Vol. 75, No. 3

# The Pennsylvania Psychologist

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

March 2015
QUARTERLY

## PPA2015

## Innovative Models for the Future

June 17–20, 2015 • Hilton Harrisburg • Harrisburg, PA

Convention brochure inside!
Page 9

PPA's Premier Event!

**ALSO INSIDE:**

- Prevention models for 2015
- Partnering with primary care physicians
- Act 31: New mandated continuing education
- Technological innovations for your practice


# *Your life now may be very different than it was ten years ago...*

Has your financial planning changed to fit your current or future picture? A new or expanding business, mortgages, automobiles, a larger family… these can all contribute to a very different picture of your financial responsibilities today.

## Group Term Life Insurance

Term Life Insurance can play an important role in your family's continued financial security should you die prematurely. Whether you need initial coverage or want to add to what you have, Trust Group Term Life Insurance[1] is affordable and has the features you will need to keep pace with changing family and financial responsibilities.

Call us at **1-877-637-9700** or visit **trustinsurance.com** for a no-obligation consultation.

### Great Coverage at Affordable Premiums Including These Features:

- **Inflation Safeguard** — designed to prevent changes in the cost of living from eroding your death protection.[2]
- **Living Benefits** — allows early payment of death benefits if you become terminally ill.
- **Disability Waiver of Premium** — waives your premium payment if you become totally disabled.

THE TRUST

www.trustinsurance.com

[1] Available in amounts up to $1,000,000. Coverage is individually medically underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. Plans have limitations and exclusions, and rates are based upon attained age at issue and increase in 5-year age brackets.

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

**Pennsylvania Psychological Association**
416 Forster Street
Harrisburg, PA 17102
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, 416 Forster Street, Harrisburg, PA 17102.

**Copy Editor:** Karen Chernyaev
**Graphic Design:** LiloGrafik, Harrisburg

Vol. 75, No. 3

# The Pennsylvania Psychologist

Editor: Tracie Pasold, PhD

**March 2015 • QUARTERLY**

## REGULAR FEATURES



Get 1 CE credit for this issue! Also available online! Page 34

## SPECIAL SECTION—PPA2015



## SPECIAL SECTION—INNOVATIONS IN HEALTH CARE : NEW DIRECTIONS FOR PSYCHOLOGY



## STUDENT PERSPECTIVE



## SCHOOL PSYCHOLOGY SECTION



## ALSO INSIDE

# A Brighter Light at the End of the Tunnel

*Bruce E. Mapes, PhD*

*Dr. Bruce E. Mapes*

Change is an inevitable part of our daily lives. The uncertainty inherent in any change is stressful and can arouse feelings of helplessness, frustration, and anger. Health-care reform and the reorganization of PPA are major changes confronting us today. Even the most optimistic psychologist who tends to view the glass as half full can, at times, feel discouraged or overwhelmed by the changes we are currently undergoing.

Some of us will resist change and try to preserve the status quo, which only leads to further frustration. Others will accept the inevitable and adapt to new ways of thinking and doing things. When we are able to embrace change, rather than resist it, we are able to look at the future with excitement over the many new possibilities rather than with angst.

It is true that health-care reform is requiring major changes in the way we do things through such mandates as integrative care, medical houses, and outcome measures. Psychologists are being required to communicate and collaborate with other professionals in new ways as efforts are made to improve the overall quality and delivery of health care. Technology is becoming an integral part of the delivery of all behavioral health services and is no longer limited to large group practices.

PPA is actively involved with other stakeholders to keep the membership informed in order to facilitate the many transitions we have to make. Fortunately, many Pennsylvania psychologists are in the forefront of the change process and can help to guide us through the process.

My theme for this year's convention is *Innovative Models for the Future*. It focuses on how Pennsylvania psychologists are successfully making the transition. You are strongly encouraged to attend this year's convention to learn what your colleagues are doing. I am sure you will leave with new practical ideas and greater optimism about your future as a psychologist and the future of psychology in Pennsylvania.

PPA is also changing to position itself to better and more efficiently meet your current and future needs. Plans have been made to accommodate Sam's retirement so that his valuable assistance will still be available to PPA. There are several major staff changes. Judy D. Smith, CMP-HC, is our new professional development specialist and brings extensive experience in health-care event planning and public relations. Justin C. Fleming has been hired to be our director of government affairs and brings an extensive legislative network and several years of experience lobbying for mental health. Rachael Baturin, MPH, JD, has been promoted to director of legal and regulatory affairs.

The staff reorganization is finally complete, and the new structure has already started to produce exciting ideas to meet the current and future needs of PPA and to promote the interests of psychology and psychologists in Pennsylvania. The Governance Task Force has started to critically examine our current governance structure in order to make recommendations to the Board of Directors to improve and streamline PPA's governance. As many of you are aware, it has become necessary for PPA to relocate our office. The Building Task Force is currently visiting potential sites and is optimistic about the available options.

I am excited by what I see occurring in our committees, and I cannot begin to do justice to the different committees within the space limitations for this column. Our committees are involving more graduate students, early career psychologists, and diversity in their activities. They are generating new ideas to make PPA more relevant and to promote psychology in Pennsylvania. Our committees are also playing critical roles in helping psychologists to transition to health-care reform and to support the reorganization and restructuring of PPA.

*When we are able to embrace change, rather than resist it, we are able to look at the future with excitement over the many new possibilities rather than with angst.*

We could not have accomplished what we have thus far this year without the dynamic enthusiasm and commitment of our committees and individual members. Nor could we have overcome some glitches and unexpected consequences without the cooperation, patience, and commitment of our members. I would truly like to recognize each committee and each individual for the wonderful and exciting things you have done and are continuing to do. Regretfully, all I can do here is to say thank you. Your efforts are truly appreciated!

Change is an inevitable part of our daily lives, of our profession, and of our association. It is not possible to predict ahead of time what our lives, our professions, or our association will look like at the end of the change process; we can only speculate. To successfully navigate any transition, we must take small steps rather than implement broad reforms. Sometimes, the reason for a step is quite clear; other times it may not be understood until much later. Regardless, adapting to change requires patience as the many pieces of the puzzle are put in place.

There are still many issues to address with health-care reform and the reorganization of PPA, but we are making good progress. There is a light at the end of the tunnel, and it is becoming brighter.

# Spring to New Pathways

*Krista Paternostro Bower, CAE*


*Krista Paternostro Bower*

Once again, I find myself writing my March column on a snowy January morning. As I grow older, I have come to appreciate the passing of the seasons, and the progression from winter to spring is one of my favorite pathways. It seems that this time of year offers the most hope for the future. The silence of the winter months gives way to the early blossom of the crocuses, and the daffodils making their appearance remind us that, no matter how harsh the winter, life continues.

I cannot help but think about this last season of my life. It was filled with so much hope and promise. On a personal note, I married my best friend, Jamie, in August of last year. And just this past December, I finished my master of public administration curriculum and finally received my graduate degree. Two life milestones worthy of celebration in anyone's book. But, during this season of change, I also lived through the devastating experience of unexpectedly losing my dad. I lost my dad to cancer just 9 days after my wedding day. Since that sad day in September, I still have not found my words to describe what his loss has meant to my life. I have come to realize that there may never be words that can truly capture what it feels like for a daughter to lose her dad.

But, my dad taught me to see life through his optimistic eyes–eyes that always saw the positives–and his words remind me still that if we look for something amazing, we shall always find it. I share here just a piece of what my dad wrote about the spring in March of 2002 as he walked along his property with his dogs.

*There are signs along my path of a new season waiting at the gate, ready to burst headlong into spring. I stop briefly to look carefully at the moss-covered rocks along the brook. Tiny ferns, grasses, and lichens glisten with new life, polished to a luster fit for royalty, and for me. High in the treetops, there is a flurry of bird life, darting among the branches. High overhead, I hear the yelping of another flock of geese, not visible in the overcast sky. The woods are quiet beyond the tumbling of brook water. There is peace here where the water has flowed for centuries, where the trees flourish, where the animals of the woods roam without rules. I stop for a while, resting on a large boulder. My thoughts are of the seasons changing, of the aroma of distant rain, of hemlocks and oaks, of the order and organization of these spaces. There is perfect balance at work here, and without our interference, there always will be.*

These are powerful words that remind us to be present in our own lives. The lesson in my dad's words also reminds me that even through change, there is always something good and powerful at work. This same life lesson can also be applied to our professional lives.

As we move into the spring pathway, I find myself optimistic about PPA's future. We have so many wonderful initiatives to look forward to at PPA. In this issue, you will read about PPA's annual convention and that our convention team (led by Dr. Bea Chakraborty) has been working hard to make this annual gathering a not-to-be-missed occasion. We hope that you will plan to attend the convention in Harrisburg in June!

Also inside you will find mentions of our spring conference, Advocacy Day, and other CE events to be held in the spring. We salute our volunteers and staff who are working to bring innovative and creative professional development offerings to our members. Please take a moment to read through the entire issue, as it is filled with valuable information on how PPA is helping our members to succeed.

*Continued on page 4*

## EXECUTIVE DIRECTOR'S REPORT

*Continued from page 3*

Over the past several months, we have been working to position ourselves for the future. We are building a staff team that is energetic, focused, and valued. I will close my column this month with a special spotlight introduction of our two new staff members and our recent staff promotion.

We look forward to seeing what the spring delivers for PPA this year. As the new season approaches, I hope that you take a moment to appreciate the new pathways emerging in your own life. In the meantime, on behalf of the PPA Board of Directors, please help me to welcome Judy and Justin to our team and congratulate Rachael on a well-deserved promotion!

# Welcome

### *Judy D. Smith, CMP-HC, Professional Development Specialist*

In October 2014, Judy joined PPA as our professional development specialist. She comes to PPA after spending 8 years at the Pennsylvania Medical Society (PAMED) in the Specialty Society Management Services department as a meeting manager (5 of those years as team leader). Judy's responsibilities at PAMED included managing all aspects of the annual meetings, board meetings, continuing medical education activities, as well as other types of meetings and events on a state and national level for multiple medical specialty organizations. Prior to her tenure at PAMED, Judy worked in the sales and catering departments at two area hotels.

Judy is a graduate of Bloomsburg University with a bachelor's degree in marketing. In 2011 she earned her certified meeting professional (CMP) designation and in 2014 joined the first-ever class to pass the exam for the health-care subsection of this designation (CMP-HC). Judy lives in the Harrisburg area, where she is active in her church community and is currently preparing to run her first marathon.

### *Justin C. Fleming, Director of Government Affairs*

Justin joined PPA as director of government affairs in January 2015, after spending more than 4 years directing government relations efforts for the National Association of Social Workers, Pennsylvania Chapter (NASW-PA). Despite having to work with a limited budget, Justin was able to forge relationships with members of the Pennsylvania General Assembly, which resulted in the passage of two pieces of legislation.

Prior to his work at NASW-PA, he served for more than 6 years in various public relations roles in state government, with his last appointment as press secretary of the Pennsylvania Department of Agriculture. Before entering public service, Justin worked at a local television station in Harrisburg as a producer for the weekday morning newscast.

Justin is a graduate of Millersville University with a bachelor's degree in speech communication (broadcasting emphasis) and a minor in government and political affairs. He and his wife, Lisa, reside in the Harrisburg area with their two children, Christopher and Emily.

# Congratulations

### *Rachael Baturin, MPH, JD, Director of Legal & Regulatory Affairs*

Rachael has been an integral part of our PPA team for the past 15 years. In January 2015, we were pleased to promote Rachael to her new position as our director of legal and regulatory affairs. In this position, Rachael will continue to consult with PPA members on a wide range of issues affecting psychologists. Her knowledge of the law, insurance issues, and the state regulatory environment continue to make Rachael a valuable and trusted member of our team. In her new position, Rachael will work very closely with Justin on state advocacy issues and will continue to serve as PPA's federal advocacy coordinator within the American Psychological Association network.

# Act 31: New Mandated Continuing Education Related to Child Abuse in Pennsylvania

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


Dr. Allan M. Tepper


Dr. Samuel Knapp


Rachael L. Baturin

In 2014, the Pennsylvania legislature promulgated a number of amendments to the Pennsylvania child abuse reporting statute, formally known as the Child Protective Services Law. These amendments modified portions of the existing law and instituted a number of new substantive and procedural requirements.

One of the new requirements that went into effect on January 1, 2015, states that all Pennsylvania licensees identified as mandated reporters of suspected child abuse, including licensed Pennsylvania psychologists, must accrue, as a prerequisite to license renewal, a minimum of 2 hours approved continuing education credits related to the recognition of the signs of child abuse and the reporting requirements for suspected child abuse in Pennsylvania. This requirement did not exist under the previous version of the Pennsylvania child abuse reporting statute, and thus this article shall review the logistics associated with this new continuing education mandate.

Licensing boards fall within the area of administrative law. Licensing boards are administrative bodies that are put into existence by the state legislature to protect the public. Pursuant to the statute that establishes the licensing board, the board is granted the power to promulgate regulations to carry out its public protection mandate.

In the past, many licensing boards, including the Pennsylvania State Board of Psychology, have promulgated regulations that require licensees to accrue continuing education credits as a condition of biennial license renewal. Since licensing boards are independent of each other, the rules related to the continuing regulation requirement vary, depending upon the board in question. Each individual licensing board, therefore, has the power to promulgate the number and type of continuing education credits required by its respective licensees, as well as to establish the guidelines by which a provider is granted the ability to offer a board-approved continuing education course. Later, when completing the license renewal application, the licensee is allowed to affirm that the continuing education requirement has been fulfilled, subject to a future audit at the discretion of the licensing board.

