ALSO INSIDE:

- Breaking diabetes treatment myths
- Call for proposals: PPA's 2016 convention
- Two relevant book reviews
- Status of the Helping Families in Mental Health Crisis Act

The Pennsylvania Psychologist

Vol. 75, No. 11

DECEMBER 2015 • QUARTERLY

Psychology and Medicine

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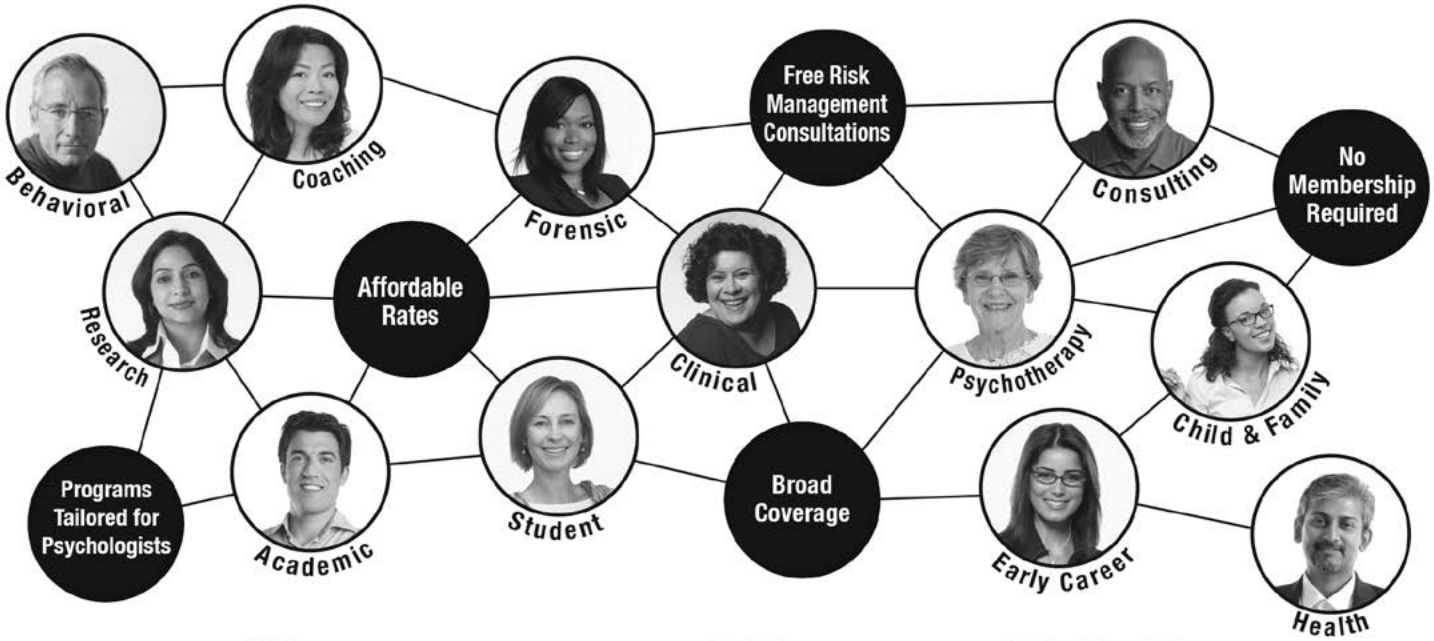

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Vol. 75, No. 11

The Pennsylvania
Psychologist

Editor: Tracie Pasold, PhD

December 2015 • QUARTERLY

Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
717-232-3817
www.papsy.org

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

The Pennsylvania Psychologist Quarterly is published in March, June, September, and December. The copy deadline is the 15th of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112.

Copy Editor: Karen Chernyaev
Graphic Design: LiloGrafik, Harrisburg

REGULAR FEATURES

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SPECIAL SECTION—PSYCHOLOGY AND MEDICINE: DOING IT BETTER, FROM COLLABORATION TO INTEGRATION

STUDENT PERSPECTIVE

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Overcoming Interpersonal Violence Throughout the Life Span

Beatrice R. Salter, PhD


Dr. Beatrice R. Salter

Domestic abuse—we all know what it means, right? Most people think about the painful violence that comprises one person physically injuring another individual. Charles Montaldo, a crime expert, states "[d]omestic abuse is not always about violence, it is about control. Many victims of domestic abuse have never been physically assaulted. Many victims of domestic abuse are not aware they are being abused because they do not recognize the controlling behaviors of their partners as abusive. There are many different ways that abusers try to maintain control, some of which may not be obvious as abusive."[1] Some of the behaviors that constitute domestic abuse include

- physical abuse;
- emotional abuse, such as intimidation and coercion;
- verbal abuse;
- financial abuse;
- sexual abuse; and
- spiritual abuse.

Another misconception is that domestic abuse only occurs between partners (i.e., couples). Have we thought about violence between and among siblings, between children and parents when the child is the perpetrator, or between caretaker and person in need of care? Regardless of the parties involved, we must consistently educate our patients and others with whom we come into contact that maltreatment constitutes abuse. Whether at the hands of partners, siblings, "friends," or children, they must be encouraged to make a report to authorities or take other actions to protect themselves. Diagnostic and intake interviews should query for interactions such as the patient being

- slapped, hit, or punched;
- threatened with a weapon;
- choked;
- called names;
- harassed;
- told that he or she is not worthy of being loved or cared for;
- prohibited from openly practicing his or her religious beliefs;
- forced to surrender his or her money for the other person to manage and control;
- prohibited from making decisions;
- forced into unwanted sexual activity; and/or
- forced into activities that put him or her at any type of risk.

Psychological and behavioral health evaluations should include educating the individual about risk factors, having a safety plan, and assessing community supports for individual and family safety. According to the World Health Organization, violence is a major public health issue around the world. It significantly escalates the cost of healthcare treatment globally and in the United States. As psychologists, we can significantly impact this issue in our communities.

1 Montaldo, C. (n.d.). What is domestic abuse? Retrieved from http://crime.about.com/od/women/a/abuse040721.htm

The 2016 PPA annual convention will address multiple areas of interpersonal violence, including the lasting impact of these experiences on the attainment of developmental stages, positive interpersonal relationships, and healthy coping skills. Areas that will be addressed include child abuse, domestic violence, intimate partner abuse, school violence including bullying, workplace violence, elder abuse, abuse of the disabled, and sexual abuse across the life span.

The goal is to establish strategies to help our communities move from cultures of detachment and violence to cultures of cooperation, peacefulness, and nonviolence. Topics will seek to identify ways to highlight psychology's value in homes, schools, workplaces, and our communities at large. We, as psychologists, can become change agents by working with other professionals and agencies to identify causes that fuel violence and develop concrete tools that address and remedy these issues. Nonviolence can be promoted through advocacy and the dissemination of educational tools that reinforce an evolving view of cultural differences, self-awareness, violence, and trauma. All topics submitted by January 8, 2016, will be reviewed by the Convention Committee, but special consideration will be given to topics that relate to this year's theme. Submit your proposal online at http://www.papsy.org/?page=Convention.

Questions about this process? Please contact Judy Smith at judy@papsy.org or (717) 510-6343

Submit Your Proposal Today!

PPA2016

Overcoming Interpersonal Violence Throughout the Life Span

Settling Into Our New Surroundings

Krista Paternostro Bower, MPA, CAE

Krista Paternostro Bower

As you read this column, it is likely that you are reading it sometime during the first week in December. Looking forward to this time, I anticipate that we will have already experienced our first snowfall and the chillier temperatures that define this time of year. Many of us will be anticipating the holiday season with a sense of wonderment and excitement that fills the air. It is a magical time on our calendars, and I offer each of you my deepest blessings for a wonderful holiday season with family and friends!

As I look back over the past 4 months, both personally and professionally, I acknowledge that it has been somewhat daunting. In July, my husband and I sold our house and purchased my mother's 100-plus-year-old farmhouse in the country, complete with a trout stream and 16 beautiful acres of land to explore. We moved into our new spaces to be closer to my mom, who would have had to maintain the homestead on her own following the untimely passing of my beloved dad in September 2014. It feels so good to be "home" again, but not as good as it did when my entire family could join together there. Being there offers a daily reminder to cherish the moments.

Just 2 months after that big move, in September 2015, it seemed my professional life was imitating my personal life. After 27 years in our downtown location, PPA sold our building and moved into a newer, more professional space that we purchased in the Linglestown area, just 9 miles from downtown.

In case you have not done it for a while, allow me to remind you: Moving is difficult. It is not just physically demanding but emotionally, as well. Packed inside of each box is a memory of a time gone by, a moment that has passed that will never be again, and wrapped up in that moment are the sounds, scents, and feelings that accompanied it. This is not exclusive to household moves but to office moves as well.

Packing the files and folders and books in my office was like revisiting the rich history of our organization, which, moment by moment, led us to our moving day. The photographs, letters, files, reports, books, and journals were all placed delicately into the box that would carry them to their new home. It occurred to me that moving them from the place they had always known did not change their purpose or meaning. In essence, neither a home nor an organization is defined by its location but rather it's the daily activity on the inside that makes up its story. For an office, it is the decisions, discussions, and communications over eight decades that have, gradually and with great thought, moved the organization forward. For a family, it is the conversations, the unplanned moments, the milestones, the celebrations, and the love that create the tapestry. Your physical surroundings matter, but not truly as much as the physical presence of those you love and those who care about you. Or in the case of work, those who believe in your mission and care deeply about the profession. Something to think about. . . .

Figure 2: A view of the meadow at our new home, Stillmeadow Farm, named by my parents when they purchased the property at an auction in 1992.

Figure 1: A look inside of our new spaces. Please stop by to visit us!

As we settle into our new surroundings here on Stevenson Avenue, I would like to thank our Board for their vision and commitment to the next generation at PPA. Their thoughtful and wise involvement in selecting our new location is to be commended.

There are exciting days ahead for our organization! We thank you for being a member at this important time in our evolution. As you will read in this issue's special section, we continue to respect the intersection of psychology and medicine. Our special section focuses on how we can do it better. Please make sure you read the great articles inside that address this important topic.

