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The Pennsylvania Psychologist

December 2014
QUARTERLY

A Tribute to Dr. Samuel J. Knapp

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The Pennsylvania Psychologist

Editor: Tracie Pasold, PhD

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Thanks Sam!

Bruce E. Mapes, PhD

Dr. Bruce E. Mapes

I was honored when asked to write this tribute to Sam Knapp, PPA's director of Professional Affairs, who is going into semiretirement after 27 years of service. I initially thought it would be easy. How wrong I was! How do you summarize all of Sam's contributions and accomplishments in 1,000 words or less? What can you say about Sam that has not already been said?

Prior to meeting Sam, I had heard a lot about him from psychologists who often quoted him and who always spoke of him in glowing terms. I recall at one time wondering whether he was a myth or a real person. Eventually I had the pleasure of meeting Sam. As I got to know him, I realized the many positive attributes were not only real but often understated.

For a long time, I found ethics to be something intimidating, boring, and often black or white, but Sam changed that. His practical understanding of the real-life issues confronting psychologists allowed him to help me to understand and resolve conflicts between competing ethical standards, as well as between ethics and law. I was sometimes frustrated when he wouldn't give me the "right answer" or tell me what to do. But his unique style of inquiry and discussion allowed me to be able to reframe the issues and ultimately make appropriate decisions. He subtly taught me a process to understand and resolve ethical conflicts, which reduced my need to consult with him.

Through Sam's consultations, writings, and continuing education programs, I have come to find ethics to be interesting and helpful rather than intimidating, and I have learned that ethics is rarely black and white. Sam truly deserves the American Psychological Association Lifetime Achievement Award for Ethics Education, which he received this year. All of us at PPA are very proud of him.

Sam's assistance was not limited to ethics. He has amassed a wealth of knowledge about psychological research and psychological literature. I have been able to consult with Sam about many diverse matters related to such things as practice management, forensics, and clinical issues. If Sam was not able to provide information, he was almost always able to recommend a resource where I might obtain it.

His empathy, warmth, and compassion allow you to feel understood and valued.

Sam has developed a large network of professionals, legislators, agency officials, and others who have the highest regard for him and his opinions. For me, a referral from Sam has opened many doors that otherwise may not have been accessible.

Sam is a staunch advocate for graduate students, early career psychologists, psychologists, and psychology in Pennsylvania. Whether working behind the scenes or leading the charge, Sam has preserved many jobs, opened up new internship opportunities, and created new employment opportunities for many psychologists. He has proactively stimulated new legislation that has benefitted psychology and psychologists in Pennsylvania. Through very conscientious monitoring of new and pending legislation, Sam has helped to ensure that many new bills are consistent with the interests of psychologists and psychology. He has kept the membership fully informed about the pros and cons of proposed legislation, and his summaries have helped me to sufficiently understand new legislation to be able to effectively advocate PPA's position with my legislators. Sam has skillfully translated sometimes complex legislation into practical, easily understood policies and procedures that even I have been able to understand and implement.

Being the director of Professional Affairs has been much more than a job for Sam. It has been a passionate commitment to the integrity and future of PPA and psychology in Pennsylvania. It has been a commitment to promoting the interests of all psychologists, regardless of their level of training or age. During his tenure, Sam's passion and commitment have greatly advanced the recognition of psychology as a field, as well as the contributions that psychology can make to the welfare of all people. His name has become synonymous with Pennsylvania psychology.

While I will always value knowing Sam as an ethics educator, as a solid resource, as an advocate, and as the director of Professional Affairs, I will cherish even more having known Sam as a person and as a friend. It is very easy to talk to Sam about one's professional and personal lives. Regardless of how busy he may be, Sam is always willing to take the time to listen in a nonjudgmental way, which quickly makes you very comfortable talking to him. His empathy, warmth, and compassion allow you to feel understood and valued. Even when Sam provides negative feedback, he does it in a way that allows you to walk away from the conversation feeling good. Sam's sense of humor is sometimes very subtle, but always enjoyable, as are his many anecdotes. Sam has touched my life in so many ways, and my personal interactions with him will provide many very fond memories that I will always cherish. I am sure the entire PPA membership can say the same.

We can all be comforted by knowing Sam will still be available to consult,

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As I See It

Krista L. Paternostro Bower, CAE

As you will see, we have dedicated much of this issue of the *Pennsylvania Psychologist* to paying tribute to our very own **Samuel J. Knapp, EdD, ABPP**! My column in this edition may seem noticeably short, as I want to leave room for the many accolades and acknowledgments of Sam's dedicated work on behalf of PPA over the past 27 years. And this is as it should be.

I have only had the privilege of working with Sam for the past 15 months, so, for me, our time together only represents a fraction of his esteemed work on behalf of psychology in Pennsylvania. However, I have been lucky enough to have an inside view of Sam in action at his workplace within our office environment.

Nothing I can write here will capture the true essence of Sam better than those who have had the pleasure of knowing him and working with him for so many years, so I will not even try. But I can say that, during my tenure with PPA, Sam has been a constant source of support, perspective, and help to me as I have waded through PPA's unfamiliar waters as its new executive director. I will miss being able to walk downstairs, close the door to his office, and just sit and ponder issues with him. He is always so good at seeing all sides of an issue. He is a great equalizer, and his views on the issues of the day always seem to make sense.

Krista L. Paternostro Bower

He never tries to be someone he is not. He is authentic, intelligent, generous, kind, and empathetic. He is a quiet leader and a humble man.

As I see it, our life's legacy is a reflection of the point where our personal and professional lives intersect. Even though these lives seem separate and distinct, our true character cannot distinguish between the two. And, that is what is so great about Sam. He never tries to be someone he is not. He is authentic, intelligent, generous, kind, and empathetic. He is a quiet leader and a humble man. I will miss seeing him in the office every day next year, but I look forward to continuing to exchange ideas from afar. Beyond just providing insight and perspective on PPA matters, Sam has been a friend to me on some issues outside of work, as well. And it is for his friendship that I will always be most grateful.

Thank you for your exceptional service to psychology in Pennsylvania, Sam! Best wishes to you in your retirement. You will always have a home at PPA.

THANKS SAM!

Continued from Page 2

educate, advocate, advise, and support us when he relocates to California. Through the knowledge and wisdom he has given us, we can feel more confident as we face the many professional challenges that will confront us in the future as we adapt to such things as health-care reform. Most important, we will continue to benefit from having had the pleasure of knowing Sam both professionally and personally.

Aside from his many roles, perhaps Sam's greatest legacy is that of a teacher. Andy Rooney once said, "Most of us end up with no more than five or six people who remember us. Teachers have thousands of people who remember them for the rest of their lives." Sam will be remembered by the thousands of people he has directly and indirectly touched through his career.

Sam, I want to wish you and Jane much happiness as you begin this next stage of your lives. I am sure you will make great use of the opportunity to spend more time with your family and engage in that wonderful thing that grandparents can do—indulge grandchildren.

Thank you, Sam, for your service to PPA!

Reflections

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

I started working for PPA three days a week on August 1, 1987. I was the only psychologist who applied for the position. Within two years, thanks in part to grants from the American Psychological Association (APA), I was employed full time by PPA. My wife and I will be moving to California at the end of January 2015 to be closer to our children and grandchildren. However, I will still be available to consult with PPA members part-time, write articles for the ***Pennsylvania Psychologist***, staff three PPA committees, and return to Pennsylvania for continuing education programs.

I have been asked to reflect on my years as a PPA employee. I am not going to engage in false modesty. I worked hard for PPA, and I think I made some contributions. But I am not going to minimize the external supports I received either ("To whomever much is given, of him will much be required"; Luke 12:48). Many PPA presidents, Tom DeWall (then executive director), and his successor, Krista Paternostro Bower, have supported my professional growth. For example, in 1999 I was asked to join the APA task force looking at revising the ethics code. It was a time-intensive commitment, but Dianne Salter, then president of PPA, believed that practitioner voices should be represented on this task force and allowed me to modify my PPA schedule so that I could participate. I wish I had the space to thank all of the other PPA presidents and members of the Board of Directors who have been so supportive.

I also benefited greatly from my relationship with the staff of the APA Practice Organization. Shirley Higuchi, Alan Nessman, and Diane Pedulla were always available to give advice and help keep me up-to-date on complex practice issues. The Practice Organization also funded regular meetings and conference calls with my fellow directors of professional affairs from 15 other states.

Dr. Samuel J. Knapp doing what he does best: listening to and helping PPA members.

I would like to comment on two aspects of my work for PPA: advocacy and ethics education.

Advocacy

My experience as a psychologist parallels that of many of my cohorts. When I started graduate school in 1973, psychologists were not yet licensed (the bill requiring licensing for psychologists had passed in 1972, but no licenses were issued until 1974). Before then, psychologists were almost never mentioned in state law because psychology did not exist as a distinct profession. Since then, we psychologists have had to struggle to receive statutory recognition consistent with our scope of practice.

In all of our advocacy work, we focused on how psychologists can promote public welfare. It is true that our work has improved the careers of psychologists and made psychology a more attractive profession. However, professional and public interests do not need to be a zero-sum game (whereby one group benefits at the cost of another). In the final analysis, the best interests of psychology are congruent with the best interests of the public. Psychology will thrive as a profession to the extent that it contributes to the public welfare.

PPA worked closely with APA on the big issues such as inclusion in Medicare and mental health parity and in the 1990 bill whereby Medicare directly recognizes psychologists for reimbursement for psychotherapy. The prime sponsor for that bill was the late William Coyne of Pittsburgh, one of the finest public officials I ever met. I attended my first meeting proposing mental health parity in 1988 and got to watch on television while the Senate voted to adopt it in 2008. I got to work with Bryant Welch, Marilyn Richmond, Peter Newbould, and Doug Walter from APA's Government Relations staff and with Steve Pfeiffer from the Association for the Advancement of Psychology, which was psychology's national political action committee.

Each of these initiatives took years to bring to fruition, and the fight is never really over. What we won in Medicare, for example, is being eroded by a series of small cuts to reimbursement levels, which is making public access to psychologists under Medicare more difficult.

In addition to focusing on the big and long-term issues, Tom DeWall and I also tried to get one small piece of state legislation passed every session that would advance the statutory recognition of psychology (we called it the "brick by brick" approach). Although any one of these minor laws might seem trivial, cumulatively they helped distinguish psychologists from other mental health professions. We secured legislation that allowed psychologists to evaluate impaired drivers, testify at the sentencing hearings of persons convicted of drug and alcohol offenses, evaluate police officers and firefighters, be appointed by courts to testify in hearings of competence to stand trial, and much more.

On the state level, two initiatives particularly stand out for me: the "Great Provider Rebellion of 2005" and the effort to abolish corporal punishment in public schools.

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The Great Provider Rebellion of 2005

PPA lead the Great Provider Rebellion of 2005, when the inefficiencies in Magellan Behavioral Health's authorization process led to a major drain on the resources allotted for mental health care. Our data showed that between 50 and 60% of moneys allotted for outpatient mental health care were being spent on administration and not patient care! This was a provider issue in that psychologists had to spend huge amounts of money processing claims. But it was also a public interest issue because such huge amounts of money were being spent to support a bureaucracy that contributed nothing to patient care.