*Licensing boards are administrative bodies that are put into existence by the state legislature to protect the public.*

*Continued on page 6*

**LEGAL COLUMN**

*Continued from page 5*

The new child abuse continuing education requirement falls outside any particular licensing board's continuing education regulation. That is, irrespective of a particular board's continuing education requirement, beginning on January 1, 2015, all Pennsylvania licensees identified as mandated reporters of child abuse must accrue at least 2 hours of continuing education in child abuse as a condition for renewal of their license. In addition, the application process associated with a provider being able to offer an approved child abuse continuing education course is controlled by the revisions to the child abuse reporting statute, rather than being contained in a particular licensing board regulation. Currently, this mandated child abuse continuing education requirement is being referred to as Act 31 credits.

The amended child abuse statute states that an Act 31 child abuse continuing education course must be approved by each licensing board in consultation with the Pennsylvania Department of Human Services (DHS), formerly Pennsylvania Department of Public Welfare. More recently, this aspect of the law has been interpreted to mean that an Act 31 child abuse continuing education course must be approved by the Pennsylvania Department of State (DS) and the Pennsylvania DHS.

Entities seeking to offer approved Act 31 child abuse continuing education courses can obtain an application from the Pennsylvania DHS. As part of the approval process, an Act 31–approved provider must agree to report to the Commonwealth a licensee's completion of the child abuse continuing education course. That is, the completion of the child abuse continuing education requirement is not reported to the Commonwealth by the licensee, and the requirement is not subject merely to a random audit. Rather, if the Commonwealth has not received notice from the Act 31 provider that the requirement has been fulfilled, the license will not be renewed.

What are the practical logistics associated with this requirement? First, all licensees should ensure that the provider offering the course has been approved by the Commonwealth's DS and DHS to offer Act 31 credit hours. This approval should be listed on the course provider's advertisements, as well as on the certificate issued upon the licensee's completion of the course.

Second, all licensees should ensure that, upon completion of the course, the provider asks for their social security number. The request for this personal information indicates that the provider shall be conveying the fulfillment of the child abuse continuing education requirement to the Commonwealth on behalf of the licensee.

Lastly, all licensees must provide their name as it appears on their license to practice.

A third issue involves whether the Act 31–approved course also fulfills the respective board's general continuing education requirement. The amendment to the child abuse statute states that the continuing education on child abuse "shall be completed as a portion of the total continuing education required for biennial renewal." The implication is that the legislature is not increasing the total number of continuing education credits required by each board. A question arises, however, as to whether an Act 31–approved child abuse course also constitutes a *board-approved* course necessary to fulfill the respective board's continuing education requirement.

For example, the Pennsylvania State Board of Psychology requires that a licensee accrue 30 *psychology board–approved* credits on a biennial basis. The

*Continued on page 7*

# PPA Advocacy Day—May 4, 2015

The PPA leadership has selected Monday, May 4, 2015, as our Harrisburg Advocacy Day this year. All PPA members are encouraged to attend! It will again be in the state Capitol Building, room 60 East Wing. The schedule will consist of registration at 9:30 a.m., an issue orientation session from 10:00 a.m. to 11:30 a.m., and meetings with legislators after that. New this year will be a press conference that PPA will hold at 1:00 p.m. in the East Wing Rotunda to highlight issues surrounding child mental health and wellness.

PPA will be addressing several new legislative proposals for dealing with child abuse reporting and a bill making numerous changes to the Professional Psychologists Practice Act. The state and federal constitutions guarantee the right of citizens to petition the government for a redress of grievances. This is your chance to influence the process of informing psychology practice in Pennsylvania!

We will soon provide more information about the event via e-mail and on our website. Plans for continuing education credit are also in the works.

To register for this great event, please visit

www.papsy.org

**LEGAL COLUMN**

*Continued from page 6*

psychology board's regulation outlines what constitutes a board-approved provider of continuing education credits. Such approval includes recognition by a national association, such as the American Psychological Association (APA), or specific approval by the psychology board. Presently, the DHS is not a psychology board–approved provider of continuing education credits.

Since the amended child abuse statute does not increase the total number of required continuing education credits, does a psychologist still need 30 psychology board–approved credits, in addition to at least 2 Act 31–approved credits for a total of 32 credits, rather than a total of 30 credits?

If the Act 31 course has specific psychology board approval, such as approval by the APA, coupled with approval by the DS and the DHS, this appears to be a moot point, and the psychologist would have accrued a total of 30 psychology board–approved credits, including the 2 required Act 31 credits. For example, the child abuse continuing education course PPA currently offers has all three approvals.

However, what if the psychologist has 28 board-approved credits and 2 Act 31 credits and later is the subject of a continuing education audit? Would the psychologist be deemed to have met the biennial continuing education requirement if the Act 31 credits did ***not*** have specific psychology board approval?

Presently, the Pennsylvania Board of Psychology has not issued any written opinion or guideline regarding this issue. In response to an oral question presented to them during the course of their October 28, 2014, meeting, however, the board stated that 2 approved Act 31 credits will count as part of the 30-credit requirement, whether or not the 2 Act 31 credits have specific psychology board approval. In this regard, if a psychologist had 28 psychology board–approved credits, coupled with 2 Act 31 approved credits, the psychologist would be deemed to be in compliance with the biennial continuing education requirement.

One final point on this matter: The amended child abuse statute states that Act 31 credits must be completed *per licensure cycle*. Pending future pronouncements from the legislature, therefore, this language must be interpreted to mean that beginning on January 1, 2015, a designated licensee must accrue at least 2 Act 31 credits for *each* succeeding biennial period, not just the first biennial period following the January 1, 2015, date of implementation.

# The Bill Box

**Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists**

**As of March 1, 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<br>- Sen. Stewart Greenleaf (R-Montgomery) | Against | In Senate Public Health and Welfare Committee | N/A |
| **SB 63**<br>**HB 92** | Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years<br>- Sen. Stewart Greenleaf (R-Montgomery)<br>- Rep. Kate Harper (R-Montgomery) | For | In Consumer Protection and Professional Licensure Committee | In Professional Licensure Committee |
| **SB TBA**<br>**HB TBA** | Updates the psychologists licensing law, eliminates certain exemptions, and modernizes the experience requirements<br>- Sen. John Gordner (R-Columbia)<br>- Rep. Marguerite Quinn (R-Bucks) | For | In Consumer Protection and Professional Licensure Committee | In Professional Licensure Committee |
| **HB 54** | Requires licensed psychologists to take 1 hour of continuing education in the assessment, treatment, and management of suicide risks<br>- Rep. William Adolph (R-Delaware) | Against | N/A | In Education Committee |
| **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<br>- Rep. Thomas Murt (R-Montgomery) | For | N/A | In Human Services Committee |
| **HB 214** | Increases oversight and accountability in Home and Community-Based Services<br>- Rep. Mauree Gingrich (R-Lebanon) | For | N/A | In Aging and Older Adult Services Committee |

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

# PPA2015

## Innovative Models for the Future

June 17–20, 2015 • Hilton Harrisburg • Harrisburg, PA

PPA's Premier Event!

### Welcome to PPA2015!

In an effort to streamline our communications, PPA has combined the March *Pennsylvania Psychologist* and the convention brochure into one extremely informative piece! In this section, you will find all you need to know regarding our 2015 convention, including the events that you have grown to appreciate as well as new events and registration rates.

As always, PPA office staff is happy to help with the registration process and any questions you may have. Specific questions regarding the convention? Please contact our professional development specialist Judy Smith at **judy@papsy.org** or **717-232-3817**.

We are really excited about PPA2015, and we look forward to seeing you in June at the Hilton!

*Registration available starting* ***April 1*** *www.papsy.org*

# What to Look For

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

Celebrate life, learning, and having fun.

The call for papers for PPA2015, *Innovative Models for the Future*, offered a unique and intriguing challenge for new and veteran PPA convention workshop presenters. Each year, our presenters strive to provide convention-goers with stellar, high-quality workshops that reflect and endorse the convention theme. This year (a license renewal year), to no one's surprise, presenters have gone above and beyond the call to make it possible for you, dear colleagues, to enjoy a veritable feast of refreshing and stimulating continuing education (CE) programs (to include Act 48 credits).

Forty-three workshops (two for students only) will cover the latest in innovative psychological science in multiple disciplines, from hot topics in diversity and ethics to working with athletes in your clinical practice. Also, look for select fresh and dynamic programs designed specifically for students and early career psychologists (ECPs), including Research Poster sessions and the ECP/Student Reception on Friday.

PPA2015 promises to feature and celebrate innovations of Pennsylvania's psychologists in such pivotal areas as integrative care, evidence-based treatments, use of 21st-century technology, medical home models, and strategies to expand internship and other training opportunities for pre- and postdoctoral students.

Invited guest speakers include Pennsylvania psychologists who are highly respected members of PPA, who have embraced and demonstrated *Innovative Models for the Future* in their practices, and who can address specific models of keen interest, such as the path to prescription privileges for psychologists in Pennsylvania and ethical issues emerging with integrative care and telepsychology.

Respected names to look for include: Drs. Don McAleer, Linda Knauss, John Gavazzi, and Sam Knapp. Forums for guest speakers include the Keynote Address on Wednesday morning and the Psychology in Pennsylvania Luncheon on Friday.

New in 2015 is a *free* Mind-Body River Walk to "rev" you up for Thursday's events and a VIP Breakfast on Friday morning for registrants who choose the all-inclusive VIP registration option. Also new is the Exhibitor Wine & Cheese Reception and a fabulous gala PPA Annual Banquet & Awards Dinner on Thursday night.

So come on out and join us for PPA2015, June 17–20, at the Harrisburg Hilton.

# Overview

*Judy D. Smith, CMP-HC*
*Professional Development Specialist*

PPA President Dr. Bruce Mapes's theme for PPA2015, *Innovative Models for the Future*, sets the tone not just for the convention in June but for 2015 as a whole: The ongoing evolution of health-care reform has presented psychologists with many challenges, which have stimulated numerous innovative programs in Pennsylvania. This year's convention will celebrate the innovations of Pennsylvania psychologists in such areas as integrative care, evidence-based treatments, the use of technology, models of medical homes, and emerging strategies to expand internship/training opportunities for pre- and postdoctoral students.

## Why should you attend this year's convention?

Up to 28.5 CE Credit Hours

- Receive up to 28.5 hours of CE credit
- Access $500 worth of CE credits for half the cost
- Network with friends and colleagues
- Influence PPA—talk to officers and staff and have your voice heard
- Choose from 43 CE workshops (2 for students and early career psychologists)
- Earn Act 48 credits

Along with the programs that you've enjoyed in previous years—the Town Hall Plenary Session and the Psychology in Pennsylvania Luncheon, for instance—we've added some exciting new events, including a VIP Breakfast and our first PPA Annual Banquet & Awards Dinner.

So check out the convention schedule and description of new events on pages 12–13. To see the complete workshop schedule, go to pages 15–18.

We're excited about everything PPA2015 has to offer and hope that you will join us June 17–20 at the Hilton in Harrisburg!

## Convention Committee

Dea Silbertrust, PhD, JD
*Chair, Program and Education Board*

Beatrice H. Chakraborty, PsyD
*Chair, Convention Committee*

Ellen M. Adelman, PhD
Gail Cabral, IHM, PhD
Sunshine Collins, MS
Molly Haas Cowan, PsyD
Allyson L. Galloway, PsyD
Michael W. Gillum, MA
Tad T. Gorske, PhD
Gail R. Karafin, EdD
Charles LaJeunesse, PhD
Mark R. McGowan, PhD
Marie C. McGrath, PhD
Cathy C. Petchel, MA
David A. Rogers, PhD
Nancy L. Rogers, MS
Beatrice R. Salter, PhD
Christine M. Samuelsen, PsyD
Adam C. Sedlock Jr., MS
Bernard Seif, SMC, EdD, DNM
Christina B. Shook, PsyD

# CONVENTION SCHEDULE

| | |
|---|---|
| **Wednesday, June 17** | |
| 8:00 a.m. – 5:15 p.m. | Registration |
| 8:00 a.m. – 9:00 a.m. | Continental Breakfast |
| 9:00 a.m. – 10:00 a.m. | Welcome and Overview of PPA2015 ✸ |
| 10:00 a.m. – 10:30 a.m. | Break |
| 10:30 a.m. – noon | Keynote Address |
| noon – 1:30 p.m. | Lunch (On Your Own) |
| 12:30 p.m. – 3:30 p.m. | Executive Committee Meeting |
| 1:30 p.m. – 4:30 p.m. | Workshops |
| 4:30 p.m. – 5:00 p.m. | Break |
| 4:30 p.m. – 6:30 p.m. | General Assembly Meeting |
| 5:00 p.m. – 8:00 p.m. | Workshops |
| **Thursday, June 18** | |
| 7:30 a.m. – 5:15 p.m. | Registration |
| 7:30 a.m. – 8:00 a.m. | Mind-Body River Walk |
| 7:30 a.m. – 8:30 a.m. | Continental Breakfast in Exhibit Hall |
| 8:30 a.m. – 11:30 a.m. | Workshops |
| 11:30 a.m. – 11:45 a.m. | Break |
| 11:45 a.m. – 12:45 p.m. | Psychologically Healthy Workplace Awards |
| 12:45 p.m. – 1:45 p.m. | Give Back Luncheon ✸ |
| 1:45 p.m. – 2:00 p.m. | Break |
| 2:00 p.m. – 5:00 p.m. | Workshops |
| 2:00 p.m. – 5:00 p.m. | PennPsyPAC Board of Directors Meeting |
| 2:00 p.m. | Exhibit Hall Closed |
| 5:30 – 6:30 p.m. | Exhibitor Wine & Cheese Reception ✸ |
| 6:30 – 8:00 p.m. | PPA Annual Banquet & Awards Dinner ✸ $ |
| 8:00 p.m. | Leadership Orientation Reception (invitation only) |
| **Friday, June 19** | |
| 7:00 a.m. – 5:15 p.m. | Registration |
| 8:00 a.m. – 9:00 a.m. | Continental Breakfast in Exhibit Hall |
| 8:00 a.m. – 9:00 a.m. | VIP Breakfast ✸ $ |
| 9:00 a.m. – 10:30 a.m. | Town Hall Plenary Session |
| 10:30 a.m. – 11:00 a.m. | Break |
| 11:00 a.m. – 2:00 p.m. | Research Poster Sessions |
| 11:00 a.m. – noon | Conversations with Poster Presenters |
| noon – 4:45 p.m. | Early Career Psychologists and Students Learning Lounge |
| 12:15 p.m. – 1:45 p.m. | Psychology in Pennsylvania Luncheon $ |
| 2:00 p.m. – 5:00 p.m. | Workshops |
| 2:00 p.m. – 5:00 p.m. | Pennsylvania Psychological Foundation Board of Directors Meeting |
| 5:00 p.m. – 6:00 p.m. | Student/ECP Speed Mentoring |
| 5:00 p.m. – 7:00 p.m. | Early Career Psychologists and Students Networking Reception |
| **Saturday, June 20** | |
| 8:00 a.m. – 1:30 p.m. | Registration |
| 8:00 a.m. – 9:00 a.m. | Continental Breakfast |
| 9:00 a.m. – noon | Board of Directors Meeting |
| 9:00 a.m.-4:00 p.m. | Workshops |

✸ *New* $ *Additional fee applies*

# WHAT'S NEW AT PPA2015?



## Wednesday, June 17

**9:00 a.m.**

### Welcome & Overview of PPA2015

New to PPA? New to the PPA convention? Interested in learning how to maximize your time during the convention? This fun, informative 1-hour session will take place on the first morning of the convention. As an added bonus, earn 1 CE credit for attending!

