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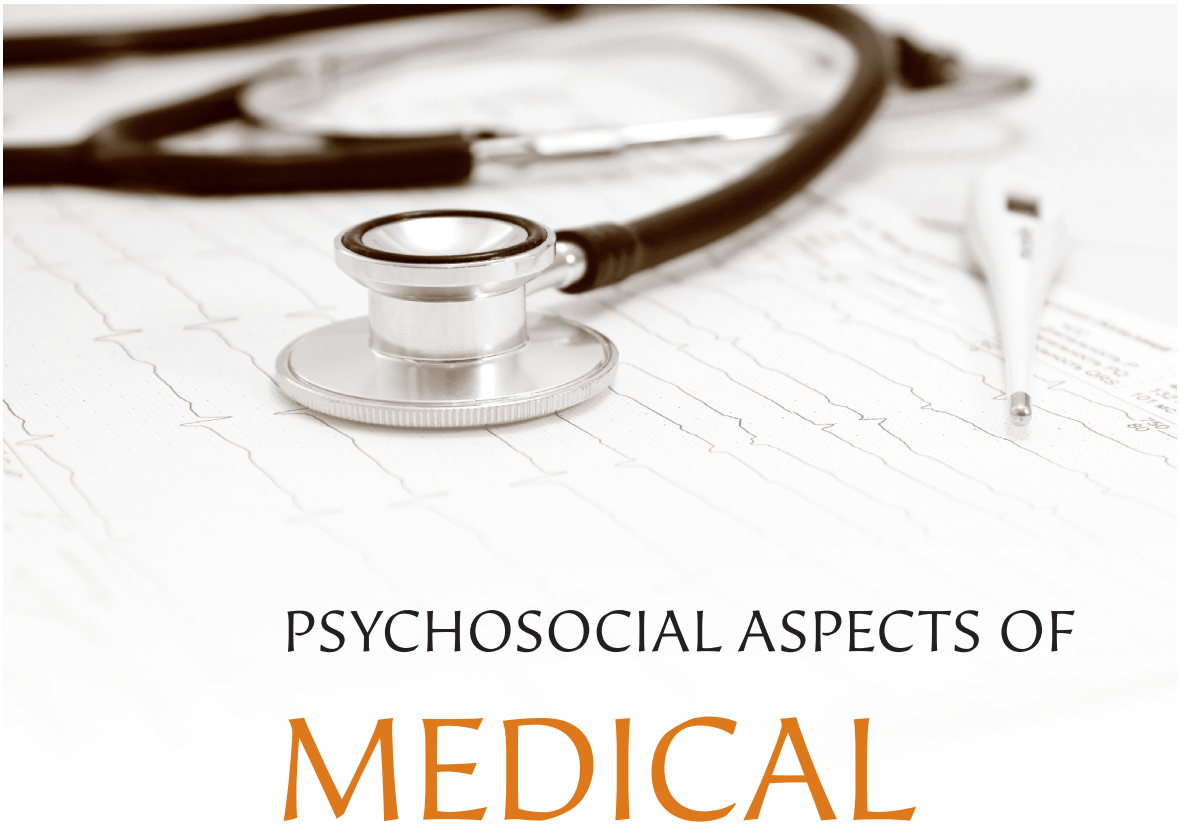

PSYCHOSOCIAL ASPECTS OF MEDICAL CONDITIONS

IMPACTS AND INTERVENTIONS

ALSO INSIDE: Positive multiculturalism • Legal column: Parental consent and treatment of minors • New psychotherapy CPT codes • Identification of specific learning disabilities

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Psychologist

Editor: Kathryn L. Vennie, MS

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SPECIAL SECTION — PSYCHOSOCIAL ASPECTS OF MEDICAL CONDITIONS: IMPACTS AND INTERVENTIONS

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SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Positive Multiculturalism

David J. Palmiter, Jr., PhD, ABPP

Dr. David J. Palmiter

In my last column I proposed this definition of "positive multiculturalism" (Palmiter, 2012, pp. 8-9):

> To explore and understand our cultural differences and to learn how an understanding of such can enrich our professional missions. This process endorses the concept that all humans are impacted by cultural differences in a manner that traverses a wide continuum of reaction, some of which are conscious and some of which are unconscious, some of which are adaptive and some of which are not. In considering these issues positive multiculturalism eschews the promotion of shame and embraces the promotion of enrichment.

In this column I'd like to summarize why I asked the Committee on Multiculturalism to form a Subcommittee on Positive Multiculturalism, focusing on one component of multiculturalism: race. As someone who works regularly with youth, I note two relevant trends in the literature:

- There is a consistent trend for under-treatment of minority youth, even when controlling for financial resources of the family (e.g., Zewalanji, Evans, & Barbour, 2005; Burns, Phillips, Wager, Barth, Kolko, Campbell, & Landsverk, 2004; Leslie, Weckerly, Landsverk, Hough, Hurlburt, & Wood, 2003; Kataoka, Zhang, & Wells, 2002; Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995).
- Minority youth are treated differently from Caucasian youth when interacting both with traditional mental health systems (e.g., Zito, Safer, dosReis, & Riddle, 1998; Kilgus, Pumariega, & Cuffe, 1995) and systems serving youth at-large (e.g, Zewalanji, Evans, & Barbour, 2005).

Similar trends exist among adult minority populations as well (e.g., Fortuna, Margarita, Alegria, & Gao, 2010). Indeed, the October 2012 edition of the *American Psychologist* has a special section on "Ethnic Disparities in Mental Health Care." I don't believe this occurs because the mental health community is racist or evil. While I can't argue why it does happen, I believe a major contributing factor is the way we discuss, or don't discuss, race. I have five related vignettes from my own journey.

#❶ My wife of 22 years, Lia, is African-American and I'm an Irish guy. Early in our marriage we entered a church in the southern suburbs in Chicago (this was during a time when *National Geographic* could create a map of neighborhoods in Chicago based on ethnicity). Lia was the only person of color there. I remember a palpable and strong feeling of being unwelcome. I had never had this feeling before in my life and I certainly wasn't expecting to feel it then. If someone had challenged, "well, what did anyone say or do to make you feel unwelcome?" I would have had to do a "hummida, hummida, hummida," as I couldn't say. (It harkened me back to many of the diversity trainings I had had through the years when I thought the presenter, usually a person of color, was overreacting to a concern under review.)

❷ I previously worked at a large outpatient medical facility in northwestern Indiana. The clientele and the clinical team were diverse. On the day that the OJ verdict was due to be delivered clinicians were gathered in the physicians' lunchroom. This was the only time that the African-American and Caucasian clinicians were segregated by those designations. When the verdict came in the African-American clinicians were bombastically jubilant while the Caucasian clinicians were somberly silent. Though this phenomenon was nearly as in our faces as the verdict itself, no one talked about it.

❸ A few years ago I needed to get rehab for an injury. As Lia had been to that same facility months earlier, she asked me to remember her to some of the clinicians there. The clinician who did my intake remembered Lia and was joyful in recounting their interactions. This clinician then called over a colleague and cheerfully said "This is Lia's husband!" The second clinician didn't know whom she was talking about. So, the first clinician started rattling off a bunch of Lia's characteristics (but not her race), which wasn't helping the second clinician. I thought to myself "say she's Black. Y'all don't get a lot of Black folks in here and that'd do it." I speculated that the clinician who remembered Lia was worried that bringing up race could somehow make her look racist. So, finally, I, with a neutral tone, said "Lia is Black." Which had two immediate effects: the second clinician remembered who she is and both clinicians became visibly uncomfortable.

We seem slow to acknowledge how others' differences (e.g., skin color, sex, sexual orientation, religion) impact us.

❹ At a diversity training event I attended a few years ago only a few attendees actively engaged dialogue with the presenter, even though the presenter was striving for an interactive training. Afterwards I was discussing this with a colleague. This psychologist is a gentle soul who doesn't have a discernable aggressive or rude bone in her body. But she said, "I was afraid to speak some of my doubts out loud about the material out of fear that I'd unknowingly commit a microaggression."

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Your Dues Money At Work

Thomas H. DeWall, CAE

Thomas H. DeWall

An important aspect of PPA's strategic plan is advocating for public access to psychological services. To achieve this strategic initiative we maintain an active presence in the state Capitol and a vibrant grassroots network. Many of the issues on which we have been active in the last year have required us to defend against limitations on or interference with the practice of psychology.

One such issue was House Bill 1570, which became a matter of immediate concern in October. This bill would have updated several aspects of the Health Care Facilities Act, which hasn't been updated for 20 years. Though our staff thought the bill was dead in June when the General Assembly recessed for the summer, the Medical Society kept pushing on it. Our concern was over one provision of it, which was an attempt to write in statute what is now only in regulations – that only physicians, dentists, and podiatrists may be members of general hospital medical staffs. It would actually have removed the authority of the Secretary of Health to grant an exception to appoint other professionals such as psychologists, as he did in the case of Geisinger Medical Center years ago. Rep. Bryan Cutler (R-Lancaster) had an amendment that would preserve that authority, but only if the Department of Health found an "unreasonable hardship." That term is not defined. Rep. Pam DeLissio (D-Phila.) had prepared an amendment that would eliminate the language about medical staff membership. The state House was planning to bring it up for consideration and a vote, but we helped make it too controversial to deal with in the limited time they had left. PPA acted in a coalition with the Pharmacists Association and several nurses' associations. Our message was to support the DeLissio amendment or to kill the whole bill. The leadership decided to table it, so it is dead for this session. We will be watching for this issue to be resurrected in 2013.

There were other issues on which PPA had to play "defense." One was House Bill 1776, sponsored by Rep. Jim Cox (R-Berks). This bill's goal was to eliminate property taxes and substitute other taxes in their place, such as broadening the sales tax. Unfortunately, it appeared that, although it exempted "medical care," other types of health care, including psychological services, may have been subject to the tax. A wide range of organizations including PPA communicated their opposition to this policy, and the bill was shelved. In its place the House of Representatives established a Select Committee on Property Tax to look for other solutions.

Another issue requiring defense was a proposal to make changes to the Workers Compensation system that could have had a negative effect on injured workers. House Bill 808, sponsored by Rep. Gordon Denlinger (R-Lancaster) would have, among other provisions, extended the period of time from 90 days to 180 days in which an injured worker could be seen only by the employer's medical panel. In a letter to legislators PPA pointed out that methods of pain control become harder to implement after too long a period. The 90-day time frame had already been increased from 30 days in the 1990s and was the result of a compromise at that time. HB 808 was subsequently dropped but is expected to be back in some form in 2013.

We had high hopes for a bill authorizing psychologists to make insanity determinations in criminal cases. This bill, House Bill 1405, introduced by Rep. Glen R. Grell (R-Cumberland), was reported out of the state Senate Judiciary Committee on October 2. It had already been passed by the House in March. However, the Senate ran out of time to consider it before they adjourned for the election recess. Thus it appears that we will have to get it reintroduced in 2013. HB 1405 is a bipartisan bill that would clear up the ambiguity that currently exists whereby courts are permitted to appoint psychologists to do some insanity evaluations under the Rules of the Supreme Court, but are not permitted to appoint psychologists to do such evaluations when they also need a determination of competency to stand trial. HB 1405 would resolve this problem and allow the courts to appoint psychologists as evaluators of insanity. Currently only physicians are allowed to make those recommendations to judges, but the association representing psychiatrists did not oppose the bill.

Many of the issues on which we have been active in the last year have required us to defend against limitations on or interference with the practice of psychology.

An issue that took up a great deal of staff time and effort this fall was a set of proposed regulations from the State Board of Psychology intended to update the Ethics Code for psychologists. Upon feedback from PPA, the State Board of Psychology decided to withdraw the regulations for further review.

In the wake of the Penn State child abuse scandal the Pennsylvania General Assembly appointed a Task Force on Child Protection and charged it with studying all aspects of child protective services, including the role of mandated reporters of abuse. Dr. Sam Knapp did a thorough review of the issue and prepared testimony for the task force. Although a common first reaction among legislators was to increase the penalties for failure to report suspected child sex abuse, Dr. Knapp found that other aspects of child abuse were more problematical. They included a major decline in recent years in substantiated reports of child abuse, and an especially low number of children who are being identified as victims of neglect, emotional abuse,

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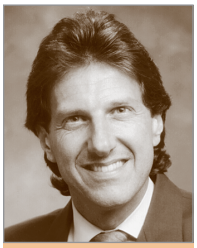
Questions and Answers About Parental Consent and Treatment of Minors

Samuel Knapp, EdD, Director of Professional Affairs
Rachael L. Baturin, MPH, JD, Professional Affairs Associate
Allan M. Tepper, JD, PsyD, Legal Consultation Plan


Dr. Samuel Knapp


Rachael L. Baturin


Dr. Allan M. Tepper

Q Are the rules governing the consent to treatment of minor children uniform?

A No. The rules regarding the age of consent for treatment of minors in Pennsylvania vary according to the nature of the service provided or the profession of the provider. The age of majority in Pennsylvania is 18. Nonetheless, any minor 14 years or older can consent to voluntary outpatient mental health treatment without the consent of the parent, and any minor, regardless of age, can consent to treatment for substance abuse. In addition, psychologists are required to follow Pennsylvania State Board of Psychology decisions which have been interpreted to require the consent of all legal custodians in shared legal custody cases in which the minor is less than 14 years of age.

