Chair’s Remarks

What Have We Done and Where Are We Going?

Doug Johnson-Greene, Ph.D., ABPP

A Fond Farewell. This is the last Chair’s Remarks I have the privilege of writing as I am at the end of my eight-year term of service. The past two years have been witness to many positive changes on the Board, and I take enormous pride in what we have been able to accomplish. I have every reason to expect that the Board will continue to serve with grace and dignity and that professional psychology in Maryland will grow and thrive.

I leave the board with considerable personal gratification. The responsibilities of being a board member, and particularly Chair, are enormously time-consuming and one can be an easy target for criticism, but it is a unique educational experience and a pleasure to work with many truly impressive psychologists both on and off the board that I might otherwise never have met. I entered service on the Board with the hope of contributing to meaningful change in the State of Maryland and I looked forward to the opportunity and privilege to give back to my profession. Thanks to a great group of board members and staff, I consider both missions to have been accomplished. Hopefully, other talented members of our profession, and the public, will consider serving on the Board in the future. I leave you with a few of the Board’s accomplishments during the past two years:

We have enhanced licensure mobility for psychologists coming to our State by decreasing the time to obtain a license from an average of 6 months to approximately 6 weeks. This involved computerizing the state exam, which is now offered on a monthly basis, and streamlining the application and licensure process. These changes have made Maryland among the most efficient for obtaining licensure.

We have enhanced our information technology capabilities considerably. We now have a website (http://www.dhmh.state.md.us/psych/) where one can verify licensure status online, obtain forms and information, and we have launched an online renewal system that will be in full operation for the end of the year renewal period.

Continued on page 2
Chair’s Remarks  
Doug Johnson-Greene, Ph.D., ABPP

After nearly a decade, the Board of Psychology and the Board of Licensed Professional Counselors and Therapists came to an agreement with regard to the use of psychological tests. As of this writing, a bill in this regard was passed in both the House and the Senate.

We have developed and are in the process of finalizing orientation procedures for a network of supervisors and preceptors to meet the Board’s disciplinary needs. The group is diverse in both areas of expertise and geographic location.

We have streamlined many procedures such that licensee complaints are being handled more expeditiously and efficiently than ever before, resulting in a considerably smaller backlog.

We have a completed draft outlining changes in our existing continuing education regulations which we expect to implement in the near future.

We have held multiple working retreats and invited the public to take part in these discussions. During these retreats, topics of discussion have included revising the supervision requirements for licensure and creating a Health Service Provider (HSP) Designation.

Again, it has been a pleasure serving on the Maryland Board of Examiners of Psychologists.

With Fond Regards,
Doug Johnson-Greene, End

Disciplinary Actions

The Maryland Public Information Act was developed to ensure access to information about governmental affairs while protecting legitimate privacy interests. Information disclosed by government offices can include final orders and findings that result from formal disciplinary actions (excerpted from Ch. 13 of the Maryland Public Information Act, published by the Office of the Attorney General).

As listed below, the Board newsletter summarizes the types and disposition of cases, including the number of cases received by the Board since printing of the previous newsletter. Except for public orders, all Board disciplinary actions in the newsletter are worded to avoid specific identifying data. These data may include, but is not limited to, types of allegations, numbers of complaints and categories of violations, and informal disciplinary actions. Typically, each complaint alleges multiple violations, therefore the number of complaint types will surpass the total number of complaints received by the Board.

Summary July 1, 2007 to present
Total Number of Cases Received - 41
Public Orders/Formal Actions - None

Number & Types of Alleged Violations
9—Acts Inconsistent with Generally Accepted Practice Standards
9—Unethical Behavior
9—Unprofessional Conduct
5—Failure to Protect the Interests of a Minor or Vulnerable Adult
5—Failure to Uphold Civil and/or Legal Rights
5—Impaired Competence/Objectivity
4—Discrimination against age, gender and/or race
4—Failure to Administer Psychological Tests According to Practice Standards
4—Failure to Make Advance Financial Arrangements
4—Improper Assessment Techniques Compromising Objectivity
4—Practicing Outside Areas of Competence
3—Exploitation or Harm to Client
3—Failure to File Report in Timely Manner
3—Failure to Obtain Informed Consent
2—Dual Relationships
2—Failure to Assume Responsibility for Professional Decisions/Actions
2—Failure to Comply with CE Requirements
2—Failure to Register Psychology Associates
2—Fraudulent or Deceptive Use of a License
2—Misrepresentation of Qualifications
2—Practicing Psychology without a License
2—Release of Test Protocols to Unqualified Persons

Counselor Testing Bill—Final Passage

The HB 494, entitled Licensed Counselors and Therapists – Appraisal Activities, sponsored by Delegate Hubbard, has passed! After nearly ten years of struggle to come to agreement on the qualifications needed for Licensed Professional Counselors to use advanced assessment instruments, the Board of Psychology and the Board of Licensed Professional Counselors and Therapists have succeeded without compromising public safety and professional standards. As opposed to the last nine years of conflicting and at times contentious testimony, both boards and the involved professional associations were supportive. The bill was heard in the House Health and Government Operations Committee, chaired by Delegate Hammen, on February 20, 2008 and was passed by the House of Delegates with a vote of 138 to 0. It was heard by the Senate Health, Education, and Environmental Affairs Committee on March 26, 2008 and approval was announced April 1, 2008.

