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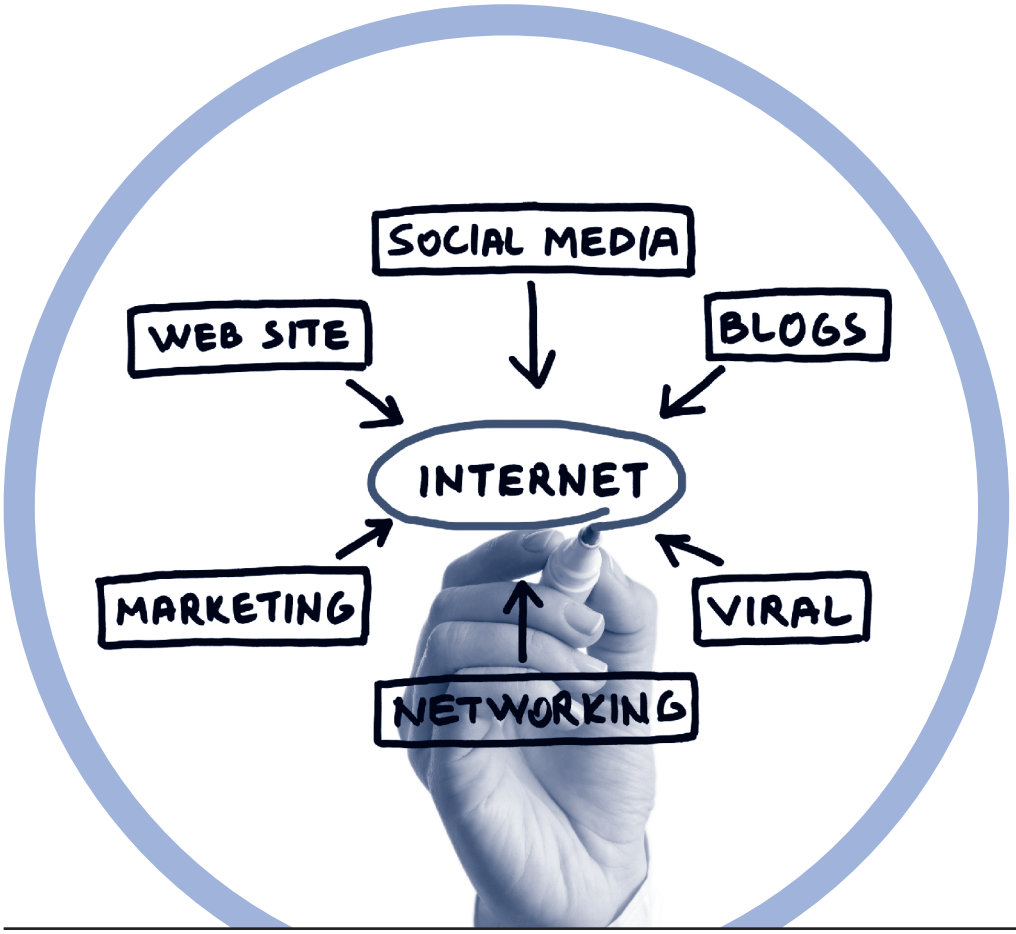
The Pennsylvania Psychologist

June 2013
QUARTERLY



Digital Media and Marketing of Psychology

ALSO INSIDE:

- Informed consent to treatment of older adults
- Current child abuse legislation
- Cost-effectiveness of psychological services
- Teen sleep issues

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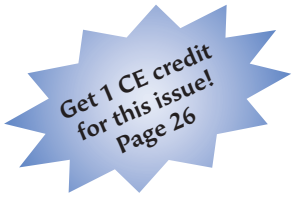


REGULAR FEATURES

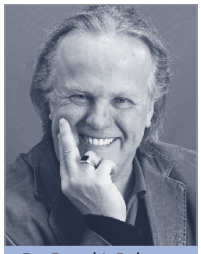
SPECIAL SECTION – Digital Media and Marketing of Psychology

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

What's It Like to Serve on PPA's Board of Directors?

David J. Palmiter, Jr., PhD, ABPP



Dr. David J. Palmiter

The most common question I've heard since July 2012 has been "what's it like to be president of PPA?" In this column I'd like to expand that question and share what it's like to serve on the Board of Directors (BOD). While I'll be writing from my perspective, I believe what I'll assert here is generally held by those who likewise serve or have served.

I remember when I used to walk by the BOD meeting rooms during conventions before I started serving. I wondered, "who are these people, how do they get on the BOD and what do they do?" Well, let me say a little bit about that.

PPA has 28 committees, the composition of which is laid out on the governance section of our website, www.PaPsy.org[1]. About 10% of our membership currently serves on these committees. The committees are organized under six boards, each of which is managed by a board chair. Board chairs are on the BOD as are PPA's officers (i.e., president, president-elect, past president, secretary, and treasurer), our two representatives to APA's Council, and the chair of the Pennsylvania Psychological Association of Graduate Students (PPAGS). The president of the Pennsylvania Psychological Foundation is an ex-officio, non-voting, member, and the chair of the PennPsyPAC Board is invited to every meeting. Staff members who attend our meetings are our executive director, director of professional affairs, professional affairs associate, business and membership manager, and conference and communications manager. The BOD has five meetings per year (including the General Assembly meeting, which expands the BOD by including all committee chairs), two of which occur at the Annual Convention in June. Various members of the BOD have other meetings they attend, but the permutations are too varied to review here.

I joined the BOD almost six years ago as the Communications Board chair. My first impression was that PPA is a well-oiled machine built upon a sophisticated and strong mission statement, strategic plan, bylaws, and policies and procedures. This impression was confirmed when I attended my first State Leadership Conference (i.e., the annual meeting, hosted by the APA Practice Organization each year in DC, that leaders from all state and provincial psychological associations attend). Though I was a rookie at that conference, I felt, and was treated, like an elder statesman in small group discussions because of all that PPA has accomplished. (In case you don't know this, our association is perceived to be a leader across the country.)

My second impression occurred at my first BOD meeting, and it has been my most enduring one: the BOD is made up of a very effective group of psychologists and staff. I cannot believe how strongly the following attributes are shared by those who attend board meetings:

- selflessness;
- a very high sense of mission;
- individual professional success;
- a very high tolerance for debate (this is one of my favorite attributes about life on the BOD; we can have vigorous debates that both remain professional and appear only to enhance our personal relationships);
- a high degree of wisdom, creativity, and openness to new experiences.

While I just reviewed "selflessness" as a characteristic of board members, I've benefited a great deal from my service. I'll mention just four examples. First, the synergy created in BOD meetings is AMAZING. I *always* leave BOD meetings with more energy than I had when I arrived. The quality of the experience is that uplifting. Second, hanging out with board members socially is one of my favorite things to do. The camaraderie and laughter are both rejuvenating; numerous times I've found myself laughing so hard that I couldn't breathe. Third, if I have a professional issue or conundrum I can be in touch with a nationally known expert in that problem area who will not only respond quickly and helpfully but will also allow me to call her or him friend. However, the fourth benefit is my favorite one: the meaning I take from the service.

My first impression was that PPA is a well-oiled machine built upon a sophisticated and strong mission statement, strategic plan, bylaws, and policies and procedures.

Serving on the BOD allows one to address meaningful goals. When I was board chair I was able to partner with like-minded colleagues and staff to accomplish mutually valued outcomes (e.g., the creation of a committee to publish an e-newsletter for the public and another to explore and implement technology, the creation of public education talks at our convention, and the reorganization of the wonderful resources on our website). As president I've been able to do the same. For example, so far the Pediatric Mental Health Task Force has arranged for more than 2,000 kids to be screened for mental health concerns in pediatric practices; our BOD recently partnered with leadership from our Positive Multiculturalism Subcommittee to do an experiential training on Harvard's Race IAT test; our Succession Development Task Force has created, and is in the process of implementing, a very well designed protocol for hiring a new

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[1]See under the Members-Only tab after you login – your username is your four-digit member number, which you can get by looking at your mailing label or by requesting such to iva@PaPsy.org, while your login is your last name with the first letter in caps.

PPA Promotes Professional Development of Members

Thomas H. DeWall, CAE


Thomas H. DeWall

Typically columns about governance and organizational finances are the least read in association newsletters. Nonetheless, these issues are very important because they provide the infrastructure that allows PPA to promote the interests of its members. I have been fortunate to have had a strong Board of Directors which has helped PPA maintain its institutional viability and efficiency. PPA has transformed itself as an organization in the period since 1987, when I started as the executive director. I stated in my first column, in the March/April 1987 *Pennsylvania Psychologist*, "My goals for PPA are to harness the enormous energy and dedication of the members; to keep PPA in a sound financial position and expand the membership base; to keep the association in the forefront of health care policy initiatives in Pennsylvania...; and to make our new Harrisburg office a strong resource for PPA members, with high quality publications, continuing education programs, and other services."

The practice of psychology in 1987 was far different from what it is today. Malpractice and licensing board complaints were far less common, and managed care had little penetration into the insurance market. There was no mandatory continuing education for psychologists (or any other health profession in Pennsylvania). However, PPA has had to expand its services to psychologists to account for these changes in the workplace. In the March 2013 issue I wrote about the advances we have made since that time in the area of public policy. I will now focus on the two other strategic actions from our strategic plan: promoting and advancing psychology in Pennsylvania, and building and maintaining organizational strength.

We have made significant strides in professional development of our members. In 1987 we offered only occasional continuing education programs. Now for the past several years we have presented more than 100 in-person CE programs annually, plus more than 30 home study and online CE offerings, with substantial discounts for members. Our outstanding annual conventions provide a range of educational opportunities for psychologists. Another aspect of professional development is this publication, the *Pennsylvania Psychologist*. We have published monthly since August 1988 (with a quarterly journal and a monthly update), whereas it was bimonthly before that – and the substantive articles of direct benefit to our members have increased as well. The quarterly issues have featured themes relevant to psychological practice as well as a school psychology section. The monthly updates frequently have public policy analysis from Dr. Sam Knapp and other timely information to benefit our members.

In addition to this printed publication, which is also available on our website, we now publish an e-newsletter for the public on a quarterly basis. Our redesigned and expanded website is another source of professional development for members and the general public with a wide range of information available. We have carried out a significant public education campaign for many years in partnership with APA, to help make psychology a household word. We have engaged the business community to create a synergy with psychology, as the strategic plan calls for. This includes the Psychologically Healthy Workplace Awards. And of course, one of the most significant aspects of professional development we offer is the consultation that members get from our professional staff on innumerable issues that arise in psychology practices.

The Board of Directors, the Internal Affairs Board, and the staff have focused a great deal on building and maintaining organizational strength. Our budget has grown from $203,000 in 1985-86 ($430,000 adjusted for inflation) to $900,000 this fiscal year. Today our nondues revenue is 32% of the budget, up from 25% in 1985-86. We needed more resources to provide the necessary services to our members. Most of the increase in revenue has come from an increase in membership and nondues income. The dues amount per member is actually slightly lower, when adjusted for inflation, than the dues in 1986. We own our headquarters building in Harrisburg and have a net worth of $960,000, so we are on solid financial footing. The increased income has allowed us to expand from 3½ staff positions to 7. This in turn has enabled us to provide more services to the members in terms of advocacy and the issues discussed above. When I started in 1987 we owned one computer for word processing and contracted with an outside firm to maintain our database of members. Today we have a server and seven workstations with multiple programs. Of course, we engage in whole new ways of communicating, such as through e-mail, the Internet, our website, listservs, social media, etc.

