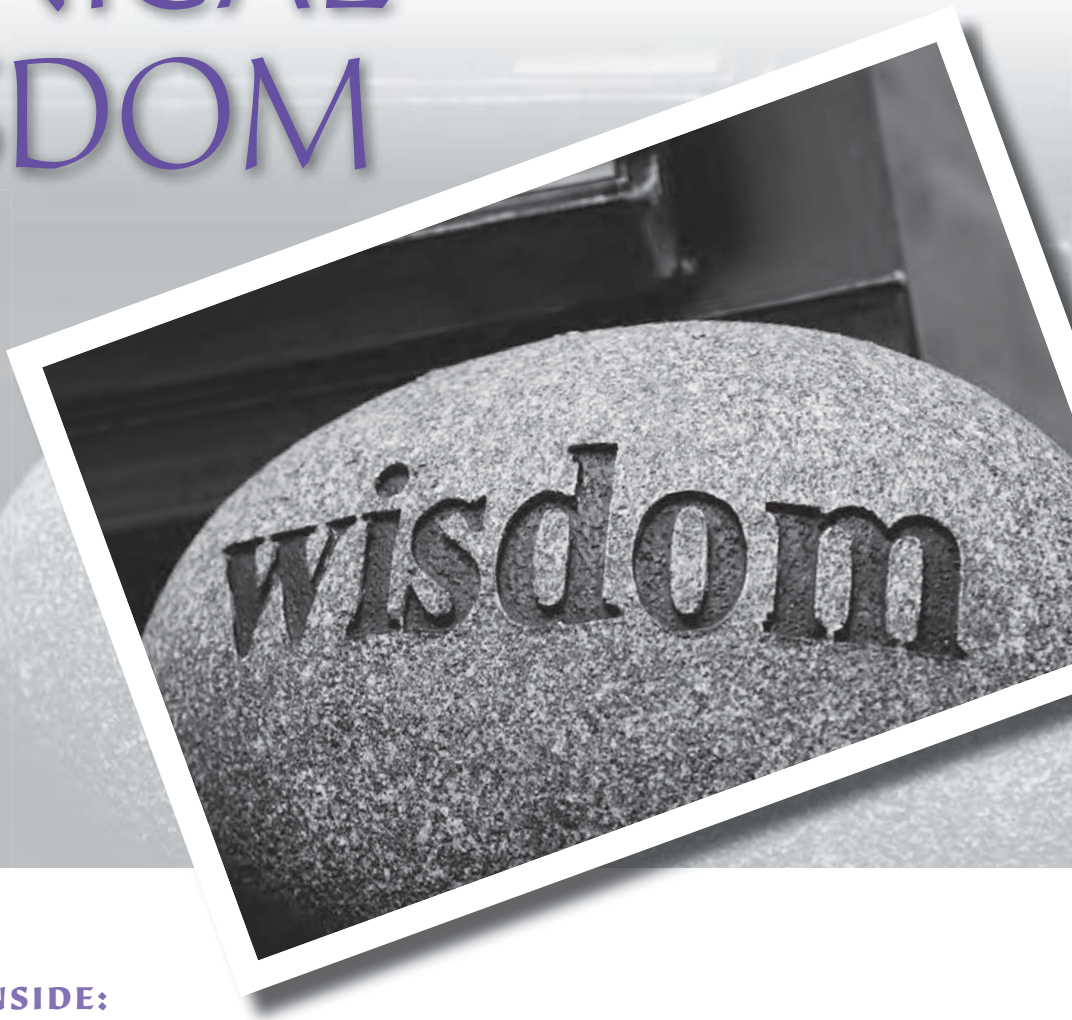
Vol. 73, No. 11

A PUBLICATION OF THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION • www.PaPsy.org

The Pennsylvania Psychologist

December 2013
QUARTERLY

CLINICAL WISDOM



ALSO INSIDE:

- The importance of ethics consultations
- Fetal alcohol syndrome interventions and supports
- Implications of Lyme disease
- Electronic health records and psychologists

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The ***Pennsylvania Psychologist*** is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in the *Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

The *Pennsylvania Psychologist* Quarterly is published in March, June, September, and December. The copy deadline is the 15th of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 416 Forster Street, Harrisburg, PA 17102.

Copy Editor: Karen Chernyaev
Graphic Design: LiloGrafik, Harrisburg

Vol. 73 No. 11

The Pennsylvania
Psychologist

Editor: Dea Silbertrust, PhD, JD

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Ch-Ch-Ch-Ch-Changes!

Vincent J. Bellwoar, PhD

"Progress is impossible without change, and those who cannot change their minds cannot change anything."

—George Bernard Shaw

Dr. Vincent J. Bellwoar

Change is underway for Pennsylvania psychologists! Healthcare reform is here, and psychologists have much to learn about how its implementation will affect them. There are numerous other challenges to psychologists as outlined previously by Sam Knapp and me. As the winds of change continue to swirl around us, a significant transition is underway within PPA's leadership. Krista Paternostro, our new executive director, officially began working in the position on August 15. Like anyone taking over the reins from a long-established leadership, Krista needs to assess the situation and set her own course. PPA's Board of Directors not only knows this but expects it.

As president of PPA, one of my most important jobs is to facilitate the successful transition to our new executive director. Last year I consulted with other state psychological associations who had hired new executive directors. What made the process successful? What led to disaster? PPA's Board of Directors was very pleased to have hired an executive director with Krista's résumé. The board now needs to work with Krista as we create PPA's new direction and provide her with the resources and support to enact the changes necessary to PPA's long-term success. Borrowing from my "PPA is a ship" metaphor, since coming onboard, Krista has been assessing the inner workings of our ship. Where are its strengths and its weaknesses? How does the ship function on a daily basis, and how can it function better? Indeed, if the PPA ship is headed for a "perfect storm" of events, how can we improve the ship to not only weather the storm but to propel through it?

Much of Krista's early assessment has less to do with the field of psychology than the business operations of PPA. With years of association leadership behind her, Krista understands what makes associations great. She subscribes to Jim Collins's business philosophy of "good to great." Make no mistake: PPA, with an annual budget of almost $900,000 and seven employees, is a business wherein each member is a stockholder. Krista needs to figure out how to make PPA not only relevant to its members but a necessity in their professional lives. Psychology is a broad field and financial pressures are mounting. Healthcare reform brings many promises and pitfalls. Nevertheless, the first task of our new captain is to assess the inner workings of the PPA ship so that it can weather the challenges ahead.

Assessing the condition of the ship and implementing changes is not being done in isolation. PPA bylaws state that the executive director must carry out the policy and directives of PPA's Board of Directors. Also, a smaller working group within the board, the Executive Committee, is specifically instructed by PPA bylaws to act as the administrative agent of the Board of Directors and supervise the work of the executive director. As chair of the Board of Directors and Executive Committee, I will work closely with Krista to offer direction, support, guidance, and encouragement so that she can be successful.

For many years, the relationship between the president and executive director was relatively straightforward and consistent. With two decades of PPA experience, former executive director Tom DeWall had a well-established system and process. Presidents didn't face many surprises during their tenure. Such predictability and consistency allowed for smooth operations. Over time though, as in any business, consistency can lead to complacency. PPA's current changes will undoubtedly bring some chaos. The board understands change is coming and looks forward to channeling that change into creativity, vigor, and opportunity for our future.

The board understands change is coming and looks forward to channeling that change into creativity, vigor, and opportunity for our future.

The change process began in June when Krista attended our annual convention. She eagerly absorbed every aspect of PPA and impressed us with her poise and enthusiasm. There were a few key highlights that I witnessed: the warmth, affection, and humor resonating throughout Tom's retirement party; young psychologists eagerly lining up at the Early Career Psychologist reception to meet Krista; and Executive Committee and board meetings wherein Krista targeted questions about PPA's finances and IT capabilities. The education continued over the summer as Krista familiarized herself with PPA history and joined Tom at the APA convention in Hawaii. In mid-August Krista and Tom overlapped their roles for two weeks in the PPA office. Finally, Krista went solo on September 1.

As chair of the executive director Search Committee and now president of

Continued on Page 6

Moving Forward With the Past in Mind

Krista L. Paternostro, CAE


Krista L. Paternostro

I attended my first-ever PPA Ethics Educator Conference on October 4 in Harrisburg. An exceptional meeting, this conference reinforced for me how technology is impacting the way our members interact with their clients. The morning session was focused on the topic of telepsychology. As a nonpsychologist, I found the discussion fascinating. Maneuvering through the ethical implications of providing electronic or distance therapy, as well as teaching others how to instruct on this emerging topic, seemed quite complex. A vocation with its roots steeped in the personal interactions between psychologist and client, the whole business of psychology could fundamentally change with the introduction of faster, more convenient, and more comprehensive communication methods.

I sat in the meeting trying to see this challenge through my nonpsychologist eyes. Would I want to participate in a session of this sort over Skype? Could I truly gain the same important experience working over e-mail or through other electronic means? The value of sitting in on this session and hearing the discussion helped me to better understand the environmental influences that our members are facing. During lunch I was about to realize that, at some level, pressures from technological advances face all of us.

I sat down at the table with one of the last empty seats to join Dr. Jeff Sternlieb and Dr. Gerstein, two well-known PPA members, as well as several other engaged PPA members. I was exchanging pleasantries with my fellow tablemates but spent a considerable amount of time talking to Dr. Gerstein, who was seated beside me. I sensed his New England dialect, and we spoke about where he grew up and then we talked about Maine and our favorite places to spend time there. And then it happened.

There was a short lull in the conversation, and I reached for my phone. I was only reaching for my phone to see what time it was. At least this is what I told myself. But Dr. Gerstein knew better. And, he called me on it. He leaned over to Dr. Sternlieb and said something to him. Although I could not hear exactly what he said, I knew he was talking about me. When I asked him what he said, he told me. "I said that the minute our conversation stopped you instantly reached for your phone. It is what has become a normal reaction that people use these days to deal with the anxiety caused by silence." Wow. I felt a bit disappointed in myself because I knew he was right. I knew he was right because I had listened to others close to me utter almost the same sentiments to me time and time again. When I claimed that I was looking at my phone to see what time it was because I did not wear a watch, without missing a beat Dr. Gerstein looked at me and said, "And, why don't you wear a watch? Because you have a phone that does everything for you!" Caught again.

