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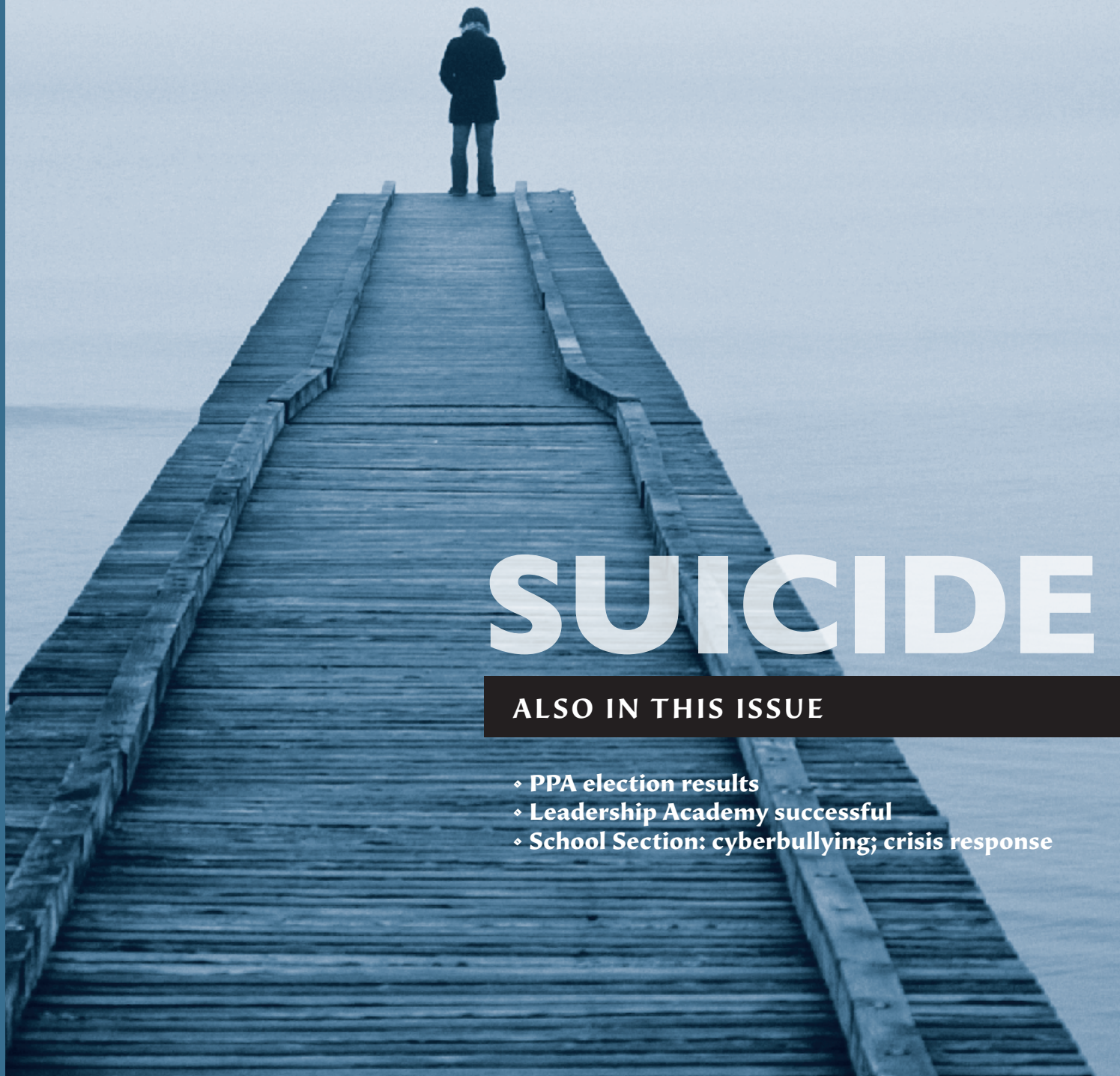
The Pennsylvania Psychologist

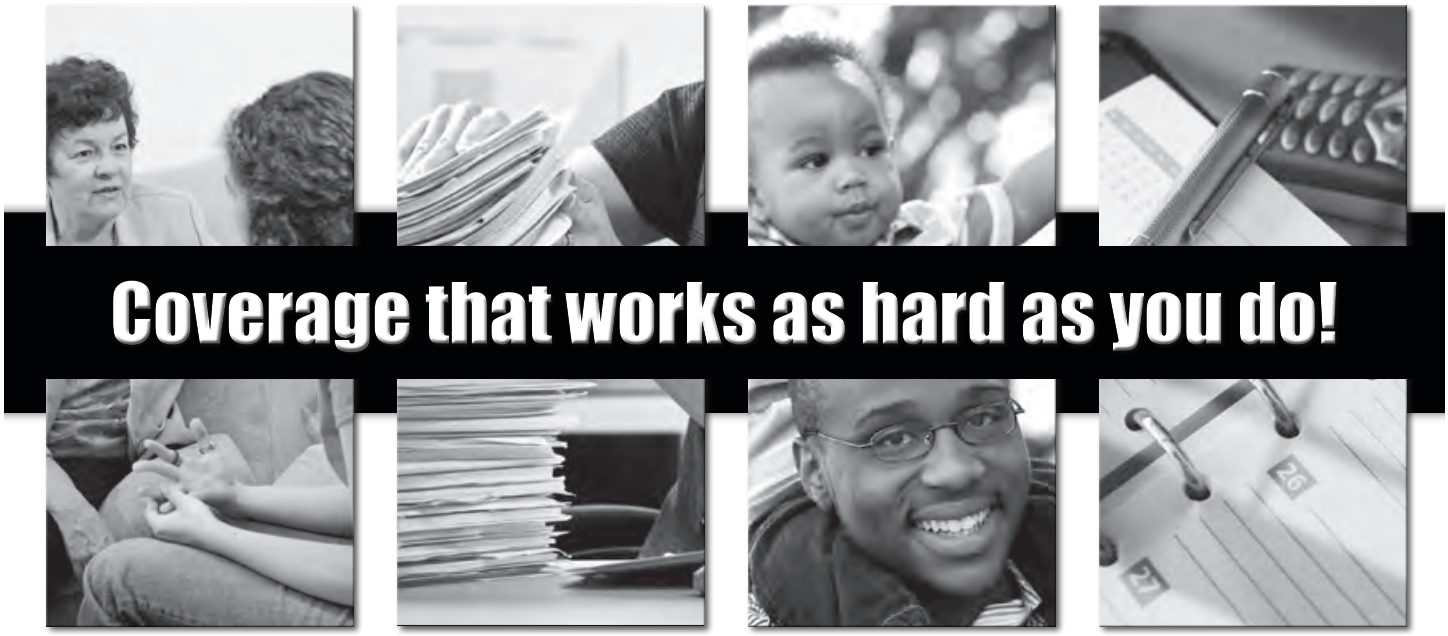
June 2011
QUARTERLY



SUICIDE

ALSO IN THIS ISSUE

- PPA election results
- Leadership Academy successful
- School Section: cyberbullying; crisis response



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Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102
(717) 232-3817
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Editor: Andrea L. Nelken, PsyD

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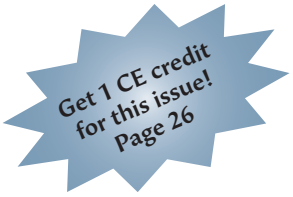

REGULAR FEATURES

SPECIAL SECTION – Suicide

STUDENT SECTION

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Suicide

Mark A. Hogue, PsyD


Dr. Mark A. Hogue

Welcome to the June edition of the *Pennsylvania Psychologist*. This issue focuses on a rather somber aspect of psychological care: suicide. As the saying goes in this business, "not if, but when." It is believed that eventually in everyone's practice, someone will attempt or successfully complete suicide. The Centers for Disease Control tells us suicide is the 11th leading cause of death for all ages: The average is 94 suicides per day, or one every 15 minutes. For ages 10–24, suicide is the third leading cause of death, and for every commission, there are 100–200 attempts; all of this takes an enormous toll on the client, family, community resources, and also on the treating psychologist.

This topic fits well into my last presidential article and the fourth topic discussed in my presidential address last June. As mentioned in earlier articles, I have focused on each area comprising the theme of this year's convention on Celebrating Human Performance: Mind, Body, Spirit, and Community. In September's *Pennsylvania Psychologist*, I discussed community. In December, I wrote about spirit and human will. In March, I wrote about the body and how it interacts with human will, and I supported prescriptive authority for psychologists. This edition helps outline thoughts I have about the mind and human will.

In truth, suicide encompasses all four aspects. Treating the suicidal client challenges us to be at our professional best. In a sense, it's the psychologist's "Olympics." While athletes may see their struggles as "sudden death" and "life or death," in the truest sense, our performance with these individuals is absolutely life or death.

I believe depression effectively alters the balance of thought and perception, and oppresses our spirit and will to live. Its footsteps are ponderous: hopelessness, beliefs of helplessness, and of the inability to persist in life, and suicidal clients feel crushed by it. Despair is the ultimate degradation of human will, and a negative willfulness (oppression) occurs. Some clients become more persistent in their willful desire to die than to live.

We as psychologists are charged with guiding and guarding the human will, I believe, and the proper engagement of human will allows people to improve their lives and enhance their well-being. Additionally, I also believe William James' assertion in 1896 that

> *Treating the suicidal client challenges us to be at our professional best.*

depression and other psychopathologies rob people of their freedom to choose. He described them as less self-directed and more "driven by their passions." Psychopathologies strip people of the ability to engage in rational thought processes and positive choices in life. I believe that this is the truest robbery of all that is human: that of our mind.

I don't intend to start a fight here, but I believe we are created to be this way. Our cortex separates us from other animals. The distinguishing feature is that of language. While we know other animals communicate, I believe we have been given the gift of words. It is within this realm that we "live" and engage our clients. Not to disenfranchise the "emotionalists" (see Zajonc's work, 1980, and others), our emotional selves are certainly mixed into this stew. It is what William James referred to as "our passions."

However, I'm kind of a "Lazarus guy." Richard Lazarus (1981, 1999) believed cognition was primary, and many cognitive theories grew out of his research. Consequently, we engage our clients in thought and perception. All of this happens within "mind." As I mentioned in the last edition, the body and biological substrait cannot be excluded from influence of our day-to-day functioning. Given these complexities, I believe psychologists are the best-trained professionals on this planet to holistically engage our clients within their spheres of existence. It is within these realms that we engage and hopefully re-engage their self-agency and help them make meaning and positive choices in the re-direction of their will. To quote our past president, Dr. Steven Cohen, in the town hall meeting last June: "We do holy work." Don't ever forget that.

Since this is my final article as your president, I want to take some time to acknowledge some people and their efforts throughout this past year. Our PPA staff are a tremendous asset to this great organization, and I have repeatedly acknowledged this when I interact with other state leaders. The APA also looks to our organization to take on a leadership role among the state and provincial organizations. The fact that we have more than 300 member volunteers, (about 10% of our membership), involved in the workings of this organization speaks volumes about the breadth and depth of leadership among Pennsylvania psychologists. However, the fact that our 3,000 members represent only half of all licensed psychologists in Pennsylvania disturbs me. ALL licensed psychologists derive benefit from PPA, and many non-members have no clue about what our organization does to safeguard and promote the science and practice of psychology, and to ensure our very future as a profession.

I became involved through the personal invitation and mentoring of one of my partners, past president Dr. Donald McAleer, who encouraged me to come

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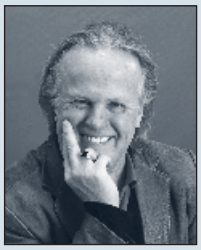
Dr. Palmiter Wins Presidential Election

Good Year for Guys Named Dave



Dr. David J. Palmiter

Dr. David J. Palmiter Jr., of Clarks Summit, won the election for the presidency of PPA. He will serve as president-elect starting this month and will be president during the 2012-13 program year. For the past four years he has served as the Communications Board chair and APA's public education coordinator for Pennsylvania. He is the past chair of the Task Force on Cybertechnology and a past member of the Executive Committee, Electronic Media Coordination Committee, Public Education Committee, and 75th Anniversary Task Force. He is a past recipient of PPA's Psychology in the Media Award, the author of more than 30 professional articles, and the author of the recently published *Working Parents, Thriving Families*. He is a professor and director of the Psychological Services Center at Marywood University in Scranton, and maintains a private practice. He earned his PhD degree from George Washington University in 1989.