Continued on pg. 3
Dr. Morris Roseman: A Brief Interview with a “First”

Dr. Morris Roseman is licensed psychologist number 0002 in the state of Maryland. He is a pioneer, the first vice-chair of the first Maryland Board of Examiners of Psychologists; a husband, married to the former Myra Goldenberg, father of 3, one of whom became a psychologist, Dr. Lisa Schusterman; grandfather to six, and great grandfather to one. Morris Roseman, Ph.D. is a native Baltimorean. His parents ran a local grocery store and Morris graduated high school from the Baltimore Polytechnic Institute in 1936. Flirting briefly with engineering at Johns Hopkins, he dropped out, worked in his parents’ store, then returned to school majoring in English and Psychology at the University of Maryland, College Park, and graduating in 1942. He continued on for a master’s degree in education then served in the Army Air Corps until 1946. He and Myra settled in Durham, North Carolina and were invited to live with the noted parapsychologist on the Duke faculty, J.B. Rhine, while awaiting availability of the house they were purchasing. Dr. Roseman began looking into a large part of his time evaluating applicants for BG&E and Calvert Cliffs nuclear power plant workers. He later pursued investment-advising business and a master’s degree in education then served in the Army Air Corps until 1946. He and Myra settled in Durham, North Carolina and were invited to live in the University of Maryland Dental School in the Department of Community Dentistry. There were only about seven such departments in the country at the time. He also developed a private practice and dedicated himself to full time clinical practice in 1977 where he spent a considerable part of his time evaluating applicants for BG&E and Calvert Cliffs nuclear power plant workers. He later pursued investment-advising business and gradually reduced his clinical practice.

September 2007
Cynthia Ann Bouret, Ph.D.
Jamie D. Davis, Ph.D.
Sara Melissa McCracken, Psy.D.

October 2007
Leila A. Bakey-Becker, Psy.D.
John T. Beeter, Ph.D.
Aditya A. Bhagwat, Ph.D.
Lynda M. Bonieskie, Ph.D.
William L. Brim, Psy.D.
Yaphet U. Bryant, Ph.D.
Linda Dixon, Ph.D.
Brenda M. Elliott, Ph.D.
Trent H. Evans, Ph.D.
Mark C. Fleming, Ph.D.
Keshia LaShawn Gilmore, Ph.D.
Peter A. Girolami, Ph.D.
Nicole P. Glick, Psy. D.
Anthony H. Henley, Psy.D.
Virginia Samford Hornbeck, Ph.D.
Deborah Lynn Ice, Psy.D.
Samantha R. Kane, Ph.D.
William T. Leonard, III, Psy.D.
Yung Mei Leong, Ph.D.
Laura Christine Smith, Ph.D.
Catherine A. Timko, Ph.D.
Kimberly A. Wincezak Psy.D.
Parin R. Zaveri, Ph.D.

November 2007
Elise G. Abromson, Psy.D.
Jacquelyn E. Duval-Harvey, Ph.D.
Cynthia Elko, Psy.D.
Jaime Fenton, Ph.D.
Michael C. Freed, Ph.D.
Cynthia T. Gragnani, Ph.D.
Patricia M. Mattens, Ph.D.
Michael Morter, Psy.D.
Gabriel Newman, Ph.D.
Lisa J. Pate, Ph.D.

December 2007
Laura Jane Dunlap, Ph.D.
Sarika Garga, Ph.D.
Elise M. Gordon, Ph.D.
James E. Gordon, Ph.D.
Amanda Lynn Gmyrek, Ph.D.
Keith M. Hindleir, Ph.D.
Corine Hyman, Ph.D.

Alison Esposito Fritchard, Ph.D.
Imran A. Riaz, Psy.D.
Kathryn M. Rickard, Psy. D.
Tracy D. Vannorsdall, Ph.D.

January 2008
Andrew David Blair, Psy.D.
David Earl Crane, Psy.D.
Tamra Jones-Brooks, Psy.D.
Caitlin D. Joy, Psy.D.
Linda Fleming McGhee, Psy.D.
Amy N. Cunningham, Psy.D.
Gabriel Eldelman, Psy.D.
John A. Hunter, Jr., Ph.D.
Amy Saunders Provan, Psy.D.
Cheryl S. Rubenstein, Ph.D.
Tiffany G. Townsend, Ph.D.
Mary Neal Vieten, Ph.D.