At the state level, there has been traction on the update to our licensure bill as well as momentum at the federal level regarding Congressman Tim Murphy's mental health legislation. Please take a moment to read Justin Fleming's Happenings on the Hill piece on page 7. We anticipate that the next year will bring new ideas, creative innovations, and more and more changes within the health-care environment. Through it all, we will continue to serve our members. We look forward to creating new moments with you that upcoming generations will cherish as "memories." God bless.

Third-Party Evaluations: How to Stay Out of Trouble

Rachael L. Baturin, MPH, JD; Director of Professional Affairs
Samuel Knapp, EdD, ABPP; Director of Professional Affairs


Rachael L. Baturin


Dr. Samuel Knapp

A psychologist may be asked to conduct evaluations of a person or entity at the request of the third party, such as employee evaluations for employers. In these situations, it is very important for the psychologist to understand the ethical principles that guide these requests, including the nature of the relationships and limits of confidentiality.

Nature of the Relationships

The APA Ethical Principles of Psychologists and Code of Conduct Standard 3.07 states that:

> When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.

Similarly, the Pennsylvania State Board of Psychology's regulations state that, "When a psychologist agrees to provide services to a client at the request of a third party, the psychologist assumes the responsibility of clarifying the nature of the relationships to all the parties concerned" (49 Pa Code § 41.61 Principle 6 (c)).

Therefore, it is very important for the psychologist to clarify with the client that the psychologist is providing the evaluation on behalf of a third party and that the third party is the psychologist's client—*not* the person being evaluated. This is important because clients often assume that because the evaluation is being provided to them and they are consenting to the treatment that they are the client of the psychologist and not the third party who is making the request. Who the client is needs to be made crystal clear to the person receiving the services. It's an important distinction.

From a risk-management perspective, it is usually a good idea to have the person receiving the services sign a document that explains that the evaluation is being provided at the request of the third party, the third party is therefore considered the client, and the third party is the one that controls the record. It is also important to document that the person receiving the service understood and signed this document.

Limits of Confidentiality

Another ethical principle to keep in mind while providing these services is APA Ethical Principles of Psychologists and Code of Conduct Standard 4.02, which states:

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

It is very important to explain to the person receiving the services the limits of confidentiality. They should be made aware that the information from the evaluation provided to them will be shared with the third party and in fact, in most cases, the third party controls that information. Oftentimes, the person being given the evaluation assumes that they are the client and that they control the evaluation report but typically the evaluation report goes to the third party and the person receiving the service does not have a right to receive a copy of it.

Psychologists who are conducting evaluations on behalf of a third party should notify the person receiving the evaluation ahead of time of the nature of the relationship being established (i.e., they are not the client but the third party is), the limits of confidentiality (i.e. ,the report is not really confidential because it usually only goes to the third party), and that the third party controls the release of the record (meaning that the person receiving the evaluation will not be entitled to receive a copy of the report).

Most psychologists who get in trouble for violating these sections of the APA Ethics Code fail to provide adequate notice ahead of time to the person receiving the service.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of November 9, 2015

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 21	Provides for assisted outpatient treatment programs in the Mental Health Procedures Act. - Sen. Stewart Greenleaf (R-Montgomery)	Against	In Public Health and Welfare Committee	N/A
SB 63 **HB 92**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years. - Sen. Stewart Greenleaf (R-Montgomery) - Rep. Kate Harper (R-Montgomery)	For	(HB 92) In Consumer Protection and Professional Licensure Committee	Passed House 4/21/15 (194–0)
SB 554	Amends the Insurance Company Law providing for retroactive denial of reimbursement of payments to healthcare providers by insurers. - Sen. Dave Argall (R-Schuylkill)	For	In Banking and Insurance Committee	N/A
SB 772	Updates the psychologists licensing law, eliminates certain exemptions, and modernizes the experience requirements. - Sen. John Gordner (R-Columbia)	For	Passes Senate 10/13/15 (49–0)	Referred to Professional Licensure Committee
HB 64	Requires licensed psychologists to take 1 hour of continuing education in the assessment, treatment, and management of suicide risks. - Rep. William Adolph (R-Delaware)	Against	Referred to Consumer Protection and Professional Licensure Committee	Passed House 6/10/15 (188–0)
HB 132	Provides Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee
HB 133	Act establishing a bill of rights for individuals with intellectual and developmental disabilities and conferring powers and duties on the Department of Human Services. - Rep. Thomas Murt (R-Montgomery)	For	N/A	Reported as Committed from House Appropriations 9/29/15
HB 214	Increases oversight and accountability in Home and Community Based Services. - Rep. Mauree Gingrich (R-Lebanon)	For	N/A	In Aging and Older Adult Services Committee
HB 706	Provides for insurance companies to reimburse practitioners for telehealth services - Rep. Mark Cohen (D-Philadelphia)	For	N/A	In House Insurance Committee

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

CALL FOR PROPOSALS

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Questions may be directed to:

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One Down, One to Go

Justin Fleming, Director of Government Affairs


Justin Fleming

Senate Bill 772, which makes needed changes to the Professional Psychologists Practice Act, has received the approval of the Pennsylvania Senate. Sponsored by Senator John Gordner (R-Columbia), the legislation passed the Senate 49–0 in a vote taken on Tuesday, October 13, and will now be referred to the House Professional Licensure Committee. While our journey for passage is halfway completed, there is much more work to accomplish before the bill is signed into law. We will need your help to get this bill across the finish line, so look out for action alerts from PPA on ways you can support the practice of psychology by aiding in passing this legislation.

Your help is also needed to improve the delivery of services for severely mentally ill individuals. Congressman Tim Murphy (PA, 18th District) has introduced H.R. 2646, the Helping Families in Mental Health Crisis Act. The legislation helps psychologists through important reforms, including the following:

- Focus on reforming programs and providing resources for individuals with severe mental illness and their families
- Make psychologists eligible for Medicaid and Medicare electronic health record incentive payments
- Expand authority for mental health services financed by Medicaid and eliminate the long-standing discriminatory 190-day lifetime limit in Medicare for psychiatric hospital services
- Encourage development of new evidence-based programs for treatment of mental illness
- Provide incentives for assisted outpatient treatment, rather than mandates
- Enforce parity in coverage between physical and behavioral health services

Congressman Murphy has led the charge to reform mental health treatment across the country for quite some time. PPA has contacted every member of Pennsylvania's Congressional Delegation urging them to support H.R. 2646, and we need you to do the same. Feel free to call or write a letter or e-mail to your Member of Congress indicating your support for H.R. 2646.

With nearly half of the 2015–2016 fiscal year gone, Pennsylvania remains without a state budget. Governor Tom Wolf and legislative leaders still have not come to an agreement on an approximately $30 billion spending plan. Both sides disagree about the level of revenues needed to balance this and future state budgets. Governor Wolf believes the state needs to raise revenues (taxes) to significantly reduce the state's structural deficit. Leaders in the House and Senate believe they passed a package of budget bills that the Governor should have signed into law. Unfortunately for school districts, hospital and health-care systems, state contractors, and others, our budget stalemate remains in effect.

While our journey for passage is halfway completed, there is much more work to accomplish before the bill [SB 772] is signed into law.

It is my extreme pleasure to represent psychologists and this wonderful profession. If you have questions or concerns, don't hesitate to contact me at 717-232-3817, justin@papsy.org or find me on Twitter @PAPsychGA!

Reflections on Joining a Team

Nicole P. Quinlan, PhD

Dr. Nicole P. Quinlan

"The only thing constant is change." That quote, oft attributed to Heraclitus, is a fair summary of my still-early career. Change is good. As we learn, we evolve, with new experiences and outside pressures shaping our path.

When I started my graduate program, I was certain that I was headed toward a research career where I could spend hours (days? months? years?) poring over experimental designs and data until achieving a full understanding of the human condition—or at least a certain process. With practicum experiences, my desires shifted toward a fully clinical career where I could spend hours (days? months? years?) in my office with patients to fully understand their concerns and systems and provide evidence-based interventions to move them toward their wellness goals. A comfortable office space, with calming décor, not too bright lighting, and plenty of inviting toys, would assist in this process. I would reflect on the information gathered after the interview, calling on those years of classroom discussions, supervision, and case presentations, to come up with a diagnosis and intervention.

Although this "full understanding" sometimes takes several sessions to build, I have learned to, over the course of 90 minutes, get a fairly comprehensive assessment completed and begin moving forward in a treatment plan to address presenting concerns. This was the plan, and, for the most part, comprises a fair chunk of what I still do. But along the way, new opportunities surfaced and outside pressures have shifted me toward a very different style of practice.

As we know, health-care reform is moving all in the industry toward models of integration and multidisciplinary collaboration. What started as small ripples has become a strong current and was the overarching theme for PPA's past president Dr. Bruce Mapes. Interest in the integration of behavioral health services into both primary and disease-specific care (e.g., weight management, oncology, pain) has grown in the last decade among health-care providers, delivery systems, insurance companies, and professional organizations.

Multidisciplinary care brings together provider teams to treat the whole person and is patient centered; and, psychologists' role in this care is clear. More than 25 years of research and clinical practice have shown that behavioral changes can help people feel better physically and emotionally, improve health status, increase self-care skills, and improve their ability to live with chronic conditions. Behavioral interventions also can improve the effectiveness of medical interventions and reduce overutilization of the health-care system and the overall costs of care. Additionally, as noted by past APA president Dr. Suzanne Bennett Johnson in 2012, "Having a psychologist on the health-care team eases the burden on the patient, family, and the medical provider. . . . [It] eliminates the stigma of seeing a psychologist for the patient and family and provides immediate access to someone with specialty training." It is for these reasons that many multidisciplinary teams require psychologist involvement in order to be accredited by their governing bodies.