Lynne DiCaprio, Vince Bellwoar, Tom Whiteman, Frank Schwartz, and I met with Independence Blue Cross (IBC) periodically for several years arguing on this issue.[1] I got to see the Magellan bureaucracy that isolated itself from the day-to-day implications of its actions. The meetings were tense (I referred to them as "brain surgery"). I sternly admonished Tom Whiteman and Vince Bellwoar to keep their tempers and act professionally despite provocations. Of course I was the one who got red in the face, pointed my finger, pounded the table, and shouted short words that rhymed with "truck" and "wit."

Eventually Magellan dropped authorizations. I assume that IBC told them that they had to. I think in part it was because the medical director at IBC eventually believed our data on the impact of authorizations. Also, it was clear by then that Stacy Mitchell from the Department of Health was going to make them follow state laws concerning authorization. And our supporters in the Pennsylvania House of Representatives—Dennis O'Brien, George Kenney, and Kathy Manderino—had enough influence so that the possibility of a state bill restricting authorizations was always looming in the background.

Corporal Punishment

Like many psychologists, I believe that violence is an over-rated way to improve human behavior, particularly when it comes to the use of corporal punishment in public schools. PPA had first supported a bill to abolish corporal punishment in 1988, but it was not until 2005 that we got it abolished through regulations.

We knew that its abolition was inevitable as public opinion polls showed that the primary factor that distinguished supporters of corporal punishment in the schools was age (older Pennsylvanians tended to support it). Other than that, opposition cut across gender, religious, and political lines. It had been abolished in the most liberal states (such as Massachusetts) and the most conservative states (such as Utah). Nonetheless, its supporters in Pennsylvania adamantly opposed any change.

The late Irwin Hyman of Temple University advocated tirelessly for the abolition of corporal punishment in the schools, conducted research on it, and created a cadre of younger school psychologists who shared his conviction. He always brought students to our annual Advocacy Day. One student of his asked if she could visit Senator James Rhoades, who was then chair of the Senate Education Committee. Hyman and Rhoades were once next-door neighbors. During her visit, the student raised the issue of corporal punishment and convinced Rhoades that the time had come to abolish it in the public schools of Pennsylvania.

Next year the State Board of Education introduced regulations that would abolish corporal punishment in public schools. But all regulations have to go through a complicated review process, which includes review by the relevant House and Senate committees and final approval by the Independent Regulatory Review Committee (IRRC).

The Senate Education Committee, chaired by Senator James Rhoades, did not oppose the change. PPA's representatives, Ron Farkas and Helene Tuleya-Payne, presented strong evidence opposing corporal punishment before the House Education Committee, but that committee voted to oppose the State Board of Education's proposal, arguing that such a ban was contrary to state law, which makes schools ***in loco parentis*** for children so that teachers can physically punish children the same as parents can. Their opposition was passionate. Some members seemed to think that the regulation dealt with parental discipline of children. Other representatives mocked witnesses and asked inappropriate questions ("Were you ever spanked as a child?"). One referred to us as "bleeding psychologists" (apparently meaning bleeding-heart psychologists).

The final decision concerning the regulations rested with IRRC. As part of a hearing on this issue, an IRRC commissioner asked his staff if there was any public comment on this measure. The staffer responded that they had received 61 letters on the issue, that 60 of them supported the ban proposed by the State Board of Education, and that almost all of the supporting letters had come from Pennsylvania psychologists. In addition, Dr. Helena Tuleya-Payne presented testimony before IRRC. I withheld an important argument in our testimony before the House Education Committee but decided to use it in her testimony before IRRC. Dr. Tuleya-Payne noted that twice before the House Education Committee had approved regulations that banned corporal punishment for children receiving special education, so it was inconsistent for them to say now that they had no legal authority to ban corporal punishment. After Dr. Tuleya-Payne gave her brief presentation, one commissioner stated, "I find your arguments compelling." I realized then that we had won.

Ethics Education

Much of my time with PPA involved consulting with our members, writing articles, or giving presentations on legal and ethical issues. Too often, I saw people take unusually legalistic interpretations of ethics and sometimes I saw people in positions of authority use ethics as a weapon or as a means to embarrass or denigrate others. Dr. Richard Small had some of the same reactions as I did, which is why in 1997 we did a workshop called "Ethics Is More Than a Code" and began to use the term "positive ethics," whereby we view ethics as a way to improve our professionalism and the quality of our services to our patients.

At times, psychologists have to face obviously difficult situations, and my

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1 Lynne, Vince, Tom, and Frank received a Presidential Citation from PPA for their services, although few psychologists realize how much time and effort they put into promoting psychological services and how deeply indebted we are to them for their work.

PPA Ethics Educator Lifetime Achievement and Appreciation Award

Samuel J. Knapp, EdD, ABPP

How do you say thank you to someone who has done so much and given so much to ethics education, psychology, and Pennsylvania? For many years whenever anyone has had a question regarding ethics, the first response has been, "Ask Sam." His answers are always honest and helpful. Sam always makes time to answer one more question even at the end of a long and busy day. He has probably answered more ethics questions than most ethics educators, teachers, and scholars combined. In addition to his infinite fund of knowledge, kindness, patience, and thoughtfulness, Sam is also extremely humble and clearly loves what he does.

Sam truly embodies the higher-order moral principles by: respecting people's autonomy, doing good, avoiding harm, acting honestly, and being fair. With his emphasis on positive ethics, Sam has encouraged psychologists to think about the aspirational aspects of ethics rather than create anxiety by focusing on misconduct, punishment, and legal sanctions. For Sam, ethics is about who you are and how you think, not just about following the rules. He has changed the way psychologists think about ethics education: from unpleasant and frightening, to inspiring and uplifting. He has encouraged us to strive toward the highest ideals, not just avoid rule violations.

To list all of Sam's many accomplishments would require a book, but a few highlights are included here. Sam served as the editor-in-chief of the *APA Handbook of Ethics in Psychology* and has written several books, numerous book chapters and peer-reviewed articles, and given hundreds of professional presentations mostly on ethical issues. He has also written countless articles on ethics for the *Pennsylvania Psychologist*. Sam created the opportunity for ethics educators to come together annually to discuss ethical dilemmas and ethical decision making in a collegial atmosphere through the Ethics Educators workshop. He served as a member of the task force responsible for rewriting the 2002 American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* and as a consultant for the APA Insurance Trust. He received the 2001 Ethics Educator Award from the Pennsylvania Psychological Association, the 2009 Award for Ethics Education from the APA Ethics Committee, and in 2014 received the Lifetime Achievement Award for Ethics Education from the APA. In addition, Sam has inspired the next generation of psychologists to focus on the positive aspects of ethics through teaching a course in ethics in the doctoral program in clinical psychology at the Philadelphia College of Osteopathic Medicine.

Sam has been a leader in the field of psychology for ethics and ethics education. He has helped us get excited about ethics and improved our ethical decision-making skills. With sincere appreciation for your lifetime of contributions to ethics education, psychology, Pennsylvania, and the nation we would like to say, "Thank you."

REFLECTIONS

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ethics collaborators and I do not gloss over them. But we think our ability to handle these situations improves when we have a strong ethical foundation and embed ourselves in a protective social network. More recently my collaborators (Randy Fingerhut, John Gavazzi, and Molly Cowan) and I have been looking at ways to inform and improve the professional practice of psychology by integrating recent findings from social psychology and the science of morality.

Science historian Steve Johnson wrote that a "good idea is a system," meaning that good ideas usually come out of the interaction among many different participants. If I have had any good ideas, they certainly came from my many interactions with others, including Leon VandeCreek, who got me started in professional writing on ethics and was my collaborator in more than 100 publications;[2] Peter Keller and Denny Murray, who emphasized the importance of ethical cultures; Linda Knauss ,who helped think through issues on ethical decision making; John Lemoncelli and Alan Tjeltveit, who shared their perspectives on religiously informed therapy; Allan Tepper and Rachael Baturin, who added a legal perspective; Rachael Baturin again for helping me over the last 15 years think through difficult ethical issues on a daily basis; Mitchell Handelsman for introducing the Ethics Acculturation Model; Michael Gottlieb for his dedication to precise and clear writing; both Mitchell and Mike again for expanding on the meaning of "positive ethics;" John Gavazzi for modeling excellence as an educator and encouraging me to use technology in teaching; the late Patricia Bricklin for her knowledge of ethics and law; Dianne and Beatrice Salter and Jeanne Slattery for teaching me about multiculturalism; Bruce Bennett, Eric Harris, Jeff Younggren, and Jana Martin of the APA Insurance Trust for emphasizing the importance of ethically informed quality enhancement (risk management) strategies; Donald Jennings and Jeff Sternlieb, who clearly see the link between public responsibility of self-care; Jay Mills, who teaches me about supervision; and many others. I know that this short acknowledgment leaves out many important collaborators.

Although my role with PPA is changing, this is not a farewell column. I expect to hear from you in the coming year, and I hope to see you at the next PPA convention.

2 We wrote together so much that I was once introduced at a professional meeting as Leon VandeCreek.

Understanding the Department of State Licensing Board Complaint Process

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


Rachael L. Baturin


Dr. Samuel Knapp


Dr. Allan M. Tepper

A license to practice psychology is a legal privilege that can be restricted or revoked in Pennsylvania if psychologists transgress the rules and regulations established by the Pennsylvania General Assembly and the Pennsylvania State Board of Psychology. For this reason, it is important that Pennsylvania licensees understand the Pennsylvania Department of State Licensing Board complaint process, as well as how several departments within the Department of State (DOS) work together on this complaint process.

Complainants must file licensing-board complaints with the Pennsylvania DOS. The complainant can call the Professional Compliance Office hotline at 800-822-2113 (if calling from within Pennsylvania) or at 717-783-4854 (if calling from outside of Pennsylvania) to obtain a copy of the complaint form or can visit www.dos.state.pa.us/portal/server.pt/community/file_a_complaint/12406 to download the form. The completed form should be mailed to: DOS, Professional Compliance Office, PO Box 2649, Harrisburg, Pennsylvania 17105-2649. In addition to filing the complaint form, the complainant can include any attachments and supporting documentation. Anyone can file a complaint, and complaints can be made anonymously.

Once the Professional Compliance Office receives the complaint form, a file is opened and assigned to a legal assistant for review to determine whether an investigation is warranted. In many instances, the legal assistant may consult with a prosecuting attorney in the DOS's Legal Office to make this determination. Often an investigation is requested to determine whether there is sufficient information to move forward, as well as to determine the credibility of the complaining and supporting witnesses. At this stage of the proceedings, there is no finding of wrongdoing by the psychologist.

Once a decision is made to initiate an investigation, the complaint is forwarded to the DOS's Bureau of Enforcement and Investigation. The bureau assigns an investigator from one of four regional offices to obtain additional information to enable the Legal Office to determine whether formal complaint should be filed against the licensee. Investigations include conducting interviews with the parties and obtaining the patient's clinical records.