Q When the parents of a minor less than 14 years of age are seeking treatment, do psychologists need the consent of both parents to treat the minor?

A If there is no court order granting shared legal custody, it is assumed that either parent may consent to the treatment of the less-than-14-year-old minor. Although this interpretation is not codified in the Pennsylvania Minors Consent to Treatment statute, it generally is assumed that if "a" parent can consent to the treatment of the 14-year-or-older minor pursuant to the Minors Treatment statute, then "a" parent also can consent to the treatment of the less-than-14-year-old minor. If the parents are unmarried, there is a similar assumption that either parent can consent to treatment of the less-than-14-year-old minor.

Q When the parents of a minor less than 14 years old are seeking treatment for the minor, and there is a court order or custody agreement granting shared legal custody, do psychologists need the consent of both parents to treat the minor?

A When there is a court order granting shared legal custody, the Pennsylvania State Board of Psychology has ruled that the consent of all of the legal custodians is necessary prior to evaluating the minor, irrespective of the age of the minor. The State Board of Psychology has not ruled specifically upon the issue of whether psychologists need the consent of all of the legal custodians prior to conducting treatment of a minor in a shared legal custody situation. It has been the experience of the third author, however, that the generally accepted interpretation of existing Board decisions indicates that if there is a court order granting shared legal custody, such shared consent is necessary prior to initiating treatment, at least in cases involving the less-than-14-year-old minor.

Pursuant to the Minors Treatment statute, the 14-year-or-older minor can consent to treatment, even without the consent of a parent. This provision of the statute suggests that in such situations, treatment can be initiated, irrespective of a shared custody order.

In this regard, if a psychologist chooses to treat the greater-than-14-year-old minor in a shared custody situation pursuant to the Minors Treatment statute, caution must be exercised to ensure, in the written record, that such treatment is being conducted with the specific informed consent of the greater-than-14-year-old minor, not merely the consent of one of the legal custodians.

It should be noted that although such treatment may be allowed under the Minors Treatment statute, it is not mandated by the statute. In light of the clinical and legal issues surrounding such cases, therefore, the psychologist should consider obtaining the consent of all of the legal custodians prior to initiating treatment in any shared legal custody situation.

Table 1

Age of minor	Court order of shared legal custody	Can minor consent?	Can "a" parent consent to treatment of the minor?
less than 14	Yes	No	Unclear, but highly unlikely
less than 14	No	No	Yes
14 or older	Yes	Yes (allowed, but not mandated)	Unclear, but highly unlikely
14 or older	No	Yes	Yes

Q How and when should psychologists determine the marital status of the parents and the legal custody of the minor being presented for treatment?

A It is prudent to inquire about the marital status of the parents and the legal custody of the minor prior to scheduling an appointment with the minor. If the parents are unmarried, and there is no custody order in effect, the Minors Consent to Treatment statute allows treatment to be initiated with "a" parent. If the parents are married, the Minors Consent to Treatment statute allows treatment of the greater-than-14-year old minor, and, presumably the less-than-14-year-old minor, to be initiated with the consent of "a" parent. If the parents are separated, and there is no custody order in effect, the Minors Treatment statute allows, *but does not mandate*, the consent of "a" parent to initiate treatment. In this regard, in situations where the parents are separated, the psychologist should consider obtaining the consent of both parents prior to initiating treatment with the minor. In addition, it is important to note that the Board's record-keeping regulation requires notation of legal custodial arrangements if a minor's parents are separated. (A decision tree for those making decisions about consent for minors can be found on the PPA website, www.PaPsy.org, members-only section; the user name is your member number, which can be found on the mailing label of your *Pennsylvania Psychologist*; your password is your last name with the first letter capitalized).

Q Should psychologists document informed consent?

A Pursuant to the APA Ethics Code Standard 3.10(d), psychologists must document informed consent. The Board's record-keeping regulation requires psychologists to document the names of the parents or the name of the legal guardian if the client/patient is a minor. If a minor's parents are separated, the record-keeping regulation requires notation of legal custodial arrangements. Although a written informed consent form can be utilized, and generally constitutes a good record-keeping practice, oral consent to treatment fulfills the Board's informed consent requirement, as long as such oral consent is documented fully in the written record.

Q How should psychologists respond if the presenting parent reports that the parents are divorced, there is no shared legal custody, and the other parent cannot be located?

A In such situations, the psychologist should make a good faith attempt, prior to initiating treatment, to determine the legal custody of the minor. In some situations, the non-presenting parent just cannot be located. In other situations, however, there may be a telephone number or a mailing address. In those cases, a telephone call, followed by a letter forwarded to the last known address, can be viewed as a good faith attempt to contact the non-presenting parent to clarify the legal custody situation. It is recommended that these efforts to contact the non-presenting parent be documented fully in the written record. If, following these good faith efforts, there is no response from the non-presenting parent, the psychologist could initiate treatment with the consent of "a" parent pursuant to the Minors Treatment statute. It should be noted, however, that if it later is determined that there is shared legal custody, treatment would need to be suspended pending consent of all of the legal custodians.

Q Should psychologists get a copy of the custody order prior to the initiation of treatment?

A There is no legal requirement to obtain a copy of the custody order prior to initiating treatment with a minor. Nonetheless, if one parent claims that he or she has "custody" and that the consent of the other parent is unnecessary, it would be prudent to review a copy of the custody order prior to initiating treatment. Many good parents do not understand the distinction between legal and physical custody, especially for the parent who is responsible for negotiating most of the minor's everyday and logistical needs. Given past Board decisions, however, it is clear that the ultimate responsibility for determining the legal custody of the minor rests with the psychologist.

Nominations Needed for Four Awards

Several PPA committees are still seeking nominees for awards for 2013. For each nomination you would like to make for the categories below, please prepare a one-page narrative describing the person's contributions and his/her vitae. Mail the information to the PPA office or e-mail mevans@PaPsy.org .

Psychology in the Media Award: Members of the Pennsylvania Psychological Association and members of the media in Pennsylvania who have presented psychology and psychological issues to the public are encouraged to apply for the 2013 Psychology in the Media Award. Applicants who have received this award in the past are not eligible. Deadline for entries is **December 31, 2012**.

Award for Distinguished Contributions to School Psychology: The School Psychology Board nominates a candidate annually for this award. Criteria for nomination include contributions in the areas of research, public service, assessment, media, or advocacy on behalf of children. Deadline for entries is **December 31, 2012**.

Early Career Psychologist of the Year Award to be given to a Pennsylvania early career psychologist (ECP) who, in his or her practice is making a significant contribution to the practice of psychology in Pennsylvania. Deadline for entries is **January 31, 2013**.

Student Multiculturalism Award to be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology-related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. Deadline for entries is **January 31, 2013**.

Criteria and applications for these awards are available on the PPA website, www.PaPsy.org.

Nominations Needed for Governance Positions

PPA is looking for nominations for the Board of Directors for the 2013 elections. The following positions will be on the ballot: president (a 3-year commitment – as president-elect, president, and past president), treasurer, and the chairs of the Communications Board, Internal Affairs Board, and School Psychology Board. These are 2-year commitments (except the president) and people can serve for two consecutive terms.

To learn more about each position, visit the PPA website at http://www.PaPsy.org/index.php/governance/. This is in the members-only section, so you will need your member number (found on this issue's mailing label) for the username and your last name for the password. Click the tab "Nominations & Elections." Then please nominate yourself or a colleague using the form on that page. Nominations are due to the PPA office by January 14, 2013.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of November 1, 2012

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 10	Constitutional amendment prohibiting implementation of federal health care mandate - Sen. Joseph B. Scarnati III (R-Jefferson)	Against	Passed, 3/28/12, 29-19	Passed by State Government Committee; tabled 6/23/12
HB 42	Prohibits Pennsylvania from implementing the federal health care mandate - Rep. Matthew E. Baker (R-Tioga)	Against	None	Passed by two committees, tabled 10/26/11
HB 300	Prohibits discrimination based on sexual orientation in housing, employment, and public accommodations - Rep. Dan Frankel (D-Allegheny)	For	None	In State Government Committee
HB 646	Authorizes licensing boards to expunge certain disciplinary records after four years - Rep. Kate Harper (R-Montgomery)	For	In Professional Licensure Committee	Passed 6/18/12, 197-0
HB 808	Changes Workers Compensation system, requires in-house medical panel for 180 days - Rep. David S. Hickernell (R-Lancaster)	Against	None	Passed by Labor & Industry Committee 2/24/11; tabled 6/8/11
HB 1405	Authorizes psychologists to testify in court on the determination of insanity and competency to stand trial - Rep. Glen R. Grell (R-Cumberland)	For	Passed by Judiciary Committee 10/2/12; tabled 10/16/12	Passed 3/12/12, 193-0
HB 1570	Restricts hospital medical staff to physicians, dentists, and podiatrists - former Rep. Reichley; now Rep. Bryan Cutler (R-Lancaster)	Against	None	Passed by two committees; tabled 9/24/12
HB 1776 SB 1400	Eliminates property taxes by raising other taxes, possibly including sales tax on psychologists' services - Rep. Jim Cox - Sen. David G. Argall (R-Schuylkill)	Against	In Finance Committee	In Appropriations 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

5 For years I asked graduate students and workshop attendees to do a simple exercise. I asked them to take out a piece of paper and number it from one to six. I told them that I would name a variety of demographic characteristics and then have them write a "yes" if they would alter their clinical methods based upon that characteristic and a "no" if they would not. I then called out characteristics like this: (1) race, (2) sex, (3) sexual orientation, (4) age, (5) psychological mindedness, and (6) psychiatric condition. I found that about ≥40% would say that they would not alter a case approach based on the first three while ≥ 80% would on the final three. My speculation is that folks feared that if they said they altered how they approached clinical work based on the first three that they could be deemed as suffering from an "ism."

I offer that all of the above are facilitated by the difficulty we have thinking and talking about diversity. As I wrote in my last column, we seem slow to acknowledge how others' differences (e.g., skin color, sex, sexual orientation, religion) impact us. We fear that this human condition (i.e., to be impacted by differences) could make us, or could be used to label us, as racist, sexist, ageist, homophobic, etc. The harmful ripples from this paralysis in open discussion are many (e.g., the sorts of unfortunate outcomes I reviewed at the top of this article).

I would propose three immediate action steps. First, take Harvard University's Implicit Test which is located at implicit.harvard.edu. This is one resource to help us to consider our humanity as we interact with people who are different from us. Second, I would propose considering whether there could be value in asking clients who are different from us, or who have some salient minority status in their community, two questions. First, "(client's name), I'm (salient characteristic), you're (salient characteristic). How does that affect you?" Second, "you're (salient minority characteristic), living in (location). What's that like for you?" These questions communicate at least two things: we get how important these matters can be and it's not dangerous to be able to talk about them. Third, when we come together to share our perspectives on our differences, let's assume that all of us are good hearted, well-intended people who only want to discover how each other's differences may enrich us. So, let's be slow to use words like "racist," "sexist," and "microaggression," just like the positive ethics people ask us to be slow to use words like "unethical." Such a kind and respectful approach can't be the wrong thing to do. Right?

Please also stay tuned to the work generated by the aforementioned subcommittee. I think it is going to be exciting.

References

References are available from the author at Palmiter@maryu.maywood.edu or on the PPA website, www.PaPsy.org.

In Memoriam

Dr. Norman Weissberg of Bucks County died suddenly on September 11. He had been chair of the Psychology Department and dean of undergraduate studies at Brooklyn College, CUNY. He was on the faculty at Brooklyn College from 1964 to 2000 and since then had the title of professor emeritus. He earned his PhD degree from the University of Michigan in 1968. He was an expert in, among other things, working with adult suicidal patients, and authored an extensive article on that subject for the June 2011 *Pennsylvania Psychologist*. He had been a member of PPA since 2007.

EXECUTIVE DIRECTOR'S REPORT

Continued from page 3

and non-accidental injury. A report and article on his findings will be forthcoming in the near future.

Since the passage of Act 62 in 2008 requiring insurance coverage for people with autism spectrum disorders, PPA has been communicating with state officials about some uncertainties and ambiguities concerning its interpretation.

In a similar vein on a separate issue, PPA staff and volunteer leaders have been advocating for the inclusion of psychologists to be appointed by the court as parenting coordinators for divorcing couples. A committee of the Supreme Court has recommended a rule that reserves that role to attorneys, and our advocacy efforts have promoted a policy allowing the appointment of psychologists as well. This issue is not yet settled.

PPA leaders met with the State Board of Psychology to discuss proposed amendments to the Professional Psychologists Practice Act. Several of the changes are noncontroversial administrative provisions, but some of the substantive amendments would (1) provide an option for candidates for licensure to earn the required two years of supervised experience pre-doctoral instead of requiring that one year of supervision has to be post-doctoral, (2) better define "psychological testing," (3) add *diagnosis* to the definition of the practice of psychology, (4) remove the clauses in the licensing law that exempt unlicensed persons in state agencies to use the word "psychology" in their work titles, and (5) phase out the exemption for certified school psychologists practicing privately while grandfathering current school psychologists and students enrolled in school psychology graduate programs. This last provision was just approved as policy by the PPA Board of Directors in September. A bill with the above principles is expected to be introduced in the state Senate in 2013.

