MARYLAND BOARD OF EXAMINERS OF PSYCHOLOGISTS

SUMMER 2013

INSIDE THIS ISSUE

Chair's Column

Steven A. Sobelman, Ph.D.

I hope everyone is enjoying the shift from spring to summer. Welcome to heat and humidity.

The Board of Examiners experienced quite a roller coaster ride during the 2013 Legislative Session. Of particular importance, the Board submitted a bill to increase regulatory oversight of Psychology Associates. Although the Psychology Associate bill did not pass, several other pieces of legislation were successful and have impact on Board operations and/or the practice of psychology. The following is a summary of some relevant legislation:

HB 274/SB345 – *State Board of Examiners of Psychologists – Psychology Associates – Licensure* – Failed

A major impetus for the Board's review of the Psychology Associate status was to comply with the State of Maryland Department of Legislative Services' program evaluation (Sunset) recommendation in their 2010/2011 report to the General Assembly which strongly suggested that the Board review current Psychology Associate regulations. It was apparent to Legislative Services that the Psychology Board does not have regulatory (legal) oversight of non-licensed practitioners, which is an aberration among the health-occupations boards. Essentially, if a Psychology Associate does not practice within the ethical standards of the profession and a complaint comes to the Board, the Board lacks the authority to take any formal action against the Psychology Associate. The Board's primary recourse with respect to a complaint against a Psychology Associate is to investigate and discipline the supervising licensed psychologist. As a licensed psychologist, you can see how this puts you and your license in jeopardy if the Psychology Associate you're supervising strays from practicing in an ethical manner. From a public protection perspective, it is clear that the Board's lack of direct oversight over Psychology Associates permits an unnecessary risk. As such, the Board examined ways to tighten the licensing laws in order to protect the public by creating a mechanism to license Psychology Associates and thus have direct regulatory/legal control over them. In the end, the Board submitted legislation to revise the Maryland Psychologists Act in order to license Psychology Associates, but it did not pass. The Board worked with the MPA leadership to improve upon the previously submitted legislation. Here are some pertinent aspects of the bill that will be introduced for the 2014 Legislative Session will:

- Still require psychology associates to be supervised by licensed psychologists;
- Help clarify the roles of psychology associates and psychologists to the public;
- Enable the Board to develop and monitor the psychology associate program; and
- Allow the Board to discipline psychology associates when applicable.

At the end of our approximately 2-hour evening meeting, which was also punctuated with storytelling and good humor, I believe that all who attended would agree that a meaningful, collegial, and successful discussion occurred. As such, I would like to thank the MPA leadership for their assistance in strengthening the Psychology Associate 2013 legislation and the Board looks forward to MPA's support when the Psychology Associate bill is reintroduced during the 2014 legislative session. *Continued on page 2*

Continued from page 1 Chair's Column Steven A. Sobelman, Ph.D.

A second piece of legislation was submitted by the Behavior Analysts. It was called: HB 474 - *Health Occupations - Maryland Behavior Analysts Act* – **Failed**

The behavior analysts came to the Board of Examiners of Psychologists asking if they could be licensed and practice behavior analysis under the Maryland Psychologists Act. Currently, qualified individuals engaged in behavior analysis may practice as a psychology associate under the supervision of a licensed psychologist; or, if qualified, practice as a licensed psychologist. However, the behavior analysts proposed the following: establishing a Behavior Analyst Advisory Committee under the State Board of Examiners of Psychologists; requiring the Board to adopt regulations and a code of ethics; requiring the Board to set fees for services provided by the Board to behavior analysts; providing for the composition, appointment, and terms of the Committee members; establishing powers and duties of the Committee; requiring specified persons to be licensed by the Board before performing specified work in the State, except under specified circumstances; etc.

The Board has been consistent in responding with the following: The Board believes it sets a bad precedent to open the "Practice Act" to license those individuals with specialized training, as opposed to the current academic and training requirements and standards as set forth by the American Psychological Association and current statutes (Title 18). Thus, the Board of Examiners does not license "techniques" or "methods of therapy" or "assessment." In other words, in Maryland we just have "licensed psychologist" and not licensed "marriage and family psychologists" or "substance abuse psychologists" or licensed "child psychologists" or any other form of special training designation.

There is no question that behavior analysts provide a valuable service to their patients. That was not an issue with which the Board had concerns. The issue centered on the behavior analysts' proposed legislation to change and alter the Maryland Psychologists Act to meet their specific needs.
The following summarizes the Board's discussion and position:

1. The Board was opposed to amending the Practice Act to accommodate specialty providers; and,
2. Behavior analysts, at minimum, should adhere to the same criteria applicable to psychology associates, to include application, academic training, and supervision.

With all of that said, the Board anticipates that the behavior analysts will submit legislation for the 2014 session.

Here are some other bills that may be of interest to psychologists:
HB98/SB254 – *State Board of Examiners of Psychologists – License Renewal* – **Passed.** The Board submitted the license renewal bill to allow the Board to disseminate license renewal notices via electronic mail.