Dr. Palmiter stated, "We all know that PPA is one of the most effective organizations within psychology. I will endeavor to actualize, in increasingly measurable ways, PPA's mission statement and strategic plan, emphasizing those components that educate the public, legislators, and insurance companies about what we do. The more the truth of us is known the more our problems dissipate and our missions are realized."

Dr. David L. Zehrung

Elected treasurer was **Dr. David L. Zehrung**. He is from Greencastle, Franklin County, where he maintains a private practice, and also works at the Lebanon VA Medical Center. He received his PhD in clinical psychology from George Mason University in 1997. For the past year he chaired the Committee on Technology Implementation, and he is the past chair of the Bulletin Committee and the Electronic Media Coordination Committee. He was also a member of the task forces on the bylaws, cybertechnology, and non-dues revenue.

Dr. David A. Rogers

Dr. David A. Rogers, of Hershey, was elected chair of the Internal Affairs Board. He has been involved in PPA governance for many years, is currently serving as chair of the Continuing Education Committee, and as a member of the Convention Committee, the Early Career Psychologist Committee, and the Insurance and Managed Care Committee. He received his PhD in 1985, has been in private practice since 1988, and is clinical director of Hershey Psychological Services. He is a consultant and trainer for the Pennsylvania State Police Member Assistance Program. He taught psychology at Penn State Harrisburg and the Philadelphia College of Osteopathic Medicine.

Dr. Dea Silbertrust

The Communications Board chair will be **Dr. Dea Silbertrust**. She earned both PhD and JD degrees from the law-psychology program at Hahnemann (now Drexel) and Villanova Universities. She maintains a private practice, Bala Psychological Resources, in Bala Cynwyd. She currently serves on numerous PPA committees including those on Public Education, CE, and Ethics, and is secretary/treasurer of PennPsyPAC. She is a past president of the Philadelphia Society of Clinical Psychologists.

Dr. Marie C. McGrath

Dr. Marie C. McGrath will chair the School Psychology Board. She has been a member of the Public Policy Committee within this board as well as the Trainers of School Psychologists and APA Division 16. She is an associate professor of psychology at Immaculata University and a contracted school psychologist for the Chester County Intermediate Unit. She also maintains a private practice in Kennett Square. She is a certified school psychologist and licensed in Pennsylvania. She was awarded PhD and MEd degrees in school psychology from Temple University.

All of the positions except president-elect are for the two-year period of June 2011 to June 2013. PPA congratulates the winners and appreciates the participation of all members who ran for office. The fact that we have contested elections of highly qualified candidates speaks to the health of PPA as an organization.

PPA Staff Supports Association's Goals

Thomas H. DeWall, CAE


Thomas H. DeWall

"The manner in which an association's staff and volunteers are organized has a major impact on the way the association serves its customers (members)" (VanBremen, 1990). PPA's seven staff members work on behalf of our 3,000 members, and with our 300 active volunteers, in carrying out our strategic plan. PPA members might like to have a better idea of what each of these staff members does.

Dr. Sam Knapp is our director of professional affairs. In this role he spends a great deal of time consulting directly with members on a wide range of ethics and other practice issues. He provides staff support to the Ethics Committee, drafting ethics dilemmas that are posted as blogs on our website. He originated and continues to manage the annual Ethics Educators Conference and the Doctoral Summit. He provides support to the committees on Colleague Assistance, Insurance, Legislative and Governmental Affairs, and Psychopharmacology, among six others. Sam analyzes bills and drafts letters to legislators on a range of issues as well as testimony for legislative hearings. He has provided background information for our Licensure Task Force, which is considering numerous changes to the Professional Psychologists Practice Act. He is a prolific writer, which all readers of the *Pennsylvania Psychologist* know, but that also extends to peer-reviewed journals. Much of the content on our website is also authored by him. He is in demand as a speaker and leads many continuing education presentations every year.

Working closely with Sam, **Rachael Baturin** is our professional affairs associate. She is our main expert on health insurance issues and answers hundreds of related questions from members each year. As an attorney with an MPH degree, she is also an expert on the laws and regulations pertaining to psychology in Pennsylvania. She lends her expertise to the Insurance and Managed Care Committee's initiatives. She staffs the Child Custody Committee and has branched out to be the point-person for joint committees with the Pennsylvania Bar Association, the Association of Trial Judges, and other groups working to promote parenting coordination. She is our liaison to the State Board of Psychology and attends all of their meetings, lending her expertise to them on behalf of PPA. She writes articles for this journal and presents CE workshops on these issues. Rachael is our grassroots lobbying coordinator for both state and federal issues, sending out legislative alerts on pending bills. She organizes our annual advocacy day as well as our visits to Capitol Hill in Washington during the annual State Leadership Conference. She also staffs our Early Career Psychologist Committee and the Pennsylvania Psychological Association of Graduate Students, in addition to four other committees.

Marti Evans, our conference and communications manager, does a great deal of work with the Program and Education Board, which comprises the Convention and Continuing Education Committees. She is often recognized at our meetings as the person behind the scenes who makes everything happen. She negotiates with hotels for meeting space, corresponds with speakers, sets up audiovisual and other meeting logistics, writes the brochures describing the programs, and makes sure everything is in place for granting CE credit. She recruits exhibitors, sponsors, and advertisers for the convention. She staffs the Awards Committee, publishes announcements, organizes the ceremonies, secures the plaques and certificates, and writes the brochure. She also staffs the Committee on Multiculturalism and the Leadership Development Committee, which this year presented another successful Leadership Academy in April for our potential future leaders. Marti also does a lot of work with the Communications Board. She is one of our APA-recognized public education coordinators (along with Dr. David Palmiter). Working with the relevant committees she sends out press releases, helps set up the workshops for the public at the convention, assists with the e-newsletter, and solicits ads for the *Pennsylvania Psychologist*, among many other tasks.

PPA's seven staff members work on behalf of our 3,000 members, and with our 300 active volunteers, in carrying out our strategic plan.

Our business and membership manager is **Iva Brimmer**. She manages all of our computer and database operations. She manipulates the database for mailings and e-mails to all members or any subset of them, or to all non-member psychologists and other mental health professionals for recruitment and to promote the convention, other CE events, or other activities. She has done yeoman's work in building our new, user-friendly website, www.PaPsy.org, just launched in January, and she staffs the Committee on Technology Implementation. She manages the clerical workflow in the office, increasing our efficiency. Working with the Membership Committee, she oversees our member dues billings and all other membership recruitment and retention activities. Iva is also in charge of our everyday finances, including monthly reports, processing income and expenses, and preparing for the annual audit, on behalf of the Budget and Finance

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Confidentiality and Suicide

Rachael L. Baturin, MPH, JD, Professional Affairs Associate
Samuel Knapp, EdD, Director of Professional Affairs


Rachael L. Baturin


Dr. Samuel Knapp

So, you are reading the newspaper or watching the news, and you find out that one of your patients has committed suicide. The next morning you go to your office and there is a message from the patient's family or the executor of the estate, asking to speak with you. What do you do? Can you call the family or executor and tell them that you have seen the patient? Can you give them information about therapy and help shed light on why the patient may have done this? Can you provide a copy of the patient's medical record?

According to a legal opinion of the State Board of Psychology, you may not break confidentiality after a patient dies. Confidentiality continues after the grave. Therefore, you can release information only if you have a signed release from the patient before death or a court order from the judge. In Pennsylvania, a subpoena from a coroner serves as a court order.

The psychologist-client privilege is derived from the Judicial Code and is limited in scope to the question of whether evidence is admissible in a civil or criminal proceeding. 42 Pa. C.S. §5944 states, in pertinent part, that:

> No... person who has been licensed... to practice psychology shall be, without the written consent of his client, examined in any civil or criminal matter as to any information acquired in the course of his professional services in behalf of such client. The confidential relations and communications between a psychologist... and his client shall be on the same basis as those provided or prescribed by law between an attorney and client.

A psychologist's ethical responsibility to safeguard the confidentiality of information obtained during the course of a professional psychological relationship extends beyond the testimonial privilege found in 42 Pa. C.S. §5944. Ethical Principle 5 of the Code of Ethics (49 Pa. Code. §41.61) for psychologists in Pennsylvania states, in pertinent part:

Principle 5. Confidentiality

(a) Psychologists shall safeguard the confidentiality of information about an individual that has been obtained in the course of teaching, practice or investigation. Psychologists may not, without the written consent of their clients or the client's representative, or the client's guardian by order as a result of incompetency proceedings, be examined in a civil or criminal action as to information acquired in the course of their professional service on behalf of the client. Information may be revealed with the consent of the clients affected only after full disclosure to them and after their authorization.

The Commonwealth Court of Pennsylvania has held that this duty is absolute and can be waived only after there has been full disclosure and written authorization by the client. (See *Rost v. State Board of Psychology,* 659 A. 2d, 626).

Thus, because a psychologist must obtain the written authorization of a client prior to the release of confidential information to a third party, it follows that, without written consent, a psychologist may not release to the deceased client's family any information obtained during the course of a professional psychological relationship.

The rationale for this can be found in an excerpt in *The Psychologist's Legal Handbook* (Stromberg et al., 1988):

> Although "privacy" as an individual right normally ends at death, the same is not true of confidentiality. This is because it would seriously undermine confidence in the therapeutic relationship while it was occurring if the patient knew that confidentiality would not be preserved following his death. (p. 402)

Therefore, if you received a call from the family or the executor of the estate after a patient commits suicide, you cannot break confidentiality unless you have a signed release from the patient before death or a court order from the judge. Therefore, you would not be able to identify their loved one as a patient and you could not release any medical records.

Reference

Stromberg, C. D., et al. (1988). *The psychologist's legal handbook.* Washington, D.C: National Register of Health Service Providers in Psychology.

Continued from page 4

Committee. She also manages the fundraising mailings for PennPsyPAC and our foundation, and provides staff support to the PPF board.

Peggie Price, our administrative assistant, works closely with Iva on processing membership applications, database management, and dues statements. She works closely with Marti on the convention and CE programs, managing registration, correspondence with presenters and attendees, handouts, evaluation forms, CE certificates, and recruiting and deploying student volunteers. She also takes care of correspondence with PennPsyPAC and PPF donors, among other duties.

Our secretary, **Katie Boyer**, is the first voice most people hear when they call the office. She takes care of most of the basic jobs for a smooth-running office: copying, processing the mail, ordering supplies, word processing, proofreading, etc. She also does extensive data entry and works with Iva to prepare documents for posting on the website. She manages the CE tests in this journal as well as all Act 48 records for our school psychologists. She takes charge of the Legal Consultation Plan, including billing members and paying attorneys. She processes checks and credit card payments that come in to the office. She has created many of PPA's flyers and forms for our conferences, and is now helping to design our quarterly e-newsletter for the public.

My own role consists of working with the Executive Committee and the Board of Directors in guiding PPA in pursuit of our strategic plan, as well as supervising all other employees toward the same end. I serve as managing editor of the *Pennsylvania Psychologist*. I provide staff support, along with Iva, for the committee overseeing the listserv and other electronic communications, and I provide some of the content for the website. I work with the Nominations Committee, and, along with Sam and Marti I provide staff support for the School Psychology Board. I am a registered lobbyist and am active in the state Capitol promoting PPA-backed legislation. I attend many legislative fundraising events on behalf of PennPsyPAC. I am a ghost writer for most fundraising letters, membership recruitment letters, and the like. I do the first draft of the budgets for PPA, PennPsyPAC, and PPF, monitor our progress on them, and oversee all finances of the organizations.