On top of all of the above issues PPA responded forcefully on federal issues such as Medicare reimbursement rates, including psychologists in the definition of "physician" within Medicare, and making psychologists eligible for incentive payments for adopting electronic health records. The response of PPA members on most of the federal legislative alerts far outpaced all other state associations.

PennPsyPAC Contributes to PPA's Successes

Thomas H. DeWall, CAE
Samuel Knapp, EdD, ABPP

Political action committees (PACs) are considered one of the three legs of effective governmental advocacy, along with grassroots lobbying and professional governmental affairs representatives (lobbyists). An essential goal of PPA's long-term advocacy program is to ensure that psychologists will be able to practice to the full extent of their licenses. In addition we have been continually vigilant and active in stopping bills that would harm the practice of psychology.

For example, we were successful in 2011 with passage of the Safety in Youth Sports Act, which authorizes psychologists to make return-to-play decisions for student athletes suffering concussions, passage of a bill in 2010 promoting the use of mental health courts, and numerous earlier laws benefiting psychologists and their patients. We have also been successful recently in helping to defeat legislation that would have impinged on or curtailed psychological practice. However, we can always do better, and in fact will need to in order to mount successful efforts on issues such as full mental health coverage under state implementation of the Affordable Care Act.

An analysis of 2011 fundraising and expenditures by political action committees (PACs) affiliated with health care associations in Pennsylvania showed that PennPsyPAC was in the middle of the pack, although some other health care professional associations' PACs outraised PennPsyPAC by significant amounts.

PennPsyPAC raised approximately $48,000 in that year while PAMPAC raised about $186,000. The PACs for optometrists reported about $90,000, dentists $67,000, and ophthalmologists $66,000. The pharmacists' PAC was just ahead of PennPsyPAC at about $50,000, while the physical therapists came in at just $25,000. Several others raised much smaller amounts, including the PACs for chiropractors, nurse anesthetists, psychiatrists, and nurses. (*See Table 1.*)

During 2011 PennPsyPAC raised funds almost exclusively for state legislative races, but also for one judicial race. Others also focused on legislative elections but may have spent money on other races. PAC contributions help get supportive candidates elected or re-elected. They can play a significant role in pursuing an organization's public policy agenda.

On many legislative issues, including mental health parity and funding of the public mental health system, associations such as the Psychiatric Society work in concert with us. On others where they oppose us they will usually call in "reinforcements" from the Medical Society, which has much greater resources. Thus the PAC money they have at their disposal is significant. As an association we are doing well considering that psychologists are vastly outnumbered in Pennsylvania by physicians, dentists, pharmacists, and others.

We are indebted to PPA staffer Katie Boyer for doing the research on the Pennsylvania Department of State's website to compile all of these figures. We will update this analysis with data for 2012 in the spring of 2013.

Table 1
Amounts Raised and Spent in 2011

Name of Association	Name or Acronym of PAC	Raised	Spent
PA Medical Society	PA Medical PAC (PAMPAC)	$185,729	$172,678
PA Optometric Association	PA Optometric PAC	$89,712	$72,527
PA Dental Association	PA Dental PAC (PADPAC)	$67,022	$68,914
PA Ophthalmology Association	PA Ophthalmology PAC	$66,103	$72,430
PA Pharmacists Association	PA Pharmacy PAC (PHARMPAC)	$49,928	$21,049
PA Psychological Association	**PennPsyPAC**	**$48,436**	**$51,486**
PA Physical Therapy Association	PA Physical Therapy Pos. Action Cmte.	$25,119	$28,048
PA Assn. of Nurse Anesthetists	PA Assn. of Nurse Anesthetists PAC	$7,375	$3,609
Chiropractic Fellowship of PA	Chiropractic Fellowship PAC	$3,850	$2,750
PA Psychiatric Society	Psychiatric Physicians of PA PAC	$2,577	$1,938
PA State Nurses Association	PSNA PAC	$2,570	$1,479

The Basics of Working With Chronically or Acutely Ill Clients

Terry Wolinsky McDonald, PhD

Dr. Terry Wolinsky McDonald

Although I have written regular quarterly newsletter articles for patients for many years, I have only written four articles specifically targeted for psychologists. The first, and most important, fact to know is that if you are uncomfortable with or around illnesses, your client will know, so if you are not comfortable do not see physically ill people in your practice. Refer them to someone else. It is not in anyone's best interest. If a client has an illness about which you are not familiar, ask them to share information and possible websites. Then, make sure to do your homework. Your interest in their illness will help solidify the therapeutic relationship if they perceive you as someone who sees them as a "whole" person. If we, as psychologists, cannot bond with our clients as human beings, the therapy will be compromised. It is important to recognize this at the outset.

Mortality issues are at the very core of the human condition; fear of death and dying/ not having a "normal" life (whatever that means) surface and affect the ill client's or caregiver's long-held belief system. As per Piaget, people develop "schemata," and these determine how people perceive events. It is far easier to alter something new to fit an existing schema than to change the actual schema. Changing no longer helpful schemata will be part of the therapeutic work. Be prepared for the long haul, since usually this is a relatively slow process, and do not try to rush it. Clients vary greatly in terms of their time lines, and it is important to pace their therapy based on their terms. Be particularly careful not to have preconceived notions about how the therapy (presenting problem) time line is for you. The client may be in total or partial denial or able to accept their condition only on an intellectual (vs. feelings) level. Follow their lead as you work with them; pushing too hard will often be counterproductive. To a very large extent, these clients must go through the "grieving" process. It is not the same for everyone, as you know. Be sensitive to your client's individual needs; all chronically or acutely ill patients will not follow one particular protocol.

If your client was referred by her physician, she may be manifesting her depression/anxiety as anger, isolation, feeling misunderstood, agitation, irritation, sleep and/or appetite changes, feelings of hopelessness or helplessness, and even despair. Her behavior may have changed dramatically, or in more subtle ways, but she will never be the same again – even if "cured." It is important for patients to feel validated, and this is important for you, the psychologist, to do. If you were diagnosed with a serious chronic and/or potentially fatal illness, wouldn't these be natural feelings? This is part of connecting with your client on the human level. They appreciate being viewed as human beings with an illness as opposed to "walking diseases."

As psychologists we often try, unsuccessfully much of the time, to coordinate care with the client's physicians. When there is a serious medical condition, coordination of care is not optional unless the client has refused it. This is actually quite rare. As the psychologist you will likely have more of an opportunity to monitor the person than their physicians do. These clients are even more likely to share noncompliance issues with you, if there is the necessary trust. The last thing they want is more pills or diagnostic tests. Don't push, but express your sincere concern. If you are not sincerely concerned, you need to refer this person to someone else who will be. It can be a fine line, not being overly concerned and being positively objective.

One of the most frustrating things for a person with an illness that may not improve or has no cure, is when others greet them saying they must be feeling better since they look better. It can, and often does, make the ill person feel even more misunderstood. There is a general notion that sick people usually or always look sick; this is not always the case, and being on the receiving end of these comments can be extremely difficult. Often I will explain to clients that "Hi, how are you?" is just a greeting. Most people are not really interested in the details of how the other person is really feeling. One interesting experiment the client can do as homework is to answer that greeting with an answer like "absolutely" and keep on going. Most people are not really listening for an answer and will say something like "great!" or just continue to move on. Seriously and chronically ill patients frequently have a need to tell others how they are feeling when others are not interested. This is part of what makes these clients so vulnerable and misunderstood. Again, they do need to be validated. For many of the illnesses there are websites. I often tell these clients to carry around cards or papers with the website. If someone asks about their illness, the person can hand them the website and tell them to look it up if interested. The truly interested (maybe 1 in 10-20, from my experience) will look it up. This keeps things in perspective. It also allows clients to not use whatever limited energy they have in negative ways.

As the psychologist you will likely have more of an opportunity to monitor the person than their physicians do.

It is also important to recognize, at the outset, if your client is more (or less) resilient, whether or not he feels any control, and, as time moves on, if old problems or traumas that he thought had long ago been put to rest have resurfaced.

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It Only Hurts When I Breathe

Louis D. Poloni, PhD

Dr. Louis D. Poloni

Chronic pain is a term that can conjure up many different images. However, for the purposes of this article specific focus will be given to the psychological factors involved in treating patients with chronic benign pain conditions of a musculoskeletal nature.

Pain is an experience we can all relate to for various reasons at different points throughout our lifetime. Acute pain is what we experience when the onset of discomfort occurs and is typically associated with physical trauma such as a sprained ankle, a burn, or a fractured bone. However, in some instances discomfort does not subside despite treatment and a normative healing period of three to six months. The result is lingering pain for many more months or even years that is not easily obliterated.

When pain begins we readily assume that hurt is synonymous with harm to the body. However, with chronic benign pain this association is no longer accurate. A good distinction is comparing acute pain to the sound of a car horn. It serves a functional purpose to warn us of potential harm. In contrast, chronic benign pain is much like a stuck car horn. It's annoying and it won't go away. However, it no longer serves to accurately communicate impending danger.

Acute pain interventions typically include such things as rest, immobilization, and inactivity. Most of us have heard the recommendation, "If it hurts don't do it." However, when pain persists beyond its acute phase, inactivity can quickly become part of the problem rather than part of the solution. Prolonged inactivity has been demonstrated to inhibit the proliferation of beta endorphins which are more commonly known as the body's natural "morphine" (Wells & Lessard, 1989). Our goal should be to develop a more functional approach for patients who might otherwise adapt by doing less.

Fortunately, most individuals do endeavor to "carry on" with varying degrees of functioning in spite of chronic pain. However, for those who don't, the consequences can become emotionally devastating. Doing less to help minimize pain can rob patients insidiously of the meaning and joy that activities can provide. A sense of helplessness is often expressed by patients who report, "I hurt if I do it and I hurt if I don't do it." Consequently, it is essential to assess this patient population for depression as a result of their chronic pain.

Anxiety has also been well documented as an influence in adversely affecting pain tolerance. In some populations it is even more prevalent than depression (McWilliams et al., 2004). Patients who are showing increasing levels of anxiety may fear that their pain must come from "something worse." For others, experiencing any exacerbation of discomfort can lead them to fear that they have somehow caused more damage and harm to their body.

Establishing rapport

When patients are referred to a psychologist for pain management intervention physicians have typically exhausted their options to relieve the chronic pain. Many patients are told to "learn to live with it" so when a patient follows through with a referral they may present with a set of assumptions that need to be addressed if rapport is to be established.

Patients frequently come to treatment with some measure of guardedness if not suspicion. The patient may believe that the clinician will think the pain is "all in my head" and they expect the psychologist to confirm their worst nightmare. Consequently, establishing rapport is essential to credibility. For the psychologist, acknowledging the patient's frustrations and belief that the pain is real goes a long way in developing a therapeutic relationship. Valuable treatment time is lost by the naïve clinician who wants to determine if the pain is real or if it is as severe as the patient reports.

Biopsychosocial factors

Correlations between self report of pain experience and abnormalities demonstrated on diagnostic tests have historically not been very impressive. Often, this led to erroneous conclusions that a patient's pain complaints were not legitimate. However, these disparities gave way to eventual formulation of a biopsychosocial model of pain that conceptually aids us in understanding the complex interactions between specific physical and psychological events (Turk and Flor, 1984).

As a result, research has grown in recent years exploring an array of variables that mediate individual differences in pain tolerance including, but not limited to, age, coping style, gender, ethnicity, mood, personality traits, and even sleep patterns. Moreover, Porter et al. (2007) reviewed studies providing preliminary evidence suggesting that even anxious attachments in childhood may be associated with maladaptive appraisals of and/or reactions to pain that could predispose individuals to develop persistent pain conditions. As you can see, one size does not fit all.

Interventions

Efforts to control and eliminate chronic pain can be as elusive as trying to nail pudding to a wall. However, we can be productive in aiding our patients in learning strategies to ameliorate discomfort, to cope more adaptively, and to function better despite chronic pain.

Instruction in diaphragmatic breathing, visual imagery, mindfulness meditation, self hypnosis, and a variety of other relaxation-based techniques can help alter pain perception as well as physiological response, i.e. decrease stress arousal, and reduce muscular tension.

Teaching pacing skills is often an essential component to a treatment regimen to help patients from becoming their own worst enemy. Specifically, these patients are often at risk for overextending themselves physically with activity when pain lessens for any reason. As a result, they tend to utilize the presence or absence of pain incorrectly as a primary or sole determinant for functioning,

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The Psychological Aspects of Physical Illness

Hilda K. Schorr-Ribera, PhD, ABMPP

Dr. Hilda K. Schorr-Ribera

I have been in private practice since 1993. My strong interest and specialty have always been the relationship between psychology and physical illness. I have viewed this area as being complex and challenging.

My patients range in age from children of the age of 2 to adults in their 90s. My patients have been struggling with psychological reactions to physical symptoms that may have been occurring long before the actual diagnosis of the illness. The diagnosis itself can also bring psychological reactions. The surgery and/or treatments and their side effects bring physical and psychological changes and, of course, result in psychological reactions. When one adds the age, life experiences, belief systems, and support and/or non-support of family members and friends, the psychologist and the patient have a set of very challenging issues with which to deal at the sessions.