HB 225/SB273 – *Veterans Full Employment Act of 2013* - **Passed** This bill primarily requires all DHMH health occupations to expedite the licensure, certification, or registration of a service member, veteran, or military spouse that meet certain requirements.

HB 331/SB826 – *Open Meetings Act – Violations and Penalties* – **Passed** This bill sets a civil penalty for violation of the Open Meetings Act at $250.00 for the first violation and $1,000 for subsequent violations occurring within 3 years of the first violation.

Continued on page 3

2013 BOARD MEETING DATES

July 12, Sept. 13, Oct. 11, Nov. 8, Dec. 6

Open meetings begin at 9:00am

2013 JURISPRUDENCE EXAM DATES

July 19, Aug. 23, Sept. 20, Oct. 18, Nov. 15, Dec. 13

For examination information contact Dorothy Kutcherman, Licensing Coordinator (410)764-4703.

Continued from page 2 Chair's Column Steven A. Sobelman, Ph.D.

The above is merely a sampling of the myriad issues in which the Board is involved. Future Newsletters will keep you posted on other evolving issues before the Board.

In closing, I want to acknowledge a change in the Board's composition for the 2013-2014 term. It is indeed an honor to be selected to be a Board member and I am grateful to my colleagues for the regard and respect they accord me for serving on Board. I have served as the Board's Vice-Chair and for the past two years, Board Chair. I continue as Board Chair for the 2013-2014 term and share the helm with Dr. Jeffrey Barnett, Board Vice-Chair for 2013-2014.

I absolutely could not do my job without the support of my fellow Board members (psychologists and consumer members) nor without the support of the Board's staff, both legal and professional. I believe we have a great team.

Two new Board members were appointed by the Governor's office and join us in 2013 – *Dr. Christopher L. Bishop and Dr. James F. Gormally.* And with that, two Board members leave. I am most grateful for the dedicated service that *Dr. Joann Altiero* has provided during her 4-year term, as she has decided to leave the Board after one-term. Joann is a dedicated psychologist who brought significant expertise to the task of being a Board member. She will be missed.

I also want to pay special tribute to *Dr. Robert Brown*, who leaves the Board after completing his second term. As many of you may know, Bob and I have a long history through psychology circles. Bob served as Vice-Chair and Board Chair and he also served as a wonderful mentor to me. He has been invaluable to the Board as he brought a special level of understanding and knowledge through his long history with APA, MPA, ASPPB, and involvement with legislative issues. I found him to be a tireless volunteer who has an uncanny ability to take complex tasks and make them look easy. I will personally miss you, Bob.

And to all the professional psychologists in Maryland, thank you for providing the public with a safe road on which they can travel to get their mental health needs met as you adhere to the high professional and ethical standards of our profession. ***—End—***

Disability: Part of the Diversity Spectrum
Irene W. Leigh, Ph.D.

As Americans are living longer, they increasingly confront the possibility of a disability, either temporary or permanent. Statistics indicate that disability is the largest minority group in the United States (Olkin, 1999), with approximately 54 million (one in five Americans), currently living with a disability (U.S. Department of Education, 2007). Consequently, it is likely that every psychologist engaged in the practice of psychology may encounter a person with a disability or work with someone dealing with disability issues in the family. Principle E of the American Psychological Association's (2010) ethical standards states that psychologists are aware of and respect cultural, individual, and role differences, including those based on multiple factors, one of which is disability. This statement affirms that disability is part of the spectrum of diversity.

Interestingly, in the ethical standards, race/ethnicity is mentioned 16 times while disability is mentioned 19 times (Fisher, 2003). In reality, much less attention is paid to disability. Psychologists generally receive minimal or no assessment or psychotherapy training in this area (Olkin, 2002), leaving them insufficiently prepared to provide competent services. Ethical Standard 2.01 (a) emphasizes practice only within the boundaries of one's competence (American Psychological Association, 2010). If practicing psychologists encounter clients with disabilities, the American Psychological Association's (2012) *Guidelines for Assessment of and Intervention With Persons With Disabilities*, hereafter referred to as the *Guidelines*, is a valuable resource. Information in this article is drawn from the *Guidelines.*

Definition of Disability

First of all, what is disability? Disability covers physical mental, and/or sensory characteristics that affect a person's ability to engage in activities of daily life (U.S. Department of Health and Human Services, 2005). It is a dynamic construct whose causes, types, and experiences vary widely (Burch, 2009). Disability may or may not be stable, depending on age of onset, extent of disability, etiology of disability, status as temporary or permanent, and whether visible or invisible (Leigh & Brice, 2003). It is a construct that many people may be uncomfortable with because of perceptions that it limits one's quality of life and renders that person different from what is a "normal," perception that may not necessarily hold true for the person in question or situations in which that person finds herself or himself. Disability has multiple manifestations and there is a wide range of individual responses to disability. Some individuals are very comfortable with disability as part of themselves, as Laurie Rubin, a mezzo-soprano who happens to be blind and sees herself as "a normal person," while others see her as "very different and isolated," and are scared to allow her on stage for fear of accidents (Brown, 2012). On the other hand, many do struggle to varying degrees with their disability.