This was precisely the catalyst for one of the more recent changes in my professional career. Within the Geisinger System, we have many specialty multidisciplinary teams, and the involvement of psychology on these teams is rapidly expanding and growing. As our Cleft Palate/Craniofacial (CPCF) Team looked to move toward accreditation, they approached psychology to fill a gap in the patient-centered care they were already providing. Although my knowledge of cleft and craniofacial conditions was limited to say the least, and my experiences of working with multidisciplinary teams were entirely different in structure, this opportunity to expand and diversify the scope of my practice within the context of the shifting landscape of health care was one that I could not pass up. But it took some adapting of my style of practice, in addition to education on the conditions treated and the other team members' roles.

Multidisciplinary care brings together provider teams to treat the whole person and is patient centered . . .

Unlike my previous multidisciplinary team experiences, which were more akin to being a consulting member who would see patients separately for assessment or treatment and then communicate back to other team members, my CPCF team experience involves truly working within a model of care that is "wrapped around" the patient. Fifteen times a year, we see patients in the dental medicine clinic, where each exam room is equipped with the tools required for oral exams and X-ray equipment is easily accessible. This was one of the first aspects that put me out of my therapist "comfort zone"—so much for comfortable rooms, calming décor, and subtle lighting! Dental offices have "scary" equipment, bright lights, and no seating that could be described as comfortable.

When patients arrive (often at an approximation of their scheduled time—adjustment #2), they are settled into a room and remain there while each team member cycles in to conduct his or her examination and speak with the family. Our team consists of specialists in plastic surgery, dentistry, oral surgery, orthodontics, ENT, speech and language, genetics,

Continued on page 12

Motivational Interviewing Is a Promising Framework for Collaboration in the Patient-Centered Medical Home

Scott Glassman, PsyD; scottgl@pcom.edu

Dr. Scott Glassman

The patient-centered medical home (PCMH) model of primary care embraces team-based approaches to wellness, with new certification standards that highlight the need to integrate psychological and medical services ("Joint Principles," 2007; NCQA, 2014). Optimal patient outcomes in a PCMH system depend on effective interprofessional collaboration where knowledge and methods from different disciplines are joined to develop solutions (Bronstein, 2003; D'Amour & Oandasan, 2005; Interprofessional Education Collaborative Expert Panel, 2011). For example, an adult with poorly managed diabetes and recurrent major depression, who is also at risk for homelessness, may benefit most by meeting with the team's psychologist, social worker, dietitian, and physician to develop a coordinated plan that includes housing resource support, behavioral activation, and nutritional counseling.

The conceptual basis for good collaboration in integrated settings includes mutual trust, respect, role clarity, flexibility, and clear, concise communication (Bronstein, 2003; D'Amour et al., 2005; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Allport (1954) observed that simply putting people from different backgrounds in the same room was insufficient to promote cooperation. His contact hypothesis identifies common goals, equal status, and low levels of competition as conditions critical for strengthening relationships among group participants. In translating Allport's (1954) theory into interprofessional training, Mohaupt et al. (2012) found that jointly discussing a case and developing procedural guidelines led to more positive attitudes toward collaboration among students from different medical backgrounds. These activities were designed in part to help participants learn about one another's roles, expectations, and competencies.

In working with support group cofacilitators, Banach and Couse (2012) specifically set aside time for this type of interpersonal learning prior to service delivery. The authors pointed out the importance of building relationships by sharing approaches and ideas during this phase. In the PCMH model, the previsit "huddle" provides a similar opportunity for trust and mutual respect to develop among team members as they participate in care-planning discussions. Huddles have been rated one of the most helpful resources for PCMH implementation (Gale et al., 2015). Reviewing collaborative interactions in debriefing sessions can also open communication channels and may lead to additional improvements in care coordination.

Developing positive collaboration in a PCMH may start with structured activities such as previsit huddles, but it may also require close attention to the conversational styles nested within those activities.

With their expertise in relationship building, psychologists are uniquely positioned to foster a patient-centered care environment, one characterized by respectful, effective interactions between providers (Nash, Khatri, Cubic, & Baird, 2013). Developing positive collaboration in a PCMH may start with structured activities such as previsit huddles, but it may also require close attention to the conversational styles nested within those activities. Typically regarded as a patient-focused behavior change intervention, motivational interviewing (MI) (Miller & Rollnick, 2013) offers a way to enhance colleague-centered communication. MI spirit encompasses the relational principles of acceptance, partnership, and evocation, whereas MI method addresses the corresponding active listening skills that help establish this mutually respectful, person-centered atmosphere. These skills are represented by the acronym OARS: open questions that invite elaboration, often beginning with "what," "why," and "wow"; affirmations or verbal acknowledgments of personal strengths; and reflective listening statements that convey understanding, periodically gathered in the form of summaries. As a framework for provider-to-provider communication, MI does not elicit language in favor of a particular health behavior change. Nevertheless, one might think of MI as helping to evoke positive change talk and attitudes around the idea of working together in an interdisciplinary setting.

MI-based communication carries a tone of reciprocal interest and valuing that can strengthen a sense of acceptance, sending the message that psychology and other allied disciplines are more than "guests" (Hughes-Reid & Lines, 2015) in the PCMH system. Collaborators might ask open questions about each other's professional knowledge base and affirm the importance of each other's roles in patient care. Responding to coworkers' frustrations with reflective listening represents a potentially powerful form of accurate empathy, another key component of acceptance. Reflection and nonjudgment may enhance trust through empathic attunement to concerns or attitudes related to medical home challenges (Young, 2013). Autonomy support, a crucial part of Miller and Rollnick's (2013) concept of acceptance, can mean expressing support for a colleague's decision-making control within his or her domain of expertise (e.g., a physician's prescribing decision or a psychologist's referral to a specialty mental health provider). This could occur within the process of role clarification that is thought to contribute to effective interdisciplinary practice (San Martin-Rodriguez et al.,

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MOTIVATIONAL INTERVIEWING

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2005). MI spirit is instructive in that it encourages balancing one's professional assessment and expertise with openness to others' input (e.g., "It seems Mrs. Jones would benefit from intensive group therapy, but how do you think it might affect her diabetes and renal care?").

In the context of integrated care, the MI concepts of partnership and evocation suggest establishing shared ownership of treatment goals while defining or recognizing a common mission (Bronstein, 2003). The elicit-provide-elicit (EPE) process of information exchange in MI can foster respect, consensus, and power sharing as these goals take shape. In the first step of EPE, a provider might ask permission to share ideas for treatment or learn what other collaborators deem as the most important, relevant, or desirable data within that clinical domain (e.g., "Mrs. Jones is suffering from depression, limited family support, and financial distress. While depression seems like the most pressing concern, what area would the team want to know more about in terms of her diabetes management?"). The last step in EPE involves soliciting reactions to the information provided, maintaining a climate of openness to alternative ideas. EPE's "evoke-first" principle can also be useful in exploring conflicting views of a patient's presenting problem. Reconciling divergent perspectives before treatment planning can circumvent tensions that could disrupt future collaboration (McDaniel, Doherty, & Hepworth, 2014).

Health-care providers in large PCMH systems are beginning to receive formal training in MI, removing the sole responsibility from psychologists for modeling and teaching this mode of communication (Cucciare et al., 2012). Although MI training has traditionally focused on patient-provider interactions, infusing integrated settings more broadly with an MI-based conversational style promises to improve cohesiveness, cooperation, and communication flow within team-based care.

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The Benefits and Challenges of Behavioral Health Services in the Medical Setting

Vincent J. Bellwoar, PhD, and Troy L. Brindle, LCSW

Dr. Vincent J. Bellwoar

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A key tenet of health-care reform is the patient-centered medical home (PCMH) model (APA, n.d.; NCBH, n.d.; SAMSHA, n.d.). Primary care physicians (PCPs) sit at the epicenter of this reform as they identify, treat, and manage the patient's overall care. Those who tout health-care reform advocate strongly for behavioral health (BH) interventions at the PCP level. To better address these needs, many PCPs seek to integrate BH services within their practice. Emerging models include the use of care managers, BH specialists, and consultation. Some large hospital systems or physician practices have attempted to directly hire BH providers. In doing so, some have met with success while others continue to struggle. We believe a viable alternative is for hospitals or physician groups to partner with independent BH practices that can then offer a range of services while also being flexible enough to meet patient needs. Partnering allows BH providers to remain financially independent of the medical group while aiming for clinically aligned, if not integrated, services.

Springfield Psychological is a large multispecialty outpatient practice that began providing colocated BH services in PCP offices throughout southeastern Pennsylvania two years ago. We started in one PCMH office for 4 hours a week after convincing physicians and their staff that colocated BH care would be good for their patients, the PCP's stature in the community, and their relationship with insurers. We promised to decrease their headaches by dealing with difficult patients whose needs went beyond the physicians' training and limited schedules. We advocated that easier access to BH services would result in healthier patients. We assured them they could part ways from us immediately if they wanted, or, more important, we could easily replace an ineffective BH provider with another clinician. (Sometimes the fit just isn't good, but when that happens, there is no need to shelve the whole operation.) In short, our philosophy centers on the belief that BH services in the medical world are a necessity for health-care reform, to create a healthier patient population.

With persistence, flexibility, and creativity, we won over the first practice and within four months they were asking us for more time. In approaching the physician as a consumer, we spent substantial energies and resources doing what was necessary to effectively collaborate with them and their patients. From that first PCMH practice, we have expanded to six other PCMH offices. Our eighth practice will be an oncology and hematology group that is recognized by Medicare (CMS) as the national model for patient-centered oncology medical homes.

Of course, winning over the physicians and their staff is the first obstacle to overcome. Choosing the right BH provider is the next challenge. BH providers must embrace the fast-paced environment. They need to successfully navigate the challenge of winning over physicians and their staff. They must be comfortable with managing paperwork for new patients and attend to collecting copays each visit. They must be dynamic, engaging, and able to connect with the widest range of patient issues and physician personalities. Everything must be handled by the colocated therapist as the PCP office staff are not there to support our operations. The BH providers approach their role in a respectful but assertive manner, looking to "prove their worth" every day.