**10:30 a.m.**

### Keynote Address

PPA welcomes all attendees to the Keynote Address, which now takes place on the first day of the convention! Join PPA members and leaders in their fields Don McAleer, PsyD, Linda Knauss, PhD, John Gavazzi, PsyD, and Samuel Knapp, EdD, along with moderator Timothy Barksdale, PsyD, as they discuss the convention theme: *Innovative Models for the Future.*

## Thursday, June 18

**12:45 p.m.**

### Give Back Luncheon

Register for this complimentary luncheon to learn more about the Pennsylvania Psychological Foundation (PPF) and the Pennsylvania Psychological Political Action Committee (PennPsyPAC). These organizations work to further the field of psychology in Pennsylvania—so why not spend an hour to find out what they are doing for you while eating a free lunch? We'll make it entertaining, educational, and definitely worth your while! Optional donations to either or both organizations will be accepted at the door.

*Donations to PPF are 100% tax deductible, as allowed by law.*

**5:30 p.m.**

### Exhibitor Wine & Cheese Reception

We've stepped up the Exhibitor Networking Reception and made it even better for you! Join your peers and our exhibitors in the exhibit hall for this event on Thursday evening. What makes this different than usual? No tickets are needed this year! Sample food, wine, and other beverages served by our exhibitors at their booths and then stay for our next event.


**6:30 p.m.**

### PPA Annual Banquet & Awards Dinner

For the first time, PPA will be hosting a dinner event at the convention! Join us as we celebrate the recipients of this year's Distinguished Contributions to the Science and Profession of Psychology Award and the Distinguished Service Award. We will also use this opportunity to "pass the gavel" from PPA's outgoing president, Bruce Mapes, PhD, to Beatrice Salter, PhD. PPA committees are encouraged to purchase a table and sit together during this celebratory event. This dinner event follows the new Exhibitor Wine & Cheese Reception in the exhibit hall.

*The VIP registration rate includes a ticket for the Annual Banquet & Awards Dinner.*

## Friday, June 19

**8:00 a.m.**

### VIP Breakfast

Specifically for PPA members who register at the VIP rate, this breakfast promises great food and even better company! Enjoy a full, hot breakfast while chatting with other VIPs. This discounted rate (over what you would pay for registration and all ticketed events) is worth its weight in food!

CONTINUING EDUCATION

# Continuing Education Credits

## Psychologists

PPA is approved by the American Psychological Association (APA) to sponsor continuing education credits for psychologists. PPA maintains responsibility for all our continuing education programs and their content. The continuing education credits for each workshop are designated in the workshop descriptions. You must attend the entire program in order to receive the credit(s), complete the Participant Satisfaction/Evaluation form, and return it to your presenter or monitor at the conclusion of the program.

> ***Partial credits will not be given. A participant may arrive no more than 10 minutes late nor leave more than 10 minutes early to receive credit for a program. There will be no exceptions.***

Certificates of Attendance will be available at www.papsy.org after the convention.

## Act 48 Credits

PPA is an approved provider for Act 48 Continuing Professional Education Requirements as mandated by the Pennsylvania Department of Education. **Certified school psychologists who need Act 48 credits need to include their Professional Personnel ID (PPID) number on the registration form. Non-PPA members must pay an additional $10 for this service.**

Direct questions about Act 48 credits to Katie Boyer, PPA secretary, secretary@papsy.org.

## Social Workers, Marriage and Family Therapists, and Professional Counselors

Social workers, marriage and family therapists, and professional counselors can receive continuing education from continuing education providers approved by APA. Since PPA is approved by APA to sponsor continuing education, licensed social workers, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors will be able to fulfill their continuing education requirement by attending PPA continuing education programs.

For further information, please visit the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors (www.dos.state.pa.us/social).

# Wednesday, June 17

*Complete workshop descriptions are available at **www.papsy.org***

**1:30 p.m.–4:30 p.m.**

*3 CE Credits, Introductory*
**W01 Essentials of Telepsychology Part 1: Foundations for a Telehealth Practice**
Wayne L. Roffer, PsyD

*3 CE Credits, Introductory*
**W02 Special Considerations When Working With Athletes in Your Clinical Practice**
Mark A. Hogue, PsyD

*3 CE Credits, Introductory*
**W03 Underachieving Boys: What's Up?**
Jerry McMullen, PhD

*3 CE Credits, Intermediate*
**W04 Effective Treatment of Substance Use Disorders in the Criminal Justice Population**
Ken Martz, PsyD

*3 CE Credits, Introductory*
**W05 The Remembering and Experiencing Selves: Implications for the Future of Psychology**
Steven Pashko, BA, MA, PhD

*3 CE Credits, Intermediate*
**W06 Just Ethics: The New Science of Morality as Applied to Ethics**
John D. Gavazzi, PsyD

## Program Categories

**Introductory:** Participants need no prior knowledge of your specific topic or content to participate fully and effectively in the program. The information you are presenting or the skills you are teaching will be unfamiliar to those enrolled, although they will be practicing mental health providers or active teachers/researchers.

**Intermediate:** Participants should have some basic knowledge of the specific content you will cover but need not have in-depth knowledge or skills. The program will provide information at a level beyond the basic knowledge of the topic.

**Advanced:** To participate fully, those enrolled must possess a substantial working knowledge or skill level in your specific content area. Generally, the knowledge or skill involved is currently used by the participant in his or her job. At this level, advanced techniques or knowledge would be offered to refine and expand current expertise.

*3 CE Credits, Intermediate*
**W07 Record Keeping and Confidentiality**
Samuel Knapp, EdD, ABPP; Rachael Baturin, MPH, JD

**1:30 p.m.–3:30 p.m.**

*2 CE Credits, Introductory*
**W08 The Validity and Utility of the Rorschach in Pennsylvania Courts**
Shannon Edwards, PsyD, MA; Teal Fitzpatrick, PhD, MA

**5:00 p.m.–8:00 p.m.**

*3 CE Credits, Introductory*
**W09 Essentials of Telepsychology Part 2: Advanced Topics**
Wayne L. Roffer, PsyD

*3 CE Credits, Introductory*
**W10 A Social Security Disability Primer for Psychologists Working With Adults and/or Children**
Marjorie Portnoy, Esq, JD

*3 CE Credits, Intermediate*
**W11 The Adult ADHD Toolkit: Coping Inside and Out**
J. Russell Ramsay, PhD

*3 CE Credits, Intermediate*
**W12 Information From the State Board of Psychology**
Kenneth J. Suter, JD; Richard F. Small, PhD, ABPP; Karen C. Cahilly, Esq; Steven Cohen, PhD; Vito J. DonGiovanni, PsyD; Joe French, EdD, ABPP; Bridget K. Guilfoyle, Esq; Jason E. McMurry, JD; Rodd Narvol, JD; Christina Stuckey

*3 CE Credits, Intermediate*
**W13 Child Custody Evaluations: Best Practices in Selection of Assessment Tools**
Shannon Edwards, PsyD; Sam Schachner, PhD; Teal Fitzpatrick, MA; Ashley Milspaw, PsyD

*3 CE Credits, Intermediate*
**W14 Treating Binge Eating Disorder in the Era of the *DSM-5***
Karen Scher, PhD

*3 CE Credits, Intermediate*
**W15 Ethics Hell**
John Gavazzi, PsyD, ABPP; Samuel Knapp, EdD, ABPP

# Thursday, June 18

*Complete workshop descriptions are available at **www.papsy.org***

**8:30 a.m.–11:30 a.m.**

*3 CE Credits, Intermediate*
**W16 The Hidden Ethics Code**
Samuel Knapp, EdD, ABPP; Jeff Sternlieb, PhD

*3 CE Credits, Introductory*
**W17 Assessment Techniques for Talent Management in Business Settings**
Ross DeSimone, MA

*3 CE Credits, Advanced*
**W18 Psychological Treatments in a Primary Care Setting**
Allen R. Miller, PhD, MBA; Chris Echterling, MD

*3 CE Credits, Intermediate*
**W19 Applications of Family Therapy Concepts and Practices to Culturally Diverse Families**
Francien Chenoweth Dorliae, PsyD; Dawn George, MS

## Workshop Handouts

PPA2015 is paper light! In an effort to be environmentally responsible, PPA is trying to reduce the amount of paper we use at our annual conventions. Workshop handouts will be available at www.papsy.org. We encourage you to download handouts to view on your electronic device during the workshop. We will be copying a very limited number of handouts this year.

## Comfort & Etiquette Considerations

Please turn off your beeper or cell phone or set them to vibrate. If you need to answer your phone, please leave the meeting room to avoid disturbing the training. Bring a jacket or sweater since it is often difficult to control the temperature in the meeting rooms.

**9:30 a.m.–11:30 a.m.**

*2 CE Credits, Introductory*
**W20 Understanding Drug and Alcohol Tests and Their Use in Forensic Evaluations**
V. Richard Roeder, PhD

*2 CE Credits, Intermediate*
**W21 Pediatric Sleep Dysfunction and Its Consequences**
Gail Karafin, EdD

**2:00 p.m.–5:00 p.m.**

*3 CE Credits, Intermediate*
**W22 Hot Topics in Diversity: Applying Positive Ethics and Multiculturalism to Therapeutic Practice, Consultation, and Interventions**
Timothy Barksdale, PsyD; Linda Knauss, PhD, ABPP; Beatrice Salter, PhD; Jeanne Slattery, PhD

*3 CE Credits, Introductory*
**W23 Beyond Bullying: Developing Traits of Character**
Gail Cabral, PhD

*3 CE Credits, Intermediate*
**W24 Evaluations and Assessments of Children Under the IDEA and Section 504**
David Painter, PhD, JD; Marie McGrath, PhD

*3 CE Credits, Intermediate*
**W25 Review of the Laws and Ethical Standards in the Practice of Psychology With Children in Pennsylvania**
Samuel Knapp, EdD, ABPP; Marolyn Morford, PhD

*3 CE Credits, Introductory*
**W26 Using the CANS-Based DataPool to Improve Your Community-Based Service Prescription**
Dan Warner, PhD; Tom Crotty, PhD; Dale Brickley, PhD, MBA

*3 CE Credits, Intermediate*
**W27 Assessment of Social and Emotional Functioning in Autism Spectrum Disorders (Act 48)**
Rosemarie Manfredi, PsyD

*3 CE Credits, Introductory*
**W28 Defending the Civil Right to Treatment for Children With Disabilities**
Steven Kossor, MA

# Friday, June 19

*Complete workshop descriptions are available at **www.papsy.org***

**2:00 p.m.–3:00 p.m.**

*1 CE Credit, Introductory*
**W29 Leadership Approaches According to Santa**
Ross DeSimone, MA

**2:00 p.m.–5:00 p.m.**

*3 CE Credits, Introductory*
**W30 Complicated Grief and Its Treatment: An Overview**
Bonnie J. Gorscak, PhD; Natalia Skritskaya, PhD; Allan Zuckoff, PhD; Valerie Richards, PhD

*3 CE Credits, Introductory*
**W31 Expanding Training Opportunities in Pennsylvania**
Rosemarie Manfredi, PsyD; Williametta Bakasa, PsyD, MBA

*3 CE Credits, Introductory*
**W32 Self-Care: An Ethical Imperative**
Kimberly Richards, PsyD; Jesse Matthews, PsyD; Angela O'Neill, BA

*3 CE Credits, Intermediate*
**W33 Understanding and Applying the APA Guidelines on Telepsychology**
Samuel Knapp, EdD, ABPP; Rachael Baturin, MPH, JD

*3 CE Credits, Introductory*
**W34 Cognitive-Behavioral Therapy for Overcoming Insomnia**
Christina B. Shook, PsyD; Kevin W. Kelly, PsyD; Mark Cassano, MS

*3 CE Credits, Intermediate*
**W35 Integration Into Primary Care: Different Views**
Allen R. Miller, PhD, MBA; TBD; Health Systems: TBD; Vincent Bellwoar, PhD; Daniel Warner, PhD