> *PPA had won the award from APA's Division 31 as the Outstanding SPTA in 1992.*

I was fortunate to have inherited a stable organization served by Dr. Zita Levin, who was the executive officer for most of the previous 12 years. Many members regarded her as the "mother" of PPA, although there had been a previous part-time executive secretary, Dr. William Cohen, who served from 1962 to 1971, followed by three very short-term staffers until Dr. Levin was hired in 1975. The association was much smaller then in terms of budget, staffing, volunteer leadership, and membership. When I started PPA had 2,142 members. We grew to a high of 3,240 on December 31, 2007, after which, due to the Great Recession, it has declined somewhat to 2,918 as of March 31, 2013. We have

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PRESIDENT'S MESSAGE
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executive director. These are just a few examples of the multitude of projects that are done that produce significant doses of meaning for those involved.

Interested in serving on the BOD? Well, don't be shy about that! There are so many paths to such. While mine was sort of idiosyncratic (on a dare from my children I did a dance as I was accepting a media award) there is a common one I can suggest: do a good job chairing a committee. If you're not on our leadership team now, but wish to be, just survey the list of committees, joining any that overlap with your professional mission(s). Then, let the committee and board chairs know that you are interested in being considered as a successor to the committee chair (please don't be shy about this).

I will end this article by offering an invitation (and if you stand to add to the diversity of our leadership team I especially want you to "feel me" in this invitation). As of our June convention, when I take over the office of past president, I'll become chair of the Nominations and Elections Committee. So if you have a track record of service in PPA, or are otherwise known within our community, please let me know that you'd like to run for a position on the BOD. You could be in touch in any way that you'd like, but if you come to the convention (June 19-22 at the Harrisburg Hilton) we could find a quiet corner and discuss how you might use PPA to benefit your personal and professional life (which, by the way, overlaps with the theme of our 2013 content-packed, star-studded, and rockin' convention: www.ppaconvention.com).

State Supreme Court Bars Parenting Coordination

The Pennsylvania Supreme Court has outlawed parenting coordination in Pennsylvania effective May 23. This was based on the recommendation of the Supreme Court Rules Committee, not a case brought before the court. The court sees parenting coordination as an improper delegation of judicial responsibility.

This is a big blow as it takes away one of the few effective tools for helping high conflict families. Many judges, lawyers, and psychologists are very upset about this. Several years ago PPA organized a statewide task force composed of psychologists, judges and lawyers. The task force met for about a year to develop qualifications, training, etc., as well as a model order for appointing parenting coordinators. PPA has been at the forefront of implementing parenting coordination in Pennsylvania.

Currently, members of that task force are in discussions about what options there may be about this unfortunate decision by the Supreme Court. We are unaware of any other state taking such an action.

EXECUTIVE DIRECTOR'S REPORT
Continued from page 3

more members participating than ever, with about 300 serving in a governance role, compared to 145 such members in 1987. PennPsyPAC also saw substantial growth during that period. The PAC raised about $13,000 per year in the late 1980s. That figure rose to $54,800 in the most recent fiscal year, which has enabled us to be a more effective advocate on legislative issues at the state level.

Our governance structure has become more streamlined and effective over the years. In 1987 our primary governance body was the Executive Council, with 17 members, including the presidents of 5 divisions. We had 29 committees, all written into the bylaws, two task forces, and no student organization. A reorganization in 1989 consolidated 18 committees into 4 boards, plus the 5 divisions. Our affiliated philanthropic organization, the Pennsylvania Psychological Foundation, was founded in 1990 to offer programming that was best done through a charitable, tax-deductible organization. More reorganization occurred in 1995-97, when the divisions were abolished, with only the School Division living on in the form of one of now 6 boards. The next year the Executive Council was transformed into a smaller Board of Directors. Only four standing committees were still defined in the bylaws, with the rest established or dropped as needed each year by the Board of Directors. With the streamlined structure the board began focusing more on strategic direction and policy decisions.

PPA had a Student Involvement Committee and a student member category as early as 1979. In 1994 the president started inviting a student representative to attend meetings of the Executive Council. In 2002 PPA granted student members full voting rights within the association, and in 2003 the Pennsylvania Psychological Association of Graduate Students was created, with the chairperson a voting member of the Board of Directors. In 2004 the American Psychological Association of Graduate Students gave PPA the Award for Outstanding State, Provincial, or Territorial Association (SPTA).

PPA had won the award from APA's Division 31 as the Outstanding SPTA in 1992. I believe we have built upon our accomplishments since then and have established one of the premier SPTAs in the country. Together with our dedicated volunteers and staff, we have realized many of the goals I had set out in 1987. Despite the numerous challenges facing the field of psychology today, I believe PPA will help ensure a bright future for psychologists.

Informed Consent to Treatment of Older Adults

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


Dr. Samuel Knapp


Rachael L. Baturin


Dr. Allan M. Tepper

A psychologist is required to obtain informed consent prior to instituting treatment with a patient. If the patient is greater than 18 years old, informed consent must be obtained from the individual. If the patient is 14 to 17 years old, informed consent must be obtained from the individual or a parent of the individual. If the patient is less than 14 years old, informed consent must be obtained from a parent of the individual.

Treatment of the elderly patient can raise unique informed consent issues for the psychologist. Often such treatment is performed in a hospital, nursing home, or skilled care facility. The psychologist may be on staff at the facility, or may be an independent contractor who is utilized on an as-needed basis.

Three general situations can exist when providing treatment to an elderly patient. First, a guardian may have been appointed authorizing him or her to make treatment decisions for the patient. Second, the patient may have executed a power of attorney allowing another individual to make treatment decisions. Third, the psychologist may be asked to render treatment to a patient with marginal decision-making abilities.

Guardianship in Pennsylvania is governed by statute and requires a judicial determination of incapacity. A formal petition for guardianship is required, along with expert testimony rendered by an individual with training and experience in evaluating the alleged incapacities. Often psychologists offer this expert testimony. If a guardian is appointed for the patient, the resulting Court Order will outline the decision-making powers granted to the guardian. In such situations, it is imperative that the psychologist (or the institution overseeing the treatment of the patient) obtain and review a copy of the guardianship Court Order prior to instituting treatment to ensure that the guardian has been granted power to make mental health treatment decisions for the patient.

Without a judicial finding of incompetency, the onus is upon the psychologist to determine if the patient presently is capable of engaging in the informed consent process.

A power of attorney is a document executed by the individual without the need for a judicial proceeding. A power of attorney grants an outside third party the present ability to make designated decisions on behalf of the patient, but lapses upon the incapacity of the individual. A durable power of attorney grants an outside third party the ability to make designated decisions on behalf of the patient presently and in the event of the incapacity of the individual. A limited power of attorney grants an outside third party the ability to make designated decisions on behalf of the patient only if and when the patient becomes incapacitated. Once again, prior to instituting treatment with the elderly patient, the psychologist (or institution overseeing the treatment of the patient) must inquire, obtain, and review any power of attorney presently in effect. If a limited durable power of attorney is in effect, the present incapacity of the patient should be determined by the agent designated under the power of attorney, rather than by the treating psychologist.

In many clinical situations, a guardian has not been appointed for the elderly patient, and the elderly patient has not executed a power of attorney. Nonetheless, the staff psychologist or the consulting psychologist may be requested to evaluate the patient's decision-making ability or provide mental health treatment.

Pursuant to the 2002 APA Code of Conduct Section 9.03(a), a psychologist is allowed to evaluate an individual's decisional capacity without obtaining informed consent. In these situations, the psychologist must employ the clinical interviews, consultations, record review, or testing necessary to assess the nature and extent of the individual's incapacities; assess the manner by which these incapacities interfere with the individual's ability to receive and weigh information; and assess the individual's ability to formulate and communicate decisions.

If the psychologist is asked to provide mental health treatment, the elderly patient must be able to understand and consent to the proposed treatment. Pursuant to the 2002 APA Code of Conduct Section 10.01(a), the psychologist must inform the patient about the nature and anticipated course of therapy, fees, involvement of third parties, and the limits of confidentiality. The psychologist must provide the patient with sufficient opportunity to ask questions, receive answers, and accept or decline treatment.

Often, the capacity of the individual to engage in this informed consent process may be marginal, or may fluctuate according to time, setting, or other

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LEGAL COLUMN

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physical, emotional, or logistical factors. In such situations, the psychologist must strive to assess the patient's present decision-making ability. That is, without a judicial finding of incompetency, the onus is upon the psychologist to determine if the patient presently is capable of engaging in the informed consent process.

In such cases, a psychologist is allowed to exercise his or her professional judgment in reaching this determination. Ultimately, however, it is the psychologist's responsibility to determine if the patient can consent to treatment. That is, the psychologist may not be able to rely upon a general informed consent form executed by the patient upon admission to the facility. The psychologist also should not agree merely to follow the desires of the administrative staff. In addition, regardless of the outcome of the informed consent determination, the informed consent dialogue that transpired between the patient and the psychologist should be documented clearly in the clinical record.

Child Abuse Legislation Tops Agenda

Although PPA has been trying to focus attention on the urgent need for reform of the Medicare funding formula – an issue that needs to be fought at the federal level – we have had to expend a great deal of time and energy this spring on the myriad of child abuse bills in the Pennsylvania General Assembly. More than 70 bills dealing with this topic have been introduced in the state House and Senate, and several are moving quickly. Some of them are helpful in further substantiating child abuse where it occurs, but many are problematic to health care providers and other mandated reporters and would not help abused children.

PPA has convened meetings in Harrisburg of representatives of 15 other health care professional associations, including those from the Pennsylvania Medical Society, the Pennsylvania Academy of Family Physicians, and many non-physician organizations that are members of the Alliance of Health Care Providers.

Our most immediate concern is House Bill 431, sponsored by Rep. Mauree A. Gingrich (R-Lebanon). This bill passed the House on April 17. PPA supports the general thrust of its goal to require more education on child abuse reporting. However, it needed some amendments, and we were able to win some – for example, changing the timing of the requirement to comport with the biennial licensure renewal, allowing Act 48 credits conferred by the Department of Education to count toward the requirement for professional licensure, and having the curricula approved by the Department of Public Welfare instead of provided by them.

Nevertheless, further amendments are needed to keep the requirements meaningful. At press time PPA and the other organizations are considering amendments for the following:

- education required before licensure to be determined by the licensing boards,
- the continuing education curricula for licensees to be determined by the licensing boards,
- a waiver or equivalent requirements for professionals who do not treat children.

Once we have agreement on these issues we will be advocating for amendments in the Senate to make the requirement more salient.