Continued on page 4

Continued from page 3 Disability: Part of the Diversity Spectrum

Impact of Attitudes

As psychologists, our attitudes towards disabilities will influence our work with clients with disabilities. For example, do we believe that all persons with disabilities cannot produce as much in the work environment compared to the typical worker? Or all persons with amputated limbs should wear prostheses in public? Do we believe that such individuals are "courageous, resilient, adaptable" or "objects of pity?" Do we believe that all disabilities "need to be fixed?" Or do we view disability as a product of environmental limitations? Psychologists can endeavor to scrutinize such attitudes and, according to Principle E (American Psychological Association, 2002), eliminate the effect of possible biases in their work. They also need to be comfortable when working with people with various disabilities and asking questions about disability in initial interviews, whether with the individual or with caregivers, parents, or child of parents with disability.

Laws Governing Disability

Psychologists should be aware of the provisions of the Americans with Disabilities Act of 1990 and the Americans with Disabilities Amendments Act of 2009 (http://www.ada.gov/pubs/ada.htm). These acts serve to protect anyone encountering discrimination based on disability and prohibits considering mitigating measures such as assistive technology, medication, and prosthetics in determining disability. In other words, even if a profoundly deaf person can talk on the phone with the assistance of a hearing aid or surgically inserted cochlear implant, that person is still deaf, not hearing, and cannot be discriminated against as a person with a disability. In minimizing discrimination, psychologists are encouraged to ensure that their offices are in compliance with the regulations governing access for persons with disabilities as this reinforces the concept of equitable access for all potential clients.

Assessment Issues

When assessing individuals with disabilities, as the *Guidelines* indicate, it helps to keep in mind that a disability diagnosis does not automatically predict outcomes. Much depends on individual characteristics, such as cognitive abilities, personality, social support, and so forth that can impact functioning potential. Overall, it is important to elucidate strengths as well as limitations and assess disability in context rather than focusing on the disability alone. "When appropriate in the context of the assessment's goals the psychologist may ask about the client's type and origin of disability, the client's perception of disability-related strengths and limitations; the functional impact of the client's disability, the reactions of others to the client's disability; required aids accommodations, treatments, and medications; and necessary lifestyle modifications" (*Guidelines*, p. 54). In the process of assessing the client, quantitative, qualitative, and ecological perspectives should be analyzed carefully and integrated into the report. Ecological perspectives include consideration of familial, educational, and occupational aspects. Taking a multidisciplinary approach and consulting with relevant colleagues can be helpful in considering the client's abilities.

The *Guidelines* emphasize that psychologists can strive to utilize assessment approaches that are most psychometrically sound, fair, comprehensive, and appropriate for clients with disabilities. Unfortunately, few tests are standardized for persons with disabilities. Psychologists need to determine whether or not accommodations will yield a valid score on a test. A testing accommodation involves a change in test format, content, or administration that does not alter the construct being measured but makes the test accessible to individuals who otherwise might be unable to complete the measure. Examples include changes in presentation, such as a large-print format, changes in response mode, such as the use of an iPad instead of a pencil, or changes in timing or setting. Some may consider extended time for tests to be an unfair advantage. However, individuals with movement disorders may take longer to fill in the bubbles on a response sheet, in which case extended timing may not adversely affect validity. In contrast, test modifications may impact construct validity. For example, if a measure is translated into American Sign Language, or any other language, the validity of the translated measure needs to be examined.

Continued on page 5

Continued from page 4 Disability: Part of the Diversity Spectrum

When compiling the assessment report, it is important to document all test accommodations and modifications, and clarify both the individual's disability and the construct measured by the test, as these will influence the interpretation of the results. The psychologist can also examine competing hypotheses regarding client performance and issues and validate them based on confirmatory or nonconfirmatory evidence. Simplified interpretations of test scores that can lead to inappropriate conclusions about the client's real capabilities should be avoided. To minimize bias, professional judgment about the client should be delayed until all data are available for the report.

Treatment

Depending on the individual and the nature of the disability, providing a hospitable environment will enhance the client's ability to benefit from treatment. To maintain a client-centered and disability affirmative approach, psychologists will find it helpful to ask questions about why the client is requesting treatment and explore the client's perspectives. Not all clients come for psychotherapy because of their disability. Some clients will focus on their disability while others will present with interpersonal or occupational issues, for example. Within the context of psychotherapy, psychologists are encouraged to balance strengths and limitations while in the process advocating for client self-determination, integration, choice, and least restrictive alternatives. Adjusting the number of sessions and session length as needed to accommodate the client's physical and psychological needs may be helpful. Flexibility in terms of communication is important; this can involve the use of audiotapes, visual aids, and written summaries for those clients with language processing, attention, and memory problems. Clients need to know that confidentiality will be maintained, particularly if family members, interpreters, personal attendants, or caregivers are involved.