Following the completion of the investigation, the bureau forwards the investigation report to the Professional Compliance Office, which sends the matter to an assigned prosecuting attorney for review. If there is insufficient evidence to warrant the filing of a formal disciplinary action, the case is closed, and the psychologist will receive a letter from the prosecuting attorney stating that no further action will be taken in the case. If there is sufficient evidence to proceed, the prosecuting attorney will initiate a formal action by filing what is known as an Order to Show Cause.

The Order to Show Cause is a legal document that contains a brief, factual statement and lists the specific rules and regulations believed to have been violated by the psychologist. The Order to Show Cause provides notice that a written Answer must be filed within 30 days addressing the allegations contained in the Order to Show Cause.

It should be noted that prior to the filing of an Order to Show Cause, the State Board of Psychology has no involvement in the case. Following the filing of the Order to Show Cause, the board first becomes aware that a formal complaint has been lodged

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PPA Legal Column Tribute

Since 1991, the Legal Column has been a regular feature of the *Pennsylvania Psychologist*. Over the years, this column has strived to provide PPA members with current, practical, and understandable information regarding the application of ethical and legal principles to the practice of psychology.

As Dr. Sam Knapp moves into the next phase of his career, we wanted to take a moment to thank him for his time, energy, and insights, all of which have helped the column become a useful resource for the practicing psychologist.

Sam, it has been an honor and a pleasure to be able to collaborate with you on these articles. And, through the power of e-mail and the Internet, we are hopeful that, despite any change in geography, this collaboration shall continue into the future.

Rachael L. Baturin and
Allan M. Tepper
November 2014

DEPARTMENT OF STATE LICENSING BOARD COMPLAINT PROCESS

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against the psychologist and begins to oversee the case.

The filing of the Answer sets into motion a number of procedural steps that are governed by the Pennsylvania Rules of Administrative Procedure. A formal complaint can be resolved through the use of a Consent Agreement. In such situations, the parties enter into negotiations regarding the factual statement, the number of violations, and the proposed penalty and sanction. All Consent Agreements must be presented to the board for approval prior to becoming final. The board can accept the Consent Agreement, reject the agreement as being too harsh, or reject the agreement as being too lenient.

It is important to note that a Consent Agreement does not constitute an informal resolution of the case. Rather, if the board accepts the Consent Agreement, the violation becomes a permanent finding against the psychologist's license.

If the case cannot be resolved through a Consent Agreement, the matter will be scheduled for a formal hearing before the State Board of Psychology or delegated to an administrative hearing officer. During the course of the formal hearing, the board or the hearing officer sits as the trier of fact. The prosecuting attorney and the psychologist, now collectively referred to as the Respondent, present their evidence and witnesses to the trier of fact. Following the completion of the formal hearing, the board renders a final decision through an Adjudication and Order. An appeal of the Adjudication and Order is filed with the Commonwealth Court.

The filing of a licensing-board complaint sets into motion an adversarial process. Thus, beginning at the investigation stage of the case, psychologists must decide whether they are going to represent themselves in this matter or whether they are going to seek legal counsel. Even in situations where psychologists believe that they have engaged in no wrongdoing, the adversarial nature of the proceedings brings into play rules, personalities, tactics, and decisions that are different from the usual clinical setting. For these reasons, psychologists must proceed with caution when responding to a licensing-board complaint.

Change Your Informed Consent Forms or Privacy Notices

As readers know from previous articles in the ***Pennsylvania Psychologist***, changes to the Child Protective Services Law go into effect on December 31, 2014. One of the important changes in the law is that mandated reporters do not have to see the child in their professional capacity in order to make a report. As a result of these changes, a psychologist may be a mandated reporter if anyone aged 14 or older discloses that he or she engaged in child abuse, even if the abuse occurred many years ago and no child is currently in danger. In addition, psychologists will have a duty to report suspected child abuse if any patient or collateral contact discloses that he or she knows of a child who is currently being abused.

Psychologists will need to modify their HIPAA Privacy Notice or informed consent agreements with patients to reflect these changes. Here is suggested language that will accurately reflect the changes in the child-abuse reporting requirement:

> If I have reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child-abuse investigations. I am required to make such reports even if I do not see the child in my professional capacity.
>
> I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger.
>
> I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused.

In addition to including this information in the privacy notice or the informed consent agreement, we recommend that psychologists review the information verbally with their patients at the start of treatment or as soon as feasible. It may also be necessary to remind patients of the reporting requirements periodically during the course of therapy.

PennPsyPAC: Why Give?

Dea Silbertrust, PhD, dcsilbertrust@comcast.net

The time is *now* to donate to PennPsyPAC.

What is the PAC again? Political Action Committees are set up to advocate and make political contributions for a particular interest group, in this case Pennsylvania psychologists. The more we donate, the louder our collective voice. Together, we are able to argue against groups, such as the insurance industry, with far louder voices. Without contributions to PennPsyPAC, psychology's voice becomes a whisper.

There are two ways to make psychology heard in our state capital. One, contact your state senator and representative whenever you receive a legislative alert. Two, make a donation to the PAC. This allows our staff lobbyist to maintain psychology's visibility in a way none of us can do as individuals.

Don't just complain about what is happening in Harrisburg. Donate today. Go to www.papsy.org, scroll over Advocacy, choose PennPsyPAC, and click on Contribute to PennPsyPAC to make an online contribution. Or send a check made out to "PennPsyPAC" to PPA, 416 Forster St., Harrisburg, PA 17102.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of October 17, 2014

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 300 **HB 300**	Adds sexual orientation to the Human Relations Act re: discrimination in employment and public accommodations - Sen. Patrick M. Browne (R-Lehigh) - Rep. Dan Frankel (D-Allegheny)	For	In State Government Committee	In State Government Committee
SB 980	Updates the psychologist licensing law, eliminates certain exemptions, and modernizes the experience requirements - Sen. John R. Gordner (R-Columbia)	For	In Professional Licensure Committee	None
SB 998	Limits retroactive denial in insurance reimbursement - Sen. David G. Argall (R-Schuylkill)	For	In Banking and Insurance Committee	None
SB 1025 **HB 1011**	Prohibits the outsourcing of prison psychologist positions - Sen. Timothy J. Solobay (D-Washington) - Rep. Michael E. Fleck (R-Huntingdon)	For	In Judiciary Committee	In Judiciary Committee
SB 1164	Prohibits criminal charges against a person seeking medical help for a drug overdose or against someone helping that person - Sen. Dominic Pileggi (R-Delaware)	For	Passed 12/1013, 50–0	Passed 9/17/14, 194–0; signed by Governor 9/30/14 as Act 139
HB 336	Authorizes licensing boards to expunge disciplinary records for certain technical violations after four years - Rep. Kate Harper (R-Montgomery)	For	Passed by Professional Licensure Committee 5/7/14; in Appropriations	Passed 2/13/13, 195–1
HB 430	Allows reports of child abuse to be submitted through advanced electronic communications - Rep. Katharine M. Watson (R-Bucks)	For	In Aging and Youth Committee	Passed 6/20/13, 184–6
HB 1655	Establishes Patient-Centered Medical Home Advisory Council, including a representative of mental health providers - Rep. Matthew E. Baker (R-Tioga)	For	Passed 10/15/14, 48–0	Passed 1/14/14, 197–0; awaiting vote on concurrence in Senate amendments
HB 2190	Establishes fair contracting standards between physicians and insurers (needs amendment adding other providers) - Rep. Nick A. Miccarelli (R-Delaware Co.)	Under review	None	In Insurance Committee

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

A Tribute to Dr. Samuel J. Knapp

We know that so many of our members have had both impactful and important interactions with Sam over the years. In recognition of this, we wanted to ask them to write to Sam describing some of their fondest memories. On these pages, we invite you to read what a few of them had to say:

"He steered us through the bureaucracy. . . . We took his advice and before long were granted our PA licenses."

– Dr. Barry Hart

"You have been the "go to guy" for everything from soup to nuts . . . like a pinch hitter who always came through in the clutch."

– Dr. Steven Simminger

"I for one am concerned that PA psychologists like myself will find ourselves ethically adrift without your perspective. . . . Thank you for your service and thoughtful guidance."

– Dr. Scott Buchanan

"I will remember you for your wisdom, gentle nature, your stories, and your sense of humor. . . . I take comfort in knowing that you will still be among us in ways that are immeasurable."

– Dr. Lou Poloni

"Sam stands out among these people as the most talented and beloved. I will miss his humor and wisdom."

– Dr. Ruth Morelli

"I can't imagine PPA without Sam. He has been a shining light, a knight in shining armor, one I will truly miss."

– Dr. Julie Allender

"All of us in California will gain so much from having him here! And, yes, I live in California myself!"

– Dr. Ginette Perrin

"Over the years . . . the special part was his kind and welcoming attitude, which made me feel as if he had been sitting by the phone waiting for my call!"

– Dr. Pauline Wallin

"Thank you so much for all of your help and words of wisdom over the years. . . . I always knew that you would be a phone call away. . . . Thank you so much for all that you do. You will be greatly missed."

– Dr. Lenny Paul

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Did you know . . .

that Dr. Sam Knapp is a huge Pittsburgh sports fan? In honor of his love for the Steel City, this tribute issue is presented in the colors of the Pittsburgh Steelers!

"Thank you, Sam, for being gentle but firm. We all love you and are grateful."
– Dr. Bernard Seif

"You have been consistently helpful, demonstrate impressive competence and ethical standards, and are an exemplary representative of psychologists."
– Dr. Lew Neumann

"His ability to both clearly see the nature of a problem, and walk through to its solution, is a true wonder. You're irreplaceable, Sam!"
– Dr. Daniel Warner

"Sam is not only the consummate PPA representative, he is a consummate psychologist. . . . Thank you, Sam, for helping all of us to navigate the world of psychology!"
– Dr. Mary Wiley

"At first I was apprehensive about speaking with the 'great Sam Knapp.' But he couldn't have been more welcoming and down-to-earth. . . . We put him on a pedestal, but he sees himself in the midst of us."
– Dr. Dea Silbertrust

"Thank you so much for being at the other end of the line whenever I had a difficult question. . . . Your presence was as important as your answer."
– Dr. Michele Hyman

"Thank you, Sam, for many years of advice and support."
– Drs. Ron and Diane Langberg

"You have been a wealth of information regarding the dreaded topic of ethics. . . . You have always made ethics interesting, and you have extended your help and made it easy to reach out to you."
– Ms. Jamie Via

"I have personally benefited from the vast knowledge and expertise of Sam Knapp. Thank you and best wishes on your retirement!"
– Mr. Albert Jumper

"If there is a penultimate model of professionalism, ethics, dignity, and inspiration it is Dr. Sam Knapp. . . . Thanks, Sam, for showing the way it's done!"
– Dr. Ann Durshaw

"Sam, I simply wish to say thank you. . . . You are so helpful, kind, thorough, and careful in your statements that I constantly feel you are going above and beyond."
– Dr. Samuel Schachner

"What I do know is that Sam has shaped my vision of what it means to be a consummate professional: hard working, smart, collegial, ethical, modest, aspirational in orientation. My hero."
– Dr. Jeanne Slattery

"Thank you so much for being at the other end of the line whenever I had a difficult question. . . . Your presence was as important as your answer."
– Dr. Michele Hyman

"PPA Ethics Educator Lifetime Achievement and Appreciation Award given to Sam at the 2014 Ethics Educators Conference on October 10, 2014. . . . With sincere appreciation for your lifetime of contributions to ethics education, psychology, Pennsylvania, and the nation we would like to say, 'Thank you.'"
– Dr. Linda Knauss

"Great guy. Great moustache."
– Dr. Eric Affsprung

"Sam is one of a kind, probably the best professional association consultant/expert on practice issues. And he provides this service with great patience, clarity, and timeliness. . . . Thank you Sam."
– Dr. Dennis Valone

"Sam Knapp has been an inspiration and support in my journey as a psychologist for almost 30 years. . . . Thank you, Sam! . . . Know that you will be greatly missed!"
– Ms. Gwendolyn Minnix

To see more quotations, visit http://www.papsy.org/blogpost/1203827/Community-Blog

Emerging Trends in Psychodynamic Psychotherapy

Janet L. Etzi, PsyD; jetzi@immaculata.edu

Dr. Janet L. Etzi

An important trend is emerging in psychoanalysis and psychodynamic psychotherapy. The trend is sometimes referred to as a paradigm shift (Schore, 2012), and it is linked to the interdisciplinary domain of neuropsychoanalysis, which is also the title of a journal. The paradigm shift discussed by Schore has emerged as a result of recent advances in neuroscience and the widely accepted demonstration of the importance of unconscious, or implicit, processes. The decade of the brain focused mainly on conscious cognition, but the most recent data demonstrate that affect, or emotion, and unconscious, or implicit, processes are a critical part of human development, the psychotherapy process, and the development of psychopathology.

