the demographic pool of student and early career psychologists is quite diverse and that our membership marketing campaigns should focus on these groups. The success of these outreach campaigns will add diversity to the GPA membership.

Second, the Council on Diversity will focus on member retention by supporting and collaborating with the Membership Committee on retention initiatives. It is critical that GPA members continue to recognize GPA as the “preeminent resource and advocate for Georgia psychologists” and see the value in continued alliance and membership in GPA. To that end, the Council plans to conduct survey assessment to aid us in keeping our finger on the pulse of changing needs. Members will have the opportunity to share ideas on their beliefs about GPA and the extent to which their perceptions of GPA’s diversity initiatives impact member retention. Another consideration is to determine the utility of unique benefits and services that might be attractive to diversity advocates in GPA, such as specialized online communities and referral lists. We recognize that members today have unique needs, that demographic shifts with respect to diversity impacts the “face” of GPA, and that organizational impact plays a tremendous impact on retention. Overall, our overarching aspirational goal is to support GPA’s membership initiatives and to highlight GPA’s diversity efforts as a membership benefit.

Third, we are planning a social event for all GPA members for the purposes of face-to-face social connection and networking. We hope that all members will enjoy the opportunity to interact with one another, to learn about the work of the Council on Diversity and to communicate ideas and creative planning to help improve the Council.

We hope that you will consider joining the Diversity Council to help our numerous membership initiatives. We need the expertise from members at all levels—the wisdom of seasoned professionals, emerging professionals who can effectively speak to our changing culture, and psychologists who have recently moved to the state bringing ideas from other state associations. The Council needs breakthrough strategies, vibrant energy, and commitment to establish diversity as integral to all that GPA stands for and accomplishes.
The formation of GPA’s new Council on Diversity invites us to consider GPA’s role in diversity training. To do so, best practices encourage us to re-visit the context of mental health care with diverse groups in the United States, as well as a prevalent approach to diversity training. Only then can we think critically about GPA’s role in this important responsibility.

Mental Health Disparities in the United States

In 1999, under Dr. David Satcher’s leadership, the first report of the Surgeon General to focus exclusively on mental health was published. It concluded: “Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services….viewed readily through the lenses of racial and cultural diversity, age, and gender” (DHHS, 1999, p.vi). In 2001, these disparities were further explored in the U.S. Department of Health and Human Services report Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General. The report’s central theme emphasized that cultures of racial and ethnic minorities alter the types of mental health services they need: “Clinical environments that do not respect, or are incompatible with, the cultures of the people they serve may deter minorities from using services and receiving appropriate care.” More recently, the National Alliance for the Mentally Ill (NAMI, 2006, p. 1) cited subsequent governmental reports that “have continued to highlight the myriad of barriers to accessing mental health treatment, as well as the poor quality of care received by ethnic/racial communities.”

Diversity Training and Multicultural Competence: Professional Imperatives

For a state psychological association, diversity training is challenging. The development of multicultural competence is expected of both psychology trainees and practicing psychologists (i.e., “diversity” and “multicultural” will be used interchangeably here). For trainees, and aligned with recommendations of the President’s New Freedom Commission for Mental Health Report (2003), APA mandates that its accredited doctoral programs require a multicultural competence course. Surveys indicate, however, that only 62% of responding programs offer courses that focus on minority groups (Sehgal et al, 2011; Sherry et al., 2005) with counseling psychology programs possibly more likely to provide courses than clinical programs (Norcross et al., 1998). Regardless, effectiveness of diversity courses is hard to determine due to minimal research and no clear guidelines that provide specifics about how to develop or evaluate multicultural competence (Jones et al., 2013; Sehgal et al., 2011).
Setting standards around attaining/maintaining multicultural competence for practicing psychologists is even more elusive. Many attended doctoral programs before diversity courses were mandated. In Georgia, the Board of Examiners requires a minimum of three hours of continuing education (CE) in cultural diversity for first-time license renewals. This requirement can be waived for licensees who document completion of a graduate cultural diversity course. Nonetheless, it is possible that the three hours of required CEs may be the only formal diversity training some psychologists receive during their careers.

Regardless of whether it is three hours of diversity CEs or 45 plus hours of face-to-face graduate instruction, our ethical principles reflect that diversity training cannot end there. Cultural competence and the maintenance of “cultural literacy” (Jones, 2009) are a career-long, life-long journey—colored by one’s own values, attitudes, and beliefs—and governed by one’s self-awareness and ability to self-assess.