Persons with disabilities often have to deal with community agencies and systems. Psychologists can work with these agencies and systems in a collaborative manner, always keeping in mind that the goal is to create enabling environments and involve the clients in the process to the greatest extent possible. Depending on the nature of the disability, psychologists need to be sensitive to health issues. Persons with disabilities can be healthy, while others need to work on maintaining their health in conjunction with their disability.

Conclusion

Psychologists who actively seek continuing education and consultation in the area of disability and consistently monitor themselves for bias will enhance their competence to treat clients with disabilities. The goals are to assist clients in becoming self-determining individuals through disability affirmative treatment that focuses on balancing strengths and limitations, and to ensure that assessment approaches are valid and appropriate for specific clients with disabilities. *References furnished upon request.* ***—End—***

Newly Licensed Psychologists

July 2012
Pamela Sandeau Baer, Ph.D.
Amie F. Bettencourt, Ph.D.
Marianne Grace Dunn, Ph.D.
Randall Drake Ehrbar, Psy.D.
Oscar J. Harp, III, Ph.D.
Linda Jones Herbert, Ph.D.
Lisa Holt Jaycox, Ph.D.
Elizabeth Malesa, Ph.D.
Sally A. Mays, Ph.D.
Jessica Marie Parrish, Ph.D.
Michelle Janette Pearce, Ph.D.
Katharine C. Powers, Psy.D.
Colleen Quinn, Ph.D.
Tanya Ergh Sherman, Ph.D.
Elizabeth A. Tsakiris, Ph.D.
Hoa Thi Vo, Ph.D.

August 2012
Jennifer M. Aakre, Ph.D.
Ann M.T. Brugh, Psy.D.
Diana Jean Fitek, Ph.D.
Jill Cherie Fodstad, Ph.D.
Renee Cutiongco Folsom, Ph.D.
James Hansell, Ph.D.
Jocelyn Helwig, Ph.D.
James L. W. Houle, Ph.D.
Stacy A. Koutrakos, Psy.D.
Stacey R. LeFevre, Psy.D.
Alicia Meyer, Ph.D.
Valerie Paasch, Ph.D.
Rebecca Penna, Ph.D.
Treloar Anna Price, Psy.D.
Maegan D. Sady, Ph.D.
Dominick A. Scalise, Ph.D.
Patricia T. Spangler, Ph.D.
Laura E. Sproch, Ph.D.
Doris Staeudle, Psy.D.
M. Reneé Mottenon-Thompson, Psy.D.
Alyssa D. Verbalis, Ph.D.
Elizabeth Anne Wangard, Psy.D.
Brittney Elizabeth Ziskind, Ph.D.
Leslie Frances Zirkin, Psy.D.

September 2012
Kelly Beakley Lane, Psy.D.

October 2012
Jaime L. Benson, Ph.D.
Rashanta Aneisha Bledman, Ph.D.
Tyler Ray Calabrese, Psy.D.
Jennifer A. Cameron, Ph.D.
Katren E. Clark, Psy.D.
Lillian A. DePetrillo, Ph.D.
Kiu Amani Eubanks, Ph.D.
Barbara Joanne Francis, Psy.D.

Newly Licensed Psychologists cont.

October 2012 cont.
Travis Charles Frank, Psy.D.
Laura Goldstein, Psy.D.
Margaret Ray Gsell, Ph.D.
Peggy Amanda Howard, Ph.D.
Lisa A. Joseph, Ph.D.
Tara B. Louchery, Psy.D.
Mariana Martinez, Psy.D.
Erika N. Morton, Ph.D.
John Robert Parker, Ph.D.
Ann Schlegelmilch, Psy.D.
Jen Sermoneta, Psy.D.
Kerry A. Silvia, Ph.D.
Carrie Singer, Psy.D.
Amanda Leigh Skowron, Psy.D.
Abram Sterne, Ph.D.

November 2012
Jacob Alan Bentley, Ph.D.
Lori A. Day, Ph.D.
Anne F. Lagor, Psy.D.
Margaret R. Laracy, Psy.D.
Eleanor Race Mackey, Ph.D.
Aleah L. Nathan, Ph.D.
Amber Kay Schuhler, Psy.D.

December 2012
David T. Goode-Cross, Ph.D.
Aaron Jade Hamann, Psy.D.
Heather Lynn Iepson, Psy.D.
Tiffany Wen-Ting Lin, Psy.D.
Sahair Kaboli-Monfared, Psy.D.
Christina Massari, Psy.D.
Sarah J. McQuide, Psy.D.
Taryn Brianne Millar, Psy.D.
Cathryne L. Maciolek Waugh, Psy.D.
Jason Douglas Wemmers, Psy.D.