The paradigm shift is good news for those psychotherapists who work with unconscious, or implicit, phenomena since it provides a scientific basis for the unconscious aspects of personality, or emotional functioning. The word ***implicit*** is increasingly replacing the word ***unconscious***. Unconscious phenomena traditionally referred to parts of the self that are inaccessible to conscious awareness, and, in that sense, are qualitatively different and separate forms of mental functioning. In comparison, the newer term ***implicit*** refers to those mind/brain processes that work too rapidly to remain in conscious awareness yet infuse and color our everyday emotional and psychological lives.

We make sense of the vast amount of information we encounter, and we process it in an effort to adapt to a complex environment, especially a complex and ambiguous social and emotional environment. If we were able to process everything we were consciously aware of, we could not get through a normal day. If we were only able to detect a personal or emotional threat to our sense of self using conscious cognition, we would become entangled in the complex nonlinear data that our minds and bodies process automatically to give us this information efficiently and quickly. The brain's two hemispheres specialize their functioning: The right hemisphere manages implicit emotional processing while the left hemisphere processes conscious verbal information (McGilchrist, 2009). Keep in mind that this is an oversimplified explanation since the brain and its processing are vastly more complicated; hence the emergence of the field of neuropsychoanalysis.

What does this new trend and paradigm shift mean for the work of psychodynamic psychotherapy? As already stated, psychodynamic therapy has a basis in the neuroscientific study of the brain and how the mind/brain develops and changes. In addition, it means that clinicians and researchers have embarked on the path of exploration, study, and practice to further refine and improve our understanding of nonconscious processes and to help in defining very practical ways of using those processes in the moment-by-moment work of psychotherapy.

We make sense of the vast amount of information we encounter, and we process it in an effort to adapt to a complex environment.

These trends are evident in the relatively recent emphasis placed on embodied, mindful, and relational psychoanalysis. In brief, these ways of working engage the implicit responses of the body, emotions, and the nonconscious back-and-forth interactions between therapist and patient. Psychoanalysis has long been engaged in this work, for example, in the use of transference and countertransference, and in the work with enactments (Bromberg, 2011). By linking conscious verbal understanding with the implicit nonverbal and emotional communications of both members of a therapeutic dyad, the patient is given opportunities to experience novel ways to engage more diverse emotions and to regulate his or her emotional responses to a wider range of social experiences.

Most psychoanalytic psychotherapists will recognize that they are already working this way. The new trend is mainly a matter of emphasis on emotions and affect and their importance for the development of the individual and for therapeutic change to occur.

In discussing these ideas with colleagues, I find myself tweaking some of the language in order to bring the old psychoanalysis closer to the scientific findings. For example, Bromberg (2011) illustrates the problems that can arise when the analyst focuses only on verbal or cognitive insight, brought about by using verbal free association and interpretation of the unconscious derivatives found in the patient's language. The newer version of psychoanalytic therapy requires that therapists engage emotionally and personally, bringing their subjective experience into the therapeutic process, especially when patients are unable to verbally express emotional difficulties. This engagement is viewed to be critical to patients' ability to find themselves being attuned to affectively by the therapist and then to discover something new about those emotions.

In other words, when patients experience the therapist as intersubjectively engaged with them, whether or not the therapist is comfortable in that engagement or logically understands it, they will be encouraged to explore those previously intolerable affects. This promotes learning something new about these emotions and finding ways to manage and even exploit them for personal understanding, change, and growth.

References

Bromberg, P. M. (2011). *The shadow of the tsunami and the growth of the relational mind.* New York, NY: Routledge.

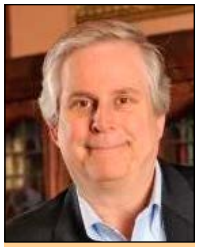
McGilchrist, I. (2009). *The master and his emissary: The divided brain and the making of the western world.* New Haven, CT: Yale University Press.

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

Psychotherapy Relationships That Work

A Practice-Friendly Research Synopsis

John C. Norcross, PhD, University of Scranton



Dr. John C. Norcross

As every half-conscious psychologist knows, the therapeutic relationship is a pivotal determinant of psychotherapy outcome. Our theoretical predilections flavor our beliefs about the curative nature of the relationship: Some psychotherapy systems posit that the relationship serves as the active mechanism of change while others view it as an important precondition for therapy to succeed. The 75%–80% of practicing psychologists who have undergone personal therapy understand the power of the therapeutic relationship in a more immediate way as the primary source of their behavior change and as the most frequent feature of treatment they try to replicate with their patients (Geller, Norcross, & Orlinsky, 2005). As both clinicians and clients, then, psychologists know in their bones the power of the therapeutic relationship.

Precisely which behaviors of that global relationship are effective has proven elusive. Proliferating theories have proffered a cacophony of relational terms—empathy, mirroring, validation, support, challenge, transparency, congruence, immediacy, presence, ad infinitum—and legions of psychotherapy researchers have produced a huge literature of largely uncontrolled correlational studies.

The American Psychological Association Division of Psychotherapy (29) and Division of Clinical Psychology (12) commissioned interdivisional task forces to identify, operationalize, and disseminate information on the therapeutic relationship. The original task force (Norcross, 2002) and its subsequent effort (Norcross, 2011) a decade later were launched in the hopes of balancing the importance of the relationship with the importance of treatment methods already in the field. As the evidence warranted, evidence-based relationships could take their rightful place alongside evidence-based treatments.

The task force compiled a series of original meta-analyses to determine which features of the relationship work. Authors of the meta-analyses estimated the percentage of variance each relationship behavior accounted for in predicting client change; the results pertaining to the therapeutic relationship are largely correlational (except collecting client feedback and repairing alliance ruptures). Details of the meta-analytic methodology and results can be found in the second edition of *Psychotherapy Relationships That Work* and on the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices website (www.nrepp.samhsa.gov/Norcross.aspx).

Table 1 summarizes the meta-analytic results on the association between relationship behaviors and treatment outcomes. The association can be expressed as a simple correlation coefficient (*r*) or as a conventional effect size (*d*). The meta-analyses revealed remarkable consistency in estimates of the correlation between the relationship behaviors and therapy success across populations (e.g., individual, child, family, groups) and across behaviors (e.g., empathy, alliance, collaboration, positive regard, cohesion). Therapies under consideration were also diverse and included humanistic, psychodynamic, cognitive-behavioral, and systemic. In fact, the bulk of the evidence summarized in the meta-analyses comes from nonrelational psychotherapies.

As both clinicians and clients, then, psychologists know in their bones the power of the therapeutic relationship.

The robust, consistent correlations between the relational behaviors and client improvement averages about .25–.30. This translates to an effect size (*d*) of about .55 and indicates that clients receiving psychotherapy characterized by high degrees of empathy, collaboration, and the like will experience a decided advantage over clients who receive (or perceive) relatively lower degrees of those relationship attributes. Although this estimate of relationship effects may seem rather modest, bear in mind the large number

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Table 1. Effect Sizes (*r* and *d*) for Relational Behaviors and Psychotherapy Outcomes

Meta-analysis Authors*	Relationship Behavior	*r*	*d*	% of Variance in Outcome
Horvath et al.	Alliance in individual adult therapy	.28	.58	8
Shirk & Karver	Alliance in youth therapy	.19	.39	4
Friedlander et al.	Alliance in couples/family therapy	.26	.53	7
Burlingame et al.	Cohesion in group therapy	.25	.51	6
Elliot et al.	Empathy	.30	.62	9
Tryon et al.	Goal consensus and collaboration	.34	.72	12
Farber et al.	Positive regard/affirmation/support	.27	.56	7
Kolden et al.	Congruence/genuineness	.24	.49	6
Lambert et al.	Collecting client feedback	.25	.51	6
Safran et al.	Repairing alliance ruptures	.24	.49	6

*All published in Norcross (2011).

PSYCHOTHERAPY RELATIONSHIPS

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of complex variables that contribute to treatment outcomes. Also bear in mind that the average *d* between psychotherapy and no psychotherapy hovers about .80–.85; any single relational behavior in Table 1 comes in at an impressive effect size of .55.

Consider the exemplar of the therapeutic alliance in individual therapy. The alliance has been defined in a number of different ways, but many favor Bordin's (1979) tripartite conceptualization of the alliance as a positive emotional bond, agreement on treatment goals, and a committed consensus on the specific tasks of therapy. The meta-analysis was conducted on 201 adult studies encompassing approximately 14,000 patients. The effect size between the alliance and outcome reflected a medium but very robust association indicating the magnitude of this relation to account for roughly 8% of the total variance in therapy outcomes. The effect sizes are similar across different psychological treatments, indicating that developing a good alliance is beneficial regardless of the type of psychotherapy. In general, clients' ratings of the alliance provide the best prediction of outcome. The correlation between alliance and outcome increases as therapy progresses, but alliance assessment early in therapy (third through fifth sessions) provides reliable prognosis.

On the basis of the meta-analytic evidence, the task force reached a series of conclusions and advanced a series of evidence-based practices, including:

- The therapeutic relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment.
- The therapeutic relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method.
- Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapeutic relationship.
- Efforts to promulgate best practices or evidence-based practices without including the relationship are seriously incomplete and potentially misleading.
- The therapeutic relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations.

The practice recommendations follow directly from the research evidence:

1. Practitioners are encouraged to make the creation and cultivation of a therapeutic relationship, characterized by the elements found to be effective, a primary aim in the treatment of patients.
2. Practitioners are encouraged to routinely monitor patients' responses to the therapeutic relationship and ongoing treatment. Such monitoring leads to increased opportunities to re-establish collaboration, improve the relationship, modify technical strategies, and avoid premature termination.
3. Concurrent use of evidence-based therapeutic relationships and evidence-based treatments adapted to the patient is likely to generate the best outcomes.