What followed this exchange was a wonderful discussion among the three of us, including Dr. Sternlieb, about technology and how it has fundamentally changed the way we interact with each other, communicate with each other, and, in many cases, how we spend our quiet time. We talked about grandchildren, nieces and nephews, and those in an even younger generation than mine who have grown up with instant access to information and data and other distractions that keep them from just being kids. We talked about how we have lost the ability to be okay with silence and to enjoy just being in the moment. We talked about the unknown implications of all of this for our future. I know that there were no new revelations at our table that day, but the discussion over lunch brought me back to my thoughts from the morning session, which brings me to today.

As an organization, our members are constantly bombarded with shifting external pressures, from dealing with nationwide economic uncertainties, decreasing reimbursements, competition from other disciplines, new health insurance regulations, to—well, the list goes on. The introduction of technology brings new considerations into the mix. These impacts are not only changing the way our members do business but the way the world works . . . with far-reaching implications we have yet to anticipate.

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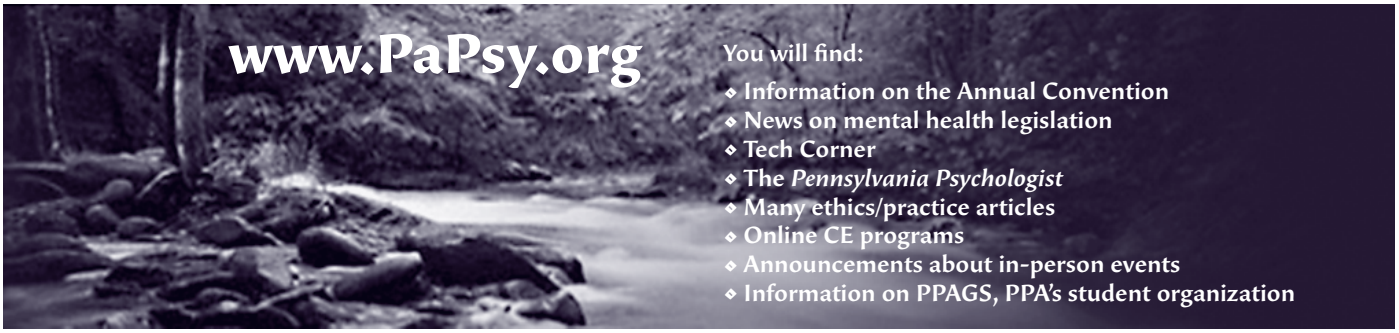

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of November 13, 2013

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 20	Expands definitions of child abuse and perpetrator - Sen. LeAnna Washington (D-Philadelphia)	Under review	Passed by Aging & Youth Committee; in Appropriations	None
SB 21	Requires reporting suspected child abuse even if the child is not seen in a professional capacity or upon getting the information secondhand; report must be made to county as well as to ChildLine - Sen. Kim L. Ward (R-Westmoreland)	Requested amendments	Passed 10/2/13, 50–0	In Children & Youth Committee
SB 22	Increases penalties for intentional failure to report child abuse - Sen. Kim L. Ward (R-Westmoreland)	Under review	Passed 10/2/13, 50–0	In Children & Youth Committee
SB 28	Increases penalties for child abuse, for failure to report under certain circumstances, or to prevent someone from reporting - Sen. Patrick M. Browne (R-Lehigh)	Under review	Passed 10/16/13, 49–0	In Judiciary Committee
SB 31	Adds requirements on school employees for reporting child abuse - Sen. Wayne D. Fontana (D-Allegheny)	Under review	Passed 10/16/13, 49–0	In Children & Youth Committee
SB 980	Updates the psychologist licensing law, eliminates certain exemptions, and modernizes the experience requirements - Sen. John R. Gordner (R-Columbia)	For	In Professional Licensure Committee	None
SB 1025 **HB 1011**	Prohibits the outsourcing of prison psychologist positions - Sen. Timothy J. Solobay (D-Washington) - Rep. Michael E. Fleck (R-Huntingdon)	For	In Judiciary Committee	In Judiciary Committee
HB 21	Authorizes psychologists to testify in court on the determination of insanity and competency to stand trial - Rep. Glen R. Grell (R-Cumberland)	For	In Judiciary Committee	Passed 10/23/13, 198–0
HB 336 **SB 619**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after four years - Rep. Kate Harper (R-Montgomery) - Sen. Stewart J. Greenleaf (R-Montgomery)	For	In Professional Licensure Committee	Passed 2/13/13, 195–1
HB 316	Establishes child advocacy centers to investigate allegations of child abuse - Rep. Julie Harhart (R-Northampton)	For	In Aging & Youth Committee	Passed 2/12/13, 198–0
HB 430	Allows reports of child abuse to be submitted through advanced electronic communications - Rep. Katharine M. Watson (R-Bucks)	For	In Aging & Youth Committee	Passed 6/20/13, 184–6
HB 431	Mandates training in child abuse; needs amendments including waiver for those who do not treat children - Rep. Mauree A. Gingrich (R-Lebanon)	Requested amendments	In Professional Licensure Committee	Passed 4/17/13, 191–0
HB 436	Requires reporting suspected child abuse even if the child is not seen in a professional capacity or upon getting the information secondhand; requires reporting a patient for disclosing past child abuse - Rep. Todd Stephens (R-Montgomery)	Against	In Aging & Youth Committee	Passed 6/24/13, 194–4
HB 580	Provides mandated reporters of child abuse with information on reports they have filed - Rep. Louise Williams Bishop (D-Philadelphia)	For	None	In Children & Youth Committee
HB 673	Makes failure to report suspected child abuse a felony - Rep. Kevin J. Boyle (D-Philadelphia)	Against	None	In Judiciary Committee
HB 726	Expands definition of child abuse, especially in the area of serious physical neglect - Rep. Scott A. Petri (R-Bucks)	For	In Aging & Youth Committee	Passed 6/24/13, 191–6

Information on any bill can be obtained from http://www.legis.state.pa.us/cfdocs/legis/home/session.cfm

Ethics Consultation to Professional Psychologists

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


Dr. Samuel Knapp


Rachael L. Baturin


Dr. Allan M. Tepper

It is common for psychologists to hear "consult, consult, consult" when they are faced with a difficult ethical issue. Often, however, the next step is unclear. For example, the APA Ethics Code in General Principle B, Fidelity and Responsibility notes that "psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work" (American Psychological Association, 2002). Consultation is also referenced in Standard 2.01 as a means by which psychologists can ensure their competence. The codes are silent, however, as to what steps should be instituted when seeking such consultation.

The need for consultation can arise in different situations. Psychologists may seek consultation when they need to know the law applicable to a specific clinical situation; when they are faced with decisions where there is no clear regulation or legal ruling; or when they are faced with decisions in which they may need to balance competing ethical demands.

PPA members are strongly encouraged to seek consultation when they are faced with difficult ethical issues. The PPA website (members only section) includes a substantial bank of articles on ethics and law.[1] At times, however, psychologists will face ethical problems for which they require direct consultation. Fortunately, PPA members have several sources available for such consultation.

Many PPA members can obtain factual information, learn about resources, or receive adjunct advice by posting questions on the PPA listserv. The value of the listserv for more complex consultations, however, is more restrictive. That is, given the concerns regarding patient privacy, the clinical details that can be conveyed over the listserv may be limited in nature.

For a more in-depth discussion of legal or ethical concerns, PPA members are encouraged to call the PPA office at 717-232-3817 or e-mail Sam Knapp (sam@PaPsy.org) or Rachael Baturin (rachael@PaPsy.org). Sam and Rachael strive to provide information appropriate to the situation, identify resources, or otherwise help members think through complex ethical issues.

Many PPA members belong to PPA's Legal Consultation Plan. This prepaid plan provides up to three hours a year of legal consultation with an attorney–psychologist at a reduced fee of $150 per year. The legal consultation offered through the plan is covered under the attorney–client privilege, which allows for an open, protected discussion between the PPA member and the plan's attorney. Although PPA staff member Rachael Baturin is an attorney, the PPA Board of Directors does not permit her to enter into an attorney–client relationship with PPA members, and thus no attorney–client privilege attaches when discussing issues with Rachael. In addition, if a psychologist requires future legal representation, the experienced trial attorneys associated with the plan are familiar with the procedural and substantive issues associated with ethical and licensing board complaints, and thus they may be available to represent a PPA member in an outside legal matter.

Some professional liability carriers, such as the APA Insurance Trust (APAIT), provide consultation services that can serve as another valuable resource for the psychologist. The consultants affiliated with APAIT are extremely knowledgeable and experienced in the area of ethics and clinical practice, and they are often able to resolve questions or suggest additional individuals who may be of assistance.

At times psychologists should consult with their professional liability insurance carrier. If a patient has filed a malpractice complaint, demands a monetary settlement in lieu of filing a malpractice action, or requests a detailed letter of apology, the psychologist is advised to consult his or her professional liability carrier. For instance, refunding money to a patient in response to a malpractice complaint or in response to a threatened malpractice complaint could be construed as an admission of liability. The refunding of such money, absent the knowledge and approval of the professional liability carrier, also could be construed as a violation of the psychologist's contract with the carrier, thereby allowing the carrier to refuse to defend the psychologist in a subsequent legal action.

Ethical consultation constitutes good professional practice. Such consultation can help navigate difficult clinical issues or ethical dilemmas. Such consultation also may be necessary to respond to an ethical or licensing board complaint. In all situations, however, the admonition to "consult, consult, consult" is good practical advice.[2]

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073.

Knapp, S., & VandeCreek, L. (2009, Fall). Disciplinary actions by a state board of psychology: Does gender and association membership matter? *Focus on 31 Division 31 Newsletter*, p. 7.

[1] The PPA website is www.PaPsy.org. To get to the members only section, enter the user name (the four-digit member number found on the mailing label of the *Pennsylvania Psychologist*) and the password (your last name with the first letter capitalized). Go to "Members Only," then "Publications," and then "Legal and Ethical Issues" to search for the relevant articles.