From the very beginning of my graduate training at the University of Pittsburgh, I was fortunate to have had strong support from my mentor, Dr. Milton Seligman, and from professors such as Dr. Richard Desmond. In my internships here in Pittsburgh, I benefitted from having had the supervision and guidance of psychologists such as Dr. Joseph Cvitkovic and Dr. William Cagney – both of whom have broken new ground with patient populations and psychotherapeutic techniques.

I have always had and continue to have support from the medical and hospital communities here in Pittsburgh. Most of my patients are dealing with various cancer diagnoses as well as with other physical conditions such as heart ailments, strokes, migraines, RND, arthritis, muscular sclerosis, muscular dystrophy, and chromosomal abnormalities. The work with my patients has given me a strong belief in a mind/body relationship. The psychotherapeutic sessions are so important in helping a patient to cope with a diagnosis and physical aspects of the disease as well as with the side effects of the treatments. I have never had difficulty in obtaining information from the patients' physicians, no matter their specialties, and I communicate with them as well. This team approach is vital! I need to have an accurate understanding of what my patients are experiencing physically, and the physicians need to know what psychological approaches work well with their patients. As we communicate with each other, we are better able to help the patients through the many bumps in the road that may occur.

The overriding statement that I can make about this population is that each case is different. No two patients are alike, even if the diagnoses might be the same. Although I rely on my training in various psychological therapies, I have certain favorite approaches. Also, I have had to develop my own approaches, especially when it has come to working with young children. In general, I like to use a cognitive/behavioral approach. I like to guide the patients in the reframing of statements from negatives to positives; for example, I like to say, "Turn the coin over from the negative side to the positive side." "Every negative has a positive." We work with this approach at the sessions – especially when patients are dealing with depression and/or anxiety – and even children are able to do drawings that show negative and positive feelings and are able to act out stories using toys, play figures, dolls, and stuffed animals in order to alter their feelings from negative to positive.

Granted, some negative statements are harder to change than others, but I urge patients to stay in the here-and-now in order to be better able to take positive control of their thoughts and feelings. Examples are replacing the negative, "I have stage 4 breast cancer," with positives such as "there are dramatic treatments today to deal with that," "this is a beautiful day and I feel good today," "I have confidence in my doctor(s)," "my mind is sending positive messages to my body, and my body will respond in sending positive messages to my mind. There is a feedback loop."

I worked with a 9-year-old boy who was battling a brain tumor. His right arm and fingers were paralyzed as a result of the surgeries and seizures he experienced. He was undergoing physical therapy, but the doctors were not able to predict its outcome, so this boy needed to deal with the anger he was experiencing because of the paralysis; for example, he would express constantly that he wanted to play baseball and basketball with his friends, and his frustration would manifest itself

I need to have an accurate understanding of what my patients are experiencing physically, and the physicians need to know what psychological approaches work well with their patients.

in his drawings and the stories he would develop at the sessions. At one session, while he was using play figures to develop a story, he started to hum, and I realized that he had a beautiful voice. I asked him if he liked music, and he said that he loved to sing. I knew from his parents that the family was very involved in their church. So this 9-year-old and I worked on certain positive statements such as: "I can sing well." "I love music." "I will speak with my parents about asking the priest if I can sing in the church choir." "Dr. Hilda will speak with my parents about my taking piano lessons." (I told him and his parents about a pianist who had been injured in a past war, and who wrote piano compositions for the left hand. His

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THE PSYCHOLOGICAL ASPECTS OF PHYSICAL ILLNESS

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parents said that they would look into it.) As this 9-year-old's anger was converted to positive energy, his anger lessened and his depression lifted.

There are so many examples to choose from. In general, children do not understand what cancer is and what cells are, so I have a way of drawing a simple cell diagram in which I show them what happens when new healthy cells grow in a normal way and what happens when cells change and form a tumor. I use correct terminology as much as possible, and I write the words that I use, so the children can see the spelling. I have children's books that show pictures of cells, so the children have a better idea of what is happening in their bodies. Always, I stress that when their physicians use surgery, medicine (chemotherapy) and/or a special light (radiation) to kill the bad cells, good, healthy, new cells grow in their place.

In general I like to use hypnosis with patients of all ages to deal with pain management. Children use a favorite stuffed animal or doll to go into a hypnotic trance. I ask that the parents go through the hypnotic exercise along with the child, so they can understand how to guide the child at home. Also, I make a tape that patients can use at home.

There is a long road in dealing with a physical illness, and the road is often not a smooth one. The psychotherapeutic session is an important place where patients can vent feelings that they find difficulty in expressing among family members, parents, or children who might become upset or frightened by them. It is vital that the patient has a set of psychological or cognitive/behavioral techniques that move the patient forward after the expression of these feelings; for example: "See a stop sign and see a TV screen with static. The static is removing the feelings that upset you. Now come up with the first positive feeling or positive thought to move you forward." We practice this type of approach at the sessions.

Patients tend to perseverate, and I talk about a CD that gets stuck and keeps playing the same song again and again. I give patients alternative approaches to deal with this; for example, I suggest that they can set the stove timer or their phone timer for a certain number of minutes (maybe 10, maybe 30) and during that time they can deal with the thoughts and feelings that are overwhelming them, but once the timer rings, they have to end these thoughts and feelings, and they must stay focused on a positive feeling or positive statement for the rest of the day. When the next day comes, they can repeat this procedure again, and they can try to reduce the time on the clock. We talk about how it worked when I see the patient at the next session.

My office is in a separate section of my home and, because of this, my assistant, Dr. Gizzy, was able to work with me for 15 years. Dr. Gizzy was a cat, and he had a PrD (a doctorate in purring). Gizzy was very affectionate, and he talked a lot. Children and older patients often asked for him. In Gizzy's last year and a half of his life, he was in dialysis, and a veterinary technician came to my office each day to give him a treatment. Gizzy had a port, and the children who were undergoing cancer treatments had ports; the child would sit on the floor with Gizzy, and they would talk to each other. The children would pour out their hearts to Gizzy about how they felt about their treatments, and Gizzy would crawl into their lap, put his paws around their neck, and give them hugs while he talked to them.

I had a 4-year-old little boy who was especially close to Gizzy as Gizzy was getting weaker and sicker. It happened that Gizzy died before this child's next session, and I worried how he would react. When I told him that Gizzy had died, the little boy said to me with a smile that now he wouldn't have to be afraid. This child knew that he was very ill, and he asked me if I could help him to talk with his parents because they wouldn't talk with him about how sick he felt and about dying.

This child's parents were very open to working with their son, and the sessions helped the three of them to express feelings with each other that they weren't able to express easily on their own. The parents and I stressed that the child's physicians were working hard to help him get well, that the medicines themselves (the chemotherapy) were strong, and they were making him feel sick but they have to do that in order to make him well. Always, I try to take a positive approach because, over the years, I have had experiences where patients responded well to a new treatment, and the patient would go into remission. I know that cancer and other illnesses can be unpredictable.

This child's parents did help him keep a positive attitude while being supportive to his negative feelings when he felt very sick. Sadly, he did die several weeks later, and I would like to believe that his parents, his psychotherapy sessions, and Dr. Gizzy helped his death to be peaceful.

THE BASICS OF WORKING WITH CHRONICALLY OR ACUTELY ILL CLIENTS

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Probably most importantly, you will need to help your clients realize that they always have a choice, even if not the choices they want. Teaching your clients to be proactive and not just passengers in their health care is extremely important. If their doctor(s) are the "pilots," then they need to be taught how to be "copilots." Even little things, like keeping an up-to-date health history on their home computer or written legibly gives more control. Every time they visit a new doctor they do not have to complete endless forms. Usually a stapler and the signing of a HIPAA form are all that are required. The person can sit in the physician's waiting room with a book, crossword puzzle, smartphone or another activity of their choice.

The purpose of this article is help psychologists when faced with challenging patients with Axis III diagnoses. These are just the basics with some general guidelines, which will benefit both psychologists and clients.

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Comfort in the Gray

Mindfulness and Role Balance at the Intersection of Physical and Mental Health

William S. Chase, II, PsyD

Dr. William S. Chase, II

As a field, psychology has borne its fair share of internal debate which has served as one of the primary forces driving our progress as a discipline and science. In our relatively brief history, we have tackled a spectrum of hallmark questions including: are we destined by nature or molded by nurture, is our motivation driven primarily by unconscious impulses or external reinforcement, is our development a process of continual or punctuated change, and perhaps the most enduring, what is the nature of the mind/body relationship? The resulting understanding reached in each of these great debates was that neither side could fully do justice, or explain, the complex phenomenology of the human organism. Thus, when trying to establish which camp in each discussion is 'correct,' the only correct answer was 'both.' This brings us to the current Zeitgeist that has morphed the classic debates from one of black versus white to discussion of where within the gray area various examples fall. While ambiguous, it is in realizing the comfort that the gray area affords that allows us to maintain flexibility in our roles as professionals.

Unfortunately, as human nature dictates, psychologists are creatures who tend to react poorly to such ambiguity as demonstrated by our tendency to seek form in the formless (e.g., the cluster of spring clouds that looks remarkably like a bunny rabbit). This propensity toward needing form, at times, does a great disservice to us as professionals. While it may help at times where organization and coordination demand specific definition, it is our adaptability that may be our greatest professional attribute. Consider for a moment the diverse settings in which psychologists practice. Hospitals, prisons, schools, private businesses, government agencies, and military postings are just a short list of the places we deliver our services and each has its own set of demands placed upon us professionally. Thus, to define ourselves in the context of a single setting belies the variable, or 'gray,' nature of our field.

Take for example the integration of various psychological approaches into the medical community such as the much discussed mindfulness-based interventions. These interventions have been applied in a wide array of medical and psychological treatment settings and have been used in the treatment of chronic pain (Kabat-Zinn, Lipworth, & Burney, 1985), immune functioning (Davidson, Kabat-Zinn, Schumacher, Rosenkranz, et al., 2003), psoriasis (Kabat-Zinn, Wheeler, Light, Skillings, et al., 1998), as well as chronic physical illnesses such as breast or prostate cancer (Carlson, Speca, Patel, & Goodey, 2004). This list of potential medical applications has been consistently lengthened with each passing year of published literature. With such broad medical applications suggested for this psychological approach, the line between the psychological and medical is easily blurred. Where once our methods were primarily aimed at easing mental suffering, empirical evidence now supports tangible medical benefit arising from some of these same interventions. To some this represents an uncomfortable quandary but it can be argued that this must be instead viewed as an opportunity.

This current trend toward defining the expanding role of psychologists in the treatment of physical illness allows us to serve not only as consultants or support professionals but rather essential components of broader treatment teams. The desire to work as equals with our colleagues in the medical realm is justified, and in many cases essential with regard to continuity of care, despite the fact that many struggle with conceptualizing the Venn diagram-like nature of the health care professions. Perhaps we need to turn again to the concept of mindfulness to guide us in this struggle. To borrow from a definition provided by Jon Kabat-Zinn, one of the forerunners of the current psychological/medical fusion, to ignore opportunities provided by the present moment, "...we may not only miss what is most valuable in our lives but also fail to realize the richness and the depth of our possibilities for growth, and transformation." (Kabat-Zinn, 1994, p. 4).

Conceptually, as well as practically, it is essential that balance be established between accepting the singular, unified nature of the mind/body and determining to what extent physical and mental health be seen as separate but equally important components to the overall concept of health and wellbeing. It is thus equally important to understand the separate but equally important role we play as psychologists, as opposed to medical doctors, in the treatment of physical maladies. On the surface this may appear to be a black-and-white issue but in practice, the plenitude of gray area becomes apparent.

No psychologist wishes to be seen as replaceable by a pharmaceutical product, yet every day patients across the country begin psychiatric treatment for conditions with little to no consideration of psychological methods (although it seems that the inverse of this occurs far less frequently). Thus, psychologists should readily embrace the increasing respect, equality, and collegiality being shown by many of our medical counterparts. When called upon, and when appropriate, psychologists must be ready to serve in a complementary, yet variable role to continue to establish and promote our legitimacy as a field. Whether the presenting issue is depressive symptomology or dermatological pathology, each opportunity to blur the lines traditionally set between psychology and medicine should be seized upon. This is not to say we should forget the limitations of our competency but rather we should stand firmly behind the broad application of our treatment methods and the potential benefits (both explored and otherwise) we offer to the medical community.

Just as it can no longer be argued that the mind and body are separate entities,

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Are Psychological Treatments for Medical Disorders Cost-Effective?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Health experts are increasingly recognizing the ways that psychological interventions can contribute to alleviating physical conditions. A few examples include relaxation exercises for chronic pain, biofeedback for migraine headaches, or the treatment of urinary incontinence after a stroke. Several insurers, such as Medicare, recognize these procedures and code them under the category of health and behavior codes. They differ from other psychological interventions in that they target the patient's physical illness (not mental illness).

Psychological interventions for medical conditions can improve the quality of life, increase attendance at work, or reduce physical symptoms for many problems. For example, in 2009 Buse and Andrasik found that behavioral interventions for headaches "have been found to be superior to various control conditions, and the benefits from these treatments are generally maintained over time" (p. 339). In 2011 LeBlanc et al., writing a review for the U.S. Preventive Services Task Force, found that "behaviorally based treatments are safe and effective for weight loss and maintenance" (p. 434; Rappange et al., 2009). On the other hand, one team of researchers cautioned that the decreases in health care costs from the success of these programs may be offset by costs incurred because the patients are living longer!