## Students/Early Career Psychologists

**12:30 p.m.–2:30 p.m.**

*2 CE Credits, Student/ECP*
**S1 Student Leadership Development: Stepping Up to the Plate** *(Discussion)*
Mary Wiley, PhD; Vincent Bellwoar, PhD; Shannon Edwards, MA, PhD; Bruce Mapes, PhD; Gail Karafin, EdD; Tamare Piersaint, MA; Kylie McColligan, MA

**2:45 p.m.–4:45 p.m.**

*2 CE Credits, Student/ECP*
**S2 Ethics and the Student Clinician** *(Roundtable Discussion)*
John Gavazzi, PsyD, ABPP; Bruce Mapes, PhD; Tamare Piersaint, MA; Kylie McColligan, MA

# Saturday, June 20

*Complete workshop descriptions are available at **www.papsy.org***

**9:00 a.m.–noon**

*3 CE Credits, Introductory*
**W36 Create Educational Handouts to Ethically Market Your Practice**
Pauline Wallin, PhD

*3 CE Credits, Introductory*
**W37 Introduction to Exposure Therapy for Obsessive Compulsive Disorder**
Katherine L. Muller, PsyD

*3 CE Credits, Intermediate*
**W38 Ethical Issues in Supervision**
Samuel Knapp, EdD, ABPP; John A. Mills, PhD, ABPP

**1:00 p.m.–5:00 p.m.**

*4 CE Credits, Introductory*
**W39 Eating Disorders: What Professionals Need to Know**
Tracie Pasold, PhD; Jennifer Misunas Buckwash, MA; Whitney Chappell, MA

**1:00 p.m.–4:00 p.m.**

*3 CE Credits, Introductory*
**W40 Sluggish Cognitive Tempo: What Do Clinicians Need to Know?**
Marie C. McGrath, PhD; Jessica Hessler, BA

*3 CE Credits, Intermediate*
**W41 The Effective Supervisor: Training and Competencies**
Rachel Daltry, PsyD; Kristin Mehr, PhD

# REGISTRATION RATES



## Registration Rates*

| Member Category | By June 1 | | After June 1 | |
|---|---|---|---|---|
| | Full | Daily | Full | Daily |
| PPA Member | $365.00 | $170.00 | $430.00 | $200.00 |
| Non-Member | $570.00 | $285.00 | $670.00 | $335.00 |
| Affiliate Member | $215.00 | $110.00 | $250.00 | $125.00 |
| First-Year Post-Doc Member | $65.00 | $50.00 | $70.00 | $55.00 |
| Full-Time Student Member | $65.00 | $50.00 | $70.00 | $55.00 |
| Full-Time Student Non-Member | $135.00 | $65.00 | $155.00 | $75.00 |
| Retired Member | $215.00 | $110.00 | $250.00 | $125.00 |
| VIP (Members Only) | $450.00 | N/A | $515.00 | N/A |
| Guests and Spouses | $85.00 | $55.00 | $95.00 | $65.00 |

*Registration fees cover attendance at most activities. See page 13 for exceptions. The VIP rate is all inclusive.

**PPA Member**—To qualify for membership rates, PPA membership dues must be current for the 2014–2015 association year. New members may qualify for PPA member rates by submitting their completed membership application and first year's dues ($99) to the PPA office with their convention registration form. If you would like more information regarding membership, please contact Iva Brimmer, business manager, at 717-232-3817 or iva@papsy.org.

**Affiliate Member**—Affiliate members are persons with a legitimate professional, educational, or scientific interest in the field of psychology who are not eligible for a higher level of membership (high school teachers of psychology, for example).

**Student Member**—Student members must be either PPA student members or in full-time study. Documentation, if not a PPA student member, is required at time of registration (i.e., student university ID card).

**Retired Member**—Retired member rates apply to PPA members who are 65 years of age or older who are retired and no longer in practice. Documentation is required at time of registration (i.e., copy of driver's license).

**Members Only**

### All-Inclusive VIP Rate!

- All four conference days
- All ticketed events, including:
  - Give Back Luncheon
  - Exhibitor Wine & Cheese Reception
  - PPA Annual Banquet & Awards Dinner
  - Psychology in Pennsylvania Luncheon
  - Special VIP Breakfast

NEW

***Plus, VIPs enjoy a 10% discount on standard rates!***

**Guests and Spouses**—Spouses and guests of convention registrants must accompany someone registered for the convention to qualify for this rate. This special rate applies only to those guests or spouses who are not in a mental health profession (i.e., social work, psychiatric nursing) but wish to participate in the program. One cannot be the guest of a presenter unless that presenter is registered for the convention. Please indicate the name of the registered guest on the registration form.

*Please use promotional code GUEST when processing your registration.*

# REGISTRATION INFORMATION

## Workshop Preregistration

When you register, please select which workshops you will be attending. Every effort will be made to place you in the workshops of your choice; however, due to space limitations or presenters' requests for limited numbers of participants, this may not be possible. Workshops are listed on the online registration form by date, time, workshop number, and abbreviated title.

## Special Needs

PPA is committed to providing access and support to persons with special needs who wish to participate in the programs we sponsor. Persons with disabilities and special needs are asked to contact PPA before June 1:

**Judy Smith**
*Professional Development Specialist*

717-232-3817
or
judy@papsy.org

---

## CONVENTION QUESTIONS?

## 717-232-3817

**Beginning April 1**
register at
www.papsy.org

**No registrations can be processed without payment**
★
**Discounted registration deadline is June 1**

## Convention Registration

- Registration begins April 1. Visit **www.papsy.org** to register online or to print the registration form. You can also call 717-232-3817 to register over the phone.
- On-site registrations will be accepted at the regular convention rate. On-site registration is contingent upon seating availability.
- **Participants are required to preregister for all workshops**. Early registration is advised as seating is limited for some workshops. If you decide to change workshop selections at the convention, we cannot guarantee space availability.
- Every effort will be made to confirm registrations received by June 12, 2015.
- Workshops with insufficient registration as of June 1, 2015, may be cancelled.
- Convention registration fees cover attendance at all activities except ticketed events. The VIP rate, however, includes ticketed events at no extra charge.

## Cancellation Policy

Convention cancellations made by June 10, 2015, will result in a 50% refund. Convention registration cancellations must be received in writing. **Meal and event tickets are not refundable.** Please mail, e-mail, or fax your written notice to Iva Brimmer, Business Manager, PPA, 416 Forster Street, Harrisburg, PA 17102 (iva@papsy.org or fax 717-232-7294). **Refunds requested after June 10, 2015, will not be honored.**

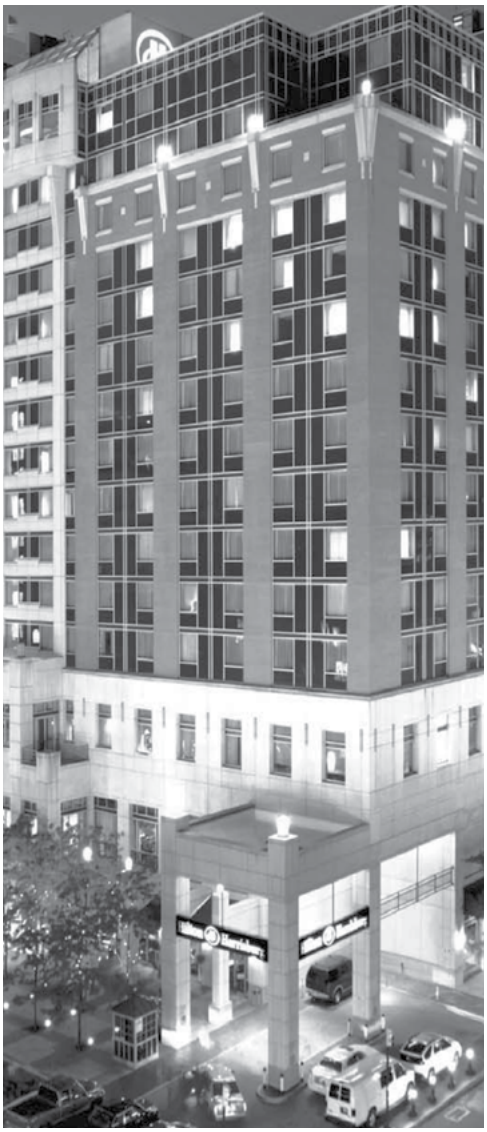
# HOTEL ACCOMMODATIONS



## Hilton
### Harrisburg

1 N. Second St. • Harrisburg, PA

**1-800-HILTONS or 717-233-6000**



The Hilton Harrisburg will be the host hotel for PPA2015. Reservations should be made directly with the hotel.

**When phoning for accommodations please identify yourself as a participant in PPA2015 to obtain the convention group rate.**

**To make your reservation online, visit www.harrisburg.hilton.com. Use the conference group code PAPSYC in the Special Accounts category to get the group room rate.**

**Group Room Rates:** $142 single/double, plus tax. The group rate is protected until May 20. If the room block is sold out before May 20, reservations will be accepted on a space availability basis only, and the rate you are charged will be higher. **Make your reservation early!** We expect the room block to sell out before May 20.

Convenient indoor parking is available in the Walnut Street Parking Garage, attached to the Hilton Harrisburg/Strawberry Square. Parking fees are the responsibility of convention attendees.

**Check-in time begins at 4:00 p.m. Check-out time is 11:00 a.m. If you require a late check-out, please check with the staff at the hotel front desk to see if your request can be honored.**

**PPA CANNOT BE RESPONSIBLE FOR LATE CHECK-OUT FEES OR PARKING FEES.**

The **Hilton Harrisburg** is centrally located near popular Gettysburg, Hershey, and Lancaster attractions. The hotel is 12 miles from the Harrisburg International Airport and 2 blocks from the Amtrak Station. The Hilton is a short walk to many of the city's main attractions and many downtown restaurants. The specialty shops and casual eateries of Strawberry Square are connected directly to the hotel by way of an enclosed arcade. Also connected is the IMAX Theatre and Whitaker Center for Science and the Arts. Just 2 blocks north, you can tour the magnificent Capitol Building and its landscaped grounds. Or, see our state's natural history and fine art on display at the Pennsylvania State Museum.

**www.harrisburg.hilton.com**

# Join the Juggernaut. Or Don't.

*Edward Zuckerman, PhD*

*Dr. Edward Zuckerman*

## The Gods of Our Juggernaut and Their Histories

Big Pharma makes big money. The largest component of increased health-care costs over the last few decades has been the enormous increase in drug cost and use. Generic drugs have reduced profits and, therefore, research on costly side-effects. The low effectiveness has accumulated, and government and professional pushback has limited Big Pharma's "unethical" marketing abilities. While the new psychiatric drug pipeline is empty—Big Pharma has left psych drugs and moved on to cancer and similar high-tech fields—there are still enormous profits being made on the drugs still being prescribed widely.

HIPAA originated in the praiseworthy efforts of lawmakers to limit the payers' denials for pre-existing conditions by requiring "portability" (the "P" in HIPAA). To determine the effectiveness of this policy, the law required computerizing insurance. This is why the largest and most invisible (to us) part of HIPAA is the Electronic Transaction Rule, which standardizes the electronic format of health-care data. Over the last decade, a gigantic computerized system has been put in place by the "insurers."[1] They signed on to HIPAA's Security and Privacy Rules and the hassle of being covered entities because they got the ability to replace all the paper and clerks and back and forth of insuring (verification of benefits, copayments, deductibles, coinsurance, explanations of benefits, and so forth) with computerization. This allows them to save billions of dollars, which, rather than improve services, access, and outcomes, they take out as profit and in outrageous salaries. The data on this is very clear.

The computerization of health care was necessary and then inevitable. Over the last decade, we have seen developments that fit together, such as:

- The implementation of 4010 and then the 5010 protocols for transferring data. The 5010 is incredibly more capable of moving and organizing more data.
- Electronic health records. These are medical devices that have been implemented without Federal Drug Administration oversight, without pilot studies or cost/benefit perspectives, and without the absolutely essential function of interoperability, or sharing data across providers.
- The *ICD-10* with its much finer-grained diagnoses. When combined with revised Current Procedural Terminology (CPT) codes, the *ICD-10* allows for the unbundling of services so that each can be billed for separately. Because more services are delivered and billed, there is greater income to hospitals (but not providers) and more cash flow for payers to take a share of.

The Affordable Care Act has permanently replaced health care with health insurance (possible payment for care), guaranteeing payers a 20% profit and decision control of all payments and therefore services ("care"). As with all things political, it was a compromise—providing (but not guaranteeing) the opportunity for access to minimal care to almost everyone in exchange for ceding control to corporations. For example, payers dealt with the costs of removing the limits on pre-existing conditions and other increased expenses by raising copayments to unrealistic levels (50% of our usual fees) and the deductibles to multiple thousands of dollars.

Psychiatry hopes to stay alive as a medical specialty and not become just a neuroscience. Psychiatry has been shrinking in numbers and quality for many years. Theirs is a harsh situation with a nonunique skill set (psychopharmacology, diagnosing), the abandonment of both historical medical skills and psychotherapy, and the absence of multipliers in their work. While profitable, escaping insurance is not a viable long-term strategy.[2] The recent *DSM-5* should be viewed in this light: Publishing is more than half of the American Psychiatric Association's income. Owning the diagnoses by writing the book that everyone needs and medicalizing more problems have been good strategies. Having said all this, I must recognize that the neuroscience may yet help psychiatry. See, for example: http://www.frontiersin.org/Journal/10.3389/fpsyt.2013.00178/full.

> *The computerization of health care was necessary and then inevitable.*

Health-care corporations seek to maximize profits at the expense of others (externalizing costs; creating moral hazards; shifting most administrative costs to providers; and creating barriers to paying, such as copayments, annual caps, deductibles, medical necessity, and so forth). Based on their actual processes, health-care corporations have largely abandoned insurance (risk spreading) and instead devote most of their efforts to rationing care based on profitability. Medical practices (but not psychological ones) are bought by hospitals to control the flow of their referrals, both in and out. Locally, we see this vertical integration of health-care provision and health insurance at UPMC and Highmark.