We quickly realized that PCP colocated services would be a "loss leader." Fortunately, we are a large enough practice to absorb this initial negative financial impact. Within the first few months of colocation, BH providers struggle to maintain a full schedule. Substantial time needs to be spent consulting with physicians on cases in order to gain their trust and respect. Although consulting with PCPs leads to increased referrals, commercial insurers typically do not reimburse for consultation time. Until the payment delivery system moves away from the fee-for-service model, integrating BH services in the medical community faces significant hurdles.

We believe a viable alternative is for hospitals or physician groups to partner with independent BH practices that can then offer a range of services while also being flexible enough to meet patient needs.

Clinically, our goal is to utilize talented clinicians to provide direct, rapid assessment and treatment services within the PCMH. Our focus shifts from "episodic acute care" to placing a greater emphasis on overall health management of identified patients. Within the PCMH, we offer linkages to community supports and resources, as well as enhancing the coordination and integration of primary and BH services to better meet the needs of consumers who struggle with multiple chronic illnesses. This approach centralizes care management and supports consumers as they work toward improved self-regulation goals. A primary goal of this model is to improve health-care quality while also reducing costs. Our BH providers remain ever mindful of this focus. We strive for more than a mentally healthy patient; we want to play a key role in achieving a more medically healthy consumer.

Consumer feedback has been very positive overall regarding our colocated

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THE BENEFITS AND CHALLENGES OF BEHAVIORAL HEALTH SERVICES

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services. Physicians appreciate that 90% of their patients referred to our on-site BH provider show up for the appointment (versus the 30–50% who make it to an outpatient BH practice). Patients feel less stigmatized when they can access these services in the same location where they receive medical services. Rapid assessment and triage is more readily available and better coordination of care is evident between the BH provider and physician. Linkages to additional services are also easily provided and monitored to assist with better compliance and patient follow-up.

While we have attracted the attention of commercial payers who continue to emphasize the need for BH services in the medical setting, we find that many in southeastern Pennsylvania remain stuck in the fee-for-service system. We continue to encourage and push insurers to think outside the box. We point to our relationship with Aetna's behavioral health services and how they have used financial incentives via creative CPT coding and value-based contracting to facilitate the success of BH colocated services. Once other payers address the need to reimburse colocated BH providers differently, there will be easier opportunities for success.

The federal Mental Health Parity and Addiction Equity Act of 2008 solidified the notion that BH services should be on par with medical services. Placing BH providers in medical facilities such as PCP offices, as well as in PCMHs, is one way to realize the notion of parity. We still have work to do to show the consumer and insurer how BH services are integral to the overall health of the patient. Challenges remain in removing unnecessary barriers to providing BH care in the medical setting. From our firsthand perspective, we continue to break through these barriers and embrace BH's role in health-care reform.

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REFLECTIONS ON JOINING A TEAM

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social work, and psychology. That is a total of nine specialists that need to see each of the 12–15 patients within our 5-hour clinic block and give each patient the time and attention appropriate to their needs.

In order to make this feasible, team members must do their assessment and intervention (if appropriate) and offer feedback as efficiently as possible. This was adjustment #3—so much for 90-minute (or even 60-minute) assessments. I need to review each patient's functioning (emotional, social, academic) and provide feedback within 10–15 minutes! This was not easy at first, and only after several months did I finally feel like I was not only getting the hang of this style of practice but also that what I was doing was indeed valuable and appropriate. Having families complete the demographic questionnaires and broad screening measures prior to meeting with them also helps gather basic information and allows me to focus on areas of greatest concern.

Like the general population, most children with cleft conditions develop typically with no psychological problems; however, for those who struggle with emotional, behavioral, academic, or social concerns (either related or unrelated to their condition), that brief assessment works to identify the concern and help plan for additional follow-up. For these children, referrals are then made for a more comprehensive psychological evaluation, either within our own clinic or to a local provider. Because we see these children yearly, we can identify concerning changes early—often before a family might consider a psychological referral on their own—and can facilitate more-immediate access to an appropriate professional.

Following a patient's visit, each team member must summarize his or her evaluation and recommendations in a note and review them in a postclinic team meeting. This was adjustment #4—no poring over my report, noting every piece of information, and carefully phrasing my formulation and recommendations. Learning to consolidate information quickly, in both written and verbal form, and convey only that which is most pertinent, is a skill that has taken time to develop but one that serves me outside this unique setting as well. In addition to the monthly clinics, I also provide presurgery evaluations and can sit in on consultations with patients when either the surgeon or family feels it would be beneficial (often in cases of high anxiety or concerns about comprehension).

My involvement on this multidisciplinary team has diversified my scope of practice, increased my confidence and efficiency in consulting with other medical providers, and increased my collaboration with colleagues with whom I might not normally interact. It also gives me a monthly break from my usual outpatient population. I have also learned the difference between hypo- and hypernasality, what a pharyngeal flap is, and why you shouldn't brush your teeth right after eating citrus!

As opportunities like this become more and more available—and essential—for psychologists to stay at the forefront of a quickly changing health-care landscape, I encourage you to look into whether joining a team like this might fit into your practice and, perhaps, change things up a bit!

BOOK REVIEWS

James Morrison's *When Psychological Problems Mask Medical Disorders* and Robert L. Taylor's *Psychological Masquerade*

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Dr. Edward Zuckerman

Care that integrates the mind and body, medical and psychological, psychosocial and biological, is the current model for the future of health care and so the direction that psychologists are and should be moving. What will they find when they get there? Other articles in this issue have elucidated some issues and solutions. I want to address a more formalized one: What should we know about how disorders, diseases, and diagnoses from one side affect the other? The two books reviewed below offer very similar information but approach this question quite differently.

James Morrison, a psychiatrist and teacher, has written "a guide for psychotherapists" entitled *When Psychological Problems Mask Medical Disorders*. It offers a condensed, fact-filled catalog of disorders and symptoms.

What should we know about how disorders, diseases, and diagnoses from one side affect the other?

The first part of the book is devoted to a superb discussion of what to observe and how to do a thorough mental status exam. I heartily recommend these 35 pages for introducing graduate students to how to begin and what to notice. The bulk of the book, 168 pages, addresses 66 medical diseases so each gets three to five pages of tightly written text. After the basics of definition, occurrence, gender, age of onset, and, handily, which medical specialty treats the disease, he explains the disease's dynamics. Next he reviews the physical symptoms across the body's systems. The mental symptoms are then presented and related to their physical causes. Lastly, he describes the tests for evaluation and the outlook, or prognoses.

What we need is the converse: Given the presenting psychological symptoms, what diseases ought we to consider as causative (and, we hope, treatable)? Uniquely among authors in this arena, Morrison actually offers this in 20 pages of tables showing each kind of symptom across all 66 disorders. Depending on the symptom, you may have to read up on only a few or very many diseases.

Ideally, a clinician could use this information to develop a checklist of medical diseases to consider when presented with a psychological symptom. While Morrison offers a general idea of how common each medical condition is (not its psychological presentation), what is still needed is some way to prioritize the options for efficient evaluations.

All this is solid and useful information, and, while not superficial, it will not make any of us into medical providers. As Alexander Pope said, "A little learning is a dangerous thing." Many forget the next lines: "Drink deep or taste not the Pierian spring: There shallow draughts intoxicate the brain, and drinking largely sobers us again." Venturing into integrated care raises both technical and knowledge issues and the ethical one of being cautious and thoughtful about potentially exceeding one's areas of competence. As the research clearly indicates, we are all subject to excessive estimation of our expertise and knowledge. Unjustified overconfidence is a risk factor for patient harm. Integrated care programs should consider addressing this completely predictable dynamic as part of ongoing staff training.

While Morrison's book is a catalog, Robert L. Taylor's *Psychological Masquerade: Distinguishing Psychological from Organic Disorders* is a textbook and training manual on how to think better as a clinician faced with a patient needing good diagnosing. Taylor leads with a chapter on the nervous system most of us can skip but then begins teaching a cumulative clinical strategy. He presents common errors of clinical judgment such as mistaking the symptoms for their causes and being seduced by the story. This is followed by a return to the brain with a discussion of a broad "brain syndrome" presented in terms of the symptoms, such as memory impairment, disorientation, amnesias, and sensory difficulties. The next chapter returns to the thought processes of the clinician with several basic alerting cues and then more presumptive cues to discovery of an organic basis for the psychological presentation. Returning to clinical work, four common "masqueraders" are discussed: brain tumors and infections, seizures, and endocrine disorders, especially the very common thyroid disorders.

Integrated care programs should consider addressing this completely predictable dynamic as part of ongoing staff training.

As the clinical sophistication of the reader progresses, Taylor presents four chapters on special topics: drug-induced organic mental disorders (the most common cause of masquerades), the variations on somatization, and the common problems of the young and the elderly. Dozens of brief cases are sprinkled throughout the chapters, totaling 22 cases for the reader's self-testing. Overall, almost all of us can benefit from Taylor's guidance to enlarge our index of suspicion for the organic causes of problems we see in our practices.

Lastly, let me mention two items you might find relevant. Chapter 29 of my book, the *Clinician's Thesaurus*, lists the medications and the medical conditions that are known to cause

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Psychology and Medicine Integration: The Present, the Future, and the Challenges of the Journey

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Dr. Jeffrey L. Sternlieb

It is no secret that the U.S. health-care system is in crisis, disarray, and has created controversies. The powers of large insurance companies, varied political and social philosophies, and the various factions of health-care professionals have been lobbying and debating a system that we can no longer afford, that does not provide services for all, and yet has an unrealized potential for the most-advanced health care available anywhere.

What is most disappointing to me is how little has evolved in the nearly 400 years since Descartes described a mind-body dualism. This is exquisitely exemplified by the siloed professions of primary care, psychiatry, and psychology. Psychosomatic is the equivalent of a four-letter word in public discourse; yet so much of what ails us requires a true behavioral medicine approach. Much of this state of affairs is cultural, and some of it relates to organizational identity and affiliation, as well as the impact of well-established systems of service providers, payment, and even professional education and training.

With my 35-plus-year history of having worked in a hospital's mental health center, a psychotherapy practice, and at a family practice residency program, I have experienced a number of challenges and opportunities. The challenges seem to be primarily related to the professional cultures of each discipline. In contrast, the opportunities lie in the wide range of unmet needs of patients and professionals.