[2] The use of PPA-sponsored consultation resources may be one reason that there is a low percentage of disciplinary actions against PPA members. Since 1998, for example, only 10% of Pennsylvania's State Board of Psychology disciplinary findings of serious boundary violations have involved PPA members, whereas PPA members constitute approximately 50% of the licensed psychologists in Pennsylvania (updated information from Knapp & VandeCreek, 2009).

Continued from Page 2

PPA, I have worked closely with Krista throughout this transitional period. Although she's had to absorb a substantial amount of information, she's done it very well. Her leadership experience in other associations has been of tremendous value in assessing how PPA can do better. She's worked collaboratively with PPA staff members, especially Sam Knapp, tapping into their decades of experience regarding what it takes to be one of the best state psychology associations.

The PPA board meets quarterly to review the progress on a range of issues addressed by PPA staff and volunteer committees. At September's board meeting Krista presented her initial assessment of the current state of PPA: our advantages, challenges, pressures, and opportunities. Some areas require more immediate attention than others, including upgrading our IT capabilities, refurbishing the PPA building, revising the strategic plan, and paying for it all.

IT and communications

The board has recognized for a few years that PPA needs to upgrade its technology. These days, the business that is behind the curve in technology is a business that loses customers. We are in the process of a thorough assessment of current needs and a long-term comprehensive plan of how to get there. PPA needs to do a better job in recruiting and maintaining its membership, especially of early-career psychologists. The younger generation uses and relies on technology differently than those of us born before the Kennedy administration. PPA needs to adjust how we communicate with—and therefore attract—younger members.

Many of our IT tools are antiquated. Our computers and operating systems are susceptible to significant security threats and so we must purchase new ones. PPA staff interacts with the Internet via the turtle-like speed of DSL and so we will upgrade to cable access. The membership database needs to be placed on a platform that more easily interacts with other software programs. Improved IT systems can help to make our convention more meaningful and relevant to younger members. The world of CEs is quickly changing. Unless we evolve now, the world will pass us by, and we will lose members and CE income. Lastly, we need to upgrade our website to one that members want to visit on a regular basis.

Plant working conditions

PPA owns the building in which staff works. Two decades ago some very wise PPA members recognized the financial benefit to owning a building and did the hard work to make the dream come true. Just like our own home, the PPA building needs upkeep. Without such, the investment begins to suffer. The PPA building is our investment, and we need to protect our investment by keeping it in good form. And, from a human resources standpoint, PPA staff deserves quality working conditions. If we expect professionalism and efficiency from PPA staff members, we should be prepared to provide them with a professional and efficient work space.

Strategic planning

Although due for a revision in March 2013, the PPA strategic plan will be revised by members of the General Assembly (that is, the board and all committee chairs) in December 2013. It seemed most appropriate to wait until our new executive director was in place, as she will play a key role in implementing the strategy. The plan serves as our compass, giving the board, committee chairs, and PPA staff the guidance needed to stay on course. In rewriting the plan the General Assembly and PPA staff will consider a few questions: What are PPA's top three strengths? What are the top three programs/initiatives/things that PPA should stop doing? In 2020 what should PPA look like?

PPA finances and reserves

One of Krista's key early actions was to dive into our finances. With Iva's and Tom's assistance she went through our budget line by line, again and again, until she understood every item. She has introduced some ideas about how we can control our finances differently and how we can present our finances in a more "user-friendly" manner to the PPA board and committees. PPA operates on a tight budget. The changes described above will not come cheaply. Upgrading our IT and our building will come at a cost. Such things always do, but these are sorely needed investments in our future.

These days, the business that is behind the curve in technology is a business that loses customers.

Once again, thanks to some very wise former PPA volunteer leaders, PPA has a robust reserve fund. PPA policy states that our reserve fund should be used to sustain operations during economic downturns and to cover unbudgeted and extraordinary expenditures. Over the next year we expect to see proposals for improvements to our IT capabilities and upgrades to our building. We expect that such projects will be funded by tapping into our reserve funds. Be assured that any such use of the reserve fund will be seriously considered by the Budget and Finance Committee, Executive Committee, and Board of Directors.

The board expects Krista to proceed with making the PPA ship "storm ready" for the challenges ahead. We know a significant storm is brewing out there. Assessing the ship's capabilities and its potential is a key step as we propel the ship into future challenges. Change is necessary. If done well, with due diligence and wisdom, these changes will serve PPA's best interests for years to come.

EXECUTIVE DIRECTOR'S REPORT
Continued from Page 3

PPA, as your professional organization, is striving to anticipate the barriers ahead by creating new pathways that will eventually lead us toward new directions and new opportunities. Everything that happened that day during the Ethics Educator Conference in October helped me to see the bigger picture just a little more clearly. But, it also left me with some unanswered questions:

- How can PPA position itself to embrace and use new technologies to make the delivery of services to our membership better, faster, and more efficient?
- How can we continue to provide relevant and timely opportunities for our members to collaborate about matters impacting psychology?
- How can technological advances help our members? What can we do to facilitate this?
- How will the world communicate in five years? Ten years? Will our organization be ready?
- How can we embrace the changes impacting the profession and turn them into positive, value-added experiences for our members?

There are many bright days ahead for PPA. Of this, I am certain. And, with your input, support, and ideas, the answers to these questions will reveal themselves over time. In fact, our strategic planning process commences in December. I know that involving the collective minds of our engaged General Assembly, our fearless facilitator Dr. Rex Gatto, and our esteemed president, Dr. Vince Bellwoar, will allow us to create a strategy and a plan that pushes these questions a little farther down the road. Undoubtedly, along this road of change, new questions will emerge, and we will be ready. There is no other choice. But, in the meantime, I am going to buy myself a new watch.

Pennsylvania Psychological Association

2014

Award Nominations Sought

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 with contact information and send the information to Marti Evans, mevans@PaPsy.org, or to the following address by the deadline listed:

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

Award for Distinguished Contributions to School Psychology
The School Psychology Board of the Pennsylvania Psychological Association nominates a candidate annually for this award. To meet the criteria for this award, nominees must have contributed significant research in the field of child, adolescent, school, or educational psychology; contributed significant public service to children, families or schools; made major contributions to the field of assessment; made significant contributions in the media; advocated politically for children, families, or schools; been a voice advocating for school psychologists in Pennsylvania; and/or made significant contributions to the Pennsylvania Psychological Association. Deadline for entries is **December 31, 2013**.

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 2014 Psychology in the Media Award. Members who have written newspaper or magazine articles or books; hosted, reported or produced radio or television shows or commercials about psychology or psychological issues; or designed psychologically oriented websites are eligible for the award. We are seeking candidates who have had a depth and breadth of involvement in these areas with the media over a period of time. Some of the work must have been published or broadcast during 2013. An application form, which is available at www.PaPsy.org, must accompany all entries for this award. Applicants who have received this award in the past are not eligible. Deadline for entries is **December 31, 2013**.

Early-Career Psychologist of the Year Award
This award is to be given to a Pennsylvania early-career psychologist who, in his or her practice as an early-career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2014**.

Student Multiculturalism Award
This award is 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. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2014**.

Clinical Wisdom and Brain Science: Implications for Practicing Psychotherapy

Janet Etzi, PsyD


Dr. Janet Etzi

Recent advances in neuroscience are corroborating what practicing psychotherapists have known and experienced in relation to their clinical work for quite some time. An accumulation of clinical experience results in a type of knowledge, attitude, and skill set that is difficult to define but that perhaps can be referred to as *clinical wisdom*. In relation to wisdom there is much to be gained by understanding how the mind/brain works, and this accumulating knowledge is contributing to the effectiveness of psychotherapy and to the overall well-being of psychotherapists and their patients.

Siegel (2012) addressed wisdom specifically in relation to life-span development. The research strongly suggests that due to the brain's neuroplasticity, or its capacity for structural and functional change throughout the life span, development is a lifelong process. Wisdom, in other words, is closely related to new learning and the integration of complex and varied types of experiences. One implication of this research for psychotherapists is that accumulation of clinical experience leads to continuing professional development and growth, especially to the extent that the therapist remains open to new learning and novel experiences. In other words, when viewed neuroscientifically, wisdom is closely related to new learning and the integration of complex and varied types of experiences.

The concept of *integration* has been used to explain the mechanisms underlying the experience or expression of wisdom (Cozolino, 2008; Siegel, 2012). *Integration* refers to the brain's innate tendency to organize the constant flow of energy and information into coherent, meaningful experiences. As a self-organizing set of processes, the brain has evolved to handle tremendously complex types of information in order to adapt to a continuously changing physical and social environment. By integrating diverse types of information and experience, a person gains the capacity to tolerate and benefit from a wider and wider range of experiences, recursively stimulating further differentiation, or richness of experience, and "integrating" the sense of self with others. Emotional tolerance is one area that has been studied as a subcomponent of wisdom (Meeks & Jeste, 2009).

It is likely that wisdom is constituted by complex interacting processes, functions, and attitudes, making it difficult to measure with current technologies.

As neurons fire, they consolidate into patterns, or neural networks. Various patterns represent types of emotions, cognitions, and states of mind. When linked, neural networks set the stage for increasing levels of complexity in structure and functioning of the mind. Siegel (2012) postulated that wisdom may be the outcome of the integrative capacity "to focus on patterns over time and across situations" (p. 346).

It is likely that wisdom is constituted by complex interacting processes, functions, and attitudes, making it difficult to measure with current technologies. In his discussion of healthy aging brains, Cozolino (2008) states that "it is safe to assume that we would see more diverse brain activation, slower processing, and an integration of intellectual and emotional functioning" (p. 133). He goes on to point out that a "well-regulated OMPFC-amygdala [orbital and medial prefrontal cortex] network may well be a prerequisite for psychological maturity and the attainment of wisdom" (p. 151).

Compare the mature brain to the youthful brain: The aging brain slows down its processing and remains open to a wider range of types of information and experiences, increasing its capacity for perspective, patience with taking in jarring types of information, and comfort with ambiguity and uncertainty. A study performed in 1998 showed that training in clinical psychology was the most significant variable in wisdom-related performance. The sample of clinical psychologists differed from other professionals in *openness to experience* (Staudinger, Maciel, Smith, & Baltes, 1998).