Of course, no research base is beyond cavil and without caveats. There is significant overlap among several of the relationship behaviors; for instance, collaboration is reported in a separate meta-analysis but is frequently included within alliance measures. Insufficient research exists to draw any conclusions at this juncture on the effectiveness of many relationship behaviors, such as therapist humor or self-disclosure, but that will not stop us from clinically pursuing and employing them.

Then there is the sticking point of correlation. Causal inferences are perennially difficult to make concerning process variables, such as the therapeutic relationship. Does the relationship cause improvement or simply reflect it? The meta-analyses report associations; only the meta-analyses on collecting client feedback and repairing alliance ruptures feature randomized controlled trials capable of demonstrating a causal effect.

At the same time as we acknowledge this central limitation, let's remain mindful of several considerations. First, within these reality constraints, dozens of lagged correlational, unconfounded regression, structural equation, and growth curve studies suggest that the therapeutic relationship probably casually contributes to outcome (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003). Second, some of the most precious behaviors in life are incapable on ethical grounds of random assignment and experimental manipulation. Take parental love as an exemplar. Not a single randomized clinical trial has ever been conducted to conclusively determine the causal benefit of parents' love on their children's functioning, yet virtually all humans aspire to it and practice it. The inability to randomly assign may, in fact, signal the essentiality of the relationship.

We have neither completed the research nor exhausted the relationship behaviors associated with therapy success. Still, we have amassed an impressive body of research rivaling that of any in the psychological or biomedical sciences. We know what works in the therapeutic relationship. The task now, of course, is to ensure that training programs are facilitating these behaviors, practitioners are offering them, and insurance companies are recognizing their evidence-based import.

References

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcomes beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68*, 1027–1032.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16*, 252–260.

Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (Eds.) (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives*. New York, NY: Oxford University Press.

Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., . . . Keller, M. B. (2003). Therapeutic alliance in depression treatment: Controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology, 71*, 997–1006.

Norcross, J. C. (Ed.) (2002). *Psychotherapy relationships that work* (1st ed.). New York, NY: Oxford University Press.

Norcross, J. C. (Ed.) (2011). *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press.

A Practice in Your Hand: Apps for Psychologists

Christopher Royer, PsyD

Dr. Christopher Royer

What practice tools can you hold in your hand? It's almost a year and a half since my first review of apps for psychologists. I'm willing to bet that in that time a lot of you have started using your phone for more than just checking e-mail and flashing your selfies on Facebook!

When choosing new technology, it's good to remember that any time you incorporate something new into your work life, it's a habit change and it's effortful. It's a good idea to take some time with an app before incorporating it into your routine. This article looks at some useful apps that might be worth that effort. Most of the apps reviewed here are for the Apple iOS operating system. Many are available for Android systems as well.

Apps for Your Clients

For cognitive training, a popular app is Lumosity (Lumos Labs). It's designed to bring the popular cognitive-training service to the portable market and has garnered rave reviews. Formatted for smaller screens, the app provides cognitive activities and a useful tracking system for setting goals and monitoring progress. Lumosity is a subscription service, requiring a small monthly fee. Cognifit (Cognifit), Brain Trainer Special (Inloop, s.r.o.), and Brain Fitness Pro (Burlaciuc Vlad) are other cognitive-training apps.

Clients use apps to help monitor and improve emotions. Personal Zen (Hadley Harris) presents a happy sprite making a path through pixelated grass. The goal is to swipe your finger along the "happy" path, thus reducing stress. The app has gotten some national press. Users seem pretty polarized, either loving or hating it. The iMoodJournal (Inexika Inc.) is one of many mood-tracking apps. It has an easy interface, allowing you to rate your mood at various times of the day. You can make notes, identify triggers, and attach ratings to different people or situations. Panic? (Geert Verschaeve) offers education and brief exercises for managing panic attacks. Created by a client for clients, the exercises are straightforward and streamlined. Individuals suffering from posttraumatic stress disorder may benefit from PTSD Coach (Dept. of Veteran's Affairs et. al.). This is an excellent app for education and self-assessment, providing resources for connecting to professionals.

For relaxation, Breathe2Relax (National Center for Telehealth and Technology) continues at the top of the list. The app features a large number of user-adjustable settings, including length of inhale/exhale, visual and auditory prompts, stress ratings, and background music. Long Deep Breathing (Tech 2000 Inc.) offers a simpler interface. Breathing Lessons (LifeBreath Inc.) provides a comprehensive tutorial on breathing techniques. Simply Being Guided Meditation (Meditation Oasis) offers several choices for meditation type and length. Relax Melodies (iLBSoft) offers a huge array of sounds, melodies, and sound stimulation to aid the sleep process.

Many utilities are available to make life easier for the psychologist.

Many "therapy" apps focus on cognitive-behavioral therapy (CBT) techniques. Although some are advertised as therapist replacements, they best serve as adjuncts for structuring activities, tracking progress, and doing homework outside the session. Many such apps are available. Mood Kit (Thriveworks) clearly stands at the top. This highly integrated app offers mood records, cognitive-challenge activities, refocusing, and reframing. It provides a resource of over 200 activities to help people cope with negative thoughts. The interface is user-friendly and customizable. Thriveworks also produces a companion app for psychotherapy called Therapy Buddy. This app offers an efficient way to track goals, make notes, and get reminders about appointments. Other therapy apps include iCouch CBT (ICouch), one of the first CBT apps developed. Pocket CBT (Cogitate Software) is a similar app that provides an opportunity to create and rate thought records and set up thought-challenge scenarios.

For the Professional Psychologist

When it comes to apps for the professional psychologist, no one is in your pocket like the American Psychological Association (APA). The initial offering, PsycEssentials, is still available, and it is the only app in this article that could be called pricey at almost $40. Essentially, it's a database for assessment tools and referrals created to assist therapists. The APA Monitor (GTxcel) has its own app that includes current and past installments of the venerable periodical. There is also a journal app, APA Journals Pro, which provides full-text articles of journals accessed through subscriptions. PsycNET Mobile lets tenacious researchers search for articles anywhere their cell phones might get reception. APA also produces excellent apps for its convention every year providing schedules, event notifications, and contact information. Students and authors will love the APA Referencing Guide (AyClass Apps) which has some great features such as scanning barcodes to create citations. The app remembers all the citations you create.

Many utilities are available to make life easier for the psychologist. Dictamus (JOTOMI GmbH) is a super dictation app. You create dictations in a variety of file types and can share files with different services such as e-mail, Dropbox, and many others. Once you dictate a file, you can play it back through a cable or you can send it as a file and use Dragon's transcription feature to create the text. Make sure you proofread

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Recent Developments in Cognitive Behavior Therapy

Judith S. Beck, PhD, President, Beck Institute for Cognitive Behavior Therapy;
Clinician, Associate Professor of Psychology in Psychiatry, University of Pennsylvania

Dr. Judith S. Beck

A great explosion has taken place in the field of cognitive behavior therapy (CBT) in recent years, on many fronts. This article focuses on four aspects of the expansion of this form of psychotherapy: the modification of CBT for different disorders and populations, the use of technology to deliver treatment, the greater use of interventions derived from many psychotherapeutic modalities, and the movement toward establishing evidence-based strategies in training and supervision.

CBT has now been adapted and tested for a wide range of conditions, comorbidities, and psychological problems. Well over 1,000 randomized controlled trials and a large number of meta-analyses have established its efficacy not only for psychiatric disorders (including severe mental illness) but also for a range of psychological issues and for medical conditions with psychological components.

Psychiatric disorders for which CBT has been shown to be effective include attention-deficit/hyperactivity disorder, Asperger's, a range of depressive disorders (including treatment-resistant depression) and anxiety disorders, posttraumatic stress disorder, obsessive-compulsive disorder, somatic disorders, eating disorders, substance use disorders, bipolar disorder, schizophrenia, and personality disorders. Studies have also established its effectiveness for anger, test anxiety, procrastination, and relationship problems. It has been successfully modified for various populations (children, adolescents, older adults, pregnant and postpartum women, caregivers, homeless populations, athletes, and for people with various sexual orientations and from different cultures) and in a variety of settings (including schools, hospitals, prisons, community mental health centers, and primary care offices).

CBT has also been applied to and studied for a large number of medical conditions. CBT may help medical patients reduce the symptoms of a condition, decrease depressive or anxious symptoms, cope with their condition better, and/or improve their adherence to medication or treatment. Some of these conditions include hypertension, chronic pain, minimal brain injury, fibromyalgia, chronic fatigue, colitis, noncardiac chest pain, premenstrual syndrome, tinnitus, cancer, obesity, and insomnia. CBT has been shown to be effective in various therapeutic formats: individual and group treatment and in couples and family therapy. And perhaps even more important, CBT is efficacious in preventing certain disorders, in reducing the severity and duration of episodes, and in limiting relapse.

Technology has begun to play an important role in the delivery of CBT.

Technology has begun to play an important role in the delivery of CBT. Over 100 CBT computer programs have been developed and tested. Some are stand-alone programs for people with milder symptoms. Others are used as part of treatment, necessitating fewer face-to-face sessions with a CBT therapist.

The United States has lagged far behind in the development of CBT computer programs, but researchers in other countries have been in the forefront of creating programs for conditions such as depression, anxiety, insomnia, substance abuse, headache, pain, irritable bowel syndrome, pathological gambling, and tinnitus. Virtual reality programs have been tested in CBT for burn victims, people with schizophrenia, and individuals with airplane phobia. And a number of apps help clients practice CBT skills outside of the therapy office.

The techniques used in CBT have also expanded. CBT therapists, working from a cognitive formulation of clients' disorders and a cognitive conceptualization of the individual client, may adapt interventions from Gestalt therapy, motivational interviewing, interpersonal psychotherapy, dialectical behavior therapy, acceptance and commitment therapy, mindfulness, psychodynamic psychotherapy, compassion therapy, positive psychology, and others.

When clients have a personality disorder, for example, standard methods need to be varied or supplemented. Clients may need help in identifying their core values and increasing their motivation to work toward the achievement of their goals. If they experience intense emotion, or fear such an experience, therapists may teach them emotion-regulation techniques. If significant rumination, obsessive thinking, or attentional fixation is part of the clinical picture, an emphasis on mindfulness may be indicated. Techniques from compassion therapy are useful when clients are highly critical of others or themselves. Experiential techniques such as imagery, role playing, and psychodrama help clients change their beliefs at an emotional level.

Strategies from interpersonal and psychodynamic psychotherapy are also adapted for some clients. A strong therapeutic alliance has always been and continues to be considered a key principle of treatment for all clients, but therapists now may use additional relationship techniques, especially for clients with personality disorders, to strengthen the alliance; to help clients modify dysfunctional beliefs about themselves, others, and interpersonal

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relationships; and to learn interpersonal problem solving.

Therapists need to be acutely attuned to clients' change of affect in session (noticing their body language, facial expression, tone of voice, and choice of words) so they can elicit clients' thoughts when they detect a negative reaction. They positively reinforce clients for expressing negative feedback and then work collaboratively with them to evaluate their cognitions and solve the problem. Therapists help clients reach new understandings about the therapist and about their relationship and then help clients apply what they have learned to specific relationships outside of therapy.