As noted there are many other bills in the legislature dealing with aspects of child abuse. Our coalition is considering the following areas. The first is keeping the connection between the mandated reporter and the child; several bills would require reporting to ChildLine even if the child did not come before the provider in a professional capacity. The second is redefining child abuse so that cases that actually involve child abuse do not get dropped by caseworkers or judges because the incidents did not meet the current narrow definition. And the third is making any penalty for failure to report proportionate to the offense. Several bills would greatly increase the penalties up to and including felonies, even in cases where the suspected child abuse is ambiguous. These issues were described in more detail in the May 2013 *Pennsylvania Psychologist* and will be further explored in future issues.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of May 17, 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	In Aging and Youth Committee	None
SB 21	Requires reporting suspected child abuse even if the child is not seen in a professional capacity or upon getting the information second-hand; report must be made to county as well as to Childline – Sen. Kim L. Ward (R-Westmoreland)	Needs to be amended	In Aging and Youth Committee	None
SB 22	Increases penalties for failure to report child abuse – Sen. Kim L. Ward (R-Westmoreland)	Under review	In Aging and Youth Committee	None
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	In Judiciary Committee	None
SR 6	A resolution requiring a study by the Joint State Government Commission and an advisory committee on violent crime – Sen. Stewart J. Greenleaf (R-Montgomery)	For	Passed 1/9/13	No action needed. Study is underway.
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	None	In Judiciary Committee
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 and Youth Committee	Passed 2/12/13, 198-0
HB 430	Allows reports of child abuse to be submitted through advanced electronic communications – Rep. Katherine M. Watson (R-Bucks)	For	None	In Children and Youth Committee
HB 431	Mandates training in child abuse for all licensees; needs amendments including waiver for those who do not treat children – Rep. Mauree A. Gingrich (R-Lebanon)	Needs to be amended	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 second-hand; requires reporting a patient for disclosing past child abuse – Rep. Todd Stephens (R-Montgomery)	Needs to be amended	None	In Children and Youth Committee
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 and 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	None	In Children and Youth Committee

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

Digital Presence for Psychologists: Using Social Media

Christopher Royer, PsyD

Dr. Christopher Royer

Stop and think for a minute how many times a day most of us use some type of electronic media to communicate, and you might get dizzy. My 81-year old mother, getting her Facebook account reconnected after a computer outage told me, "This is a colossal waste of time, but it's really fun!" Spin it any way you like, more and more people are spending more and more time connected to others through digital media. And it's not just social. The avenues for education, advocacy, and marketing have never been so plentiful. Every day we are within arm's reach of a podium, a printing press, a studio.

The PPA Committee on Technology Implementation twice surveyed PPA members regarding their comfort levels and use of various technologies. Initially, the results indicated that most folks tended to be pretty uncomfortable with technology. The result a year and a half later? Not much change. Most of the initial group of respondents reported feeling the same level of comfort at the end of 2012 as they did in the middle of 2011. We're a tough bunch!

So why should we break through our discomfort and connect with our consumers using electronic media? First, we have the potential to bring an enormous amount of useful information into people's lives. Second, most people look for services online. Google, Yahoo, and Wiki are the first places people turn to find the who, what, when, where, and why for any question they ask. And it's not all about the consumer. Presenting information online keeps us up-to-date and sharp about issues in our field. Much of what psychologists publish on the Web falls under education and dissemination of resources. Is that good for referrals? You bet it is!

This article presents the nuts and bolts of getting started with a number of electronic media designed to make connections with others over the Internet. It's not even close to an exhaustive list, and there is no consensus on the "best" way to have a professional presence online. The only common thread is that having an online presence takes time. Providing new and varied information means you'll be researching and providing input on a regular basis. To reach an audience on some services, it's good to develop "followers" who keep coming back to your site to view new posts. The best way to get some people to view your site and follow you is to view and comment on theirs.

So let's get started.

How do I start a website?

Building a website used to involve only two choices: You could either learn HTML and create it yourself, or you could pay someone to create it for you. (We won't even get into having the server hardware to host it yourself!) Both of those ways still exist, and fantastic web designers can create superb sites. However, a third option is to use a website service that creates templates from which you select and then fill with whatever information and graphics you like. Let's look at an example of one service – although I will use the service to illustrate this process, I am by no means endorsing the service exemplified.

To create a website in an afternoon, you can use a template service like *Therapy Sites* (www.therapysites.com). Go to the home page, then click on the button that says, "Get Started, try it for free." You will be given a choice of design, selecting from more than 20 page layouts. Don't worry about all the pre-populated text or themes, you can replace all or part of it at any time. Fill in the brief questions about your name, degree, subtitle (e.g., "Individual and Couples Therapy"), and office address. Click on "Preview Site" to see what your site will look like. At this point, you'll be able to edit every page of the site, add pictures, delete or modify text, and decide what other pages you want. For example, there is a pre-populated set of links of resources for clients. You can keep what they offer, add your own links, or hide the page from your site. It's important to note that you don't have to make all of those changes right off the bat. You can choose to have your site start with only one page covering basic information about you, and hide all the others until you have had time to edit them and then turn them back on, thus adding them to your site. The service does allow you to take Visa payments right from the page if you choose.

If you decide to go on to "buy" the site you create, then you have to pay a monthly fee ($59 per month in the case of *Therapy Sites*). Of course, there are many such services and we are not endorsing any particular one. Prices and features vary from service to service. They will then help you pick a domain name (e.g. drrsmith.com) to have as your web address. This may take a little time; try not to be wedded to one name. I hear PaPsy.org is taken!

We have the potential to bring an enormous amount of useful information into people's lives.

How do I create a professional Facebook page?

Go to www.facebook.com/pages/create.php. Once there, choose a classification. Let's pick "Local Business or Place." You will get a menu to fill in some identifying information. Choose "Professional Service" for the type of business. Enter the rest of the information, agree to the terms of service, and click "Get Started." You may be directed to a prompt to add your profile picture, or you may end

up on a page that will try to get you to advertise. If you end up on the advertising page, under No. 1, click "get started" to create a page. You may have to fill in your demographics again, and then you will be sent to the profile picture page. Upload a picture from your computer or from the Web. You will then be asked to write a brief summary of your business, maybe three or four sentences. Skip the next two steps (about advertising) for the time being, and voilà, you are looking at your Facebook Admin Panel, which is where you shape your page. Take a minute to add your hours, add more pictures or even videos, and start posting!

How do I open a Twitter account?

Go to www.twitter.com. Enter your full name, e-mail address, and password to create an account. On the next page, you will be asked for further information and to select a username. Then you will be taken through a brief tutorial about how to add people or organizations to the list of those you will follow. Following on Twitter means you will see those people's "tweets," which are brief posts. There are three rounds of this, so you will be following 15 users/sites when you are done. You're then prompted to add a few words to describe yourself and upload a profile picture. At that point, you're sent to your Twitter feed. You can "tweet" statements of 140 characters or fewer. There is a lot of shorthand to Twitter, and you can find a guide by typing "Twitter abbreviations" in any search engine such as Google. Twitter also offers an easy to use, robust help section at https://support.twitter.com/groups/31-twitter-basics.

How do I create a YouTube account?

If you don't already have one, create a Gmail account. Go to www.gmail.com and follow the steps to create an account. You will need to offer an alternate e-mail address in order to retrieve your Gmail information should you lose your password. Once you have your Gmail account, you can go to www.YouTube.com. Log in with your Gmail e-mail address and password if you are not already logged in. Notice you didn't have to create a separate YouTube account. From here you can click on "Upload a Video" to publish a video to YouTube. Most of the common video file formats are accepted by YouTube, including .MOV, .MPEG4, .AVI, .WMV, .MPEGPS, .FLV, 3GPP, and WebM. You can also publish to YouTube remotely from almost any cell phone with a video camera. Some videos are posted to YouTube without editing. Others are quite heavily edited. Editing software ranges from very basic features like voice-over, cutting and splicing, and scene transitions, to quite complex, including green screen and special effects. Prices range from free or a few dollars to hundreds of dollars.

When you have a video uploaded, make sure you use the Video Manager to set the security for your video. You can decide whether to offer your video to the public or only to a limited audience by using the "Unlisted" or" Private" settings. An unlisted video can be shared only by sending the video's link to someone directly. A private video can be shared with as many as 50 people included in a list of potential viewers (e.g., your subscribers or other friends with a YouTube account). Your videos become part of your YouTube channel. This means people who like your videos can subscribe to your channel and will be notified when you publish new videos.

How do I start a Blog?

A blog is a chronological recording of your writing, pictures, and video on whatever topic you want to have published on the Web. Like YouTube and Twitter, you can have followers who visit your blog and see what you have published recently on a topic. Blogs can be public or private. Private blogs restrict access to readers you designate. Public blogs are searchable and can be viewed by anyone. You can set permission for readers to comment on your blog, or you can choose to blog without comments. Two popular sites for creating blogs are www.blogger.com and www.wordpress.org. Both sites are free and feature a simple interface for adding and arranging content. It's very easy to start a blog. On Blogger, begin by logging on with your Gmail information. Click "New Blog" in the upper left. Select a name and a design and "continue." You're ready to post on your blog. Be sure to click "settings" to choose your security settings and any restrictions on who can post to your blog. You can let anyone post, identify specific people who may post, or allow no posts. There is also a setting to review and moderate posts before they go live on your blog.

That's it! You can use any of these social media services to connect to consumers and make a wealth of information available to a vast audience. You will read in this issue and in other articles about ethical issues and precautions associated with using social media as a psychologist. It's important to pick services that fit with your comfort level and what you most want to accomplish. We change hats multiple times every day as we switch roles, and we relate differently to our clients than to everyone else. Remember to keep your personal and work-related social media activities rigidly separate and keep that psychology hat on!

The committee is available to help anyone get started with these media. Feel free to contact drroyer.neuropsych@gmail.com.

Psychological Blogs: The Wave of the Future

Jacqueline B. Sallade, EdD

Dr. Jacqueline B. Sallade

Everyone turns to the Internet to locate services and find information. So it's no surprise that psychologists have an increasing presence on the Web. One way to share psychological knowledge with the public, and potentially attract new clients, is through a blog.

The term "blog" came from "web log." The first blogs were online journals or diaries but quickly expanded to include regular postings by professionals in many fields. Psychologists who blog typically write short articles related to their specialty or on current hot issues. This article will describe three very different blogs hosted by psychologists in Pennsylvania.

If you want to know more about ethics in our field, check out PPA's Ethics Blog (www.PaPsyblog.org). Dr. John Gavazzi came up with this idea while chair of PPA's Ethics Committee. The committee had a bulletin board on PPA's website, but that format was underutilized and discontinued when the website was overhauled a few years ago. So Dr. Gavazzi turned to blogging.

The blog has been a huge hit with 600-800 viewers a day and nearly 200,000 views last year. Currently, 260 people from 128 countries follow the blog via e-mail, GooglePlus, or Twitter. Other psychological associations, including those of Ohio and Australia, as well as many professors, use the blog for ethics training.

Posts include vignettes, some of which Dr. Gavazzi writes in response to ethical questions sent in by psychologists. But most of the posts come from a feed reader which Dr. Gavazzi regularly reviews. There are more than 1,000 articles on topics ranging from lawsuits over Zoloft to the ethics of torture to health care policies. There are even articles on philosophy, such as Michel Foucault's ideas on social justice. This well organized and brilliant blog has become a model for psychological ethics around the world.

This well organized and brilliant blog has become a model for psychological ethics around the world.

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Additional PPA Member Blogs

Dorothy Ashman, MA
Outreach Ethiopia
teaching EMDR therapy in Ethiopia
www.outreachethiopia.blogspot.com

Dennis Given, PsyD
SuccessfulPractice.net
private practice growth & development
www.successfulpractice.net

Edward Jenny, PsyD
(no title – blog on website)
varied topics
www.dredwardjenny.com

Peter Langman, PhD
Keeping Kids Safe
school shooters
http://www.psychologytoday.com/blog/keeping-kids-safe

Barry Lessin, MEd, CAADC
People Use Drugs for Reasons
substance use, addiction, and the family
http://www.barrylessin.com/blog

Jesse Matthews, PsyD
(no title)
varied topics: parenting; Asperger's and other autism spectrum disorders; ADHD; learning disabilities; social skills; technology and mental health; mental health stigma; mental health advocacy
http://drjessematthews.com

Gail Post, PhD
Gifted Challenges
psychological and educational concerns affecting gifted children and adults
www.giftedchallenges.blogspot.com

Pauline Wallin, PhD
1. *For the public* – on APA's Public Education blog, http://yourmindyourbody.org
2. *For mental health professionals* (issues of business and marketing your practice) – The Practice Institute http://thepracticeinstitute.com/tpi-blogrss

She also writes columns for a local newspaper, which they post on their blog: http://topics.pennlive.com/tag/pauline%20wallin/index.html.