In the work of psychotherapy, clinical wisdom might entail therapists' ability to recognize patterns that emerge across their varied and accumulative experiences and then to use what they observe or learn about those patterns. For example, therapists would be increasingly able to recognize their own blind spots when it comes to working with an angry client, especially when the anger is directed toward them, and to be able to tolerate the emotional discomfort associated with it. In addition, over a career, personal experiences would influence the clinician's attitudes and perspectives, adding another dimension to the work of psychotherapy. For example, a veteran psychotherapist may have experienced the loss of a spouse or a serious illness or may have successfully raised teenagers. These significant life-altering events bring with them the opportunity to reprioritize what is important in life, resulting in new perspectives. The clinician integrates experiences and associated emotions and cognitions into a coherent, meaningful whole, and they become part of the individual's evolving sense of self. Another component of wisdom, *compassion* is often associated with difficult life experiences and increases the capacity to know firsthand the suffering of others.

Much clinical wisdom happens outside of conscious awareness, or at least focal attention, and includes a felt sense of something important or productive or even profound happening in the therapy,

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Creating Conditions to Support Ethical Clinical Decision Making and Practices

Chris Molnar, PhD


Dr. Chris Molnar

Practitioners who base decisions largely on intuition and related subjective forms of clinical wisdom are prone to information and emotional processing biases that can produce inaccurate judgments. Relying largely on subjective approaches to processing clinical information can result in unethical practices that can extend suffering and cause harm to our clients (Grove, Zald, Lebow, Snitz, & Nelson, 2000). Thankfully, the scientific method and related procedures for prediction can guard against the pitfalls of using exclusively intuitive and other subjective approaches to clinical decision making that are prone to bias. This article highlights some of the research designed to guide us in creating conditions that result in ethical clinical decisions and practices likely to benefit rather than unintentionally harm those we serve.

When we diagnose clients and recommend specific treatments we process large amounts of data from many sources in order to arrive at judgments. Judgments usually include diagnosis, likelihood of future behaviors, and the intervention most likely to result in desired outcomes. This process, whether it depends on intuition or application of the scientific method of processing, is referred to as the clinical prediction approach. It is time consuming, costly, and prone to many information and emotional processing biases, especially when conducted intuitively.

The alternative approach is referred to as the mechanical prediction approach. It relies on formal algorithmic procedures to process large amounts of data. After conducting a large meta-analysis, Grove et al. (2000) discovered that the mechanical method is often superior or comparable to the clinical method at predicting outcomes. Of course the mechanical approach relies on humans to conduct research, choose prediction equations, and creatively identify the predictor variables that serve as input for mechanical processing. Computers are not prone to information processing biases but are objective in processing data and arriving at decisions in ways that can serve many more in need and much more efficiently and often affordably. If you think you are the exception, read Grove and Meehl (1996).

One particularly exciting application of both the scientific and mechanical methods to detect who will attempt suicide was reported by Nock et al. (2010). In this study the patients in an emergency room with a history of attempting suicide and the clinicians attending to them were asked to judge the likelihood of future attempts. Patients also completed a behavioral task that measured their reaction time (RT) to classifying semantic stimuli words that referred to the self, life, and death/suicide. Those with the fastest reaction times to suicide-related stimuli were presumed to have a strong implicit or automatic association between self and suicide. The mechanical prediction approach that used the implicit association RT index as a predictor was superior to patient and clinician prospective predictions of suicide attempts even after controlling for all of the usual risk factors. So it seems that the automaticity of the client, but not the clinical judge, can be a useful source for predicting an outcome very important to psychologists.

Many different investigators have proposed two distinct processing systems, both of which have specific relevance to the topic of clinical decision making. The automatic System 1 is the basis for intuition and is often referred to as implicit. It relies on primitive structures of the brain evolutionarily. It occurs without consciousness or intention, integrates large amounts of data quickly based often on reflex or past conditioning, does not require a high level of processing resources, and generates quick associations in response to stimulus cues and emotional states.

System 2 is volitional and conscious and the basis for rational and logical thought processes. It allows for objective evaluation of data systematically using the scientific method and is based on verbal and mathematical processes. It relies on evolutionarily more recent regions of the brain and requires attention, intention, and consciousness. It is much slower to arrive at conclusions and requires greater processing resources than System 1. For a review of several dual-processing theories see Hodgkinson, Lagan-Fox, and Sadler-Smith (2008).

Thankfully the two systems can be integrated and interact so that we can bring awareness to the automaticity. In fact, awareness of mental activity or metacognition that is marked by intention, attention, and a relational quality of kindness is also referred to as mindfulness and can allow us to integrate the two systems and reduce the automaticity that can result in clinical errors and unnecessary suffering.

When we diagnose clients and recommend specific treatments we process large amounts of data from many sources in order to arrive at judgments.

A highly recommended resource for reducing judgment errors is the chapter by Ruscio (2010) and the text in which it appears. Briefly, Ruscio suggests that we stay mindful of classic cognitive biases and heuristics, including confirmation and hindsight biases, and instead generate multiple hypotheses for which we systematically evaluate evidence before forming a conclusion (i.e., apply the scientific method). He suggests that we apply basic principles of probability,

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CLINICAL WISDOM AND BRAIN SCIENCE

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whether or not it can be articulated in the moment. Neuroscientific data (McGilchrist, 2009; Schore, 2012) that demonstrate how the right hemisphere is dominant for implicit, nonconscious processes and nonverbal emotional communications is mounting. Implicit processing is relevant to the neuroscientific understanding of clinical wisdom because it represents at least part of what psychotherapists do. For example, empathy and nonverbal emotional communication are by and large implicit processes.

It must be clear to most seasoned and empathic clinicians that a significant part of the clinical work they perform is difficult to articulate yet experienced as powerful and even perhaps personally meaningful. Neuroscience is demonstrating that this part of our work is crucial to its effectiveness.

References

Cozolino, L. (2008). *The healthy aging brain: Sustaining attachment, attaining wisdom*. New York, NY: W. W. Norton & Company.

McGilchrist, I. (2009). *The master and his emissary: The divided brain and the making of the western world*. New Haven, CT: Yale University Press.

Meeks, T. W., & Jeste, D. V. (2009). Neurobiology of wisdom: A literature overview. *Archives of General Psychiatry, 66*(4), 355–365.

Schore, A. N. (2012). *The science of the art of psychotherapy.* New York, NY: W. W. Norton & Co.

Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Press.

Staudinger, U. M., Maciel, A. G., Smith, J., & Baltes, P. B. (1998). What predicts wisdom-related performance? A first look at personality, intelligence, and facilitative experiential contexts. *European Journal of Personality, 12,* 1–17.

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statistics, and research evidence to individuals and integrate data about base rates into our decision-making processes. Importantly he suggests we not habitually conclude that our clients are exceptions to what well-designed research studies show. He gives the example of clinicians who do not use evidence-based interventions in the treatment of anxiety disorders despite the massive amount of research in support of this treatment as a first-line intervention. What Ruscio (2010) describes is essentially application of the scientific method and, thankfully, there are many efforts to support this practice, including guidelines for evaluating evidence-based practices (EBP) and the literature in which they are described (Spring, 1997).

Compilations of examples show how various clinicians apply research findings in practice. For an example see the chapter by Molnar (2014), which describes the integration of the scientific method into practice to diagnose and treat generalized anxiety disorder (GAD). Clinicians often automatically associate the report of "racing thoughts" with a diagnosis of bipolar disorder when clients are actually referring to the mental activity of worry that is a hallmark of GAD. Assessment that employs standardized and valid measures to determine diagnosis and track outcome can support us in forming accurate judgments likely to result in selection of interventions (if we use EBPs) that will benefit our clients.

In summary, subjective approaches to clinical judgment, including use of intuition, are subject to information and emotional processing biases that can produce inaccurate judgment and result in maladaptive behaviors, including interventions not matched to treatment needs that can cause harm to our clients. Use of the scientific method and associated mechanical prediction procedures can be integrated into our clinical process and reflect an ethical practice.

References

Grove, W. M. & Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical–statistical controversy. *Psychology, Public Policy, and Law, 2,* 293–323.

Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E., & Nelson, C. (2000). Clinical versus mechanical prediction: A meta-analysis. *Psychological Assessment, 12*, 19–30.

Hodgkinson, G. P., Lagan-Fox, J., Sadler-Smith, E. (2008). Intuition: A fundamental bridging concept in the behavioral sciences. *British Journal of Psychology, 99*, 1–27.

Molnar, C. (2014). Generalized anxiety disorder. In L. Grossman & S. Walfish (Eds.), *Translating research into practice: A desk reference for practicing mental health professionals*. New York, NY: Springer Publishing.

Nock, M. K., Park, J. M., Finn, C. T., Deliberto, T. L., Dour, H. J. & Banaji, M. R. (2010). Measuring the suicidal mind: Implicit cognition predicts suicidal behavior, *Psychological Science, 21*(4), 511–517.

Ruscio, J. (2010). Irrational beliefs stemming from judgment errors: Cognitive limitations, biases, and experiential learning. In D. David, S. J. Lynn, & A. Ellis (Eds.), *Rational and irrational beliefs: research, theory, and clinical practice* (pp. 291–333). New York, NY: Oxford University Press.

Spring, B. (1997). Evidence-based practice in clinical psychology: What it is, why it matters, what you need to know. *Journal of Clinical Psychology, 63*(7), 611–631.

Pearls of Wisdom From PPA Members

There are many ways to define "wisdom," but most people agree that it is more than the accumulation of information. Wisdom is acquired over time and involves the integration of knowledge with experience and deep understanding.

One advantage of being part of the professional community of PPA is our access to the wisdom of more than three thousand psychologists. At conferences, on the listserv, and on committee conference calls we form a collective voice that includes varied perspectives, experiences, and beliefs. Many studies suggest that the power of the group is greater than the sum of its parts, and so it is with PPA.

Clinical wisdom cannot be put into words easily, but words are the primary medium through which we work. Following are some pearls of wisdom shared by PPA listserv members (and a few nonmembers). Many of these statements apply not only to clinical work but to life in general. This should not be surprising given that the psychologist's office is often a microcosm of the world.

I will begin the list with a quote from an unlikely source—Jimi Hendrix—who said, "Knowledge speaks, but wisdom listens." We are wise when we listen to our clients, ourselves, and each other.