January 2013
Carolyn Winn Breslin, Ph.D.
Michelle Chabbott, EdD
Madeleine J. Dunn, Ph.D.
Pamela Judith Finder, Psy.D.
Brandy Elizabeth Hellman, Psy.D.
Lacey Levitt, Ph.D.
Matthew P. Mychailyszyn, Ph.D.
Eric D. Rose, Ph.D.
Shannon Senefeld, Psy.D.

February 2013
Lisa Danielle Bailey, Ph.D.
Nazli Fouladi, Psy.D.
Kevin Gormley, Psy.D.
Gloria L. Mathis, Ph.D.

February 2013
Jauffmick Michel, Psy.D.
Peggy V. Nave, Psy.D.
Ajunwa M.E. Nwogu, Psy.D.
Adria Jean-Michaelle Trotman, Ph.D.
Joni Lynn Utley, Psy.D.
Cixin Wang, Ph.D.

March 2013
Celeste May Amadei, Psy.D.
Melinda C. Capaldi, Psy.D.
Ida C. DeLiberis, Psy.D.
Ilana Jackson, Psy.D.
Johanna Kaplan, Ph.D.
Jeffrey W. Martens, Ph.D.
Bevin E. Merles, Psy.D.
Aaron Rakow, Ph.D.
Jennifer Goldberg Schneyer, Psy.D.

April 2013
Stephanie Bader, Ph.D.
Lisa H. Berghorst, Ph.D.
Kristin Noelle Bianchi, Ph.D.
Lauren A. Bynum, Ph.D.
Jeremiah D. Ford, Ph.D.

April 2013
Lindsay D. Holbein, Psy.D.
Jelena Kecmanovic, Ph.D.
Miranda M.G. Kofeldt, Ph.D.
LaFaye F. Marshall, Psy.D.
Joslyn Cynkus Mintz, Ph.D.
Connie Elka Myerson, Ph.D.
Monique Vulin Reynolds, Ph.D.
Stacey M. Rumerman, Psy.D.
April Simcox, Ph.D.
Kevin Roy Simonson, Psy.D.
Laurie S. Slavit, Psy.D.
Ashley K. Stewart, Ph.D.
Melissa A. Tanner, Ph.D.
Tiffany K. Washington, Ph.D.

May 2013
Jesse G. Brand, Ph.D.
Sarah Crawley, Ph.D.
Talia Sue Cronk, Psy.D.
Katherine D. Daly, Ph.D.
Tanisha E. Drummond, Psy.D.
Samuel S. Dutton, Ph.D.
Shannon Erklin, Ph.D.
Patrick Hamilton Finan, Ph.D.
Evie J. Gerber, Ph.D.
Angelo C. Giolzetti, Psy.D.
Daniel S. Lewin, Ph.D.

May 2013
Anne T. Molloy, Psy.D.
LaNiña E. Mompremier, Ph.D.
Abigail Mintz Romirowsky, Ph.D.
Stephanie A. Sacks, Ph.D.
Rachel R. Singer, Ph.D.
Veronica G. Tilden, Psy.D.
Shouh-Rong Vivian Tsai, Psy.D.
Kristine I. Vindua, Psy.D.
Sarah M. Weisberg, Psy.D.
Claudette Williamson-Taylor, Ph.D.

June 2013

Melissa C. Blackwell,Psy.D.
Lindsay D. Clendaniel, Ph.D.
Corine Bell Crowley, Ph.D.
Renee L. DeBoard-Lucas, Ph.D.
Alana Riss Fine, Ph.D.
Daniel L. Gadke, Ph.D.
Erin Lewis-Morrarty, Ph.D.
Angelika Marsic, Ph.D.
Laura L. Neely, Psy.D.
Steven J. Porter, Psy.D.
Colleen Clarkin Schreyer, Ph.D.
Jillian Panuzio Scott, Ph.D.
Elizabeth Ann Willems, Psy.D.
Alison Rebecca Zisser, Ph.D.

Clinical Supervision Basics and Beyond

Jeffrey E. Barnett, Psy.D., ABPP

Clinical supervision is an integral component of every mental health professional's training and is of vital importance for the development of each clinician's clinical competence. In addition to didactic training to obtain needed knowledge, clinical supervision is one of the primary ways supervisees develop competence through the development of clinical skills, judgment, attitudes, and values that are so integral to clinical competence (Bernard & Goodyear, 2004).

What is Supervision?

Clinical supervision is contrasted with administrative supervision and with consultation. Administrative supervision involves supervision and oversight of administrative tasks such as the performance of non-clinical work duties. These may include the submission of time cards or logs of hours worked and related work activities. Consultation is an activity between two independently licensed professionals. The consultant may offer insights, ideas, and suggestions to the colleague who seeks the consultation. But the consultant bears no legal responsibility for the actions taken by the consultee and the consultee is under no obligation to follow the advice or suggestions provided by the consultant. In essence, consultation is something that occurs between equals.