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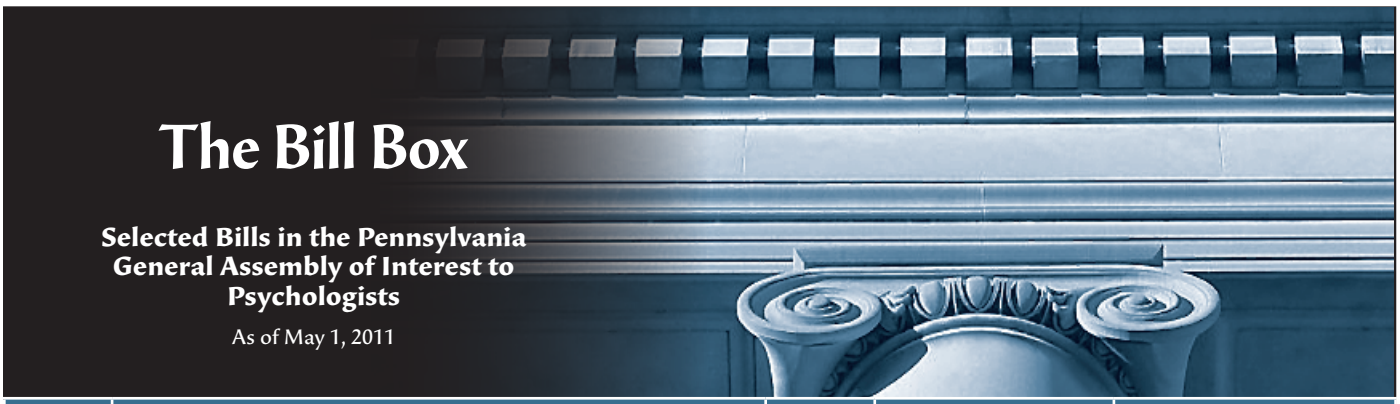

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of May 1, 2011

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 115 HB 58	Provides for involuntary commitment to outpatient treatment – Sen. Stewart J. Greenleaf (R-Montgomery) – Rep. Mario M. Scavello (R-Monroe)	Opposed unless amended	In Public Health & Welfare Committee	In Human Services Committee
SB 200 HB 200	Provides for management of head injuries among high school athletes and evaluation by psychologist or other provider – Sen. Patrick M. Browne (R-Lehigh) – Rep. Timothy P. Briggs (D-Montgomery)	For	Passed by Education Committee, 2/8/11, 10-0. In Appropriations Committee	In Education Committee
SB 850	Provides for the offense of cyberbullying and sexting by minors – Sen. Stewart J. Greenleaf (R-Montgomery)	For	In Judiciary Committee	None
HB 42	Prohibits Pennsylvania from implementing the federal health care mandate – Rep. Matthew E. Baker (R-Tioga)	Opposed	None	Passed by Health Committee, 2/7/11, 14-9. In Appropriations
HB 663	Restricts insurance companies' retroactive denial of reimbursement – Rep. Stephen E. Barrar (R-Delaware Co.)	For	None	In Insurance Committee
HB 978	Credentials drug and alcohol counselors based solely on their life experience – Rep. Louise Williams Bishop (D-Philadelphia))	Opposed	None	In Human Services Committee
HB 1405	Authorizes psychologists to testify in court on the determination of insanity – Rep. Glen R. Grell (R-Cumberland)	For	None	In Judiciary Committee

Information on any bill can be obtained from http://www.legis.state.pa.us/WU01/LI/BI/billroom.htm

PRESIDENTIAL PERSPECTIVE

Continued from page 2

to Harrisburg, get involved, and take responsibility to help this organization move psychology forward. It's not so different from our professional work, where we make a difference by taking on people one on one, or perhaps by groups or organizations. It is relationship that always wins the day. As I leave my presidency in the capable hands of Dr. Judith Blau, I want to encourage all of you to find a colleague who is not involved in PPA, and to encourage and mentor that person to join this incredible organization. Additionally, as we look toward succession planning for some of our most key staff professionals in the near future, we will need strong leadership to maintain and move this wonderful 78-year-old organization. Once again, it has been a huge privilege to serve as your president. Please come to our convention, which Celebrates Human Performance in Mind, Body, Spirit, and Community, from June 15 to 18, at the Harrisburg Hilton.

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Working with Adult Suicidal Patients

Norman C. Weissberg, PhD

Dr. Norman Weissberg

Let's begin with this: Working with suicidal patients is scary. It is stressful, demanding, and threatening to one's image of oneself as knowledgeable, competent, and efficacious. While a decision to end one's life is an action for which the suicidal individual is solely responsible, a mental health professional's actions or inactions may increase or decrease the likelihood that one's patient will enact lethal self-injury. Clinicians who have experienced the suicide of a patient – 50% of psychiatrists and 25% of psychologists – often question their professional judgment and report feelings of guilt, shame, loss, anger at the patient, and fear of facing a malpractice suit (Chemtob, C. M., Hamada, R. S., Bauer, G., Torigoe, R. Y., & Kinney, B., 1988; Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S., 2000). Because encountering suicidal patients in one's practice is unavoidable, this article offers recommendations for working with suicidal patients.

The initial assessment

Rarely is suicidal ideation identified as the presenting problem by adult patients in their first session with a psychologist. More likely, patients will present with a mood disorder, an anxiety disorder, an impulse control issue, or a relationship issue. Clients may not reveal that they have suicidal thoughts in the very early stages of therapy. But if suicidality is present, the earlier it is recognized and addressed, the better. Tiptoeing around the word "suicide" not only sends a message of shame and stigma, but delays appropriate interventions. The potential cost of delay is evident when one considers that 36% of women and 18% of men had contact with a mental health professional within one month of their suicide (Luoma, Martin, & Pearson, 2002).

I advocate, therefore, that we adopt, with modifications, an approach often employed by physicians, who require first-time patients to complete a form that asks, among other questions, whether the patient is depressed. The suggested modifications: first, that we ask our questions verbally rather than in print, and second, that we ask three questions about suicide: "Are you having suicidal thoughts?" "Have you thought about suicide in the last two months?" and "Have you ever attempted suicide?" If any of these questions is answered in the affirmative, the therapist is obliged to conduct a thorough suicide risk assessment.

I want to emphasize that an initial suicide risk assessment entails more than asking about a patient's suicidal ideation and plans. In a study reported by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2009), adult respondents 18 and older were asked whether they had serious thoughts of suicide in the past year, whether they had made a plan to commit suicide, and whether they had attempted suicide in the past year. An estimated 8.3 million (3.7% of the adult population) acknowledged having had serious thoughts of suicide in the past year, 2.3 million had made a plan (28% of those with ideation), and of those with a plan, 0.9 million (39%) had made an attempt. Thus, while ideation and a plan are warning signs for suicide, they are not sufficient in themselves to assess the likelihood of an imminent attempt. Patients entertaining these thoughts are in intolerable psychological pain and can think of no way other than suicide to escape that pain. Yet, in most cases, patients also are ambivalent about ending their lives. Exploring the sources of the pain, the intensity of the desire to die, as well as the beliefs, values, and connections to others that argue against committing suicide are all part of an initial suicide risk assessment. Introducing the word "suicide" does not plant the idea in a patient's head or fertilize a thought that is already there. On the contrary, talking about one's suicidal thoughts with someone who cares and is both compassionate and nonjudgmental is often a welcome relief.

Many models exist for conducting a thorough risk assessment (Jobes, 2006; Joiner, Van Orden, Witte, & Rudd, 2009; Rudd, 2006; Shea, 2009), all of which emphasize the importance of generating a comprehensive understanding of experiences, precipitating events, beliefs, cognitions, emotions, and environmental factors (e.g., access to a firearm) that drive the patient's suicidal thoughts. Among the specific variables to be explored are: recent losses (death of a loved one, breakup of a relationship, loss of one's job); feelings of hopelessness ("nothing will ever change") and helplessness (feeling trapped and powerless to effect change); perceiving oneself as isolated and disconnected from others; viewing oneself as a burden ("my family and friends would be better off without me"); a prior attempt (and the patient's feelings about having survived); substance abuse; presence of a plan and fearlessness about self-injury and death; having experienced the suicide of a family member or friend; and relationships, values, and beliefs that support the part of oneself that doesn't want to die. It is not sufficient merely to recognize the presence of these events, emotions, beliefs, and cognitions; it also is essential that one assess their frequency, intensity, and duration. The greater the number of these variables that apply to the patient, and the more intense and frequent the thoughts are, the closer the patient is to a suicide attempt. However, a conversation about these matters with a warm, caring, empathic, nonjudgmental therapist may mitigate the desire to convert these thoughts into a lethal action. One means to assess the impact of such a conversation is to close the exploration phase of the assessment with a question: "We've been talking about many things in our time together today. I'd like to ask how you are feeling

right now. On a scale of 1 to 5, how likely are you to kill yourself, where 1 means 'definitely not' and 5 means 'definitely will'?" If the patient responds with a 4 or 5, it signals a suicidal crisis and the therapist is obliged to take immediate action to ensure the patient's safety – e.g., calling 911. If, however, the patient responds with a 3, then the therapist is faced with a judgment call (immediate hospitalization or intensive therapy) based on assessment of the information gathered in the conversation preceding the patient's answer. If the psychologist believes the patient does not require immediate hospitalization, outpatient treatment can begin.

Treating suicidal patients

A common error in working with suicidal patients is to focus treatment on the symptoms associated with the patient's DSM diagnosis. However, overwhelming evidence exists that such an approach does not lead to a reduction in suicide attempts (Linehan, 2008). While 90% of those who completed suicide had a DSM diagnosis, and while several diagnoses, such as bipolar disorder, major depression, and borderline personality disorder, are risk factors, only 10–20% of patients with these diagnoses succeed in killing themselves (Black, D. W., Blum, N., Pfohl, B., & Hale, N., 2004; Fountoulakis, K. N., Gonda, X., Siamouli, M., & Rihmer, Z., 2009; SAMHSA, 2006). Accordingly, the focus of one's treatment should be on suicidality itself.

Unsurprisingly, the therapeutic relationship is a critical component of the effort to engage patients in a collaborative journey to maximize the desire to live and

A common error in working with suicidal patients is to focus treatment on the symptoms associated with the patient's DSM diagnosis.

to minimize the likelihood of suicide. The optimal therapeutic stance for achieving these goals is one in which the therapist provides support and instruction, and focuses interventions on those factors that feed suicidal desire and capability (Joiner et al., 2009, p. 15).

Ground rules for enhancing the therapeutic relationship and structuring therapy

- First, reduce the physical distance between you and the patient. One of the experiences most frequently reported by suicidal patients is that they feel isolated and disconnected from others. Sitting close to patients reinforces the perception that one wants to bond in a collaborative effort to confront the problems that are generating his/her desire to die.
- Request that the patient sign a "Commitment to Treatment Form" (Joiner et al., 2009; Rudd et al., 2001).

This is a substitute for the discredited "No-Suicide Contract" (Rudd, M. D., Mandrusiak, M., & Joiner, T. E. (2006). It details the patient's responsibilities in the treatment process, such as attending all the sessions, setting goals, and voicing thoughts and feelings openly and honestly, including feelings about whether the treatment process is working. It also contains a statement that the patient agrees to make a **commitment to living**. In addition, the patient is asked to agree to implement a crisis response plan should suicidal thoughts increase in intensity and frequency. The crisis response plan is a written list of actions the patient agrees to take when thinking of suicide, written on an index card (Crisis Card) that is kept available 24/7. The items on the card, generated collaboratively by the patient and the psychologist, are intended to regulate mood and/or distract the patient from suicidal thoughts. The list is built upon past actions of the patient that have helped reduce suicidal thoughts and impulses. Examples include calling a friend or family member, working a crossword puzzle, volunteering for a charity, engaging in exercise or an athletic event, listening to soothing music, and buying something for oneself. The Crisis Card also lists telephone numbers the patient can call should such efforts to alleviate suicidal thoughts not succeed. The numbers should include the therapist's number, the National Suicide Prevention Lifeline Number (1-800

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WORKING WITH ADULT SUICIDAL PATIENTS

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273-TALK), and other numbers in one's geographic area that connect to an agency that responds to psychiatric crises.

- Prepare a form that states the limits of confidentiality (reasonable cause to suspect child abuse, a threat of **imminent** homicide or suicide, and a court order) and have the patient sign it.
- The number of sessions per week should be scheduled based upon the therapist's judgment of the client's level of risk. Welcome and encourage between-session telephone contacts.
- Seek consultation with other clinicians and document these contacts.
- Since suicidal risk is fluid, assess the patient's risk status at each session.

Therapeutic targets

Let's assume the precipitating events that triggered suicidal thoughts have been identified as part of the initial suicide assessment. The next task is to identify how the patient's interpretations of those events led to entertaining suicidal thoughts. The central targets are:

1. Perceived burdensomeness (a belief that one is worthless, a failure, and such a burden on others that they would be better off without the patient)
2. Feelings of hopelessness (a belief that the emotional pain being experienced will never recede and that the future will be no better than the present)
3. Thwarted belongingness (feeling lonely, isolated, unconnected, and estranged from others)
4. Feelings of helplessness (believing that one is trapped and unable to do anything to ameliorate one's problems)
5. Emotional dysregulation and distress intolerance

Different psychologists are likely to approach these targets in different ways. However, the data suggest that certain interventions are more efficacious than others (Rudd, M. D., Joiner, T. E., Jobes, D. A., & King, C. A., 1999; Weinberg, I., Ronningstam, E., Goldblatt, M. J., Schechter, M., Wheelis, J., & Maltsberger, J. T., 2010). A common theme is addressing skill deficits and teaching problem solving, with a focus on distress tolerance, emotion regulation, anger management, and dysfunctions in the patient's interpersonal relationships. In addition, the therapist is advised to focus directly on the cognitive distortions that feed suicidal desire, e.g., hopelessness, helplessness, perceived burdensomeness, and failed belongingness. Moreover, because 90% of those who commit suicide have a DSM disorder, the therapist may also address the symptoms associated with that disorder.