"Live your life and base your practice on hope and not fear."

Mary O'Leary Wiley, PhD, ABPP

"When working with patients, think about your own theory of change."

Louis Moskowitz, PhD

"The only difference between great people and ordinary ones is the frequency of their great acts. Life is very short. Don't waste your time."

Stephen Ragusea, PsyD

"The one thing that contributed the most to my effectiveness as a therapist was not my education or my supervision (though both were invaluable) but my experience in the other seat, as a client. Be a client; you won't regret it."

Nancy Chubb, PhD, MBA

"The beginning of wisdom is found in doubting; by doubting we come to the question, and by seeking we may come upon the truth."

Pierre Abélard

"Almost everyone believes they hold a monopoly on reality, including myself. The first step toward change or resolution of conflict is a willingness to recognize this fact and that maybe one's perceptions and beliefs and memories are incorrect."

Frank Sergi, PhD, MBA

"Thoughts and impulses will often pass without your doing anything about them. This was said to me by a great supervisor."

Amy F. Cades, PhD

"My three-step psychological operating manual (with gratitude to the Buddhists):
1. shit happens
2. everything you do matters
3. learn from disasters"

Allen Zaklad, PhD

"Seek the wisdom that will untie your knot. Seek the path that demands your whole being."

Rumi

"Replenish . . . replenish . . . replenish. These words were a gift from Dr. Bob Myers."

Michele Hyman, PsyD

"When subtlety fails, try cream pie."

Mick Sittig, PhD

"Wisdom is the orchestration of mind and virtue."

Paul Baltes, PhD

"The more I let go of certainty, the wiser I get."

Janet L. Etzi, PsyD

"Psychology is strongest when all psychologists are active and unified."

John Gavazzi, PsyD

"Supervision and training are integral to lifelong learning. Peer supervision and consultation are part of a healthy diet in practice."

Darren Aboyoun, PhD

"Intense engagement in at least one nonwork activity is a key to maintaining freshness and excitement about work."

Sam Knapp, EdD

"Even if you can't take on a potential new client who may call, spend a few minutes helping him or her find a referral and offer some encouraging words."

Brother Bernard Seif, EdD

"Carpenters have hammers, surgeons have scalpels, but we are the primary tools of our trade. So we must care for and replenish ourselves before caring for others, as well as maintain balance between parts of our lives."

Christina Carson-Sacco, PsyD

"Some of the clients I'm not crazy about stay in therapy a long time and I wind up really appreciating them as human beings . . . once I understand them. This suggests that dislike of others may have a lot to do with not understanding their perspective."

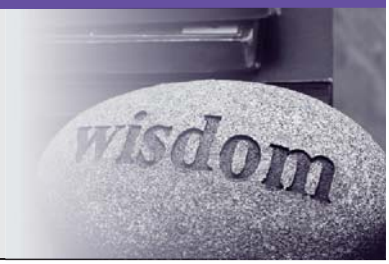
Gregory Estadt, PsyD

"Wisdom is not a product of schooling but the lifelong attempt to acquire it."

Albert Einstein

Clinical Wisdom: The Student's Perspective

Kylie McColligan, BS, and Kathleen Childs, BA



It is not uncommon for student–trainees to be plagued by feelings of self-doubt and inadequacy when they first begin working with clients. In the early stages of clinical work, most student–trainees rely heavily on textbooks, treatment manuals, and supervisory directives to best inform their approach to treatment. Most students, however, will tell you that the advice, or "clinical wisdom," offered by seasoned clinicians is some of the most powerful material available for developing self-efficacy as a clinician. This information resonates far more with student–trainees than any clinical knowledge gleaned from course work.

External pressures exist at every stage of training, and it is in every student's best interest to be motivated by his or her internal desires.

Clinical wisdom is routinely shared in psychology training programs, but advanced student–trainees often note that they wish they had known more about certain aspects of working with clients prior to starting their clinical work. Students in Marywood University's clinical psychology doctoral program were asked to share knowledge that they wish they had had before beginning their clinical work, as well as their own clinical wisdom. What follows is a summary of their responses.

If we knew then what we know now . . .

Therapy wears many hats: When a student–trainee conducts therapy for the first time, he or she often has many questions surrounding the process: How do I sit with a client? How exactly should I structure the therapy hour? And, am I really doing anything at all? It is not uncommon for student–trainees to believe that therapy is supposed to look a certain way. When student–trainees embark on a journey with their clients, they often don't realize that therapy looks different for each and every clinician. As training advances, students begin to understand that a standard format does not exist. While sessions may be structured based on theoretical orientation, it is okay (and good!) for a clinician to tailor therapy based on his or her individual style. Student–trainees can easily be overwhelmed by the pressure to implement techniques properly, offer interpretations, and monitor their own insecurities. Prior to working with clients, however, it is important for student–trainees to know that they can be of great service to a client while feeling like they are doing very little.


Kylie McColligan


Kathleen Childs

Take care: Psychology doctoral programs take an emotional and physical toll on student–trainees. Thus, the importance of developing self-care strategies cannot be overstated to novice clinicians. Student–trainees are directed to establish boundaries and nurture their personal lives while simultaneously facing the pressure of performing enough clinical hours for internship. Although at times it seems insurmountable for students to establish a balance between clinical work and a social life, supervisors have a duty to encourage students to engage in self-care. External pressures exist at every stage of training, and it is in every student's best interest to be motivated by his or her internal desires. Student–trainees often need encouragement to understand that it is okay to say no and that it is imperative to set boundaries.

Words of wisdom

Remember the relationship: As beginning student–therapists, we struggle with feelings of insecurity, incompetence, and anxiety regarding how to work with clients. Early discussions with supervisors are often focused on techniques and how to deal with hypothetical crises. Student experiences, however, indicate that supervisors sometimes neglect to confront or validate the innate anxiety surrounding initial therapeutic interactions, often resulting in difficulty establishing rapport in favor of exploring ways to do "better therapy." In the words of one student, "It's probably impossible to overcome [the fear of] working with your first client, but I never realized just how hard it would be to bring *myself* into the therapeutic relationship because of it."

Many students were in agreement when asked about ways to combat the "first client jitters." While all acknowledged that anxiety was inevitable in the initial interaction, some suggested that supervisors try to remember that developing a therapeutic relationship with a client may not come naturally to students.

Model, model, model: As seasoned clinicians, many supervisors likely forget that students often have extremely limited exposure to what a therapeutic interaction looks like. While training videos and role plays are helpful, many times these feigned scenarios are ideal in the simplicity of their presentation or are so truncated that students fail to see more than the specific technique being highlighted. During our

discussions, one student commented that the greatest momentum she had gained as a beginning clinician was through cofacilitating a group with her supervisor. This student indicated that she "learned how to better interact with clients because [she] saw how a professional approached them and then had the opportunity to ask 'why' afterward."

In our profession many clinicians hail the benefits of modeling as a satisfactory and effective intervention for work with parents, children, families, and couples. As therapists we make frequent attempts to model appropriate and helpful behavior for our clients. We, however, urge those who supervise students to reflect on how they model a satisfactory therapeutic relationship for their students. While the observations of other student–therapists are helpful, they do not have the same weight as the observations offered by a licensed clinician. The seasoned clinician's willingness to directly engage in cotherapy with a supervisee, or to allow students to observe how they work with a client of their own rather than see the "ideal" approach to a one-dimensional client on a recording, can be invaluable.

Many clinicians who have matured in this profession own their skill sets to the point of carrying them out without having to give them much thought. It can be relatively easy for these clinicians working with student–trainees to overlook the need to give support and direction with regard to some aspects of psychotherapy that have become ingrained. Despite all of the insecurity and anxiety innate to the student–trainee position, however, even students can offer a valuable perspective to their supervisors. *This* "clinical wisdom" is rarely considered seriously but is more likely written off as inexperience. As supervisors of students, clinicians are wise to remember that they are the experience needed to better inform our clinical judgment and, indirectly, the clinical wisdom we pass on to our future student–supervisees.

Interventions and Supports for Children and Adolescents With Fetal Alcohol Syndrome

Alison Marciano, MSEd, and Marie C. McGrath, PhD

Fetal alcohol spectrum disorders (FASD) have significant and lifelong implications for cognitive and behavioral functioning. Fetal alcohol exposure is a leading cause of intellectual, developmental, and learning disabilities in youth. It is also an entirely preventable cause of such disabilities, as it cannot occur in the absence of maternal alcohol consumption.

Fetal alcohol exposure is a leading cause of intellectual, developmental, and learning disabilities in youth.

The exact nature of the relationship between amount of alcohol consumption during pregnancy and severity of FASD symptoms and characteristics remains unclear. For these reasons FASD-related public education efforts have emphasized abstinence from alcohol during pregnancy. Though these efforts seem to have been effective in reducing FASD in the United States over the past four decades (Sampson et al., 1997), the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that at least 1% of all children born in the United States each year have been exposed to sufficient amounts of alcohol *in utero* to cause some level of neurologic and/or physical abnormality and that at least 3% of pregnant women engage in "high-risk" drinking (defined as five or more drinks in any single episode or seven or more drinks per week) during pregnancy (SAMHSA FASD Center for Excellence, 2006).

Given these statistics, and the potential implications of FASD for learning and behavior, it is highly likely that school psychologists and others who work with pediatric populations will encounter children with FASD. Despite this, in a 2003 APA survey (Kohout, Wicherski, & Randall, 2004) of practicing psychologists (n = 447), 70% of respondents indicated that they were "very" or "somewhat" unprepared to identify children with FASD, and over 80% reported that they were unprepared to manage treatment of children with these disorders. Additionally, an overwhelming majority of respondents endorsed one or more incorrect beliefs about FASD (e.g., 81% responded that alcohol withdrawal at birth was the worst consequence of prenatal exposure). Finally, respondents expressed a desire for additional training and/or resources to use in practice, but the majority reported that they lacked access to such resources. This article attempts to address that need by briefly exploring the prevalence and characteristics of the syndrome, describing educational implications and interventions, and providing resources to readers.