[1] I prefer the term "payers" to "insurers." Insurance has a basis in the brilliant concept of the sharing of risk: take a little from many each year and give it the few who need it that year, as in homeowner's and auto insurance. Payers still do that but it is a small share of their work—my guess would be about 25%.

[2] Among medical specialties the highest rate of opting out of Medicare is psychiatry by a wide margin.

*Continued on page 24*

### JOIN THE JUGGERNAUT

*Continued from page 23*

Notably absent from the juggernaut of health care is organized psychology. Psychologists have failed to become legally recognized "physicians," failed to convince decision makers of the value of psychotherapy versus drugs or of doing assessments, and are not seen as contributing much value in the integrated care/medical home/teamwork/capitated model. We, as well as the physicians, can be and will only be employees with different job descriptions in the juggernaut of health care.

The Industrial-Medical-Big Pharma juggernaut spends hundreds of millions of dollars each year in lobbying, and they would not do that if it did not work for their interests.

## Why Is All This Happening?

Health care is the last major industry to be industrialized, and industrialization has well-recognized components and sequences:

- Standard parts: CPT codes for services
- Standardized labor: all laborers become "providers"
- Standardized processes: DRGs, manualized treatments, guidelines, best practices, and treatment plans; Weberian rationalization of the steps of all processes
- Removal of outliers (psychologists) in costs (waste reduction) and performance (undocumented but asserted superiority)
- Professional managers (nonclinicians); costs relentlessly being driven down, especially labor (Remember why unions were created?)

And all the rest, just as industrialization hit gunsmithing by Colt in the 1790s, transportation with the gas engines in the 1920s, and farming with tractors and fertilizers in the 1930s. The Internet hit everything in the 1990s.

The Industrial-Medical-BigPharma-Government Juggernaut: unstoppable, inevitable. Technology and money drive our society and its structures and processes, not history, not ethics, not religion. If you are happy enough with eating all your food at McDonald's and buying all your stuff at Walmart, you will be satisfied with industrial health care.

## What of the Future for Psychologists?

The first decision every clinician must make is to participate in health care or to go elsewhere. Health care and psychology are rapidly and unalterably separating, and we have been trying to straddle them for years with our inventive combinations of income streams. Paraphrasing U.S. Senator Michael Enzi, APA executive director of professional development Katherine Nordal said, "We have to be at the table, or we will be on the menu." Succinct.

I must recognize that there are possible ways to join health care while respecting private practice (independent practice associations, for example), and I don't know their local status. Non–health care is all kinds of training ("skill building"), using psychological principles (but likely not identified as "psychological"), therapy for those few who can afford our fees, forensics for those who must afford our fees, and a hundred other niches.

I see the future of psychologists as outside formal psychology. I call it FOPINIP for the "future of psychologists is not in (what is currently called) psychology." For example, behavioral

*The first decision every clinician must make is to participate in health care or to go elsewhere.*

economics is completely psychology. Computers are some hardware, some software, and a lot of design, interface, and psychology. The Internet is all interface. Businesses love and need the social psychology of "leadership," which is either personality or small group dynamics; "succession planning," which is family dynamics; positive psychology, which speaks to creativity and innovation; and the decision sciences of "thinking smarter." Politics is almost all psychology (influence, persuasion, and small group dynamics with a little economics). No human activity is devoid of psychology, and we are its experts.

On the horizon for the next decade is some potentially good news. Over the next decade we will see the implementation and integration into the juggernaut of the *ICD-11* and the other ICs: International Classification of Functioning, Disability, and Health; International Classification of Health Interventions; and IC for causations. Use of all of these together will close the circle from cause to symptoms to loss of function to treatment. Add in the full information on costs and outcomes and the actual monetary and human costs of prevention can be documented.

# Integrating Behavioral Health and Primary Care: Why the Fuss and Where Are the Opportunities?

*Paul Kettlewell, PhD, ABPP*

*Dr. Paul Kettlewell*

Interest in the integration of behavioral health (BH) and primary care (PC) services has exploded in the past decade among broad groups, including health-care providers, health-care delivery systems, insurance companies, and professional organizations.

Many psychologists are committed to this new paradigm, believing it to be a critical opportunity for our profession to embrace. The American Psychological Association (APA) has taken some bold steps to prioritize both advocacy and education: The May 2014 edition of the *American Psychologist* was devoted entirely to a scholarly review of this paradigm; APA's president, Barry Anton, PhD, has chosen the expansion of integrated care as the priority for his presidency; and APA hired Douglas Tynan, PhD, as director of integrated health care. PPA likewise has emphasized integrated care with multiple continuing education offerings. David J. Palmiter, PhD, ABPP, has led a successful joint task force with Pennsylvania psychologists and pediatricians, and Dan Warner, PhD, ably leads the current Integrated Care Task Force.

## Why the Fuss?

The failure of American health systems to meet BH needs represents a serious public health concern. Let's look at some of the facts and the rationale:

1. *BH disorders occur frequently.* Approximately 1 in 5 Americans (20%) has a BH disorder. When expanded to include subdiagnostic BH problems, prevalence increases to over half of the population (Cunningham, 2009). Many BH problems emerge early in life and persist into adulthood (Kessler et al., 2005).
2. *We have BH treatments that work.* The evidence of effective treatments for most BH disorders is compelling. The potency of those treatments (as measured by effect size of treatment) is strong or stronger than those for widely accepted treatments for many medical disorders (Weisz, Sandler, Durlak, & Anton, 2005).
3. *Most people with a BH disorder do not get treatment services.* Barely 1 in 3 people with a BH disorder actually receive BH care (Wang et al., 2005; National Institute of Mental Health [NIMH], 2012). Rates of BH services being provided are even lower for children in need and those in rural areas.
4. *The consequences of unmet BH needs are substantial.* The lack of BH services for those in need contributes significantly to a range of social problems and causes significant impairment for those not receiving care. For children, untreated early onset BH disorders are significantly related to early school termination (Breslau et al., 2009). For adults, BH disorders are identified by the NIMH as a leading category for disability-adjusted life years lost in the United States (Mojtabai et al., 2011).
5. *We cannot adequately address increasing health-care costs unless we address the deficiencies in BH care delivery.* Untreated BH disorders impact medical outcomes and result in increased use of medical services. Individuals with untreated BH problems visit medical providers twice as often as those receiving BH services.
6. *The integration of BH and PC services represents an opportunity to substantially improve the BH delivery system and help more people with BH problems.* Primary care physicians (PCPs) are the de facto providers of BH care in this country; yet, they clearly do not have enough time, are not adequately trained, and do not have financial incentive to provide BH care. They need our help.

## What Do We Mean by "Integrated Care," and What Evidence Is There for This Model?

The term "integrated care" is used in a variety of ways to indicate collaboration between BH providers such as psychologists with PCPs. Lewis, Colla, Schoenherr, Shortell, and Fisher (2014) identified three categories of integrated care: (1) consulting models, in which PCPs use a BH provider consultation service; (2) co-located models, in which BH providers and PCPs share physical space; and (3) embedded models, in which BH providers work directly and daily on PC teams. We especially need to be clear about what model we are discussing when we consider outcomes.

Although a thorough review of the evidence supporting integrated care models is well beyond the scope of this article, outcomes are quite encouraging: increased identification of BH problems; improved access to BH care; and increased patient, as well as BH and PC provider, satisfaction. Positive clinical outcomes include changes in target symptoms, improvements in quality of life, and less reliance on unnecessary medical care, resulting in some reduced health-care costs.

The Institute of Medicine has identified research that will clarify the consequences of integrated care models as one of the Top 100 Research Questions. Similarly, the Agency for Healthcare Research and Quality identified outcome research of integrated care models as a critical future research need.

## Does Integrated Care Provide a Cost Offset, and Should It Matter?

Some advocates of integrated care have suggested that implementation will result in a cost offset—that the expenses associated with its expansion will be offset by the health-care cost savings associated with its implementation.

*Continued on page 26*

**INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE . . .**

*Continued from page 25*

No compelling evidence exists to fully demonstrate this yet. However, I frankly take offense at the suggestion that expanding BH services requires a cost offset for its justification. Consider just these two facts: 20% of those in our society have a BH disorder, yet 67% of them get no BH services at all. Would we tolerate not treating 67% of those in our society who suffer from a type of medical disorder?

The percentage of total health care dollars spent on BH care has decreased from approximately 7.5% in 1986 to 6.0% in 2014. We clearly underfund BH services, and increasing BH care is justified on multiple levels, not solely because of anticipated overall health-care cost savings. Integrated care models clearly hold promise for delivering BH services to more people more efficiently and should, therefore, be evaluated as potentially cost-efficient models even if a cost offset is not fully demonstrated.

## Where Are the Opportunities for Us?

The opportunities for those of us practitioners who work in integrated health-care systems seem clear. However, I would like to strongly encourage those of us in solo or small group practice to both embrace the compelling need for change in how we deliver BH services and look for opportunities to make some changes in how we practice. Here are some suggestions:

1. Form alliances with PCPs in your area. They share many of your values, the most important of which is your commitment to the welfare of your clients.
2. Listen to the main concerns of PCPs—those that they express directly to you and those that they have already well articulated. Consider PCPs as clients or customers who want better BH services for their patients and try to address some of their main concerns. You will likely hear PCPs state concerns about inadequate time to screen for BH problems, lack of knowledge and comfort about how to efficiently conduct BH assessments, lack of time or skill to provide BH care, and financial disincentives to discuss behavioral or emotional problems with their patients.
3. Pick practical small steps you could take to collaborate more effectively with PCPs, such as providing a certain number of urgent appointment slots for their referrals, giving PCPS one BH screening tool to use and helping them use it, or sharing very brief and clear bottom-line conclusions regarding your evaluation of their referrals.
4. Join all of us at PPA to encourage expansion of integrated care models, outcome research, training models for students in integrated care settings, and advocacy for changes in how we deliver and pay for BH services in this country. The challenges are significant but with those challenges come great opportunities.

## References


Breslau, J., Miller, E., Breslau, N., Bohnert, K., Lucia, V., & Schweitzer, J. (2009). The impact of early behavior disturbances on academic achievement in high school. *Pediatrics, 123*(6), 1472–1476.

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs, 28*(3), w490–w501.

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., & Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine, 352*(24), 2515–2523.

Lewis, V. A., Colla, C. H., Schoenherr, K. E., Shortell, S. M., & Fisher, E. S. (2014). Innovation in the safety net: Integrating community health centers through accountable care. *Journal of General Internal Medicine*. 2014. *29*(11): 1484–1490.

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., . . . Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine, 41*(08), 1751–1761.

National Institute of Mental Health. (2012). Any mental illness (AMI) among adults. Retrieved from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 603–613.

Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*(6), 628.

# Primary Care Behavioral Health: Improving Access to Care

*Shelley Hosterman, PhD; Tawnya Meadows, PhD; Monika Parikh, PhD*


*Dr. Shelley Hosterman*


*Dr. Tawnya Meadows*


*Dr. Monika Parikh*

Behavioral health needs in children and adolescents represent a serious public health concern. Estimated lifetime prevalence for a behavioral health diagnosis is 49.5% up to age 18 with 20% of youths meeting criteria for multiple disorders (Merikangas et al., 2010). Pediatric behavioral health problems result in substantial costs to both financial and functional domains. Annual economic costs of behavioral health problems in young people were estimated at $247 billion in 2007 (Eisenberg & Neighbors, 2007). Individuals with untreated behavioral health needs create a burden within the health-care system by visiting medical providers twice as often than those receiving behavioral health services (Lechnyr, 1992). Research indicates that patients with untreated psychiatric diagnoses utilize 57% more medical services when compared to treated counterparts (Borus et al., 1985). A meta-analysis indicates reductions in medical costs when patients receive behavioral health interventions (Chiles, Lambert, & Hatch, 1999).

## The Current System Is Not Meeting Needs

There is increasing evidence that many children with behavioral health disorders do not receive any behavioral health specialty services (Burns et al., 1995; Leaf et al., 1996). Data across populations indicate only 37% of people with a disorder actually receive behavioral health care (Barry, 2004). Indeed, 4 out of 5 children (80%) with diagnosable behavioral health problems presenting in primary care are not receiving any behavioral health services (Costello, 1986).

Behavioral health problems are prominent in primary care practice. Studies show between 15 and 21% of pediatric visits are made solely for behavioral health concerns (Williams, Klinepeter, Palmes, Pulley, & Foy, 2004). Parents or pediatricians mention psychosocial issues during 50 to 80% of appointments (Cassidy & Jellinek, 1998).

During direct observations of primary care visits in an integrated clinic, parents or pediatricians discussed behavioral, developmental, or emotional concerns in 23.6% of visits while only 9% of visits were made specifically for those concerns (Cooper, Valleley, Polaha, Begeny, & Evans, 2006). Surveyed pediatricians rank behavior as the most common problem in their practice, with oppositional behaviors labelled most frequent and challenging (Arendorfer, Allen, & Aljazireh, 1999). Among parents in rural settings, 63% identified their pediatrician as their main source of help for behavioral health concerns, whereas only 24% of patients had sought assistance from mental health providers (Polaha, Dalton, & Allen, 2011).

## Problems With Behavioral Health Management in Traditional Primary Care

Management of behavioral health concerns increases appointment duration in primary care and places a burden on primary care providers (PCPs). Mention of behavioral health concerns adds 5 minutes to average appointment times, and visits scheduled specifically for behavioral health problems last 7 minutes longer than typical medical appointments (Cooper et al., 2006). Reimbursement rates for visits focusing only on behavioral health generate fewer dollars per minute of physician time when compared to visits focusing only on aspects of physical health (Meadows, Valleley, Haack, Thorson, & Evans, 2011).