Conclusion

There are an average of 25 attempts for every completed suicide. Psychologists can play an important role in reducing the frequency of completed suicides, but to do so, they must acquire appropriate training. Regrettably, graduate schools and internships devote insufficient attention to both assessing suicide risk and treating suicidal patients. Not only do a minority (40%) of doctoral programs in clinical psychology provide formal training in suicide, but the training itself is often inadequate (Bongar, 1992; Dexter-Mazza & Freeman, 2003). Compounding the problem, postdoctoral training and education are equally haphazard, leaving too many practitioners who employ inadequate interventions (e.g., a no-harm contract). It is my hope that this article generates more widespread and systematic training, and that our profession assumes its rightful place in society's efforts to reduce suicide attempts and completions.

References are available on the PPA website, www.PaPsy.org, or upon request from the author at normanw@brooklyn.cuny.edu

Children Grieving a Death Colored by Suicide

Andrea Lurier, PhD, andrea.lurier@highmark.com

Dr. Andrea Lurier

For children of all ages, the death of a parent or close family member is a most disruptive, disorganizing, and upsetting life event. Not only do children lose the person and the daily presence of that person, they lose their family as they knew it and the future they had hoped for. Integral to the child managing such an event is having a trusted adult close by, even when that adult may also be managing grief.

The impact of the loss of a significant caregiver challenges all developmental fronts. This overwhelming new reality confronts those in the process of developing and mastering the emotional and cognitive tools necessary to do so. Further complicating this daunting task, the child's preferred person for comfort may be the person who has died. Finally, the nature of death by suicide presents its own unique challenges.

Grief is the emotional, cognitive, physical, spiritual impact of significant loss. Mourning is the process or work of reconciling oneself to that loss. Grief researchers and theorists have described the tasks of mourning (e.g. Wolfelt, 1996; Worden, 1996). These tasks touch on the reality of what has happened, the range of feelings that might be present, the transformation of the relationship, and changes in self-identity. The tasks are neither prescriptive nor linear. They are worked and reworked as the child grows.

How do professionals support a child in taking in, making sense of, and reconciling this significant and traumatic loss at any point in development? We do so by creating a safe environment within which we invite and bear witness to the work, appreciating the developmental and relational nature of this process – a process colored by a specific type of death: suicide.

Children who have experienced the death of a family member, especially a parent, need permission to develop and tell their stories in their own time and pace, in their own language and in the presence of an attentive other.

To begin, children need accurate information attuned to and respectful of their developmental level. Even so, there is a necessary gap between being told and knowing (Cain, 2002). New words must be used and practiced before they are fully understood – even as a way of understanding. Comprehending the words "dead" and "permanent," by their very nature, requires the experience of time passing.

With the first seeds of information, children need many opportunities to tell their story and honest answers to their questions as they work to master the enormity of their loss. Death by suicide brings a unique combination of questions, feelings, and misunderstandings that color and complicate the process: *What is suicide? How did it happen? Why does suicide happen? How could someone choose to take his or her own life? Was it a choice? Was it my fault? Is there something wrong with me? Will I share the same fate? Where was God?*

This process evolves best not in a vacuum but in relationship. Children can begin to give voice to unspeakable fears and protest the unfairness of it all when a caring other allows questions to be asked, even if there are no clear answers. Yet in the midst of their own grief, surviving caregivers may have difficulty finding the right words, sitting with their child in intense pain, allowing the questions, and tolerating the process.

Telling a child that a parent has died by suicide is difficult. To protect the child from this painful knowledge, a parent may not tell them how the person died or may lie about the cause of death – even if the child was present when the suicide occurred or when the body was found. Others delay the "telling" until they feel ready or they feel the child is ready. Even then, parents struggle to find words simple enough to explain the death. Yet without accurate information, children are left to their own fears and suspicions to fill in the gaps. Their imaginings can be more frightening than reality if only because children are alone with unspoken dread and self-blame. Other times, adults whisper "over the heads" of children. These overheard secrets put children in a quandary, knowing something that should not be known.

> *With the first seeds of information, children need many opportunities to tell their story and honest answers to their questions... .*

Suicide is bewildering for anyone – child, caregiver, or professional. The act seems to contradict life's strivings for growth and survival. All explanations lead to further questions. We understand that brains malfunction, and that begins to satisfy our need to understand. Yet suicide is often precipitated by stress and interpersonal crisis, dragging an "other" into the equation. Conversely, relying heavily on genetic explanations reduces hope for prevention. Even for professionals, making sense of suicide is a process. We, too, need permission to give voice to our questions, even as we witness and support another's process.

The role of psychologists

As psychologists, we work within a relational frame. Providing a trusting relationship, developmentally appropriate context, and respect for the process, we let the child lead. With each new telling comes greater integration. Questions will

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Repercussions of a Patient's Suicide

Robert M. Gordon, PhD, ABPP

Dr. Robert M. Gordon

Psychologists approach their voice-mail messages knowing the full range of human drama might come pouring forth. Entering my 35th year of practice, I was a bit weary of hearing them. Freud warned us never to expect appreciation, no matter how hard one works, from the three impossible professions: parenting, governing, being a psychotherapist. I was not expecting to hear gratitude.

The first message was from five attorneys who were having drinks when they discovered they all had been in treatment with me. On the message, they joked that they were debating over who needed a tune-up. Their appreciation felt good. I will always remember that first message and the one that followed.

The second message began, "Dr. Gordon. You do not know me, but Calvin always spoke highly of you. ..."

How nice, I thought, Calvin is referring his friend. Calvin was 45 when he first came to me after the death of his widowed mother about 10 years ago. He was an only child. Calvin was friendly, but very shy. He occasionally dated but never married – except, perhaps, his profession: He was brilliant, a scientist devoted to his work. Calvin had lifelong obsessive-compulsive disorder and Asperger's syndrome. Following the death of his mother, he had his first major depression. He was seeing a good therapist in his community and continued to see him for years. However, he had found my papers online and asked to see me for consultation. He hoped a psychodynamic approach might provide a more comprehensive perspective. As it turned out, the interpretations helped Calvin feel more deeply understood, which in turn deepened our therapeutic relationship.

Calvin traveled an hour and a half to see me, first weekly, then, after resolving his depression, about once a month for years. He had formed a strong attachment. Before leaving, he had the habit of shaking my hand three times, and saying three times, "Thank you." One day, quite spontaneously as he left, he said, "I love you." I said I loved him, too. Frankly, at first I said it to be gracious. But in time, I did feel love for Calvin.

> *And now I was struggling not only with the first suicide of a patient, but the suicide of someone I cherished.*

I hadn't seen him for quite a while, but last year Calvin was let go from his job. His work was his source of identity and reliable connection to this world. He fell into a severe depression. Medications were not working. His psychiatrist suggested hospitalization, but Calvin was terrified of it. He trusted my opinion and I told him it was now necessary. Eventually, only ECT brought him out of his psychotic depression. When I last saw Calvin a month before this call, he was better, but remained lost.

The voice continued, "When I hadn't heard from Calvin for a few days, I went to his home. I found him in the kitchen. He had shot himself. ..."

I felt an internal protest against his words. I heard someone crying and then realized my face was wet. My emotions had outraced my cognition. The tears flowed uncontrollably.

I called Calvin's friend. I needed details to help process the unbelievable.

I went into professional autopilot for the rest of the day. That evening, as I told my wife, I cried again.

What made it awful was not just his death, but the horror that preceded it. I kept envisioning this gentle person who knew nothing of firearms, buying a powerful gun, writing out instructions so others would know what to do and be minimally inconvenienced. Then, all alone, feeling the most profound despair, squeezing the trigger. No good person should die that way.

Throughout more than 30 years, I had not lost a patient to suicide. To outsiders, I would tell of my skillful rescues. To fellow professionals, I confessed it was mainly luck. And now I was struggling not only with the first suicide of a patient, but the suicide of someone I cherished.

When part of a person wants to end suffering or punish someone from the grave, there is usually enough conflict to send out a verbal or nonverbal message that reads, "Please stop me." However, when there is little conflict, a person just does it. I know we cannot control others. Nevertheless, I obsessively reviewed what I could have done.

In the weeks that followed, I would overreact to my patients' suicidal thoughts. I went too soon to discussions of a safety contract, medication, interpersonal supports and even the possibility of hospitalization with clients who wished to die but who were not actively suicidal. For a period, my empathy was compromised by my anxiety. One patient said, "Relax. I am only sharing feelings. I would never kill myself." If patients do not overtly tell us we are off-target, they may become more symptom-focused and banal in the narrative. They will re-enact how they shut down in the absence of empathy. Patients' reactions provide immediate supervision to those open to hear it.

In time, my affects eased. However, they unconsciously surfaced as defenses. I would not take referrals if I thought the person was a potential suicide risk, such as someone suffering from borderline personality disorder or major depression. I considered reducing my hours. I shifted from mainly direct care to more diagnostic consultations and forensic work. These decisions were multi-determined, as are all rationalizations. But the fuel beneath was my fear of another suicide.

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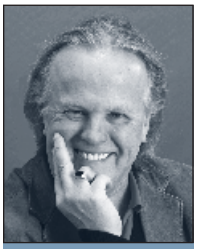
Assessing Teenagers for Suicidal Ideation

David J. Palmiter Jr., PhD, ABPP



Dr. David J. Palmiter Jr.

The Youth Risk Behavior Survey, conducted every two years by the Centers for Disease Control (CDC), is a national survey of risky behaviors by high school students in the United States. The most recently published edition (CDC, 2011) surveyed 16,410 students in 2009. The survey found that 13.8% of these teens had thought seriously about committing suicide in the past year, while 6.3% had attempted. The CDC also reported that 12% of deaths among people aged 10–24 are caused by suicide. I believe these data can be reasonably partnered with two other recent studies of adolescent mental health. (Authored by the same research team, the national sample sizes exceeded 10,000 adolescents.) The first study reported that 49.5% of teens met criteria for at least one class of mental health disorder, with one in four suffering severely (Merikangas, et al., 2010). The second study found that 63.8% of teens suffering from a mental health problem had not received any mental health care, and that about half of those who had received care were limited to six or fewer outpatient visits (Merikangas, et al., 2011). (For more information see my related blog entries at www.hecticparents.com.) While there are many implications of data like these (e.g., the critically important role of public education), here I wish to focus on assessment methods for identifying, and perhaps reducing, the occurrence of teen suicide.

As a new PhD practicing in rural New York in 1989, one of the first things I learned that helped me avoid excessive anxiety when providing on-call emergency services was that psychologists are not legally required to keep people from committing suicide. Of course, this is what we hope to do. But no court requires us to do it. What we are required to do is to ask those questions and follow those procedures to which a reasonably prudent clinician would subscribe. While a comprehensive list of questions and procedures to use in screening adolescents for suicide is beyond the scope of one article, included are some general suggestions and resources.

The opening question I use with a teen, which typically follows a description of the presenting complaint(s), goes something like this: "Joe, when (the most painful presenting problem) is at its worst, and the minutes are going by like hours, and it might seem like there is no way out, have you ever had thoughts of wanting to hurt yourself?" A "no" response is followed up with, "How about in the past?" A "yes" response to either question would call for asking an assortment of other questions, either in the moment or before the interview is completed. The domains I suggest covering include:

- sleep habits
- eating habits
- physical activity
- concentration (Someone whose body is breaking down from poor health habits, and who cannot concentrate well, will often have a difficult time resisting harmful impulses.)
- lethality of the ideation, ranging from passive ("I just wish God would strike me dead") to active thoughts with access and intention ("I'm going to go home, close the garage door and let the car keep running.")
- lethality of previous attempts, including what the teen thought would happen (Only a third of teens who attempt suicide report a wish to die; Brent and Poling, 1997.)
- substance abuse (Abusing substances weakens impulse control and worsens mood, if not during use then afterwards.)
- history for impulsive actions (fighting, promiscuity, risk-taking behaviors)
- association or identification with someone who committed or attempted suicide
- hopelessness (Given the degree of pain that depression causes, whether or not the teen believes there will be an end to the pain is very important.)
- family psychiatric history, including a history of harmful ideation and action
- Some open-ended questions that can generate clues about morbid thinking are listed below. In parentheses are answers a suicidal teen might generate:
  a. If you could have three wishes and could wish for anything but money or more wishes, what would you wish for? ("Who cares? Nothing matters" or "A drug to make this pain go away.")
  b. If you had to be an animal instead of a person, what would you choose? After the answer is given, "What would you like about being a _____? ("I'd be a worm, because then someone would be more likely to step on me.")