However, the escalation of health care costs in recent years inevitably raises the question as to whether the procedures covered under the health and behavior codes actually reduce overall health care costs. The study of cost-offset can be quite complex because, for example, researchers may measure cost-effectiveness differently, some studies combine two or more behavioral interventions, or other methodological factors may influence the interpretation of the results. For example, initial studies of smoking cessation showed that patients who quit smoking had higher future health care costs compared to those who did not quit smoking. At first glance it appeared that smoking cessation programs were of no value. However, Fishman et al. (2003) found that, when controlling for pre-existing conditions, "smoking cessation does not increase long-term health care costs" (p. 733).

In addition, studies have shown that the procedures covered under the health and behavior codes can reduce overall medical costs. As it applies to chronic pain, for example, Brooks et al. (2009) found that hospital costs were reduced by an average of more than $1,500 when patients with hip fractures received behavioral interventions focused on reducing acute pain. Also, physician visits fell by one-third after patients with chronic pain participated in psychologically based pain management programs (Caudill, 2009).

In addition, a series of studies by Lorig and colleagues found that self-management programs (which often involve components that would be covered by health and behavior codes) reduced the length of hospital stays, emergency room visits, and overall medical costs (Brick, n.d.). Furthermore, psychological services appear especially important in controlling the medical conditions arising out of excess weight. A review of many studies found that diabetes prevention programs reduced health care costs (Saha et al., 2010). For example, "the incremental cost-effectiveness ratio for a three component strategy of diet, exercise, and behavior modification in women was $12,600, relative to routine care" for the treatment of excess weight (Roux et al., 2007, p. 1101). Wolf et al. (2007) found that lifestyle management interventions among obese patients with type 2 diabetes led to modest cost savings. In addition, staff education combined with screening for diabetes led to decreased health care costs (Icks et al., 2007).

We do not have data on the cost impact of every procedure that would be covered by the health and behavior codes. Nonetheless, the medical cost-offset data read in combination with data on treatment effectiveness show that psychological treatments belong in the mainstream of contemporary health care practice.

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References are available from the author at sam@PaPsy.org or on the PPA website at www.PaPsy.org.

COMFORT IN THE GRAY...

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we must equally accept that the roles of medical doctor and psychologist cannot be seen in absolute terms. As medicine may improve psychotherapeutic outcomes in our patients, so too may our psychological methods serve to improve medical outcomes. To deny the resultant gray area is to resign ourselves to being marginalized paraprofessionals rather than integral members of the broader health community.

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The Integration of Psychological and Medical Care in IBD

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Hollie Dean-Hill

Inflammatory bowel disease (IBD) is a lifelong autoimmune condition which includes Crohn's disease (CD) and ulcerative colitis (UC). IBD is characterized by high morbidity, low mortality, complicated medication and surgical treatment, and a chronic course of incurable symptoms. Consequently, many of those diagnosed with IBD experience social isolation, impaired quality of life, functional abdominal pain, and increased anxiety and depression (Karwowski, Keljo, & Szigethy, 2009; Szigethy, McLafferty, & Goyal, 2010). Interactions between disease flares, life stress, and psychopathology make IBD an ideal model to study brain-gut interactions.

The psychological manifestations of the illness, including depression, anxiety, and both sleep and pain difficulties (Szigethy, McLafferty, & Goyal, 2010). With IBD being prevalent and diagnosed as early as childhood (Karwowski, Keljo, & Szigethy, 2009), these children and families have complex needs. The developmental period of childhood and adolescence is pivotal in the construction of identity, the development of cognitive and social skills, and emotional and physical changes. It has been documented that those with chronic childhood diseases, like IBD, are at risk for depression, anxiety, social isolation, altered self image, family conflict, treatment adherence problems, and school absences, impacting one's quality of life and the larger family context (Karwowski, Keljo, & Szigethy, 2009).

Anxiety and depression rates within this population range between 25% and 40%, and both can negatively influence the course of IBD. In fact, depression symptoms occur at higher rates than in other chronic physical diseases, can influence a relapse, aggravate symptoms, challenge life quality, and interfere with treatment adherence and response. Children with IBD have to adjust to an illness, cope with a diagnosis and a damaged sense of self, and also may experience feelings of pessimism, shame, embarrassment, fear, and guilt. Many may struggle with unexplained symptoms, unsettling responses to the unknown, a grief reaction to a loss of "healthy self," an inability to control or predict symptoms, and fear related to treatment course and intervention. Anxiety and pain associated with illness may impact sleep, therefore even further dysregulating one's immune response, challenging healing, and impacting functioning and quality of life. In summary, although many compounding factors are contributing to decreased psychological and physical wellness in this population, these modifiable risk factors also provide an opportunity to develop treatment paradigms for psychological symptoms (anxiety and depression), pain, sleep, and coping with IBD (Mackner, Crandall, & Szigethy, 2006; Thompson, Delaney, Flores, & Szigethy, 2011).

The practice of integrating physical and psychological domains when one is coping with a physical illness has produced positive outcomes.

The Medical Coping Clinic of the Children's Hospital of Pittsburgh was developed to translate behavioral research findings into improved psychological care for patients with IBD and other gastrointestinal disorders. Utilizing both medical and mental health professionals to work collaboratively with children and families, the clinic works to integrate behavioral health into medical treatment. The practice of integrating physical and psychological domains when one is coping with a physical illness has produced positive outcomes. For example, screening for depression has helped identify at-risk patients to prevent syndromal depression and anxiety. Psychological treatment strategies have been shown to be useful in the treatment of depression in IBD. Within the clinic, the employment of cognitive behavioral therapy (CBT), hypnosis, physician-endorsed exercise, and pharmacotherapy as needed have been studied and practiced. CBT has been modified to address physical illness, incorporating education about depression and IBD. Hypnosis is useful in coping with anxiety and abdominal pain, and contributes to increased immune functioning. The use of physical illness narratives allows for the exploration and targeting of themes and problems most acknowledged by those being treated. Most commonly, IBD-related themes include: feelings of the damaged self, a lack of control over disease, pessimism, shame, and guilt of being a burden. These themes can be directly targeted to help illness perception become less pessimistic. CBT has allowed for a decrease in depression, improved quality of life, more optimistic views of illness, decreased medical utilization, and improved abdominal pain and fatigue (Szigethy, 2004b).

Effective treatment has been focused on the biological, psychological, and social domains. In treating the underlying organic problem with exercise, medication adherence, and alternative methods (e.g., hypnosis), the symptoms of IBD are manageable. The use of CBT techniques, specifically cognitive restructuring, symptom monitoring, and behavioral activation, are empirically supported treatments. Conflict resolution and activity scheduling allow for psychological improvement in managing the dynamics of coping with disease, depression, anxiety and pain. Education of life quality expectancy, family dynamics, and school, work, and social issues further allows for the learning of how to navigate through the course of chronic

Continued on next page

THE INTEGRATION OF PSYCHOLOGICAL AND MEDICAL CARE IN IBD

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illness (Mackner, Crandall, & Szigethy, 2006; Thompson, Delaney, Flores, & Szigethy, 2011). The empirical evidence of the use of CBT with IBD has shown an altering in behavior and thinking to change mood. CBT also utilizes cognitive reframing to interrupt automatic emotional responses that maintain negative thinking. The teaching of problem-solving allows for the adjustment of thoughts and behaviors surrounding the element of control. The use of CBT allows for significant management of anxiety and depression symptoms as well as psychosocial elements associated with the impact of disease (Szigethy et al., 2004a; Thompson, Delaney, Flores, & Szigethy, 2011). Recent evidence also suggests that techniques like CBT and hypnosis may have a positive impact on IBD activity and course.

In conclusion, practitioners must consider the impact of biological factors as well as the psychological impact of having a chronic physical illness. With children and adolescents, the impact of typical developmental milestones contributes to further difficulty in coping with a chronic illness. Adequate acknowledgement and sensitivity given to the management of illness, and the coping with life stressors and life changes associated with illness, allows for an integrated behavioral-medical approach to further contribute to greater quality of life.

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IT ONLY HURTS WHEN I BREATHE

Continued from page 10

which contributes to their engaging in an all-or-none activity pattern. Cognitive distortions including perfectionism can also contribute to this needless suffering. Many patients persist in spite of horrific pain with the attitude "once I start something I want to keep going until it's done."

Teaching pacing skills is essentially time management for this patient population. Learning to take breaks, planning ahead for activities, alternating physical posture, and using objective measures such as time or distance instead of pain levels can gradually increase and improve a patient's tolerance for activity overall.

Counseling patients in appreciating the mind-body interaction can empower them to obtain a better understanding of variables that can adversely impact their pain tolerance. Understanding the role of factors such as stress, mood, coping style, and even sleep disturbance can assist them in making sense of otherwise inexplicable changes in their pain levels. Relying on this knowledge can aid the patient in implementing targeted coping strategies which can lessen discomfort and improve quality of life.

Working with individuals who have chronic pain has its challenges and its rewards. Assisting these patients in becoming more productive and helping them to restore meaning and a greater sense of personal control to their lives are all worthwhile endeavors.

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Crosswalk of 2012 Psychotherapy CPT® Codes to 2013 Codes

Effective January 1, 2013

2012 Code	2013 Code(s)
Diagnostic interview procedures	
90801, Psychiatric diagnostic interview examination	**90791,** Psychiatric diagnostic evaluation
Psychotherapy	
90804, outpatient psychotherapy 20-30 min **90816,** inpatient psychotherapy 20-30 min	**90832,** Psychotherapy, 30 minutes with patient and/or family member
90806, outpatient psychotherapy 45-50 min **90818,** inpatient psychotherapy 45-50 min	**90834,** Psychotherapy, 45 minutes with patient and/or family member
90808, outpatient psychotherapy 75-80 min **90821,** inpatient psychotherapy 75-80 min	**90837,** Psychotherapy, 60 minutes with patient and/or family member
90845,* Psychoanalysis	**90845,** Psychoanalysis
90846,* Family psychotherapy without the patient present	**90846,** Family psychotherapy without the patient present
90847,* Family psychotherapy, conjoint psychotherapy with the patient present	**90847,** Family psychotherapy, conjoint psychotherapy with the patient present
90849,* Multiple-family group psychotherapy	**90849,** Multiple-family group psychotherapy
90853,* Group psychotherapy (other than of a multiple-family group)	**90853,** Group psychotherapy (other than of a multiple-family group)
Codes for interactive services	
90802, Interactive psychiatric diagnostic evaluation	**90791 plus interactive add-on code (90785)**
All current interactive psychotherapy services **(90810 – 90815, 90823 – 90829)**	**90785,** Add-on code to be used in conjunction with appropriate psychotherapy code based on length of the session
90857, Interactive group psychotherapy	**90853 plus interactive add-on code (90785)**
Pharmacologic management add-on code	
90862, Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy	**90863,** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services; used only as add-on to principal psychotherapy code (90832, 90834, 90837)

* The codes shaded in orange are the same for 2012 and 2013

For complete information on the 2013 psychotherapy codes, visit **www.apapracticecentral.org/codes**.
For additional questions, email us at praccodes@apa.org.

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Ethical Implications of Psychologists Using Social Networking Sites

Melissa L. Krop

Editor's note: Ms. Krop, a student at LaSalle University, was awarded the 2012 Patricia M. Bricklin Student Ethics Award in October for this essay.

Melissa L. Krop

Separating the personal from the professional is challenging as the world becomes increasingly linked by social networking sites. Social networking sites, while providing a multitude of beneficial services to psychologists, also give rise to new ethical dilemmas. As psychologists increasingly use social media to educate the public on mental health issues, the need for standards of quality governing online resources becomes progressively more apparent. In addition, the use of advertising through social networks has become relatively commonplace for psychologists. Ethical issues such as engaging in client solicitation online, requesting testimonials, and paying for exposure via someone's blog are all addressed to some degree by the APA Ethics Code; however, more specific and thorough standards are needed. The majority of psychologists and graduate students do engage in social networking for personal reasons, resulting in the emergence of ethical issues related to self-disclosure and multiple relationships. As social media is evolving faster than ethical guidelines, it is imperative that psychologists address the importance of ethical implications of social networking sites on the profession.

Public education can be considered a primary ethical obligation of practicing psychologists. Due to its ease of access and low cost, the Internet provides an excellent means of communicating information to the public. However, problems arise when websites contain information that is low quality, misinterpreted, or used as a substitution for professional assessment and therapy. Therefore, there are a number of ethical considerations that the practitioner must consider when adding supplemental resources to their web pages. Psychologists must ensure that psychoeducational resources are accurate, informative, and unbiased. Including a resource on one's website without thoroughly examining its content could have negative repercussions for the clinician and consumers, such as facilitating inaccurate self-diagnosis or the decision to forgo a professional assessment. The need for meticulous review of potential resources is substantiated by the uneven quality of mental health care sites. This variability in terms of quality and quantity of the information available on mental websites is partially due to the lack of standards and regulations governing Internet use. Another issue is the adulteration of content by those with commercial agendas. The presence of this bias is particularly strong in sites targeting depressed and anxious individuals (DiBlassio et al., 1999). In addition, practitioners must consider their own commercial agendas. Any conflicts of interest should be clearly stated for the consumer so that resources can be assessed fairly.