Challenges

It is said that "Culture eats strategy for lunch." Whether we focus on a micro level of a psychologist's strategy to help a struggling family change their culture or a political system's strategy to resolve major cultural divides, culture usually wins. Cultures are deep, ingrained, and usually span generations. Strategies tend to be focused on systems and generally do not take culture into consideration. A classic example is remarkably well told in the story of efforts to provide medical care to a Hmong child with a seizure disorder (Fadiman, 1997).

What is most disappointing to me is how little has evolved in the nearly 400 years since Descartes described a mind-body dualism.

A second reality is that "if we are not at the table, we are on the menu." We may not be seated at the head of the table, but we must take our place and contribute. I have witnessed an example of this firsthand. The role of the behavioral scientist in medical education is an evolving one. I believe that the single most significant contributor to psychologists having a voice in medical education (despite explicit mandates from the Accreditation Council of Graduate Medical Education) is participation in the governance of the Society of Teachers of Family Medicine (STFM). Identifying what our contribution can be is very different from actually making that contribution.

Opportunities (Just a Few Examples)

The low-hanging fruits are the many unmet needs in every corner of our society. Meeting these needs often requires creativity; I believe creativity is one of psychology's strengths. However, we may need to think of our role in broader contexts, our skills in different applications, and our impact crossing professional boundaries. For example, there are over 400 family medicine residency training programs in the United States. Many, many more people go to their family physician with depression and anxiety symptoms than go to therapists. We also know that therapy and psychotropics together are more effective than either one alone. Further, we know that the professional habits developed in training are the most likely ones to continue in practice. Why aren't we even more active than we already are in collaborating with medical training programs in creating cotraining environments for psychologists and physicians?

A very small percentage of patients account for a disproportionally high percentage of medical costs, especially due to an indiscriminate use of hospital emergency department services. By examining who these "super-utilizers" are and what their needs are, Jeffrey Brenner, a family physician in Camden, New Jersey, created a unique approach. He established an office in the midst of a population of super-utilizers; recruited community care workers, nurses, social workers, and so forth to respond to this group's psychosocial needs; and saved millions of taxpayer dollars, which he split with Medicare/Medicaid to fund this "super-utilizer" program (Gawande, 2011). This creative solution crossed professional lines and was recognized by the MacArthur Foundation with one of their genius awards. The grant that accompanied this award has been funneled into creation of super-utilizer programs in other communities, and psychologists have been involved in these efforts.

More and more primary care offices in our Lehigh Valley Health Care system (and many others around the state and the country) employ therapists with credentials ranging from licensed professional counselor to doctorate and who periodically gather for support, consultation, and training. There are huge advantages for physicians who are able to invite

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PSYCHOLOGY AND MEDICINE INTEGRATION

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a therapist into the examination room and introduce him or her to a patient. I suspect there are many different models for how this collaboration can occur. Opportunities for creativity will emerge from relationships we develop with physicians, physician groups, and health-care systems. It is up to us to initiate these discussions and develop these relationships. The medical literature has had recent discussions of physician burnout, the increased incidence of resident and physician suicide, and the impact of the changes in health-care delivery on physicians. Psychologists are uniquely equipped to develop alliances that can be mutually beneficial to medical professionals and patients alike.

Begin the Process

Psychologists clearly have a wide range of therapeutic, consultative, and teaching skills that are both necessary and sufficient to successfully integrate our work into the medical community (Sternlieb, 2014). I'd like to suggest several steps to begin this process:

1. Learn as much as possible about what it's like to learn or work in a medical culture. Think of this as our cultural anthropological work. While we are at it, we might give some thought to describing our own culture.
2. Listen, listen, and listen some more *without* thinking about a response. Just listen! It's much easier to learn when we are not preoccupied with a response or a fix.
3. Identify unmet needs—for patients, for physicians, for systems. Frame and reframe these needs in as many different ways as possible.
4. Broaden our skills. The outer edge of our comfort zone (which may be the door of our office) is the leading edge of our learning curve. If we are not better at pushing our own envelope, it will only be stationary.
5. Network, network, network—especially outside of our usual circles!

Final Note: I know that there are colleagues who are already engaged in coordinated efforts with medical colleagues. I invite you to send me a brief description of your program of collaboration or integration with the medical system. All of our colleagues can benefit from learning about these, and descriptions of these programs can only support further collaboration.

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BOOK REVIEWS

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seven common psychological symptoms. Although you can't print it, if you Google "psychiatric masquerade," a few pages will be shown. Second, on my website, www.TheCliniciansToolBox.com, under the tab "Free Tools" is an informative and current list of "100 Common Psych Medications," which you can download and print.

Given the intertwining of the physical and the psychological, the books reviewed here as well as the other tools mentioned can serve those in the field of psychology well. Additionally, competence in this area will serve to facilitate the integration of psychology into medical practice.

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Integrating Mindfulness Into Psychology and Medicine:

Growing Evidence and Emerging Mechanisms for How to Better Treat Stress-Related Disorders

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Stress is associated with many of the most common and costly mental and medical conditions facing society today. From depression, anxiety, insomnia, and chronic pain to obesity, diabetes, high blood pressure, and asthma, the perception of stress, and the biological pathways through which stress perceptions are conveyed throughout the body, afford a unique opportunity for psychologists to integrate mindfulness into health care and medicine. Mindfulness—which can be defined as awareness of one's experience in the present moment with acceptance—is traditionally cultivated through meditation practice. Since the conception of mindfulness-based stress reduction (MBSR) by Jon Kabat-Zinn and colleagues in the 1970s, a variety of other mindfulness-based interventions (MBIs), such as mindfulness-based cognitive therapy (MBCT) and mindfulness-based relapse prevention (MBRP), have since been developed to treat and prevent stress-related disorders. Given the prevalence of stress in society, and the high rate of comorbidity among stress-related mental and medical conditions, taking a collaborative, mindfulness-based approach to care, in which psychologists and other health-care providers encourage patients to actively participate in their own health and healing, holds significant potential for better treating stress-related disorders and potentially saving costs (Ruff & Mackenzie, 2009).

There are many psychological and biological pathways through which stress, and particularly *chronic* stress, can increase susceptibility to mental and medical conditions. These pathways range from repetitive negative thinking, in the form of worry, rumination, or catastrophizing, for example, to the neural underpinnings of self-referential thoughts and emotions, including "default mode network" processing and limbic system activation. Consequently, organs and cells receive neural and biochemical signals to produce stress-related physical symptoms, such as muscle tension, gastrointestinal upset, headache, fatigue, vasoconstriction and high blood pressure, among others. Therefore, better treatment and prevention of stress-related symptoms and illness can benefit from thoughtful integration of mindfulness, psychology, and medicine. Moreover, as psychologists, being mindful not only of the mind-brain-body connection but also the innate potential for each person to become more aware of his or her experience of stress and how stress might affect health and behavior, means we can take a leading role in the integration process. From a practical standpoint, there are many ways in which psychologists can teach clients how to become more mindful, including (1) being conversant with current research findings that directly relate to a client's mental or medical condition; (2) offering brief mindfulness skills training in session if one has some personal experience with mindfulness, and/or offering longer, group-based MBIs if one acquires more extensive professional training; and (3) directing patients to resources where they can learn more about the science and practice of mindfulness, perhaps inspiring patients to explore daily mindfulness practice as a form of "participatory" medicine (Santorelli, 2000).

Mindfulness training programs in psychology and medicine are typically secular, psychoeducational, and rooted in self-regulation theory. Specifically, by learning to self-regulate the mind, brain, body, and behavior through regular meditation practice, one can fundamentally shift one's perception of stress and therefore manage stress-related mental and physical symptoms and possibly prevent stress-related disorders. Growing evidence from increasingly rigorous clinical trials has consistently shown a benefit of MBIs for reducing symptoms of stress, anxiety, depression, and pain on the one hand, and for increasing qualities of mindfulness, psychological well-being, coping, and quality of life on the other (Goyal et al., 2014; Greeson & Eisenlohr-Moul, 2015; Khoury et al., 2013).

Some of the established and purported mechanisms by which MBIs exert clinical effects include changes in brain structure, function, and connectivity; changes in physiological stress reactivity; changes in cognitive and somatosensory perception and emotion regulation; greater control of behavioral impulses; and a shift in self-view (Greeson, Garland, & Black, 2014). Despite relatively consistent effects on self-reported symptoms, however, the efficacy of specific MBIs on *objective* measures of specific mental and medical disorders remains to be established, as do many of the underlying mechanisms for *how* MBIs work. For example, the ongoing Serenity Study (www.serenitystudy.org)—an NIH-funded, multisite trial at the University of Pennsylvania (Penn) and Kent State University—is testing whether an 8-week, MBSR program can lower elevated blood pressure by teaching individuals to better regulate their reactions to emotional stress and by facilitating healthy lifestyle behaviors, including regular exercise, a low fat and low sodium diet, and good quality sleep. Another ongoing clinical trial at Penn, called Serenity N.O.W. (New Opportunities for Wellness), is investigating changes in stress and mood symptoms, immunity, and inflammation,

There are many psychological and biological pathways through which stress, and particularly chronic *stress, can increase susceptibility to mental and medical conditions.*

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Psychologists, and other health-care providers, can learn the basics of mindfulness practice themselves, using the same resources referenced here.

after an 8-week MBSR program, among depressed individuals living with HIV, who also have increased risk of cardiovascular disease. Finally, a new study at Penn funded by The Institute for Integrative Health (www.tiih.org), is exploring whether 8-weeks of mindfulness meditation training in stressed, but generally healthy, adults is associated with lower levels of stress hormones, proinflammatory cytokines, and gene expression involved in controlling inflammation.

Taken together, these and similar ongoing clinical studies will help to strengthen the evidence base for specific mindfulness training programs to treat specific stress-related conditions, while elucidating the psychological, biological, and behavioral mechanisms by which MBIs may benefit mind-body health. In the meantime, psychologists can work together with physicians and other health-care providers to (1) educate patients about the current compelling evidence for mindfulness as a stress reduction practice; (2) teach patients the basic skills of mindfulness (i.e., present-focused attention and nonjudging awareness) if they are open, interested, and receptive; and (3) point patients to self-help resources, including meditation classes, books, CDs, and free MP3s online and via smartphone applications (see Resources below).