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Helpful Websites

To aid us in our work, some helpful websites exist. Entering the term "suicide" in the search engines on the following sites will yield an assortment of related and helpful articles and resources:

- www.PaPsy.org
- www.apahelpcenter.com
- www.nimh.nih.gov
- www.menningerclinic.com

A few helpful websites more specifically dedicated to suicide are:

- www.aacap.org/cs/Depression.ResourceCenter
- www.sprc.org
- www.211bigbend.org/hotlines/suicide/resources.htm

CHILDREN GRIEVING A DEATH COLORED BY SUICIDE

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change, reflecting more sophisticated levels of understanding and capacity to cope. Ideally, we support the surviving caregivers' mourning process, too, and assist in creating an emotional frame capable of supporting their children's work. By becoming a safe, present adult who bears witness to the caregiver's story, we give caregivers the experience we are asking them to provide for their children.

Psychologists help caregivers recognize that for children, grief and mourning are ongoing processes that continue throughout life. Think of the pathways of grief and mourning as intertwining spirals. The movement along the spiral captures the dynamic nature of both (Giannotta & Woods, 2003). When the intensity of feelings returns or a task is worked and re-worked, time and development drive change, preventing one from "moving in circles" but rather in a spiral, and within that movement is hope – change for the better. The "loops" can be large or small, as well as the spaces between them. Expected events – holidays, anniversaries – or structured mourning may bring the intensity to the forefront, as will unexpected "triggers" that catch a person by surprise.

A child and adult's spirals also intertwine, influencing one another's journey. Children express and work to manage their feelings as caregivers listen and allow it. In return, we recognize that the child's process may strain the adult's process. Each retelling heard, each question posed, requires the adult to confront the work with the child. We prepare caregivers for these moments. Yet a child's questions, realizations, and discoveries often influence and grow the adult's process – and our own.

Dr. Lurier is a child grief specialist with Highmark's "The Caring Place" in Pittsburgh.

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REPERCUSSIONS OF A PATIENT'S SUICIDE

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I found it helpful to share my feelings with close colleagues, but mostly with my wife, a psychoanalytic candidate and my best support. She knew how to listen with empathy, without resorting to psychological Band-Aids.

Then our *Pennsylvania Psychologist* editor, Dr. Andrea Nelken, wrote that she wanted to do a special issue on suicide in response to military and bullying deaths. She asked whether, if a client of mine had ever committed suicide, I would be willing to write about the experience.

She did not know I had lost my first patient to suicide just two months earlier. I did not want to do it. However, being a psychologist has taught me the value of honestly sharing our pain. Writing this has helped me to accept the reality of this tragedy, even while part of me waits for Calvin to shake my hand three times once again.

ASSESSING TEENAGERS FOR SUICIDAL IDEATION

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c. What's your favorite movie? ("The Virgin Suicides.")
d. If you could meet someone famous who has died and ask them something, who would you choose and what would you ask? ("Kurt Cobain. 'Did it feel better to end it all?' ")
e. What's your favorite website? ("I go on Facebook a lot, but people are extremely fake.")
f. What's your favorite song? ("Adam's Song" by Blink-182)
g. What are you hoping your life might look like in 10 years? ("I can't even think about tomorrow, never mind 10 years from now!")

Psychometric information also can be helpful. The Children's Depression Inventory is my favorite commercial product, though there are reasonable choices available in the public domain (e.g., the Center for Epidemiological Studies – Depression Scale). Information from parents, stepparents, teachers, and others who know the teen, gathered either by interview or rating scales (e.g., the BASC-2), also can be most useful.

Knowing what to do can be difficult, and to be prudent in ascertaining a reasonable standard of care has been met, it is almost always a good idea to seek out peer consultation regarding the data collected and the best course of action. Completing and documenting this step can help identify important additional content to solicit, gain clarity in developing a treatment plan, and be protective in the (statistically unlikely) event that a tort action or licensing board complaint is later filed.

In closing, please keep in mind that National Depression Screening Day is October 6, 2011. This affords us all a wonderful opportunity to prevent suicide. For more information on the day, visit www.mentalhealthscreening.org. I would also be happy to discuss how to run and market one of these events (palmiter@marywood.edu or (570) 587-2273).

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The Soldiers' Story: Reflections on Risk, Thrill-Seeking, and Suicide

Frank Farley, PhD, Temple University, Philadelphia

Dr. Frank Farley

A few years ago, a four-star Army general asked me to spend a day in a retreat at a Southern military base with the brass. They were aware of my work on risk-taking and thrill-seeking (the "Type T Personality") and wanted to discuss its implications for soldier behavior in combat as well as outside of combat, especially non-combat deaths including accidents and suicide. My view of the military is that there is positive risk-taking/thrill-seeking (T+) that is unfortunately necessary for certain aspects of combat success in modern conflicts, and negative risk-taking/thrill-seeking (T-) that can lead to non-combat deaths (e.g., drug/alcohol related, motorcycle accidents, weapons accidents, and possibly suicide).

The T- aspect is significant. The *New York Times* reported (2010) that non-combat deaths (accidents plus suicides) exceeded in number the deaths due to combat. The possible connection of Type T behavior to most military suicides seems rather unlikely to me, in that I have usually found these individuals to have a strong love of life, of living it to the fullest. Not a "death wish," a life wish. Accidental deaths, on the other hand, are a highly likely outcome of some risk-taking tendencies, and the military is attempting various strategies to reduce these. And it is sometimes difficult to determine if a particular non-combat death is accidental or a suicide. One might speculate that even a few combat deaths could be suicide, roughly analogous to the concept of "suicide by cop."

In an all-volunteer military, we can expect some extremes of risk-taking/thrill-seeking to be a characteristic among some of those volunteering in the hope of adventure (note some military recruitment advertisements) and possibly combat. And as noted above, some likely T+ qualities could be attractive to the military, such as fearlessness, self-confidence, lack of aversion to risk, motivation for combat engagement, inventiveness, quick thinking (consider the central figure in the Oscar-winning film "The Hurt Locker").

We might normally expect high suicide rates in the military, given the often high levels of stress, anxiety, transitions, uncertainty and threat, economic and career issues (e.g., opportunity costs due to military commitment, future job prospects), personal loss (e.g., the "Dear John"/"Dear Jane" letter, death of a fellow soldier), isolation and separation from loved ones, family, and friends. These soldiers are usually young people with little experience of such lengthy and often distant separations, as well as the other challenges noted above, who are in an age range now frequently labeled as a mere extension of adolescence, "emerging adulthood," i.e., not fully adult. By comparison, civilian "emerging adults," those who do not volunteer for the military during war, rarely confront such challenges. But here's an interesting fact: historically, the suicide rate in the military has been lower than that for comparably aged civilians (U.S. Department of Defense, 2010)! Given my hypothesized over-representation of "T Types" in the volunteer military, this might be argued to suggest lower risk of suicide in such individuals – at least the T+ ones. But very recently, for both the Army and Marines, that suicide comparison with civilians has reversed itself. The 2009 figures: Marines 24 suicides per 100,000; Army, 22; civilians, 20.

> *Intensive research and prevention efforts are under way in the military to reduce unacceptable rates of suicide... .*

This recent relative increase in military suicides is a puzzle, evoking several theories. One is that with the massive demands of engagement in two wars, the military may be retaining more substandard trainees than in the past; that is, retaining some despite psychological and behavioral problems. An argument is that these substandard recruits may be more suicide-prone.

Intensive research and prevention efforts are under way in the military to reduce unacceptable rates of suicide, including raising awareness of warning signs, special training for leaders, peer help ("battle buddies"), professional help (the Army has substantially increased the number of available professionals, including psychologists and psychiatrists, in recent years), joining together with civilian efforts to reduce all U.S. suicides via the National Action Alliance for Suicide Prevention, launched jointly in 2010 by Defense secretary Robert Gates and Health and Human Services secretary Kathleen Sibelius (U.S. Department of Defense, 2011), among other efforts.

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Siblings of Suicide: The Lost Survivors

Sarah Kathryn White, MS, Chestnut Hill College, hellosarahwhite@hotmail.com

Ms. Sarah Kathryn White

According to the American Foundation for Suicide Prevention, a person dies by suicide every 16 minutes. According to the National Institute of Mental Health (NIMH), suicide has become the third leading cause of death among 15- to 24-year-olds. These statistics have profound implications. Each completed suicide leaves many bereaved individuals, including parents, siblings, extended relatives, friends, teachers, coaches, coworkers, and neighbors. Anyone who has experienced the loss of a loved one to suicide bears witness to the devastation it can cause.

The term "suicide survivor" has come to refer to a person who is grieving after the suicide of a loved one. While each suicide survivor has a unique experience, most are left not only with typical grief reactions, but also shame, fear, rejection, anger, and guilt (Linn-Gust, 2001). Many survivors are overwhelmed with questions regarding why the suicide occurred (Linn-Gust, 2001). Recent evidence suggests that suicide survivors are more likely than natural death survivors to show symptoms of complicated bereavement.

Grieving a suicide can be a profoundly isolating experience. Cerel, Jordan, and Duberstein (2008) note three communicative problems that frequently occur in families and social networks after a suicide: (1) the development of blame for the suicide; (2) the perceived need to keep the suicide a secret; and (3) the social ostracism and self-isolation among survivors.

Surviving siblings of any type of death, including death by suicide, have been referred to as "the forgotten mourners" (Linn-Gust, 2001). The literature suggests that sibling survivors struggle in the lack of recognition of their grief (Woodrow, 2006; Dyregrov & Dyregrov, 2005). Some consider sibling loss to be a type of disenfranchised grief. Concerned relatives and/or friends often ask surviving children how their parents are doing, failing to ask the same question relative to the siblings' well-being. For the most part, whatever their age or situation, siblings and their feelings tend to be either discounted or relegated to a secondary position. For siblings overcome with grief and loss, their pain is intensified when it isn't acknowledged.

In her study, Woodrow (2006) invites survivors to tell their stories of losing a sibling. Woodrow's study reveals that the loss of a sibling does not occur in a vacuum but has echoes that reverberate, changing life on many levels. In Woodrow's words:

> It is evident that one cannot truly understand the pain of the surviving sibling if one does not attend to the rupture in the total fabric of the family and the interplay between individual and relational factors: the fundamental interconnectedness among the members of a family that is so powerful that it inevitably accompanies us throughout life. (p. 212)

Woodrow refers to the experience of sibling loss as a "double loss:" the loss of a significant other *and* the loss of the family as one knew it. Linn-Gust (2001) refers to this phenomenon as becoming "double orphans" – losing, in a sense, both the sibling and the parent(s). Surviving siblings often feel as though their parents are not emotionally available to them (Cerel, Jordan, & Duberstein, 2008). Not only have siblings lost their brother or sister, they experience the loss of assurance and security derived from the assumed ability of their parent(s) to handle whatever life has to offer (DeVita-Raeburn, 2004; Becvar, 2001).

Research suggests that children are frequently more upset by the anxiety of other survivors and their own fantasies than by exposure to death and dying alone. For example, many parents develop considerable anxiety about losing another child. In Smith's (1995) research on sibling survival, she discovers that for some siblings, the most difficult part of their survival involves issues with their reconstructed family and/or their parents' unresolved grief.

In an international literature review of the last 30 years, only eight empirical research studies were found that focused on the situation of sibling survivors of suicide (Dyregrov & Dyregrov, 2005). Jamison (1999) writes:

> The impact of a suicide on the lives of brothers and sisters has been almost entirely ignored in the clinical research literature, an omission made the more remarkable by the closeness of emotional ties between siblings and the possibility that they may be more likely to kill themselves because of shared genes and environment. (p. 297)

Cerel, a recognized national expert on suicide survivors, calls for rigorous study, using both quantitative and qualitative measures, of the phenomenology of survivor experience both at the individual and family system level (Cerel, Jordan, & Duberstein, 2008). Linn-Gust, president of the American Association of Suicidology (AAS) and advocate for sibling suicide survivors, also encourages researchers to pursue this important, uncharted territory (2001).

Many of us – graduate students, professionals, life-long learners, allies of families enduring such loss – have much to learn about how to competently and empathically work with siblings impacted by suicide.