Therapists also do preventive work, using CBT techniques themselves to prevent or modify their own dysfunctional beliefs about themselves or about clients. Doing so enables them to maintain realistic views to avoid a therapeutic rupture, or breakdown, in the alliance.

The approach to serious mental illness, such as schizophrenia, is changing too. Traditionally, CBT therapists have focused on reducing positive symptoms. Now researchers, who have been influenced by the recovery movement, focus on helping clients engage as fully as possible with the outside world. They emphasize identifying aspects of life that are most important to clients and collaboratively work toward achieving highly meaningful goals and treating symptoms as problems to be solved.

Advances are also being made in the training and supervision of CBT therapists, as the field increasingly recognizes that therapists need to view extending their competence and effectiveness as a lifelong endeavor. Our institute in Philadelphia, as well as training organizations elsewhere, is using the research literature on adult learning to improve programs for therapists at every stage of development. For example, we incorporate pre- and postworkshop learning activities for trainees. We provide experiential learning exercises. We use the Internet to post videos of master CBT therapists and provide webinars, consultation, and supervision. We also use emerging research on evidence-based practices for training and supervision. And we study the findings from implementation science to improve training for a wide variety of staff in organizations to ensure that CBT programs become firmly and effectively established and maintained.

Future challenges include incorporating sound CBT programs in graduate study and continuing education for both health and mental health practitioners.

The future of CBT is exciting. Future challenges include incorporating sound CBT programs in graduate study and continuing education for both health and mental health practitioners. Far too many professionals who believe they are practicing CBT do not work from an accurate cognitive conceptualization of the client or do not consistently or effectively employ even the most basic structural components of CBT, such as assessing (and sharing) client progress, setting a complete agenda, collaboratively designing homework, or eliciting feedback from clients. Many practitioners are also not up to speed on the latest research on how treatment must be modified for specific disorders or co-morbidities or for individual clients. Fortunately, new technology will enable us to do more widespread and efficacious training so we can help reduce clients' suffering as quickly as possible and keep them better.

Judith S. Beck, PhD, is president of the Beck Institute for Cognitive Behavior Therapy, a nonprofit organization in Philadelphia that provides national and international training in CBT and clinical services for a variety of outpatient problems.

A PRACTICE IN YOUR HAND

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your documents, as dictation software remains less than perfect.

For office productivity, Microsoft Office apps are now available for iPhone and iPad. In addition to Apple's own Pages, Keynote, and Numbers, Google Docs now has a stand-alone app that allows creation and editing of all Google document types.

Psychologists involved in psychological assessment will appreciate the PAR Toolkit (PAR Inc.). This useful app allows you to make popular conversions and calculate ages. It also has a silent stopwatch customizable to left- or right-hand use. You can purchase add-ons for scoring self-reports such as the BRIEF. Pearson Assessments produces a similar app for Spanish-speaking users. PAR sells an MMSE/MMSE-2 app for quick administration of this instrument.

For electronic medical records (EMRs), look at Insight Notes (Adam Alban). This straightforward EMR is for therapists who want a HIPAA-compliant way to take notes without a billing module. The Therapy Outcome Management System (Mark McCinn) allows therapists to rate a number of variables at the beginning and end of each session, provide daily session reports, and track outcomes over time.

While there are hundreds more apps to explore, there is one last tip worth remembering. When using a smartphone or a tablet, any website can become an app. For example, I use an EMR that doesn't have a stand-alone app. Most mobile web browsers provide the option to save a webpage as an icon on the home screen of your phone. In Apple's Safari browser, load the webpage, tap the Share button in the bottom center, and tap the Add to Home Screen button. You now have an icon on your device for that webpage. This feature is extremely useful for websites with mobile versions.

Your smartphone can be a great way to bring efficiency and quality to your practice. Always understand potential data security issues and passcode your phone. For questions about this and other technologies, I highly encourage you to join the PPA listserv, a great resource for psychologists with tech questions.

Opportunities in Clinical Health Psychology: Thinking out of the Practice Box for 2016 to 2020

Helen L. Coons, PhD, ABPP

Dr. Helen L. Coons

Psychologists across the country have worked in academic health centers, community medical practices and hospitals, and health systems for decades. Health, pediatric, family, rehabilitation, and neuropsychologists, for example, routinely provide clinical services; interprofessional education; program development, evaluation, and research; and communication skills training in a broad range of in- and outpatient medical settings. With the passage of the 2010 Patient Protection and Affordable Care Act, or the ACA, colleagues working independently and in groups are now asking pressing questions about new practice and reimbursement models in and outside of traditional health centers. Fortunately, health-care reform brings an impressive range of opportunities in clinical health psychology for the practice community—especially if you think outside of the box!

The ACA prioritizes the triple aims to increase access to comprehensive, coordinated health care for children and adults across the life span; improve patient outcomes; and reduce costs to the nation's health-care budget. The legislation highlights the importance of integrated services, including behavioral health in primary care. Consequently, health systems in public (e.g., VAs and federally qualified health centers) and private sectors are hiring psychologists and other behavioral health providers as part of integrated care teams. The ACA also emphasizes health promotion and prevention initiatives to reduce the incidence, burden, and costs of chronic physical conditions. This article highlights practice opportunities in primary care, specialty, and community medical settings; health promotion and prevention; as well as innovative ideas for health psychology services in community and corporate locations.

As you contemplate new practice and business options in clinical health psychology, consider the following questions: Do you have the clinical and professional competencies to provide care and collaboration to patients in medical settings (Belar et al., 2001; McDaniel et al., 2014)? Are health-care practices the right place for you (Kelly & Coons, 2012)? Do you currently have the collaborative relationships with health-care providers to locate your health psychology practice in (or integrate into) medical, community, or business settings? If you are planning to transition to a health-care setting as an independent contractor under a rental agreement or as a practice partner, have you consulted a health law attorney with expertise in regulatory, legal, and contractual issues in health settings (Coons & Gabis, 2010)?

If you already provide clinical health psychology services, consider getting out of your traditional-practice office. Establish whether you are interested in transitioning to primary care or specialty medical settings or prevention and wellness programs. Another option is to bring clinical health psychology services to community organizations, settings, and businesses. Primary care sites typically include family practice, internal medicine, obstetrics/gynecology, and pediatrics and are considered the ***de facto*** mental health system because most patients receive their mental health care from physicians and advanced practice or midlevel providers (i.e., nurse practitioners and physician assistants) in these settings.

Over the past decade, several psychologists in independent practice have been providing health psychology services within primary care and specialty medical settings. For example, Diana L. Prescott, PhD, is located in a pediatric obesity clinic in Maine, and Steven Walfish, PhD, routinely sees patients in surgeons' offices in Atlanta for prebariatric surgery evaluations. Kate F. Hays, PhD, goes on-site to a sports medicine practice in Toronto, while former American Psychological Association president Carol D. Goodheart, EdD, works with patients in retirement communities in Princeton, New Jersey, and Dawn Jewell, PsyD, rotates to an occupational medicine practice in Greeley, Colorado. And the author spent more than ten years in obstetrics/gynecology, oncology, and women's health multispecialty practices collaborating with providers from internal medicine, obstetrics/gynecology, reproductive endocrinology, urogynecology, breast surgery, and nutrition.

Large group practices are also collaborating within and outside of primary care and specialty practices in the private and public sectors to provide health psychology services. Pennsylvania's Delaware County Professional Services and SRI Psychological Services, the Center for Integrated Care in Rhode Island, Psychological Health Care in New York, and Assessment and Therapy Associates in North Dakota each staff one or more primary care or specialty sites in their communities. In addition, Behavioral Health Consultants provides inpatient consultation services at acute, rehabilitation, and long-term care facilities in Texas. In the years ahead, group practices may contract with patient-centered medical homes and Accountable Care Organizations to see patients at the medical office or receive coordinated referrals to provide mental health and health psychology services.

If you already provide clinical health psychology services, consider getting out of your traditional-practice office.

Hospital- and community-based primary care and specialty medical

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practices, as well as local chapters of disease-focused organizations (e.g., Resolve, American Cancer Society, Lupus Foundation, Gilda's Club, MS Society, etc.) also frequently request speakers for patient- and staff-focused workshops on health psychology issues. Consider collaborating with groups to present on any number of health-related topics such as: pre- and postbariatric surgery challenges, sexual health and body image, chronic pain, weight loss, insomnia, pregnancy loss, infertility, advanced cancers, talking with children when a parent is ill, caregivers of patients with dementias, and other chronic and life-threatening conditions—just to name a few. Furthermore, staff members typically appreciate and remember "lunch and learn" presentations on these and other topics.

Health-care reform has certainly increased the focus on integrated primary care. But don't forget about the broad range of other settings to provide health psychology services in the public and private sector. For example, consider collaborative care within a physical therapy office, at school-based health centers, in pediatric dental offices, or with advanced-practice nurses at urgent care sites. How about at your local Y, where individuals and families come to exercise and children are there for daycare and/or after-school programs? In addition, corporations across the country have wellness programs—some of which are run internally while others are outsourced to health-focused companies. Consider offering prevention programs at wellness, fitness, and community centers; spas; hair salons or barbershops; and places of worship! We can deliver evidence-based, clinical health psychology services in any number of nontraditional locations by considering what the marketplace is interested in and willing to pay for in a fast-paced, global world.

Additional paid opportunities in health psychology include: actively serving on pharmaceutical and psychological testing corporation advisory boards (Van Dorsten, 2014); giving presentations to consumer and professional groups on the broad range of health psychology services (Coons, 2014); communication skills training for health-care providers; and program development, grant writing, and outcomes evaluation in health settings (McDaniel & Coons, 2014).

Over the next several years, we will no doubt continue to see marked changes in the health-care delivery system, financing, and models of reimbursement for all services. Consider your business plan, seek consultation, and enjoy thinking out of the box! Clinical health psychology will continue to be a rich area of practice in and outside of medical settings.

For general information about health psychology practice, education, and training and research, please visit www.health-psych.org.

References

Belar, C. D., Brown, R. A., Hersch, L. E., Hornyak, L. M., Rozensky, R. H., Sheridan, E. P., . . . Reed, G. (2001). Self-assessment in clinical health psychology: A model for ethical expansion of practice. *Professional Psychology: Research and Practice, 32*(2), 135–141.

Coons, H. L. (2014, August). *Transitioning your psychology practice to primary care and specialty medical settings: Competencies, collaborations and contracts.* CE workshop presented at the American Psychological Association Division 42 Fast Forward Conference, Long Beach, CA.

Coons, H. L. & Gabis, J. E. (2010). Contractual issues for independent psychologists practicing in health care settings: Practical tips for establishing the agreement. *Independent Practitioner, 30*, 181–183.

Kelly, J. F. & Coons, H. L. (2012). Integrated health care and professional psychology: Is the setting right for you? *Professional Psychology: Research and Practice, 43*(6), 586–595.

McDaniel, S. H. & Coons, H. L. (2014, September). *Leadership issues for health psychologists navigating health care reform: Turning challenge into opportunity.* American Psychological Association Division of Health Psychology Teleconference Series on Health Care Reform.

