The Pennsylvania Psychologist

Vol. 76, No. 9 OCTOBER 2016 • UPDATE

SPECIAL EDITION

Suicide: An Introduction

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

Suicide is one of the leading causes of death worldwide, with an average of about 15 deaths per 100,000 persons (in the United States the rate is around 12 per 100,000). Suicide rates vary widely across the world. Rates tend to be higher in the countries formed out of the former Soviet Union, such as Belarus, Russia, or the Ukraine; and lowest in Muslim countries where suicide is considered a serious sin (Hawton & van Heeringen, 2009). However, reporting bias may misrepresent the actual rates there. Suicide is the 10th leading cause of death in the United States and has been slowly increasing in the last 20 years. Twice as many Americans die from suicide as die from homicide.

Suicide is hard to study as it is influenced by a complex mixture of personal, situational, and cultural factors. Nonetheless, substantial progress has been made in identifying and preventing suicide in the last decade; there is reason that more strides will be made in the future as well. One of the pernicious myths of suicide is that if a person really wants to die from suicide, then there is nothing anyone can do about it. Like all myths, it contains a grain of truth: ultimately, no one can make individuals live if they really do not want to. But this myth omits crucial qualifications that can have deadly consequences: effective health systems can save the lives of many persons who would otherwise die from suicide. The evidence is overwhelming.

Consider these findings: Vision Zero, a suicide prevention initiative of the Henry Ford Health System, has kept suicide rates at 5.8 per 100,000, a rate almost half of Michigan's overall suicide rate. Denmark reduced the suicide rates of adolescents in half, primarily by restricting easy access to over-the-counter drugs commonly used in suicide attempts (Erich, 2016). Studies of the prevention programs funded by the Garrett Lee Smith youth suicide prevention programs showed that counties with prevention grants had significantly reduced rates with the targeted group (youths 16 to 23), compared to control counties that did not receive a grant (Garraza et al., 2015).

Suicide is hard to study as it is influenced by a complex mixture of personal, situational, and cultural factors.

The United States Air Force started an initiative to reduce suicides in 2001. Suicide rates were cut in one third. When the implementation of the program was relaxed in 2004, the suicide rates rose again to the 2001 levels. When the initiative was restarted,

Continued on page 4

The Pennsylvania Psychologist
5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112
www.papsy.org

Editor Tracie L. Pasold, PhD
PPA President David A. Rogers, PhD
PPF President Pauline Wallin, PhD
Executive Director Krista Paternostro Bower, CAE

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.

Recognition of Suicide as a Public Health Issue: Where Have We Come From? Where Are We Going?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

For most of history, suicide has been considered a moral or religious issue. Only recently has it been recognized as a public health issue. Research into suicide was not a major focus in the early history of American psychology and psychiatry. Early works on suicide, such as Emile Durkheim's 1897 book *Le Suicide*, offered a theoretical framework for suicide, but the data set available to Durkheim and other writers was limited. Although psychiatric practitioners had discussed suicide in their writings and had dealt with suicidal patients, long-term empirical programs in the scientific study of suicide did not start until the 1950s, led primarily by Edwin Schneidman and Norman Faberow. Their work led to the creation of the American Association of Suicidology, the journal *Suicide and Life Threatening Behavior*, the first national conference in suicide, and greater public awareness of the importance of addressing suicide (Spencer-Thomas & Jahn, 2012).

Also, the work of Schneidman, Faberow and other pioneers led to the creation of a number of non-profit organizations dedicated to suicide research and prevention. For example, the American Foundation for Suicide Prevention, founded in 1987, has been especially active in funding research on suicide and suicide prevention. Other organizations have been developed to address more targeted concerns. For example, the Jed Foundation focuses more on prevention with college age adults.

In 2004 the Garrett Lee Smith Act was passed to provide federal funding for suicide prevention programs. Both APA and PPA advocated strongly for this act.

A major shift in attitudes toward suicide was represented by a series of reports on suicide such as the Surgeon General's report in 1999. In 2004 the Garrett Lee Smith Act was passed to provide federal funding for suicide prevention programs. Both APA and PPA advocated strongly for this act. This attention is only fitting, because suicide has been a leading cause of death for many years. Suicide is slightly behind nephritis and pneumonia as a cause of death in the United States. Could the reader imagine public health officials debating the need for research into lung and kidney disorders?

The good news is that we now have professional standards on what constitutes good assessments, management, and intervention with patients at risk to die from suicide. Nonetheless, our assessment skills are limited, resulting in many false positives, and do little to predict when a suicide attempt will occur.