Providing access to high quality information still yields several ethical problems. For instance, if a website provides symptom checklists, some individuals may misinterpret them; others may be in a unique circumstance to which the information does not apply. According to the APA Ethics Code Standard 9.01, "...psychologists provide opinions on the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions." Disclaimers informing that these are not replacements for actual evaluations could assuage some of these concerns, but the potential for misuse cannot be completely eliminated.

For practitioners looking to promote their services, social networking sites offer a plethora of advertising opportunities. Social networking sites make it easier to advertise to specific target populations. Therefore, practitioners must ensure that they are not engaging in uninvited solicitation of potential clients. An example that may constitute in-your-face solicitation would be a psychologist collecting e-mails from a discussion forum or listserv for people who lost loved ones and messaging them about grief counseling services offered at her practice. Perhaps less obvious would be the case of a psychologist who posts a comment about these services on a blog related to loss of loved ones. Advertising via blogs and discussion boards presents a number of ethical concerns which have not been adequately addressed by the APA Ethics Code and for which there is little precedent.

Clients discovering personal information about their clinicians, such as personal blog posts, political affiliation, and various posts on websites, can lead to irreversible changes in the nature of the relationship and blur professional boundaries (Tunick, Mednick, & Conroy, 2011). "Small world hazards" or "everyday life hazards," in which connections to a current client are revealed, have also become more problematic with the growing use of social networking sites. Typically, these connections are dealt with directly in therapy. However, when these "small world hazards" occur over the Internet, often the clinician cannot determine whether any disclosure has been made, eliminating the opportunity for the clinician to deal with the situation appropriately (Taylor et al., 2010).

Handling "friend requests" from clients on social networking sites, such as Facebook, has become a common dilemma among practitioners. Receiving a friend request from a client puts the practitioner in a difficult position. The friend request can be rejected or ignored, which may create issues or tension with the client; if it is accepted, the client gains access to personal information and the issue of dual relationships is raised (Taylor et al., 2010). Therefore, personal policies on social networking with clients should be discussed early in treatment to prevent uncomfortable situations. Other multiple relationship issues related to the "small world hazards" previously mentioned can result from clinicians' personal use of social networking sites. In

a survey by Taylor et al. (2010), respondents reported that they discovered mutual connections with their clients when they inadvertently saw pictures of clients on social networking sites of friends or family members. Some respondents reported anonymous dating sites had even matched them with current or former clients.

As social media is constantly evolving, psychologists need to continue to educate themselves on the emerging technologies and their associated ethical issues. Social networking sites are effective tools for educating the public on mental health issues; however, they also come with a number of ethical considerations that need to be addressed in terms of content quality and potential misuse of the information. Advertising through social networking sites presents an easy, wide-reaching method of promoting one's services. The APA Ethics Codes still applies to this form of advertisement; though adapting it to social media can be complicated and relies, to a certain degree, on the judgment of the clinician. Using social media for personal reasons can create ethical problems such as allowing clients to access personal information and the formation of dual relationships. In an age in which Facebook alone has more than 900 million monthly active users (Facebook, 2012), the impact of social networking on the field of psychology should not be underestimated.

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"Can't We All Just Get Along?"

Jeanne M. Slattery, PhD, jslattery@clarion.edu

Dr. Jeanne M. Slattery

I was talking with students after a colleague's presentation about growing up in the segregated South. Despite having heard about the civil rights movement since they were young, and having just finished reading a memoir about race and racism (Williams, 1995), they felt that my colleague's presentation "made it real" in ways that other experiences had not. They had a hard time hearing and understanding racism, special difficulties recognizing more subtle forms of racism, and resisted descriptions of others' oppression or their own privilege.

Oppression and privilege are difficult to acknowledge. Like many other white girls raised in upper-middle class families (Brown, 1998), I was taught to avoid seeing or talking about bad things. I can't even say how I learned this (I suspect that this was partly related to never seeing my parents argue), but it came to feel wrong to be angry or to talk about toxic things. In my early years as a therapist, I learned that anger and other difficult emotions were not necessarily wrong and that talking about problems was better than avoiding them.

Whites can attempt to reduce their anxiety, guilt, and confusion about racism using strategies like those that I used as a child – through avoidance. Maybe this is why the previously-described students had read or heard other descriptions of racism without experiencing them as real, and why they resisted naming oppression and privilege. Others approach uncomfortable feelings using a colorblind stance (Greene, 1985; e.g., "I see everyone as the same," "I don't see color; I see a person"). Colorblindness, however, can mask racism rather than curing it, by creating communication barriers that make some issues off limits and by failing to address basic issues that stand in the way of healthy and productive discussions. Unfortunately, Whites who avoid discussions on race may be perceived as more racist, and less genuine and likable than Whites who are more prejudiced (Shelton, Richeson, Salvatore, & Trawalter, 2005; Vorauer & Turpie, 2004).

Eric Holder suggested, "certain subjects are off limits and... to explore them risks, at best, embarrassment, and, at worst, the questioning of one's character" (in Mendoza-Denton, 2010, p. 88). Our president, Dr. David Palmiter, has asked that we discuss these off-limit subjects. Doing so may cause some to suspect that PPA is raising discussions about positive multiculturalism as a way of reducing Whites' discomfort with discussions of privilege, oppression, and microaggressions. Perhaps. Talking about race is difficult and anxiety-provoking.

Our discussion on positive multiculturalism would be problematic if we used it to push ongoing problems underground. With my clients, however, I suggest that dealing with anxiety-provoking issues is adaptive and can be a step toward reducing problems. Rather than avoiding dangerous discussions, we consider how we might have such discussions and how we can make them more effective. We wonder when such conversations are already occurring and what makes them effective. Perhaps PPA can begin to identify factors allowing us to develop more effective and productive ways of discussing race, oppression, privilege, and other difficult issues. Perhaps, as Palmiter (in press) suggests, we can be slower to label behavior as racist (or with other isms) and instead develop nondefensive, open ways of talking with each other.

Bottom line, like Rodney King, I want us to get along, but I also hope that we begin to acknowledge each of our weaknesses and strengths, that we begin to build bridges rather than walls. Our lives are interconnected. When oppression of any sort prevents you – or anyone like you – from meeting your goals, my life is poorer. Conversely, when we create a welcoming environment that is not only accepting but celebrating of differences, all of our lives are enhanced.

References

References are available from the author at jslattery@clarion.edu or on the PPA website, www.PaPsy.org.

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 to the public. We thank them for helping to "make psychology a household word" in Pennsylvania.

Recipients of the **2012 Psychology in the Media Award included:** PPA member, **Mr. Michael Gillum** and **Ms. Maiken Scott**. Mr. Gillum was instrumental in launching the investigation into the Jerry Sandusky child sex abuse scandal which has garnered national media attention. Mr. Gillum exemplified an excellent professional presence in the media both locally and nationally. He came across exactly how we want a psychologist to come across: ethical, intelligent, articulate and compassionate. He has been interviewed by Harrisburg's *Patriot-News*, *20-20, CNN* and *USA Today*, and numerous other publications. Mr. Gillum's efforts in the past year with the victims and with the press have further educated the public about the insidious nature of child sexual abuse. Ms. Scott is the Scattergood Foundation Behavioral Health Reporter for WHYY public radio in Philadelphia, and the executive producer of "Voices in the Family" with Dr. Dan Gottlieb. She researches and reports on a wide range of psychology-related topics of interest to the general public. The award was presented to them on June 22 during our Annual Convention.

During the 2012 Annual Convention, a series of 12 free Mind-Body Health Workshops for the Public were held on June 20 and 21 at the Hilton Harrisburg. The workshop presenters included: **Gemma Boyd, Esther Brahmstadt, Krystle Evans, Kristin Pitman, Jane Thompson-Rosenzweig,** and **Drs. Scott Browning, Laura Campbell, Beatrice Chakraborty, Sue Ei, Margaret Gsell, Katherine Hammond Holtz, Gail Karafin, Marie McGrath, Nicole Quinlan, Christie Sworen-Parise** and **KristiLynn Volkenant**.

The members of the E-Newsletter Committee continue to make psychology a household word by publishing PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." Pennsylvania is the only state psychological association with an e-newsletter for the public. **Allison Otto**, and **Drs. Tim Barksdale, Gail Cabral, Sue Ei, Pamela Ginsberg, David J. Palmiter Jr., Christie Sworen-Parise** and **Pauline Wallin**, contributed articles for the June and September 2012 issues. The e-newsletter creative director is **Dorothy Ashman**. The chair of the E-Newsletter Committee and editor of the e-newsletter is **Dr. Christina Carson-Sacco**.

Dr. Julie Allender was the keynote speaker for the January 27, 2012, Temple University College of Education graduation. Her topic was "Regrets to Achievements." Sewickly psychologist, **Dr. Allison Bashe**, was interviewed for an article in the April 2012 issue of *Pittsburgh Parent Magazine*, "Prepare Your Child to Be Safe This Summer."

Dr. Kelly O'Shea Carney, Executive Director of the Phoebe Center for Excellence in Dementia Care in Allentown, was interviewed for an article on Alzheimer's disease for the September 7, 2012, issue of www.lvb.com (Lehigh Valley Business online newsletter). **Dr. Ray Christner** of Hanover was interviewed three times by Fox 43 News in York: Habits Parents Teach Their Children (August), Sibling Rivalry (May), and Cyberbullying (September).

Dr. Helen Coons presented "Controlling Worry" to 25 people at the Annual Conference for Women Living with Advanced Breast Cancer in April in Philadelphia, and "For Single Women! Dating After Breast Cancer" to 75 people at the Annual Conference for Young Women Affected by Breast Cancer in February in Orlando, Florida. She was interviewed as an expert source for *Completelyyou.com* in September on "Women's Fears of Breast Cancer," *Today.com* in September on "Weight Loss After Pregnancy," *NBCphiladelphia.com* in August on "Mothers Who Murder," *iVillage.com* in May on "15 Ways to Tame Arthritis Pain with Your Mind," WHYY Radio in Philadelphia in April on "Controlling Worry in Women with Advanced Breast Cancer," *Women's Health Magazine* in February on "Anxiety and Depression in Women," *More Magazine* in February on "Sexual Desire in Women in Their 30s, 40s and 50s," *LearnVest.com* in January on "Gender Differences in Stress," *Fit Pregnancy Magazine* in January on "Pregnancy and Post-Partum Depression," and *ABCNews.com* in January on "Families and Pregnancy Loss."

Ms. Mary Pat Cunningham was interviewed for the June/July issue of *The Valley's Child*, a newspaper serving Lackawanna and Luzerne counties. The article was entitled "Helicopter Parents, Stop Your Hovering." **Dr. Andrea Delligatti** made five presentations on Psychologically Healthy Workplaces: January 5 to 28 members of the Paoli-Malvern-Berwyn Rotary, January 11 to 15 members of the Downingtown Business and Professional Women, January 11 to 30 members of the Berywyn-Devon Business Association, September 25 to 32 members of the Business Network International in Malvern, and September 27 to 19 members of the Paoli-Malvern-Berwyn Rotary.

On March 3, 4, 10, and 11, Bloomsburg psychologist, **Dr. Sue Ei** did a radio interview about "Stress, Exercise and Time Management (aired on B98.3, ESPN1240 and Max Potential Podcast). On April 10, **Dr. Audrey Ervin** presented "The Superwomen Phenomenon: Women and Stress" to 15 people at the Warrington Health and Wellness Center.

Dr. Kathleen (Kayta) Curzie Gajdos writes a column, "Mind Matters" for the online newspaper, Chadds Ford Live (*www.ChaddsFordLive.com*), and her articles also appear on her website, www.drgajdos.com. The article on October 3 featured "Why We Cry." Dr. John Gavazzi was interviewed for a story on June 17 about "Two Dad Households" on CBS Channel 21 in Harrisburg.

Dr. Sybil L. Holloway co-authored a *Selfhelp Magazine* article on September 22 with her Bloomsburg University colleague, **Dr. Barbara Yingling Wert**, "Ten Ways for Students with a Learning Disability to Achieve Success in College."

Dr. Virginia Koutsouros, presented "Anger Management and the Physiology of Anger" to a community group of 12 male leaders in West Philadelphia attending the Brothers Helping Brothers meeting on September 26 and "Stress Management: It's Personal" at the Spectrum Health Services Annual Health Fair in West Philadelphia on August 17. **Dr. Valerie Lemmon** presented "Seasonal Affective Disorder" to 40 members of the Low Vision Support Group at Bethany Village in Mechanicsburg on August 28. **Dr. John Lobb** presented "Managing Serious and Chronic Illness" to 17 people in the Diabetic Support Group at DuBois Regional Medical Center on March 20.

On May 27, **Dr. Terry Wolinsky McDonald** presented "Role of Psychology and Support Systems in Chronic Illness" to 40 people at the International Pemphigus and Pemphigoid Foundation in Boston. Since 2004, she has written quarterly articles in a "Psychologically Speaking" column for the International Planned Parenthood Federation newsletter.

Ms. Patricia McGettigan presented "Stress and Depression" to a group of 100 seniors at the Falls Township Senior Center in Fairless Hills on June 20. **Dr. Mary Lou Mlecko** presented "Brain Plasticity: It's More Than What You Think" to 181 members of Road Scholar on September 13 at Chautauqua Institution in Chautauqua, New York.

