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The Pennsylvania Psychologist

March 2014
QUARTERLY

PPA Annual Convention

June 18–21, 2014
Hilton Harrisburg

Recalibrating Our Compass to the Opportunities and Challenges

ALSO INSIDE:

- Special section: Psychology and the military
- The state of private practice in Pennsylvania
- Benefits of Junior ROTC
- New CMS form

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The Pennsylvania Psychologist

Editor: Dea Silbertrust, PhD, JD

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REGULAR FEATURES

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CONVENTION 2014

SPECIAL SECTION—PSYCHOLOGY AND THE MILITARY

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Joining Together to Recalibrate Our Compass

Vincent J. Bellwoar, PhD

Dr. Vincent J. Bellwoar

Every year a few state psychology associations engage in the search for a new executive director (ED) or deputy of professional affairs (DPA). And every year we inevitably receive calls from these state associations inquiring about how we set up our succession planning. Of course, we just hired a new ED and in 9 months we will hire a new DPA to succeed Sam Knapp. To do this we rely on a succession plan that works. This year it struck me: Word is spreading that PPA, once again, is doing it right!

PPA has been actively developing its succession plan for many years. The process began 7 years ago thanks to the efforts of former PPA president Andrea Delligatti. Andrea set forth a mind-set that there are many pieces to a good succession plan and that each piece needs to be given its proper attention. Things really kicked into high gear in 2012 when Tom DeWall announced his retirement, and the PPA Succession Development Task Force began searching for our new ED. Now that Executive Director Krista Paternostro has taken over the helm, the succession process is ready to move into two other critical phases.

As Krista, the PPA staff, Board of Directors, and I reevaluate many aspects of PPA operations, we do so with an eye toward determining the best way to bring aboard a new first mate. As we prepare to say good-bye to Sam and welcome our next DPA, you can bet that this person will bring fresh energy, insight, and a new way of doing things. He or she will come aboard a PPA ship that is in "full steam ahead" mode. Health care reform and other challenges to PA psychology, with their promises and perils, won't wait around for us to change. We need to be in gear and ready to go.

Amidst all of these changes PPA will steam ahead, as it must in order to survive. But what direction do we take, and who decides this course? The compass we use is PPA's strategic plan. The strategic plan is a vital part of the succession process, and it is an exercise that we purposely delayed until Krista came aboard. The strategic plan is written by a healthy microcosm of PPA membership: the General Assembly (GA), which is comprised of the elected Board of Directors and the chairs of every PPA committee.

The GA last met to determine PPA's strategic plan in 2007. On a snowy Saturday this past December the GA met again in Harrisburg to recalibrate the ship's compass—to reconsider and revise the direction in which we are headed over the next 5 years. The planning session was graciously orchestrated by Rex Gatto, also known as the human spark plug. Rex leads businesses of all sizes through strategic planning, and he brought his expertise to Harrisburg that Saturday morning. As most can imagine, getting a roomful of psychologists (about 40 of us, including PPA staff—thank you for coming PPA staff!) to agree on anything is no small task! Thanks to Rex and the lively input of all, the task was accomplished in 7 intense and exhausting hours.

A strategic plan is the heart of any good business. It gives the organization a bearing, a point in the future to sail toward. It serves as a lighthouse and can be a lifesaver when the ship is struggling in stormy seas. Strategic (and succession) planning isn't very sexy, but when done correctly, it optimizes success. We all do such planning, in one form or another, at various times in our lives. We make plans for our career, marriage, kids, kids' college, 401ks, retirement, and even end-of-life decisions. Some types of strategic planning aren't a lot of fun, but they are absolutely necessary to improve the chances of being successful even as external threats abound. Not planning for the future invites havoc and potential disaster, whether it pertains to an individual or an organization.

PPA's planning session was actually a lot of fun. I found it intriguing to engage with others about where PPA should head. We wrestled with the issues that challenge PPA every day: How can we do a better job being of "value" to our members? How can we get better at branding and help members improve their own branding? Are we here for our members, for society, both? Is our association model outdated? How much is PPA a business? What about diversity, technology, ECPs, advocacy, ethics, CEs, and academia? What are PPA's greatest strengths, and what should we get rid of? How do we help psychologists answer the question, *Why should I join PPA?* How can we better inform the public about what psychologists do?

> *PPA promotes the science and practice of psychology by supporting psychologists to meet the evolving needs of the public.*

There are three main pieces to the strategic plan. The first is to set a vision. A vision statement is like standing on the top of a mountain, pointing to a place far in the distance, and saying: "We want to go there!" PPA's vision is as follows: *PPA promotes the science and practice of psychology by supporting psychologists to meet the evolving needs of the public.* With this overview in place, we then completed the second step and set the mission.

A mission statement acts as a more detailed description of how we are going to get to that place far in the distance—the specific valleys and hills we will traverse to get there. PPA's mission is threefold: *(a) Effectively communicate to the public, policy makers, and membership the value of evidence-based and ethical practice; (b) support the lifelong learning of competent and ethical psychologists; and (c) promote and connect our membership to foster a community of professional psychologists.*

Continued on Page 5

This Spring a New Direction Awaits

Krista L. Paternostro, CAE

Krista L. Paternostro

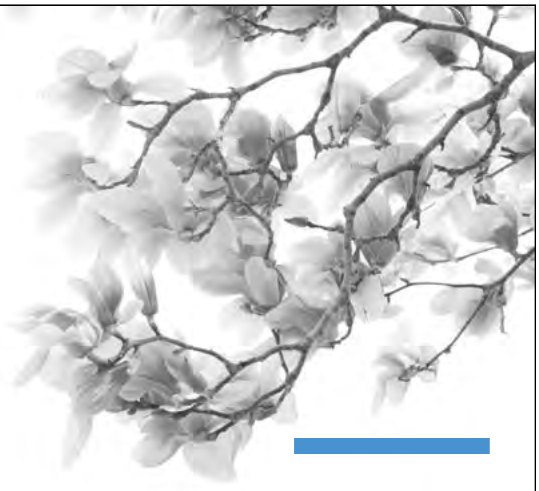
As I sit here at my desk on this brisk January morning, I cannot help but anticipate what the weather will hold when this article is published in early March! I look forward to the changing of the seasons, and the transition from winter to spring is always my favorite. As we move through the first quarter of the year and the daylight gains strength, I eagerly await the moment when I step outside and feel a subtle shift in temperature. It is still cold, but there is a layer of warmth beneath it that we have not felt since the fall. It is then that I know for sure that spring has arrived.

Admittedly, I have never been a winter person, but over the past few years, I have learned to appreciate that winter provides a time for reflection and anticipation in my personal and professional life. Winter affords a time to hunker down, to reflect on the past year's accomplishments, to anticipate the upcoming year, and to plan for what is to come. And, there is a lot to anticipate for PPA in 2014.

Most notably and perhaps most visibly, PPA leadership is engaged in an intensive and important strategic planning process, setting the course for the organization for the coming years. This edition of the *Pennsylvania Psychologist* is rich with updates on this initiative, written from the perspective of our current PPA president, as well as from the viewpoint of two members of our General Assembly, who share their insights on the process and on the plan's importance to our future. We hope to have a final document in place sometime this spring, and realizing that every PPA member is an important part of our success, we will circulate the plan for your consumption.

On another front, I would like to share with you some important news from inside of the walls of the PPA office. As you have read in recent issues, we are transforming the technology platform at the office to bring it into alignment with faster Internet speeds, more contemporary hardware and software solutions, as well as a consistent e-mail and calendar-sharing platform. These enhancements will allow staff to be more agile and responsive to your needs and ensure ease of communication among the members of our internal team.

Secondly, we have partnered with YourMembership.com, a membership association service, to provide a new suite of offerings for PPA members, with primary focus centered on a new membership database. This new software-as-a-service solution will make available much-needed enhancements for our members, including online event registration, online membership renewal, online CE tracking, as well as a reengineered website. For PPA, YourMembership.com is a comprehensive solution. Their dynamic system accommodates all aspects of the PPA organizational structure, including fundraising platforms for the PennPsyPAC and the Pennsylvania Psychological Foundation, as well as organizational communication tools. It is also important to note that YourMembership.com is currently used by at least 24 other state psychological associations, so we are confident that the company understands the unique needs of organizations like ours. We expect to see improvements in efficiency and savings in time and money as this product will help our staff to become more efficient and productive in their daily work.



This journey into these new realms is exciting and filled with possibility.

While a lot of thought and planning must take place to ensure a smooth transition to this new system, we have set a "go live" date of April 15, 2014, and anticipate that by the time of the 2014 Annual Convention we will be well into the active-use phase of our implementation. This year, for the first time, convention attendees will be able to register for the convention, select workshops, and register for other convention activities online. We know that you will enjoy this new platform, which should be relatively seamless from your perspective, and we hope that you will embrace this vibrant direction!

We are certainly partners in progress on these and other initiatives with our visionary Board of Directors and General Assembly. We salute our leaders for their faith in our vision and for reminding us why these decisions are vitally crucial to our future relevancy and sustainability. For us, this journey into these new realms is exciting and filled with possibility. And, just as the advent of the spring weather brings me great joy, I equally anticipate launching these new products and services to our membership with boundless enthusiasm, for I fully expect them to have a profound and lasting impact.

PPA's Strategic Planning

Two General Assembly Members Weigh In

Jeanne M. Slattery, PhD, and Jeffrey L. Sternlieb, PhD

Dr. Jeanne M. Slattery

On December 7, Jeff and I met with about 35 other General Assembly members, along with PPA staff members and facilitator Rex Gatto, to plan for PPA's future. Our existing strategic plan was already 6 years old, and with our new executive director, Krista Paternostro, onboard and Sam Knapp on deck to retire next year, our fearless leader, Vince Bellwoar, argued that the time was ripe for another planning session. He was right.

Over the course of the day we updated our vision and mission statements, incorporating feedback provided by every committee about PPA's strengths, weaknesses, and desired direction for the future. We carefully considered why someone would want to become a PPA member and what could make us stronger as an organization. We all agreed we needed an identifiable message that would inspire our existing membership, clearly articulate the value of membership to new and potential members, and ensure PPA's financial viability into the future. We also acknowledged that we cannot be everything to everybody.

What do we see as PPA's current strengths? Almost unanimously, we noted the consultation services offered by Sam and others, the professional staff's ethical and legal expertise, and our leadership's tireless advocacy for our profession. We appreciate the networking and support we gain from our colleagues both on the listserv and at meetings. We value PPA's topnotch staff and the wisdom and generosity of our members. For many of us, even some of the newer members, PPA is a kind of second family comprised of collegial and friendly people who care about and support each other.

We carefully considered why someone would want to become a PPA member and what could make us stronger as an organization.

We also identified a number of challenges that we face—both from inside and outside PPA. We are worried about the Affordable Care Act, Medicare, the internship crisis, and mental health parity in terms of how they will affect us individually and our profession. We need to update the organization's technology and ways of communicating with its members. We want the membership of PPA to become more diverse by attracting a greater number of early career psychologists and other underrepresented groups.

Our new vision statement is short and sweet: *PPA promotes the science and practice of psychology by supporting psychologists to meet the evolving needs of the public.* Compared to our 2008 statement, however, our new three-fold mission is longer and clearer:

- Effectively communicate to the public, policy makers, and membership the value of evidence-based and ethical practice.
- Support the lifelong learning of competent and ethical psychologists.
- Promote and connect our membership to foster a community of professional psychologists.

At the end of a long yet invigorating day Rex observed that we had come together and worked hard; he also asked us what we were going to do next. How were we going to implement our vision and mission? He correctly noted that unless we all committed to doing something, this day was just a nice day of camaraderie.

We are optimistic about our commitment to moving PPA forward, as well as our ability to maintain our strengths and be proactive in meeting the challenges we face as individual psychologists and as an association.

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Dr. Jeffrey L. Sternlieb

It's 2014! Do you know where your professional organization is and where it is going? Ten percent of PPA's membership (about 300 psychologists) attended the 2013 annual conference and witnessed the end of an era (Tom DeWall's retirement), the changing of the guard (Krista Paternostro's introduction), and the impending retirement of Sam Knapp. For some all of this change feels like a crisis, while others see it is an opportunity! One percent of PPA's membership (which is most of its leadership) recently devoted an entire day to examine our future opportunities together.

For some all of this change feels like a crisis, while others see it is an opportunity!

I attended this strategic planning meeting in my role as chair of the Colleague Assistance Committee; however, it seemed to me that all participants reflected their wide range of experience and perspectives. While Jeanne has provided a great description of the program, I would like to add some thoughts and

observations that this experience stirred up in me.

What I appreciated most was the opportunity to witness and participate in a lively discussion of a plethora of topics important to psychology in general and to PPA in particular—and to do so with a group of colleagues I respect. While I was aware of the specific needs of the association throughout the meeting, it was impossible not to also think about my personal "strategic planning." As psychologists much of our time is spent delivering content—doing psychotherapy, teaching, and consulting. How often do we take a step back, away from our professional routines, to ask ourselves a few questions about where we are and how we are doing?