Prevalence and characteristics of FASD

As previously noted, FASD is thought to affect at least 1% of all children born in the United States. FASD is an umbrella term that encompasses several conditions, including Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND), and Alcohol-Related Birth Defects (ARBD) (SAMHSA FASD Center for Excellence, 2006). Prior to 1996, the term Fetal Alcohol Effect (FAE) was used to refer to ARND- and ARBD-related symptoms that do not meet FAS criteria; currently, the two terms are used in order to distinguish among the neurodevelopmental atypicalities that characterize ARND- and ARBD-related anomalies in other systems of the body (e.g., cardiac, urinary, skeletal). Of these conditions, FAS is considered to be the most severe, encompassing both ARND and ARBD symptoms. FAS is also signified by the presence of characteristic facial features that tend to be most evident in childhood and adolescence, including small head size (microcephaly), small eye openings, a flattened appearance to the midface, and an indistinct philtrum/upper lip (Sampson et al., 1997). Epicanthal folds of the upper eyelid, a low nasal bridge, minor ear anomalies, and a small jaw (micrognathia) may also be evident. The prevalence of FAS has been estimated between .05 and .2% of all U.S. births (SAMHSA FASD Center for Excellence, 2006).

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Subgroups of the U.S. population that routinely experience health disparities (e.g., individuals from low socioeconomic status backgrounds) often abuse alcohol at higher rates than the overall population and thus also demonstrate above-average rates of FAS and FASD; for example, research with Native American samples has revealed FAS rates as high as 1.5%–2.5% (SAMHSA FASD Center for Excellence, 2007a). The prevalence of both FAS and FASD is thought to be even greater in countries with higher levels of alcohol consumption. Additionally, since children surrendered to foster care or state custody are more likely to have been exposed to alcohol *in utero,* children with FASD are often overrepresented among children available for adoption in the United States and other countries. For example, in Russia, which has among the highest rates of alcohol abuse and dependence in the world, Miller et al. (2006) studied 234 toddlers in institutional care settings and found

that 58% had facial phenotypes suggesting prenatal alcohol exposure.

Educational implications of FASD

The neurodevelopmental consequences of FASD can have wide-ranging effects on learning and behavior. Fetal alcohol exposure can disrupt the formation, differentiation, and organization of neurons throughout the central nervous system, leading to potentially widespread disruption in functioning. Guerri (1998) reported that children with FAS may have up to one-third fewer neurons in their brains than children without similar fetal alcohol exposure. Commonly impacted regions include the hippocampus, which is implicated in memory and attention; the cerebellum, involved in motor coordination; and all lobes of the cortex. Alteration in normal neurodevelopmental trajectories can therefore result in widespread cognitive difficulties (including sensory, motor, and language issues), as well as behavioral dysregulation.

Many children with FASD qualify for special education services. Common eligibility categories under which children with FASD are served include Intellectual Disability, Other Health Impairment, Orthopedic Impairment, and Emotional Disturbance, among others. However, the majority of children with FASD do not meet two-pronged eligibility criteria for special education and are served through general education, though they may be eligible for accommodations under a Section 504 agreement (Deming & McCabe, 2010).

Given the potential impact of FASD on multiple systems within the body, children with FASD may demonstrate complex neurocognitive and medical needs that can impact school functioning in a variety of ways. Multidisciplinary assessment and intervention to determine a child's specific pattern of strengths and difficulties in the areas of cognition, learning, behavior, and sensorimotor functioning is therefore critical. In addition to school psychologists, general and/or special education teachers, speech and language therapists, occupational and physical therapists, school nurses, orientation and mobility specialists, and assistive technology specialists are often involved in assessing and intervening with this population. Additionally, given the medical complexity of FASD, ongoing coordination with other healthcare providers outside the school setting is critical.

Interventions for youth with FASD

There is no cure for FASD; the neurological and physical consequences of the disorder persist throughout the life span and may present differently at different points in development. As a result, interventions and modifications must be tailored to the severity of need; the specific constellation of symptoms exhibited by the child; the child's developmental level; and the supports needed by the child and the family. The use of strategies such as explicit contingences, verbal instructions that are broken down into component parts, visual aids, behavioral rehearsal and practice, and predictable routines and activities may be helpful for students with FASD (Paley & O'Connor, 2009).

Functional analysis of behavior can assist in understanding and addressing behavioral issues that arise. Therapies addressing sensory, motor, and language needs, as well as adaptive, social, and safety skills interventions, may be needed. Modifying educational environments by decreasing auditory and visual distractions, increasing navigability for children with mobility needs, and providing more intensive adult support can be helpful. Because many psychologists, teachers, and other staff who work with children with FASD report that they lack knowledge about the condition, they would benefit from having access to educational resources.

A number of websites and publications that may prove useful for individuals who work with youth with FASD can be found in the reference list for this article.

Resources for practitioners and educators

Deming, E. J., & McCabe, P. C. (2010). Prenatal alcohol exposure: Biological and behavioral outcomes. In P. C. McCabe & S. R. Shaw (Eds.), *Genetic and acquired disorders: Current topics and interventions for educators* (pp. 70–79). Thousand Oaks, CA: Corwin Press.

Centers for Disease Control and Prevention National Center on Birth Defects and Developmental Disabilities. (2004). *Fetal alcohol syndrome: Guidelines for referral and diagnosis.* Retrieved from http://www. cdc.gov/ncbddd/fasd/documents/fas_guidelines_accessible.pdf.

SAMHSA FASD Center for Excellence. (2004). *Fetal alcohol spectrum disorders: Tips for elementary school teachers.* Retrieved from http://fasdcenter.samhsa.gov/documents/WYNKTeachersTips2.pdf.

SAMHSA FASD Center for Excellence. (2006). *Fetal alcohol spectrum disorders by the numbers.* Retrieved from http://fasdcenter.samhsa.gov/documents/WYNK_Numbers.pdf.

SAMHSA FASD Center for Excellence. (2007a). *American Indian/Alaska Native/Native Hawaiian resource kit.* Retrieved from http://fasdcenter.samhsa.gov/grabGo/NativeKit.aspx.

SAMHSA FASD Center for Excellence. (2007b). *Reach to teach: Educating elementary and middle school children with fetal alcohol spectrum disorders.* Retrieved from http://fasdcenter.samhsa.gov/documents/Reach_To_Teach_Final_011107.pdf.

Pennsylvania-specific resources

National Organization on Fetal Alcohol Syndrome. (n.d.) *State resources for Pennsylvania.* Retrieved from http://www.nofas.org/state-resources-for-pennsylvania/.

SAMHSA FASD Center for Excellence. (n.d.). *State systems: Pennsylvania.* Retrieved from http://fasdcenter.samhsa.gov/ statesystemsofcare/states/pennsylvania.aspx.

Other references

Guerri, C. (1998). Neuroanatomical and neurophysiological mechanisms involved in central nervous system dysfunctions induced by prenatal alcohol exposure. *Alcoholism: Clinical and Experimental Research, 22*, 304–312.

Kohout, J., Wicherski, M., & Randall, G. (2004). Knowledge of fetal alcohol syndrome among APA member practitioners: 2003. Retrieved from: http://www.apa.org/workforce/publications/03-fas/report.pdf.

Miller, L. C., Chan, W., Litvinova, A., Rubin, A., Comfort, K., Tirella, L., . . . Boston-Murmansk Orphanage Research Team. (2006). Fetal alcohol spectrum disorders in children residing in Russian orphanages: A phenotypic survey. *Alcoholism: Clinical and Experimental Research, 30*, 531–538.

Paley, B., & O'Connor, M. J. (2009). Intervention for individuals with fetal alcohol spectrum disorders: Treatment approaches and case management. *Mental Retardation and Developmental Disability Research Reviews, 15*, 258–267.

Sampson, P. D., Streissguth, A. P., Bookstein, F. L., Little, R. E., Clarren, S. K., Dehaene, P., . . . Graham, J. M. Jr. (1997). Incidence of fetal alcohol syndrome and prevalence of alcohol-related neurodevelopmental disorder. *Teratology, 56*, 317–326.

Lyme Disease: Cognitive and Educational Implications for Children and Adolescents

Danielle Coluccio, BA, and Marie C. McGrath, PhD

Lyme disease is the most common vector-borne illness in the United States (Fallon, Vaccaro, Romano, & Clemente, 2006). The disease is caused by the spirochete *Borrelia burgdorferi* and is contracted via the bite of an infected *Ixodes* tick. Though these ticks are known colloquially as "deer ticks," they have been found on over 30 types of wild animals and 49 distinct species of birds (Fallon et al., 2006). These ticks are most frequently found in the Northeast, the upper Midwest, and the Pacific coastal region of the United States (Fallon et al., 2006).

Lyme disease was first identified in 1975, when a number of individuals in the towns of Lyme and Old Lyme, Connecticut, began to experience similar clusters of physical and cognitive symptoms that later came to characterize the disorder. Given the high concentration of *Ixodes* ticks as well as the high population density in the Northeast, it is unsurprising that two thirds of Lyme diagnoses occur in this region of the United States (Lyme Disease Association, 2011). In 2011 (the most recent year for which statistics were available at the time this article was written), Pennsylvania led the nation in the number of reported cases of Lyme, with a total of 5,362 "confirmed" and "probable" cases (16% of the national total for that year) reported to the Centers for Disease Control (Lyme Disease Association, 2011).

In the early 20th century, *Treponema pallidum*, the microorganism that causes syphilis, was described as "the Great Imitator" because of its tendency to present as a variety of physical and psychiatric illnesses (Fallon, 2004). More recently, Lyme disease has been described as "the new Great Imitator," not only because of its similar spirochetal origins and its course of a rash followed by increasingly serious neuropsychiatric problems (Fallon, 2004) but because of the difficulty distinguishing it from other medical and behavioral conditions that produce similar symptoms (Fallon et al., 2006). Due to the high incidence of Lyme disease in Pennsylvania and the disease's nonspecific presentation, it is important for Pennsylvania's school psychologists and other professionals who work with children and adolescents to be familiar with the symptoms of this "new Great Imitator."