Our code of ethics guides psychologists to practice within our scope of competence. Further, the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Culturalism against the damaging effects of individual, institutional, and societal racism, prejudice, and all forms of oppression based on stereotyping and discrimination.”

Multicultural Competence: Knowing That We Don’t Know

As the leading voice of psychologists in Georgia, GPA must not only honor the ethics of our profession but also must incorporate and cultivate best practices in doing so. This poses additional challenges. One is the “abstract nature” of multicultural competencies (Kim & Lyons, 2003; Jones et al., 2013) and the many definitions of multicultural competence. NAMI (2013) states that it is “the ability to work effectively and sensitively within various cultural contexts....The U.S. Department of Health and Human Services (DHHS), defines it as ‘a set of values, behaviors, attitudes, and practices within a system that enables people to work effectively across cultures....the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services’.”

Another challenge to multicultural competence is one common to the development of any competency: often, those who are least competent are also least able to self-assess accurately (i.e., they don’t know that they don’t know) (Boud & Falchikov, 1995; Kruger & Dunning, 1999; Zimmerman, 2002). Continuing disparities in mental health services, however, suggest that each of us does not know that we do not know at least some of the time. Clearly, we have much room for improvement.

GPA: Setting the Standard

As a highly respected state psychological association and key gatekeeper, GPA is in a unique position to set a state standard for diversity training. This standard must involve two levels of diversity training. One, the explicit curriculum, is the manifest content that is delivered via workshops, etc. The other, and perhaps most important—is the hidden curriculum: “everything that students are learning besides what teachers are explicitly teaching” (Jackson, 1968; Stinson, 2005, p. 52).

With explicit curriculum, Sue et al.’s model (1992) instructs us to address four domains: beliefs and attitudes; knowledge; skills; advocacy and action. Experts agree that diversity training must begin with self-awareness. This is challenging when those with the greatest need for training are least likely to know that they need it. The question arises of whether yearly CE in diversity training should be mandatory. Views vary. In 2004, recommendations of the...
California Board of Psychology work group on cultural competence were inconclusive. Yet, the medical profession is trending toward mandatory continuing education in multicultural competence—and California already requires this. The question bears further consideration.

Knowledge and skills training tend to be less controversial than experiential training that addresses beliefs and attitudes. Nonetheless, clinicians may not effectively apply knowledge and skills mastered in isolation to clinical situations (Cardemil & Battle, 2003; Hansen et al., 2006; Sehgal et al., 2011). Further, best practices dictate that specific needs of diverse populations must not only be addressed in workshops that target these populations. Needs of diverse groups must be infused in all content offerings.

The advocacy and action domain remains a growing edge for many. Organizationally, GPA addresses this area via multiple committees (e.g., including Legal and Legislative, Public Education) as well as through the work of the GPA Political Action Committee (PAC). Clinicians readily understand advocacy regarding individual clients; however, they may not view political advocacy as part of their clinical role even though APA’s best practice guidelines for multiple diverse populations cite systemic advocacy as a clinical practice domain.

The hidden curriculum is far more challenging to address. Skills and knowledge mean little if members of diverse groups do not see viable role models present in adequate numbers and as gatekeepers in positions of power. The under-representation of African Americans as psychologists, faculty in higher education, and doctoral students is well documented. African Americans comprise 5.8% of those earning doctoral degrees, yet only 1.4% are members of APA. Latino psychologists comprise 9.7% of doctoral degrees, yet only 2 percent are APA members. The under-representation of women as higher-level administrators and tenured faculty is also well documented, despite the fact that APA membership as of 2009 reflected 66% women and 33.5% men (APA, 2009).

For GPA, creating a progressive hidden curriculum falls to every facet of our organization with key roles played by the Executive Committee, Council on Diversity, Membership Committee, Public Education Committee and Council for Early Career Professionals/Emerging Professionals. Workshop content means little if members of racial and ethnic minorities and other diverse groups do not see their peers represented abundantly at every level of the organization. In diversity training, recruitment and retention of psychologists from diverse groups need to be our number one priority.