- What am I satisfied with in my work life? What am I dissatisfied with?
- Do I want to change how I do things or what I do? Are there other things I would like to be doing?
- Is this the setting and location I want to occupy?

When was the last time you created an opportunity to ask these kinds of questions? What would it mean to plan a professional retreat or to think about personal strategic planning?

Early in my career I thought I had a lot of answers, but in truth I have always had more questions than answers. I also somehow knew that I needed my work to provide intellectual stimulation and meaning in my life. Whenever I did not feel fulfilled in these two areas, I started exploring alternative opportunities. I have made several intentional shifts in my work setting and in my primary responsibilities. The fact that we have so many potential roles we can play is one of the strengths of psychology as a field. Although some changes occur because of a crisis—"opportunities" that tend to be episodic and unpredictable—it's helpful to occasionally make a conscious effort to change as part of a regular process of self-examination.

With this in mind, here is one more set of questions: It is 2014. Do you know what your relationship is with your state psychological organization? How does PPA play a role in your professional life? How does PPA fit into your strategic plan? What do you get? What do you give? What do you want? Let's talk!

PRESIDENTIAL PERSPECTIVE

Continued from Page 2

With the first two pieces in place, the last piece will be listing the operational tactics we will use to achieve each piece of our three-part mission statement. In short, how can we operationalize the vision and mission? To flesh this out, the committee chairs will seek input from their committees regarding how their committee work can reflect the vision and mission. For example, the third piece of the mission statement can be operationalized by many committees. The Committee on Multiculturalism (CoM) is a very popular committee that does a wonderful job reaching out to diverse members of the organization and educating our membership about diversity. How would you, CoM, state what you are going to do over the next 1–5 years to realize this part of our mission? Of course, I have asked the same question of our Early Career Psychologist Committee—as well as of all our committees. After all every committee in one way or another works toward fostering a community of professional psychologists.

Every committee in one way or another works toward fostering a community of professional psychologists.

This last piece, then, involves reaching out to our 300 volunteer members for final input as to how they see their role in operationalizing the PPA Strategic Plan. After all, who is PPA? It is you and me, not him or her. If we want to see PPA continue its success, it's up to you and me to contribute, to play an active role in propelling the PPA ship through the stormy seas. It is up to you and me to continue to give of our time so that we can make sure that PA psychology has a voice, a strong voice, in this rapidly changing world. And if you are not one of those 300 volunteers, become one! We are a welcoming group that is always looking for fresh ideas and fresh energy.

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Advocacy Day Is Upon Us

The PPA leadership has selected Monday, April 28, 2014, as this year's Harrisburg Advocacy Day. PPA members are urged to attend. It will again be in room 60, in the East Wing of the capitol building in Harrisburg. The schedule will consist of registration at 9:30 a.m., an issue orientation session from 10:00 a.m. to 11:30 a.m., and meetings with legislators after that. We will be advocating for a bill that would make numerous changes to the Professional Psychologists Practice Act and the insanity bill. This is your chance to influence the process for how psychology is practiced in Pennsylvania. No room for social loafers here!

For more information and to register for Advocacy Day visit our website at www.papsy.org. If you have any questions about Advocacy Day, please contact Rachael Baturin at rachael@papsy.org.

Please note that those who attend the advocacy training session will receive 1.5 hours of continuing education credit.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of February 7, 2014

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 21	Requires reporting suspected child abuse even if the child is not seen in a professional capacity or upon getting the information secondhand; report must be made to county as well as to ChildLine - Sen. Kim L. Ward (R-Westmoreland)	Needs to be amended	Passed 10/2/13, 50–0	Amended and passed by Children and Youth Committee, 11/19/13; on House calendar
SB 31	Adds requirements on school employees for reporting child abuse - Sen. Wayne D. Fontana (D-Allegheny)	Under review	Passed 10/16/13, 49–0	In Children and Youth Committee
SB 300 **HB 300**	Adds sexual orientation to the Human Relations Act regarding 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
HB 21	Authorizes psychologists to testify in court on the determination of insanity and competency to stand trial - Rep. Glen R. Grell (R-Cumberland)	For	Passed by Judiciary Committee, 1/28/14; on Senate calendar	Passed 10/23/13, 198–0
HB 336 **SB 619**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years - Rep. Kate Harper (R-Montgomery) - Sen. Stewart J. Greenleaf (R-Montgomery)	For	In Professional Licensure Committee	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 431	Mandates training in child abuse, overseen by licensing boards, which can waive it for those who do not treat children - Rep. Mauree A. Gingrich (R-Lebanon)	For	Passed by Professional Licensure Committee 11/19/13; tabled in Senate	Passed 4/17/13, 191–0
HB 436	Increases penalties for failure to report child abuse - Rep. Todd Stephens (R-Montgomery)	Against	Passed by Aging and Youth Committee, 12/3/13; tabled in Senate	Passed 6/24/13, 194–4
HB 580	Provides mandated reporters of child abuse with information on reports they have filed - Rep. Louise Williams Bishop (D-Philadelphia)	For	None	In Children and Youth Committee

Bills Enacted and Signed by Governor

SB 28	Increases penalties for child abuse, for failure to report under certain circumstances, or to prevent someone from reporting - Sen. Patrick M. Browne (R-Lehigh)	None	Passed 10/16/13, 9–0; concurred in House amendments 12/11/13; signed by Governor 12/18/13	Amended and passed, 12/10/13, 194–0
SB 1116	Changes "serious physical injury" to "bodily injury;" requires coordination of children and youths with law enforcement in investigating child abuse - Sen. LeAnna Washington (D-Philadelphia)	For	Passed 10/16/13, 49–0; concurred in House amendments 12/11/13; signed by Governor 12/18/13	Amended and passed, 12/11/13, 194–0
HB 726	Expands definition of child abuse, especially in the area of serious physical neglect - Rep. Scott A. Petri (R-Bucks)	For	Amended and passed 12/11/13, 49–0	Passed 6/24/13, 191–6; concurred in Senate amendments 12/16/13; signed by Governor 12/18/13
HB 726	Expands definition of child abuse, especially in the area of serious physical neglect - Rep. Scott A. Petri (R-Bucks)	For	In Aging and Youth Committee	Passed 6/24/13, 191–6

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

Confidentiality and the Release of Records When Laws Are Unclear

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Dr. Samuel Knapp


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Legal rules concerning confidentiality are contained in a number of different statutes and regulations. At times it may be unclear as to how a rule applies in a particular factual situation. Because of such ambiguity it is often necessary to make a reasoned decision regarding the release of confidential information. This article explores a number of situations in which the law may be unclear but a reasoned course of action is necessary.

The Release of a Minor's Voluntary Outpatient Treatment Records

In Pennsylvania the consent of a parent is necessary to institute voluntary outpatient treatment for a minor under the age of 14. If records are requested prior to the minor turning 14 years of age, the consent of a parent is necessary to release the minor's records.

In Pennsylvania the consent of a parent *or* the minor is necessary to institute voluntary outpatient treatment with a minor 14 years old. In these treatment situations, the consent of the 14-year-old minor is necessary to release the minor's records.

There is a question, however, as to the consent needed to release records for a minor who was under 14 years of age when treatment began but is now 14. There also is a question as to what, if any, difference exists if treatment has ended or if treatment is ongoing in nature.

Pursuant to the Pennsylvania Minors' Consent to Medical, Dental, and Health Services (35 P.S. Section 10101.2[d]), a minor who is 14 years old controls the release of records if the minor was 14 years old at the initiation of treatment. Once again, however, this statute is silent as to the release of records in which treatment was initiated prior to age 14 for a minor who is now 14 years old.

Despite this ambiguity it is recommended that once a minor turns 14, the psychologist obtain the consent of the minor before releasing any treatment records generated prior or subsequent to the minor turning 14. This analysis appears consistent with the Minors' Consent to Treatment statute. That is, at the time of the 2005 amendment to the statute, the Pennsylvania legislature extended certain voluntary outpatient treatment decisions to minors 14 years of age and older. It is reasonable to assume, therefore, that if the consent of the minor who is 14 or older is necessary to release records generated for treatment that initiated at age 14 or beyond, the release of the minor who is 14 or older is necessary to release records generated prior to age 14.

The Release of Marital Therapy Records

Different techniques and modalities are used when conducting marital, couples, or conjoint therapy. At the onset of treatment, however, it is necessary to clarify which individual or individuals are the focus of treatment. Such clarification is necessary to establish clear clinical objectives, as well as to anticipate future release of records issues.

Psychologists vary on how they handle patients who come into therapy with spousal or significant other relationship issues. For example, a psychologist may identify one individual as the patient, give that patient a diagnosis, and bill the insurance company under the name of the identified patient, even though the spouse or significant other may participate in most or all of the therapy sessions. This is entirely justified as long as medical necessity requirements have been met; that is, the patient has a diagnosis and the treatment is directed toward alleviating that diagnosis. In this situation the identified patient controls the release of the records.

If the psychologist identifies the couple (or the relationship) as the patient and sees both parties together in an ongoing

Continued on Page 8

Continued from Page 7

manner, it is reasonable to require the consent of both participants before releasing any treatment records. Although insurance companies are unlikely to pay for therapy when there is no identified patient, it is certainly within the scope of a psychologist's practice to identify a couple, family, or a relationship as the identified patient.

It is not unusual, however, for the psychologist not only to see the couple together but also to conduct individual sessions during the course of treatment. In those situations, there is a question as to whether there are three sets of records, rather than one joint record, and whose consent is necessary to release the "individual" records.

Once again the prevailing rules are unclear regarding the release of records involving joint and individual therapy. Although the individual sessions may be conducted outside the presence of the other person, the psychologist may be drawing upon information gathered throughout the course of treatment. In this way, all of the records may be considered "joint" in nature, thereby requiring the consent of both individuals prior to the release of the records.

Much depends on how the psychologist represents this arrangement to third-party payers. It does not make sense, for example, for a psychologist to tell the insurance company that John Doe is a patient for purposes of billing and then, when the patient wants to release records, turn around and claim that the records cannot be released because the Doe family itself was the patient and that John Doe was never the patient.

On the other hand, if the psychologist is not billing insurance under the name of an individual patient, and views the individual sessions as an integral part of the marital sessions, it is possible for the psychologist, as long as this is communicated clearly to both partners at the start of treatment, to consider the individual sessions as a subset of the marital therapy, which would require the release of both spouses. At a minimum, therefore, it is strongly recommended that these issues be discussed and documented at the onset of treatment.

The Release of Family Therapy Records

Issues involving the identified patient, confidentiality, and the release of records in family therapy are similar to those encountered when conducting marital therapy. It is important to clarify and document at the onset of treatment who the active members of treatment are versus who may serve as collateral contacts during the course of treatment.

Collateral contact with other individuals can occur in family, marital, conjoint, or individual treatment. For example, treatment may focus upon the mother, father, and son, and the daughter may attend an intermittent treatment session. Or treatment may focus upon the mother and father, and another adult relative may attend an intermittent treatment session. Or treatment may consist of some other combination of family members meeting periodically in therapy.

Because confidentiality "attaches" to the patient, it is important to discuss and clarify at the onset of treatment which individual or individuals are the focus of treatment. A family member or spouse who attends a session to benefit the identified patient is considered a collateral contact, and his or her presence as a collateral contact should be documented in the record. Although psychologists need to respect the privacy of information obtained from collateral sources the consent of a collateral individual is not necessary when responding to a request for records. Confusion can occur, however, if the psychologist fails to distinguish between who is or is not a recipient of treatment. Sometimes ill feelings have resulted in situations when family members regularly attended therapy sessions assuming that they were patients with control over the release of the records, only to find out later that they have no status to control the release of the records.

Discussion

Confidentiality attaches at the onset of treatment. Once treatment commences confidentiality must be maintained and proper consent must be obtained prior to the release of treatment records. At times the rules surrounding the release of confidential treatment records may be ambiguous. On those occasions it may be necessary to make a reasoned decision based upon existing rules and regulations. On other occasions it may be necessary to acknowledge the ambiguity and obtain further guidance prior to responding to the request. In all situations, however, it is best to anticipate future questions by discussing and documenting clinical objectives and confidentiality concerns at the onset of treatment.

New CMS Forms Required Beginning April 1, 2014

Starting on April 1, 2014, health care professionals must use the new reimbursement form for health care insurance (identified as CMS-1500, New 02-12 Version). From January 6 through March 31, 2014, providers can use either the old or the new CMS forms. This new form contains changes that will accommodate the new ICD Codes that insurers will require beginning October 1, 2014. However, health care professionals will continue to use the ICD-9 diagnostic codes until then.

Instructions on using the forms may be found at:

http://www.nucc.org/%5Cimages%5Cstories%5CPDF%5C1500_claim_form_instruction_manual_2012_02.pdf

Ahoy There, Mates!