Lyme disease is classified into three stages: early localized, early disseminated, and late disseminated (Fallon et al., 2006). The early localized stage begins approximately 24 hours following a tick bite, when the *B. burgdorferi* spirochete is transmitted into the skin and the *erythema migrans*, or bull's-eye rash, develops (Fallon et al., 2006). Flu-like symptoms, including fever, fatigue, *arthralgias* (joint pain), and *myalgias* (muscle pain), generally follow (Tager & Fallon, 2001). However, these symptoms may be very mild and the rash may not be large or noticeable so approximately one third of patients do not see a rash or visit a doctor during this phase.

Due to the high incidence of Lyme disease in Pennsylvania and the disease's nonspecific presentation, it is important for Pennsylvania's school psychologists and other professionals who work with children and adolescents to be familiar with the symptoms of this "new Great Imitator."

The early disseminated stage can occur anytime from the first few days after infection to several months later and is characterized by the passing of the spirochete into the vascular system (Fallon, 2004; Fallon et al., 2006; Tager & Fallon, 2001). Via the bloodstream, the bacterium moves on to major organs such as the heart and liver, the joints, the eyes, and the nervous system. Symptoms in this stage may include meningeal symptoms (e.g., headaches, stiff neck, light sensitivity, and nausea), fatigue, moodiness, cognitive issues such as poor memory and slower processing speed, balance problems, sensory sensitivity, and behavioral alterations.

Danielle Coluccio

Dr. Marie C. McGrath

Late disseminated Lyme disease can present as neuropathies, encephalopathy, or neuropsychiatric symptoms (Fallon, 2004; Fallon et al., 2006; Tager & Fallon, 2001). Mild-to-moderate cognitive deficits in short-term memory, word finding, processing speed, and spatial orientation; severe fatigue; sleep difficulties; irritability and lability; depression; and anxiety may be seen.

It is generally acknowledged that Lyme disease impacts cognitive functioning in infected adults, particularly in the disseminated phases of the disease (Adams, Rose, Eppes, & Klein, 1999; McAuliffe, Brassard, & Fallon, 2008; Tager & Fallon, 2001). However, the impact on cognition and behavior in children and adolescents is less clear, and several of the studies conducted to date have yielded inconsistent results. Adams, Rose, Eppes, and Klein (1994) administered a number of neuropsychological measures to 41 children who had been treated for Lyme disease, 23 of their healthy siblings, and 14 children with other rheumatoid conditions. Two years posttreatment, Adams et al. (1994) found no significant difference among the groups on any of the measures administered. They also examined GPA

and school attendance and found that the children who had been treated for Lyme disease did not differ from their healthy siblings or show changes pre- and postdiagnosis on these variables. In 1999, Adams et al. reassessed the same cohort of children with virtually identical results, though the group that had been treated for Lyme performed slightly lower on measures of short-term visual memory than controls.

In contrast, Bloom, Wyckoff, Meissner, and Steere (1998) studied the progress of five children diagnosed with late disseminated Lyme disease who had demonstrated marked neurocognitive symptoms during their treatment. All five children had been treated with intravenous antibiotic therapy and deemed recovered. In follow-up interviews and cognitive testing conducted over a five-year time span (two years to seven years postinfection), Bloom et al. (1998) found the children demonstrated behavioral symptoms, increasing levels of forgetfulness, persistent headache, and fatigue. Additionally, despite average IQ scores, all five children displayed difficulties in auditory and visual sequential processing. Tager and Fallon (2001) studied 20 children with chronic Lyme disease and 20 healthy controls and found that the Lyme group had significantly elevated scores on all of a variety of measures of physical distress, as well as on parent and child self-reports of neurocognitive symptomology. They also found that the Lyme group had significantly lower Full Scale IQ, Performance IQ, Perceptual Organization Index, and Freedom from Distractibility Index scores of the WISC-III and the General Memory, Verbal Memory, and Visual Memory indices of the WRAML. Similarly, in a study of 25 children with late disseminated Lyme disease and 25 healthy controls, McAuliffe et al. (2008) found that the children with Lyme disease displayed significant deficits in long- and short-term verbal and visual memory, attention, concentration, recognition memory, and spatial planning, as well as in GPA and school attendance. They also determined that the children with Lyme disease reported an increased *subjective* experience of cognitive difficulties, in addition to lower performance on standardized measures, when compared to the children in the control group.

Tager and Fallon (2001) studied 20 children with chronic Lyme disease and 20 healthy controls and found that the Lyme group had significantly elevated scores on all of a variety of measures of physical distress, as well as on parent and child self-reports of neurocognitive symptomology.

Due to the neurocognitive symptoms and behavioral issues that may arise as a result of the disease, Hamlen and Kliman (2010) note that children and adolescents with Lyme disease may qualify for school-based accommodations, interventions, and/or specially designed instruction under a variety of state and federal laws, including Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. Children and adolescents with chronic Lyme disease may benefit from provision of the following:

- flexibility in attendance requirements, up to and including provision of homebound instruction, if mobility issues, fatigue, and/or treatment protocols make regular attendance at school difficult
- provision of learning support services if the impact of the disease is significant enough to preclude meaningful participation in the academic curriculum
- extended time and/or extension of deadlines for work completion
- provision of quiet, distraction-reduced environments for work and test completion
- use of memory aids and strategies as needed to address visual and/or verbal memory difficulties related to the disease
- provision of note-taking accommodations, including the use of computers, audio-recording devices, and/or access to teachers' or peers' notes as appropriate
- provision of counseling services and/or other interventions designed to address mood-related symptoms of the disease, as well as to enhance students' ability to cope with the condition and advocate for their own needs

Practitioners may also find the following websites, which contain information on the disease itself, empirically supported treatments and interventions, and resources available to individuals directly impacted by the disorder and their families, to be helpful in working with children and adolescents affected by the disorder:

- International Lyme and Associated Diseases Society (http://www.ilads.org/)
- Lyme Disease Association (http://www.lymediseaseassociation.org/)
- Lyme Disease Association of Southeastern Pennsylvania (http://www.lymepa.org/)

References

Adams, W. V., Rose, C. D., Eppes, S. C., & Klein, J. D. (1994). Cognitive effects of Lyme disease in children. *Pediatrics, 94*, 185–189.

Adams, W. V., Rose, C. D., Eppes, S. C., & Klein, J. D. (1999). Long-term cognitive effects of Lyme disease in children. *Applied Neuropsychology, 6*(1), 39–45.

Bloom, B. J., Wyckoff, P. M., Meissner, H. C., & Steere, A. C. (1998). Neurocognitive abnormalities in children after classic manifestations of Lyme disease. *The Pediatric Infectious Disease Journal, 17*(3), 189–196.

Fallon, B. A. (2004). Neuropsychiatric Lyme disease: The new "Great Imitator." *Psychiatric Times, 21*(6), 44–48.

Fallon, B. A., Vaccaro, B. J., Romano, M., & Clemente, M. D. (2006). Lyme borreliosis: Neuropsychiatric aspects and neuropathology. *Psychiatric Annals, 36*(2), 120–128.

Hamlen, R., & Kliman, D. S. (2010). Lyme disease and tick-borne infections: Causes and physical and neuropsychological effects in children. In P. C. McCabe & S. R. Shaw (Eds.), *Pediatric disorders: Current topics and interventions for educators* (pp. 91–100). Thousand Oaks, CA: Corwin Press.

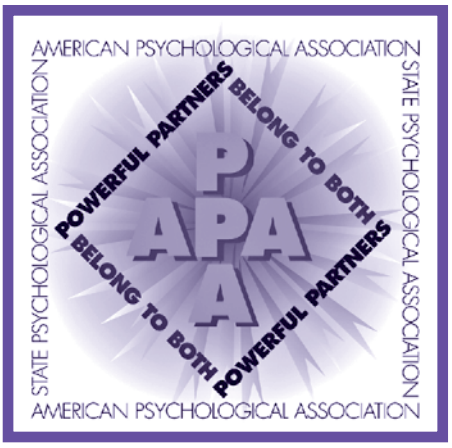
Lyme Disease Association (2011). Cases, stats, maps, and graphs. Retrieved from http://www.lymediseaseassociation.org/index.php?option=com_content&view=category&layout=blog&id=69

McAuliffe, P., Brassard, M. R., & Fallon, B. (2008). Memory and executive functions in adolescents with posttreatment Lyme disease. *Applied Neuropsychology, 15*(3), 208–219. doi:10.1080/09084280802324473

Tager, F. A., & Fallon, B. A. (2001). Psychiatric and cognitive features of Lyme disease. *Psychiatric Annals, 31*(3), 173–181.

Welcome, New Members

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between August 1 and October 31, 2013!



NEW FELLOWS

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CE Questions for This Issue

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

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

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address and sign your form. Allow three to six 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, 2015.

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

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

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

Bellwoar

1. The author proposes three major updates that need to take place for PPA to continue to thrive. They include all of the following except:
   a. upgrading IT capabilities
   b. refurbishing the PPA building
   c. revising the strategic plan
   d. raising PPA salaries

Knapp, Baturin, & Tepper

2. Although PPA staff member Rachael Baturin is an attorney, the PPA Board of Directors does not permit her to enter into an attorney–client relationship with PPA members, and thus no attorney–client privilege attaches when discussing issues with Rachael.
   True
   False

Etzi

3. According to recent research, there is no empirical evidence for wisdom as one of the brain's functions.
   True
   False
4. *Integration* is related to the brain's processing of wisdom because:
   a. integration is understood to be the result of wisdom
   b. integration is the way the brain organizes various types of information and experience into a coherent whole, and this is thought to be part of what wisdom is
   c. both a and b
   d. neither a nor b
5. Wisdom behaviors and attitudes are largely explicitly processed, meaning the clinician has to intend wise interventions otherwise they will not occur.
   True
   False

Molnar

6. Which of the following is the name of the information processing system that allows for the automatic and quick processing of large amounts of data, relies on evolutionarily primitive brain structures, and is especially prone to both information and emotional processing biases?
   a. System 1
   b. System 2
   c. mechanical learning system
   d. mechanical processing system
   e. none of the above
7. Which of the following is *not* a useful strategy suggested by John Ruscio (2010) for reducing incorrect clinical decisions?
   a. stay mindful of classic cognitive biases and heuristics
   b. generate multiple hypotheses for which we systematically evaluate evidence before forming a conclusion
   c. apply basic principles of probability, statistics, and research evidence to individuals and integrate data about base rates into our decision-making processes
   d. look for ways that our clients are exceptions to what well-designed research studies show
   e. all of the above are useful
8. Which of the following approaches forms clinical judgments that rely on formal algorithmic procedures to process large amounts of data and is often superior or comparable to the clinical prediction approach?
   a. intuitive
   b. automatic
   c. implicit
   d. mechanical prediction
   e. none of the above

McColligan & Childs

9. What are some of the things students wish they knew before seeing their first client?
   a. Some specific things they can do to foster a therapeutic relationship.
   b. There is more than one right way to conduct therapy.
   c. It is essential that student–trainees take care of themselves and set proper boundaries.
   d. All of the above.