Listservs From a Graduate Student Perspective

Adrienne B. Gallo, MS, and Brian D. Barber, MS, MDiv

Adrienne B. Gallo

Brian D. Barber

As future psychologists, the idea of having one's thoughts, opinions or questions read by hundreds of colleagues on a listserv can be intimidating. Additionally daunting is the idea that this information could potentially be perceived in a negative manner, further amplifying the spotlight that many graduate students may already experience. Anxious feelings aside, a listserv is a professional resource whose abundant benefits are often untapped by graduate students. Listservs allow individuals to initiate and maintain relationships, explore and further engage with topics of professional development, and provide an opportunity to identify valuable resources for dissertation research. As with other social media, one must be aware that when utilizing listservs as a professional resource there are rules and expectations of etiquette to be followed. Thus, it is important to outline listserv guidelines in order to assist young professionals in maximizing effectiveness, while being mindful of common courtesy and respect.

As in all areas of psychology, listserv subscribers are expected to abide by the Ethical Principles of Psychologists and Code of Conduct set forth by the American Psychological Association. First and foremost, this means abiding by the General Principles, including Principle B: Fidelity and Responsibility, as it pertains to upholding professional standards of conduct, roles and obligations, and interaction with other professionals (APA, 2010). While a listserv can provide a common ground for sharing and obtaining expertise in a specific area, one must keep in mind the boundaries of competence (2.01), not only concerning one's own participation but also the limited information known about others who may be posting as well. Further, any discussion concerning specific client information would warrant particular care with Standard 4: Privacy and Confidentiality, as it applies to maintaining confidentiality (4.01), disclosure (4.05), and consultation (4.06). It should go without mentioning that when utilizing a listserv one refrains from using the forum for illicit intentions. This includes defamation and any violation of intellectual property laws, antitrust or unfair competition laws, and other criminal laws (PPA, 2010).

Although not required to actively participate through postings, new members are encouraged to introduce themselves (PPA, 2010). Listservs are designed to allow members to express professional viewpoints and reflections without fear of rebuttal. Personal opinions about another member or his/her posting, including criticism or personal attacks, are strictly prohibited. Similar to other areas of professional development, one should employ appropriate and respectful communication among colleagues in all online communications.

Listservs are often used to discuss issues involving professional advancement including posts about employment opportunities and post-doctoral positions. But listservs should not be used for commercial purposes that benefit the author directly (PPA, 2010). For instance, one may not list office space availability, directly solicit members to purchase services or products, or advertise non-PPA continuing education workshops or events. Instead, members should focus on information that is factual and relates directly to the practice of psychology. For instance, one may submit a posting about particular books, groups, or training material that may provide insight or perspective relevant to the particular topic. Listserv members may be reprimanded if they attempt to disrupt others by sending unsolicited advertising or chain mail. No matter how worthy the cause, no listserv messages are allowed except those related to psychologists and psychological issues.

The chair, or a designee, of the Electronic Media Coordination Committee (EMCC), which monitors PPA listservs, will privately contact any

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PSYCHOLOGICAL BLOGS...

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A very different blog is www.hecticparents.com. It is the brainchild of current PPA president, Dr. David Palmiter, who developed it shortly after his parenting book appeared on shelves. He uses humor to educate parents on how to raise their children more effectively without losing their sanity.

The weekly posts are relatively long and designed to help parents directly rather than generate discussion. The blog holds about 100 posts so far, and gets 50-100 hits each day with 17,000 visits in 2011.

Dr. Palmiter writes weekly, usually over the weekend, and then appears each Monday on the NBC affiliate talk show "PA Live" to discuss his blog entry. This clever and useful blog automatically goes to Twitter, LinkedIn, and Facebook. Readers ask to republish them, and Google Alerts shows a link to this blog. The biggest publicity comes from Twitter, where re-tweets are common.

My experience is quite different. As a writer of old-time public service announcements, I welcomed the Internet as a place to send out tidbits of psychological knowledge that are well known in the profession but not to lay people. The online magazine Salon (www.salon.com) has a section called "Open Salon." I joined (a matter of simply signing in with a username and password) and started my blog, Dr. Jackie's Mental Health Moment.

At first I posted daily (or not at all when travelling), but now a couple of times a week. The posts are short, usually one to five paragraphs. I thought no one noticed, but eventually I got followers, comments, and e-mails. Although I do not keep count of hits or views, enough people mentioned that they read the blog that I was inspired to do more. I contacted WITF, Harrisburg's public radio station, and asked if I could contribute. Now my blog entries also appear on the WITF website (www.witf.com) bulletin board called Self-HelpNow.

Unlike the blogs written by Drs. Gavazzi and Palmiter, I cover a wide range of topics: bullying, Asperger's, obesity, love, anger, fun, wisdom, grief, depression, authoritarianism. Anything that comes up in work or life that inspires me can become a blog entry. My goal is to share my thoughts and stimulate insight.

I have had only one bad experience during my year of blogging. An angry patient who did not like my office posted a nasty comment. I responded and hoped readers would not take it too seriously. The overwhelming response I receive is positive and I plan to continue blogging. It's fun!

There are many ways to start a blog as a psychologist. (See Dr. Royer's article in this issue for more details.) For example, you can be part of the *Psychology Today* website for a monthly fee and contribute to their discussion groups as well. On existing sites, like www.salon.com/opensalon, you will have the opportunity to discuss issues not just with your followers but with other bloggers.

Blogging is a great way to join the community of psychologists and others interested in psychological issues. So power-up your laptop or tablet and start reading, writing, and discussing.

LISTSERVS...

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member who violates a listserv rule (PPA, 2010). The EMCC will provide a detailed explanation of the violation and a reminder of the listserv rules. If a member commits a second violation within one year, the EMCC will inform the individual of the nature of the violation and include a reminder that a third violation will lead to a six-month suspension from the listserv. In addition, the EMCC will monitor the member's future postings for six months. During this probationary period, only postings deemed appropriate by the EMCC will be posted. A third infraction within one year will lead to a six-month suspension. After this time period, the member may apply for re-subscription but is not guaranteed immediate reinstatement. If the member is reinstated, prior offenses will be disregarded and the violation procedure will begin anew. If the member is not reinstated, a rationale will be provided.

In order to encourage respectful and professional communications, PPA suggests thinking carefully before posting on a listserv (PPA, 2010). First, consider the legitimacy of the message and the potential consequences of its posting. Second, refrain from posting when in an emotionally aroused state. Third, be mindful of what you are sharing with others; do not post anything that you would not want published on the front page of a newspaper (PPA, 2010). Finally, if seeking increased privacy, consider joining a more private list or utilize a different mode of communication. Graduate students, as well as professional psychologists, must adhere to these rules in order to maintain a supportive professional community aimed at addressing challenges in the field and furthering professional development.

As with other social media, one must be aware that when utilizing listservs as a professional resource there are rules and expectations of etiquette to be followed.

Graduate students face many challenges, including limited financial resources, time constraints, and an internship crisis. While not providing all of the answers, listservs abound with opportunities for professional growth. They disseminate current information about clinical issues, impending changes to the DSM, ethical dilemmas, and relevant legislation. They provide opportunities to network, gain referrals, solicit research participants, and learn about upcoming events (Collins, 2007). Finally, listservs assist in developing a sense of community, providing support and inspiration, allowing for shared emotional connection, while helping to bridge the physical distance that too often keeps us apart.

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Pennsylvania Psychological Association. (2010). *PPA listserv rules*. Retrieved from http://www.papsy.org/collaboration-communication/listserv-rules.html.

Cost-Effectiveness of Psychological Services

Roger Brooke, PhD, and Jeremy Axelrad, Duquesne University

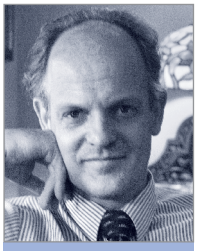
Current political forces and changes in health care mean that we psychologists and our political leaders need to be informed about the large body of research supporting the human benefits and economic value of our profession. The significant cost-effectiveness of psychological services is indicated across a range of situations, including hospital care, family practice, and outpatient psychotherapy, as are the effects of such services in terms of reducing overall health care costs. What follows is a summary of a fuller discussion available online (Brooke & Axelrad, 2013).

The cost-benefit studies

Psychosocial intervention has been correlated with subsequent reductions in health care use and costs across various types of inpatient and outpatient care. Chiles et al. (2006) estimate that it reduces health care costs in general by about 20%, although Crane et al. (2008) found greater reductions for the "high utilizers" of health care in that it reduced health screening visits by 68% and urgent care visits by 78%. Indeed, many forms of behavioral health services, particularly when delivered as part of primary medical care, can be central to a large-scale improvement of the health care system, specifically by reducing morbidity and mortality and increasing the cost-effectiveness of care (Blount et al., 2007).

The recent findings on health care cost-offset have a distinguished history. Nearly 30 years ago the review by Yates (1984) found that psychological services can be used to prevent heart disease, cancer, accidents, violence, and respiratory disease, providing evidence that psychological techniques are useful and cost-saving companions to traditional medical treatments.

There is strong support for the claim that psychologists can reduce medical care overutilization and unnecessary medical expenditures (Crane et al., 2008), significantly and reliably offering less costly and more appropriate alternatives. These findings have emerged from studies of diverse populations, including



Dr. Roger Brooke

Jeremy Axelrad

those with depressive disorder (Smit et al., 2006), personality disorders (Chiesa et al., 2002), and the most severe psychiatric disorders, including schizophrenia, bipolar disorder, and borderline personality disorder (Gabbard et al., 1997). A variety of empirical studies suggests that counseling is an effective addition to general practitioner care (Bower et al., 2003).

Psychotherapeutic treatment outcome has been found to have a significant impact on the reduction of medical costs and hospital days for adults and children (Kraft et al., 2006), as well as the frequency of visits to family doctors and days missed from work (Golden, 1997). Although the evidence in support of the cost-offset hypothesis is quite robust, little has been done to implement integrated health care (Levant et al., 2006).

Indirect benefits

In addition to these direct cost-offset and effectiveness effects, a sizable corpus of evidence supports the view that the benefits of psychological interventions extend beyond the individual recipient of those services, positively impacting the functioning of other family members – most significantly their children and spouses – and lowering their overall health care costs as well.

Even moderate reductions in parental symptoms of dysthymia are associated with reductions in childhood behavioral problems and in expenditures for the child's use of services (Byrne et al., 2006), and successful treatment of parents' depression is associated with an improvement in children's symptoms and functioning (Garber et al., 2002; Gunlicks et al., 2008).

Likewise, the benefits of child therapy extended to parent and family functioning, even though these may not be focused on directly in the children's treatment (Kazdin et al., 2002).

On psychodynamic psychological treatments

We are aware that psychodynamic therapy has been disparaged in the popular press and even training institutions as lacking empirical support. This is despite the fact that many psychotherapists in the field (rather than in university research settings) practice in that tradition or draw significantly from it, and that therapists of all persuasions tend to go to psychodynamic practitioners when they themselves are in distress (Norcross, 2005). We think it appropriate to draw attention to the following findings out of Holland and Germany.