Beatrice Chakraborty, PsyD, Chair, Program and Education Board
chakrabortybh@gmail.com

On behalf of PPA president Dr. Vince Bellwoar, the Board of Directors, the Convention Committee, and PPA staff, I extend an invitation to you to join us for PPA's biggest event of the year, our 2014 Annual Convention, June 18–21, at the Hilton Harrisburg.

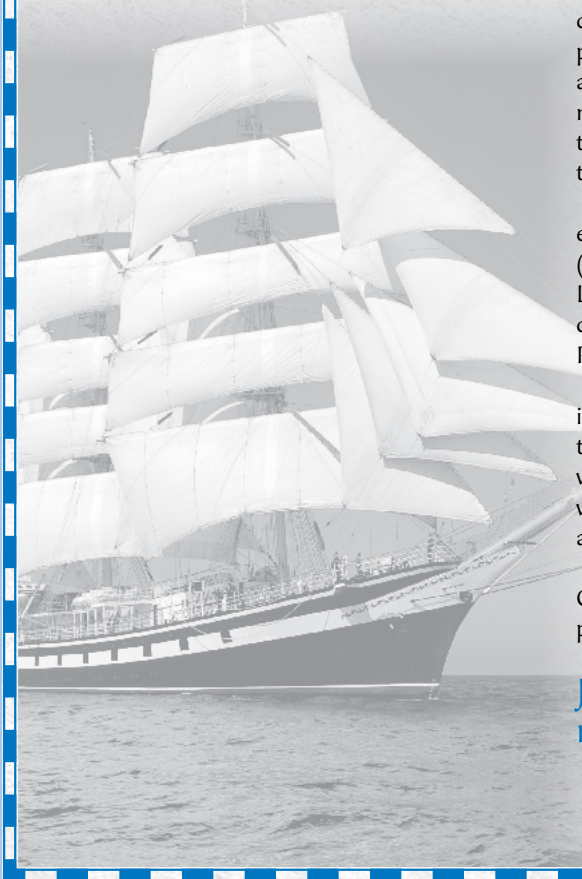
The President's Theme, which characterizes the 2014 Convention, is *Health Care Reform: Recalibrating Our Compass to the Opportunities and Challenges*. Under the very capable leadership of Convention Committee chair Dr. Mark McGowan, PPA volunteers have developed a most energizing convention program that essentially demonstrates how our PPA members practice and embrace this theme.

I urge you to register early to attend a variety of dynamic continuing education workshops that address the very latest in psychological science and practice, including an impressive array of programs designed specifically to inspire and motivate students and early career psychologists (ECPs). The General Assembly will meet on Wednesday (4:00 p.m.–6:30 p.m.) to review and evaluate the many committee activities and events of the "Good Ship PPA" that took place during 2013–14.

Opportunities for learning and networking will be greatly enhanced and facilitated by the three major convention speakers: (1) Keynote: David R. Kraus, PhD, (2) Psychology in Pennsylvania Luncheon: Katherine C. Nordal, PhD, and (3) Psychopharmacology Breakfast Symposium: Walter J. Clark, MD, and Jeffrey L. Peters, MD.

Informal and formal venues for professional and social networking and fun include poster sessions, the Mind-Body River Walk, the ECP/Student Reception, and the Exhibitors' Networking Party, where exhibitor giveaways and pretty amazing door prizes are just waiting for you. Yes, you must visit to win. Also, check out the new and refreshing look and tempo of the awards ceremonies this year.

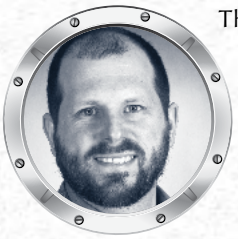
Finally, join us at the Town Hall Plenary Session and Awards Ceremony on Friday (8:00 a.m.–10:30 a.m.), where we will reveal the presidential theme and an exciting course of action for 2015.



Just do it: set sail upon a sea of change and renewal for your mind and body!

Invited Addresses and Workshops

Mark R. McGowan, PhD, Chair, Convention Committee
dr.mark.mcgowan1@gmail.com



The theme of this year's convention—*Health Care Reform: Recalibrating Our Compass to the Opportunities and Challenges*—is focused on the timely topic of change in our health care system. Our speakers offer unique opportunities for gaining insight into impending changes, as well as the potential influence these changes may have on our personal and professional lives. It is not often that we encounter a topic that reaches so broadly across every subspecialty of psychology.

Our keynote speaker, **Dr. David R. Kraus**, will be discussing the role of outcome measurement in health care reform in his talk entitled *The Elite Therapist Network: A Model for Capitalizing on Each Therapist's Unique Skills*. Dr. Kraus is a licensed psychologist and a marital and family therapist with experience as a clinician and hospital administrator prior to founding Outcome Referrals in the early 1990s. Outcome Referrals is the largest independent provider of outcome management services (OMS), having measured nearly 1.5 million patients for entire state Medicaid systems, commercial insurance carriers, hospitals, community mental health centers, and clinicians in private practice. This talk promises to be one you will not want to miss as you prepare to navigate the sea of change associated with health care reform.

On Wednesday morning, please join us at the Psychopharmacology Breakfast Symposium, where **Drs. Walter Clark** and **Jeffrey Peters** will be offering a talk entitled *Primary Care Integration With Behavioral Health: Making This Work in an Integrated Health Care System*. Both speakers are joining us from the VA Pittsburgh Healthcare System. Dr. Clark is the vice president of Primary Care Health Services and oversees primary health care for veterans served within the system's network of ambulatory health care facilities throughout southwestern Pennsylvania. Dr. Peters is an associate professor of psychiatry who works in the Veterans Affairs Medical Center. Their talk will provide insights gained from the application of the Behavioral Health Primary Care Integration model currently being used by the VA. The challenges and opportunities of this type of integration will also be explored with a specific focus on the clinical services that may be best served through this approach.

Finally, I am pleased to announce that **Dr. Katherine Nordal**, the American Psychological Association's executive director for professional practice, will be delivering the Psychology in Pennsylvania Luncheon address. Dr. Nordal's talk will address parity advocacy on behalf of patients and the profession in light of the final parity rule released in November 2013. She will also discuss the APA Practice Organization's collaborations with state associations on provider reimbursement and other parity issues affecting psychologists and their patients.

We are excited to be able to have several notable invited guests to speak with us at this year's convention. Please join us in benefiting from their knowledge and respective areas of expertise.

Convention 2014 . . . A Preview

Marti Evans, Conference and Communications Manager, mevans@papsy.org

PPA's Annual Convention, June 18–21, is an excellent time to connect with colleagues and friends and learn the latest psychological knowledge in addition to the initiatives designed to enhance psychology as a discipline and profession in Pennsylvania. Celebrate with us!

REGISTRATION FEES

To help you properly plan and budget for the convention, the following convention registration fees will apply. If you need a preliminary convention registration form for your employer's check processing or approval, please contact Marti Evans at the PPA office by e-mail or phone (717-232-3817).

	EARLY REGISTRATION *(postmarked by June 1)*		REGULAR REGISTRATION *(postmarked after June 1)*	
	All	**Daily**	**All**	**Daily**
PPA Member	$355	$180	$430	$200
Nonmember	610	305	670	335
PPA Affiliate Member	200	100	250	125
Early Career Psychologist PPA Member	70	35	75	40
Full-Time Student Member	70	35	75	40
Full-Time Student Nonmember	145	70	145	75
Retired PPA Member	235	120	250	125
Spouse/Family/Guest	90	45	95	50

HOTEL ACCOMMODATIONS

The Hilton Harrisburg will be the host for the 2014 Annual Convention. To make a reservation, call 1-800-HILTONS or 717-233-6000 and identify yourself as a participant in the PPA Annual Convention to obtain the group rate: $137 single/double (plus tax). The group rate is protected until May 28. If the room block is sold out before May 28, reservations will be accepted on a space availability basis only, and you will be charged a higher rate. **Please make your reservation early! We expect the room block to sell out before May 28. NOTE: Last year the room block sold out in April.**

PROGRAM TOPICS

The 2014 Convention Committee wishes to thank those who submitted proposals for this year's convention. Program descriptions will be listed in the convention program booklet, which will be available at www.papsy.org in April.

The members of the Convention Committee (see sidebar) and PPA staff will continue to work hard to ensure a high-quality convention. We look forward to greeting you in person in June!

2014 CONVENTION COMMITTEE

Beatrice Chakraborty, PsyD
Murrysville
Chair, Program and Education Board

Mark McGowan, PhD
Indiana
Chair, Convention Committee

Ellen Adelman, PhD
Elkins Park

Gail Cabral, IHM, PhD
Scranton

Molly Haas Cowan, PsyD
Camp Hill

Mary Pat Cunningham, MA
Peckville

Allyson Galloway, PsyD
Havertown

Michael Gillum, MA
Williamsport

Simone Gorko, MS
Ardmore

Tad Gorske, PhD
Pittsburgh

George Herrity, MSW
Pittsburgh

Gail Karafin, EdD
Doylestown

Charles LaJeunesse, PhD
Dallas

Marie McGrath, PhD
Immaculata

Cathy Petchel, MA
McMurray

Stephanie Phillips, PsyD
Mars

David Rogers, PhD
Hershey

Nancy Rogers, MS
Hershey

Beatrice Salter, PhD
Philadelphia

Christine Samuelsen, PsyD
Mechanicsburg

Adam Sedlock Jr., MS
Uniontown

Bernard Seif, SMC, EdD, DNM
Broadheadsville

Christina Shook, PsyD
Enola

Linda Taylor, PhD
Wynnewood

Convention Theme/Health Care Workshops

Christina B. Shook, PsyD, cbshook@comcast.net

This year's convention will highlight the various and exciting roles of psychologists in health care reform and assist attendees in gaining a better understanding of how health care reform is affecting psychologists.

In *Psychologists' Guide to Creating and Sustaining Integrated Primary Care Practices*, Drs. Shelley Hosterman, Tawnya Meadows, Amanda Bleck, Monika Parikh, Sean O'Dell, and Christine Chew will discuss the logistics of integrated primary care practice and how they function successfully in Geisinger Medical Center's pediatric model.

Drs. Christina Shook and Theresa Kovacs will present *The Future of Integrated Behavioral Health in Primary Care and Patient-Centered Medical Homes (PCMH)*. They will provide an overview of primary care mental health integration focusing on components of co-located, collaborative care programs, as well as demonstrate assessment and treatment strategies in primary care.

In *Rural Psychiatry and Managed Care: A Collaborative Approach*, Drs. Manuel Reich and Stephen Neal will discuss how a managed care company partnered with providers in a rural region to provide mental health services.

Drs. Nicole Quinlan, Laura Campbell, Vanessa Casavant, Christine Chew, and Tawnya Meadows, as well as Amy Williams will present *Psychology in Multidisciplinary Specialty Care: Opportunities for Collaboration and Integration*. They will emphasize opportunities for psychologists to expand their scope of practice into specialty medicine by collaborating on multidisciplinary teams such as pain, sleep, cystic fibrosis, diabetes, GI, and pediatrics.

In *Lessons Learned at the Intersection of Psychology and Community Mental Health*, Dr. Adrienne Ingram will discuss serving the most vulnerable populations and persistently mentally ill in community mental health centers, with a focus on person-centered recovery principles and shared decision making.

In *Changes in Health Care Delivery 2014*, Drs. Samuel Knapp, Daniel Noam Warner, and Vincent Bellwoar, as well as Rachael Baturin will discuss implications for psychologists and patients given the changing nature of health care delivery with the Affordable Care Act, Medicare adjustments, electronic medical records, and an increased focus on treatment outcomes.

Convention Presentations: Children and Adolescents

Gail R. Karafin, EdD, grkarafin@gmail.com

The 2014 Convention Committee has selected several workshops focusing on the treatment of children and adolescents. Diane Snyder and Dr. Robert Reed have prepared a review of instruments used in the assessment of children, including cognitive, behavioral, and personality measures. They will include instrument descriptions, costs, psychometric properties, recommended uses, and comparable tests. Audience participation will be encouraged. Participants will be able to make informed choices when considering instruments for their practices.

Drs. Brad Norford and David Palmiter Jr. will prepare a very novel workshop addressing a method for overcoming common youth resistance to therapy. Magic can be used to establish a therapeutic alliance and to energize interventions for social skills and self-esteem deficits. A research base for their work will be included. Participants should come prepared to learn at least five amazing tricks and how to implement them in clinical work.

High-conflict families are a concern to all psychologists working with children of divorce. Drs. Steven Cohen and Eve Orlow as well as Jane Iannuzzelli have prepared a workshop for the practical issues in the treatment of high-conflict families. Topics to be covered include (a) necessary modification in the rules of treatment to account for the high family stress, (b) the role of the treating psychologist when child custody evaluations are being conducted, and

(c) roles for psychologists in alternative dispute resolution capacities.