Given these facts, it is not surprising that pediatricians do not always respond to behavioral health issues. In one study, 50% of families took the opportunity to raise behavioral or psychosocial concerns when offered, but PCPs responded with information, guidance, reassurance, or referral in just 40% of observations in which a behavioral concern was raised (Sharp, Pantell, Murphy, & Lewis, 1992).

PCPs report significant barriers to assisting patients with behavioral health needs. Surveyed pediatricians note lack of time (77%), specialist wait lists (74%), lack of training (65%), limited confidence in counseling (62%) and medication (59%) treatments, and lack of local child providers (61%) as barriers to management of behavioral health in patients (Horwitz et al., 2007).

Parent-report data indicate that just half of children whose parents consulted with pediatricians regarding behavioral health concerns received services, although speaking to a pediatrician did increase rates of initial contact with mental health services from 18% to nearly 50% (Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000).

## Promising Outcomes

Integration of behavioral health providers into primary care offers a promising solution to shortcomings within the current system. There is evidence of improved access to care, with 81% of patients attending their first behavioral health visit in integrated settings (Valleley et al., 2007).

Following a brief course (one to six visits) of integrated behavioral health consultation, 74% of children experienced improvement or resolution of problems as measured by behavioral checklist ratings. Medical utilization of patients receiving psychological consultation was significantly reduced during the treatment, while utilization in a comparison group remained

*Continued on page 28*

**PRIMARY CARE BEHAVIORAL HEALTH . . .**

*Continued from page 27*

unchanged (Finney, Riley, & Cataldo, 1991).

Similarly, data indicate that the overuse of primary care is reduced after children with disruptive behaviors engage in a brief course of behavior therapy (Valleley, Polaha, & Evans, 2004). In a study examining outcomes across two primary care behavioral health (PCBH) clinics, parent and therapist ratings of symptoms demonstrated significant reductions after a brief course (one to five sessions) of behavior therapy, even when a full course of treatment was not completed. Patients felt recommendations from therapists were reasonable and reported satisfaction with integrated services. Finally, pediatricians reported satisfaction with integrated services (Sobel, Roberts, Rayfield, Barnard, & Rapoff, 2001).

## The Geisinger PCBH Model

Geisinger pediatric clinics are staffed by psychologists and postdoctoral fellows. On-site services include brief, problem-focused family, individual, and group therapy. Schedules account for prearranged visits, physician consultations, brief unscheduled patient visits, crisis evaluations, and same-day assessments. Efforts to increase physician knowledge and skills include training and support in behavioral health screening tools, medication consultation with psychiatry, and shared behavioral health handouts. Collaborative patient care is supported by shared medical records and an open door policy between physicians and behavioral health providers. Program evaluation data indicate positive outcomes paralleling those in the national literature.

Surveys indicate increased satisfaction with services among families and PCPs working within PCBH clinics. Data demonstrate clinically significant reductions in symptom severity following brief courses of treatment in PCBH clinics with concurrent increases in parent-reported quality of life.

PCPs in PCBH clinics view behavioral health as a core part of their treatment teams and report a unified treatment approach compared to providers from traditional clinics. Frequency of collaboration between psychologists and PCPs has increased over time and accounts for 25% of patient contacts.

*PCBH is a promising new direction in psychology and is prominent in domains of national policy, research, and clinical care.*

Evidence of potential cost savings includes reduction in prescription costs in PCBH clinics relative to comparison sites and prevention of emergency department visits and psychiatric hospitalizations due to availability of same-day crisis appointments.

Most important, there is evidence to suggest dramatic improvement in patient access to care. This includes shorter wait time to first appointment, reduced driving distance to receive care, impressive appointment show rates, and increased referral rates for behavioral health care. In sum, outcome data from the Geisinger PCBH model indicate that this type of model is a feasible, acceptable, and effective solution to service challenges within Pennsylvania.

## Preparing Psychologists in Pennsylvania

Psychologists interested in PCBH practice can take small steps toward establishing partnerships with interested clinics. These could include mailings to local primary care offices offering meetings or educational sessions or holding a brown bag lunch to discuss benefits of an on-site psychologist. Partnership may begin with just 1 day per week of on-site services and increase over time. Practitioners looking to learn more about integrated care psychology can consult books, view webinars, and attend local and national conferences specific to integrated care (e.g., Collaborative Family Healthcare Association and the Geisinger Integrated Care Conference).

Pennsylvania psychology training programs must also prepare trainees for this new direction in the field. This includes course work in integrated care, practicum and internship in PCBH settings, and revising competencies to those relevant to a brief, integrated treatment approach.

There are significant needs for advocacy related to integrated care and sustainability of the new model. Current billing codes do not support payment for many collaborative patient tasks conducted by psychologists in PCBH settings.

PCBH is a promising new direction in psychology and is prominent in domains of national policy, research, and clinical care. PPA members and leadership should collaborate on PCBH initiatives to ensure that Pennsylvanians benefit from this cutting-edge approach.

## References


Arndorfer, R. E., Allen, K. D., & Aljazireh, L. (1999). Behavioral health needs in pediatric medicine and the acceptability of behavioral solutions: Implications for behavioral psychologists. *Behavior Therapy, 30*(1), 137–148.

Barry, C. L. (2004). Trends in mental health care. *Issue Brief (Commonw Fund)*, 1–8.

Borus, J. F., Olendzki, M. C., Kessler, L., Burns, B. J., Brandt, U. C., & Broverman, C. A. (1985). The 'offset effect' of mental health treatment on ambulatory medical care utilization and charges: Month-by-month and grouped-month analyses of a five-year study. *Archives of General Psychiatry, 42*(6), 573–580.

Briggs-Gowan, M. J., Horwitz, S. M., Schwab-Stone, M. E., Leventhal, J. M., & Leaf, P. J. (2000). Mental health in pediatric settings: Distribution of disorders and factors related to service use. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(7), 841–849.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3),147–159.

Cassidy, L. J., & Jellinek, M. S. (1998). Approaches to recognition and management of childhood psychiatric disorders in pediatric primary care. *Pediatric Clinics of North America, 45*(5), 1037–1052.

Chiles, J. A., Lambert, M. J., & Hatch, A. L. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology: Science and Practice, 6*(2), 204–220.

Cooper, S., Valleley, R. J., Polaha, J., Begeny, J., & Evans, J. H. (2006). Running out of time: Physician management of behavioral health concerns in rural pediatric primary care. *Pediatrics,118*(1), e132–e138.

Costello, E. J. (1986). Primary care pediatrics and child psychopathology: A review of diagnostic, treatment, and referral practices. *Pediatrics, 78*(6), 1044.

Eisenberg, D., & Neighbors, K. (2007). *Economics of preventing mental health disorders and substance abuse among young people.* Paper commissioned by the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising


*Continued on page 30*

# New Tools for Assessment, Treatment, and Research: Technology Innovations That Enhance Practice

*Patricia Gratson, MS*

*Patricia Gratson*

Technology has become integrated into our everyday lives in many ways. A new trend that is rapidly developing is the practice of using technology to enhance mental health services. From smartphone and tablet applications to virtual simulators, technology is making its way into the field of psychology. This article examines just a few of the tools currently available to assist psychotherapy clients and psychologists.

## Virtual Simulators

Virtual reality simulators are devices that create computer-simulated environments that can re-create real-world experiences and sensations. This type of technology has been researched and improved upon for many years. Most of the applications this technology has been used with are in the area of video gaming. However, virtual reality simulators have also been in use for several years to assist therapists with alleviating various types of anxieties in their patients.

The Virtual Reality Medical Center, with multiple locations on the West Coast and in Orlando, Florida, utilizes virtual reality-enhanced cognitive-behavioral therapy to treat panic disorder, specific phobias, agoraphobia, and social phobia. In addition, they have created programs to provide virtual reality treatment for posttraumatic-stress disorder and stress inoculation trainings for the military. The center uses a progressive approach to treatment that starts with using biofeedback to help clients recognize the signs of stress and anxiety and to learn to relax themselves when stressors appear. The virtual reality exposure begins after the client has learned anxiety management skills, and the exposure allows the client to practice these skills in a virtual world. As with any exposure therapy, the level of exposure increases as the client becomes more comfortable with the stressor being presented. The clinic lists as advantages of virtual reality therapy reduced costs and risks over traditional in vivo exposure and a more complete control of the exposure experience.

## Wearable Technology

Wearable technology is becoming increasingly available for psychotherapy uses. Wearable technology consists of items such as watches, wristbands, and various articles of clothing. Generally these types of tools use sensors to analyze various physiological functioning in order to track physical performance or monitor health-related conditions. Recently, mental health providers and researchers have adapted wearable technology to assist with symptom management as well as research into the physiological aspects of various mental health disorders.

The University of Pennsylvania has been working on the development of a digital watch for use with patients diagnosed with schizophrenia. The watch is able to be programmed with personalized messages that help the patient cope with symptoms. For example, for a patient who experiences auditory hallucinations via voices, the watch can be programmed to scroll messages that coach the individual through relaxation exercises to help with the stress caused by the voices.

The W/Me wristband, created by a company called Phyode, analyzes a wearer's moods and offers interactive guides for controlling them. Each band contains a medical-grade sensor the company calls the "life spectrum analyzer." The device is able to capture and analyze electrical impulses emanating from the wearer's right atrium. When a user touches and holds the wristband, a set of measurements are generated and transmitted to the user's smartphone. The data produce graphs that chart the user's score on various measures of anxiety. If any score is extreme, the application has a virtual coach that guides the user through breathing exercises.

Researchers at the University of California–San Diego are using a tool called the LifeShirt, a computerized vest that continuously monitors a wearer's movements, to help monitor the brain functions of individuals with bipolar disorder. LifeShirt measures hyperactive and repetitive movements and collects data on respiration and heart rate, as well as other physiological measures. There is also a camera embedded in the vest that records the wearer's movements.

## Smartphone Applications

More and more smartphone applications seem to become available each day for use in mental health assessment and treatment. Clients can interact with smartphone applications to get or track information about current mood and symptoms. In addition, these applications can use a phone's built-in technology to provide environmental data that can help predict when stressors might occur. These applications can be programmed to provide suggestions and activities that help the individual to alleviate symptoms and manage stress.

Mobile Therapy is a smartphone application that randomly allows a mood map to pop up on the user's cell phone. The user then drags a red dot around the screen to indicate his or her current mood. Based on the mood, the application offers therapeutic exercises ranging from breathing techniques to visualizations. The user and the therapist can later analyze a whole week of mood data in order to better understand what is linked to the patient's moods.

Another application currently available is Buddy, an app designed for therapists to use with their clients. The application allows clients to text daily records of their moods and goal achievements, which are later analyzed by the therapist to assess progress. The Tell Me About It! app was designed for use with children on the autism spectrum and uses applied behavioral analysis techniques to help them label, categorize, and comprehend words. Additional applications are in development to further utilize mind-mapping techniques, as well as to assess

*Continued on page 30*

## PRIMARY CARE BEHAVIORAL HEALTH . . .

*Continued from page 28*

Interventions, Board on Children, Youth, and Families, National Research Council and Institute of Medicine, Washington, DC.

Finney, J. W., Riley, A. W., & Cataldo, M. F. (1991). Psychology in primary health care: Effects of brief targeted therapy on children's medical care utilization. *Journal of Pediatric Psychology, 16*(4), 447–461.

Horwitz, S. M., Hoagwood, K. E., Kelleher, K. J., Stein, R. E. K., Storfer-Isser, A., & Youngstrom, E. A. (2007). Barriers to the identification and management of psychosocial issues in children and maternal depression. *Pediatrics, 119*(1), e208–e218.

Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., & Hoven, C. W. (1996). Mental health service use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(7), 889–897.

Lechnyr, R. (1992). Cost savings and effectiveness of mental health services. *Journal of the Oregon Psychological Association, 38,* 8–12.

Meadows, T., Valleley, R., Haack, M. K., Thorson, R., & Evans, J. (2011). Physician "costs" in providing behavioral health in primary care. *Clinical Pediatrics, 50*(5), 447–455.

Merikangas, K., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., & Cui, L. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). Journal of the *American Academy of Child and Adolescent Psychiatry, 49*(10), 980–989.

Polaha, J., Dalton, W., & Allen, S. (2011). The prevalence of emotional and behavior problems in pediatric primary care serving rural children. *Journal of Pediatric Psychology, 36*(6), 652–660.

Sharp, L., Pantell, R. H., Murphy, L. O., & Lewis, C. C. (1992). Psychosocial problems during child health supervision visits: Eliciting, then what? *Pediatrics, 89*, 619–623.

Sobel, A. B., Roberts, M. C., Rayfield, A. D., Barnard, M. U., & Rapoff, M. A. (2001). Evaluating outpatient pediatric psychology services in a primary care setting. *Journal of Pediatric Psychology, 26*(7), 395–405.

Valleley, R. J., Kosse, S., Schemm, A., Foster, N., Polaha, J., & Evans, J. H. (2007). Integrated primary care for children in rural communities: An examination of patient attendance at collaborative behavioral health services. *Families, Systems, & Health, 25*(3), 323–332.

Valleley, R. J., Polaha, J., & Evans, J. (Fall, 2004). The impact of behavioral healthcare services on medical utilization for children with externalizing disorders in a rural community. *Journal of Rural Community Psychology, E7*(2).

Williams, J., Klinepeter, K., Palmes, G., Pulley, A., & Foy, J. M. (2004). Diagnosis and treatment of behavioral health disorders in pediatric practice. *Pediatrics, 114*(3), 601–606.

## NEW TOOLS FOR ASSESSMENT . . .

*Continued from page 29*

user mood based on typing style and steadiness of grip on the phone.