February 2008
Eleni M. Boosalis, Psy.D.
Courtney B. Ferrell, Ph.D.
Margaret L. Mallory, Ph.D.
Amy Rabino-Leisewitz, Ph.D.
Jessica Gayle Samson, Psy.D.
Michelle M. Schmitt, Ph.D.

March 2008
Lisa L. Rue Arceneaux, Psy. D.
Nancy B. Hartsco, Psy.D.
Hira S. Girgiani, Ph.D.
Stephanie A. Saunders, Psy.D.

April 2008
Natalie E. Agent, Psy.D.
Perrette L. Arrington, Psy.D.
Suzannah Mary Allison, Ph.D.
Alfred J. Amado, Ph.D.
Samantha H. Rukert, Psy.D.
Ivette Sanchez-Carlobo, Ph.D.
Andrew P. Santanello, Psy.D.
Kristin Schoener Reese, Psy.D.
Elisbeth Neiman Bell, Ph.D.
Kenneth J. Scott, Ph.D.
James Bender, Psy.D.
David O. Black, Ph.D.
Tali Shokek, Psy.D.
Victor W. Weltzant, Psy.D.
Cerise McKenna Vablaiz, Ph.D.

Brian Howard Freedman, Ph.D.
Anne Wideman, Ph.D.
Amy Keefer, Ph.D.
Jennifer L. Robertson, Psy.D.
Cheryl Lynn Wu, Psy.D.
Elsie M. Gordon, Ph.D.

Continued from pg. 2  Final Passage–Testing Bill

A committee of the two boards, led by Board of Psychology Chair, Doug Johnson-Greene, Ph.D., ABPP and Board of Counselors Chair, Joanne Faber, MS, LCPC, met for over two years before finalizing an agreement that both boards felt offered adequate protection to the public for education and training requirements needed to employ tests beyond straightforward scales and inventories. The committee reviewed the licensing laws, the content of the various professional counselor licensure requirements and examinations for licensure, and the criteria for an approved professional counselor and psychologist graduate curriculum. The committee met with several representatives over the years from a marriage and family therapy program and other programs to understand their curricula.

The bill, defines appraisal and among other things, requires counselors who want to use more advanced instruments to have nine separate graduate courses, including, for example, tests and measurements, advanced statistics, intellectual and personality assessment, a practicum in advanced assessment, completion of a minimum of 500 supervised assessment experience hours which must include 100 hours of face-to-face supervision, and passage of a national examination that evaluates knowledge of the theory and practice of advanced assessment (the LPC examination has such questions).

The two boards agreed in 1998 that there were some counselors who had the requisite qualifications to perform some types of psychological testing, and a bill was passed that demanded that the two boards write regulations of the education and training necessary to prepare counselors to conduct advanced assessments. Over the years, progress was sporadic, with a variety of bills by one or the other board or one of the professional associations being heard in committee and either defeated, or simply not being voted on. The relationship between the boards was often strained, but, in the last two years, the focus has been toward points of agreement and writing a bill that was at least minimally satisfactory to all parties. It is a credit to both of the current boards, and their chairs, that they were persistent in this effort and worked collaboratively to develop the final bill.
Custody & Parenting-Competency

Evaluations: Some Things to be Aware of

Robert Brown, Ph.D., ABPP

Based on numerous complaints that have come before the Board of Examiners around custody evaluations and/or parenting fitness assessments, the Board sees several potential areas of concern to which psychologists should pay special attention. As anyone who has performed such assessment knows, the strong feelings, contentious relationships, and high likelihood of client disagreement with the findings and recommendations in these cases mean it is critical to carefully attend to ethical and legal standards in each phase of the evaluation. Many clients come to the assessment setting when they are angry, confused about the proceedings, and desperately hoping for an outcome consistent with their perspective on what would be a satisfactory resolution of disputes. The situation is ripe for misunderstandings and misinterpretations. The Board’s primary responsibility is to see that psychologists do what they can within the roles assigned, to protect the welfare of the adults and children involved. The points below refer to some common sources of complaints to the Board. These points by no means cover all issues clients may find unfair or confusing that can lead to them filing a complaint against the evaluating psychologist.

Financial Concerns

Many, if not most, clients in such assessments are stressed financially as well as emotionally. Psychologists should be crystal clear, preferably both verbally and in a written contract, as to the payment requirements for the psychologist’s services, the expected range of costs, and how, when, and by whom payment is expected. For example, does the estimate cost include court testimony? If not, what are the charges for testimony, and does that include travel and waiting time as well as time before the court? What are cancellation or missed appointment charges? To what, exactly, does the charge entitle the client, e.g., follow-up visits, test data, diagnostic information about themselves, spouse and/or children, reports to the judge? What is the psychologist’s policy if the client does not pay?