We have much to do to fulfill GPA’s potential for state leadership in diversity training. We must stay abreast of research and best practices in psychology and in related mental health disciplines. Most importantly, however, we must have psychologists from diverse populations well represented in our membership and in positions of leadership; their voices must be heard and heeded in establishing GPA’s agenda. The newly formed Council on Diversity invites your participation; please join us and lend your voice to this important mission.
The DSM-5 attempts, as did its predecessor, to guide mental health practitioners to deliberately assess and incorporate culture into diagnostic decision making. Highlights of how considerations of culture are included in the DSM-5 and changes from DSM-IV-TR (APA, 2000) are included here. DSM-5 (APA, 2013) retains many of the features of DSM-IV-TR in that it contains an outline for a cultural formulation, a glossary of describing patterns of behavioral and psychological distress related to culture, and cultural considerations for the use of diagnostic categories and criteria. A chapter titled Cultural Formulation appears in Section III of the new DSM ancillary to the description of mental disorders, amongst chapters on assessment instruments, an alternate DSM-5 model for personality disorders and conditions for further study. In the main body of the manual, description of cultural and gender variations such as differences in prevalence, symptoms, and course of a disorder appear in the text description for most disorders or in the actual symptom criteria sets. Cultural, gender and age considerations are given in separate sub-sections in the DSM-5 as compared to the DSM-IV-TR where they were combined. Descriptions of cultural considerations in the text vary considerably in length and depth with, for instance, a one line description for trichotillomania and a more detailed discussion in panic disorder. The entry for trichotillomania notes that this disorder is thought to manifest in a similar manner across cultures but that there is a dearth of data outside non-Western locales. The entry for panic disorder notes specific cultural syndromes that may be similar to the disorder, that cultural explanations may make it difficult to confirm the attribution of unexpectedness of panic attacks and the prevalence rates and levels of severity seen in some groups in the United States. The diagnostic criteria for panic disorder also notes which culture-specific symptoms should not count as one of the four required symptoms for a panic attack. Such culture-specific instructions for criteria appear relatively infrequently in the manual.

Culture-Bound syndromes are acknowledged in the new DSM as of limited utility in its ability to describe cultural variations in expressions of psychopathology and distress. The term Cultural Concepts of Distress is introduced as an umbrella term describing “...ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions” (APA, 2013, p. 758). Three cultural concepts fall under this umbrella:

* Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. Cultural idioms of dis-

(Continued on page 14)
stress are ways of expressing distress that many not involve specific symptoms or syndromes, but that provide collective, shared ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns....Cultural explanations or perceived causes are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology or symptoms, illness, or distress (APA 2013. p. 758).

Thus, the new DSM includes discussion of all such concepts where relevant throughout the manual. Some of the previously described culture-bound syndromes remain in the Glossary of Cultural Concepts of Distress, namely ataque de nervios, dhat syndrome, nervios, shenjing shuairuo, susto, and taijun kyoofusho. Three have been added: khyal cap, kufungisisa, maladi moun. And, several have been deleted, namely amok, bilis, colera, boufee delirante, brain fog, dhat, falling-out, ghost sickness, hwa-byung, koro, latah, locura, mal de ojo, piblokktoq, qigong psychotic reaction, rootwork, sangue dormido, shen-k’uei, shenkui, shin-byung, spell and zar.

The outline for cultural formulation provided in the new DSM is practically the same as previously. In the DSM-5 it is described as “... a framework for assessing information about cultural features of an individual’s mental health problem and how it relates to a social and cultural context and history” (APA 2013, p. 749). More generally, a cultural formulation may be described as a way to systematically elicit, integrate and conceptualize the impact of cultural factors on the presenting mental health issues (Lewis-Fernandez & Diaz, 2002). A side-by-side comparison of the versions in DSM-IV-TR and DSM-5 indicate slightly different labels of the categories in the outline and changes in the wording describing them, but little substantive change in the meaning of these categories. Additionally, preceding these descriptions, the DSM-5 adds clinically-relevant definitions of the constructs culture, race and ethnicity. The five areas delineated in the DSM-5’s cultural formulation are:

1. Cultural identity of the individual—how the patient describes the groups to which they belong.
2. Cultural conceptualization of distress—how the patient describes the cause, mechanism, label and impairment of the problem.
3. Psychosocial stressors and cultural features of vulnerability and resilience—how aspects of the social environment such as family, friends, significant others, religion and other social networks function as stressors or support to the patient.
4. Cultural features of the relationship between the individual and the clinician—identification of differences between clinician and patient and description of how, if at all, the patient views the cultural background of the clinician affecting treatment.

Overall cultural assessment—an integrative summary of the role of culture on diagnosis and treatment.