A practical tip when teaching mindfulness is to "teach what you know." Psychologists, and other health-care providers, can learn the basics of mindfulness practice themselves, using the same resources referenced here. Another tip for psychologists is to embody the core qualities of mindfulness (e.g., attention, awareness, acceptance, and kindness/compassion) as best one can, knowing that others can recognize and model the expression of mindfulness in us. Working together, then, psychology and medicine can better treat stress-related disorders by integrating mindfulness into clinical care, educating patients about mindfulness research relevant to their symptoms or conditions, sharing resources and training opportunities to explore mindfulness as a means of self-regulation, and, ultimately, using the mind-brain-body connection to heal.

Resources

Mindfulness for Beginners. Book and accompanying CD by Jon Kabat-Zinn.

Mindfulness applications (apps) for smartphone or Internet use. http://www.mindful.org/free-mindfulness-apps-worthy-of-your-attention/

Penn Program for Mindfulness. http://www.pennmedicine.org/mindfulness/

Penn Behavioral Health, 4-week Mindfulness Skills Course for Penn Employees. http://www.pennbehavioralhealth.org/mindfulness.aspx

The Mindfulness Solution. Book by Ronald Siegel. Guided meditations available at: www.mindfulness-solution.com

UCLA Mindful Awareness Research Center. Guided Mindful Awareness Practices (MAPs). http://marc.ucla.edu/body.cfm?id=22

UCSD Center for Mindfulness. Guided mindfulness meditations. http://health.ucsd.edu/specialties/mindfulness/programs/mbsr/Pages/audio.aspx

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The Intertwining of the Physical and the Psychological Lends Itself to Integration of the Disciplines

Keri Condoluci, MS; PsyD Year III, Chestnut Hill College; Communications Chair, PPAGS

Keri Condoluci

The original Adverse Childhood Experience (ACE) Study assessed the frequency of maltreatment in childhood. The study consisted of over 17,000 adults completing a quantitative survey that assessed the number of adverse experiences they had encountered prior to the age of 18. Results revealed that the more adverse experiences an individual endured in childhood might be correlated with behavioral issues and both mental and physical health conditions in adulthood. In addition, studies have specifically shown that witnessing violence and experiencing childhood toxic stress can lead to negative health outcomes and behaviors, including the abuse of substances, development of depressive disorders, diabetes, and obesity and may also lead to suicide attempts, anxiety, hyperarousal, and aggression. Adults who have experienced adverse events in their childhood may develop and exhibit trauma-related symptoms later in life as well (Anda et al., 2006).

I first became interested in integrated health care and the coordination of care during graduate school, where I concentrated on trauma studies. Learning about the ACE Study marked the first time I could connect someone's past traumas with the physical symptoms and disorders I was encountering as an intern at my first clinical practicum. From my first day at a community counseling center, I carried a substantial caseload and collaborated with clients who ranged in ages from 7 to 65. Though primary care physicians had referred many clients to our facility, this was not always the case. The medical records I sometimes received often provided the missing pieces to fully understand and examine the extensive histories of many of the clients with whom I worked. In a way, it allowed an individual's history to unfold beyond our weekly 50-minute sessions, and I was better able to conceptualize and collaborate with them moving forward knowing the other side of their health picture.

Results revealed that the more adverse experiences an individual endured in childhood might be correlated with behavioral issues and both mental and physical health conditions in adulthood.

One client with whom I worked exemplified how important the ACE Study and integrated health care is for our field. For this graduate student, he illustrated the intersection of childhood trauma and later-in-life mental and physical health challenges.

My client was age 65 when we first began working together. Though he was forthright at our intake about the psychological trauma he encountered from a young age, it took many sessions to build trust and create a safe haven where we could explore his whole history. This client survived emotional and physical abuse, neglect, and was often left in charge of his younger siblings with few resources and food. As a teenager, he began using substances, a behavior that continued to a 30-year addiction to methamphetamines. This addiction may have lead to many of the physical health disorders he carried, including hepatitis C. During our work together, I learned about his significant losses and interpersonal challenges, and we often discussed his challenge with caring for his physical self, as he felt shameful in his body. Because of this, he had not seen any medical professional in over 30 years, aside from the physician at the hospital where he had been admitted for suicidal ideation prior to coming to our agency as part of his aftercare plan.

During our work together, we created schedules to keep him accountable and compliant with taking his medications. He attended our weekly sessions and had begun an outpatient program to increase social support, but the divide in caring for his physical health was large. He felt uncomfortable visiting a doctor and expressed both concern for his health, but also indifference. It proved near impossible for him to visit a primary care physician until a family member was willing to go with him.

I believe this case was good practice in educating clients—and myself—on the link between mental health and physical symptomatology. It also allowed me to grow as a clinician in understanding the complexity that often comes with caring for both sides of the medical coin—the physical and the mental. Integration of medical and psychology disciplines would benefit patient care that is holistic.

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Teaching Reflective Practice in Doctoral Training

Edward B. Jenny, PsyD


Dr. Edward B. Jenny

Effective psychotherapy and assessment practice involves the active use of reflection on the part of the clinician tasked with making sense of subtle shifts in transference and countertransference phenomena as well as multiple shifting data points. Both activities involve what I like to think of as *in vivo hypothesis testing*, meaning that the clinician needs to organize information into coherence but without investing rigidly in the solution. As new data contradict or expand the picture, the attentive clinician must be able to adapt with agility.

Reflective practice, or reflection in action (Schon, 1983), is a process in which the clinician observes his or her work, steps back to reflect upon it, and modifies his or her process in response to this reflection. Reflective practice is differentiated from technical epistemology, which advocates a script-like adherence to technical skills. In short, reflective practice is more like improvisation on a theme than recitation of notes on a page.

Reflective practice has important implications for ethical practice in that the clinician who is able to actively reflect and modify behavior based upon reflection can better adapt to the complexities of real-world clinical practice. Technical epistemology could be equated with following the strict letter of the ethics code, while reflective practice allows for the subtle balancing of competing ethical values in light of the evolving best interest of the client.

It is imperative that instructors in clinical training programs model reflective practice and foster its development in students. Modeling reflective practice involves talking through complex decision making with students and a willingness on the part of the instructor to be transparent. Effective instructors are comfortable in disclosing difficult moments in their clinical practice, as well as mistakes and the reflection that led to their recognition and correction.

Training that relies on application of technical skills alone fails to equip students with the skills needed to treat the complex cases encountered in the field. While technical skill is necessary it is not sufficient. Clinical work involves the intersection of highly complex systems. This intersection can be quite taxing on the beginning clinician who may experience any number of conflicting and even unpleasant feelings. In order to cope with these situations, students need to develop the capacity to observe the clinical process with a level of objectivity, learn from what is reflected upon, and adapt interventions accordingly. Activities in formal coursework that encourage exploration and modification of beliefs in light of new experience are essential in developing this capacity.

As an example, in an introductory course on psychoanalytic theories and therapies students are asked to write down a few ideas about (1) what factors lead to adaptive/healthy functioning, (2) what factors lead to maladaptive/unhealthy functioning, and (3) what events or interventions in psychotherapy lead to change. Students are asked to discuss their thoughts with other students. These thoughts are then revisited periodically throughout the course, and students are encouraged to note any changes or modifications in their thoughts. The rationale for this activity is that it encourages flexibility of thinking and reflection upon the learning process. As new data or experience is added to the student's repertoire, some assumptions may subtly or not so subtly shift. Adapting to these modified assumptions allows for integration of new viewpoints and new ways of understanding client dynamics.

Similarly, in assessment courses, students are asked to develop tentative explanations for test data so that as new data are added to the mix more nuanced explanations are developed. Handler and Meyer (1998) point out several common mistakes observed in beginning assessment psychologists. These include allowing confirmation bias to influence conclusions through the exclusion of contradictory data. Reflective practice would encourage a more tentative and flexible use of data that allows for modification in light of new or contradictory information. An overemphasis on technical interpretation could lead to less contextualized, and ultimately less useful, statements in the assessment report.

It is imperative that instructors in clinical training programs model reflective practice and foster its development in students.

Students confronted with seemingly contradictory data points often feel overwhelmed or frustrated. By encouraging students to step back and view the data with some distance, they can be helped to see overlapping venn diagrams of data and understand that some variability in the data is a function of differing methodologies (self-report versus performance tasks) or vantage points (observations versus narrative) rather than invalid data. By talking through difficult assessment cases and offering examples of how contradictory data were reconciled in practice, instructors can provide modeling in reflective assessment practice.

The practice of clinical psychology is thus both an art and a science informed by technical data and the intuition of the practitioner. Reflective practice offers a means for clinicians to make sense of the complexity of the clinical encounter and to "sit with" the uncomfortable sense of not knowing that comes with this work. Students can be lulled into a false sense of security by test scores,

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Pediatric Epilepsy, Medication Management, and School Psychologists

Rachael Hoffman, MSEd, and Ara Schmitt, PhD

Rachael Hoffman

Dr. Ara Schmitt

The neuropsychological consequences of treatments for chronic medical conditions can often be inextricable from the effects of the condition itself. This is particularly true of a complex neurological condition such as epilepsy. Initial treatment of epilepsy typically involves administration of antiepileptic drugs (AEDs), which inhibit or oppose the hyperexcitable neural activity associated with seizures (Bromfield, Cavazos, & Sirven, 2006). Accompanying this influence on brain activity can be a number of unintended neuropsychological consequences, such as attention problems, memory impairment, and emotion dysregulation. An understanding of the potential outcomes of AED administration is important for practitioners across settings but is especially imperative for school psychologists who are planning and monitoring interventions for students with epilepsy.

What Is Pediatric Epilepsy?