Mobilyze, a mobile application that is still under development at Northwestern University, will be used to assist individuals with depressive disorders. The application will use sensors already built into smartphones, such as GPS and Bluetooth, to help gather data about an individual's location. The user then enters information about his or her current mood into the phone via the application. The technology in the phone "learns" to equate various environmental stimuli with the person's self-reported moods in order to passively predict the person's mental state. The application then suggests in-the-moment interventions to help alleviate depressive symptoms. An initial trial of the application was supported by a website and manualized coaching to help promote adherence to the protocol. The most current trial incorporated new features, such as personalized text messages or phone calls to prompt a user to call a family member when the application senses the user is depressed.

As our ability to design and build technology increases, so do the possibilities for using technology in the practice of psychotherapy. The applications discussed above are just a sampling of what is currently in use or being developed or test marketed. As our technological abilities continue to progress, more and more of these types of tools will become available for psychologists to help their patients improve their lives.

# School-Based Mental Health: Prevention in 2015

*Courtney L. McLaughlin, PhD, NCSP; cmc@iup.edu*


*Dr. Courtney McLaughlin*

With the arrival of a new year, Psych Central published an article by Webb (2014) titled, "The Four Greatest Psychological Discoveries of 2014." Given the current use of social media, this article, with its eye-catching title, spread quickly.

The title, however, is not the most interesting aspect of this article. The themes and findings of the four studies cited in the article are the most surprising: (1) daily activities bring more happiness than major life activities (Zhang, Kim, Brooks, Gino, & Norton, 2014); (2) awareness of our thoughts and feelings in the moment improves health (Loucks, Britton, Howe, Eaton, & Buka, 2014); (3) sleep reduces negative, anxiety-driven thinking (Nota & Coles, 2014); and (4) treating yourself with kindness and compassion contributes to better coping in life (Kelly, Vimalakanthan, & Miller, 2014). The studies certainly have limitations, especially regarding external validity; however, the themes that emerged are evident—mental health, good self-care, and prevention!

While the field of psychology is hard at work getting "the word out" about good self-care and preventing maladaptive behavior, it is unclear how this message is being communicated to children and adolescents. How are they becoming informed about the importance of good mental health care and prevention? Fortunately, in the past several years the attention on school-based mental health (SBMH) services has been on the rise. Professional presentations at national and international conferences have more than doubled and the National Association of School Psychologists made the theme of their 2015 annual convention, "Student Success: Mental Health Matters."

This new focus on SBMH is timely as the entire, broad field of mental health service providers (i.e., counselors, social workers, licensed psychologists, school psychologists) struggles to meet the demands of the public. For example, mental health systems and educational systems have only served 20% of children and adolescents who need mental health services (Burns et al., 1995; Condition of Education [COE], 2008; National Advisory Mental Health Council [NAMHC], 2001; Strein, Hoagwood, & Cohn, 2003).

Still, schools have remained the primary provider of mental health services to children and adolescents through delivery of special education services (Rones & Hoagwood, 2000; Slade, 2002). Some researchers have speculated that this is probably because children and adolescents are more likely to seek support when SBMH services are provided (Rones & Hoagwood, 2000; Slade, 2002). Additionally, a significant number of school districts have reported an increased need for mental health services in light of decreased funding (Foster et al., 2005).

Certainly, schools have a vested interest in the prevention of mental health issues. For example, in schools implementing components of SBMH, reductions in special education referrals and placements among at-risk students and improved school climates have been documented (Bruns, Walrath, Glass-Siegel, & Weist, 2004; Hussey & Guo, 2003). Additionally, schools implementing components of SBMH have reduced their disciplinary referrals and grade retentions (Bruns et al., 2004; Hussey & Guo, 2003). Some studies have demonstrated that greater provision of SBMH services positively correlated with increased standardized test scores and with improved academic performance (Fleming et al., 2005; Greenberg et al., 2003; Welsh, Parke, Widaman, & O'Neil, 2001).

## A Problem-Solving Model

The field of school psychology is in the midst of an era of the problem-solving model, where decisions are data based and interventions and support increase or change depending on how students respond. The two biggest influences of this approach have been response to intervention and positive behavior support frameworks. However, it appears that SBMH models are quickly closing in on third place.

SBMH models have developed from the public health model. Presently, there is a dearth of literature evaluating different types of SBMH programs. Nastasi and Varjas (2008) and Doll and Cummings (2008) have contributed significantly to the literature and they highlight one essential component to SBMH: prevention. A primary goal of SBMH services is to prevent children from developing more serious clinical symptoms (Adelman & Taylor, 2000; Christner, Forrest, Morley, & Weinstein, 2007; Doll & Cummings, 2008; Nastasi & Varjas, 2008; Weist, Stiegler, Stephan, Cox, & Vaughan, 2010).

This emphasis on prevention is understandable, as researchers have suggested SBMH services because such services would aim to decrease social-emotional problems for children (Doll & Cummings, 2008). Additionally, these services would increase behavioral and academic performance in children who are both at risk for developing more serious mental health problems and who already have a mental health diagnosis (Doll & Cummings, 2008).

Of course, a well-developed SBMH model should not be limited to only preventive levels of support. A comprehensive model includes tertiary and intensive levels of support to address the needs of all students. Additionally, capitalizing on the popular article by Webb on Psych Central (2015) and being careful to keep focus on all that 2015 can offer, an examination of how professionals support children and

adolescents to engage in good self-care and prevention of maladaptive mental health problems may be the best place to start or to refocus our energy.

## Developing a SBMH Preventive Approach

Strein and Koehler (2008) asserted that there are 10 critical features of successful prevention programs:

1. It is theory driven, meaning that the prevention program is founded on cognitive-behavioral and behavioral instructional methods that are proven to be efficacious.
2. The program is developed to match the desired outcomes of the system. For example, if prevention of substance abuse is desired, then focus on the environment may be a target.
3. The prevention program must be comprehensive with multiple interventions utilized across a variety of settings.
4. A variety of methods must be incorporated (i.e., skills-based and hands-on modalities).
5. The prevention program must use structured manuals and/or curricula to deliver services to ensure structure and consistency.
6. The program must encourage positive relationships between the parent and child, student and teacher, or student and student.
7. The prevention program must target interventions at appropriate developmental times. For example, a prevention of depression program beginning in 12th grade may miss a large population of students that has already progressed from an at-risk to a clinical stage of depression.
8. The staff members who implement the program should be well trained.
9. The program should be an appropriate length (i.e., not too short in duration).
10. There should be a formal evaluation of the program process and outcomes.

These 10 critical features of prevention programs are the foundation for many SBMH models.

## Conclusion

Both the dissemination of the message regarding the importance of mental health and good self-care to children and adolescents and the delivery of services are dependent on the collaboration of multiple professionals across systems. Perhaps the start of 2015 is a good time to pause and reflect on one's role and contributions to this greater system of service delivery. After all, focusing on the moment, enhancing self-awareness, improving sleep, and treating oneself with kindness and respect seem like ideal steps for everyone, regardless of age.

### References


Adelman, H. S., & Taylor, L. (2000). Promoting mental health in school in the midst of school reform. Journal of *School Health, 70,* 171–178.

Bruns, E. J., Walrath, C., Glass-Siegel, M., & Weist, M. D. (2004). School-based mental health services in Baltimore: Association with school climate and special education referrals. *Behavior Modification, 28,* 491–512.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs* (Millwood), *14,* 147–159.

Christner, R. W., Forrest, E., Morley, J., & Weinstein, E. (2007). Taking cognitive-behavior therapy to school: A school-based mental health approach. *Journal of Contemporary Psychotherapy, 37,* 175–183.

Condition of Education (COE). (2008). *Findings from the condition of education 2008: Enrollment, student diversity on the rise*. Washington, DC: National Center for Education Statistics.

Doll, B., & Cummings, J. A. (2008). Best practice in population-based school mental health services. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology V* (pp. 1333–1347). Bethesda, MD: National Association of School Psychologists.

Fleming, C. B., Haggerty, K. P., Catalano, R. F., Harachi, T. W., Mazza, & Gruman, D. H. (2005). Do social and behavioral characteristics targeted by preventive interventions predict standardized test scores and grades? *Journal of School Health, 75,* 342–349.

Foster, S., Rollefoson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School mental health services in the United States, 2002–2003.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58,* 466–474.

Hussey, D. L., & Guo, S. (2003). Measuring behavior change in young children receiving intensive school-based mental health services. *Journal of Community Psychology, 31,* 629–639.

Kelly, A. C., Vimalakanthan, K., & Miller, K. E. (2014). Self-compassion moderates the relationship between body mass index and both eating disorder pathology and boy image flexibility. *Body Image, 11,* 446–453.

Loucks, E. B., Britton W. B., Howe C. J., Eaton, C. B., & Buka, S. L. (2014). Positive associations of dispositional mindfulness with cardiovascular health: The New England family study. *International Journal of Behavioral Medicine,* 1–11.

Nastasi, B. K., & Varjas, K. (2008). Best practices in developing exemplary mental health programs in schools. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology V* (pp. 1349–1360). Bethesda, MD: National Association of School Psychologists.

National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development Employment. (2001, October). *Fact on children's mental health in America.* Retrieved from http://www.nami.org/Template.cfm?Section=Federal_and_State_Policy_Legislation&template=/ContentManagement/ContentDisplay.cfm&ContentID=43804

Nota, J. A., & Coles, M. E. (2014). Duration and timing of sleep are associated with repetitive negative thinking. *Cognitive Therapy and Research,* 1–9.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3,* 223–241.

Slade, E. P. (2002). Effects of school-based mental health programs on mental health service use by adolescents at school and in the community. *Mental Health Service Research, 4,* 151–166.

Strein, W., Hoagwood, K., & Cohn, A. (2003). School psychology: A public health perspective. *Journal of School Psychology, 41,* 23–38.

Strein, W., & Koehler, J. (2008). Best practices in developing prevention strategies for school psychology practice. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology V* (pp. 1309–1322). Bethesda, MD: National Association of School Psychologists.

Webb, J. (2014). The four greatest psychological discoveries of 2014. *Psych Central.* Retrieved from http://blogs.psychcentral.com/childhood-neglect/2014/12/the-four-greatest-psychological-discoveries-of-2014/

Weist, M. D., Stiegler, K., Stephan, S., Cox, J., & Vaughan, C. (2010). School mental health and prevention science in the Baltimore city schools. *Psychology in the Schools, 47,* 89–100.

Welsh, M., Parke, R. D., Widaman, K., & O'Neil, R. (2001). Linkages between children's social and academic competence: A longitudinal analysis. *Journal of School Psychology, 39,* 463–482.

Zhang, T., Kim, T., Brooks, A. W., Gino, F., & Norton, M. I. (2014). A "present" for the future: The unexpected value of rediscovery. *Psychological Science, 25,* 1851–1860.

# CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

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

To purchase and complete the test online, visit our online store at www.papsy.org. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before March 31, 2017.

**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.

## Zuckerman

1. The industrialization of health care can be seen in:
   a. HIPAA's Electronic Transaction Rule
   b. *ICD-10*
   c. The Affordable Care Act
   d. The adoption of electronic health record systems
   e. All of the above

2. Zuckerman suggests that psychologists:
   a. Have to decide to join the juggernaut or look elsewhere for livelihoods
   b. May find ways to join the juggernaut (such as Accountable Care Organizations) and still maintain the dignity of private practice
   c. Should explore FOPINIP
   d. Become involved with the *ICD-11* and International Classification of Functioning, Disability, and Health
   e. All of the above. b, c, and d

## Kettlewell

3. Which of the following are limitations or critical problems with the current behavioral health delivery system that justify the need for new behavioral health-care delivery approaches such as integrated behavioral health services with primary care?
   a. Lack of identification of people with behavioral health problems
   b. The large percentage of those with behavioral health problems not getting care
   c. The unnecessary expenses associated with health care when behavioral health problems are not addressed
   d. a and c
   e. All of the above

4. Evidence indicates that integrated behavioral health services with primary care can produce these results:
   a. Increased identification of people with behavioral health problems
   b. Improved access to behavioral health treatment
   c. Increased patient satisfaction
   d. Increased satisfaction by primary care and behavioral health providers
   e. Reduced utilization of unnecessary medical care
   f. Reduced death rate
   g. Fewer days spent in intensive care and thus reduced health-care expenses
   h. a, b, c, d, and e
   i. All of the above

## Hosterman, Meadows, & Parikh

5. What is the dominant behavioral health concern for primary care physicians?
   a. OCD
   b. Anxiety
   c. Depression
   d. Behaviors

6. Which of the following is not a benefit of the integration model?
   a. Shorter driving distance for patients and families
   b. Possible cost savings
   c. Improved access
   d. Increased emergency department visits

7. What are common barriers for primary care physicians when it comes to discussing or addressing behavioral health concerns during medical visits?
   a. Lack of time
   b. Lack of training
   c. Lack of local child behavioral health providers
   d. Limited confidence in counseling and medication treatments
   e. All of the above

## Gratson

8. Virtual reality simulators have very limited uses in the treatment of mental health disorders.
   True
   False

9. Smartphone applications can be used to:
   a. Track a user's mood and create a graphical representation of the user's mood history
   b. Learn to predict a user's mood in certain environmental situations

c. Provide in-the-moment suggestions to help a user manage his or her mood
d. All of the above

**McLaughlin**

10. Some researchers have found the following in schools implementing components of school-based mental health: reductions in special education referrals and placements among at-risk students, improved school climates, reduced disciplinary referrals, reduced grade retentions, increased standardized test scores, and/or improved academic performance.
True
False

11. According to research by Strein and Koehler (2008), the following are critical features of successful school-based mental health prevention programs:
a. Comprehensive with multiple interventions across settings
b. Structured manuals and/or curricula
c. Formal evaluation of the program process and outcomes
d. All of the above

# Continuing Education Answer Sheet

## *The Pennsylvania Psychologist*, March 2015

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

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.** | a | b | c | d | e | | | | | **7.** | a | b | c | d | e |
| **2.** | a | b | c | d | e | | | | | **8.** | T | F | | | |
| **3.** | a | b | c | d | e | | | | | **9.** | a | b | c | d | |
| **4.** | a | b | c | d | e | f | g | h | i | **10.** | T | F | | | |
| **5.** | a | b | c | d | | | | | | **11.** | a | b | c | d | |
| **6.** | a | b | c | d | | | | | | | | | | | |

### Satisfaction Rating

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

| | | | | | | |
|---|---|---|---|---|---|---|
| Was relevant to my interests | 5 | 4 | 3 | 2 | 1 | Not relevant |
| Increased knowledge of topics | 5 | 4 | 3 | 2 | 1 | Not informative |
| Was excellent | 5 | 4 | 3 | 2 | 1 | Poor |

Comments or suggestions for future issues _____

_____

*Please print clearly.*

Name _____

Address _____

City _____ State ____ZIP _____ Phone (  ) _____

I verify that I personally completed the above CE test.