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Eastern Pennsylvania PPAGS Internship Workshop

Amy André McNamee, MEd
Crystal Taylor, MS


Amy André McNamee


Crystal Taylor

The Fourth Annual Eastern Pennsylvania Internship Workshop was held on October 30, 2010, at Chestnut Hill College in Philadelphia. Approximately 50 interested students attended this event, which was changed from a fair to a workshop due to lack of response from many of the nearby predoctoral internship sites. The workshop format included six panelists from various internship facilities who engaged in a question-and-answer session for almost two hours.

The six panelists included: Dr. Pamela Abraham, professor of psychology and director of clinical training at Immaculata University; Dr. Marcy Chessler, training coordinator in the Psychological Services unit of Tuttleman Counseling Services at Temple University; Toni Giordano, a PsyD student at Chestnut Hill College and predoctoral intern at Life Counseling Services in Paoli, PA; Dr. Linda Knauss, associate professor and director of internship training at Widener University's Institute for Graduate Clinical Psychology; Dr. Edward Moon, a Veterans Administration psychologist with 18 years' experience at the Coatesville Veterans Administration Medical Center, where he is also director of training for the Internship Program; and Elisabeth Roland, a graduate of Chestnut Hill College's PsyD program, who is currently serving as a postdoctoral fellow at Pennsylvania Hospital. The panelists answered a variety of questions, including how to present at an interview, what to wear, suggestions for essay writing, whether or not it was advantageous to defend one's dissertation before internship year, and many more questions. The panel also offered the attendees sample interview questions that may be asked at predoctoral internship interviews.

Although the number of students attending this function has increased since its inception, the number of sites has decreased sharply since the 2009 event. While reflecting on this year's site attendance, PPAGS chair Kate Altman stated, "Getting internship sites to participate in the event was very challenging this year—much more challenging than in the past few years of organizing the internship fair." With only six sites represented this year, site attendance declined more than 50 percent from last year's 14 participating sites. According to Ms. Altman, although many sites wanted to attend, their inability to participate reflected the national internship crisis: there are simply too many applicants and not enough sites. As a result, site directors and their staff are working countless hours to review the hundreds of applications they receive and do not have extra time to devote to outside endeavors such as the internship fair.

As the number of internship applicants continues to rise, it is imperative that strategies be implemented to increase the number of internship sites available. In an effort to address this issue, the American Psychological Association's Board of Educational Affairs (BEA; 2008) and the Council of Chairs of Training Councils held a meeting in 2008 and proposed a number of short-term and long-term recommendations for decreasing the APPIC internship-match discrepancy. Recommendations included: developing innovative ways to increase opportunities in existing sites, decreasing obstacles for sites to become APPIC-accredited, developing toolkits to assist sites in starting/expanding internships and becoming accredited, and creating partially or wholly affiliated internships (consortia). Unless these suggestions are enacted, the site attendance at internship fairs will likely continue to decrease.

In conclusion, although the attendance of internship sites declined, the internship fair/workshop will continue for graduate students, as interest among graduate students continues to rise. However, the structure of the service will depend on the number of participating internship sites. PPAGS will continue to advocate for possible resolutions to the internship crisis and hopes to see an increase in internship attendance at future workshops.

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Can We Talk?

Eric H. Affsprung, PhD
eaffspru@bloomu.edu
Colleague Assistance Committee

Dr. Eric H. Affsprung

Civic Virtue: Behavior that promotes the good of the community
Pro-Social Behavior: Caring about and acting on behalf of others

Why are these things important for psychologists? *Are* they important? How can such behavior improve our profession and our professional lives?

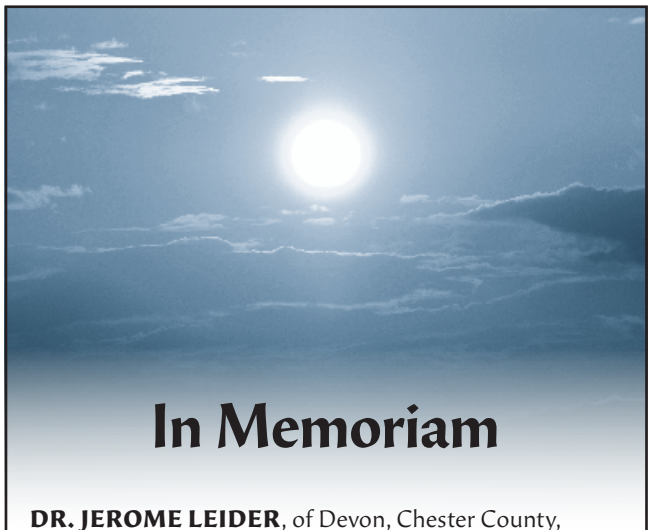
The members of PPA's Colleague Assistance Committee work to promote self-care among the membership. Last fall we found ourselves talking about what our obligations might be, as psychologists, to one another and our profession – and how such pro-social behavior is really an extension of good self-care (and vice versa). As we care for one another, we also support and nurture ourselves and our profession. We found ourselves wondering...

- Do we, as psychologists, have an obligation to support one another, to reach out to one another?
- As psychologists, have we made a commitment to one another?
- How can we support our fellow psychologists?
- How can we promote a culture of professional collegiality and support?
- How can we demonstrate care for one another in our places of employment?
- Do we promote transparency, trust and open communication at work and when working with other members of PPA? Or do we engage in splitting, triangulation, one-upmanship, and gossip?
- When we need to correct a colleague, do we do so in a manner which is affirming of his or her value as a fellow human being? Do we take the opportunity to teach, or do we belittle and punish?
- Do we have an obligation to mentor younger psychologists and those new to the profession?*
- Do we ask for help when we need to?

Are there things that we, as psychologists, don't talk about with our colleagues? Are there things that you wish that you could talk about? Why don't we talk about these things?

What do you think?

*** Did someone act as a mentor to you? If not, what kind of mentor do you wish you'd had? Whom can you mentor? Please consider serving as a mentor for one of PPA's early career psychologists. If you are interested, contact Dr. Michelle Herrigel, chair of the ECP committee: michelleherrigel@gmail.com.**



In Memoriam

DR. JEROME LEIDER, of Devon, Chester County, died suddenly of a heart attack in April. He had served as chair of PPA's Internal Affairs Board from 1999 to 2003. Prior to that he participated in numerous committees. He was president of the Philadelphia Society of Clinical Psychologists from 1997 to 1999. He earned his PhD degree in clinical psychology in 1972 from Temple University. He was a member of PPA since 1973. He maintained a private practice and specialized in geriatrics. Jerry's smiling face and friendly demeanor were a constant at PPA conventions, and he will be missed. He will also be remembered, in the words of Dr. Julie Levitt, "for his openness to new ideas, his enjoyment of life, and his good work as a skilled and compassionate clinician."

DR. CLORINDA G. MARGOLIS, of Philadelphia, died in April. She joined PPA in 1971, after having earned her PhD in clinical psychology from the University of Cincinnati in 1968. She was in full-time private practice for many years and retired about four years ago.

Upcoming Themes

The themes for the special section in the next four quarterly issues of the *Pennsylvania Psychologist* are as follows:

- **September 2011**
  Geropsychology
- **December 2011**
  Psychologists' Resilience
- **March 2012**
  Convention/Genders and Therapy
- **June 2012**
  Medical Procedures for Mental Illness

PPA members with particular interest and/or expertise in these areas are welcome to contact our editor, Dr. Andrea Nelken, at nelken.andrea@gmail.com to discuss authoring an article on one of those themes.

2011 Leadership Academy a Great Success

Judith Blau, PhD

Dr. Judith Blau

The Leadership Development Committee of PPA, co-chaired this year by Drs. Judith Blau and Jeffrey Pincus, and PennPsyPAC co-sponsored a Leadership Academy on Sunday, April 10, at the Hilton Harrisburg. About 50 people attended the 5½-hour event, which was scheduled in conjunction with Advocacy Day on Monday, April 11, at the State Capitol Building.

The purpose of the Leadership Academy was to educate and encourage current leaders and potential leaders, and to enhance the skills of those members who have already assumed or will be assuming leadership roles in PPA. The attendees were a mix of officers, committee and board chairs, and committee members, and ranged in professional experience from graduate students to early career to senior level psychologists. PPA staff members Tom DeWall, Dr. Sam Knapp, and Marti Evans were also present. The Leadership Academy focused on legislative advocacy, association leadership, and ways to encourage diversity in leadership. All of the workshops and audience participation highlighted the importance of personal contact and relationships in getting people involved in leadership and advocacy.

The first workshop, "Motivate to Activate: Political Advocacy, Leadership and Organizational Strength" by Dr. John Gavazzi, focused on the importance of advocacy, leadership responsibilities for advocacy, the importance of building relationships with legislators, and psychology's successes, including getting recognition and reimbursement under Medicare, achieving mental health parity, and getting corporal punishment banned in schools. The second workshop focused on "The Nuts and Bolts of Leadership in PPA." Dr. Andrea Delligatti discussed recruitment issues and the tasks and characteristics of effective leaders, and Dr. Judith Blau discussed PPA's specific organizational structure and strategic plan, and some practicalities for effective functioning in PPA leadership positions. Workshop three, "The Journey to Leadership: Pathways to Follow," presented rewards and challenges for being in leadership positions in PPA, and the importance of giving back to the profession and mentoring others. Drs. Stephen Berk, Emily Stevick, Jeffrey Pincus, Hue-Sun Ahn, and Ms. Amy André McNamee gave perspectives from their personal experience and encouraged comments and questions from the audience. The last workshop, "Encouraging Diversity in Leadership: Individual and Organizational Multicultural Competence," given by Dr. Audrey Ervin, addressed characteristics of the multicultural skilled leader, the identification, implications, and prevention of individual and organizational microaggressions, and strategies to overcome hurdles to systemic change.

> *PPA is blessed in our having a wealth of talented and dedicated volunteer leaders supported by a wonderful staff.*

The day was a great success, generating strong feelings of enthusiasm, energy, and camaraderie. PPA is blessed in our having a wealth of talented and dedicated volunteer leaders supported by a wonderful staff. All of our members are encouraged to join and participate in our committees to help strengthen the organization and direct the activities and goals that are accomplished. Please check our website at www.PaPsy.org in the members-only section for a list and description of committees – and JOIN.

Thanks to Our Members Who Help to Make Psychology a Household Word

Marti Evans, APA Public Education Campaign Coordinator for Pennsylvania

The vision of the American Psychological Association's current public education campaign focus, *For a Healthy Mind and Body...Talk to a Psychologist*, is to help the public recognize the health benefits of caring for both mind and body. Recent studies and media reports conducted by APA have shown that more people than ever realize that physical health and mental health are intertwined and that psychologists are at the forefront of this public awareness. More and more PPA members have become active in our public education campaign and have let us know about their outreach activities in the period of November 1, 2010, to April 30, 2011. We thank them for helping to "make psychology a household word" in Pennsylvania.

The members of the E-Newsletter Committee continue to promote psychology by publishing PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." **Drs. Michele Angello, Gail Cabral, Kenneth M. Cohen, Marolyn Morford, David Palmiter Jr., Ritch C. Savin-Williams, Pauline Wallin,** and **Kimberly S. Young** contributed articles for the December 2010 and March 2011 issues. The e-newsletter editor is **Dr. Marolyn Morford** and the creative director is **Dorothy Ashman**.

Krista Boyer was interviewed by BCTV's *Talking Mental Health* program in November on "Seasonal Affective Disorder: The Winter Blues."

Dr. Helen Coons was interviewed by *Redbook* magazine for "Would You Get a Mommy Tuck?" in April.

"Prevalence of Combat Stress Disorders in the National Guard and Reserve Population" was presented by **Dr. Michael Crabtree** in November in Southwestern, PA, and in January at Ft. Indiantown Gap, PA.

Dr. Audrey Ervin presented "Man's Search for Meaning: Resiliency and the Human Spirit" on November 8 to 30 college students, faculty, and community members at Delaware Valley College in Doylestown. She was also interviewed in December by the college's magazine, *Rampage*, for an article about bullying and gay youth.

Dr. Robert Gallagher, former vice chancellor for student affairs of the University of Pittsburgh, was interviewed for an article in the *New York Times* on January 13 about "Dealing with Mental Disorders on Campus."

About 175 residents of the Rydal Park Retirement Community in Rydal, PA, heard **Dr. Steven Harlem** talk to them on November 11 about the "Effects of Alcohol on the Brain and Body and Its Interactions with Medications."