The DSM-5 goes beyond DSM-IV-TR in providing a semi-structured interview, the Cultural Formulation Interview (CFI), which may be used by the clinician to elicit information from the client to complete the Cultural Formulation. It is a template for conducting a cultural assessment. In the DSM-5 field trials it was conducted prior to any focused diagnostic questioning to establish a diagnosis, however no such instruction appears in the DSM-5. Person-centered in orientation according to the manual, the CFI focuses on eliciting the patient’s perspective of distress. Their experiences of the problem, explanations of the problem, cultural identifications and help-seeking experiences are assessed. Specific domains assessed in the 16-question CFI include: cultural definition of the problem; cultural perceptions of cause, context and support; cultural factors affecting self-coping and past help, and; cultural factors affecting current help seeking. A version of the interview designed to be used with collaterals, the Cultural Formu-
lation Interview (CFI)-Informant Version, also appears in the manual. Additionally, 12 supplementary modules providing questions to explore the domains assessed in the basic CFI in greater depth, and to assess issues relevant for use with children and adolescents, elderly individuals, immigrants and refugees, and caregivers are available on the associated website [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5). In practical application, the CFI suffers from many of the pitfalls of structured or semi-structured interviews. Using simply the questions provided is unlikely to provide the clinician with the level of information necessary to complete a nuanced cultural formulation. It seems helpful both as a guide to remind the clinician that questions relating to cultural context should be asked and as a guide to how they should be asked. For example, the CFI suggests the following statement followed by specific questions to tap the impact of cultural identity on the presenting problem:

Sometimes, aspects of people’s background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender, or your faith or religion. For you what are the most important aspects of your background or identity? Are there any aspects of your background or identity that make a difference to your [PROBLEM]? Are there any aspects of your background or identity that make a difference to your [PROBLEM]? (APA, 2013, p. 753).

To its credit, this is the first DSM attempting to integrate and describe culture, not as a variation of the prima facie valid disorders it describes, but as a variable integral to the conceptualization/existence of the disorders themselves. It notes prominently in the introduction, “Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides the interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis” (APA 2013, p. 14). Later, a more bold statement, albeit appearing in the ancillary section on cultural concepts of distress, acknowledges the culture-specific nature of the DSM itself:

“The current formulation acknowledges that all forms of distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes, and became widely accepted as a result of their clinical and research utility” (APA 2013, p. 758).

In summary, no major shift in the way culture is incorporated into this diagnostic lexicon occurs. Rather, most of the changes may be considered updating and expansion of the existing scheme. Unequivocally, the DSM-5 reflects a medical model of psychological distress and it is therefore limited in its ability to capture human suffering in the behavioral and psychological realms outside of this scheme. It aims to be relevant cross-culturally relevant and is more successful in doing so than its predecessors however to be knowledgeable on cultural issues related to diagnosis, the psychologist must go beyond the DSM-5 to consult the disorder-specific literature.
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Chapter Five of the State Board of Examiners’ Rules ("Licensure Rules") is defined as the Supplemental Code of Conduct, which addresses areas not included in the APA Ethics Code (incorporated as Chapter Four of the Licensure Rules). According to Chapter 510-5-.02 (Definitions), psychologists can delegate and supervise psychological services for three categories of individuals: (1) trainees, (2) employees, and (3) individuals who are also employed by the same institutional employer. Supervision requirements generally fall within one of two types of settings.

**Training settings** involve supervisees who are pre-doctoral interns or post-doctoral fellows. A training setting may include “a hospital, accredited school, university, consulting firm, public agency, public or private organization, or public or private practice” (Chapter 510-2-.05 [2] [c]). Because supervision of pre-doctoral interns and post-doctoral fellows has been addressed elsewhere (Campbell & Webb, 2004; Doverspike, Campbell, Meck, Sauls, & Webb, 2009), the present article addresses only supervision in employment and independent practice settings.

**Employment settings** involve supervisees who are employed by either a psychologist (e.g., the psychologist’s practice) or by an institutional employer (e.g., an agency). An employee is someone who receives an IRS Form W-2 from either the psychologist or from an institutional employer by whom the psychologist is also employed. An employee would not be an IRS Form 1099 independent contractor. Regardless of whether supervision occurs in an institutional setting or by a psychologist in independent practice, all fees for services shall be paid directly to the institution or, in the case of psychologists in independent practice, directly to the supervising psychologist.¹ Client/patient fees would never be made payable to a psychological assistant or psychometrist. Psychologists who pay psychological assistants or psychometrists as independent contractors are aiding the illegal practice of psychology without a license.

**Delegation to and Supervision of Supervisees of Psychological Services (Chapter 510-5-.06 [(3)]**

(a) Psychologists shall not delegate professional responsibilities to a person who is not qualified to provide such services. [For example, Licensed Professional Counselors (LPCs) are not qualified or personally competent to perform psychological testing, and to allow them to do so in their capacity as LPCs is considered aiding illegal practice.] Psychologists delegate to supervisees, with the appropriate level of supervision, only those responsibilities that such persons can reasonably be expected to perform competently and ethically based on the supervisee’s education, training, and experience.