There is strong support for the claim that psychologists can reduce medical care over-utilization and unnecessary medical expenditures.

Despite the common perception that long-term psychodynamic treatment is expensive treatment, evidence suggests that it results in decreased consumption of medical care and higher work productivity right after psychoanalytic treatment, and significant cost savings and economic benefits in the long term (Berghout et al., 2010; Beutel et al., 2004). Two years after treatment, the health care system's total cost savings were approximately $4,500 per person per year (Berghout et al., 2010). Significantly reduced health care costs were still accruing 7 years after termination (Beutel et al.,

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2004). These major studies showed good to very good improvements in physical and mental health and job performance, among other measures, as well as fewer days of sick leave, fewer hospital visits and lower medication costs, not only with respect to their own pretreatment functioning, but also compared to the general population. The same outcomes were found in the Jungian analytic field (Keller et al., 2002).

Effect sizes for psychodynamic psychotherapy have been found to be as large as those reported for other therapies that have been actively promoted as "empirically supported" and "evidence-based" (Shedler, 2010). Also, some well designed research suggests that non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques central to good psychodynamic practice (Ablon & Jones, 1998).

Conclusion

Psychological services are beneficial across a variety of settings, from hospital to family practice to outpatient practice, and across a wide range of psychological and psychiatric difficulties, including severe mental illness, depression, anxiety, and the difficult-to-treat personality disorders. The benefits accrue not only to the individuals directly concerned but also to others in their families. The benefits are also evident in significant cost reductions and savings with regard to hospitalizations, other health care utilization, and work absenteeism. In sum, those beneficiaries who use psychological services, as well as their non-treated family members, tend to cost significantly less to the system than those who do not. They also feel and function a lot better.

References

References are available on the PPA website, www.PaPsy.org, or from the first author at brooke@duq.edu.

Roger Brooke, PhD, ABPP, is professor of psychology at Duquesne University and a licensed and board-certified clinical psychologist with a special interest in outcomes research. Jeremy Axelrad is a doctoral student in the APA-accredited clinical psychology program at Duquesne University.

PPA Selects Noteworthy Award Recipients

Paul Kettlewell, PhD

On Friday, June 21, 2013, at our annual convention several impressive individuals who have contributed to our society and PPA will receive awards.

- **DR. REX GATTO** will receive the **Distinguished Service Award** for consistently outstanding service to the Pennsylvania Psychological Association. He has been a tireless contributor to PPA in many roles such as offering continuing education seminars primarily related to using sound psychological principles in the business community. His contributions to APA include participation in the Psychology in the Workplace Network and APA's Psychologically Healthy Workplace Award program. Even more importantly, he has provided his expertise to PPA for many years by developing and sustaining the Business and Psychology Partnership Committee and PPA's highly regarded Psychologically Healthy Workplace Award.

- **THE HONORABLE JEANNINE TURGEON** will receive the **Public Service Award** for a broad range of activities in the practice of family law and advocacy efforts related to parenting coordination. She has more than 28 years of experience in family law and has been a Common Pleas Court judge since 1992. She was on the Pennsylvania Parenting Coordination Task Force, which developed the model rule and order for parenting coordination. She has been a consistent advocate for families and understands the importance of families receiving appropriate parenting support and psychological services.

- For her pioneering work in relationship enhancement and filial therapy **DR. RISË VAN FLEET** will receive the **Award for Distinguished Contributions to the Science and Profession of Psychology**. She has extended psychological principles to work with dogs and canine-human relationships. As an accomplished author and advocate she been an innovator in using psychology to improve human welfare through strengthening our bonds of love and affection with our canine companions.

- **MS. DOROTHY N. ASHMAN** will receive the **Psychology in the Media Award**. She was instrumental in creating PPA's E-Newsletter for the public, "Psychological News You Can Use." She has been the creative director for all issues of the E-Newsletter since 2005. Her dedication to helping disseminate useful psychological information to the public is long-standing and impressive. She truly is helping to make psychology a household word.

- The recipient of the **Award for Distinguished Contributions to School Psychology** is **MS. AMY R. SMITH**. She currently is an educational consultant with the Pennsylvania Training and Technical Assistance Network (PaTTAN) of the Bureau of Special Education. She provides professional development and creates training materials and on-site coaching support for school districts. Ms. Smith is also the current president of the National Association of School Psychologists (NASP).

Come to the Awards Ceremony at the PPA Convention on Friday, June 21, 2013, at 11:15 a.m. and celebrate the work of these outstanding individuals.

Using Client Feedback to Stay on Track

Salina C. Santore, Student Member, Marywood University

Salina C. Santore

Clinicians are constantly trying to establish and demonstrate effectiveness of psychotherapeutic interventions. However, we face the problem of how to cost-effectively and validly assess effectiveness, especially across a complex array of nuanced interventions. Moreover, our relationships with our clients may leave us biased and misinformed regarding our perceptions of the work. We often see the client in a better light than what is reality (Norcross, 2011). So how can we measure if clients are really benefiting from our sessions?

Researchers such as Dr. Gary Burlingame and Dr. Michael Lambert, authors of the Outcome Questionnaire (OQ), and Dr. Scott Miller and Barry Duncan, authors of Partners for Change Outcome Management System (PCOMS), have given us the promising answer of outcome measures or client feedback. Outcome measures are standardized procedures that allow therapists to monitor and track clients' responses to treatment. This feedback allows the clinician to identify and respond to ill-fitting interventions and negative change. On the other side this data can inform when techniques are working and increase client/therapist communication, strengthening the alliance. It is likely that this feedback can improve the clinician's performance (Kluger & DeNisi, 1996) as well as client prognosis (Sapyta, Riemer, & Bickman, 2005). In fact, meta-analyses have found that compared to clients receiving treatment as usual (TAU), clients with therapists utilizing client feedback were 68% (PCOMS) and 70% (OQ) better off at termination (Norcross, 2011) – meaning that many fewer symptoms.

However, like most interventions, in order to achieve the best outcome there are conditions that need to be met. Sapyta, et al. (2005) describe the contextual feedback intervention theory as the conditions for clinicians to best benefit from feedback:

Contextual feedback intervention theory conditions

- Commitment to improving on performance
- Awareness of discrepancies between reality and goals
- The source of the feedback is credible
- The feedback is immediate, frequent, systematic, clear, and understandable, and provides concrete suggestions for improvement

So how do we collect more formal client feedback? Fortunately there are two valid feedback systems available that collect such data. These systems are the PCOMS (My Outcomes, 2013) and the OQ (OQ Measures, 2013). Both systems have been found to be effective forms of feedback (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003; Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003; Norcross, 2011). See Table 1.

Allow me to describe these tools a little more.

Partners for Change Outcome Management System (PCOMS)

- Comprised of 2 scales: the Outcomes Rating Scale (ORS) and the Session Rating Scales (SRS)
- Includes a Child Outcomes Rating Scale (CORS)
- Allows one to hand graph and track feedback
- Takes 2 minutes to administer both the ORS and SRS

ORS

- 4-item scale
- Measures mental health functioning
- Modeled after OQ scale

SRS

- 4-item scale
- Molded after Bordin's (1979) concept of the therapeutic alliance
- Measures the therapeutic alliance
- 3 items measure affect bond and agreement on tasks and ultimate goals of sessions
- 1 item measures the overall rating of the relationship

Outcome Questionnaire (OQ)

- Measures mental health functioning and the therapist-client relationship
- Predicts treatment failure by comparing a real score against an expected recovery curve based on pretreatment distress (85% to 100% ability to correctly predict negative outcomes)
- Has a "Red" alert that warns clinicians of clients responding poorly to

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Table 1

Research Findings for PCOMS and OQ

	Test-retest Coefficient α	Internal Consistency	Reliability Coefficient α	Correlation with OQ 45.2	Compliance at 1st month	Compliance at 6th month	Compliance at 12th month
OQ	0.98	0.93, 0.93	0.95		33%	25%	25%
SRS	0.64		0.88, 0.93				
ORS	0.97, 0.93	0.93	0.90	0.69	3%	61%	89%
CORS	0.78	0.84					

Note. Compliance = Clinician compliance with using the measure. CORS = Child Outcomes Rating Scale.

Pursuing Doctoral Degrees Beyond the Level of Licensing: "Caveat Preemptor"

Frank M. Dattilio, PhD, ABPP

Dr. Frank M. Dattilio

The credentialing of mental health professionals has become very important, particularly with the advent of accountability and third-party reimbursement. The credibility of one's credentials is particularly essential in assuring the consumer that certain professionals are qualified and do not pass themselves off as something they are not.

Mental health professionals who have obtained their license at the master's level sometimes feel pressured to pursue advanced degrees, particularly by certain third-party payers or insurance panels who offer higher reimbursement rates. This is particularly the case with psychologists who are often differentiated by insurance panels by degree. Consequently, advancing one's credential has become very attractive, not only for higher third-party reimbursement, but also for the prestige that accompanies possessing doctoral-level education and training.

Regrettably, with the pursuit of higher education, some mental health professionals have fallen victim to the allure of non-traditional degree programs that offer a fast track to obtaining a doctorate in less time than is standard for traditional educational programs. Such doctoral degrees may be offered through unaccredited "non-traditional" or alternative programs. In some cases, these entities offer degrees that may place licensed professionals at serious risk with their respective licensing boards because they do not maintain the proper accreditations. This is not a new topic in the professional literature (Dattilio, 1987; Dattilio & Sadoff, 2007; French, 1989).

Unfortunately, due to the increased demand for upgraded credentials and the need to remain competitive within an emerging field, ersatz or questionable degree programs have become more prolific and easily accessible for a fee. As a result, licensed mental health professionals are urged to proceed with caution when selecting doctoral programs, particularly those that advertise non-traditional or alternative degree formats. The Pennsylvania State Board of Psychology requires that licensees accurately and objectively represent their professional qualifications (§44.61 at Principle 4(a) of the board's regulations), which include advanced degree programs that clearly meet the board's standards. The same holds true for other professional licensing boards, such as the State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors. Section 11(a)(4) of this act indicates that licensees may not misrepresent, directly or indirectly, or by implication their professional qualifications, such as education, specialized training experience, or areas of competence. Hence, mental health professionals licensed at the master's level who choose to pursue higher academic degrees run the risk of violating their respective state licensing laws if their newly obtained degrees do not meet the board's standards. Whereas the board's requirements may have varied in past years, more recently newly acquired psychology degrees are mandated to meet the requirements of the doctoral degree programs in psychology designated by either the Council on Postsecondary Accreditation (COPA), the American Psychological Association (APA), or the Association of State and Provincial Psychology Boards (ASPPB).

Similar requirements are outlined by the State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors, which also requires COPA accreditation, as well as recognition by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or equivalent bodies, such as COAMFTE (Marriage and Family Therapists) and CSWE (Certified Social Work Education).

Mental health professionals who choose to pursue advanced credentials should be leery of institutions or organizations that offer degrees that are "self-accredited" or simply use the term "accredited" without indicating a specific accrediting body. Due to the many unaccredited or ersatz programs offered in the United States and abroad, it may be difficult to determine which degrees are legitimate and acceptable to the licensing boards. Therefore, mental health professionals should heed the following guidelines:[1]

1. The program materials should clearly state that the school is accredited by the Council on Postsecondary Accreditation (COPA) or one of the previously mentioned organizations. If the institution is not an established university, take time to verify that it is accredited by an outside body that will be acceptable to the licensing board.
2. Do not be fooled by terms such as "state authorized" or "state approved," or if the accreditation is issued by the institution itself. Advertisements that describe programs as "non-traditional," "alternative," or "innovative" often try to camouflage the fact that they are not accredited.
3. Other red flags include: the institution uses a similar name to that of a well-known college or university; there are few full-time faculty; degree requirements are few or unspecified; credit is granted for "work" or "life experiences;" dissertations may be descriptions of a person's job or life situation; payment is per degree rather than per course; admission is relatively unselective.