In contrast, in clinical supervision, the supervisor carries a great responsibility for the clinical actions and behaviors of the supervisee. The supervisee, whether a trainee or a Psychology Associate, is not independently licensed and thus, must follow the guidance and direction of the clinical supervisor. Supervision of a licensed psychologist may also be required by the Board of Examiners of Psychologists (the Board) as a requirement for continued practice by a psychologist found by the Board to need supervision to be able to continue providing clinical services competently and ethically.

> Bernard and Goodyear (2004) define clinical supervision as:
> an intervention provided by a more senior member of a profession to a more junior member or members of that same pro fession. This relationship is evaluative; extends over time; and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she/he, or they see, and serving as a gatekeeper for those who are to enter the particular profession. (p. 8)

Thus, as can be seen in this definition, supervisors may have multiple roles and responsibilities. These may include those of educator and trainer, and of evaluator and gatekeeper, as indicated above, and possibly as professional role model and mentor.

In Maryland, in addition to Board mandated supervision described above, psychologists may serve as clinical supervisors to students in externship and internship settings, as well as in a range of settings during the post-doctoral year as part of their pre-licensure clinical training. Psychologists may also serve as clinical supervisors to psychology associates, individuals with at least a Masters degree in psychology from an accredited college or university who are approved by the Board to provide psychological services under this supervision as an exemption to the requirement to be licensed under Title 18-301 of the Health Occupations Article.

Individuals who seek to be psychology associates must submit an application to the Board. This application will include verification of the applicant's education and will specify the licensed psychologist who has agreed to be this individual's clinical supervisor if this arrangement is approved. If approved, the supervising psychologist accepts full responsibility for all psychological services provided by the psychology associate. While the minimum numbers of hours of supervision required are specified in Title 10, Chapter 07, Psychology Associate, these are minimal expectations and each supervisor should provide the amount and type of supervision needed to ensure that the psychology associate provides competent clinical services. Thus, there are a number of issues relevant to serving as a clinical supervisor with which each supervisor should be familiar.

Supervisor Competence

Each supervisor must possess adequate competence to serve in the role of clinical supervisor. This involves two types of competence. First, the supervisor must be competent clinically in the areas of practice to be supervised. Thus, if for example the supervisor is providing supervision of a trainee or psychology associate in child assessment and treatment, then the supervisor must him or herself be competent in conducting the types of child assessments and treatments to be supervised. Second, the supervisor must be competent in clinical supervision itself (Falender et al., 2004).

Thus, taking on the role of clinical supervisor must be more than just an assigned work function. Each supervisor must possess needed competencies to be an effective clinical supervisor. Developing these competencies may include formal study and coursework, supervision of their supervision, ongoing continuing education activities, and remaining current with the relevant literature.

Continued on page 8.

Continued from page. 7 — Clinical Supervision Basics and Beyond

While individual decisions will need to be made about how much education, training, supervision, and ongoing professional development each supervisor needs to be a competent supervisor, it is essential that the obligation to be a competent supervisor be carefully considered. As it is stated in Title 10, Chapter 05, Code of Ethics and Professional Conduct, "A psychologist shall limit practice to the areas of competence by which proficiency has been gained through education, training, and experience" (.04 Competence, A (1)). Along these lines, since competence in one aspect of practice does not guarantee competence in other areas of practice, in Title 10, Chapter 07, supervisors of psychology associates (and this is relevant in all supervision) are instructed to "delegate some supervisory responsibility to another psychologist licensed by the Board to ensure competent supervision of a psychology associate in areas outside the area of expertise of the supervisor" (.05 Requirements for and Responsibilities of Supervisors, A (2) a).

Like all other individuals, psychologists are imperfect at self-assessing their competence and effectiveness (Johnson et al., 2012). Therefore, it is recommended that clinical supervisors seek consultation from expert colleagues to help determine their areas of competence and areas of needed skill development, as well as when delegation of supervisory responsibilities is indicated. Additionally, rather than focus on meeting minimal expectations articulated in law and regulation, it is recommended that clinical supervisors take an aspirational ethics approach (Knapp & VandeCreek, 2012) in which they endeavor to provide the best possible supervision services at all times.

As Kaslow, Falender, and Grus (2012) advise, "training in supervisory competencies is crucial for ensuring effective professional practice" (p. 52). These authors advocate for formal training in supervision competencies by all professionals who provide clinical supervision services. They share that "several states (e.g., California) have adopted supervisory training requirements to increase the likelihood that supervisors and those they supervise perform optimally" (p. 52). See http://www.psychboard.ca.gov/cont-edu/index.shtml and look under Specific Content Mandates for these requirements.

In Maryland, the Board has developed proposed legislation that may include a requirement that all supervisors of psychology associates receive a certain minimal amount of education and training in clinical supervision both before they can be approved as a supervisor and on an ongoing basis. It is anticipated that this proposed legislation will go before the Maryland legislature in the 2014 legislative session.