Informed Consent

Title 10 (30.16.05.05.C(1)), states under the section “Financial Arrangements and Fees” that the psychologist “makes advance financial arrangements that are clearly understood by the client”. Under a section on confidentiality and record keeping (10.36.05.08.C(2)), it is noted that the psychologist maintains “clinical records of informed consent, presenting problems, diagnosis, fee arrangements, dates and substance of each billed service, original test data with results and other evaluative material, and the results of any formal consultations with other professionals”. This not only means that clarity about fees and informed consent is important, but that the psychologist may be at risk if the responsibility for fees or payment methods is not clear. Only means that clarity about fees and informed consent is important, but the psychologist may be at risk if the responsibility for fees or payment methods is not clear. In the final analysis, the licensed psychologist is responsible, and the written record – not a recollection of a conversation – is what demonstrates that this responsibility was met.

Our Code of Ethics and Professional Conduct (10.36.05) addresses in numerous areas conflicts of interest, clarity as to who is the client, impairment of objectivity, varying consent forms that apply to which psychologists should pay special attention. As anyone who has performed such assessment knows, the strong feelings, contentious relationships, and high likelihood of client disagreement with the findings and recommendations in these cases mean it is critical to carefully attend to ethical and legal standards in each phase of the evaluation. Many clients come to the assessment setting when they are angry, confused about the proceedings, and desperately hoping for an outcome consistent with their perspective on what would be a satisfactory resolution of disputes. The situation is ripe for misunderstandings and misinterpretations. The Board’s primary responsibility is to see that psychologists do what they can within the roles assigned, to protect the welfare of the adults and children involved. The points below refer to some common sources of complaints to the Board. These points by no means cover all issues clients may find unfair or confusing that can lead to them filing a complaint against the evaluating psychologist.

Taking the Computerized State Law Exam: An Examinee’s Perspective

Andrew Blair, Psy.D.

Recently, the Maryland Board of Examiners of Psychologists made the decision to computerize the administration of the Maryland State Exam thereby improving efficiency for examinees and administrators and eliminating paper exams and manual scoring. The state exam is now offered on a monthly basis as opposed to twice annually as was the case prior to 2007.

As a newly licensed psychologist in Maryland, the following conveys my experience of the application and testing process from start to finish taking the computerized version of the state psychology examination. After successfully completing the application process, I was informed of the logistical details such as location and learned that the location for the exam is the monstrous state government building at 201 West Preston St. in Baltimore, MD. To eliminate a relatively minor, but critical stressor, future test-takers might appreciate locating the building and available parking prior to the morning of the test, as the one way streets can be confusing and parking may be limited. After parking a couple blocks away, I was greeted by friendly security personnel at the entrance of the building who directed me to the testing room.

It was clear that I was in the right place when I saw fellow test-takers standing in the hallway, brows furrowed, furiously leafing through their salmon-colored copies of the Maryland Statutes and Code. Shortly, we were invited into the exam room by the test proctors, who were polite and sensitive to the stress we were experiencing. Examinees were given a quick tutorial and ample time to ask questions to clarify instructions.

The room was set up much like a classroom, with about four rows of four desks each, all of which were assigned to applicants prior to our arrival. The computer interface used for testing was straightforward and fairly simple to use. I found the computerized administration format easy to navigate, even in my high state of anxiety.

Continued on pg. 5
Standards of Practice

An area of frequent general concern is whether the psychologist has met the standards of practice for these evaluations. Title 10 states (10.36.05.03.A(c) that psychologists “provide psychological services only in the context of clear professional and scientific relationships and roles accepted by the standard of practice of the discipline of psychology”. What are the standards of practice for custody evaluations and fitness for parenting evaluations? Some of these standards are explicitly laid out in Title 10 (e.g., record keeping), but many will refer to standards to which a reasonable psychologist should adhere as learned through training, supervision and experience. While not codified in Maryland statute or regulations, many of the principles in the APA Guidelines for Child Custody Evaluations in Divorce Proceedings (American Psychologist, 1994, 49(7), 677-680, now under revision), in the APA Ethical Principles of Psychologists and Code of Conduct (APA, 2002) and in the Guidelines for Psychological Evaluations in Child Protection Matters (APA, 1998) are useful as references to guide and contextualize standards of practice. While most of these documents refer to aspirations and not obligatory guidelines, they do set out what is often seen as best practice and have gained common acceptance in the field.