[1]Psychologists also need to ensure that, despite obtaining a degree from an appropriately accredited body, their degree is also in a field acceptable to the State Board (e.g., clinical/counseling psychology as opposed to "health planning and administration," "biology," "divinity," etc.).

Mental health professionals should be reminded that it is their individual ethical responsibility to ensure that their education and credentials fall within the accepted standards of the state licensing laws, and that the use of degrees obtained beyond the granting of a license to practice that are not approved by the state boards may clearly result in sanctions for unethical behavior. In addition, mental health professionals also run the risk of violating the codes of ethics of insurance companies or third-party payer panels by misrepresentation of credentials if they claim degrees that are not properly accredited.

What if I am in the process of pursuing a doctoral degree and am unsure as to whether or not my credential will be acceptable to my licensing board?

Most programs indicate either through a website or in their written material whether or not they are accredited by any of the aforementioned organizations. If this is not clear, then you should write to the institution and ask them specifically or inform them that your intention is to eventually become licensed by your state and that you want to ensure that the program will be acceptable. Most of the time there is enough information posted that will allow you to make this determination. When in doubt, you may consider querying the licensing board in writing and obtain formal confirmation from them.

What if I have already obtained a degree from a questionable institution and have been using it on my letterhead and in all of my correspondence?

The first thing to do is to determine, as outlined above, whether or not that program fits the licensing board's requirements. In the event that you learn that it does not and that this may be a violation, it is suggested that you write to your licensing board for clarification. In the interim, it is strongly recommended that, unless you have confirmation that your degree is accredited by the appropriate bodies, you should cease and desist so that you do not violate your ethics.

What if I know someone who sports a credential that is potentially not accredited or approved by the licensing board?

The ethical thing to do is to contact that colleague directly and share your concerns. If that individual is not willing to explore or remedy the matter or document that their degree is indeed accredited, then you have an ethical obligation to report them to the appropriate licensing board so that a determination and ruling can be made officially.

It should be emphasized that this is a serious matter, particularly since it misrepresents credentials to the public and constitutes unethical behavior and, in some cases with third-party payers, even fraud. The public relies on licensing boards to guarantee that all licensees have the proper education and training required.

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

Marti Evans, APA Public Education Campaign Coordinator for Pennsylvania

The vision of the American Psychological Association's current Public Education Campaign focus, *For a Healthy Mind and Body...Talk to a Psychologist*, is to help the public recognize the health benefits of caring for both mind and body. Recent studies and media reports conducted by APA have shown that more people than ever realize that physical health and mental health are intertwined and that psychologists are at the forefront of this public awareness.

More and more PPA members have become active in our Public Education Campaign and have let us know about their outreach activities to the public. We thank them for helping to "make psychology a household word" in Pennsylvania.

The members of the E-Newsletter Committee continue to make psychology a household word by publishing PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." The e-newsletter creative director is **Ms. Dorothy Ashman**. The chair of the E-Newsletter Committee is **Dr. Christina Carson-Sacco**.

The December 2012 issue included:

- *Expanding Horizons: Psychologists Offer Ways to Achieve and Sustain Healthy Weight Loss Goals* by Anne Murphy, PhD
- *Stress-Busting Apps* by Joseph Altobelli, PsyD
- *Ready for Change? Prepare Your Family to Face Transitions Gracefully* by Marianne Herzog, PhD

The March 2013 issue included:

- *Parenting Teens Using Drugs: Get Back to the Driver's Seat of Your Family* by Barry Lessin, MEd, CAADC
- *Workplace Bullying: We're Not in High School Anymore!* by Gail Cabral, IHM, PhD
- *Five Ways to Deal with Difficult People* by Michelle Herrigel, PsyD
- *Improve Brain Power by Using Exercise* by Christie Sworen-Parise, PsyD

Dr. Julie Allender wrote an article, "Tomorrow," for the February issue of MobileWomen.org, an online magazine for women in wheelchairs. The article features seven things to do to get to tomorrow.

On November 20, **Dr. Dave Borsos** presented two workshops for 35 teachers at Springfield Township High School in Montgomery County after one of their students committed suicide: "Understanding Psychopathology and Potential Signs of Suicidality" and "Wellness, Stress, and Self-Care in Troubled Times."

On December 11, **Dr. Laura K. Campbell** did an interview for *Webb Weekly Williamsport* and *WBGM/WPGM Radio* on "Holiday Stress."

In November **Dr. Helen Coons** was an expert source on "Relationships and Body Image in Women Across the Lifespan" for *Self Magazine*, and on "Impact of Genetic Counseling on Health Decisions and Well-Being" for *New York Genome Center Magazine*.

Dr. Sue Ei was a radio guest on *Max Potential* (B98.3, Y106.4, EXPN 1240, and Max Potential Podcast) with host Jeff Shaffer on "Stress, Exercise, and Time Management" on March 3, 4, 10 and 11.

Dr. Audrey Ervin co-facilitated a book discussion on "The Secret Thoughts of Successful Women: Deconstructing the Imposter Syndrome," with author Valerie Young for 25 members of the Association for Women in Science on March 21 in Doylestown.

Carlisle psychologist **Dr. Rebekah Feeser** was interviewed for an article in the December 9 issue of the *Patriot-News*, "Five Questions About Surviving the Holidays."

Dr. Kathleen Curzie Gajdos presented "The Rise of the Wounded Feminine in the Media" on March 6 for the American Institute of Medical Education in Bangkok. She writes a column, "Mind Matters" for the online newspaper, Chadds Ford Live (www.ChaddsFordLive.com), and her articles also appear on her website, www.drgajdos.com. The article on March 20 featured "Karma and Psychology" and on March 7 "The Hidden Hunger in America."

Dr. Christine Ganis facilitated a roundtable discussion for 30 community leaders, "MissRepresentation," an award-winning Sundance documentary, on March 21 for the Sandhills-Southern Pines Branch AAUW in North Carolina. The goal of the discussion was to identify some of the major problems affecting area youth and to seek solutions by working in collaboration with other organizations in their community.

Dr. Claudia Haferkamp presented "Stress and Time Management" on October 19 and January 11 at the YWCA in Lancaster to 12 women enrolled in the Y's New Options-New Choices Career Development Program.

York psychologist **Dr. Chrissi Hart** was interviewed in December by the *Orthodox Christian Radio Network*. The episode, "Why Does God Allow Violence Against Children," addressed the murders in Newtown, Connecticut.

Dr. Nora Maidansky, a psychologist in Wyomissing, was interviewed for an article in the February 10 issue of the *Reading Eagle* about the controversial new gun legislation in New York.

On February 1, **Dr. Bruce Mapes** spoke to seniors in the West Chester Area School District about careers in psychology. The *Centre Daily Times* in State College published a column by **Dr. Stephen Ragusea** on December 20, "Our Blood Lust Continues to Breed Violence."

Dr. David Rogers of Hershey Psychological Services presented "Dealing with Difficult People" to members of the Pennsylvania State Association of County Controllers on November 14 during their fall conference.

Scranton psychologist **Dr. Chrstie Sworen-Parise** appeared on WVIA-TV's "Call the Doctors" on January 22.

Dr. Allan Tepper presented "Ethics in Mental Health" to 80 people at the Chestnut Ridge Counseling Services in Uniontown on March 1, and "Clinical, Ethical, and Legal Issues Related to Record Keeping for the Mental Health Professional" to 100 people at the Foundations Community Partnership in Doylestown on December 5.

Bradford County psychologists **Kay Vennie** and **Diane Siegmund** were quoted in a new book, *Fracking Pennsylvania: Flirting with Disaster,"* by prize winning journalist Walter M. Brasch.

Dr. Pauline Wallin writes a column, "on your mind...with Pauline Wallin" for the *Body & Mind* magazine published by the *Patriot-News* in Harrisburg six times each year. Recent topics have included, "Breast Cancer...Again? How to Cope with Recurrence," "Getting Better at Small Talk," and "Coping with the Unexpected." She was also interviewed for the following:

- "Procrastination Could Cause Tax Return Errors" – *WITF Radio*, April 4
- "Abandoning the Hearth for Christmas" – *CNN*, December 7
- "Season of Stress: How to Deal with Holiday Pressure – *Medill Reports*, Chicago Northwestern University, December 4
- "Alone on Thanksgiving? Here's a Few Things to Do to Keep You Occupied" – The *Patriot-News*, November 13
- "Avoiding Holiday Family Drama" – Examiner.com, November 21
- "Psychologist: Keep Children from Watching Detailed Reporting on School Shootings" – The *Patriot-News*, December 14
- "Study Says Younger Generations Facing More Stress Than Older Generations" – *WHP-TV Harrisburg*, February 12
- "Rutgers' Mike Rick Rage: Bad Behavior or a Mental Disorder?" – abcnews.go.com, April 4
- "There's a Reason You're Always Late" - Yahoo.com, February 15
- "6 Holiday Stress Busters" – MyHealthNewsDaily.com
- "Inner Brat Ends New Year's Resolutions" – *Altoona Mirror*, January 1
- "31 Days to a Healthy New Year" – The *Patriot-News*, December 30

Want *your* name in our next article?

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

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

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details!

We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and services psychologists offer.

Teen Sleep Issues and School Start Times, Part I

Gail R. Karafin, EdD, Public Policy Chair, School Psychology Board, gkarafin@verizon.net

Dr. Gail R. Karafin

The research on the benefits of a healthy lifestyle and the consequences of an unhealthy one cannot be disputed. One of the main components of a healthy lifestyle is getting adequate sleep. Yet sleep is something frequently neglected in our society, especially among adolescents. Continually getting too little sleep can have serious consequences, including emotional, behavioral, and performance problems. In addition, many mental disorders, such as depression, anxiety, mania, schizophrenia, post-traumatic stress disorder, and attention-deficit/hyperactivity disorder, can include sleep disturbance. This can complicate diagnosis and treatment with teens.

The National Sleep Foundation and many pediatric sleep specialists recommend the following sleep amounts relative to a child's age:

Age of Child in Years	Needed Hours of Sleep
1-3	12-14
3-6	10-13
6-11	9 ½ -12
11-18	9-9 ½

The four most common sleep disorders in children are (1) obstructive sleep apnea, (2) periodic limb movement disorder, (3) delayed sleep phase syndrome and circadian schedule disorders, and (4) narcolepsy. A more prevalent problem is not a sleep disorder, but a behavioral issue: poor sleep hygiene.

This article is not intended to discuss sleep disorders but to address the importance of sleep and the negative impact of sleep deprivation in youth. The Centers for Disease Control and Prevention reported that 25% of teens get no more than 6.5 hours of sleep nightly, far short of the 9-plus hours needed (Carpenter, 2013). Sleep deprivation is associated with information processing and memory deficits, increased irritability, anxiety, depression, decreased creativity, and decreased ability to handle complex tasks (CAREI, 2002).