Dr. Lauren Hazzouri presented "Self Esteem in the Workplace" in March to 100 members of the Scranton Chamber of Commerce, "Self Esteem: Who Are You?" in March to 45 attendees at the Leadership Lackawanna Conference, and "Self Esteem and You" in February to 200 attendees at the Lackawanna County Community Lecture Series. She also served as the program host on the *Mental Health Matters* television program in October (mood disorders), November (addiction), and April (resiliency in children) and as a panelist in December (stress in America).

Dr. Michelle Herrigel presented "Cyberbullying 101: What Every Parent Needs to Know" on October 28 at the St. Mary's School Home and School Association in Schwenksville.

The *New York Times* interviewed PPA president, **Dr. Mark Hogue,** and PPA's director of professional affairs, **Dr. Sam Knapp,** for an article on January 31 about stress related to watching the Super Bowl.

In September and November 2010 and February 2011, **Dr. Gail Karafin** presented "ADHD for Teachers" to the Bensalem Township School District.

Dr. Peter Langman, KidsPeace director of psychology, has been interviewed more than 100 times by newspapers and radio and television stations on numerous child and adolescent issues, including "Why Kids Kill: Inside the Minds of School Shooters" which is also the title of his book published in 2009. In November he was interviewed by Canadian Television in Toronto on self-injury and by British Columbia Radio on why kids kill.

"Taming the Anxiety in Aspergers: Making a Difference When Kids Are Stuck" was presented by **Dr. Brad Norford** on May 15 to 30 members of ASCEND in Rosemont, PA.

Dr. Gerald O'Brien was the guest co-host on a daily radio talk show in Lansdale on December 13 when the topic was "Coping with Holiday Stress."

Dr. David Palmiter has been interviewed numerous times by newspapers and radio and television stations on a variety of mind-body health issues, including parenting strategies, self and relationship care, adjusting to change in a community, and anxiety disorders. He also supervised an anxiety screening event at Marywood University on February 3 for 165 people.

Want your name in our next article?

If you have done a presentation about psychology and mind-body health to a community or business group, please let us know about it so your activities can be recognized in our next "Thanks to Our Members" article for the December issue of the *Pennsylvania Psychologist*. Kindly send the following information about your presentation(s) to Marti Evans at mevans@papsy.org:

- Your name
- Title of your presentation
- Name of the group
- Date of presentation
- Location of presentation (city/state)
- Number of people present

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details! We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and services psychologists offer.

Dr. David Rogers of Hershey Psychological Services has presented numerous workshops to the Pennsylvania State Police, FBI, and other law enforcement agencies, including "Marriage and Divorce" on September 13 to over 60 state police officers. He also presented several workshops during the National Law Enforcement Conference in November, which was hosted by the Pennsylvania State Police.

Adam Sedlock made guest appearances on A & E Network's *Paranormal State* program on April 18 and April 25.

Harrisburg-area psychologist, **Dr. Ron Sharp**, director of treatment at Alternative Rehabilitation Communities, was interviewed for an article in the *Patriot-News* on January 30 on "Kids Must Be Taught Gunplay's Consequences."

Dr. Pauline Wallin writes a column, "on your mind . . . with Pauline Wallin" for the *Body & Mind* magazine published by the *Patriot-News* in Harrisburg six times each year. Recent topics have included, "Child Violence: Are Video Games to Blame?," "Strategy of Doing and Thinking Shakes Feelings of Helplessness," and "Dropping a Bad Habit? Make the Hurdle Easier to Clear." She presented an online webinar, "The Real Reason You Procrastinate and How to Stop for Good," to 200 people on January 15 for the Niche Affiliate Marketing System, and "Working with Difficult People" on February 16 to 80 members of the International Facility Management Association of Central Pennsylvania. Dr. Wallin was also interviewed for an article in the *Patriot-News* on January 4 on "Christmas Cheer to Winter Blues: How to Get Over Holiday Letdown."

Dr. Zak Zakland was interviewed for an article in the *Philadelphia Daily News* on July 15 on "Look to T'ai Chi to Treat Mind, Body and Spirit."

Bylaws Amendments Passed

The PPA membership has approved the amendments to the bylaws unanimously in voting that took place during the month of April.

A more general statement of purpose was adopted, namely, "to advance psychology in Pennsylvania as a means of promoting human welfare, and to educate, update and inform the public and our membership on current psychological theory and ethical practice through education, training activities, and public policy initiatives."

The new language vests in the Board of Directors the duty of selecting a replacement for an officer or board chair who leaves office early, as well as the duty of breaking a tie in a membership-wide election. The new bylaws make the president of PPF an ex officio member of the PPA Board without vote. Currently some committees have co-chairs; the new proposal provides for the option of a vice chair in addition to the chair, and only the latter serves on the General Assembly. Project groups are eliminated and may instead become committees. Some specifics were removed on issues that can be dealt with in the policy manual. Language pertaining to elections and amendments to the bylaws is changed to accommodate electronic voting in addition to mailed ballots.

Welcome New Members

We offer a magnificent, monumental welcome to the following new members who joined the association between February 1 and April 30, 2011!

NEW FELLOWS

Lisa M. Boschi, PhD
Wayne, PA

Patricia C. Broderick, PhD
Blue Bell, PA

Benjamin T. Gliko, PsyD
Wallingford, PA

Sheila C. McManus, PhD
Philadelphia, PA

Jennifer W. Patterson, PhD
Newville, PA

Lee A. Picariello, PsyD
Yardley, PA

Wayne L. Roffer, PsyD
West Lawn, PA

Michael Suminski, PhD
Malvern, PA

Caroline T. Tisot, PhD
Holland, PA

Tara Travia, PhD
Blairsville, PA

Jeffrey K. Uhl, PsyD
Medford, NJ

Jennifer D. White, PhD
Johnstown, PA

MEMBERS TO FELLOWS

Heather Hoover, PhD
Danville, PA

Kevin W. Kelly, PsyD
East Petersburg, PA

NEW MEMBERS

Robin L. Beaumont, PhD
Quakertown, PA

Larry S. Berger, PhD
Georgetown, PA

Rebecca L. Billings, PhD
Erie, PA

David W. Brant, PsyD
Leesport, PA

Travis A. Cos, PhD
Philadelphia, PA

David Federman, PsyD
Lederach, PA

Nicholas R. Flower, PsyD
Pittsburgh, PA

Kimberly L. Hoffman, PhD
Philadelphia, PA

Rhoda J. Keener, MS
Shippensburg, PA

Michelle H. Macera, PhD
York, PA

Heidi J. McKenzie, PsyD
North Versailles, PA

Salvatore A. Palazzolo, PhD
Upper St Clair, PA

Jennifer B. Perry, PsyD
Clarks Summit, PA

Maria L. Pitale, PsyD
Havertown, PA

Christine M. Samuelson, PsyD
Mechanicsburg, PA

Nicole L. Schwartz, PsyD
Philadelphia, PA

Leanne Valentine, PhD
Exton, PA

Gabrielle M. Wilcox, PsyD
Columbia, PA

STUDENTS TO MEMBERS

Tina Bloom, MS
Venus, PA

David W. Brant, PsyD
Leesport, PA

Jennifer C. Collins, PsyD
Mount Joy, PA

Michael L. Courtney, MS
Elizabethtown, PA

B. Gary Davis, PsyD
Newtown Square, PA

Teri A. Hagen, MS
Mechanicsburg, PA

Robert M. Nichols, PsyD
Harrisburg, PA

KristiLynn Volkenant, PhD
Danville, PA

NEW STUDENTS

Justin R. Ake, BA
Altoona, PA

Rachel Battaglia, MS
Pittsburgh, PA

Rachel K. Benyola, BA
Philadelphia, PA

Krista L. Coons, MS
Holmes, PA

Elizabeth A. Cruger, BS
Harrisburg, PA

Racha Fares, MA
Erie, PA

Lisa N. Fernandez, MEd
Philadelphia, PA

Jennifer J. Good, MS
New Oxford, PA

John C. Hecker, MA
Erie, PA

Cheslsea H. Hersperger, MA
Langhorne, PA

Enith E. Hickman, MA
Sinking Spring, PA

Daniel V. Jones, MS
Chester, PA

Richard L. Khan, MA
Newark, NJ

Sarah Killian, BA
Shavertown, PA

Mi Hae Kim, BA
Chester, PA

Stephanie B. Mannon, BA
Annville, PA

Sara K. Martin, MSW
Lancaster, PA

Denise L. Minguez, BA
Langhorne, PA

Lynn M. Panattoni, MA
Harrisburg, PA

Matthew C. Parsley, BA
Sinking Spring, PA

Joseph F. Reichmann, BS
Scranton, PA

Amy Roth, BS
Hatboro, PA

Salina C. Santore, BA
Putnum Valley, NY

Shanna M. Savage, BS
Highspire, PA

Kari M. Statler, BA
Scranton, PA

Lisa M. Story, BA
Moon Township, PA

Amanda L. Surace, BS
Broomall, PA

NEW AFFILIATE

Cathy L. Fox
Belle Chasse, LA

In the Ether, Out of View: Cyberbullying and Suicide Risk

Terri Erbacher, PhD, Philadelphia College of Osteopathic Medicine

Dr. Terri Erbacher

Bullying in the digital age

Remember schoolyard bullying? Those targeted children would go home and leave their bullies behind. Now, we live in a cyberworld where there is NO escape for these victims. According to a study by the Pew Research Center, 93% of teens between ages 12 and 17 go online, 75% of them own a cell phone, and 66% say they text (Lenhart, Purcell, Smith & Zickuhr, 2010). Further, 73% of teens use social networking sites, most commonly Facebook (Lenhart et al., 2010). With so many users online, the audience is vast, so the humiliation resulting from a hurtful Facebook post can feel unending.

Cyberbullying can be defined as "an individual or a group willfully using information and communication involving electronic technologies to facilitate deliberate and repeated harassment or threat to another individual or group, using technological means" (Mason, 2008). An estimated 20% – 35% of children and adolescents experience cyberbullying (Diamanduros, Downs, & Jenkins, 2008; Kowalski & Limber, 2007). Cyberbullying can take many forms: posting embarrassing pictures or harmful comments, spreading rumors, recording conversations, pretending to be someone else online to elicit gossip, sending harassing texts or e-mails, outing someone's sexual preference online, or creating Internet polls (e.g., "Who is the ugliest girl in school?").

Experts encourage parents to monitor their children's online behavior (Ybarra & Mitchell, 2007), though this is a challenge as computer usage is often done out of parents' view – either behind closed doors in children's bedrooms or on smartphones from wherever they are. Approximately a fourth of students involved in cyberbullying report logging onto the Internet from school, libraries, or a friend's house (Hertz & David-Ferdon, 2008). Further, 56% of teens report hiding their online activities from their parents (McAfee, 2010). However, warning signs exist that a child may be the victim of cyberbullying: long hours on the computer; visible distress or anger during or after Internet or cell phone use; always claiming to be doing homework on the Internet, yet getting behind in school work; or refusing to say whom they are talking to (Hinduja & Patchin, 2009).

Cyberbullying & suicide risk

High-profile cases of teens taking their lives after being bullied online have captured the attention of the media and the general public. Research in this area indicates a direct relationship between the frequency of cyberbullying and negative psychosocial characteristics and behavioral problems (Ybarra et al., 2007). While cyberbullying may not *cause* suicidal behaviors in an otherwise emotionally healthy youngster, such harassment may increase the risk for a teen who is already struggling; cyberbullying exacerbates instability and hopelessness in those already dealing with stress (Hinduja and Patchin, 2010).

Research by Klomek et al. (2011) found that victims of cyberbullying consistently exhibit more depressive symptoms and suicidal ideation, and female cyber-victims are more likely to attempt suicide than non-victims. Interestingly, bullies are not safe from emotional harm, either. A recent study conducted by Hindaju & Patchin (2010) found that cyberbullying victims were 1.9 times more likely and offenders were 1.5 times more likely to have attempted suicide than those who were neither victims nor offenders.

Those at risk to be victimized are more likely to be searching for acceptance and attention online, more vulnerable to manipulation, less resilient in getting out of a difficult situation, less able or willing to rely on their parents for help, and less likely to report a dangerous online situation to an adult (Willard, 2007). These are the same students who may be at risk for suicidal ideation, because suicide risk factors include lack of social connections, lack of resiliency and cognitive flexibility to consider more appropriate options or to ask for help, and suffering acute disappointments, embarrassment, humiliation or threat to status (Berman, Jobes & Silverman, 2006).

With so many users online, the audience is vast, so the humiliation resulting from a hurtful Facebook post can feel unending.