Epilepsy is the most common pediatric neurologic disorder, occurring in approximately .3%–1.1% of children (Friedman & Sharieff, 2006; Hauser & Banerjee, 2008). Epilepsy is characterized by at least two unprovoked seizures that occur more than 24 hours apart. There are multiple types of seizures, which vary in the type and degree of motor activity and loss of consciousness. However, all seizures are rooted in uncontrolled electrical activity in the brain. The most common type of pediatric seizure is characterized as a generalized tonic-clonic seizure, previously known as grand mal seizure, in which the child typically exhibits dilated pupils, pale skin, contracted muscles, and rhythmic jerking of the limbs. Generalized seizures involve both hemispheres of the brain. There are several other forms of generalized seizures, such as generalized absence (petit mal), generalized atonic, generalized tonic, generalized clonic, and generalized myoclonic seizures. These seizure types are often distinguished from each other based on the associated cognitive and motor features. Not all seizures are considered generalized as seizures may also be confined to a specific part of the brain, as is the case in temporal lobe epilepsy. Seizures that occur in a specific region are termed focal seizures.

Neuropsychological Consequences of Pediatric Epilepsy

A number of negative neuropsychological consequences have been related to epilepsy. For example, research has demonstrated an association between epilepsy and lower overall IQ (Berg et al., 2008), memory impairments (Baker, Austin, & Downs, 2003; Chaix et al., 2006), and executive dysfunction, including attention and processing speed problems (Rzezak, Guimarães, Fuentes, Guerreiro, & Valente, 2012). These consequences, in conjunction with difficulties experienced by many children with chronic illnesses, are also connected to lower academic achievement and social-emotional concerns.

Treatment of Pediatric Epilepsy

First-line treatment for pediatric epilepsy typically involves the administration AEDs. However, other treatments, such as neurosurgery, may be considered for children whose seizures are intractable despite pharmacological intervention. In fact, up to 26% of individuals with epilepsy do not respond to medication and continue to have seizures (Berg, 2009). The specific AED prescribed for a child depends on multiple factors, including the type and severity of seizures exhibited, side effects associated with the drug, and other patient characteristics. Titration of AEDs can be difficult as there is often a small dosage window in which seizures are abated, but negative side effects do not significantly impact the child's functioning (Bromfield, Cavazos, & Sirven, 2006). Therefore, school staff must be aware of the potential for the full range of negative physical and neuropsychological side effects and be prepared to communicate their presence, as well as ongoing seizure activity, to the child's parents and medical team.

A number of negative neuropsychological consequences have been related to epilepsy.

The side effects of which school staff, including the school psychologist, must be aware vary according to the specific AED administered. For example, valproic acid, a medication commonly used to treat partial and generalized seizures, is related to a number of potential adverse side effects, including physical effects such as alopecia, tremors, and vomiting (Goldenberg, 2010). Valproic acid has also been associated with negative neuropsychological consequences, with processing speed deficits frequently reported (Hessen, Lossius, Reinvang, & Gjerstad, 2006). Lagae (2006) noted the many complications associated with researching the impact of AEDs on neuropsychological functioning and called for more research to better understand the cognitive side effects of AEDs when administered in childhood. That said, there is ample evidence of adult psychomotor slowing associated with many traditional AEDs. In fact, reaction time following

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AED administration may be increased by 100ms–200ms. Additionally, extended use of the AED phenobarbital has been associated with a decrease in IQ scores (Lagae, 2006). Other AEDs have also been linked to general mental slowing, concentration problems, and psychomotor slowing.

Roles of the School Psychologist

School psychologists may play multiple roles in the treatment of pediatric epilepsy and its medication management, in particular. Students with epilepsy may be referred to the school psychologist to conduct a comprehensive evaluation to establish the child's educational needs and special-service eligibility. Any evaluation to establish eligibility for special education services under the category of Other Health Impairment (OHI), or Section 504, must involve an evaluation plan to encompass the known neuropsychological consequences of pediatric epilepsy and suspected areas of functional impairment unique to the child. Given the diverse impact of pediatric epilepsy and its pharmacological management, assessment of cognitive (including processing speed), language, visual-spatial, memory and learning, attention/executive function, motor, academic achievement, social-emotional/behavior, and adaptive functioning skills should be considered. When possible, estimates of child functioning should be obtained prior to AED administration or surgical intervention, and certainly thereafter, to monitor treatment effects and the course of the disorder.

Additionally, school psychologists may play an important role in developing emergency plans, teaching medication compliance strategies, and coordinating other services. Another key role that a school psychologist may play is that of an educator. School psychologists may consult with teachers to provide information regarding the educational impact of epilepsy and its management, as well as routine accommodations and modifications to support children with this disorder in the classroom.

Through comprehensive evaluations, development of necessary plans and accommodations, consultation, and provision of appropriate resources and education, the school psychologist can help to effectively support children with epilepsy in the school environment.

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The Changing Face of Pediatric Diabetes: Update and Implications for School Psychologists

Bret A. Boyer, PhD

Dr. Bret A. Boyer

Diabetes is one of the most common childhood chronic illnesses, and almost everyone knows someone with diabetes. It is so prominent in our social consciousness that many of us assume we generally know what diabetes and its treatment are all about. Therein lies a growing problem for psychologists. Over the past decades, several changes in diabetes treatment have revolutionized diabetes care and left many of us unwittingly misinformed by myths and inaccuracies about diabetes care.

We do not have enough space, here, for a full review of current diabetes treatment (see Scheiner, 2011) or for complete review of psychological factors related to diabetes (see Boyer, 2008). In the school context, however, we sometimes only focus on a child's diabetes when it constitutes a medical classification calling for accommodations in curriculum. There are several experiential domains of diabetes, however, that will be crucial for us all to know for any child with diabetes, whether these are part of their 504 plan or not.

Let's start with the general facts. We "know" that kids with diabetes can't eat concentrated carbohydrates such as cake and cookies; have to eat at frequent, regular times or else their blood glucose (BG) will get too low; have to eat a certain amount of low-sugar foods at each meal; and have to eat snacks between meals to prevent low BG from their insulin. Well, if we are congratulating ourselves that we are indeed knowledgeable about all of these facts, we better sit down! For type 1 diabetes (T1D) self-management in the 21st century, almost everything in this paragraph has become false! To free ourselves from any outdated assumptions we may hold about diabetes, it is helpful to assess and understand the following factors for each child with diabetes in the school context.

First, it is important to note that there has been an increase in children diagnosed with type 2 diabetes (T2D), once entitled "adult onset" diabetes. A child developing T2D was nearly unheard of 15 or 20 years ago. Although the number of children with T2D has dramatically increased, children who develop T2D are still a minority of pediatric diabetes cases, of whom almost all develop T1D. Treatment for T2D usually does not require insulin, and treatment consists of reducing carbohydrate consumption, especially concentrated carbohydrates such as sugary foods and drinks; losing weight; and increasing physical exercise. This treatment regimen dramatically differs from the typical treatment plans for insulin-dependent T1D, to which I will return in the paragraphs below.

While many children with diabetes feel like outcasts because they have a chronic disease, the few children who develop T2D often feel like outcasts even among the other children with T1D, because they are a minority among the minority, with different treatment demands and strategies than those with T1D. So, as we encounter students with diabetes, it is imperative to ascertain whether they have T1D and are using an insulin regimen or whether they are among the few students with T2D and face far greater dietary restrictions.

For most students with T1D, treatment plans don't necessarily require them to avoid sweet foods, eat snacks between meals, or even eat at specific times of day anymore, as diabetes management required 15 or 20 years ago. The advent of basal-bolus insulin regimens has revolutionized diabetes management. Each time they eat, T1D students can either take a shot for the amount they consume or use continuous subcutaneous insulin infusion pumps to program and activate a bolus of insulin for the amount of carbohydrates they eat. Students using basal-bolus formats can now match specific bolus doses of insulin at the time that they eat, for the exact amount that they choose to eat at that moment, and only when they are going to eat.

The advent of basal-bolus insulin regimens has revolutionized diabetes management.

Basal-bolus insulin regimens offer the benefit of increased flexibility. It is thereby not necessary for the students to eat a between-meal snack, and they can even skip a meal, so long as they don't take any bolus insulin without eating. They can tailor their bolus insulin to how many carbohydrates they consume when they do eat, usually using a ratio (e.g., units of insulin-to-grams of carbohydrates) and maintain their BG at normal levels. The challenges that accompany this flexibility, however, are the increased demand to count carbohydrates and remember to take more insulin boli (injections or from a pump) to match the amount and timing of food intake.

When done properly, basal-bolus insulin regimens make it feasible for children to eat cake at a birthday party, so long as they accurately calculate (or guess) the grams of carbohydrates in that piece of cake and take the correct amount of analog insulin to "cover" these grams of carbohydrates. It is noteworthy that, in a study of 570 children in Pennsylvania with T1D, all but one

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participant was using a basal-bolus regimen, and that one participant was the only individual not converted to using such a regimen during the 6-year study (Boyer, Deatrich, & Miller, 2015).

Providing outpatient psychotherapy and family therapy to clients with T1D over the past 20 years, I have often heard students lament that psychologists and teachers chastise them for "doing something they're not supposed to do" when engaging in active self-management strategies, like dosing with a bolus for eating a cookie at their fellow student's birthday party. As such, it becomes imperative to learn, from students and parents, which exact type of diabetes management regimen a student is using, so that we don't confuse or alienate students by relying on our outdated mythologies regarding diabetes treatment.

Another dilemma faced by students and their parents in the school setting is the student's development of independence in their diabetes self-management. In the world away from school, preadolescents and adolescents progressively learn to take over their diabetes management, progressing from a parent-managed to a self-managed process. Many obligations in the school setting, however, are contradictory to this pursuit of self-management independence.

Outside of school, students are encouraged to master their self-management activities, carry their glucometers and test their BG whenever needed, carry glucose tablets or candy to use if their BG becomes low, and learn to check their BG and deliver insulin comfortably at restaurants and parties. This movement toward independence is contradicted by school policies that insist on students keeping their glucometers and insulin at the nurse's office. Rather than carrying their supplies with them, so that they can self-manage their BG, students need to leave class and interrupt performance of their school activities.