McDaniel, S. H., Grus, C. L., Cubic, B. A., Hunter, C. L., Kearney, L. K, Schuman, C. . . . Bennett Johnson, S. (2014). Competencies for psychology practice in primary pare. *American Psychologist, 69*(4), 409–429.

Van Dorsten, B. (2014, September). *The transition to the "real world": Confessions of a recovering academician.* Presented at the meeting of the Colorado Psychological Association, Cooper Mt., Colorado.

Helen L. Coons, PhD, ABPP, is a board-certified clinical health psychologist in integrated primary care at Denver Health and Hospital Authority and president of Women's Mental Health Associates. From 2000 to 2014, her practice rotated to multiple primary care and specialty medical practices in the Philadelphia area. She routinely presents at the national level on competencies, collaborations, and contracts for psychologists interested in transitioning their individual or group practices to primary care and specialty medical settings. Dr. Coons may be reached at 215-370-2342 or hcoons@comcast.net. Her website is www.womensmentalhealthassociates.com.

What About Nonintegrated Primary Care Physicians? Churning Passion Into a Dissertation

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Dena M. DiNardo

As a health insurance benefits consultant, an impassioned systems therapist, and a doctoral student of clinical psychology, I've been thrilled to be reading about the latest American Psychological Association and American Medical Association initiatives toward health-care integration. Institutional decisions to enhance biopsychosocial conceptualization and treatment practices by putting medical and mental health care providers on the same team mark a monumental turning point for the U.S. health-care system. Feelings of hope and promise are strengthened by knowledge that the 2015 Medical College Admission Test (MCAT) will begin testing applicants' understanding of the ways in which psychological, social, and biological factors influence patients' perceptions of and reactions to the world.

Reassurance and evidence of further commitment have come from the Liaison Committee on Medical Education's 2013–14 accreditation standards, which cite that "the curriculum of a medical education program must include current concepts in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effects of social needs and demands on care" (Liaison Committee on Medical Education [LCME], 2012). But feelings of worry, uncertainty, and curiosity still remain as research fails to show exactly how much and how quickly integration is occurring at the ground level among nonintegrated primary care physicians (PCPs).

Although I am impressed with and admire the integrated work of major medical centers and academic universities, I remain fascinated about how this will translate for PCPs in independent and small group practice. Data from 2010 show approximately 268,000 PCPs operating in the United States who, in 2008 alone, delivered more than 478 million appointments (Agency for Healthcare Research and Quality [AHRQ], 2011). These 268,000 physicians were trained and licensed prior to the inclusion of behavioral and social sciences on the MCAT and prior to their relevance being emphasized in medical schools' accreditation standards (LCME, 2012). While this does not mean that all 478 million appointments lacked an appreciation for behavioral and social implications of medically diagnosable diseases, it does mean that the education and training behind these appointments likely did not emphasize what we now confidently recognize as key influences. Fast forward to 2014: We have more PCPs than not who successfully completed medical school prior to the focus on enhancing interactions among medical and mental health care providers (Robiner, Dixon, Miner, & Hong, 2014).

What I found teeters between unsurprising and alarming and problematic but solvable.

Of particular relevance is the clear lack of supporting literature from the established, nonintegrated PCP perspective. Canada, Australia, and the United Kingdom continue to take a slight lead gathering data revealing PCPs' feelings, experiences, and perspectives regarding past and current relationships with mental health care providers (MHCPs), but this data still remains extremely limited. That said, it has become clear that a crucial component of successfully and comprehensively bridging the gap between integrated theory and independent practice must include a more thorough analysis of PCPs' awareness of and experiences with MHCPs. This would inform strategic plans for collaboration, integration, and mutually beneficial and effective health-care delivery dynamics.

As one of my most passionate career interests, I decided to use the doctoral dissertation as an opportunity to fill in some of the gap by adding U.S. nonintegrated, qualitative, phenomenological PCP data to the current research base. What I found teeters between unsurprising and alarming and problematic but solvable. In short and congruent with international data, PCPs remain largely unaware of how MHCPs, psychologists especially, are well suited for conceptualizing patients in a way that can lead to better health outcomes (Chomienne et al., 2010; Robiner, Dixon, Miner, & Hong, 2014; DiNardo, 2014).

Although incredibly dissatisfied with the results of psychiatric referrals for their patients, PCPs often turn to psychiatrists due to a lack of awareness about the efficacy of individual, family, and group psychotherapy (DiNardo, 2014). Moreover, PCPs continue to cite HIPAA as one of the largest barriers to communication with MHCPs, explicitly sharing that this is a nonissue when compared with other medical health care providers, such as orthopedists and cardiologists (Mehrotra, Forrest, & Lin, 2011; DiNardo, 2014). Finally, nearly every PCP interviewed reported that they wish they heard from MHCPs more frequently. Contrary to existing literature, none of my participants identified "lack of time" as a barrier to collaboration. In fact, all of them offered what they would ideally like to know from MHCPs so that they could enhance their current treatment and physician-patient relationship (DiNardo, 2014).

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The continued movement toward a fully integrated system remains a positive and noble effort but will not continue to develop efficiently and effectively without first mastering methods of education and collaboration. One way of looking at this problem is by seeing that it offers professional psychologists the important opportunity to not only improve PCPs' understanding of what we do but educate them about the benefits of communicating with us regarding patient care (Robiner, Dixon, Miner, & Hong, 2014; DiNardo, 2014).

While we are hearing a lot about "integrated care," it remains important to realize that the current systems remain quite fragmented ("Experts Call," 2012). Even though integration is the goal, the majority of PCPs are not yet successfully collaborating, let alone operating in an integrated setting. More than half are unsuccessful in just the act of referring patients to MHCPs ("Experts Call," 2012). Given that positive collaboration will likely precede integration, communication must be optimized to enhance benefits of significant value for mental and medical health care providers and for the patients themselves if we are to see true change in U.S. health-care delivery. It is very important that we not forget about the patients who are and will continue to be served in a segregated system.

References

Agency for Healthcare Research and Quality. (2011). *The number of practicing primary care physicians in the US.* Retrieved from http://www.ahrq.gov/research/findings/factsheets/primary/pcwork1/index.html

Chomienne, M. H., Grenier, J., Gaboury, I., Hogg, W., Ritchie, P., & Farmanova-Haynes E. (2010). Family doctors and psychologists working together: Doctors' and patients' perspectives. *Journal of Evaluation in Clinical Practice, 17,* 282–287.

DiNardo, D. M. (2014). *A qualitative study of primary care physician experience of mental health care providers* (Unpublished doctoral dissertation, Chestnut Hill College, Philadelphia, PA).

Experts call for integrating mental health into primary care. (2012, January). *Research Activities.* Retrieved from http://www.ahrq.gov/news/newsletters/research-activities/jan12/0112RA1.html

Liaison Committee on Medical Education. *Connections 2013–2014: ED-7.* Retrieved from http://www.lcme.org/connections/connections_2013-2014/ED-7_2013-2014.htm

Mehrotra, A., Forrest, C. B., & Lin, C. Y. (2011). Dropping the baton: Specialty referrals in the United States. *The Milbank Quarterly, 89,* 39–68.

Robiner, W. N., Dixon, K. E., Miner, J. L., & Hong, B. A. (2014). Psychologists in medical schools and academic medical centers. *American Psychologist, 69,* 230–248.

School-Based Psychotherapeutic Interventions and Supports

Diane Barrett, PhD

Dr. Diane Barrett

Within public school settings, the provision of psychotherapeutic intervention can most effectively occur within a tiered service delivery model. Within such a model, school-based support staff personnel (i.e., school psychologists, social workers, and counselors) can develop, coordinate, and provide increasingly intensive levels of mental health intervention.

At the broadest stratum, or Tier 1, prevention-oriented mental health programs can be universally implemented to promote and strengthen the prosocial behaviors, resiliencies, and self-capacities of all students and to enhance the overall climates of school settings. With appropriate administrative and infrastructural support, school-based mental health professionals can coordinate and facilitate the delivery of any number of research-based programs designed for this purpose (e.g., *Olweus Bullying Prevention Program, Restorative Practices,* and *Positive Behavioral Interventions and Supports*).

At the middle stratum, or Tier 2, schools can offer targeted, solution-specific interventions to those students whose mental health needs mildly to moderately exceed the resources available at Tier 1. Such students may be encountering acute problems and stressors (e.g., loss or death of a family member, a divorce, or other adjustment issues), which are serving to temporarily alter educational performance and for which brief, solution-specific interventions would be most appropriate.

At the pinnacle of the hierarchy, or Tier 3, the most intensive interventions can be offered to those students whose mental health needs are severely to profoundly debilitating and impeding educational performance. To qualify for this level of intervention, the school psychologist would need to conduct a formal evaluation to determine the extent to which a student satisfies the two-pronged eligibility requirement for "specially designed direct replacement instruction" under the emotional disturbance disability category. Students who qualify for this level of support may be presenting with a combination of strong biologically predisposing factors and exposure to chronic or more severe psychosocial stressors that have rendered them remarkably anxious, depressed, traumatized, psychotic, isolative or withdrawn, and largely unavailable for instruction.

Not only is the tiered model efficacious and systematic but it is also closely aligned and compliant with child find, coordinated early intervening services (CEIS), and related counseling service provisions that appear within the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004. Within IDEIA, public school districts are required to do due diligence in identifying and addressing the needs of students with disabilities, including students with emotional or mental health disabilities. Within a coordinated tiered model, school districts can satisfy this child-find obligation and identify students with emotional disabilities, the symptoms of which need to be adversely impacting educational performance to a marked degree and for a long duration, as those who have demonstrated limited or negligible responsiveness to Tier 1 and Tier 2 interventions.

> *In reality, many public school districts continue to be encumbered by lack of funding and resources to fully operationalize this model.*

Within the act, public school districts are permitted, and sometimes required, to use federal funds to provide CEIS. Such services are to be allocated to students who have not been officially identified with disabilities but who require more academic, behavioral, or emotional support than is universally offered at Tier 1. Within a coordinated, tiered model, school districts can satisfy this CEIS obligation by providing such students with targeted, solution-specific interventions at Tier 2. Additionally, the act requires public school districts to provide identified students (i.e., Tier 3 students) with direct counseling services "to assist with benefits yielded from special education." These services can legally be delivered by "social workers, school counselors, school psychologists, or other qualified personnel." Within a coordinated, tiered model, school districts can satisfy this related service obligation by providing identified students with targeted individual and/or group mental health interventions at Tier 3.

In reality, many public school districts continue to be encumbered by lack of funding and resources to fully operationalize this model. Over the past few years, I have become increasingly involved in the codevelopment and delivery of Tier 3 psychotherapeutic interventions to students identified with emotional disabilities. While becoming more cognizant of the servicing intentions of the act and recognizing that minimal was being done to *directly* service the needs of students with emotional disabilities, I became compelled to facilitate in the development and delivery of targeted psychotherapeutic interventions.

Unlike their learning disabled counterparts, whose needs are more readily recognizable and direct replacement instruction and accompanying progress monitoring are more comprehensible by those delivering services, students with emotional disabilities (in my experience)

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tend to be housed in "emotional support" settings with less customized behavior plans; generic or blanket accommodations; and more empathetic, understanding, sensitive, and supportive and advocating teachers. What ever happened to the "specially designed instruction" that these students were rightfully promised?