The even better news is that current research is expanding the knowledge base of suicide considerably. These research efforts have received substantial impetus from investments by the United States Department of Defense and Veterans Administration (VA). For many years the rate of suicide among military personnel was significantly lower than the rate of suicide

Continued on page 4

RECOGNITION OF SUICIDE . . .

Continued from page 3

among civilians. However, suicide among military personnel began to increase around the turn of the century until it was significantly higher than civilian rates. The reasons for the increase are not entirely clear. It may be that the nature of current insurgency warfare exacts more of a psychological toll on service members than previous wars, or it may be a function of selective enlistment in an all-volunteer army, or some combination of the two factors.

Each of the branches of the services as well as the VA are making strong efforts to address the problem of suicide among active service members and veterans. The research funds innovative and basic research into suicide. Although the results cannot automatically be generalized to civilian populations, nonetheless, I believe that many results will inform or inspire similar efforts outside the military. The accompanying article "Innovations in Suicidal Research" covers many of the innovative research projects done on suicide assessment and intervention.

References

Spencer-Thomas, S., & Jahn, D. R. (2012). Tracking a movement: U.S. milestones in suicide prevention. *Suicide and Life-Threatening Behavior, 42*, 78–85.

SUICIDE: AN INTRODUCTION

Continued from page 1

suicide rates again fell (Knox et al., 2010).[1] Other studies similarly show the benefits of interventions.

Individual psychotherapists can make a difference in preventing suicides. Effective suicide assessment protocols, such as the CAMS (Collaborative Assessment and Management of Suicidality; Jobes, 2016) represent an improvement over less structured assessment procedures. Also, evidence from controlled studies have shown that psychotherapy (and presumably accompanying suicide management strategies) will reduce the risk of suicide. The evidence is especially strong for dialectical behavior therapy with borderline personality disorder (Linehan et al., 2015) and cognitive therapy for depression (e.g., Rudd et al., 2015).

Still more needs to be done. The predictive models for suicide are good from a population perspective, but poor from an individual perspective. Age, race, gender, access to firearms, loneliness, poor physical health, suicidal ideation, and previous suicide attempts will predict suicidal behavior in the long run. But short-term predictions are poor and contain many false positives.

[1]Yamane and Butler (2009) were not convinced that the Air Force suicide prevention program was effective, noting that the trend for suicides among young men in the civilian population also decreased around the same time. However, I think they were overly cautious. First the extent of the drop in suicide rates was dramatic. Second, the variation in rates very closely mirrored the implementation, relaxation, and re-implementation of the Air Force suicide prevention program. The same fluctuation did not occur in young men within the civilian population.

The accompanying articles focus on recent developments in the study of suicide and suicide prevention, including information on innovations in suicide research, a review of recent major books on suicide, and background on promising research on suicide and suicide prevention programs. A final article describes Pennsylvania's new law requiring licensed psychologists to have training in the assessment, management, and treatment of suicidal patients as a condition of licensing renewal.

References

Erich, M. D. (2016). Envisioning zero suicide. *Psychiatric Services, 67*, 255.

Garraza, L. G., Walrath, C., Goldston, D. B., Reed, H., & McKeon, R. (2015). Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on suicide attempts among youths. *JAMA Psychiatry, 72*, 1143–1149.

Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet, 373,* 1372–1381.

Jobes, D. A. (2016). *The management of suicidal behavior* (2nd Ed.). New York: Guilford.

Knox, K. L., Pflanz, S., Talcott, G. W., Campise, R. L., Lavigne, J. E., Ajorska, A., Tu, Z., & Caine, E. D. (2010). The US Air Force suicide prevention program: Implications for public health policy. *American Journal of Public Health, 100*, 2407–2463.

Linehan, M. M., Korlund, K. E., Harned, M. S., Gallup, R. J., Lungu, A. . . ., Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *Journal of the American Medical Association, 72*, 475–482.

Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S. . . . Bruce, T. O. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: Results of a randomized clinical trial with 2-year follow-up. *American Journal of Psychiatry, 172*, 441–449.

Yamane, G. K., & Butler, J. L. (2009). Suicide burden in the Air Force: 1990–2004. *Military Medicine, 174,* 1019–1023.

Innovative Research Into Assessing and Preventing Suicide

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Although suicide is common from a population-wide perspective (the 10th most frequent cause of death in the United States), it is hard to predict on an individual level. Even in the presence of known risk factors, the rate of false positives is high and the ability to identify when (as opposed to if) a suicide will occur is limited. In a previous article I noted that interventions have been effective in reducing deaths by suicide on both a population wide and individual levels. But even one death from suicide is one death too many. Here I review some recent research innovations which may eventually have implications for suicide identification and prevention.