Centre County psychologist **Dr. Marolyn Morford** gave an interview for the Penn State report on pedophiles: http:www.youtube.com/watch?v=85Lx53JpkOs. She was also interviewed in March by the *Centre Daily Times* about the qualifications of psychologists: http://www.mcclatchydc.com/2012/03/29/143482/man-who-evaluated-alleged-sandusky.html.

Dr. Peter O'Donnell participated in a health and wellness fair in September at the Nittany Valley Rehabilitation Hospital in Pleasant Gap and presented "Stress Management and Happiness" to 80 people. On October 9 he spoke to the Traumatic Brain Injury Support Group at the same hospital.

To celebrate National Depression Screening Day on October 11, **Dr. David Palmiter**, president of PPA, and his psychology students at Marywood University coordinated free mental health screenings for over 200 community members in the Scranton area. *USA Today* interviewed him for an article on May 28 on "Parents Can Build in Special Time with Kids This Summer." He was also interviewed by Radio PA in August about "Start the School Year Off Right."

Dr. Steven Pashko presented "Our Two Selves" at the Philadelphia Meditation Center in Havertown on February 10 (31 participants) and May 4 (14 participants), "Why Meditation" on May 13 (12 participants), and "Different Meditation Practices" on June 10 (17 participants). **Drs. Patricia Post** and **Gregory Anderson** discussed "The Attention Test Linking Assessment to Services" on CBS Radio in Pittsburgh on September 16. They addressed several aspects of their seven part ADHD assessment system including diagnosis, examining comorbidities and interventions for ADHD.

The chair of PPA's Public Education Committee, **Dr. Nicole Quinlan**, was interviewed on WVIA-TV on September 18 for a Call the Doctor live broadcast on "Psychological Damage from Bullying." She had a radio interview with WPGM in February and Y106.5 in January on "Psychological Impact of Overweight."

Dr. David Rogers of Hershey Psychological Services has presented numerous workshops to the Pennsylvania State Police, FBI, and other law enforcement agencies. He also presented "Dealing with Difficult People" on May 18 to 23 staff members at the state Capitol, "Cherishing Our Differences" to 40 people for the Pathways Institute, and "Enhancing Resilience in Crisis: Understanding Coping Styles" to 30 educators at the Bible Baptist School in Shiremanstown.

Dr. Jacqueline Sallade has a blog on salon.com called "Dr. Jackie's Mental Health Moment" and on witf.org called "Self-Help Now." **Brother Bernard Seif** presented "Science, Spirituality and Healing" to 80 people at the Jesuit Center on January 27-29 in Wernersville, "Embracing a New Heaven and a New Earth" to 20 people at the Weston Summer Workshops on August 10-12 in Weston, Vermont, and "Science, Spirituality and Healing" on September 28-30 at the Kirkridge Retreat and Study Center in Bangor.

Dr. Christie Sworen-Parise presented "Rapport Building within a Medical Setting" for the Physician's Assistant Program at Marywood University and "Positive Body Image" at the Leverage Training Studio in Forty Fort.

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, "What to Do When Grandparents Become Too Helpful," "The Mental Side of Athletic Performance," "How to Escape the Worrying Cycle," "How to Stay in Love with Your Spouse for Decades." She was interviewed by CBS 21 in Harrisburg on personality disorders. Dr. Wallin also presented "Three Paths to Happiness" on July 11 to 32 staff members at the state capitol. A recipient of PPA's Psychology in the Media Award in 2002 and 2005, Dr. Wallin continues to actively reach out to the media nationally and internationally to help make psychology a household word.

Ms. Sarajane Williams presented "The Therapeutic Harp" to 18 people at the Somerset Folk Harp Festival on July 27 in Parsippany, New Jersey, and to 30 people at the Southeastern Harp Weekend on October 28 in Asheville, North Carolina.

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 June 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.

Identification of Specific Learning Disabilities in Pennsylvania's Public Schools

Timothy J. Runge, PhD, NCSP, Indiana University of Pennsylvania
Shirley A. Woika, PhD, NCSP, The Pennsylvania State University

Theoretical basis for SLD

The codification of a workable definition of specific learning disability (SLD) did not emerge until the 1960s when it was federally designated as a handicapping condition (Fletcher, Lyon, Fuchs, & Barnes, 2007). Sam Kirk (1963) first offered a definition of learning disabilities that was adopted in original special educational regulations (i.e., Education of All Handicapped Children Act). Contemporary definitions of SLD contain language very similar to the original definition including a disorder marked by deficits in the neurological system (National Joint Committee on Learning Disabilities, 1988), "abnormalities in cognitive processing" (American Psychiatric Association, 2000, p. 50), or deficits in basic psychological processes (Individuals with Disabilities Education Act [IDEA], 2004). Although these various definitions have their limitations (cf Fletcher et al., 2002), most contemporary definitions of SLD suggest that poor academic performance is related to deficiencies in cognitive abilities that otherwise are intact for typical learners.

Operational conceptualization

Psychologists working in the schools rely on the IDEA definition because assessments are typically completed to determine eligibility for school-based services. Psychologists in private practice tend to use definitional criteria from the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) as these criteria are linked to insurance reimbursement. Although there is some overlap in criteria, they do differ in significant ways.

The IDEA definition includes eight specific areas of disability to include oral expression, listening comprehension, written expression, basic reading skill, reading fluency skills, reading comprehension, mathematics calculation, and mathematics problem solving. The DSM-IV-TR defines four learning disorders: Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder NOS. The DSM-IV-TR includes Expressive Language Disorder and Mixed Receptive-Expressive Language Disorders under Communication Disorders. Only accuracy and comprehension difficulties are noted in the DSM-IV-TR's Reading Disorder, with no reference to reading fluency, while reading fluency was added to the IDEA definition during the last revision process.

The DSM-IV-TR refers to measured achievement falling "substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education" (American Psychiatric Association, 2000, p. 51). The IDEA refers to "whether the child does not achieve adequately for the child's age or meet State-approved grade-level standards ... when provided with learning experiences and scientifically based instruction appropriate for the child's age or state-approved grade-level standards" (34 CFR 300.311). These different criteria result in a major difference in interpretation. Based on the DSM-IV-TR, a child with a superior Full Scale IQ and average achievement in a given academic area could be viewed as meeting definitional criteria as a student with a learning disorder. Based on the IDEA, this would not be the case. The IDEA, first and foremost, defines a student with a learning disability as one who is not achieving adequately based on age- or grade-level standards. Thus, a child with an average achievement score could not be found to be learning disabled using the IDEA criteria regardless of his/her level of cognitive ability or the magnitude of the discrepancy between ability and achievement. This is a major difference in interpretation.

Dr. Timothy J. Runge

Dr. Shirley A. Woika

Many argue that comprehensive cognitive functioning data assessing underlying neuropsychological processes directly associated with academic skills can be insightful within an RtII eligibility model.

LEA decision-making process

Perhaps the most significant difference in the definitions is the limitation of the DSM-IV-TR to a discrepancy model while the IDEA allows districts to also use data specific to a child's lack of response to scientifically based instruction as a means to identify a child as learning disabled. Individual schools must develop a process for identifying children with specific learning disabilities, and that process is outlined in the district's Special Education Plan and must be approved by the Pennsylvania

Continued on page 24

School Psychology Perspective: Children with Cancer

Gail R. Karafin, EdD, Public Policy Committee Chair, School Psychology Board

Dr. Gail R. Karafin

There are two words that no parent ever wants to hear: *"It's cancer."* The thought brings pure panic to the most stable people. In the United States, approximately 10,400 children are diagnosed with cancer yearly (NCI, 2008). SEER (2012) reported that approximately 17 children out of every 100,000 between the ages of 0 and 19 will be diagnosed with cancer each year. The most common childhood cancers include leukemia (blood cell cancers) or cancers of the brain and central nervous system.

Over the past 20 years there has been an increase in the incidence of children diagnosed with all forms of invasive cancer; however, death rates have declined dramatically over the same period. Childhood cancer is a life-altering event that leads to numerous stressors, including emotional, psychological and often financial problems for children and their families. Stressors occur during developmental transitions, medical management, ongoing health care needs, relapse, and hospitalizations. Psychologists serve an important role in working to build resilience in children and their families.

The good news is that about 8 out of 10 children treated for cancer survive at least five years. This represents an increase in survival rate of about 45% since the early 1960s. However, the treatments that help these children survive can also cause health problems later on. These are called *"late effects."* Due to the increase in the incidence and survival of pediatric cancer patients, educators need to be cognizant of academic, physical, neurological, and psychosocial effects of the illness and the treatments.

Late effects are treatment effects caused by the injury that the cancer treatment may cause to the healthy cells in the body from surgery, radiation, chemotherapy, or bone marrow transplants. Lack of cell nourishment, chronic cell injury, death of healthy cells, and scar tissue formation may all contribute to this damage. The late effects can vary with individuals depending on the child, age of the child, the location of the cancer, and the type and dose of the therapy. These therapies can contribute to problems with the brain, eyesight, hearing, growth and development, thyroid, sexual reproduction, heart and cardiovascular system, respiratory function, muscle and bone development, teeth, and second cancers. For the purposes of this article, we will focus on late effects of the cognitive, sensory and behavioral systems.

Cancer treatments targeting the brain can create cognitive impairments and usually manifest within a few years of treatment. This includes lower IQ scores, lower academic achievement, problems with memory and attention, poor hand-eye coordination, slowed development, and behavior problems. Nonverbal skills like math are more likely to be affected than language skills like reading or spelling, but this is variable. Sometimes late effects include seizures or headaches. Effects on the pituitary gland impact on hormonal functioning and can cause fatigue, listlessness, poor appetite, cold intolerance, constipation, and problems with growth and sexual maturation.

Problems with eyesight can include problems for visual functioning such as dry eye, watery eye, eye irritation, discolored sclera, poor vision or change of vision, blurred vision, double vision, cataracts, light sensitivity, poor night vision, and drooping eyelid. Certain treatments can also impact on hearing. Problems in hearing can be ringing in the ears, hearing loss (often at the high frequency levels), auditory figure-ground problems, dizziness, and excessive earwax. In younger children, hearing deficits can cause additional problems with language development. The school nurse needs to be alerted to perform screenings on a child treated for cancer and refer any changes to the child's physicians.

> *The treatments that help these children survive can also cause health problems later on. These are called "late effects."*

Emotional issues also need to be addressed with childhood cancers. Emotional issues vary depending on the level of maturity at the time of the illness. The child's age, general resilience, and the extent of treatment may play roles in this regard. During treatment, families tend to focus on the daily aspects of getting through it and beating the cancer. Once treatment is finished, a number of emotional concerns may arise. Some of these may last a long time and can include:

- dealing with physical changes
- worries about cancer returning or new health problems developing
- feelings of resentment for having had cancer or having to go through treatment when others do not
- concerns about being treated differently or discriminated against by classmates or teachers, or conversely expectations for special considerations
- changes in attentiveness
- changes in emotional or impulse control
- concerns about dating, marrying and having a family later in life

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IDENTIFICATION OF SPECIFIC LEARNING DISABILITIES IN PENNSYLVANIA'S PUBLIC SCHOOLS

Continued from page 22

Department of Education's Bureau of Special Education. At present, there are only 25 individual schools in the state that are approved to use Response to Instruction and Intervention (RtII) data for eligibility decisions (PaTTAN, 2012). A typical school approved to use RtII data may outline a process for students in grades K-4 to be identified using RtII data specific to reading disabilities while all other disabilities are determined based on a discrepancy between achievement and ability (or predicted achievement). The criterion that students must be functioning well below grade level standards remains regardless of the identification method (discrepancy or RtII) used in the school.

Integration of IEE with LEA decision-making process

An independent educational evaluation (IEE) is the term used to designate a psychoeducational evaluation of a school-aged child that is completed by an appropriately credentialed person or agency other than the child's local educational agency (LEA). Under IDEA regulations, an LEA is required to consider, not necessarily accept, the results of the IEE when making a determination of special education eligibility. LEAs can disagree with the results of an IEE for a variety of reasons; however, one such reason may be that the IEE is not consistent with the LEA's SLD eligibility practices.

Knowing what criteria LEAs are authorized by the Pennsylvania Department of Education to use in the identification of SLD should guide the assessment battery and interpretations utilized in the IEE. If the LEA continues to use an ability-achievement discrepancy approach, then the IEE would likely include administration of a standard cognitive and achievement battery such as the Wechsler or Woodcock-Johnson series. These data would be easily integrated with LEA data when determining special education entitlement.

If an LEA, however, uses an RtII identification model for SLD, then the private practitioner needs to understand that traditional ability-achievement data many not be accepted by the LEA as evidence of an SLD. Under an RtII identification model, SLD is determined by reviewing progress monitoring data collected over multiple weeks using measures such as Dynamic Indicators of Basic Early Literacy Skills (DIBELS; Good et al., 2011) or AIMSweb (Pearson, 2012) and evidence that empirically-supported instructional practices and interventions were implemented with fidelity. A measure of cognitive abilities is not required except to rule out an intellectual disability. Therefore, traditional ability-achievement discrepancy data are typically not considered to be indicators of SLD within an RtII identification model.