Supervisee Competence

In addition to ensuring supervisor competence, an essential role of the clinical supervisor is to ensure that the supervisee possesses needed competence to provide clinical services. As such, it is recommended that each supervisee's competencies and training needs be assessed at the outset of the supervisory relationship. Doing so should provide the supervisor with a clear idea of the supervisee's areas of strength and weakness. Based on this initial assessment of supervisee competence in the areas relevant to the clinical services to be provided, the supervisor can develop a supervision and training plan tailored to fit the individual supervisee's training needs. This approach is consistent with the aspirational ideals of our profession (Knapp & VandeCreek, 2012) and helps to ensure that the clients assessed and treated by the supervisee receive the best possible professional services.

Supervisors should use the initial assessment of the supervisee's areas of competence and ongoing assessments throughout the course of the supervisory experience to determine the nature, type, and amount of supervision needed. For some supervisees this may mean observing the supervisee provide certain services, providing live feedback. With others, it may include the review of video or audio recordings of the services provided and then discussion in supervision sessions. How much and what type of supervision is provided (beyond meeting minimal requirements) should be consistent with the supervisee's training needs as determined by these ongoing assessments, so that each client's best interests and welfare are safeguarded.

Additionally, as has been stated, supervisors also serve as gatekeepers of the profession. As Johnson et al. (2008) articulate, each supervisor must carefully evaluate and assess their supervisees for suitability for continued participation in their professional role. Supervisors should conduct ongoing and periodic assessments of their supervisees' competence and provide needed feedback and opportunities for remediation throughout the supervisory experience. But, when remediation is not successful and when supervisors determine that the supervisee places the welfare of current and future clients at risk, it is essential that supervisors fulfill their gatekeeping function. This means notifying a trainee's training program and not giving a passing grade for the training experience; for psychology associates, it may involve notification to the Board, making clear the supervisor's appraisal of the psychology associate's suitability for continuing in this role.

Continued on page 10.

2014 BOARD MEMBER VACANCIES

The Maryland Board of Examiners of Psychologists (the Board) will have two (2) psychology Board member openings effective July 1, 2014. If you are interested in serving on the Board or would like to nominate someone, please contact the Maryland Psychological Association (MPA) at 410-992-4258. The MPA will accept the names of nominates from **July 1, 2013 – September 30, 2013**.

The mission of the Board involves protection of the public via licensing the professional practice of psychology and regulating the practice of psychologists in the state. The Board responsibilities include an advisory role to executive and legislative branches of state government, as well as regulatory, supervisory and administrative oversight of psychologists.

Board members can serve two four-year terms. Members attend monthly meetings and serve on 2 of four committees. The committees are Disciplinary, Licensing, Operations and Public Affairs.

Eligible psychologists must be a United States citizen, a Maryland resident and must have been a licensed psychologist for at least 5 years who practiced, taught, or engaged in research in psychology . Please contact the Maryland Psychological Association for more information.

Thank you for considering serving on the Board.

FOR YOUR INFORMATION

Board Presentations

The Board of Examiners of Psychologists (the Board) has created two informative presentations that they can present to interested institutions and groups. The first is intended for graduate students and other pre-licensure trainees. This presentation provides information about the Board, the licensure process, and ethical practice in Maryland. The second presentation is intended for licensed psychologists and provides information about recent changes that impact psychologists including continuing education requirements, child custody evaluations, and others. For information on scheduling a presentation, contact the Board's office at www.dhmh.maryland.gov/psych or at 410-764-4787.

Continued from page. 8 — Clinical Supervision Basics and Beyond

Cultural Competence

An essential aspect of each supervisor's and each supervisee's competence is that of cultural competence. Supervisors must be competent to work with supervisees from diverse backgrounds and to supervise the assessment and treatment of clients of diverse backgrounds (Millan, 2010). As is stated in the Code of Ethics and Professional Conduct (Title 10, Chapter 05), each psychologist must "acquire the special education and training needed to address the cultural differences of special populations" (.04 Competence, A (2)). Thus, cultural competence is considered an essential aspect of general clinical competence regardless of the specific services provided or settings where one works (Rodolfa et al., 2005).

Additionally, this aspect of competence should not be seen as being limited only to cultural differences, but instead to individual differences defined broadly. For guidance, readers are directed to Principle E, Respect for People's Rights and Dignity, of the APA Ethics Code (APA, 2010), which provides a useful working definition of the types of diversity each supervisor and supervisee should be competent to work with. It states in part that we each should be knowledgeable about and respect "individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status and consider these factors when working with members of such groups" (p. 3). Similarly, in the Code of Ethics and Professional Conduct, psychologists (and those they supervise) are guided to "Treat all individuals in a fair and objective manner without discrimination based on age, gender, race, ethnicity, culture, national origin, disability, socioeconomic status, or another basis proscribed by law" (Responsibilities and Requirements, A (1) (e)).