Other Common Pitfalls

If one parent has sole legal custody over a child, the limitations as to what can or cannot be shared with the other parent should be clear and agreed upon up front. Also, back channel communications with one party may lead the other party to believe that the psychologist is biased by misinformation or a personal relationship. In the contentious atmosphere of these evaluations, the client may feel that the examiner is biased against him or her and is being unfair, so avoiding as much as possible any appearance of conflict of interest, or any behavior that could be construed as favoring one party over another on grounds irrelevant to the evaluation, is critical.

There are many pitfalls inherent in these types of evaluations that fall under the general rubric of “conflict of interest”. Simply put, this refers not to multiple roles that one may play with a patient or family, but to the situation where the demands of these multiple roles may conflict. For example, if one attempts to conduct a forensic examination on a patient or family who were formerly patients, the objectivity demanded of a forensic examiner would almost certainly be impaired. And family members not seen formerly as patients, while another family member has been seen, often would see the examiner as biased against them. Likewise, if the psychologist is hired by one party to perform an evaluation, the other party could question his/her objectivity. In child custody evaluations, it is always safer to be appointed by the court as the examiner; this may be helpful in ensuring objectivity and clarifying to whom the psychologist is primarily responsible.

The concerns over bias are particularly relevant when the psychologist has not seen one of the parties, but makes comments about that party either in a report or in court. As a rule of thumb, one should comment only on the parties that have been evaluated. For example, commenting on a father’s behavior toward the children based on a mother’s report is fraught with potential for bias and inaccuracies.

Finally, it is important to have written consent forms defining the details of the responsibilities of all parties. Due to the legal complexities, and the many people involved in these evaluations, rarely if ever would a standard psychotherapy or assessment consent form be sufficient to fully inform the client(s) of all relevant ramifications of the findings. It is also important to clarify each party’s legal rights and responsibilities prior to any evaluation, e.g., so that the psychologist ensures that the person providing consent for a minor is legally entitled to do so.

The consumer comes to custody and parenting fitness evaluations with intense emotions, including fear and sometimes the ferocity of a bear fighting to protect its cub. It is therefore incumbent on the practitioner to follow the highest professional and ethical standards to ensure the well-being and safety of all children involved and to protect, insofar as possible, the rights of the adults to parent their children. Intimate knowledge of the Maryland statutes and regulations pertaining to psychologists, particularly the Code of Ethics and Professional Conduct, the APA guidelines for custody evaluations, and the APA code of ethics are good starting points.

Thanks to Drs. Jeffrey Barnett and Marla Sanzone for their comments.

Continued from pg. 4

Custody & Parenting-Competency Evaluations

Announcing Online License Renewal

During this past renewal period, the Maryland Board of Examiners of Psychologists launched an online renewal system. The system was piloted with 46 licensees renewing their license online. The feedback we received was both positive and helpful.

Thank you licensees for your help!

All licensees whose license will expire on March 31, 2009 (odd license numbers) will be able to renew their license online during the winter of 2008. The system will accept credit card payments and for those that prefer to pay by check, you can complete the renewal application online and mail your check to the Board. Later this year, instructions on how to renew your license online will be mailed to those that are scheduled to renew. The instructions will also be posted on the Board’s website, www.dhmh.state.md.us/psych.

The Board is very excited about the implementation of an online renewal system, and hopes that you will find the system convenient, user friendly and efficient.
Carl Wernicke, born 1848 in Tarnowitz Germany, believed mental illness resulted from changes in brain physiology. Among the first to assert that specific regions of the cerebral cortex were responsible for particular functions and behavior, Wernicke’s views were highly controversial at the time. Prevailing 19th century science believed brain matter to be largely non-specific. A precursor to modern neuroscience, Wernicke’s research and clinical contributions were influential in our understanding of fundamental brain processes such as localization of function, hemispheric dominance and origins of specific aphasias.

Wernicke earned his medical degree at the University of Breslau in 1870 and his psychiatry specialization in 1875 after which he moved to Berlin. In 1874, at the age 26, he published *The Aphasic Symptom Complex* in which he asserted that different types of aphasia occurred as a function of damage to different parts of the brain.

In 1873 Wernicke’s study of a stroke patient with a parietal/temporal left hemisphere lesion precipitated recognition that language comprehension was localized in the left posterior, superior temporal gyrus. It was previously believed that a related language area, Broca’s area, identified earlier by Paul Broca, was responsible for language production and comprehension. Following his extensive research, Wernicke’s accurate identification of this left parietal temporal region controlling our ability to understand written and spoken language was aptly named, “Wernicke’s Area”. Today neuroscientists believe that Wernicke's area may be involved in the semantic processing of language nuances, thus is sometimes referred to as the Receptive Language Area.