Signature_____ Date_____

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

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

# Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between November 4, 2014, and February 10, 2015!


NEW MEMBERS

**Tracey Alysson, PhD**
Bangor, PA

**Richard Barbara, PhD**
Pittsburgh, PA

**Jennifer Baumgartner, PsyD**
Lutherville, MD

**Robin Beaumont, PhD**
Quakertown, PA

**James Bechtel, PhD**
Jeffersonville, PA

**Gary Bell, MSW**
Plymouth Meeting, PA

**Adam Bennati, MA**
Coatesville, PA

**Adam Berman, PsyD**
Rydal, PA

**Mark M. Berman, PsyD**
Yardley, PA

**John M. Berna, PhD**
Havertown, PA

**Edward Bevan, PsyD**
Cresco, PA

**Andrew Bland, PhD**
Leola, PA

**Robert Bohlander, PhD**
Dallas, PA

**Marjorie A. Bosk, PhD**
Narberth, PA

**Sandy Bumgardner, PsyD**
Hatfield, PA

**Joanne Schwartz Buzaglo, PhD**
Rydal, PA

**Elizabeth Bywater, PhD**
Yardley, PA

**Bernadette Cachara, PsyD**
Carlisle, PA

**Lori L. Cangilla, PhD**
Pittsburgh, PA

**John Carosso, PsyD**
Murrysville, PA

**Jyh-Hann Chang, PsyD**
Stroudsburg, PA

**Katie Chipman, PhD**
DuBois, PA

**John Chuma, PsyD**
Lititz, PA

**Richard Citrin, PhD**
Pittsburgh, PA

**Julia Curcio Alexander, PsyD**
Philadelphia, PA

**Karen Curcio-Chilton, PhD**
Ambler, PA

**Jill Cyranowski, PhD**
Wexford, PA

**Tania Czarnecki-Wismar, PsyD**
Philadelphia, PA

**Tim Davis, PsyD**
Fairfield, CA

**Tyson Davis, PsyD**
Bethlehem, PA

**Michael J. Dolan, PsyD**
Bethlehem, PA

**Jim Donnelly, MA**
Pittsburgh, PA

**Susan Drolet Coneybeer, PsyD**
Butler, PA

**Alan Dubro, PhD**
New Rochelle, NY

**Kristen Dudley, PsyD**
Bryn Mawr, PA

**Judy Eidelson, PhD**
Bala Cynwyd, PA

**Jennifer Erickson, MA**
Pottstown, PA

**Virginia Grace Fass, MS**
Bradford, PA

**Nedra Fetterman, PhD**
Bryn Mawr, PA

**Sari Fleischman, PsyD**
Philadelphia, PA

**Mark J. Forest, PhD**
New Hope, PA

**Laura Beth Frank, MEd**
Elkins Park, PA

**Sandy Frankel, MEd**
Penn Valley, PA

**Patricia Furlan, PhD**
Wynnewood, OR

**Gregory Gaertner, PhD**
Boalsburg, PA

**Mendy Lynn Viel Ganim, PsyD**
Philadelphia, PA

**Holly Gastgeb, PhD**
Pittsburgh, PA

**Edie Goldbacher, PhD**
Jenkintown, PA

**Julie Gordon-Dueck, PhD**
Denver, PA

**Patricia Gready, PsyD**
Mount Joy, PA

**Heather Green, PhD**
Gladwyne, PA

**Michael Greenwald, PhD**
Pittsburgh, PA

**Bill Grey, PsyD**
Philadelphia, PA

**Holly Grishkat, PhD**
Drexel Hill, PA

**Lisa Ann Marie Hain, PsyD**
Narvon, PA

**Holly Harmon, MSW**
Coraopolis, PA

**Edward A. Hayduk, MS**
Riegelsville, PA

**John Hecker, PsyD**
Erie, PA

**James Hepburn, PhD**
Pittsburgh, PA

**Melanie D. Hetzel-Riggin, PhD**
Erie, PA

**Carol Hewitt, EdD**
Hollidaysburg, PA

**Erica Zucker Hindman, PhD**
Philadelphia, PA

**Shielagh Hochberg, PhD**
New York, NY

**Diana Hoffman, MA**
Scranton, PA

**Judith Temple Jackson, PhD**
Ardmore, PA

**Sharon Jacobs, PhD**
Wilmington, DE

**David Kasson, PhD**
Elkins Park, PA

**Beverly Kline-Lash, MA**
Beaver Springs, PA

**Michele Koschin, PsyD**
Philadelphia, PA

**Jessica Rutstein Lazarus, PsyD**
Bala Cynwyd, PA

**Deborah Ledley, PhD**
Narberth, PA

**Eliza Carlson Lee, PhD**
Philadelphia, PA

**Robert Lee, PsyD**
Pottstown, PA

**Sarah Levin, PsyD**
Philadelphia, PA

**Suzanne Levy, PhD**
Merion Station, PA

**Kate Linehan, PsyD**
Flemington, NJ

**Sophie A. Longwill, PsyD**
Chadds Ford, PA

**Amanda N. Luchansky, PsyD**
Jessup, PA

**Bruce Lynch, PhD**
Mount Joy, PA

**Crystal Mahoy, PsyD**
Shillington, PA

**Krista Mancarella, PsyD**
Philadelphia, PA

**Dolores R. Marchesano, DSW**
Devon, PA

**Sharon Marchon, PhD**
Cape Coral, FL

**Suzanne McAllister, PhD**
Jenkintown, PA

**Claire McGrath, PhD**
Philadelphia, PA

**Erin Leolani McKeague, PsyD**
Wilmington, DE

**Suzanne E. Messner, MA**
Bethlehem, PA

**Patricia Mikols, PhD**
Philadelphia, PA

**Jacqueline Mills, MA**
Bala Cynwyd, PA

**Gerald Mintzer, MA**
Newtown, PA

**Chet Muklewicz, EDD**
Scranton, PA

**Julie M. Mullany, PsyD**
Philadelphia, PA

**Robert C. Murphy, MDiv, MS**
West Chester, PA

**Julie Neudeck, PhD**
Bryn Mawr, PA

**Susan Page, MEd**
Bensalem, PA

**Philip Pellegrino, PsyD**
Bethlehem, PA

**Amanda Pelphrey, PsyD**
Moon Twp, PA

**Rebecca Penna, PhD**
Chesterbrook, PA

**Jenny Perschke, MSEd**
Renfrew, PA

**Kate Pickett, MEd**
Doylestown, PA

**Laurie Shannon Pittman, PhD**
East Berlin, PA

**Gregory Philip Plotica, MA**
Gettysburg, PA

**Regina Elena Polsinelli, MA**
Souderton, PA

**Howard S. Rosen, PhD**
Harrisburg, PA

**Elliott B. Rotman, PhD**
Philadelphia, PA

**Shannon Ruane, MS**
Jenkintown, PA

**Deborah Sahijwani, PsyD**
West Chester, PA

**Rachel Saks, PsyD**
Philadelphia, PA

**Robert F Sawicki, PhD**
Johnstown, PA

**Kristin Scott, MS**
Riverton, NJ

**Richard Sekula, PhD**
Erie, PA

**Don G Seraydarian, PhD**
Yardley, PA

**Mary Sharp-Ross, PsyD**
Bethlehem, PA

**Carol Graham Shekhar, PhD**
Hockessin, DE

**Ralph Shirley, PhD**
Philadelphia, PA

**Laurel M. Silber, PsyD**
Wynnewood, PA

**Amy Silverman, MS**
Allentown, PA

**Alison Joy Smith, PhD**
Feasterville-Trevose, PA

**Thomas J Smith, PhD**
Pittsburgh, PA

**Leslie Smith Varner, PsyD**
Sheffield, PA

**Pavel Somov, PhD**
Pittsburgh, PA

**Neeta Sookhoo, PsyD**
Greensburg, PA

**Eric Spiegel, PhD**
Lafayette Hill, PA

**Karen Staab, MEd**
Erie, PA

**Elizabeth Stone, MS**
Downingtown, PA

**Shiree Stuart, PsyD**
Lancaster, PA

**Keren Chansky Suberri, PhD**
Havertown, PA

**James Supplee, PsyD**
West Chester, PA

**Laure Swearingen, PhD**
Pittsburgh, PA

**Helen Bittmann Sysko, PhD**
Pittsburgh, AL

**Cora M. Taylor, PhD**
Lewisburg, PA

**Lori Thaler, MEd**
Williamsburg, VA

**Shelley Weber, PhD**
Bryn Mawr, PA

**Stephen Weiner, PsyD**
Yardley, PA

**Beverly White, PsyD**
Philadephia, PA

**Jean Wilkinson, PhD**
Ewing, NJ

**Kelly Ann Williams, PhD**
Schwenksville, PA

**Richard W. Williams, PhD**
Carlisle, PA

**Sarajane Williams, MA**
Macungie, PA

**Brad Wolgast, PhD**
Newark, DE

**Cynthia Wright, DEd**
Meadville, PA

**Nancy G. Wzontek, PhD**
Bala Cynwyd, PA

**Elisabeth Yaelingh-Scoffins, PhD**
Lancaster, PA

### NEW STUDENTS

**Ahmed Adetola, BS**
Scranton, PA

**Jeffrey Alpart, MA**
Warrington, PA

**Saira Ayala, BA**
Bethlehem, PA

**Leah Bielski, BS**
Scranton, PA

**Kayla Janee Bigley, BA**
Duncannon, PA

**Tomasina Boyd, BS**
Wilkins Township, PA

**Meghan Carey, BA**
Penn Hills, PA

**Amber Chase, BS**
Aspers, PA

**Ya-Huei Chen, MA**
Indiana, PA

**Amanda Lee Cook, BA**
Geensburg, PA

**Chenchen Dai, BS**
Bethlehem, PA

**Deangie Davis, MS**
Bethlehem, PA

**Jonesse Frances Davis, MA**
McKeesport, PA

**Katherine Ernst, BA**
Swarthmore, PA

**Eve Faris, BA**
Bethlehem, PA

**Jenna R. Flynn, BS**
Spring City, PA

**Cheryl Giacomelli, MA**
Doylestown, PA

**Nadine Gowarty, MS**
Scranton, PA

**Sarah M. Greenberg, BS**
Dresher, PA

**Nancy Greene, BA**
Pequannock, PA

**Maura E. Hanlon, BS**
Blue Bell, PA

**Jessica Harpel, MS**
Red Lion, PA

**Bobbi Jo Haviland, EdS**
Philadelphia, PA

**Melissa Castle Heatly, MS**
Baltimore, MD

**Caitlynn R Hill, BA**
Lancaster, PA

**Chris Kichline, BS**
Pottstown, PA

**Kimberly King, BA**
East Petersburg, PA

**Kristin E Klingensmith, BS**
Carlisle, PA

**Kayla Kuykendall, BA**
Pittsburgh, PA

**Leigh Kwasny, BA**
Philadelphia, PA

**Austin Kenneth Loukas, BA**
Bethlehem, PA

**Stephen Maitz, BA**
Chalfont, PA

**Ariel Mankin, BA**
Philadelphia, PA

**Gail Monteith, MS**
Downingtown, PA

**Danielle Marie Restrepo, MA**
Paterson, NJ

**Bethany Reynolds, EdS**
Honesdale, PA

**Jacqueline Rochmann Yasky, BA**
Pittsburgh, PA

**Cavonne Sedeno, BA**
Lansdowne, PA

**Richard Persaud Shur, BA**
Fountainville, PA

**Noah Sideman, MS**
Philadelphia, PA

**Erin Smith, MS**
Willow Grove, PA

**Keri Smotrich, MS**
Philadephia, PA

**Dylan Songer, BA**
Wexford, PA

**Alina Vaisleib, MA**
Pittsburgh, PA

**Kaelyn Vantine, MS**
Cranberry Township, PA

**Carina Vecchi, MA**
Wilmington, DE

**Kyle Venella, BA**
Mount Joy, PA

**Samantha Robin Wertheimer, BA**
Philadelphia, PA

**Lauren Wiegand, BA**
Pittsburgh, PA

**Numra Yaqub, BA**
Allentown, PA

# Classifieds

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

Vol. 75, No. 3

The Pennsylvania
# Psychologist

March 2015 • QUARTERLY



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

# CE Calendar

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

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

**June 17–20**
*PPA2015*
Hilton Harrisburg
Harrisburg, PA

**October 29–30**
*Fall Continuing Education and Ethics Conference*
Sheraton Great Valley
Frazer, PA

Contact: judy@papsy.org

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

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

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

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

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

*Excess Weight and Weight Loss*
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

*Staying Focused in the Age of Distraction: How Mindfulness, Prayer, and Meditation Can Help You Pay Attention to What Really Matters*
5 CE Credits

*Competence, Advertising, Informed Consent, and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

*Readings in Multiculturalism*
4 CE Credits

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

**This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.*

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

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