Drs. Suzanne Levy, Stephanie Krauthamer Ewing, and Guy Diamond will be presenting on attachment-based family therapy for depressed and suicidal adolescents. Their program will address a trust-based, emotion-focused repair of family ruptures and a rebuilding of emotionally protective, secure parent–child relationships. Their process has been tested with diverse groups, including low-income and minority families. The presenters will describe strategies used in the five treatment tasks that focus on interpersonal growth rather than behavioral management.

Included in the youth workshops is a presentation by yours truly. Dr. Gail Karafin will be presenting on pediatric sleep dysfunction and its consequences. This workshop will focus on current research about pediatric sleep disorders and its impact on physical, cognitive, emotional, and behavioral functioning. Sleep dysfunction can incorrectly mimic mental disorders. Participants will be provided with recommendations for developing positive sleep hygiene. Research related to adolescent circadian rhythms and school start times will be reviewed.

Access to mental health records in child custody disputes will be presented by Dr. Arnold Shienvold and Rachael Baturin. Participants will gain an understanding of how to testify in court and when attorneys and clients may have access to mental health records. They will also discuss the ethical issues that may arise when testifying or when releasing records to attorneys or clients.

Assessment and Intervention: In the Context of the CSM and the New Health Care Environment

Gail Cabral, IHM, PhD, cabral@es.marywood.edu

This year's PPA convention provides a wide swath of workshops highlighting specific assessment and intervention issues, such as traumatic brain injury (TBI), eating disorders, posttraumatic stress disorder (PTSD), and chronic pain, in the context of a changing health care environment and a revised *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Practitioners will find thoughtful analyses of the revised *DSM* and practical uses of assessments tailored to specific diagnoses.

For an overview of major changes in *DSM-5* and their effect on clinical practice choose the workshop offered by Dr. Ralph May. He will present historical and current controversies in mental health care diagnosis, including the contrast of categorical and dimensional approaches.

TBI and concussions will be the focus of two workshops. *Traumatic Brain Injury: Basics and Beyond* by Dr. Tad Gorske will include concussion management, varying views on treatment of prolonged symptoms, and psychiatric and addiction comorbidities. Dr. Julie Guay, along with Breanne Dibble and Adam Bennati in a workshop entitled *Assessment and Treatment of Concussion and Postconcussion Syndrome*, will summarize the latest research in the field and include several case presentations.

In a workshop focusing on both the *DSM* and changing health care realities, Dr. Karyn Scher will examine the updated criteria for *Feeding and Eating Disorders* and the effects of these changes on diagnoses, treatments, and insurance coverage.

Two workshops will focus on assessment tools. *Assessment and Treatment of PTSD* by Dr. Wayne Roffer will discuss changes in diagnostic criteria in the *DSM* and will present updated assessment instruments. The availability, reliability, and validity of free assessment instruments to enhance evaluation and therapy will be the focus of a workshop by Drs. Michael Crabtree and Mary Schaffer.

In the workshop *The Biopsychosocial Model of Treating Chronic Pain: Opioids Seldom Work,* Dr. Jasen Walker will present evidence of the need for an integrative model for chronic pain prevention and management. Dr. Tad Gorske and Shannon Edwards will present the difference between capacity and competency in both clinical and forensic contexts.

Dr. Edward Zuckerman will present *Dualing Diagnoses:* DSM-5 *vs.* ICD-10, which will provide full details of the differences and advantages of both diagnostic systems.

Check out the offerings! Certainly there are workshops that will meet your interests and needs!

Therapy/Intervention Workshops

Mary Pat Cunningham, MA, mpc380@verizon.net

The June 2014 Annual Convention promises to offer workshops geared toward therapy techniques and interventions we can take home and use with the clients we serve.

First, Dr. J. Russell Ramsey will describe methods for helping adults with attention-deficit hyperactivity disorder. He will address procrastination, disorganization, and time management problems to name a few.

Dr. Katherine Muller will provide us with two hours of evidence-based exposure therapy for obsessive-compulsive disorder. She will lead a detailed discussion of exposure therapy intervention steps, including assessment, psychoeducation, hierarchy-building, and exposure sessions.

Drs. Janet Etzi and Edward Jenny will devote three hours to Affect Regulation. Their workshop, entitled *Integrating Regulation Theory into Practice Using the Rorschach to Illustrate Therapeutic Assessment*, will describe and apply Affect Regulation Theory to the assessment process and the work of psychotherapy.

If you are looking for state-of-the-art therapies, stop in for a brief workshop given by Dr. Wayne L. Roffer, who will demonstrate two mobile applications to aid in the assessment and treatment of posttraumatic stress disorder.

On Thursday, Dr. Ronald Vogt will educate us on utilizing emotionally focused therapy (EFT). Nine core skills of EFT will be presented through lecture, video, and role play.

On Saturday, Dr. Aaron Brinen will offer 6 hours of *Recovery-Oriented Cognitive Therapy (CT-R) for Schizophrenia*. CT-R is a combination of the recovery model and cognitive therapy. Its use in early episode individuals will be highlighted.

Lastly, Dr. Sue Ei will provide an introductory workshop on how to identify and treat sleep disorders in adults. Common sleep disorders, including insomnia, sleep apnea, and parasomnias, will be discussed.

Join us this summer for another rewarding and educational experience!

Ethics Workshops

Molly Haas Cowan, PsyD, mollycowanpsyd@gmail.com

Consistent with the convention theme, representatives from the State Board of Psychology, Drs. Salvatore Cullari, Steven Cohen, Karen Edelstein, Joe French, and Richard Small along with Christina Stuckey and Attorneys Jason McMurray, Todd Narvol, and Karen Cahilly will present *Health Care Reform and Other State Board Issues*. This workshop will address ways new health care legislation will impact psychology, as well as review the mission and procedures of the Board. Topics including custody issues, telepsychology, and release of records will also be addressed.

Dr. Samuel Knapp and Rachel Baturin will present *What Should Be in My Professional Records?*, which will address the standards for records set by licensing boards, professional associations, and insurers. Additionally, the presenters will discuss documentation standards to help psychologists reduce the risk of misconduct.

Law and Ethics Review, presented by Drs. Samuel Knapp and John Gavazzi, will use an ethics quiz with participant interaction to help participants understand relevant ethical and legal standards around issues dealing with confidentiality, record keeping, treatment of children, mandated reporting, and other areas.

Drs. Knapp and Gavazzi will also present *Avoiding the "Dark Side" of Ethics: Unlearning Deceptive Ethical Rules and False Risk Management Principles*. The workshop will address the difference between moral beliefs and psychology ethics and help participants know how to identify unhelpful "received wisdom" not based on ethical principles.

In *Closing a Professional Practice: Clinical, Ethical, and Practical Considerations*, Drs. Catherine Spayd and Mary O'Leary Wiley will address writing a professional will, properly disposing of treatment records, and addressing transference and countertransference issues that may arise when a professional practice is closed.

Several additional workshops highlighted elsewhere in the issue will also offer continuing education credits in ethics. Please join us for these important topics!

Diversity Workshops

Marie C. McGrath, PhD, mmcgrath@immaculata.edu

Once again, PPA's Annual Convention will offer a variety of workshops designed to increase attendees' ability to provide culturally competent, sensitive, and ethical psychological services to diverse clients. Dynamic and expert presenters, many of whom will be familiar to attendees of past PPA conventions and CE events, will (a) discuss principles of positive multiculturalism, (b) review current research findings related to culturally competent practice, (c) provide models for reflective and ethical decision making, and (d) share evidence-based strategies.

Two workshops will focus primarily on issues encountered in work with sexual minority clients. Dr. Joseph Micucci will discuss *Working With Families of Lesbian, Gay, and Bisexual Adolescents*, while Drs. Audrey Ervin, Jeanne Slattery, and Molly Haas Cowan along with Lavanya Devdas will present on *Sexual Minorities, Religion, and Spirituality: Ethical Strategies for Clinical Practice*.

In *Treating Refugees and Asylum Seekers: Challenges and Shared Learning Opportunities*, Drs. Takako Suzuki and David Goodwin will share information that will help clinicians address the unique needs of Pennsylvania's rapidly growing immigrant population. Drs. Tim Barksdale and Cheryll Rothery along with Duangporn (Kee) O'Toole will familiarize attendees with the use of culturally competent assessment and diagnostic reasoning strategies in *The* DSM-5 *Approach to Assessing Cultural Issues for Diagnostic Decision Making*.

Several workshops will focus on delivery of culturally appropriate therapeutic services. Drs. Cheryll Rothery and Susan McGroarty will present on *Effective Psychotherapy: Ethics, Empathy, and Multicultural Competence*, while Drs. Molly Haas Cowan, Jeanne Slattery, and John A. Mills will discuss *Positive Multiculturalism as Aspirational Ethical Practice: Therapeutic Applications*. Drs. Hue-Sun Ahn and Jeffrey Sternlieb along with Margarita Saenz will share information on *Utilization of Personal Stories as a Means to Cultural Competence*.

Finally, Drs. Lori Simons, Beatrice Salter, and Takako Suzuki as well as Jill Braun and Odelia McFadden will assist attendees in recognizing their own hidden assumptions and potential biases in *Are Our Eyes Wide Shut?: Identifying and Working Through Our Blind Spots*.

We look forward to seeing you at our convention!

Academia and Supervision Workshops

Cathy C. Petchel, MA, baywood260@yahoo.com

Our Annual Convention for the summer of 2014 proves to be a wonderful opportunity to connect with our friends and colleagues. The selection of workshops and training possibilities is full of diverse and exciting topics, particularly as delivery of health care requires an eye toward change. I am pleased to report that the ever-growing realm of academia and supervision will be represented with a handful of relevant and timely sessions that address effective supervision and creating an internship within a medical residency program.

As I reflect on the diverse membership of PPA, not only focusing on our individual backgrounds and cultural components but on our own particular fields of practice, I am struck by the fact that we are all teachers and supervisors of sorts. Whether we work with clients, students, staff, business development, and/or service projects we bring to the table our expertise and our ability to teach and guide. For those of us actively working within colleges and universities we welcome learning opportunities that equip us with current information and training as it relates not only to our interactions with each student but to communication processes within the institution. With the growing number of graduate students matriculating into the field and needing sound supervisory guidance, we need to be equipped with clear guidelines and expectations.

The following programs will enhance your understanding of the effective supervisory role as well as internship potential:

- *Mind Meets Body: Creating a Primary Care Psychology Internship in the Family Medicine Residency Program* presented by Dr. Ray Hornyak and Rick Kutz.
- *The Effective Supervisor: Training and Competencies* given by Drs. Kristin Mehr and Rachel Daltry.
- *Tasks and Processes of Effective Clinical and Psychological Assessment Supervision* by Drs. Jeanne DiVincenzo and Diane Sizer.

Practice Workshops

Adam C. Sedlock Jr., MS, adamsedlock@yahoo.com

This year offers great selections for the practice-oriented psychologist! You can secure your practice by attending *Professional Wills: Full Compliance Inspired by Murphy's Law*, which will be presented by Dr. Anne T. Murphy. She will discuss why practitioners may resist writing this important document and ways to overcome the resistance. Participants will learn how to identify essential items to include in a professional will and reasons why a professional will would be required.

Want to learn more about the benefits of working with the media? Michael Gillum and Drs. Pauline Wallin and Nicole Quinlan will offer *Why Do Media Interviews?: Free Publicity While Educating the Public*. This session will enable you to recognize the benefits that media contacts can provide to your practice and the public. Ethical concerns and preparation methods will also be discussed. As media interviews may be anxiety provoking, you will learn how to draw on what you already know to better communicate to others.

Universal Design in Psychological Practice: Enhancing Services for Clients With Disabilities, offered by Dr. Marie McGrath and Loretta Mestishen, will focus on the legal, ethical, and practical implication of universal design (UD) for a psychological practice. Through discussion and activities, participants will learn how to apply UD in a variety of professional settings to better serve diverse individuals.

The risk for burnout in practice is significant. However, crafting and living a well-designed mission can promote resilience. And, those living within such a mission are in a position to lead others in important causes. *Meaning and Mission Making to Avoid Burnout and to Lead* will be presented by Drs. David Palmiter Jr. and Dianne Salter.

Students and Early Career Psychologists

Allyson L. Galloway, PsyD, drallysongalloway@gmail.com
George Herrity, MSW, gherrity@live.carlow.edu

As always, there is so much to look forward to at PPA's Annual Convention! Student and Early Career Psychologist (ECP) Day on Friday, June 20, has some new and exciting changes, though it will continue to offer programming specifically relevant for us. First, there is the Research Poster Session. This year's poster session will have a new and improved venue and will even include a 1-hour CE offering, *Conversations With the Research Poster Presenters*. The Research Poster Session offers an excellent opportunity to present your research to interested professionals. Instructions for submitting an application for the Research Poster Session are available at www.papsy.org in the convention section. The deadline for applications is April 1.