Children and adolescents need to be educated about the importance of sharing secrets when they are concerned about a peer. Children learn early not to "tattle," but this can be a deadly secret. Only 50% of cyberbullying victims report it at all: only 8.9% tell their parents, while 35.7% tell a friend (Slonje & Smith, 2008). Further, students often feel adult intervention is infrequent and/or unhelpful, and fear that telling adults will only bring more harassment from bullies (Mullin-Rindler, 2003).

What is the role of the school psychologist?

As consultants to our schools, psychologists can work with administrators to help

Continued on page 25

Mental Health/Crisis Response Team: An Effective and Efficient Public School Solution

Timothy L. King, PhD (drztlk@aol.com)

Dr. Timothy L. King

THE PROBLEM: About two decades ago, shortly after the triple suicide in the Quakertown School District, Bensalem Township administrators and school psychologists recognized how severe the threat of adolescent suicide had become and began formulating a solution. The initial component of that solution encompassed workshops for teachers and parents about the warning signs for what was becoming a dangerous epidemic among adolescents. Unfortunately, as the community became more aware of the dangers and began utilizing counselors in each of the school buildings as "point persons" for referrals, psychologists in the district were called upon more frequently to screen students identified by school counselors as being at risk for aggressive or self-destructive behavior. As a result, this clinician alone was summoned more than 90 times in one school year to go to one of six elementary schools, three middle schools, and one high school to meet with students. At-risk students were being screened, but important diagnostic evaluation and IEP meetings were interrupted so frequently that the district Special Education's regular functioning nearly ground to a halt.

THE SOLUTION: The concept of a mobile crisis response team was developed to address the emergency screening and referral needs. Those selected were either administrators (e.g., assistant principals), social workers, drug and alcohol counselors, nurses, or building counselors – those who could, atop their regular duties, not only screen students in their building but travel to another school to address a more far-reaching crisis (e.g., the death of a student or teacher) that required screening of multiple students.

THE TRAINING: The initial component of the first team's training involved several days during the summer of required workshop attendance to provide a foundation of interviewing and crisis screening techniques. Emphasis was placed on the use of screening tools such as the Beck Depression Inventory and the SAL (Specific, Available, and Lethal) criteria to help members structure the screening process. Subsequent training, both ongoing and new, has encompassed less time because the team's procedures have been systematized and summarized in a manual. Both new members (e.g., newly hired counselors or nurses who wish to be part of the team) as well as those continuing on the team are now required to attend a review each fall.

In addition, attendance is required at bi-weekly meetings if any team member has handled a crisis. This meeting format gives team members the opportunity to gain feedback from this author (who has served as the moderator/clinical consultant) and other team members about the effectiveness of their interventions and whether additional or alternative steps might have been useful. In recent years, the first meeting of each month has been devoted principally to case review. The second meeting is focused on bringing in speakers from outside agencies such as Foundations Mental Health Center, NOVA, Lenape Valley Crisis Services, and ACCESS Mobile Mental Health Services, as well as individuals with a particular expertise: for example, Dr. Jay Carter gave a presentation last spring on bipolar disorder and a local counselor gave a presentation on death and dying. Finally, emergency training/support and intervention are always available to team members during school hours because this author remains on call to answer questions and assist in emergency assessment, should the need arise.

THE OUTCOME. Key among outcome data is the fact that in nearly two decades of operation, no student screened by a team member died by suicide. The team has been able to reach a significant number of students over the past two decades: 71 per year seen at the elementary level, 50 per year at the middle school level, and 65 per year at the high school level. Of the 186 cases seen by team members each year, approximately 50 are discussed in depth at bi-weekly team meetings. Since the team was created approximately two decades ago, about 2,500 cases have been screened and either returned to class or referred to outside agencies for service and/or treatment.

As the statistics suggest, team members have been able to address the needs of a large number of students in crisis. As an example of the team's responsiveness, following the accidental death by drowning of one middle school student, 17 team members were assembled within one hour to see nearly three dozen students during that one day, who were either referred for appropriate services or sent home with their parents. Meetings with individual students helped quiet the hysteria, while the team helped teachers and the principal manage student reactivity through consultation and drafting a letter to parents. In another instance, team members converged at a middle school following the accidental death of a teacher and immediately screened students, after which some students were provided additional support and referral to counseling, while others were cleared to return to class or to go home with their parents.

The team continues its operations in Bensalem Township, and welcomes the opportunity to discuss its operation and interventions with other districts.

Continued from page 23

ensure online filters are in place and to develop policies regarding cyberbullying. Because case law is only now being written regarding this topic, staying on top of new research will be integral in understanding a school's role, when much cyberbullying occurs off school grounds. Diamanduros et al. (2008) encourage schools to be clear that an anti-cyberbullying policy is being implemented for the protection of students and school staff, cyberbullying behavior is not allowed, and that those who cyberbully will face consequences if the behavior causes a disturbance at school even if the incident occurred outside of school. More information on how educators can effectively intervene can be found at www.stopbullyingnow.hrsa.gov.

School psychologists are in a perfect role to educate parents regarding cyberbullying, including the importance of monitoring their child's online interactions, how to report harassment online, how to spot warning signs that their children are being cyberbullied (Kowalski et al., 2007), and how to set parental controls on home computers and cell phones. Tips for parents on monitoring their child's online behaviors, written by a parent who lost his own son to cyberbullying and suicide, can be found at www.ryanpatrickhalligan.org/cyber_bullying/cyber_bullying.htm.

It is important that we educate our students on how to protect themselves online, where to go for help, how to document bullying behavior, and how to safeguard passwords. Information on what to do for a child who feels bullied online can be found at www.cyberbullyhelp.com.

Finally, it is integral to educate school staff, parents, and students on the warning signs of suicide. Implementing a screening program will further ensure that students are monitored for suicidal behavior. Information on evidence-based programs, such as Columbia University Teen Screen and Signs of Suicide (SOS) can be found online at www2.sprc.org/bpr/section-i-evidence-based-programs. Research on suicide warning signs, risk factors, and how to help can be found at www.afsp.org.

We need to educate our children to stand up and speak up, not to be bystanders—not with cyberbullying and not with suicide. If we can teach our children to use the Internet as a web of support rather than a means of harm, there will be no reason for online behavior to be conducted out of view.

References are available on the PPA website, www.PaPsy.org, or upon request from the author at terbacher@dciu.org

Teens Grieve Peers Who Perished on Tracks

Terri Erbacher, PhD, Delaware County Intermediate Unit

After suffering the tragic loss of two friends a year ago, seven Interboro High School seniors created a "Battle of the Sexes" event as a part of their senior project, to raise money for suicide prevention. These teens lost two 15-year-old girls, who took their lives by jumping in front of a train in February 2010. A third girl had contemplated taking her life with her two friends. In the resulting media frenzy, a private grief became all too public for many of the friends. A year later, as students at Interboro High School still struggled with the loss, these seven students stepped forward to run an event to raise funds for the Delaware County Suicide Prevention Task Force. The fundraiser netted $460 for the cause. As a school psychologist, suicide prevention specialist, and consultant to schools in Delaware County in the aftermath of these crises, I was honored to accept this check on behalf of the task force.

Photograph taken by Eric Hartline/Delaware County Daily Times

Left to right: Matt Francis, Al Murphy, Danielle Owen, Dustin Snell, Leigh Brown, Dr. Terri Erbacher, and Christina Hall. Not pictured: Joe King.

CE Questions for This Issue

The articles selected for one CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, then you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the test at home and return the answer sheet to the PPA office. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before June 30, 2013.

Return the completed form with your CE registration fee (made payable to PPA) for $20 for members ($35 for non members) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1748

Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Baturin & Knapp

1. Under which circumstances can a psychologist reveal information to the family after a client has died by suicide?
   a. if the family sends a notarized letter requesting information and limiting which information is sought
   b. if the client's executor requests information in writing, accompanied by the consent of the patient's medical durable power of attorney
   c. if the client, preceding death, has signed a release of information with full disclosure
   d. if provided to the family through the client's attorney, after the psychologist has been sent written confirmation of the attorney-client relationship
   e. B, C, and D

Weissberg

2. The majority of adults who acknowledge suicidal thoughts and a specific plan for how they will take their own life follow these thoughts and plans with a suicide attempt.
   True
   False

3. Because 90% of adults who commit suicide had a DSM diagnosis, in treating suicidal patients, it is essential that one concentrate on the symptoms associated with their diagnosis.
   True
   False

4. Recent research has supported the claim that a "no-harm contract" is unhelpful in preventing a patient from attempting suicide. A useful substitute is a "Commitment to Treatment" contract.
   True
   False

Lurier

5. The tasks of mourning include which of the following?
   a. acknowledging the reality of what has happened
   b. tolerating the range of feelings that might be present
   c. transforming the relationship
   d. experiencing changes in self-identity
   e. all of the above

6. What image is given to provide a model for understanding the dynamic nature of grief and mourning?
   a. the sign of infinity
   b. lines that move in a stepwise fashion
   c. intersecting circles
   d. intertwining spirals

Palmiter

7. According to research reviewed in the article, most teens who meet criteria for a mental health disorder do not get care.
   True
   False

8. According to research reviewed in the article, 5% of teens have thought about committing suicide in the past year.
   True
   False

Affsprung

9. PPA members who would like to mentor younger professionals should
   a. contact the State Board of Psychology
   b. attend PPA's annual mentoring conference
   c. contact the chair of the Early Career Psychologist Committee
   d. contact the Colleague Assistance Committee

Erbacher

10. Which is not a sign that a teen might be experiencing cyberbullying?
    a. spending long hours on the computer
    b. being visibly upset or angry during or after Internet or cell phone use
    c. always doing homework on the Internet, yet getting behind in schoolwork
    d. begging parents to get a new computer

11. Only 50% of bullying victims report the incidents. All of the following are true, except:
    a. They fear reporting will worsen the bully's behavior.
    b. They are afraid adults won't really be able to help them.
    c. They think it will stop on its own.
    d. They are searching for acceptance online and are less resilient in getting out of difficult situations.

King

12. Bensalem Township developed a mobile crisis response team because:
    a. there were not enough students in one of the schools needing crisis services
    b. there were too many students in one of the schools needing crisis services
    c. team members wanted the flexibility to work in different schools
    d. team members needed to be able to travel to another school to address a more far-reaching crisis (e.g., the death of a student or teacher)

13. The crisis response team's training:
    a. occurs initially, in a one-week training when members join the team
    b. occurs each fall and is ongoing, through bi-weekly meetings, case reviews and workshops
    c. is once each year, at the start of the school year, for two days
    d. is scheduled as needed after an initial training, at the team members' request

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, June 2011

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d	e	**8.**	True	False		
2.	True	False				**9.**	a	b	c	d
3.	True	False				**10.**	a	b	c	d
4.	True	False				**11.**	a	b	c	d
5.	a	b	c	d	e	**12.**	a	b	c	d
6.	a	b	c	d		**13.**	a	b	c	d
7.	True	False								

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

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I verify that I personally completed the above CE test.

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A check or money order for $20 for members of PPA ($35 for non-members of PPA) must accompany this form. Mail to Continuing Education Programs, PPA, 416 Forster Street, Harrisburg, PA 17102-1748.

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The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has reorganized a Behavioral Health Forensic Evaluation Center (BHFEC) located at the Philadelphia Family Court.

Effective April 1, 2011 consulting contract opportunities are available for qualified psychologists and child psychiatrists to perform comprehensive evaluations of children for the benefit of the Court, the children and their families.

Evaluations will be assigned, scheduled and reimbursed based on a Fee Schedule which reflects the complexity of the presenting issues, the credentials of the evaluating professional and acceptance of a completed report. The reimbursements for submitted and approved evaluation reports range from $475 to $1235.

For a review of important information (evaluator requirements and credentials, application process, evaluation guidelines, fee schedule, etc.) which will assist you in determining a decision to apply for an evaluator consultant contract, go to www.pmhcc.org, click on “Join Our Team,” then “Consulting Opportunities,” then “Behavioral Health Forensic Evaluation Center.”

We value your interest and look forward to enlisting your services for our children in need!

BHFEC, Philadelphia DBHIDS

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CALL FOR PRESENTATIONS

E-mail deadline for proposals: JULY 10, 2011

Fall 2011 Continuing Education and Ethics Conference

November 3 – 4, 2011
Exton, Pennsylvania

To obtain a copy of the Call for Presentations form, visit http://www.PaPsy.org/ce/call-for-presentations.html.

2011/12 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

June 15 – 18, 2011
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

November 3 – 4, 2011
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

March 1 – 2, 2012
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

also available at www.PaPsy.org – HOME STUDY CE COURSES

*Ethical Practice Is Multicultural Practice** – NEW!
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*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
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**This program qualifies for three contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.*

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.