During this current school year (2014–15), I have been working with one of our mental health professionals to configure Tier 3 groups and group-based instruction around common needs, including anxiety reduction, emotional regulation, stress tolerance, and the establishment of effective interpersonal relationships. With this colleague's wealth of resources, dedication, and enhanced organizational skills, we have been pulling from different treatment modalities, including cognitive-behavioral therapy and dialectical behavior therapy, to address the identified needs of students in our Tier 3 emotional support program.

We are also working on the development of ecologically valid treatment goals that focus on the generalized, authentic use of directly taught therapeutic strategies, as opposed to symptomatic amelioration or reduction. For example, in the development of a treatment or progress monitoring plan for socially anxious students, we are looking to measure how frequently the students are able to replace their avoidance or escape of feared social or public performance situations due to their use of learned strategies, as opposed to measuring how frequently the students are experiencing anxious thoughts or feelings prior to or during a feared social or public performance situation.

One major challenge that I admittedly have been encountering in this endeavor is equally complying with the act's seemingly therapeutically contraindicated accommodation provisions, which tend to entrap many well-intended practitioners. Under the act, students with disabilities are entitled to accommodations, including "adaptations to the content, methodology, or delivery of instruction to address the unique needs of the child and to ensure equal curricular access." While the entitling rights to accommodations are well established in certain cases (e.g., augmentative communication device to a nonverbal student with autism spectrum disorder; adapted physical education to a student with a severe orthopedic impairment; print enlargement software to a student with a visual impairment), these entitling rights are more ambiguous in cases where the disability is solely of an emotional or mental health nature.

In affording accommodations to students with emotional or mental health disabilities, schools naturally run the risk of perpetuating or enabling therapeutically contraindicated avoidance behaviors. For example, in cases where social anxiety or trauma-stressor related anxiety have developed in response to peer relational stressors and communicative stressors (e.g., severe phonological/articulation disorders, which grossly interfere with speech intelligibility and are the source of considerable public ridicule, embarrassment, and humiliation), accommodations (such as options for private presentations) do, in fact, promote ongoing therapeutically contraindicated avoidance behaviors. Furthermore, students in these situations might begin to experience confusion about the contradictory messages they are receiving in group (where they are provided with a sense of empowerment and direct instruction in replacement behaviors) and in the classroom setting (where they are provided with options to avoid stress-inducing situations altogether). In an attempt to achieve a degree of balance, accommodations might initially be offered in more debilitating cases and might gradually be faded once a student's coping repertoire has expanded enough to minimize more negative outcomes (e.g., school refusal and absenteeism).

Undoubtedly, much is still needed to improve the delivery of services to address the emotional and mental health needs of students. In my current school setting, we are still in the piloting stages of creating a systematic approach for the delivery and monitoring of Tier 3 psychotherapeutic interventions. Within any system, the ultimate goal is to equip students with better coping mechanisms and to improve their future educational, occupational, and interpersonal outcomes.

Training Doctoral Students to Use Personality Assessment Collaboratively With Patients

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Dr. Edward B. Jenny

Learning to interpret personality tests such as the Rorschach or the MMPI-2 is core skill in clinical training. Students approach this task with a mixture of excitement and dread; it is one of the activities that differentiate clinical psychologists from other mental health practitioners. Interpreting personality measures can seem like a mystical endeavor akin to reading tea leaves. Students often ask what variables such as the WSum6 on the Rorschach or a 2-7 profile on the MMPI-2 mean and how the descriptors from these variables can fall so close to the mark when describing a client.

When students first attempt to interpret test data, they generally rely on bland textbook phrases that lack connection to the individual. For example, when describing scanning and integrating activities on the Rorschach, "You take in about as much information as individuals of a similar age in the general population" is common language. To overcome this tendency, I ask students to explain these variables in everyday terms: What does it really mean to react strongly to color on the Rorschach and to ignore the shapes in the blots? When students position it simply, they are accomplishing two things: First, they are internalizing the meaning of the variables at a basic level, and, second, they are making the assessment data meaningful to the people they are trying to help.

One approach to assessment that encourages greater use of everyday language is collaborative assessment. This model developed by Connie Fischer (Fischer, 2000) and elaborated by Stephen Finn (Finn, Fischer, & Handler, 2012) actively engages clients in the assessment process by asking them what they want to know about themselves. Results are then discussed with the client in an active dialog with findings expressed in tentative terms, open to revision by the client. Working in this way increases flexibility in the assessment frame and encourages students to be more creative and to take risks. Students can be asked to role-play talking with clients about test findings and "playing" with language that describes what the trait would look like. Much as Winnicott (2005) equated play with learning, allowing students the freedom to "play" with assessment data and try on various ways of explaining the data frees them from the stale language often found in reports and allows them to own the data.

I have found that the collaborative approach to teaching personality assessment helps students get around the need to be the expert and to preclude interpretation of results until such time as the students feel that they have become experts in interpretation, a status rarely mastered even among seasoned clinicians.

Often, students are reluctant to share test results with clients for fear of hurting or offending them. For example, describing the personality dynamics of a client with strong borderline traits can seem like an impossible task. However, most clients with these traits could agree with the interpretation that they are likely to experience relationships as chaotic, intense, and at times frustrating. They likely will feel better understood rather than slighted by the psychologist who so aptly describes features of their life.

Similarly, testing data can be framed in language that is accessible and useful to clients. At the same time, being able to express findings in this way requires students to really get inside the data points and think about them in terms of lived experience rather than dry actuarial points. At first students struggle with expressing themselves in this way but with support and role-play practice they begin to get the hang of it. When they start to explain test findings in real-world terms, they are often excited by the process and find report writing far less arduous.

Often, students are reluctant to share test results with clients for fear of hurting or offending them.

Too often beginning clinicians produce reports that are accurate but not useful because they are too experience-distant for clients to make much use of. When assessment is tied more directly to client questions, formulated in collaboration with the assessor, it is more likely to be useful to the client. Expressing assessment results in everyday language encourages deeper learning of assessment concepts on the part of students and leads to better and more accessible reports.

References

Finn, S. E., Fischer, C. T., & Handler, L. (2012). *Collaborative/therapeutic assessment: Basic concepts, history, and research*. Hoboken, NJ: John Wiley & Sons.

Fischer, C. T. (2000). Collaborative, individualized assessment. *Journal of Personality Assessment, 74*(1), 2–14.

Winnicott, D. W. (2005). *Playing and reality*. New York, NY: Routledge.

Classifieds

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

Etzi

1. Neuropsychoanalysis has substituted the word *implicit* for the word *unconscious* because the meaning has changed so drastically as to render the word *unconscious* no longer useful.
   True
   False

2. The shift in focus from conscious cognition to implicit affect requires the psychodynamic therapist to become involved in the therapy process on a more personally relevant level.
   True
   False

Norcross

3. Research has produced formidable evidence to suggest that the therapeutic relationship influences treatment outcome independent of the specific type of treatment method.
   True
   False

4. It is recommended that clinicians regularly assess the status of the therapeutic relationship to facilitate ongoing awareness of and inform the need for intervention to re-establish a solid alliance.
   True
   False

Royer

5. Smartphone and tablet apps can be used as psychotherapy aids. How do apps help individuals participating in psychotherapy?
   a. As an alternative for traditional psychotherapy
   b. As a homework tool for psychotherapy
   c. As an adjunct to help the client track moods and engage in cognitive challenging
   d. Both b and c

6. Psychology apps are generally created by small, independent programmers and may not have empirical backing.
   True
   False

Beck

7. The recovery movement in CBT for schizophrenia primarily focuses on reducing the positive symptoms of schizophrenia.
   True
   False

Coons

8. The triple aims of the Affordable Care Act include all of the following except:
   a. Increased access to health care
   b. Improve patient outcomes
   c. Reduced costs
   d. Higher insurance premiums

9. Psychologists considering working in primary care and specialty medical settings need to consider which of the following issues:
   a. Clinical and professional competencies necessary to work in medical settings
   b. Whether a health setting is the right place for the psychologist to practice
   c. Regulatory, legal, and contractual issues related to working in health settings
   d. All of the above

DiNardo

10. The Liaison Committee on Medical Education has clear plans to re-educate primary care physicians who graduated from medical school prior to the curriculum changes regarding the behavioral and social sciences implications for medically diagnosable diseases.
    True
    False

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11. A majority of previously nonintegrated primary care physicians in the United States are now operating as fully integrated teams that include mental health care providers.
True
False

Barrett

12. To meet the two-pronged eligibility requirement for special education services under the emotional disturbance disability category, the adverse impact on educational performance needs to be to a marked degree and for a long duration.
True
False

13. Under the Individuals with Disabilities Education Improvement Act of 2004, related counseling services can only be delivered by school psychologists and school counselors.
True
False

Jenny

14. Using everyday language to explain results from personality tests requires deep understanding of the meaning of the test data.
True
False

Continuing Education Answer Sheet

The Pennsylvania Psychologist, December 2014

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

1.	T	F			**8.**	a	b	c	d
2.	T	F			**9.**	a	b	c	d
3.	T	F			**10.**	T	F		
4.	T	F			**11.**	T	F		
5.	a	b	c	d	**12.**	T	F		
6.	T	F			**13.**	T	F		
7.	T	F			**14.**	T	F		

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 _____

_____

Please print clearly.

Name _____

Address _____

City _____ State ____ZIP _____ Phone ( ) _____

I verify that I personally completed the above CE test.

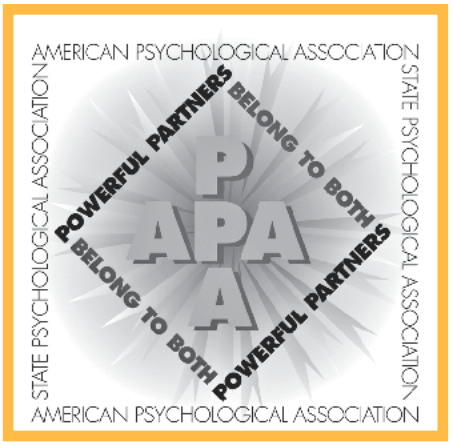
Signature_____ Date_____

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

Now available online, too! Purchase the quiz by visiting our online store at www.papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between August 8 and November 3, 2014!



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CE Calendar

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

March 19–20, 2015
Spring Continuing Education and Ethics Conference
DoubleTree Hotel Monroeville
Monroeville, PA

June 17-20, 2015
Annual Convention
Hilton Harrisburg
Harrisburg, PA

Contact: judy@papsy.org

Podcasts
New podcasts for CE credit by Dr. John Gavazzi are now available on www.papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org.

Registration materials and further conference information are available at www.papsy.org.

If you have additional questions, please contact judy@papsy.org.

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

Excess Weight and Weight Loss
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer, and Meditation Can Help You Pay Attention to What Really Matters
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*Competence, Advertising, Informed Consent, and Other Professional Issues**
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*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

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

**This program qualifies for three contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.*

NEW Home Study CE Courses, developed by Dr. Sam Knapp and Rachael Baturin, coming soon. More information will be available in early 2015.

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