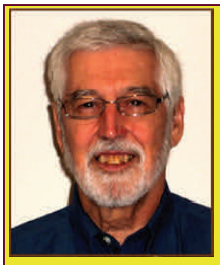
Informed Consent in Supervision

Informed consent is an essential starting point for all professional relationships. Just as it must be provided to each client by their treating clinician it should also occur between supervisor and supervisee. As Thomas (2007) highlights, there is significant overlap between what is included in the informed consent between clinician and client, and between supervisor and supervisee, which is often referred to as the supervision contract. Relevant issues to be openly discussed and agreed to through this process in supervision include "anticipated length of service, limits to privacy, fees, risks and benefits, and maintenance and storage of records" (Thomas, 2007, p. 21) as well as the goals, structure, and methods of supervision (Barnett, 2000). Additionally, it is recommended that at a minimum, each of the following be included in the supervision contract, the agreement between each supervisor and supervisee:

- The roles, responsibilities, and requirements of both supervisor and supervisee (see Thomas, 2007 for specific recommendations for each of these).
- Information on how to contact the supervisor in between supervision sessions and an agreement on the types of situations and circumstances that necessitate immediate contact with and disclosure to the supervisor.
- Documentation requirements for clinical services provided to include written notes and reports as well as audio and video recording.
- Documentation requirements for supervision sessions for supervisees and supervisors alike (Note that 10.35.06.04 requires that psychologists "Document and maintain appropriate records of professional and scientific work").
- Any specific requirements for numbers and types of clients assessed or treated
- Evaluation procedures to be utilized throughout the supervisory relationship and with whom the results of these evaluations will be shared.
- Complaint procedures and due process obligations.
- Duration and termination of the supervision contract and supervision relationship.

Conclusions

While this brief article can only provide an introduction to the important topic of clinical supervision, it is hoped that it will provide a foundation for an aspirational approach to providing competent, high quality supervision of each supervisee. While all psychologists serving as supervisors must meet all applicable minimal standards set in Titles 18 and 10, it is hoped that these will be seen as minimal expectations and that each supervisor will work on an ongoing basis to exceed them, aspiring to achieve the highest professional standards so that the best possible professional services may be provided by supervisor and supervisee alike. *References furnished upon request.* ***—End—***



"Changing of the Guard" Where does the time Go?

It's hard to believe that it is time to bid farewell to

***Dr. Robert A. Brown, Ph.D., ABPP**. His eight (8) years of service on the Board will come to a close on June 30, 2013.*

During Dr. Brown's, (fondly known as Bob) tenure on the Board he provided leadership as the Board Chair, direction as the Vice chair, and action as a Board member.

It has been both an honor and a privilege to work with such a fine gentleman. We will miss him.

With Heartfelt Memories,

Sincerely, The Staff– Lorraine, Sally, Dorothy, Patricia , and Sangetta

Changing of the Guards

The Board would like to thank

***Joann V. Altiero, Ph.D.** for her service as a Board member for the last four (4) years. The Board and staff will miss her and wish her well.*

PUBLIC ORDERS ISSUED

Public orders can be found on the Board's website at, www.dhmh.maryland.gov/psych

Lyhus, Kristina E. Psych LN: 05084
Date of Order (3/14/2013)

Margaret Reed, Psych LN:
Date of Order (5/23/2013)

Mannis, Robert - Psych LN: 02233
Date of Order (3/09/2012)

Palmisano, Mark - Psych LN: 03154
Date of Order (11/01/2012)

Perrault, Shane - Psych LN: 04005
Date of Order (05/11/2012)
Date of Order (12/13/2012)

The MD Responds Program Wants YOU!

The MD Responds Program is the Medical Reserve Corps (MRC) for the State of Maryland. The MRC is a Nation-wide network of volunteer programs, who respond to local emergencies and ongoing public health efforts. MD Responds, previously known as the Maryland Professional Volunteer Corps, is administered by the Maryland Department of Health and Mental Hygiene (DHMH), Office of Preparedness and Response (OPR).

To become a MD Responds volunteer, visit https://mdresponds.dhmh.maryland.gov/, and click the "**Register Now**" button.

The Board

Nine members comprise the Board. Seven psychologists & two consumer members are appointed by the Governor to serve 4 years on the Board.

Members:

Steven A. Sobelman, Ph.D. — Chair

Jeffrey E. Barnett, Psy.D, ABPP — Vice Chair

Christopher L. Bishop, Psy.D

James F. Gormally, Ph.D.

Irene W. Leigh, Ph.D.

Neal Morris, Ed.D, Ed.D, MS, CBSM, ABPP

Myra A. Waters, Ph.D.

Harriet Rakes—Consumer Member

Lydia McCargo-Redd, Consumer Member

Staff

Lorraine Smith, M.A., MPH, Executive Director

Sally Mitchell, Administrative Assistant

Dorothy Kutcherman, Licensing Coordinator

P. Morris English, M.S., Investigator

Sangeeta Sarkar, Data Base Analyst

Linda Bethman, JD, Board Counsel

Brett Felter, JD, Staff Attorney

ADDRESS & NAME CHANGE

Please notify the Board of any changes to your contact information. On-line at www.dhmh.maryland.gov/psych or by contacting Sally at sally.mitchell@maryland.gov