The Center for Applied Research and Educational Improvement (CAREI) at the University of Minnesota reviewed research on teen sleep. They reported that risks with teenage sleep deprivation include mood and behavior problems, increased potential for alcohol and other drug use, and vulnerability for accidents. In addition, students who evidence a "sleep lag" tend to have poorer grades. Twenty percent of high school students fall asleep in school and 50% of teens report being most alert after 3:00 p.m. Forced awakening does not appear to reset the circadian rhythm, and the sleep lag is worse in schools with earlier starting times. Sleeping in on the weekends does not ameliorate these negative effects.

Circadian rhythm in teens

All living organisms appear to have rhythmic patterns at the cellular level known as circadian rhythms. The human body has an internal clock that is normally set by daytime sunlight and evening darkness. Teens experience delayed phase sleep problems where the natural circadian rhythms have an extended day and they are excessively sleepy in the mornings. That means, as all parents know, teenagers tend to stay up later and sleep in later. Adolescents report being unable to fall asleep in time to get the amount of rest needed given their wake-up schedule. Ironically in most school districts, high school has the earliest start time, which compounds the problem for teens who are struggling with circadian rhythm shifts and delayed sleepiness. There also is the effect of modern technology: the hypnotic and addictive use of electronic devices late into the night frequently delays the onset of sleep. Adolescent chronic sleep deprivation results in a form of perpetual pseudo-jet lag.

Physical consequences of sleep deprivation

There are a number of consequences associated with sleep deprivation. Chronically getting too little sleep disrupts many aspects of physical health, including hormone regulation, glucose metabolism, insulin resistance, inflammation processes, heightened pain perception, cancer, and reduced immune function. Although many early studies on sleep deprivation focused on total deprivation, more recent attention has addressed the more common problem of "partial sleep loss" or shortened sleep. This occurs when one cuts sleep short by an hour or two. Levels of leptin, a hormone that regulates hunger and appetite, drop during partial sleep deprivation. This can have effects on dietary choices, obesity, diabetes, high blood pressure, and cardiovascular disease, now referred to as *cardiometabolic disease*. Circadian and sleep disruptions also cause a metabolic slowdown that can be attributed to a weight gain of about 10 pounds per year. Children and teens showed stronger associations between shortened sleep and these disorders, suggesting greater vulnerability to sleep loss in youth.

Cognitive consequences of sleep deprivation

Wineberg (2012) reported that sleep plays an important role in learning and memory. Many studies demonstrate a relationship between sleep deprivation and compromised cognitive functioning: impaired performance and alertness, decreased time on-task and response shifts, memory loss, reduced information processing and reduced concentration (CAREI, 2002). One study conducted at Yeshiva University showed that children who have chronic sleep problems through age 5 are more likely to require special education by age 8 (Novotney, 2012). Another study, from Northwestern University, found high school seniors performed better in the afternoon than in the morning on tests of vigilance, symbol copying, visual search, and logical reasoning. Similarly, performance on tasks measuring executive function showed

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Cyberbullying: Issues and Practices

Gail Cabral, IHM, PhD

Dr. Gail Cabral

Cyberbullying is any electronic communication by which someone is threatened, humiliated, embarrassed or targeted. According to Hinduja and Patchin (2010b), it is "willful and repeated harm inflicted through the use of computers, cell phones, and other electronic devices. The medium involved may be a text message, an e-mail, or a doctored page on a social website. The direction of the message may be to the target, to a set of friends on Facebook, or to an even larger group by way of a blog.

Examples of cyberbullying

Willard (2007) describes types of cyberbullying: harassment (multiple offensive messages), denigration (purposeful posting of harmful, untrue, or cruel speech), impersonation, outing and trickery, exclusion, and cyberstalking. In addition, she discusses cyberthreats and a variety of scenarios that make it difficult for authorities to figure out if a threat is "real." A recent episode provides evidence that we need to teach our youth that humorous or superficial language needs to be examined from the standpoint of the perceiver.

During a high school boys' basketball game between well-matched rival teams, a student who was not from either school used his Twitter account to decry the possibility that electronic warfare would break out. He expressed his distaste for this predictable aggressive communication in the following words: "If there's Facebook or Twitter fight tonight over the H C M V game I will just blow up the schools and the students involved # Goon Squad." This honor student from another school is now facing criminal charges over what would have been a simple comment laden only with frustration, if spoken privately among friends (Basketball game finally played, 2013).

One cannot fault officials for taking action to protect what might be said in humor but which might be an actual threat. The game was stopped, the arena emptied, and both schools were examined for bombs the next day. This is not an example of cyberbullying. However, it does speak to the difference the medium makes. Technology, especially the public and pervasive nature of electronic communication, changes what is offensive but not truly dangerous into what is seen as threatening and horrific.

Effects of bullying

The effects of regular bullying have been documented in the literature for years, and recent research on cyberbullying suggests at least equally harmful effects (e.g., Juvonen, Graham, & Schuster, 2003; Patchin & Hinduja, 2010). Bullying that occurs during junior/high school appears to affect students years later in college (Adams & Lawrence, 2011). Internalizing problems, such as low self-esteem, depression, anxiety, and stress, are correlated with cyberbullying (Aoyama, Saxon & Fearon, 2011). Feelings of depression, fear, anger, and sadness lead to feelings of despair (Hinduja & Patchin, 2010a). We know the news stories of violence and suicide that exemplify this pattern. As adults worry, we also need to think about how to react.

Policies and practices

Schools continue to develop policies regarding bullying and cyberbullying. One of the reactions to the seriousness of bullying is seen in "zero-tolerance" programs in which bullying of any kind is severely punished. The prescriptions, however, are sometimes Draconian and ineffective. Youth and adults are even less likely to cooperate when the consequences of cyberbullying seem inappropriate.

Aftab (2010b) discusses a mnemonic for teaching students how to react: "stop, block, and tell." The first step suggests NOT retaliating; responding with equal venom starts a cycle of aggression and ill will. "Stop" also allows the target to think about the meaning of the message, and to decide if the action really is hostile. Young people are often learning to develop friendship at the same time they are trying to develop status and power in a group. Sophisticated teasing or irony is not yet in their skill set, and their first attempts at humor may be hurtful.

If, however, it is clear that there is real aggression that seems intentional the second step is "block." Get off the website; block that person as "friend;" get a new e-mail address. These easy technological steps may not occur to a child or teenager. Either may need support and guidance in deciding what to do.

The effects of regular bullying have been documented in the literature for years, and recent research on cyberbullying suggests at least equally harmful effects.

The last step is to "tell." Here, the adult also needs to discern the seriousness of the communication, affirm the hurt the child feels, and help him or her to have a sense of real worth separate from what others think or write. The adult can also help the child to ascertain whether blocking and withdrawal are sufficient. If there is an actual threat, or an already abusive pattern, parents or professionals should take action. This action may involve saving messages, contacting parents of the bully, or contacting the server or the police.

In a metaphor for a balanced response to dealing with cyberbullying, the same site uses "Goldilocks's parents and the three bears" (Aftab, 2010a) to caution against either an all-out attack on the perpetrator, or a disavowal of the seriousness of the situation (e.g., "You're just going to have to be tougher").

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TEEN SLEEP ISSUES

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optimal performance for teens later in the day (Kirby, Maggi, & D'Anguilli, 2011).

Emotional and behavioral consequences of sleep deprivation

The emotional and behavioral consequences of sleep deprivation in adolescence are broad. Inadequate sleep is associated with increased risk of psychopathology and has a generally negative impact on school and learning. The Child Mind Institute (Miller, 2012) reported that children who got more sleep behaved significantly better in school on measures of emotional volatility, restlessness, and impulsivity, and even 27 more minutes of sleep reduced those behaviors. Conversely, cutting an hour of sleep had the opposite effect.

The National Highway Traffic Safety Administration reports driver fatigue results in 100,000 crashes annually, leading to 1,550 deaths and more than 70,000 injuries. This has frightening ramifications for teen drivers who tend to be sleep-deprived. In addition, sleep deprivation is associated with problems with moods and pain perception: it decreases optimism and sociability, and increases bodily discomfort and pain sensitivity (Carpenter, 2013).

Dahl and Lewin (2002) found that some teen substance abuse, which is used as a way of heightening arousal or decreasing anxiety and depression, can be attributed to the effects of sleep deprivation. They also documented an overlap between sleep regulation and behavioral/emotional problems in children and adolescents. Specifically, significant increases in depressed or anxious moods were found in teens reporting less than 6 hours of sleep per night. Seventy-five percent of students diagnosed with major depressive disorder report insomnia, and 25% report hypersomnia. Depressed and anxious adolescents frequently have difficulty falling asleep, are unable to get up or refuse to go to school, sleep in late in the day, complain of extreme daytime fatigue, irritability, and over time shift to increasingly more delayed sleep/wake schedules. The clinical picture for anxiety disorders largely parallels that of depressive disorders with the added feature of increased fear and vigilance, which is antithetical to sleep states. Sleep deprivation may cause difficulties with self-regulation and control, attention, and impulsivity. These behaviors are also typically associated with ADD/ADHD, excessive aggression, and conduct disorders. It is not clear how sleep deficits influence these diagnoses.

Part II of this article will address positive sleep hygiene and report on several school districts that have addressed this widespread problem among teens.

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CYBERBULLYING

Continued from page 21

Comparable advice for psychologists would include accepting the hurt the person expresses, helping the target to analyze the situation and to ascertain that the action is truly inappropriate, helping the client to recognize that s/he did not deserve the message or action, and providing the person with options about what to do next.

Cyberbullies may be people who have been bullied in the past. Bullies/victims (who both bully and are targets) in particular may need professional help and may benefit from efforts to increase self-esteem or social skills. Other approaches to dealing with bullies and bullies who were victims include working on impulse control and appropriate emotional expression (Johnson, 2011). On the other hand, some literature suggests that bullies may have discovered an efficient way to gain status and power. They don't exactly have anger issues. They are working on "social climbing" (Willard, 2007). The psychologist would then need to concentrate efforts on explaining the seriousness of the consequences of cyberbullying and investigating other dynamics. In helping the target of bullying, clinicians may focus on developing "assertiveness skills, socialization skills, and improving self-concept" (Johnson, 2011, p. 6).

What Else?

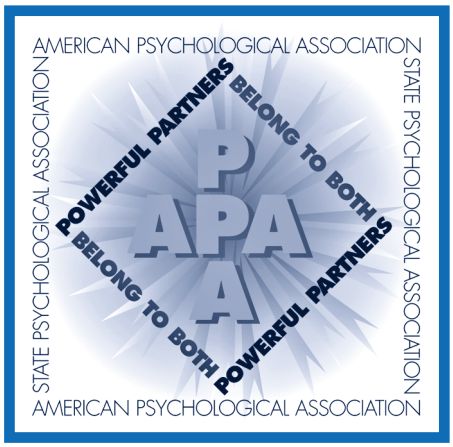
This article did not discuss cyberbullying of adults, the fact that using labels may be problematic, and other important roles of psychologists. Besides dealing with targets or bullies, and developing good educational and preventive efforts, psychologists can bring knowledge of social contextual effects and personal beliefs on bullying tendencies. The websites listed below provide many helpful links to these issues.

References

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

Welcome, New Members

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between February 1 and April 30, 2013!