Many of Wernicke’s predictions about symptoms and morphology based on his observations of brain anatomy and pathology were confirmed by subsequent research. For example, he is thought to be the first to hypothesize that a syndrome he called acute hemorrhagic suprerior polioencephalitis was caused by a thiamin deficiency. Characterized by paralysis of muscles in the eyes and particular mental and motor abnormalities, his theory was later proven to be true and the condition is now referred to Wernicke's encephalopathy.

A prolific researcher, writer and respected clinician, the 3 volumes of his *Textbook of Brain Disorders* were published between 1881 and 1883. He used case studies to identify specific brain regions in which neurological diseases were thought to originate. Wernicke published another three volume work, *Atlas des Gehirns* on neuroanatomy and pathology between 1897 and 1903, and near the end of his life, in 1903, he wrote his last work on aphasia. It was translated into English in 1908. He died in Germany from injuries following a bicycle accident in 1905.
Continued from pg. 3

Roseman: Interview

Dr. Morris Roseman is a past-president of MPA, was a representative to APA Council from Maryland, and was vice-chair and later chair of the first Maryland Board of Examiners of Psychologists. He is, among many other things, a walking encyclopedia of the challenges in Maryland to establishing a standard of practice to protect the public, the independent practice movement in Maryland beginning in the 1950’s and a strong working environment for practitioners. That the working environment is positive in Maryland for psychologists is in no small part due to his advocacy on behalf of the profession and the citizenry.  End

A Discussion with Morris Roseman, Ph.D. on the Beginnings of the Maryland State Board of Examiners of Psychologists

Robert A. Brown, Ph.D., ABPP, Vice-Chair, Maryland Board of Examiners of Psychologists
Sue Taylor Brown, M.A, Former Executive Officer of the Maryland Psychological Association
March 8, 2008

Several days after Morris Roseman’s 89th birthday, Bob and Sue Brown met with him to discuss the birth of the Board of Examiners of Psychologists in Maryland. It was a fascinating romp through a vitally important history of professional psychology in Maryland, aided enormously by Dr. Roseman’s remarkable memory of the people and events involved and his precise and articulate manner of presenting it.

In the late 1950’s, there were two organizations licensing physicians in Maryland, the Medical and Chirurgical Society that we know today as MedChi, and an agency on the Eastern Shore that was selling licenses; the latter was put out of business by the legislature. The president of MPA, Ed Slockbower, was told by a physical therapist about the scandal and the legislature’s intention to revise the physicians’ licensure law. Partially due to this scandal, and probably due to a few other states having developed some form of licensure or certification for psychologists, MPA was alerted to the possibility of developing certification to identify psychologists. The MPA appointed a committee, headed by the then chair of the Psychology Department at Morgan State, and they sallied forth with naïveté and enthusiasm to Annapolis to ask for a bill that would tag onto the new medical licensing bill. They were told that this is not the way legislative business is done, and that the psychologists would have to develop their own bill that was not under the auspices of Med Chi and would have to have a lobbyist to help shepherd it through the legislature.

The DiDomenico was a state Senator, and he agreed to introduce the bill for $1,000; Morris could not remember what the money was for, but it most probably was for legal services to draft the bill. So the committee got information from APA and a few other states such as Pennsylvania that had already passed laws, and created a bill. In addition to the person from Morgan State and Morris, Morris remembers that Stan Imber (Hopkins) and Sol Shapiro (Baltimore VA) were on the original committee. They wrote a certification bill, specifying that only people who qualified under the bill could call themselves psychologists or use the terms psychological and psychology; they did not feel at the time that there was any way they could define the practice of psychology.

There was not the emphasis then that there is now on the doctorate as the journeyperson’s degree, so the committee made a quite generous allowance for certifying anyone with a history of providing “psychological services.” Evidently many people, including physical therapists, had been offering such services and would have been eligible to be certified. The psychiatrists objected. Jerome Frank, a prominent psychiatrist and author of Bush on the Couch, at Hopkins who also had a degree in psychology, said the bill would be dead in the water if the certification doors were opened wide, so the committee settled on the necessity of a doctorate or a master’s degree in psychology plus eight years of experience; i.e., they would only certify people who were legitimately psychologists. The taint of the medical scandal was such that the legislature was receptive to the bill. The Chief Psychologist at Springfield State Hospital had an attorney friend, Bill McDonald, who was in a law firm with Anthony DiDomenico. DiDomenico was a state Senator, and he agreed to introduce the bill for $1,000; Morris could not remember what the money was for, but it most probably was for legal services to draft the bill. So the committee got information from APA and a few other states such as Pennsylvania that had already passed laws, and created a bill. In addition to the person from Morgan State and Morris, Morris remembers that Stan Imber (Hopkins) and Sol Shapiro (Baltimore VA) were on the original committee. They wrote a certification bill, specifying that only people who qualified under the bill could call themselves psychologists or use the terms psychological and psychology; they did not feel at the time that there was any way they could define the practice of psychology.