We are especially excited about the addition of the Student and ECP Learning Lounge, which will be available on Friday from noon to 5:00 p.m. The lounge will be a place to relax and regroup and will include some brief presentations of interest to students and ECPs.

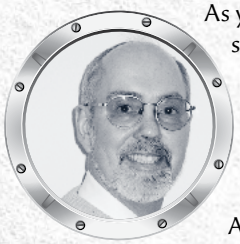
The convention offers plenty of opportunities to socialize. There are groups heading out for dinner or drinks nightly, and you won't want to miss the Student and ECP Networking Reception on Friday night! The wine and cheese reception is free for students and ECPs registered for the convention and will once again offer speed mentoring opportunities with seasoned professionals in a relaxed and informal setting.

The early registration fee is very reasonable—only $70 for the whole convention for student PPA members. Also new this year is a $70 discounted rate for ECPs. For students on a tight budget who are willing to volunteer to help out for a few hours during the convention, the registration fee is waived entirely.

Students and ECPs who attend the convention will find the informative learning opportunities and many wonderful networking experiences to be invaluable, especially for those planning on remaining in Pennsylvania.

Workshops on Older Adult Topics

Charles LaJeunesse, PhD, clajeune@misericordia.edu



As you are no doubt aware, the baby boomer sector of our country is retiring or will soon be. Working with the aged has always been meaningful and rewarding, but now there is an even greater need for those in our field to meet the needs of an ever-growing population of elders. If you attend the 2014 PPA Annual Convention, you will have access to several exciting aging-focused workshops.

The Use of Mindfulness Treatments for Geriatric Distress and Pain: An Evidenced-Based Review will be offered by Dr. John Monopoli, who has published several research articles and made many presentations on geriatric issues.

Residential-Based Psychotherapy Treatment Model for Older Adults will be presented by Dr. Maureen Sweeney. This workshop will focus on how to set up an office in a geriatric residential facility and will provide insights on clinical interventions with this population.

Dr. Christopher Royer will present *Conducting Capacity Evaluations of Aging Consumers*. This workshop will focus on the legal issue of determining capacity and whether guardianship is necessary.

Helping Those in Hospice and Their Loved Ones With the Dying Process, presented by Dr. Janet Etzi , will show us how to help families by explaining how dying can be viewed as a developmental process and not just a medical event.

I hope you see the value of these workshops in your future practice in gerontology or in dealing with your clients who are aging. Either way they merit attending. I look forward to seeing you at the convention!

"Magic" (and Fun) to Be Found at PPA's 2014 Annual Convention

David A. Rogers, PhD, hersheypsychsvcs@aol.com

Regular attendees to PPA's Annual Convention will agree that, besides the unparalleled quality CEs, the Harrisburg venue provides many and varied opportunities for fun! This year is no exception.

Consistent with our current president Dr. Vince Bellwoar's nautical theme, attendees can avail themselves of a cruise on one of the last remaining paddle-wheel riverboats in America. The Pride of the Susquehanna Riverboat is an authentic stern-driven paddle wheeler built to beautify and enrich the Hershey/Harrisburg region. Since her construction and launch in 1988, "the Pride" has carried almost a million passengers. She's been used for private functions (meetings, parties, weddings, dinners, anniversaries) as well as countless public events. During the summer, the Pride launches several times a day for 45-minute sightseeing cruises, leaving at noon, 1:30 p.m., and 3:00 p.m. Evening cruises are also available. No reservations are required (www.harrisburgriverboat.com).

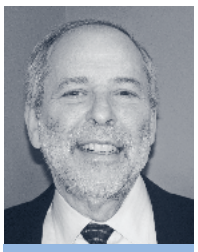
While there is always the predictable "magic" that happens when friends, colleagues, and family gather or have spontaneous encounters at the Hilton, PPA is also offering its own sponsored activities including but not limited to several formally orchestrated social activities. The Exhibitors' Networking Reception on Thursday evening will offer a time for (free) food, (free) interaction, (free) music, and (free) "stuff" offered by the exhibitors! Then, there are the various awards ceremonies that provide an opportunity to extend and experience the joy and enthusiasm of recipients being recognized for their outstanding efforts to psychology. Finally, the ever-popular Mind-Body River Walk will be held again this year. This Thursday-morning activity provides convention attendees with an opportunity to explore and enjoy the natural beauty of the Susquehanna River as it flows quietly past the City of Harrisburg en route to the Chesapeake Bay.

By the way, this year the convention is also offering a CE-approved workshop for those amateur magicians who have often considered using slight-of-hand or other magic tricks as illustrative tools in clinical work with children and adolescents (adults too)! Come listen to *Using Magic to Enhance Clinical Work With Children and Adolescents* presented by Drs. Bradley Norford and David Palmiter Jr.

Come join us for all the magic and fun to be found at the 2014 PPA Annual Convention in Harrisburg! We look forward to making another year of magical memories together!

Advocating for Military Personnel, Veterans, and Their Families

Donald N. Bersoff, PhD, JD



Dr. Donald N. Bersoff

The wars in Iraq and Afghanistan may be winding down, but the mental health problems of its participants are not. An average of 22 veterans commits suicide on any given day. In 2012, 349 active service personnel killed themselves, compared to 295 who died on military missions. The number of veterans diagnosed with posttraumatic stress disorder (PTSD) from 2002 to 2012 was over 228,000. The prevalence rate of PTSD is between 10 and 14%. The economic cost of PTSD among U.S. veterans of the wars in Iraq, defined as costs of treatment, forgone productivity, and lives lost through suicide, was $4–6 billion over a 2-year period.

Beyond the 2 million veterans of the wars in Iraq and Afghanistan, about 4 million parents have had a child deployed, 2 million children have had a parent deployed, and 1 million spouses have coped with deployment. During the height of these wars, the number of military children receiving outpatient mental health care doubled. Long and repeated deployment affects academic performance and causes depression and anxiety as well as physical health problems in children.

Finally, we have recently been informed of the military's shameful treatment of service personnel who have been victims of sexual trauma while on active duty. In 2012 over 26,000 men and women in the military were subject to some level of unwanted sexual contact. This represents an almost 40% increase from 2011. Many of the allegations involved nonconsensual sodomy, aggravated sexual assault, and rape. Yet, only a bit more than 12% of these violations was reported and a mere 302 incidents were actually prosecuted. In recent years, more than 22,000 males and almost 20,000 females have been treated by Veterans Administration mental health personnel for sexual trauma.

> *If there were a PTSD diagnosis in the 1940s he certainly would have been seen as suffering from it.*

My concern about this state of affairs led me, when I was APA president in 2013, to ensure that psychologists are in the forefront of providing behavioral health services to military personnel, veterans, and their families. I implemented this presidential initiative by presenting 21 hours of presidential programming on military issues at the 2013 APA convention in Hawaii. I was especially interested in papers and symposia that described innovative and evidence-based assessments and interventions.

Two personal sources further increased my interest in helping veterans and military families. First, I saw the toll World War II took on my father, who served in North Africa and Europe from 1942 to 1946. He was a combat engineer who helped destroy and rebuild the Bridge at Remagen, and he participated in the Battle of the Bulge. He earned two Bronze Star medals and two Purple Hearts as a result of war wounds. And, from his beginnings as a private in 1942, he rose during his reservist years to become one of the few Jewish generals in the U.S. Army. But when he returned home in 1946 he was essentially silent. He rarely spoke, never watched a war movie, refused to talk about his combat experience, and had frequent violent nightmares. If there were a PTSD diagnosis in the 1940s he certainly would have been seen as suffering from it. As a result of his almost lifelong silence, and my virtual separation from him from the time I was 2 until I was 7 years old, I have always regretted that we never had a close relationship.

The second course of my interest comes from my own experience as U.S. Air Force clinical psychologist from 1965 to 1968, 2 years of which I spent in Southeast Asia during the Vietnam War. I saw firsthand the damage war can have on the mind and the body, not only for those who serve but on their partners and their children.

In addition to allotting 21 hours of presentations on services to military personnel, veterans, and their families during my Presidential Track at the Hawaii convention, I also honored three psychologists during the convention's opening session. I gave a presidential citation to Jon Nachison, a counseling psychologist who started Stand Down in San Diego, which provides physical and mental health services to homeless veterans. In 2011 Jon and Stand Down were featured in a segment on *60 Minutes*.

I also awarded a presidential citation to Barbara Van Dahlen, who founded Give an Hour. Through Give an Hour psychologists and other mental health professionals donate at least 1 hour of their time providing counseling and therapy to military personnel and veterans. In 2012 *Time* magazine added Barbara to its list of 100 most influential people in the world.

In addition, I presented a Lifetime Achievement Award to Antonette Zeiss, who recently retired as the head of mental health services for the Veterans Administration. She is the first woman and the first psychologist to assume that role. Finally, I arranged for the showing of *The Invisible War*, a documentary about military sexual trauma that was nominated for an Academy Award in 2013.

It was a privilege serving as the 2013 APA president. But it was a more particular privilege to advocate for psychological services for our military personnel, veterans, and their families. I urge you to volunteer your time toward this effort.

Evidenced-Based Treatments for Veterans With PTSD

Marian Bova, PsyD

Dr. Marian Bova

"War is hard, but coming home isn't exactly easy" (author unknown). Resuming normal life after war can be difficult. It often catches veterans by surprise because the belief is that adjustment issues and posttraumatic stress disorder (PTSD) "happen to other people."

Deployment to war zones gives veterans unique experiences that differentiate them from civilians: issues with preparedness, combat exposure, the aftermath of battle, and the perceived and real threat of danger; prolonged difficult living and working environments; sights, sounds, and smells of war; family concerns back home; sexual assault, gender harassment, and ethnic and cultural issues, just to name just a few.

Not every veteran who returns from war needs psychological treatment. Studies (Riggs, Rothbaum, & Foa, 1995) have shown that the majority of people who experience traumatic events will recover naturally.

But some veterans will return home with one or more life-altering traumatic events etched into their minds. Their lives become disrupted. Their marriages become rocky. They become socially isolated. Their tempers flare. Their jobs become unstable. Their patience and tolerance is low. Their anxiety and depression increase dramatically. Or maybe their use of drugs and alcohol escalates. In these cases, psychological treatment becomes necessary for them to better adjust to civilian life.

Prevalence of PTSD

Statistics on the prevalence of PTSD in veterans vary widely. Norris and Sloan (2013) cited one study that found that as many as 23% of veterans who saw combat in Southwest Asia met diagnostic criteria for PTSD according to their self-report. Other studies estimated that 12% of veterans returning from Afghanistan and 18% of veterans returning from Iraq met criteria for PTSD. It is estimated that prevalence of PTSD in Afghanistan veterans will now be higher because intensity of combat in Afghanistan had increased since the study was conducted. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) calculated percentages of PTSD in veterans in the following war zones: Vietnam, 9.1; First Gulf War, 6.2; Iraq and Afghanistan, 13. PTSD prevalence in active-duty personnel from Iraq and Afghanistan appears similar (*VA/DoD Clinical Practice Guideline*, 2010). It is widely believed that more lengthy deployments and more extensive exposure to combat increased the risk of developing PTSD, perhaps up to 3 times higher (Kline et al., 2010). The long-term effects of multiple deployments continue to be investigated.

Suicide

In 2007 the VA began an intensive effort to reduce suicide among veterans by developing a comprehensive program that included educating the public about suicide risks, adding mental health resources, and tracking veteran suicides. All VA medical centers have suicide prevention counselors and programs. Yet every day about 22 veterans kill themselves. This rate is 20% higher than the VA's estimate in 2007. Robert Bossarte, an epidemiologist with the VA, determined that the rate of suicide is going up in the United States, and veterans are a part of the reason. Additional findings of the Kemp and Bossarte (2012) study found that most veteran suicides occur among those aged 50 and older. Veterans who are 49 years old and younger are below the average of their civilian counterparts in suicide completion. Veterans 29 years old and younger constitute the lowest suicide rate at 5.8%, compared to civilians at 24.4%. The Kemp and Bossarte (2012) report indicated that younger veterans from Iraq and Afghanistan are at lower risk for suicide than their comrades who are aged 50 and older. This data highly suggest that suicide prevention must continue to be a high priority, especially with older veterans.

Evidence-Based Treatments for PTSD

According to the VA, the DoD, and the Institute of Medicine, two of the most recommended and effective psychological treatments for veterans with identifiable traumatic stressors are cognitive-processing therapy (CPT) and prolonged exposure (PE) therapy.

■ ***Cognitive-Processing Therapy:*** CPT is a 12-session, trauma-focused, manualized therapy that has proven effective for symptom reduction following traumatic events (Resick, Monson, & Chard, 2010). CPT can be administered in either individual or group format. Therapy begins with the trauma memory and focuses on feelings, beliefs, and thoughts that directly originated from the traumatic event. The therapist helps clients examine whether the trauma appeared to disrupt or confirm beliefs prior to this experience. Veterans are taught to challenge their self-statements by using a Socratic style of therapy, which facilitates the veterans' understanding of their reasoning process and beliefs. The process helps bring extreme beliefs into balance.