(b) Psychologists shall not delegate responsibilities or accept supervisory responsibilities for work which they are not qualified and personally competent to perform. Psychologists must retain full, complete, and ultimate authority and responsibility for the professional acts of supervisees.

(c) The supervisee must have appropriate education and training, including training in ethical issues, to perform the delegated functions. The psychologist is responsible for determining the competency of the supervisee and will not assign or allow the supervisee to undertake tasks beyond the scope of the supervisee’s training and/or competency. The psychologist is also responsible for providing the supervisee with specific instructions regarding the limits of his/her role as supervisee.

(d) The supervisee must fully inform the patient or client receiving services of his or her role as supervisee and the right of the patient or client to confer with the supervising psychologist with regard to any aspect of the services, care, treatment, evaluation, or tests being performed.

(Continued on page 19)
(e) When clinical psychological services are rendered, the psychologist must take part in the intake process, must personally make the diagnosis when a diagnosis is required, and must personally approve and co-sign a treatment plan for each patient or client. The psychologist must meet personally with the supervisee on a continuous and regular basis concerning each patient or client and must review the treatment record, including progress notes, on a regular basis as appropriate to the task(s). The psychologist must provide a minimum of one hour of supervision for every 20 hours of face-to-face clinical contact. The psychologist shall not take primary supervisory responsibility for more than three supervisees engaged in psychological services concurrently without Board approval.

(f) The selection and interpretation of psychological tests shall only be made by the psychologist. The psychologist must personally interview the patient when a diagnosis is made or is requested. In any written report, including psychological evaluations, the psychologist must approve and sign the report. When the supervisee does not participate in the actual writing of a report, but does administer and/or score psychological tests, the supervisee is not required to sign the report, but his or her name must be listed as the person who participated in the collection of the data in the report. When the supervisee personally participates in the writing of any report, then both the psychologist and the supervisee must sign the report.

(g) When the delegation and supervision of psychological services is being conducted for training purposes towards licensure, psychologists must comply with the Rules regarding internships, fellowships, and/or postdoctoral supervised work experience.

Aiding Illegal Practice (Chapter 510-5-.10 [1] [b])

Licensure Rules specify categories of individuals with whom supervision cannot be lawfully provided. Pursuant to Chapter 510-5-.06(3), as discussed previously, psychologists “shall not delegate professional responsibilities” to persons who are not qualified to provide psychological services on the basis of their education, training, and experience. In addition to this prohibition, Chapter 510-5-.10 (1) (b) specifies four other categories of persons with whom supervision may not be conducted:

Licensed psychologists may not supervise or employ as an assistant, or in any other capacity, an individual who has (1) voluntarily surrendered his/her license to practice psychology in Georgia or in any other state, (2) been disciplined by the licensing Board, (3) been disciplined by any other lawful licensing authority, or (4) been convicted of a felony, and/or is under criminal probation. It should be noted that Rule 510-5-.10 (1)(b) may be waived or modified by the Board, in its discretion, upon a showing of extraordinary circumstances.

Readers who have questions about board rules may submit their questions to the Executive Director, Georgia State Board of Examiners of Psychologists, 237 Coliseum Drive, Macon, Georgia 31217-3858. To ensure uniformity of response, board opinions are formulated at monthly board meetings and are provided in writing.

Footnotes

1. There is an exception in the case of post-doctoral fellows, for whom fees for services may be paid directly to the agency or supervisor or, where appropriate, directly to the post-doctoral fellow. Although fees may be paid directly to post-doctoral fellows, in neither training settings nor employment settings shall client/patient fees be paid directly to pre-doctoral interns, psychological assistants, or psychometrists.

References


GPA hosted a brunch for newly licensed psychologists on Saturday, June 22 at the Georgia Tech Hotel and Conference Center. In addition to GPA staff, several members of Executive Committee and the incoming Board of Directors attended to meet and greet the new psychologists and to respond to questions or concerns that they might have about their new profession moving forward.

Past President Steven Perlow, Ph.D. provided an overview of the benefits of joining GPA while Nadya Hollahan, Ph.D., Chair of the Council on Psychology of Women and Girls highlighted the new Ambassador program. Former Co-Chair of Early Career Professionals, Will Bruer, Psy.D. invited attendees to get involved in their committee and help plan for 2013-2014. This brunch was a new endeavor for GPA and may become an annual event going forward. Appreciation is extended to all attendees for their interest in and commitment to GPA!
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