It may be that these school policies must be maintained, for liability reasons, although in 30 years of clinical practice with families and children with diabetes, I have never encountered a child injuring someone with their glucometer lancets or their syringe needles! However, if these policies are unchangeable, then it may fall upon the school psychologist to acknowledge and process these contradictory pressures with the student. In consultation with the school nurse, the student's teacher(s), and the parents, school psychologists can support the student in securing the most comfortable means of managing their diabetes and facilitate the student's understanding that these school policies do not generalize to other contexts or contradict their ongoing pursuit of independent self-management. In schools that allow exceptions for students with T1D, the school psychologist, school nurse, and teacher(s) working with the student need to be informed of the protocol that the student will be using.

Another dilemma faced by students and their parents in the school setting is the student's development of independence in their diabetes self-management.

Finally, school personnel should be informed about symptoms of low or elevated BG, or BG that falls outside the range of 70–130 (ADA, 2015). Although symptoms of hypoglycemia, or low BG, vary from one individual to the next, observable signs usually include shakiness, sweating, drowsiness, dizziness, nervous restlessness, or confusion. Hypoglycemia should also be considered if these children become agitated, unduly frustrated or angry, uncooperative, or seem to be ignoring direct instruction. When BG drops rapidly or severely, neuroglycopenia impacts cognitive function and can even induce delirium, thereby producing behavior that may be misinterpreted as oppositional or antagonistic.

If medical personnel are not available, staff should test BG with the child's glucometer to verify whether BG is low. If BG is lower than 70, feed the child any food with 15–20 grams of carbohydrates (e.g., ½ cup of juice, 6–10 crackers, banana) and retest BG in about 15 minutes. If BG continues to drop, repeat application of 15–20 grams of carbohydrates (ADA, 2015). If BG is above 70 before administering carbohydrates, hypoglycemia is not the cause of the behavior.

By observation alone, it is often difficult to determine whether symptoms result from BG that is too high or BG that is too low. If no glucometer is available, best practice is to feed the child 15–20 grams of carbohydrates and observe for relief of symptoms within 15 minutes. Immediate remedying of hypoglycemia is imperative, since hypoglycemia occurs more rapidly than hyperglycemia and can result in unconsciousness, seizures, or death. In addition, 15 grams of carbohydrates is unlikely to produce a dangerous worsening of hyperglycemia, whereas it will quickly alleviate hypoglycemia and possibly prevent death.

Ongoing communication and consultation between the school psychologist, school nurse, parents, student, and medical providers serves to identify specific patterns of hypoglycemia symptoms, coordinate treatment plans (e.g., use glucose tablets? Raisins? Crackers?), and disseminate the plan among all school staff in contact with that student.

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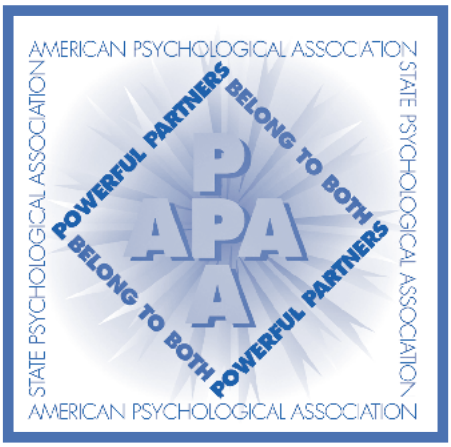
Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between July 20 and November 5, 2015!



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TEACHING REFLECTIVE PRACTICE

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diagnostic classifications, or technical interventions that promise the terra firma of reliability and validity in the face of uncertainty and the "messiness" of clinical work. This is not to say that reliable and valid techniques should be eschewed but rather that we must also tolerate the position of not knowing and allow ourselves to be informed by the subjectivity as well as the objectivity of our work with clients.

In training doctoral students, I have found that a willingness to be transparent and to talk through my own uncertainties in working with clients goes a long way toward helping students embrace this uncertainty. This in turn has the effect of reducing defensiveness in students and allowing them to better understand their own vulnerabilities and uncertainties, all of which contributes to their working more effectively with clients.

In short, clinical work is messy business and to the extent that we can utilize both objective data points and more subjective and emotional reactions to the clinical encounter we are better able to harness intuitive and deductive processes of interpretation. Both are necessary and neither is sufficient. Instructors who provide such modeling empower students to be more mindful and effective practitioners.

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

Quinlan

1. Health-care reform is moving the industry toward models of:
   a. Separation and competition
   b. Integration and multidisciplinary collaboration
   c. Speed and high turnover
   d. None of the above

2. Being part of a multidisciplinary team may require psychologists to adjust to:
   a. Shorter length of time for evaluation
   b. Providing care in a medical exam room
   c. Communicating quickly with providers of various disciplines
   d. All of the above

Glassman

3. As applicable to strengthening collaboration in the patient-centered medical home (PCMH), the only pertinent motivational interviewing spirit components are acceptance and evocation.
   True
   False

Bellwoar & Brindle

4. The patient-centered medical home model involves:
   a. Comprehensive medical treatment that is performed within the patient's own home
   b. A multidisciplinary team approach that involves different disciplines working together within one setting to treat patients
   c. A major tenet of health-care reform
   d. "b" and "c"
   e. All of the above

Zuckerman

5. Taylor notes that some medical problems are frequently encountered masquerading as psychological complaints, and so we should be suspicious of them. They are:
   a. Brain infections and brain tumors
   c. Seizures
   d. Hyper- and hypothyroidism
   e. All of the above

Sternlieb

6. Opportunities for collaboration with physicians include:
   a. Providing psychotherapy to patients of medical practices
   b. Teaching, consultation, and training of medical students and practitioners
   c. Using the wide range of skills many psychologists possess
   d. All of the above

Greeson

7. Mindfulness-based interventions (MBIs) are proven to treat specific stress-related disorders.
   True
   False

8. Teaching patients basic mindfulness skills requires professional certification.
   True
   False

Hoffman & Schmitt

9. Epilepsy is the third most common neurologic disorder in children.
   True
   False

Continued on page 27

10. Decreased processing speed is frequently associated with the use of AEDs.
    True
    False

Boyer

11. Current basal-bolus insulin regimen for type 1 diabetes requires children to do which of the following?
    a. Always eat meals at the same time each day
    b. Refrain from ever eating concentrated carbohydrates, such as candy or pastries
    c. Eat frequent snacks to prevent hypoglycemia
    d. Count carbohydrates and match insulin doses to the amounts of carbohydrates they will eat
    e. Eat the same amounts of the same food groups at each meal

12. If a child with type 1 diabetes becomes hypoglycemic in school, staff should do all of the following except:
    a. Use a glucometer to test whether BG is low
    b. Feed the child 15–20 grams of carbohydrates if BG is lower than 70
    c. Restrict child's food intake for next several hours
    d. Repeat BG testing approximately 15 minutes after treating the hypoglycemia

Jenny

13. Modeling reflective practice by instructors helps students:
    a. Develop better integrated conclusions
    b. Tolerate uncertainty
    c. Become better clinicians
    d. All of the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, December 2015**

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

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

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Overall, I found this issue of the *Pennsylvania Psychologist:*

Was relevant to my interests	5	4	3	2	1	Not relevant
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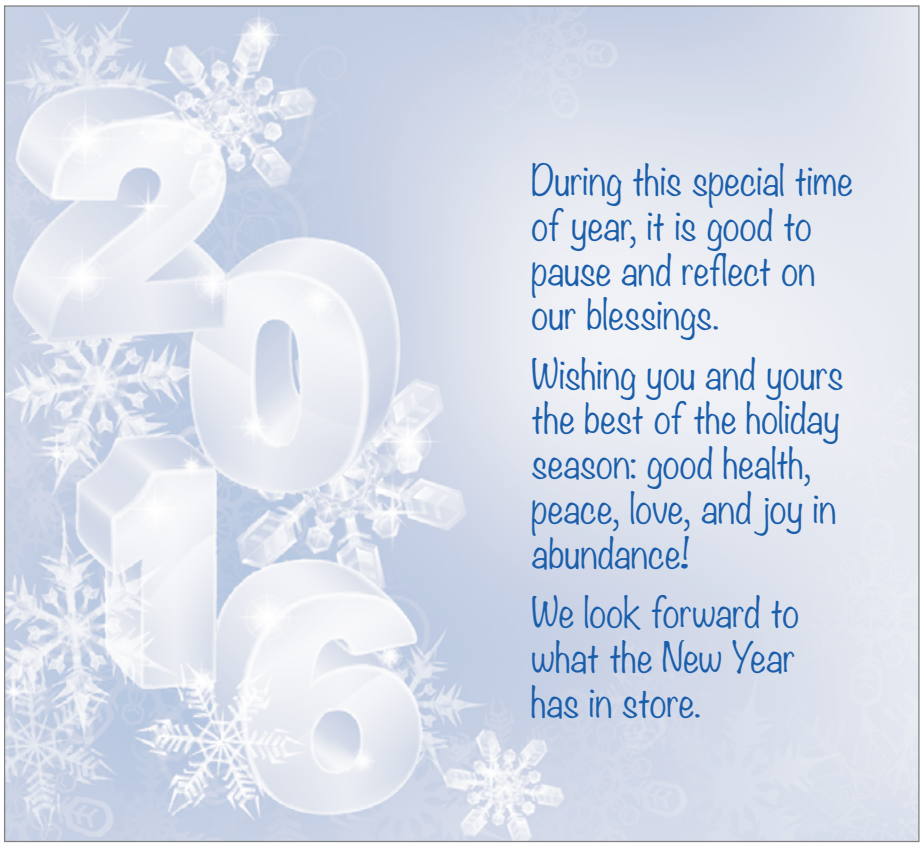

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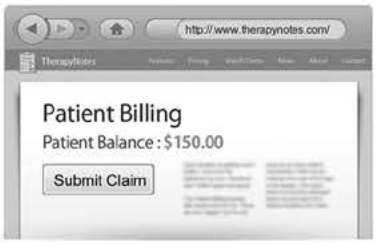

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