If conducting an IEE for a child in an LEA that uses RtII as its SLD identification model, what data can the IEE provide that will facilitate a collaborative relationship? Many argue that comprehensive cognitive functioning data assessing underlying neuropsychological processes directly associated with academic skills can be insightful within an RtII eligibility model. These data, for example, may include assessment of phonemic awareness skills, verbal memory, and executive functioning because these are cognitive skills that are known to directly influence the ability to read (Hale & Fiorello, 2004).

Those who complete IEEs are strongly advised to contact the child's LEA prior to conducting the evaluation. Once practitioners know which eligibility determination model the LEA uses, then the practitioner can tailor the evaluation to maximize the likelihood that IEE data are meaningfully integrated with the LEA's data. Failure to acknowledge the LEA's SLD eligibility model and collection of assessment data that can be integrated with that model will provide little benefit to the child, guardian, or school team.

References

References are available from the first author at trunge@iup.edu or on the PPA website at www.PaPsy.org.

SCHOOL PSYCHOLOGY PERSPECTIVE: CHILDREN WITH CANCER

Continued from page 23

Many childhood cancer survivors cope with the experience in a positive way, setting clearer priorities, and establishing stronger self-values, while others have a harder time recovering, adjusting to life after cancer, and moving on. It is normal to have some anxiety or other emotional reactions after treatment but feeling overly worried, depressed, or angry can affect many aspects of a young person's growth and get in the way of relationships, school, and/or family life. The strong support of family, of other cancer survivors, and of mental health professionals is important to their recovery.

Psychologists can help to ensure that emotional support is provided in the education and management of care for chronically ill children. This may include acting as a liaison for the hospital, school, family, and child. Mental health professionals and medical personnel can help parents tell the chronically ill child and siblings about the disease based on developmentally appropriate information and adequate background knowledge about the illness. Mental health professionals can inform teachers and administration of symptom presentation, behavioral effects, and academic performance issues, and then identify interventions that may work best given the child's health limitations.

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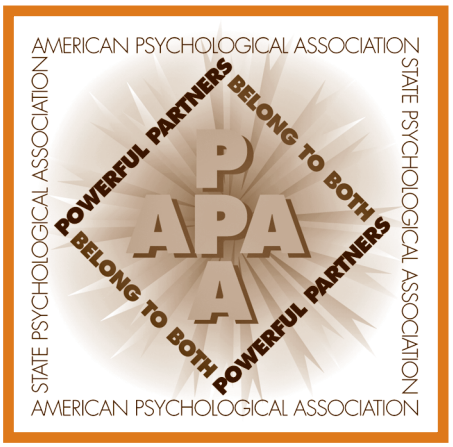
Welcome, New Members

We offer a huge, herculean, whopping welcome to the following new members who joined the association between August 1 and October 31, 2012!



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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 December 31, 2014.

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

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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.

DeWall

1. House Bill 1570 would have:
   a. provided that only physicians, dentists, and podiatrists can be members of hospital medical staffs
   b. provided an easier way for the Secretary of Health to grant exceptions for membership on hospital medical staffs
   c. added psychologists, pharmacists, and nurses to hospital medical staffs
   d. allowed each hospital to decide who is on their medical staff

Knapp et al. – Legal Column

2. A father wants his 15-year-old son to get therapy, but the mother refuses to agree to it. The 15-year-old is refusing to go to therapy. The parents are divorced with a court order of shared legal custody. In this case the psychologist:
   a. cannot treat the child simply because one parent has given consent
   b. could treat the child if the child changes his mind and agreed to treatment
   c. could not treat the child because the child is refusing treatment and the parents, who have shared legal custody, do not agree on the need for treatment
   d. all of the above

3. A mother wants her child (aged 13) to get psychotherapy, but has not had any contact with the father (who has court-ordered shared legal custody) for several years. She can give the last known address of the father. According to risk management principles suggested by the authors, in this situation the psychologist:
   a. should not treat the child
   b. should document attempts to contact the father, but need not withhold treatment if the father remains missing
   c. can go ahead and treat the child without attempting to contact the father
   d. none of the above

Poloni

4. Current research findings indicate which of the following can influence chronic pain perception?
   a. coping style
   b. anxiety
   c. culture
   d. depression
   e. all of the above

5. Teaching pacing techniques to chronic pain patients is useful for:
   a. creating an all-or-none activity pattern
   b. facilitating sleep
   c. helping them increase functioning
   d. assisting them in avoiding overexertion
   e. c and d only

Chase

6. For which of these medical conditions are mindfulness-based interventions not discussed as contributing to physical benefit?
   a. chronic physical pain
   b. Wilson's disease
   c. psoriasis
   d. immune function
   e. breast cancer

7. Psychologists should strive to make a case for a role in every dimension of the medical field.
   True
   False

Dean-Hill

8. Up to what percentage of children and adolescents with IBD struggle with comorbid anxiety and/or depression?
   a. 30%
   b. 40%
   c. 50%
   d. 60%

9. Hypnosis has been demonstrated to be useful in the treatment of which symptoms?
   a. pain
   b. anxiety
   c. both a & b
   d. neither a nor b

Slattery

10. Whites who avoid discussions on race may be perceived as _____ than more prejudiced Whites.
   a. more likable
   b. more racist
   c. less intelligent
   d. more highly genuine and authentic

Karafin

11. In the past 20 years statistics about childhood cancer indicate that childhood cancer has:
   a. increased and the survival rate has increased
   b. decreased and the survival rate has decreased
   c. increased and the survival rate has decreased
   d. decreased and the survival rate has increased

12. Cancer and its treatment can cause changes in:
   a. the brain and cognitive system
   b. vision functioning
   c. hearing functioning
   d. hormonal functioning
   e. all of the above

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, December 2012

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

1.	a	b	c	d		**7.**	T	F		
2.	a	b	c	d		**8.**	a	b	c	d
3.	a	b	c	d		**9.**	a	b	c	d
4.	a	b	c	d	e	**10.**	a	b	c	d
5.	a	b	c	d	e	**11.**	a	b	c	d
6.	a	b	c	d	e	**12.**	a	b	c	d e

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.

"Take Two Apps and Call Me in the Morning:" Apps as Health Care

Ed Zuckerman, PhD, EdZucker@mac.com

Dr. Ed Zuckerman

The basics *(Nerds can skip this section.)*

All computer-like devices have both an "operating system" (such as Mac's OSX or Windows) which runs the screen, mouse, connections to the Internet, printers, and all kinds of neat stuff in the background and a set of programs called "applications" to accomplish tasks. These are the familiar word processors, Internet browsers, spreadsheets, etc. Each of these kinds of software comes in two levels – more powerful ones to run on desktop or networked machines and smaller versions suitable for the less powerful hardware processors ("chips") in mobile devices such as smart phones and tablets. For Apples, iPads, iPhones, and iPods the operating system is called iOS while other mobile devices use the Android OS or Microsoft's "Windows."

"Netbooks" and "laptops" are portable and intermediate. Laptops run the full size operating systems and applications and netbooks run simpler versions. Cell phones that do just telephone are called "feature phones" and those that browse the Internet or run apps are called "smart phones." The software programs for mobile devices to accomplish a task are called "apps" as a minimized version of "applications." There are approximately 700,000 apps, and around 10,000 of these address health and medical concerns.

Smart phones as healthcare

Well designed apps can help diagnose, manage, and treat medical and psychological conditions. While best used as part of a therapeutic relationship they offer particular value for those with limited or no access to typical treatment modalities. It is currently possible to "prescribe" apps for disorders but this raises many questions.

- Apps have not been scientifically evaluated for risk or effectiveness and are currently unregulated (see endnote). How do they interact with medications, psychotherapy, lifestyle, and self-care?
- Can prescribing an app create legal and ethical vulnerability? Who is responsible if a condition worsens – the app's developer? The prescriber? The malpractice insurer?
- Apps rarely protect the privacy and security of the data they collect, instead relying on the generally unsophisticated user.
- And lastly, how are they supported? Are they to be bought (and bought again?) or paid for with ads? And if so, how will the ads be selected?

Electronic medical records systems are rapidly being adopted and extended. These will have to offer a "patient portal" where patients with Internet access can see their appointments, records, use e-mail and, relevant here, collect data generated by apps on their smart phones. How is this to be processed to improve care and individual outcomes? Some patients will want copies of their records and other information about their health to keep in a personal health record (PHR). This is complex because the information is in very different formats, but there are several apps for PHRs.

The psychology of apps

Psychologists are not presently among the providers being encouraged (bribed) to adopt electronic health records, but they have a great deal to contribute to the design and success of apps and the use of their data. While most think of apps as computer technology, that is really a minor part. We interact with them and that is all psychology. Let me explain.

If 99% of the DVRs in this country continue to flash the time because the owner does not understand how to set up the machine, is that a hardware problem? No, it is an interface problem – part of what is called human factors and that is part design and part psychology. If a technology is confusing or cognitively demanding, or requires learning new meanings for terms, or ignores or contradicts familiar patterns, it will not be used and its benefits lost. These factors come under the heading "usability" and psychologists can and have contributed extensively to this.

The understanding of attending, maintaining focus, planning, and sequencing are indispensable. When the way to use an app is clear, familiar, and unsurprising or undemanding, it is called "transparent" and feels comfortable. Many software companies carry out extensive testing of their human-computer interface and user satisfaction. This is all psychology.

Lastly using an app for health care requires persistence. Apps that are boring, static, obvious, uninteresting, and fail to reward the user will be abandoned and thus ineffective. Psychologists' understanding of motivation, reinforcement menus and schedules, programmed learning, and learning theory in general can contribute greatly.

Endnote

The FDA intends to get involved with these "medical devices" and has recently published guidelines for comment. See http://www.fda.gov/medicaldevices/productsandmedicalprocedures/ucm255978.htm

Member News


Dr. Jeffrey Sternlieb

Dr. Jeffrey Sternlieb received the annual Forum Impact Award from the Forum for Behavioral Science in Family Medicine for his presentation, *Introducing and Integrating Reflective Practices in the Family Medicine Curriculum*. The Forum is a national meeting that attracts more than 200 interdisciplinary professionals who teach behavioral sciences – mostly at family medicine residencies in the U.S. and overseas. Selection for the Impact Award is based on four criteria: Program Committee rating of original proposals, session ratings, nomination on the overall program evaluation, and evidence of impact on the teaching or practice of attendees as determined by a post-conference survey.

Dr. Alan Tjeltveit, psychology professor at Muhlenberg College in Allentown, was the winner of this year's Ethics Educator of the Year Award, given at the annual Ethics Educators Conference in October. The award was presented by Dr. Linda Knauss, chair of the Ethics Committee. Dr. Tjeltveit is the author of *Ethics and Values in Psychotherapy* and has written extensively and frequently presents continuing education programs in the areas of religion, psychology, and ethics.

Classifieds

POSITION AVAILABLE

PART-TIME PA LICENSED PSYCHOLOGIST (PHD/PSYD PREFERRED) FOR BUSY YARDLEY GROUP PRACTICE; 8-15 hours/week; afternoon/evening hours and Saturday mornings; supervisory experience preferred; focus on children/families; experienced in individual, couples, and family counseling; email CV, and 3 professional references to buckspsyc@yahoo.com.

Established, successful outpatient private practice in State College (statecollegetherapist.com) seeks **PA LICENSED PSYCHOLOGIST** to join our group full-time. We are particularly interested in colleagues skilled in treating substance abuse and those experienced with child therapy and custody evaluations. Generalists are also encouraged to apply. Great opportunity for dynamic, early career psychologist, or individual seeking career relocation, to live and work in vibrant university community. Email cover letter and CV to cafpc@comcast.net.

OTHER

EXPANSION OFFICE SPACE! Share quiet, professional suite near suburban Philadelphia area (Bala Cynwyd), furnished, conference room, fax/copier, etc. Flexible hours, friendly rates. 610-664-3442.

LIFE SKILLS TRAINING SUPPORT GROUP FOR YOUNG ADULTS –Life Skills Training Support Group for Young Adults to learn what parents, teachers & educators didn't teach to be able to be successful in a marriage, schooling, parenting & socially. Includes financial, healthy lifestyles, organizational, social, time management & much more. Meets alternating Sundays at 3 pm for an hour. Must pre-register. 306 Rickert Rd, Sellersville PA 18960; 215-799-2220; drjaallender@gmail.com

MOTIVATION CARDS by Dr. Julie Ann Allender; they are designed to help motivate everyone to have a better day. Each card is created with a photo chosen from an extensive photo library & includes a motivational saying. The deck of 54 cards comes with a purple collapsible desk holder for portability. $15 per set. Quantity discounts available. Cards can be viewed & ordered from www.pettherapyparadisepark.com or office: 215-799-2220.

OFFICE FOR RENT. Lovely, bright, windowed office in Lewisburg for rent. Located within a three-office suite with separate waiting room. Secretarial, billing, and/or supervision support is optional. Phone and DSL line for internet are included. Available part- or full-time. Price is dependent on days and amount of support desired. Please contact Kathleen at 570-524-0881 or at kbergesonphd@gmail.com with any question.

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2013 CE Calendar

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

April 4 and 5, 2013
Spring Continuing Education and Ethics Conference
Monroeville, PA
Marti Evans (717) 232-3817

June 19-22, 2013
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

October 31/November 1
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@PaPsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/index.php/collaboration-communication/.

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.

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

Excess Weight and Weight Loss – NEW!
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

**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.