The bill was heard in Annapolis on a Monday during the 1957 legislative session. On Saturday and Sunday before the hearing, the committee held a conference call (a technically difficult task in those years) to write three or four pages of testimony. They needed something like 50 copies, which had to be mimeographed (most of you do not remember mimeographs – long sheets of wax coated stencils that were typed, exceedingly difficult to correct, and attached to a machine that cranked out not great-looking purplish copies). That particular weekend before the hearing in 1957, Baltimore had one of the worst snowstorms in its history. Morris walked over to Stan Imber’s house Sunday night (literally a miles uphill in knee-high snow) so they could catch the 4:30 a.m. bus downtown Monday morning, to then catch a 6:00 a.m. bus to Annapolis. They sat in the back of the bus – not because psychologists were shunned, but because they had to sit on the wide seat to correct the many, many typographical errors on each copy of the testimony.

When Morris testified, he says that he was so naïve to the legislative process, that when the committee chair tried to get him to stop reading the testimony, Morris said he had to finish reading and the senator allowed it. After the certification bill passed, MPA had an election to select Board members; the top five vote getters were appointed by Governor Millard Tawes. The original Board consisted of Jerry Carter (PHS), Roseman, Stan Imber, Art Cantor, and Bob Waldrop (Univ. Maryland College Park).

Continued on pg. 8
Carter got the most votes and thus became chair; Roseman got the second greatest number and so became vice-chair. Carter left the State after one year and Morris became chair. Not so incidentally, Morris' license number is 0002. Since the legislature was not meeting at the time they were appointed, they were not to be confirmed until the legislature met again. However, the Senate took no action to confirm them as Board members. The next year they were reappointed by Governor William McKeldin, but they were still not confirmed. For the entire first two years of the board's existence, when they were writing what we now know as regulations and were selecting and rejecting applicants, they were not formally confirmed by the Senate. Only during the third year was there an official confirmation.

Roseman said that for the first several years "we tried to act as if we knew what we were doing". They were overwhelmed with work, not only developing criteria for eligibility for licensure, but also notifying people that they would need to be certified, creating application forms, reviewing applications, debating whether to certify the many marginal people who applied, and figuring out how to communicate with licensees. Remember, this was pre-technology other than dial phones without answering machines. They also needed to develop the licensure examination. They went to the University of Maryland and Johns Hopkins University and asked them what questions they were asking their students. They requested both the examinations and the answers. They were faced with the formidable task of protecting the public by certifying only people who were well-trained. They focused on developing rules and procedures that would attempt to ensure that only people with legitimate education and training were accepted.

With the mountain of work before them, the Board soon recognized that they would need a secretary. Dr. Roseman recruited Dr. Elizabeth Mays Stein (Maryland psychologist, Dr. Melinda Stein's mother and the wife of Dr. Jack Stein, also a psychologist). Her first meeting with them was in Dr. Jerry Carter's office in Silver Spring. They left Baltimore at 9:00 a.m. for the meeting, met until lunch, met again until after dinner, left Silver Spring at 9:00 p.m. and got back to Baltimore at 11:00 p.m. Dr. Elizabeth Stein called Morris the next morning and resigned! The job was clearly much more time consuming than Morris' persuasive sales pitch to her had suggested it would be.

Dr. Art Cantor then served as secretary on a temporary basis, and soon they hired a psychologist in Washington D.C. That meant that all of the Maryland Board's records were in D.C. There was a hearing of some sort in Annapolis regarding the Board. The members became anxious about the legislators hearing that all the records were in D.C. so they took back the records and Dr. Cantor again took the job. It is not clear whether the legendary Dr. Julian Abrams, Chief psychologist at Springfield State Hospital, became secretary then. If not, he soon became the secretary and served for many years.

Toward the end of the first year, the Board decided that they needed to pay themselves some type of honorarium. It was not much, but they were more concerned about the precedent than the amount. They were meeting long. Starting early and staying late and often on Sundays.

When one looks at our current law and regulations, the task that the first Board set for itself is overwhelming to contemplate. They had to develop complex criteria, settle on the content of applications, the processes and procedures for processing them, determine how to examine applicants on general psychological knowledge, and to evaluate their training. They were tasked with overcoming logistical difficulties of informing practitioners as to the need to be certified, and to communicate with them about the application process. They had to reject many applicants not well-trained. They focused on developing rules and procedures that would attempt to ensure that only people with legitimate education and training were accepted.
Maryland Board of Examiners of Psychologists

is dedicated to protecting the citizens of Maryland and promoting quality health care in the field of psychology

Vol. 2, Issue 3 Page 9

Barriers to Accessing Mental Health Services in Asian Americans

Chinese Americans are the fastest growing population in the U.S., with more than 55,000 Asian immigrants resettling in Maryland according to 2000 Census data. The underutilization of mental health services by Asian Americans has been well documented in the medical literature. However, the lack of demand for mental health services in the Asian American population does not in any way reflect low service needs. On the contrary, Asian Americans are likely to be foreign born facing ethno-cultural barriers to health care and other services. Moreover, some are refugees who have suffered harrowing experiences in their countries of origin and may be afflicted by Post Traumatic Stress Syndrome.