In the early stages of CPT, the focus is typically on self-blame. To illustrate, a veteran from Afghanistan believed that he was totally responsible for a failed mission because his .50 caliber machine gun jammed during a firefight. He blamed himself for the weapon jamming. Following this event, the veteran believed he was incompetent and worthless. The veteran's PTSD Checklist (PCL) score at session #1 was 61. CPT progresses systematically through common areas of cognitive disruption: safety, trust, control, esteem, and intimacy. Overaccommodated beliefs on these themes are challenged.

Toward the end of CPT treatment, the veteran was able to challenge his faulty cognitive reasoning. He concluded that he did the best he could in a difficult situation because the

Continued on Page 20

EVIDENCED-BASED TREATMENTS

Continued from Page 19

weapon worked properly during test fire. He considered that many other factors contributed to the mission outcome, including the extremely rough terrain, which had the Humvee bouncing over rocks. The finicky nature of the weapon also contributed to the problem. The veteran's PCL score at session #12 was 37.

Efficacy of CPT: More than two decades of investigative studies of CPT with veterans with combat and sexual trauma support the efficacy of CPT. A trial of CPT conducted within the Veterans Health Administration provided some of the most compelling results thus far for the use of this particular evidence-based treatment for military-related PTSD (Monson et al., 2006). More than 75% of the veterans in this study had fought in Vietnam; 40% of all of the participants who were assigned to receive the treatment had a remission in their PTSD at posttreatment. Results demonstrated significant improvements in both clinician- and self-reported PTSD symptoms; 40% did not meet criteria for PTSD, and 50% had a reliable change in the PTSD symptoms posttreatment assessment. The positive effects of CPT extended beyond PTSD symptoms of depression, general anxiety, affect functioning, guilt, distress, and social adjustment. Regarding the sustainability of CPT improvements, it is also encouraging that veterans continued to report improvements in PTSD symptoms, coping style, and quality of life (Alverez et al., 2011).

The *VA/DoD Clinical Practice Guideline* (2010) recommends CPT at the highest level, stating that it is their "strong recommendation that the intervention is always indicated and acceptable."

■ ***Prolonged Exposure Therapy:*** PE is an effective first-line treatment for PTSD, regardless of the type of trauma, for veterans and military personnel. PE treatment consists of 9–15 weekly or semiweekly treatment sessions that are generally 90 minutes in length. The PE protocols include components of psychoeducation, in vivo exposure, imaginal exposure, emotional processing, coping skills training, breathing retraining, and cognitive restructuring. It is designed to help veterans effectively confront their trauma-related emotions and painful memories. It is distinguished from simple discussion of traumatic experience in that it emphasizes repeated verbalization of traumatic memories. Veterans are exposed to their own individualized fear stimuli supplemented by therapist-assigned exposure and monitored self-exposure to the memories associated with the traumatic event.

PE has emerged from the emotional processing theory (EPT) of PTSD, which emphasizes the central role of successfully processing the traumatic memory to reduce the negative impact of PTSD symptoms (Foa, Hembree, & Rothbaum, 2010). PE helps people with PTSD correct faulty perceptions of danger, improve sense of control of memories and accompanying negative emotions, and strengthen adaptive coping responses under conditions of distress.

A veteran from Iraq, for example, was on a recovery mission at an aircraft crash site. One pilot was dead and the other was still "gurgling." Human flesh was everywhere. Soon after arriving at the crash site, they came under hostile fire, leaving the veteran and his team in an intense situation.

After returning from Iraq, this vet had significant sleep difficulties, serious legal issues, and job problems resulting from his raging temper. At his first PE session, his PTSD Symptom Scale–Interview (PSS-I) score was 46. Treatment for this veteran was extended to 17 sessions. Techniques used with this veteran were breathing retraining, in vivo exposure, and imaginal exposure (the biggest part of his treatment). At the end of session #17, this veteran's PSS-I was 9. His sleep returned to a normal 7 or 8 hours per night. He went shopping with his wife and was able to sit anywhere in church (and not limited to the back pew). One year later on follow-up, this veteran's PSS-I was 6.

Efficacy of PE: Studies have shown that patients treated with PE fared better than 86% of patients in control conditions at posttreatment on PTSD measures. It is effective in reducing PTSD symptomology and maintained results over time (Powers, Halpern, Ferenschak, & Foa, 2010). Extensive research and clinical practice guidelines from various organizations support this conclusion. PE has also demonstrated efficacy in reducing comorbid issues such as anger, guilt, negative health perceptions, and depression.

PE's efficacy extends to diagnostically complex populations and survivors of single- and multiple-incident traumas (Rauch, Eftekkari, & Ruzek, 2012). In light of PE's efficacy, the VA designed and supported a PE training program, training well over 1,300 mental health professionals in PE. Research examining the mechanisms involved in PE and working to improve its acceptability, efficacy, and efficiency is underway with promising results.

References

Alverez, J., McLean, C., Harris, A. H., Rosen, C. S., Ruzek, J. I., & Kimerling, R. (2011). The comparative effectiveness of cognitive processing therapy for male veterans treated in a VHA posttraumatic stress disorder residential rehabilitation program. *Journal of Consulting and Clinical Psychology, 79*(5), 590–599.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2010). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences. Therapist guide.* New York, NY: Oxford University Press.

Kemp, J., & Bossarte, R. (2012). *Suicide data report*. Washington, DC: Department of Veterans Affairs.

Kline, A., Falca-Dodson, M., Sussner, B., Ciccone, D.S., Chandler, H., Callahan, L., & Losonczy, M. (2010, February). Effects of repeated deployment to Iraq and Afghanistan on the health of New Jersey Army National Guard troops: Implications for military readiness. *American Journal of Public Health.100*(2): 276–283.

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 7*(5), 898–907.

Norris, F., & Slone, L. (2013). Understanding research on the epidemiology of trauma and PTSD. *PTSD Research Quarterly, 24*(2-3).

Powers, M. B., Halpern, J. M., Ferenschak, M. P., & Foa, E. B. (2010). *A meta-analytic review of prolonged exposure for posttraumatic stress disorder*. University of York: Centre for Reviews and Dissemination.

Rauch, S. A., Eftekkari, A., & Ruzek, J. (2012). Review of exposure therapy: A gold standard for PTSD treatment. *Journal of Rehabilitation Research and Development. 49*(5), 679–687.

Resick, P. A., Monson, C. M., & Chard, K. M. (2010). *Cognitive processing therapy: Veteran/military version*. Washington, DC: Department of Veterans Affairs.

Riggs, D. S., Rothbaum, B. O., & Foa, E. B. (1995). A prospective examination of symptoms of posttraumatic stress disorder in victims of non-sexual assault. *Journal of Interpersonal Violence, 10*, 210–214.

VA/DoD clinical practice guideline for management of post-traumatic stress. (2010, October). Washington DC: Department of Veterans Affairs/ Department of Defense.

Together Again: A Brief Look at Families After Deployment

Amy Roth, MS

Although returning from deployment is primarily a happy time, it also involves stressful adjustments for all family members (American Psychological Association, 2007). In general, military children and families have shown great resilience (Park, 2011). Some families, however, experience deployment as a burden that can result in divorce and other family-related problems, including difficulty reconnecting (Shaw & Hector, 2010).

According to Pincus, House, Christenson, and Alder (2001), there are five stages of extended deployment, which is defined as lasting 6 months or longer. Each stage is characterized by specific challenges and tasks military personnel and their families are likely to face. This paper will focus on the final stage, referred to as postdeployment.

According to Pincus et al. (2001), postdeployment begins when military personnel return to their home station and typically lasts 3–6 months, although it may last much longer. It is critical during this stage that families are patient, communicate frequently, lower expectations, and take things slowly, spending time getting to know each other again (Pincus et al., 2001).

One common frustration around homecoming is that the return date may change or be given on short notice. This can interfere with the family's ability to meet the returning soldier, leaving him or her feeling unimportant or unwelcome. In addition, expectations for the return may not be met. For example, the soldier may hope to be welcomed home as a hero but receive little or no acknowledgment from family or community. Commonly, the reunion is followed by a "honeymoon" period, which includes the physical reunion of the soldier with the spouse and family. For some military personnel, however, the emotional reconnection may be challenging or take more time than expected.

In a 2012 study by Hinojosa, Hinojosa, and Hognas, soldiers described a strain in their relationships due to communication issues encountered during deployment. These difficulties with communication were usually related to one of three issues: restrictions imposed by military operational security on what information could be shared, technical problems with the communication equipment (i.e., poor or lacking Internet and phone service), and having "nothing new to say." Often, this prohibited the soldier's family members from fully understanding the experiences of deployment, creating a strain in the family's relationships during reintegration.

Further, when deployment included traumatic experiences, family relationships tended to suffer (Baptist et al., 2011). Allen, Rhodes, Stanley, and Markman (2010) studied 434 couples consisting of husbands who were in the army and deployed within the previous year, as well as their civilian wives. This study found that deployment was related to higher levels of posttraumatic stress disorder symptoms for the soldier, which is associated with lower levels of a number of relationship markers, including marital satisfaction, confidence in the relationship, bonding between the spouses, parenting alliance, and dedication to the relationship. It was also associated with higher levels of negative communication for both spouses.

It is essential that soldiers are able to reestablish their role within their family.

Returning soldiers often want to reestablish their role in the family, take back their responsibilities, and make up for lost time (Pincus et al., 2001). It is essential that soldiers are able to reestablish their role within their family, but this can be quite challenging and require great patience. One reason for this difficulty is that things will inevitably be different from when they left: Children have grown, personal priorities have changed for both spouses, and the home spouse is likely more independent and may experience a sense of loss upon the soldier's return (Pincus et al., 2001).

If, for example, the spouse took over the soldier's role of managing the family budget, the spouse may resist giving this role back to the soldier upon his or her return. However, service members expressed appreciation when

Continued on Page 22

TOGETHER AGAIN

Continued from Page 21

their spouse was able to give them the opportunity to ease back into their roles as they were ready (Baptist et al., 2011). Additionally, civilian spouses may feel that their difficult experiences of coping with deployment are unappreciated, may resent having been "abandoned" during the deployment period, and may feel distress related to the changes that are made in order to incorporate the soldier back into the home (Pincus et al., 2001).

The reunion between the soldier and children also may be challenging at times. Children have to deal with many stressors during the deployed parent's absence, including missing the parent, fearing for his or her safety, and not having the parent available during important occasions such as holidays, birthdays, and school or sporting events (Moore & Kennedy, 2011). They also may have worried about how the home parent was coping with the deployment. Additionally, Moore and Kennedy (2011) point out that the children will have grown and developed in ways that are natural and unrelated to the deployment. Quite literally, the children are not the same as they were when the soldier deployed.

The age and developmental stage of the children in the family during this time will determine their response to deployment and postdeployment (Pincus et al., 2001; Moore & Kennedy, 2011). Babies who are 1 year old or less may not know or remember the soldier upon return. They may cry when held or react to the soldier as they do to strangers. It is important for the soldier to remember that this is a matter of brain development and memory formation, not an indication of poor parenting (Moore & Kennedy, 2011). Toddlers (ages 1–3) may take longer to warm up to the returning parent than older children. Preschoolers (ages 3–6) may respond to having experienced feelings of guilt or fear related to the separation. School-age children (ages 6–12) may be especially clingy and attention seeking upon the soldier's return. In addition to having missed the parent, these children may fear that the soldier will have to leave again.

It is equally important to pay attention to each family's unique struggles and strengths.

Teenage children can be less predictable in their response. They may be moody, indifferent, or outright hostile toward the returning parent. Often, out of loyalty to the home parent, they reject the soldier's attempts at discipline or reestablishing roles within the family. Over time, these reactions typically lessen and disappear.

According to the Demographics Profile of the Military Community report, as of 2011, there were more than 3.6 million military members. Eric K. Shinseki, secretary of Veterans Affairs and former U.S. Army chief of staff, reported that soldiers' morale, retention, and ability to successfully complete missions is enhanced by positive family functioning (2003). Therefore, even if one's focus is on supporting the soldiers, it is critical that the entire family be considered.

Although military families typically experience many of the challenges described above, it is important to note that each deployment is different, each family is different, and each individual within the family is different. It helps to understand the typical experiences of the military community, but it is equally important to pay attention to each family's unique struggles and strengths. Listen to their specific experiences and help them articulate their particular needs. And remember to include the family's perspective, as well as the service member's perspective, whenever working with returning military personnel. Deployment is, after all, an event for the entire family.

References

Allen, E. S., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2010). Hitting home: Relationships between recent deployment, posttraumatic stress symptoms, and marital functioning for army couples. *Journal of Family Psychology, 24*(3), 289–288. doi: 10.1037/a0019405

American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members. (2007). *The psychological needs of U.S. military service members and their families: A preliminary report*. Washington, DC: American Psychological Association.