NEW FELLOWS

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Pittsburgh, PA

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Philadelphia, PA

Kevin H. Bursley, PhD
Pittsburgh, PA

Kimberly Carlson, PsyD
Hershey, PA

Ellen Faynberg, PsyD
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George S. Feuer, PhD
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Karen L. Levinson, PhD
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Yvonne M. Thorne, EdD
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Tamra Y. Williams, PhD
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STUDENT TO MEMBER

Brian M. Berman, PsyD
West Chester, PA

Joanne Coyle, PsyD
Jefferson, PA

Chelsea H. Hersperger, PsyD
Media, PA

Jesse D. Matthews, PsyD
Chester Springs, PA

Peggy V. Nave, PsyD
Hephzibah, GA

NEW STUDENTS

Michelle E. Alexandrowicz, MS
Ardmore, PA

Ahmed K. Almusawi, BA
Lancaster, PA

Mariah H. Arnold, BS
Philadelphia, PA

Justin A. Barterian, MA
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Privacy, Boundaries, and Ethics in Cyberspace

Ed Zuckerman, PhD, edzucker@mac.com, and Keely Kolmes, PsyD

Dr. Ed Zuckerman

Dr. Keely Kolmes

"You have no privacy. Get over it," famously said American businessman Scott McNeally in 1999, when he was in a good position to understand this. However, I bet that even he cares who knows what about his life, family, finances, and thoughts – and that he makes efforts to discover what information is available to others, to correct misinformation, and to suppress the spread of other information.

A few years ago, an ACLU video humorously predicted and warned against the future of easy commercial access to what we thought was personal (http://www.aclu.org/ordering-pizza). Now that has come to pass. Here, from a Belgian banking organization, is an example of how efficiently and comprehensively one's private information can now be found online: http://goo.gl/o2ubD.

As psychologists, we have added responsibilities regarding our online presence. We are held, to a reasonable degree, responsible for what appears online about our professional lives. Google yourself. When I did, after eliminating other "Ed Zuckermans," there were 27,000 hits. Because Google limits searches to 32 words I could not narrow this further, but looking at the first few dozen, 90% were about me. Many were duplicates, but Google searches only about 15% of the Web and much less of the Internet. I did not pay to learn my criminal record, financial history, or which websites I have visited. Enter your own home address into Zillow.com if you own a home. Look at the pictures as well as the numbers. And have your clients reviewed you on Yelp.com?

The best rule is to assume that anything you say or post is in the public domain – you have no control over its distribution, cannot remove it or prevent its legal "discovery," and cannot imagine its consequences.

Us, online

If you have any kind of online presence, ranging from e-mail accounts to social media profiles, from blogs to websites, clients can learn a lot about you. Similarly, you can learn a lot about them. Each of these sites has varying degrees of privacy. (Remember that those that are not HIPAA-secure should never be used for exchanging protected health information.) Relying on "security by obscurity" is a rapidly weakening strategy.

The best rule is to assume that anything you say or post is in the public domain...

We have ethical obligations to not misrepresent our credentials, to avoid harming our clients, and to match our words to our deeds. Even if we do not participate in social media, there will be information about us online. Clients may access it before or after they make the first appointment (Kolmes & Taube, in preparation) and so we have an ethical and practical obligation to ensure its accuracy. Google supports removal of information at http://goo.gl/7RuQN, and you also should contact the webmasters of the sites with information you want removed. There are "people search" engines which search public records such as driver's licenses, political campaign contributions, professional licenses, and criminal records. Here are two articles with advice on how to cope with this: http://goo.gl/ejByg and http://goo.gl/0IQWZ. However, removing yourself from the Web completely may be a never-ending process.

The privacy of e-mail is open to question. Our federal government collects all e-mail and all other data flowing over the Internet although it likely will not be interested in our professional communications. (See for example www.wired.com/ /2012/03/ff_nsadatacenter/ or Google "Utah Data Center.") E-mail is essentially permanent and open to reinterpretation by unfamiliar and future readers. Casual statements, partial truths, and even humor may become harmful. Ethically, our clients should be informed of these risks before using e-mail with us. Offering professional opinions or advice online is unethical if you did not examine the patient, so be circumspect and respectful when dealing with colleagues and strangers. When you need privacy, use encrypted e-mail such as Hushmail.com or Enlocked.com. If even considering exchanging text messages with clients or colleagues regarding clinical care, consider using encrypted SMS with a service such as Wickr (https://www.mywickr.com/en/index.php).

Strategies to protect our personal lives online

We have an ethical obligation to avoid harmful multiple relationships that could lead to impaired judgment or exploitation of a client. So consider carefully before accepting clients as "friends" or "contacts" on social media sites; it may blur boundaries and adversely affect your work with them. Consider separating your professional and personal online lives to avoid overlapping roles and to protect your own privacy.

One way to manage this is to have two identities on Facebook, Twitter, Tumblr, G+, and similar social media sites. Do not post the same content on both accounts. For example, if you advertise your professional offerings on your personal profiles, you risk clients being led to those personal profiles and accounts. Be aware that on some sites, such as Facebook, having multiple accounts may be a violation of the terms of service. It is wise to use different e-mail addresses for professional versus personal communications, and then link the appropriate e-mail address to your account. This avoids clients coming up as "people you may know."

Use your professional pages for marketing, doing research, and communicating with peers, including posting blog entries. When you are using your personal accounts on a site such as Facebook, be aware that "likes" and "comments" on the walls of others may be seen by clients, and you may have some friends or contacts in common.

If you post photos of your face they can be dragged and dropped into Google Image Search, which can find every other site on which that photo has appeared. If you want to post photos, offer different ones on your social and professional pages. You may want to ask "friends" to remove your photos from their sites or delete tags of you because the visual information may be more revealing than you desire. Whenever photos of you are taken, tell people how you want (or don't want) them distributed. Try to prevent any links of your photo to your handle on Twitter even if you use a pseudonym. If you don't want everyone to know where you are, don't enable "places" on Facebook.com. Some sites like Tadaa.com allow modifying the photo to achieve more privacy before posting elsewhere. This video on Gawker is a warning of what's to come: http://gaw.kr/YcbtsJ.

Set privacy settings on various sites and test them by enlisting a friend to view them or by creating dummy profiles on each site to see if the settings work as you understood them. Ask a friend to add you as a friend on their site to further check these controls. For more on Facebook's privacy read http://on.mash.to/nfL5bm and http://bit.ly/ppHGb2. You know how much you can trust the *Onion's* investigations. This video reveals the 'truth' behind Facebook: http://goo.gl/Lrplc.

There are social media sites for professionals as well. The best known one is LinkedIn.com. It is designed for learning about other professionals' interests and activities, and seeking connections and referrals. However, the site also requires thoughtful use of privacy settings if you don't want your profile or contacts to be visible to everyone. Also, it is easy for anyone to impersonate someone you know and add you as a contact, so those who are privacy-conscious may not want to post anything on LinkedIn that they would not want a client to see.

Social media raise complex threats of violating our ethical principles. Psychologists need to be thoughtful, consult with peers, and make efforts to be well informed about the continual changes in our online world.

References

Kolmes, K., & Taube, D. O. (in preparation). Clients are searching for therapist personal information online. Data may be retrieved from http://drkkolmes.com/research/

Kolmes, K. (2009). *Managing Twitter as a mental health professional*. Retrieved from http://drkkolmes.com/2009/05/04/managing-twitter-as-a-mental-health-professional/

USING CLIENT FEEDBACK TO STAY ON TRACK

Continued from page 15

treatment and who are likely to have a negative outcome
- The Clinical Support Tool (CST): suggests empirical interventions to try
- The Assessment for Signal Cases (ASC): provides information to aid in problem solving
- **OQ-45** (Adult Outcome and Alliance)
  - Takes 3 to 5 minutes to administer
  - 45 items
  - The higher the scores the higher the levels of psychological disturbance reported

At first glance the OQ may appear to have more "bells and whistles" and thus looks like the better option. However, it may not be the most financially feasible option. The OQ has an installation fee, shipping fee, and licensing fee based upon the size of the purchasing organization, with a yearly fee for training clinics. This may make the PCOMS look more appealing considering the cost of a license for one provider is zero and there is only a onetime fee to multiple providers ranging from $99.95 to $795.95. However, both appear to be valid tools for the task at hand.

References

References are available on the PPA website, www.PaPsy.org, or from the author at sasantore@m.marywood.edu.

CE Questions for This Issue

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

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

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before June 30, 2015.

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

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

DeWall

1. Since 1985-86 PPA's nondues revenue has increased from 25% of the budget to:
   a. 30%
   b. 32%
   c. 35%
   d. 39%

Knapp, Tepper & Baturin

2. Which of the following is true concerning guardianship in Pennsylvania?
   a. Determinations of guardianship require the testimony of a physician.
   b. Guardianship is an all-or-nothing affair; either a patient is completely competent or completely incapacitated in making life decisions.
   c. Psychologists may offer testimony in guardianship hearings.
   d. Families can develop guardianship arrangements without judicial input.

Royer

3. Which of these statements about websites is true?
   a. Templates are a viable way to develop professional websites.
   b. Psychologists must hire someone to design their websites.
   c. Few psychologists have their own websites.
   d. Psychologists need to learn HTML to develop a website.

Sallade

4. Dr. Palmiter's blog focuses on:
   a. politics
   b. peaceful negotiation
   c. parenting
   d. PPA governance

Gallo & Barber

5. After the third listserv violation, how many months will a member be suspended?
   a. 3
   b. 6
   c. 9
   d. 12

Brooke & Axelrad

6. Which of the following have been shown to reduce health care costs?
   a. psychosocial intervention
   b. psychotherapeutic treatment
   c. psychodynamic therapy
   d. all of the above

Dattilio

7. Which of the following are warning signs that a program may not be properly accredited?:
   a. There is little selectivity in the admissions process.
   b. Payment is by degree versus by course.
   c. Credit is granted for life experience.
   d. all of above
   e. "a" and "b" only

Karafin

8. The appropriate amount of nightly sleep required by teenagers is:
   a. 14 hours
   b. 12 hours
   c. 9½ hours
   d. 8 hours

Cabral

9. The "stop, block, and tell" approach is likely to be useful if:
   a. adults try to limit Internet access
   b. the person is under 12
   c. adults demonstrate that they will do anything to get the behavior to stop
   d. None of these is true.

Zuckerman & Kolmes

10. Because of the risks of harmful multiple relationships we should do all of the following except:
   a. be careful about accepting "friends" on our professional pages on Facebook
   b. try to avoid someone's using our posted photos to link our professional and personal online identities
   c. use different pseudonyms on different social networking sites
   d. avoid the use of location and mapping functions on our professional websites

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

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

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

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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The GPPA NETWORKING FAIR for Mental Health Professionals

An opportunity for mental health organizations, universities, clinical hospitals, and private clinicians to meet one another and learn about the range of services available in the region. The fair includes a series of break out and networking sessions.

September 20, 2013
10:00 a.m. – 4:00 p.m.
DoubleTree by Hilton Hotel, Monroeville, PA

The 2014-2015 MENTAL HEALTH RESOURCE DIRECTORY™

This *interactive* mobile directory is cutting edge and lists professionals in the mental health field and related disciplines in the state of Pennsylvania. Specialties, geographical, and insurance indices allow you to locate services more readily.

Submissions must be received by July 1, 2013.

Cost for GPPA or PPA Members: $25
Cost for Non-GPPA or Non-PPA Members: $40

The Directory is expanding to include state-wide listings.

The current mobile directory is available for FREE at GPPA's website.

To register for the networking fair, see the full list of exhibitors, or submit your practice information to the 2014-2015 Directory, go to:
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The Pennsylvania
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Fall Continuing Education and Ethics Conference
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http://www.papsy.org/index.php/ce/ce-workshops.html

2013 CE Calendar

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

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Harrisburg, PA
Marti Evans (717) 232-3817

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

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

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

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

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

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