Marciano & McGrath

10. It is estimated that FASD affects at least _____ % of all live births in the United States.
    a. 0.1
    b. 1
    c. 5
    d. 10

11. Fetal alcohol syndrome, the most severe manifestation of FASD, may be characterized by:
    a. neurodevelopmental anomalies
    b. unusual facial features
    c. cardiac abnormalities
    d. a and b
    e. a, b, and c

Coluccio & McGrath

12. In which phase of Lyme disease can meningitis-like symptoms first appear?
    a. early localized
    b. early disseminated
    c. late disseminated
    d. tertiary

13. Which of the following cognitive difficulties have been identified in children and adolescents diagnosed with late disseminated Lyme disease?
    a. attentional difficulties
    b. short-term verbal memory difficulties
    c. spatial planning difficulties
    d. a and b
    e. a, b, and c

Zuckerman

14. EHRs are the future because they are likely to do all of the following except:
    a. increase profits for insurance payers
    b. be required by your referrers or cotreaters to coordinate with their EMR systems
    c. reduce overall healthcare costs
    d. increase the speed and efficiency of claims submission to payers
    e. all of the above

15. The four core functions of EHRs for small practice include all of these except:
    a. scheduling
    b. supporting mobile health products and services
    c. record making and keeping
    d. billing
    e. practice management

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, December 2013

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

1.	a	b	c	d		**9.**	a	b	c	d	
2.	T	F				**10.**	a	b	c	d	
3.	T	F				**11.**	a	b	c	d	e
4.	a	b	c	d		**12.**	a	b	c	d	
5.	T	F				**13.**	a	b	c	d	e
6.	a	b	c	d	e	**14.**	a	b	c	d	e
7.	a	b	c	d	e	**15.**	a	b	c	d	e
8.	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 nonmembers of PPA) must accompany this form.
Mail to: Continuing Education Programs, PPA, 416 Forster St., Harrisburg, PA 17102-1748.

Why Are We Getting Electronic Health Records Now?

Edward L. Zuckerman, PhD, edzucker@mac.com

Dr. Ed Zuckerman

The healthcare industry, which is 18% of the U.S. Gross Domestic Product, is the last major industry to be industrialized. Factories have replaced gunsmiths and locksmiths, tractors have replaced animal power, and "big-box" stores have replaced all kinds of small retailers. Because we are primarily a knowledge business, we in mental health go digital instead of analog, and we do it through electronic health records (EHRs).

Healthcare providers can choose from about 600 EHR templates, of which about 40 are suitable for or designed for mental health professionals, small practices, or small clinics. Each template has a few unusual or even unique functions so comparisons are difficult.

Electronic health records and electronic medical records: What's the difference?

The crucial difference is not content but interoperability. Electronic *medical* record (EMR) refers to the files that independent facilities (hospitals, clinics, private practices) keep in their own formats and fashions. When each facility maintains its own records tests tend to be replicated, emergency departments lack access to a new patient's medical history, private care practitioners don't get information about a recent hospitalization, and so forth. Similarly, at the public health level opportunities for efficiency and planning are invisible. And payers cannot understand the real cost of services. The means to converting all this paper to electrons and standardizing all the procedures (with Current Procedure Terminology codes, International Classification of Diseases, and many more) is creating electronic *health* records. Having these data silos converse is called *interoperability,* and this automated sharing of information will make possible significant improvements in healthcare.

Do I have to use electronic health records?

EHRs are not required for private practitioners now and are unlikely to be in the future. However, they are coming for all larger providers. Money and technology are the big forces in our society.

Most of us will eventually adopt EHRs because they are likely to be

- hugely profitable to the payers (the technology involved is invisible to us providers);
- required by state laws as part of Obamacare (Accountable Care Organizations, Health Information Exchanges, etc.);
- the standard of care/practice in the future;
- required by your referrers or co-treaters to coordinate with their EMR systems;
- adopted by providers as an opportunity to revisit, revise, and improve functions;
- part of the *consumerization* of healthcare (health searches on the Internet, apps on mobile devices, patients' self-access to their records, peer supports such as patientslikeme.com, e-health such as Google searches and WebMD, e-therapy or teletherapy, and smartphones as assessment and treatment devices).

Can I get money to buy an electronic health record system?

No. We psychologists did not get ourselves included as "physicians" so we don't get a share of the $17 billion available. However, if you take Medicare or Medicaid patients (or, very likely, any insurance) your payments will be cut by a few percentage points starting in 2014, whether you have EHRs or not.

What will electronic health records do for my practice?

We can expect four core functions or benefits of any EHR:

1. Scheduling. EHRs give us sophisticated and easier scheduling for clients, groups, rooms, consultants, equipment, and staff. An EHR allows us to view open hours on one screen, schedule the best time for each kind of client and clinician (i.e., alternating spouses), and be reminded to avoid contact between some clients. We can easily schedule visits at regular or irregular intervals and across offices and multiple providers. We can send appointment reminders by mail, e-mail, phone, or text; create ticklers for scheduling in the future; notify clients of our policy and missed appointment charges; track histories of missed appointments; and be reminded to send preappointment packages. Clients will experience the benefits as well, as they will be allowed to self-schedule appointments.

Because we are primarily a knowledge business, we in mental health go digital instead of analog, and we do it through electronic health records (EHRs).

2. Documenting. EHRs allow us to create clinical records that meet state, discipline, HIPAA, CARF, JCAHO, and other standards as well as the special requirements of some payers. Other advantages include

- legible, correctly spelled, and neat (very professional) documents;
- no missing information (because of prompts to complete paperwork);
- required reviews done and signed off on;
- faster, easier, simultaneous access for multiple users, mobile access, and guaranteed access to all charts (no lost charts except with Internet shutdown);

- ability to search contents by word, date, or phrase;
- authenticated digital signatures that document creator, date and time, and modifications so they have probative value;
- easier and faster copying and sending of records (compared to pulling files and faxing paper);
- speech-to-text transcription (versus typing); and
- HIPAA-compliant document storage.

3. Billing and collecting. EHRs simplify how we

- determine eligibility and financial responsibility, copays, and deductibles before services are provided;
- generate a bill, a receipt, or a superbill for clients;
- assure accuracy of codes and data, numbers, policies, persons for "clean claims";
- tailor claims forms to the payer;
- submit a claim (to a payer) electronically for faster cash flow;
- monitor payments received and not for follow-up.

4. Practice management. Practice management is examining how our practice is working so that we can improve planning and decision making. EHRs help us with practice management by organizing latent data, tracking referral sources for marketing efforts, and producing the actual costs of providing services so that we can better price them, alter our case mix, and shape the services we choose to provide. By gathering evidence of effectiveness, we support our clinical and practice decisions. We can

- monitor progress ("Should I change services for this client?");
- weigh outcome measures against costs and resources to reshape our practice;
- provide outcomes data to meet professional expectations and for data-based marketing;
- generate local norms;
- document how we meet national clinical standards;
- develop practice-based evidence.

We can also use effectiveness data for targeted marketing in an effort to attract referrals from current and potential referrers, potential consumers or clients viewing our practice website or portal, and funders and payers who want and believe in the data. And imagine being able to provide *data-based* and personalized feedback, or clinical decision support, to clinicians for reassurance, guidance, and training. Additionally, effectiveness data enhances recruitment efforts by impressing clinicians during the hiring process.

There are many other benefits of EHRs that cannot be covered here, such as collaboration with other current providers, inter- and intraoffice messaging, disaster management/damage control, and eligibility for pay for performance.

And how much will all this wonderfulness cost me?

EHRs cost between $40 and $100 a month per clinician, and all vendors offer free trials.

Ed will be happy to respond to questions about EHRs by e-mail.

Classifieds

OFFICE SPACE AVAILABLE

AVAILABLE PSYCHOTHERAPY OFFICE: BALA CYNWYD, PA – Very nice psychotherapy office space available for full or part-time sublet in newly renovated light-filled suite with other psychotherapists. Internet access, attractive building with good security, many amenities, free parking, location convenient to public transportation. Contact Linda Guerra PhD at 215-545-7009 or email: guerra@netmcs.com.

PROFESSIONAL OFFICE SPACE AVAILABLE, HARRISBURG, PA AREA – Successful counseling/psychotherapy practice on the West Shore (Camp Hill area) seeking Licensed Practitioner (Ph.D., Psy.D., LCSW, LPC) to share office space. Full secretarial/reception/billing services included. Please call 717-737-7332.

OFFICE SPACE AVAILABLE: BALA CYNWYD – Attractive, furnished, window office, includes Wi-Fi, fax/copier, café, free parking, flexible hours week days and weekends. Perfect for therapy and evaluations. 610-664-3442.

CENTER CITY PHILADELPHIA – Warm and modern Center City Philadelphia office available for sublease. The office is centrally located on one of the most desirable streets in Philadelphia. It is convenient to all forms of public transportation and parking garages. The office is available for sublease Mondays, Tuesdays, Thursdays, Fridays and Saturdays. Sublease includes use of the common waiting area and break room, water service, Wi-Fi, and use of the fax machine. Rates are reasonable and include both day and evening usage. The office was beautifully decorated by a leading Philadelphia staging and design firm. To view pictures, go to www.drmonicacampbell.com and click "Contact." Email inquiries can be sent to drmonicacampbell@gmail.com.

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Vol. 73, No. 11

The Pennsylvania
Psychologist

December 2013 • QUARTERLY

The Pennsylvania Psychologist
416 Forster Street
Harrisburg, PA 17102-1748

2014 CE Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

April 11, 2014
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

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

June 18–21, 2014
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

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.

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

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.