Baptist, J. A., Amanor-Boadu, Y., Garrett, K., Goff, B. S. N., Collum, J., Gamble, P., . . . Wick, S. (2011). Military marriages: The aftermath of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployments. *Contemporary Family Therapy, 33*, 199–214.

Hinojosa, R., Hinojosa, M. S., & Hognas, R. S. (2012). Problems with veteran-family communication during Operation Enduring Freedom/Operation Iraqi Freedom military deployment. *Military Medicine, 177*(2). 191–197.

Moore, B. A., & Kennedy, C. H. (2011). *Wheels down: Adjusting to life after deployment*. Washington, DC: American Psychological Association.

Park, N. (2011). Military children and families: Strengths and challenges during peace and war. *American Psychologist, 66*(1), 65–72. doi: 10.1037/a0021249

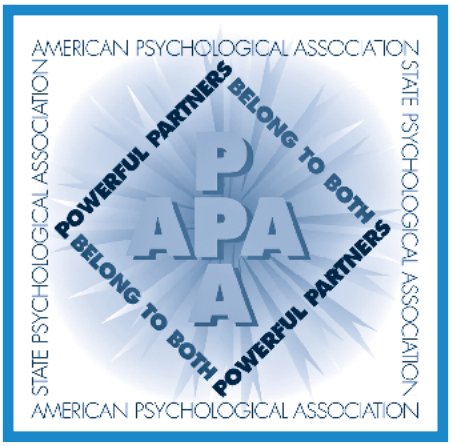
Pincus, S. H., House, R., Christenson, J., & Alder, L. E. (2001). *The emotional cycle of deployment: A military family perspective.* Retrieved from http://4h.missouri.edu/programs/military/resources/manual/Deployment-Cycles.pdf

Shaw, M. E., & Hector, M. A. (2010). Listening to military members returning from Iraq and/or Afghanistan: A phenomenological investigation. *Professional Psychology: Research and Practice, 41*(2), 128–134. doi: 10.1037/a0018178

Shinseki, E. K. (2003). *The army family: A white paper.* (CMH Pub 70-84-1). Retrieved from http://www.whs.mil/library/Dig/ARM620U_20080912.pdf

Welcome, New Members

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between November 1, 2013, and February 15, 2014!



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Junior ROTC at South Philadelphia High

Barbara Gelman, PhD, bgelman@philasd.org

Dr. Barbara Gelman

I have the privilege of working as school psychologist at South Philadelphia High School (SPHS). Unlike magnet or special admission schools, SPHS is a comprehensive school, meaning we serve a general population, including regular education, itinerant special education, autistic, and life-skills students. There are American-born students as well as students from Asia and West Africa. The school offers advanced placement (AP) courses, English for Speakers of Other Languages (ESOL), culinary arts and vocational programming, along with a full sports program. "Southern" also has a Junior Reserve Officers' Training Corps (JROTC) program. I recently interviewed First Class Sgt. Timothy Mack to learn more about it.

JROTC is the high school version of the college program that prepares students for military service as officers. Institutions that prohibit or prevent ROTC on their campuses can be denied federal funding (H.R. Res. 580, 2004). Junior ROTC began in 1916 as part of the National Defense Act and is designed to instill citizenship, patriotism, and self-reliance.

SPHS has hosted a JROTC for 18 years, and Sergeant Mack has been part of the program for 8. Currently, he and Major Alfredo Astillero run the program. Eighty-two students are part of JROTC at SPHS; some of these students request JROTC and others have the program rostered into their schedules. Students receive elective credit for JROTC participation. Almost half of the JROTC students at SPHS are girls. The school program has four components: uniform, leadership, flag, and conflict resolution. It follows a military structure with a chain of command that starts with commander followed by executive officer and senior sergeant. Sergeant Mack and Major Astillero choose the commander each year who receives the flag at a year-end ceremony.

The daily schedule of JROTC students varies. Students have coursework Mondays and Wednesdays (using a web-based JROTC curriculum), gym Tuesdays, uniform and drill Thursdays, and cardiovascular gym class Fridays. Before class begins, students say the Cadet Creed and Pledge of Allegiance. A student who is tardy is not allowed to join the class before reciting these expressions of loyalty. Sergeant Mack explained that this is a form of self-discipline and students respond positively to attempts to instill discipline.

If students do not meet the criteria required for participation in JROTC they are dropped from the program. Sergeant Mack removes about 15 students per year from JROTC, generally for class cutting and poor attitude. JROTC students are expected to be exemplary and, as such, to avoid fighting, cutting class, and other negative behavior. They are told they must not disgrace their uniform. Students wearing their uniforms and shiny shoes on Thursdays are an impressive sight.

> *This is a form of self-discipline and students respond positively.*

In addition to classes, extracurricular activities include drill team and color guard, academic team, and military fitness. Twenty-eight students participate in drill team, which practices regularly for five yearly competitions; in November 2013, SPHS's JROTC drill team took first place in overall performance in competition! The four-person academic team answers questions via a website. A military fitness team began practice in February for an April competition in the areas of first aid, orienteering, and navigation.

Sergeant Mack believes self-esteem is built though self-discipline and that one of the nice things about JROTC is that you "don't have to be a super jock or the best looking" to participate. Expectations for everyone are the same. Students tend to socialize and some prefer to eat lunch in the JROTC room rather than in the school's cafeteria. Recently, an organization called Red, White and You provided tickets to this year's Army–Navy game. Sixteen SPHS students received tickets, food, and a bus ride to the stadium to watch this storied matchup on a cold Saturday afternoon.

Sergeant Mack indicated that JROTC classes have regular education, ESOL, and AP students, as well as some special education students. Reflecting the school's population, the JROTC program includes students from West Africa, China, Nepal, and the Philippines. He would prefer more students be enrolled in JROTC. Given the problems at SPHS, this psychologist believes more parents might be interested in JROTC for their children if they learned more about what it offers students.

A few words about Sergeant Mack: He is the youngest of 12 children, seven of whom served in the army along with their father. He received his JROTC teaching certificate upon retirement from the army and went on to take the state Praxis exam. His work is important to him, but Sergeant Mack also states that "Teaching is fun." On September 11, 2013, JROTC students, in uniform, raised the American flag, reinstituting the practice at SPHS for the first time in years.

A School Psychologist's Perspective

Ninety-seven percent of SPHS students are deemed economically disadvantaged. Number of years spent in poverty is one factor associated with academic and behavior adjustment problems in children. In addition demographic risk factors associated with poverty include absence (presence) of father figure, mother's level of education, and number of children in the home (Dubow & Ippolito, 1994). Given such findings, it is safe to say that a number of SPHS students face considerable barriers to educational success. Psychological

Continued on Page 26

Is Psychological Private Practice Dying in the State of Pennsylvania?

Timothy L. King, PhD, drkingtesting@gmail.com

Dr. Timothy L. King

At the June 2013 convention, one of the attendees at the Leadership Seminar asked the presenter whether she had any observations to share with PPA after spending several days with its members. The presenter paused for a moment and then stated, "When I looked at your membership rolls, it is clear you have a lot of older members." My concern parallels that observation: Not only do we need to attract more psychologists of all ages to PPA but we also need to encourage them to consider private practice as a viable career option.

When I first entered the world of psychological private practice in the fall of 1981, I worked for a large private practice organization. Over the years, I worked my way up "through the ranks" and eventually became a clinician/administrator in charge of the part-time clinicians working their way toward licensure. Each year they stayed in the organization they not only gained the hours needed for licensure but they increased their knowledge of what it takes to be self-employed as a psychologist. That knowledge included the therapeutic and diagnostic skills needed to be a competent professional, as well as the marketing strategies and business tools necessary for running a successful practice. The latter included scheduling, setting and collecting fees, managing files, working with insurance companies, hiring clerical staff, and consulting with fellow group members to avoid ethical violations.

When I left the private practice group and started my own practice, I continued supervising psychologists who were working toward licensure. If they worked in my practice, I could sign insurance forms as a supervisor, and the psychologists would receive reimbursement for their patient hours. Eventually supervisees accrued enough hours for licensure and either moved up in my organization or moved out on their own to create the next generation of private practitioners. Those who worked hard and developed areas of specialization did well, both financially and in terms of personal satisfaction. It seemed this would continue for generations to come. That is, until managed care arrived and "slammed the door" on the ability of a supervisee, even if closely monitored and well supervised, to receive reimbursement. Within a period of 3 months, four psychologists I was supervising lost thousands of dollars because insurance carriers decided to stop reimbursement. So began the erosion of a critical segway for "private practice hopefuls."

There is no question that there are fewer avenues for psychologists to learn the ropes of private practice. I turn away many well-trained clinicians hoping to move from the public sector into private practice. In addition, insurance reimbursements for psychotherapy have steadily declined, and the software that is becoming essential for billing is expensive.

So how do "newcomers" get into the private practice world? A few options include (a) working for reduced fees with no insurance reimbursement while working under supervision, (b) performing diagnostic testing under the supervision of a licensed psychologist and being paid as a technician, and (c) working at a university mental health clinic. The options are limited and do not provide financial incentives that even begin to compare to those that were available 20 years ago.

Further, some of the university faculty members of PPA's Board of School Psychology have begun to express concerns about an "internship crisis," noting that it is becoming increasingly difficult to find sites for clinicians that will give them the experience and training they need to advance in their careers. PPA's listserv recently published an e-mail noting that some clinicians are considering a move out of "solo" private practices into group practices, apparently as a venue to respond to declining reimbursements and increased costs of being in private practice.

There are fewer avenues for psychologists to learn the ropes of private practice.

Fortunately the news is not all bad. More children are slated to receive mental health coverage under "Obamacare," so there may be an increased willingness for parents to seek out services in private settings for their children. Even more importantly, psychologists who have specialty niches are still thriving, even when clients are fully reimbursed for the services they receive. Not a month goes by when I do not have at least a half dozen individuals who I cannot see and need to refer, not only because of time and geography but because they have specialized therapy needs. A quick look at the listserv suggests I am not the only clinician who regularly looks for psychologists to refer to.

So, despite the fears of many, we private practitioners are not dying. There is every reason for clinicians coming into the field, as well as more experienced psychologists, to believe that private practice can be a pathway toward a professionally and financially rewarding career in psychology. The road is "rocky" but not closed.

For example, Dr. Joseph Bavonese, director of the Relationship Institute in Michigan, recently observed that if you believe that what you do as a psychologist is helpful and even unique, then you have a responsibility to "get the word out," or

Continued on Page 26

JUNIOR ROTC AT SOUTH PHILADELPHIA HIGH

Continued from Page 24

evaluation results of these students suggest they frequently lack both academic and organizational skills.

The discipline required for JROTC may help students manage stressors associated with economic disadvantage and lessen incidents of negative behavior such as fighting and class cutting. One way to measure an "enhanced self-discipline effect" would be to compare attendance and discipline records of JROTC students with those in the general student population. Admittedly, behavior ratings for JROTC students should be better or "controlled" as Sergeant Mack weeds out the least cooperative students.

A second line of inquiry might examine the extent to which JROTC students, accustomed to structure and demands for self-discipline, can profit from learning organizational techniques such as "chunking" assignments into manageable parts and outlining subject matter for exam preparation. Comparing grades pre- and postintervention would be one means of measuring any effect. If training is effective such findings may generate a means to adapt organization and study training for groups of non-JROTC students.

The above empirical investigations could generate support for the multiple benefits Southern's JROTC program appears to offer students and may also motivate other high schools to expand their JROTC programs.

References

H.R. Res. 580, 108th Cong., 150 Cong. Rec.—House 5628 (2004) (enacted)

Dubow, E., & Ippolito, M. (1994). Effects of poverty and quality of home environment on changes in the academic and behavioral adjustment of elementary school-age children. *Journal of Clinical Child Psychology, 23*, 401–412.

IS PSYCHOLOGICAL PRIVATE PRACTICE DYING?

Continued from Page 25

to let people know what and where your services are as well as how to obtain them (Bavonese, 2013). More specifically he stated:

> In today's world, the traditional means of getting the word out—a discrete ad here, a few hints to colleagues there, some folders or business cards sprinkled around town, even a website with your impressive credentials listed in chronological order—won't remotely cut it. In a sound-bite-saturated world of information overload . . . having a brand that stands out is probably the only way you'll have a chance of capturing the attention of potential clients. . . .Your brand individuates you and what you do from the huge genetic category of others. (p. 34)

Bavonese (2013) later added, "Psychotherapy is among the most rewarding types of work when you are passionate about the issues you work with, but if you don't truly love what you do, your brand will fail" (p. 37).

I hope the above thoughts and attached reference encourage psychologists who are considering private practice to start working to develop a "brand" and not give up the goal of a personally and financially satisfying career in private practice in Pennsylvania.