Mental health illness in persons with linguistic and culturally diverse backgrounds poses unique challenges to health care providers. Particularly challenging is diagnosis and identification, where providers must appreciate the “norm” in the context of the socio-cultural dimension of the patient’s community of origin. Moreover, logistic issues such as high cost of interventions may impede access to services. Other issues which may limit access to mental health services include perceptions related to the relevance and credibility of treatment; denial of need for services; and fear of stigma and “loss of face.”

A recent unique study of the perceived barriers to mental health services among Chinese Americans in Southern California illuminates key factors for mental health workers (Kung, WW, 2004. Journal of Community Psychology, Vol 32, No 1, 27-43). The study is based on a three-stage probability sampling of Chinese American Households in Los Angeles County. More than 1,700 interviews (reflecting a 82% response rate) were conducted by bilingual and bicultural interviewers. The study’s results showed that among seven barrier items looked at, those of practical nature, such as cost, language, time and knowledge of access were rated higher as impediments to mental health treatment than those forming cultural barriers. The cost of treatment stood as the single highest barrier to seeking mental health care among the Chinese American population looked at when even controlling for Socio Economic Status.

While practical barriers seem to rate higher than others, cultural factors related to mental health services among Asian Americans are significant as well and must be attended to. For example, the literature suggests that at times, emotional problems may be viewed as reflecting a personality weakness with the expectation that with a strong enough will power the individuals must be able to “combat” problems without professional help. Somatization of emotional problems may in turn lead people to turn to physicians, herbalists, shamans, and fortune tellers for help. Other important issues may deal with credibility of mental health workers, while the latter may tend to be of the “dominant” culture and viewed as less supportive. Withdrawal and resignation have also been identified as means of coping with mental illness among Asian Americans. These characteristics of course are maladaptive and can exacerbate symptoms. Lastly, the intense stigma associated with seeking mental health care may be rather intimidating for the person and the family and delay or preclude the attainment of services.

While we caution that these examples identified in the literature should not be extrapolated to the entire Asian American and Pacific Islander population which is very diverse, they illuminate some of the barriers to mental health services that the Asian population faces. Outreach education that is linguistically and culturally appropriate is essential as well as the on-going training of mental health providers in culturally responsive care. Lastly, foreign-born and foreign-trained mental health providers from Asian countries are available resources in providing services to Asian Americans.

Ihana S. Mittman, PhD, MS

DHMH – Office of Minority Health and Health Disparities

Concluding Comments from a Consumer Member By Adele Hammerman, MLA

Eight years ago, when I received my appointment to serve on the Board of Examiners of Psychologists, many anxious thoughts ran through my mind. What is my role? Who am I protecting? What can I, a high school teacher, have to contribute to the profession this Board regulates? As time and meetings passed, I realized that as a public member, I was indeed as valuable a board member as those who practice the profession. What I brought to the table was my accumulated experience, knowledge and desire to improve Board functions from a non-psychologist’s perspective. I recognized that there is a special place for citizens on health boards which helps to keep the focus on the goal to protect the public health and welfare. Consumer members speak for the public and remind practitioners how we may interpret, perceive or feel about a given situation which may be less obvious to them. It is somewhat expected that practitioners may want to protect their profession, even while acknowledging an inappropriate practice. There are times I find myself “on the teacher’s side” when I am aware of parent’s complaining about teachers. However, as a citizen member of the Board, one unique point of view I bring to issues is that I have no personal identification as a health care provider that we regulate. In addition to my point of reference as a teacher, I am the parent, daughter, sister, neighbor, or protector of sorts to whomever may have been treated inappropriately. That role requires a discipline of fair mindedness, empathy and compassion both for the complainant and the licensee. We need to appreciate the background of what has happened, examine the laws and arrive at an intelligent and fair decision. I have been fortunate to have worked on a Board that makes every effort to safeguard the health, safety and welfare of the citizens of Maryland. I have learned, grown and come away from this experience with memorable positive feelings due to working with colleagues who strive to act with intelligence, knowledge and fairness.  

-end-
**Composition of Board and Staff**

The Board consists of 9 members, 7 psychologists and 2 consumer members. The Governor appoints Board members to serve a four year term. Members may be reappointed at the end of a four year term to serve an additional four years. Appointed Board members cannot serve more than two consecutive terms, or eight years.

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