Reference

Bavonese, J. (2013, September/October). What's in a Brand? *Psychotherapy Networker, 37*(5), 32–37.

Frank Dattilio Recognized With AAMFT Award

Dr. Frank Dattilio

"Dr. Dattilio has devoted his life to bringing harmony to families and to the training of those who can carry on the AAMFT mission."

– Cloé Madanes, chair of the board for the Council for Human Rights of Children

In October the American Association for Marriage and Family Therapy (AAMFT) honored University of Pennsylvania School of Medicine faculty member Frank Dattilio, PhD, ABPP, with the 2013 Outstanding Contribution to Marriage and Family Therapy Award. The award, which recognizes exception and significant contributions to the field of marriage and family therapy, was formally given to Dr. Dattilio during the association's annual conference in Portland, Oregon.

Erin Schaefer, member of the AAMFT Board of Directors and chair of its awards committee, noted that, "[Dr. Dattilio] has been a leader in the promotion of cognitive-behavioral therapy with couples and families for several decades."

Dr. Dattilio has delivered numerous lectures around the world and developed written works in 30 languages available in over 80 countries. He currently serves as a faculty member with the Department of Psychiatry at Harvard Medical School and at the University of Pennsylvania, Perelman School of Medicine, where he is responsible for training psychiatric residents in the use of marriage and family therapy techniques.

He has also made significant humanitarian contributions to underprivileged nations around the world in the form of scholarship funds and training time. Cloé Madanes, chair of the board for the Council for Human Rights of Children, which Dr. Dattilio serves on, remarked, "Dr. Dattilio has devoted his life to bringing harmony to families and to the training of those who can carry on the AAMFT mission."

AAMFT is the professional association for the field of marriage and family therapy. They represent the professional interests of more than 50,000 marriage and family therapists throughout the United States, Canada, and abroad. For more information, visit www.aamft.org.

Act 26 Sets Payment Limits for Copying Records

Under 42 Pa.C.S.§6152 and 6155 (relating to subpoena of records and rights of patients), the secretary of health is directed to adjust annually the amounts that a health care facility or health care provider may charge upon receipt of a request or subpoena for production of medical charges or records. Because the law specifically references "health care providers," as opposed to just physicians, PPA believes that the law applies to psychologists.

Effective January 1, 2014, the following payments may be charged by a health care facility or health care provider for production of records in response to a subpoena:

	Not to Exceed
Search and Retrieval of Records	$21.33
Amount charged per page for pages 1–20	1.44
Amount charged per page for pages 21–60	1.06
Amount charged per page for pages 61–end	0.35
Amount charged per page for microfilm copies	2.12

In addition to the amounts listed, charges may also be assessed for the actual cost of postage, shipping, and delivery of the requested records.

In addition, the secretary sets a flat fee for the purpose of supporting a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program or a request made by a district attorney. The flat fee a psychologist can charge for a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program is $27.02 plus charges for the actual cost of postage, shipping, and delivery of the requested records. The flat fee a psychologist can charge for a request made by a district attorney is $21.33 plus charges for the actual cost of postage, shipping, and delivery of the requested records.

Requests from independent or executive branch agencies of the government are exempt from the record copying fee requirements. This law does not apply to copying required by insurance companies to monitor services under an insurance contract. The rate is increased annually according to the Consumer Price Index.

The law does not alter the requirement that psychologists must have a signed release from the patient before releasing the information to a third party.

CE Questions for This Issue

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

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

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before March 31, 2016.

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

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

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

Knapp, Tepper, & Baturin

1. It is recommended that once a minor turns 14, the psychologist obtain the consent of the minor prior to releasing any treatment records generated prior to or subsequent to the minor turning 14.
   True
   False

2. It is important to clarify and document at the onset of treatment:
   a. Who may serve as collateral contacts during the course of treatment
   b. Who the active members of treatment are
   c. Who made the initial appointment for therapy
   d. Who wishes not to participate in therapy

Bersoff

3. The economic cost of posttraumatic stress disorder in veterans of the wars in Iraq over a 2-year period is estimated to be between:
   a. $1–2 billion
   b. $4–6 billion
   c. $2–4 million
   d. $4–6 million

Bova

4. Studies suggest that the majority of people who experience traumatic events require psychological treatment to reach recovery.
   True
   False

5. The highest veteran suicide rate occurs within the following age range:
   a. 50 years and older
   b. 30–49 years
   c. Less than 29 years
   d. The rate is consistent through age groups

Roth

6. By the time military personnel return to their home station, family members should be doing all of the following except:
   a. Communicating frequently with the soldier
   b. Lowering expectations
   c. Quickly returning to the relationship they had prior to deployment
   d. Getting to know each other again

7. Communication issues encountered during deployment are usually related to:
   a. Restrictions imposed by military operational security on what information can be shared
   b. Having "nothing new to say"
   c. Technical problems with the communication equipment
   d. All of the above

Gelman

8. Being involved in JROTC may have negative consequences for students, including increased fighting and class cutting.
   True
   False

King

9. Private practice in psychology in the state of Pennsylvania is a dying profession and should be avoided by those entering and already in the field.
   True
   False

10. If you want to make others aware of what you do and how valuable it is, set up a website with all of your credentials and wait for people to respond.
    True
    False

Zuckerman

11. Veterans report that the telehealth program is inconvenient, cold, and impersonal.
    True
    False

12. Soldiers report preferring in-person mental health screening over telecommunications.
    True
    False

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, March 2014

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

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

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I verify that I personally completed the above CE test.

Signature_____ Date_____

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

Telepsychology and the Military

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

Dr. Ed Zuckerman

Militaries have always loved technology,[1] and because we are committed to endless war we see technological leadership by our armed forces. Besides weapons and the weaponization of other technologies at least three technologies relevant to psychologists' work are increasingly being used.

First, the Veterans Administration (VA) and the active military are trying to mesh (interoperate is the technical term) their different electronic health records for improved communication and care. They are having great difficulty and have failed several deadlines. Their example is the only one I know in which sincere effort is combined with sufficient resources and full support from the leadership but the poor outcome does not auger well for similar and needed civilian efforts. The parallel is the offer of financial carrots (but mostly sticks) through the meaningful use of two components of the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A second area of current success and even greater promise is the use of virtual reality (VR) for training, by simulating battle spaces just as video games now do, and the use of VR in therapy and rehabilitation. Two diagnostic foci are cognitive rehabilitation for traumatic brain injuries (TBIs) and the treatment of posttraumatic stress disorder (PTSD).

Lastly, and most relevant to practitioners, is the use of electronic telecommunications for therapy. Telemedicine started with the military and has reached its highest development in that arena because of the need and the available funding. Beginning more than 20 years ago the military recognized the value of making available the medical specialists located in major care centers for the treatment of injuries to sailors at sea and soldiers in remote locations.

These technologies have been carried through to postcombat services from the VA. Girard (2007) found the following:

> Telemedicine . . . allow[s] the surveillance and care of patients who are isolated by geography, poverty, and disability. In military settings, telemedicine is being widely used to identify injury and illness and aid in the treatment, rehabilitation, and recovery of combat-wounded soldiers in theater. . . . transforming the way clinicians provide care, education, and support to patients with traumatic brain injury (TBI) and their families. . . . [These] technologies . . . enhance the *identification* [emphasis added] of TBI, *management of symptoms in theater* [emphasis added], and application of proven technologies (interactive video, Internet, and World Wide Web) to improve overall *care coordination* [emphasis added] throughout military and VA systems. (p. 1017)

A recent study (Riegler, Neils-Strunjas, Boyce, Wade, & Scheifele, 2013) demonstrated the value of teletherapy. When a web-based videophone cognitive treatment for TBI was offered to those who were previously nonadherent to clinic-based therapy two-thirds of the participants completed the course of treatment. There was no difference in effectiveness between the two modalities.

Telecommunications could offer better allocation of scarce mental health resources. Here is a summary of a recent study (Hess, 2012) on this option:

> Service members returning from Iraq and Afghanistan often require substantial amounts of mental health care, causing surges in demand at military hospitals. . . . *service members and their families seek more care after each deployment. . . . [and] at higher rates in predictable intervals following their deployments. . . . [It is] very difficult for individual military hospitals to offer access to care using only their own mental health care providers. Allowing hospitals to share their providers with one another offers little improvement* [emphasis added]. . . . First, a service wide or joint scheduling system should be created. Second, telehealth can best support overburdened hospitals when some providers are dedicated solely to surge support.

The VA has implemented a telehealth (both medical and mental health) program on a large scale (Jordan, 2013): "About 80,000 veterans took part in more than 200,000 telehealth consultations with doctors and therapists in 2012." Of note is that these "telehealth conferences, consultations and therapy sessions are not recorded and are not made part of a veteran's health record." The VA notes the substitution of these programs for inpatient admissions has reduced "veterans' bed days by 58 percent and admissions by 38 percent." This program "allows DOD-contracted healthcare providers to treat patients in other states and countries where they are not licensed. Those directly employed by the DOD already get worldwide privileges at military treatment facilities with only one state medical license."

Telecommunications could offer better allocation of scarce mental health resources.

A different press report (Reed, 2013) on this program reports that veterans "value the convenience and don't feel like it's cold or impersonal." It also saves money: "A highly secure and stable video-teleconferencing system goes for roughly

[1] An old example is that the process of preserving food by sterilization and canning was created as a result of a prize offered by Napoleon. In 1810 Nicholas Appert, after 15 years of experimentation, won the prize.

$200,000—about the same as the cost to medevac a patient to the U.S. . . . If we can avert one transfer, it essentially pays for itself."

However, the results are not all so positive. Jones, Etherage, Harmon, and Okiishi (2012) found that soldiers prefer in-person mental health screening over telecommunications, that such screening is more expensive when there are time pressures, and that there are no cost savings with electronic methods.

From my perspective all of these suffer from the limitations of putting "old wine in new bottles." This is not new: Freud did therapy by mail ("Little Hans"); Rodgers' methods were computerized in the ELIZA program; some may remember the "bug in the ear" real-time supervision of therapy that was replaced with video recording of sessions for feedback and supervision; and the British National Health Service has been offering cognitive-behavioral therapy for many problems and populations by phone for years. Significant progress will only occur when new wine is brewed using such new bottles as wearable computing, multiple sensors, avatars, and not-yet-envisioned tools for our always-connected world.

Resources

- Jeffery Barnett argues that with ***forethought and attention to several key issues***, telepsychology innovations can be integrated into one's practice ethically, legally, and competently. "Key issues in telepsychology and the integration of technology into practice." November 14, 2013. Available from http://div46amplifier.com/2013/11/14/key-issues-in-telepsychology-and-the-integration-of-technology-into-practice/
- Ken Pope's superb site offers links to all the professional guidelines for telepsychology, citations to 177 recent articles, and links to state board policies and opinions all at http://bit.ly/kenpopetelepsychologyresources
- Two organizations provide all kinds of current information and resources for teletherapists: The International Society for Mental Health Online at www.ismho.org and the Association for Counselling and Therapy Online at http://acto-uk.org/

References

Girard, P. (2007). Military and VA telemedicine systems for patients with traumatic brain injury. *Journal of Rehabilitation Research and Development. 44* (7), 1017–1026. doi: 10.1682/JRRD.2006.12.0174

Hess, J. (2012). *Deployment related mental health care seeking behaviors in the U.S. military and the use of telehealth to mitigate their impacts on access to care.* (Master's thesis, Massachusetts Institute of Technology). Abstract retrieved from http://hdl.handle.net/1721.1/76102

Jones, M. D., Etherage, J. R., Harmon, S. C., & Okiishi, J. C. (2012). Acceptability and cost-effectiveness of military telehealth mental health screening. *Psychological Services, 9*(2):132-43. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22662728. PMID: 22662728

Jordan, B. (2013, July 31). VA touts telehealth program used by 80K vets. *Military.com News*. Retrieved from http://www.military.com/daily-news/2013/07/31/va-touts-telehealth-program-used-by-80k-vets.html

Reed, C. (2013, March 13). Telehealth offers hopes for better access to specialists, lower costs. *Stars and Stripes*. Retrieved from http://www.stripes.com/news/telehealth-offers-hopes-for-better-access-to-specialists-lower-costs-1.212850

Riegler, L. J., Neils-Strunjas J., Boyce S., Wade, S. L., & Scheifele, P. M. (2013). Cognitive intervention results in web-based videophone treatment adherence and improved cognitive scores. *Medical Science Monitor, (15)*19, 269–75. doi: 10.12659/MSM.883885

Classifieds

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[2] Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.

Vol. 74, No. 3

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2014 CE Calendar

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

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

April 28, 2014
Advocacy Day
Harrisburg, PA
Rachael Baturin, MPH, JD
(717) 232-3817

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

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

For CE programs sponsored by one of the regional psychological associations in Pennsylvania, visit http://www.papsy.org/index.php/collaboration-communication/.

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

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

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