Can implicit measures of suicidal cognitions predict later attempts? Implicit association tests have been found to predict behavior related to interpersonal bias. It uses the fact that people tend to link related concepts together ("big" and "giant") than unrelated concepts ("short" and "giant"). The reaction time between these two words suggests the extent to which the two words are linked in an individual's actual thought process, even though the direction or strength of such processes may be outside the awareness of an individual. Randall et al. (2015) studied the link that participants had with death and life words. When looking at multiple variables, they found that an implicit bias toward death significantly improved the likelihood that a future suicide attempt would occur. This study needs replication across different populations. Nonetheless, if findings continue in the direction of Randall's study, then implicit measures may add to the predictive ability of existing measures.

Can social media provide clues as to the imminence of suicidal risk? Bryan and others (2016) looked at social media postings of individuals who died from suicide compared to others who did not die from suicide. A month before their deaths by suicide, the number of postings about maladaptive behavior (such as increased alcohol consumption) increased but discussions of negative emotions declined. Such studies, if replicated, could eventually provide supplemental information on suicide risk.

Do linguistic patterns of clinicians suggest impending suicide? Westgate and others (2015) looked at the notes written by clinicians who were treating suicidal patients to determine if the content varied between patients who later died from suicide and patients who did not die from suicide. They hypothesized that clinicians anticipating the death of a patient from suicide would use more distancing language (third person as opposed to first person) as an attempt, probably outside of their conscious awareness, to reduce the emotional harm that would occur to them when their patients died. They found no such effect. Nonetheless, their research showed the potential to use linguistic analysis to study suicide.

Can biomarkers predict suicidal risk? It would be advantageous to predict suicidal behavior through a particular physical test obtained from a sample of blood or other easily acquired test. No such biomarkers currently exist that have practical applications, but research is suggesting links between physiological states and suicidal risk. Activation of the immune system is common among individuals who attempt to die from suicide. For example, looking at cerebrospinal fluid, Lindqvist et al. (2011) found that elevated cytokines (hormones secreted by the immune system to fight infections or the effects of trauma) in persons who had a suicide attempt. Also, it is known that the administration of interferon (a class of proteins linked to the human immune system) for patients with certain cancers or infections often precipitates serious depression and suicidal thoughts (Brundin, et al., 2015).

This inflammation/suicide link needs to be interpreted in light of other findings reviewed by Kiecolt-Glasser (2015). Although her research deals with depression, not suicide, it eventually may have implications for suicidal patients. Pain, depression, poor diet, poor sleep, excess weight, lack of exercise and inflammation are all linked statistically and interact in complex ways. Evidence suggests possible common interactive physiological pathways between many of these conditions.

When looking at multiple variables, they found that an implicit bias toward death significantly improved the likelihood that a future suicide attempt would occur.

We are a long way from prescribing a particular diet to fight depression. However, at least for some patients, diet may be an element in recovery from depression. We know that physical and psychological stressors can impact the human digestive system. It is likely that the "signals produced by the gut can in turn affect the brain and emotional responses" (Kiecolt-Glasser et al., p. 1077).

Does neuro-circuitry predict suicidal intent? A variety of studies have found features commonly associated

Continued on page 6

Continued from page 5

with serious suicidal attempts such as impaired serotenergic responsivity. fMRI's have shown deficits in certain prefrontal areas and enlargement of the amygdala (associated with emotions such as fear and anger). These findings are consistent with an interpretation that suicidal patients may have impaired decision making and emotional control (van Herrigen & Mann, 2014).

A final glaring gap in research is in the relationship of gun violence to suicide[...] because Congress has placed substantial restrictions on the ability of the CDC to conduct meaningful gun research.

These findings are open to multiple interpretations; however, it is possible that early childhood adversity, a known risk factor for later suicide attempts, predisposed individuals to modified brain development. Eventually these neurobiological studies may lead to developments in the prediction with suicidal patients.

Finally, some innovations have practical applications in the present time. Behavioral studies continue to look at treatment elements that promise to improve the quality of service to suicidal patients. These innovations include adding mindfulness or motivational interviewing strategies to existing protocols, sending caring notices to patients to help increase attendance, using a computer application (virtual Hope Box; Bush et al., 2014) as a supplement to Commitment to Life agreements, among others (Conner & Simons, 2014).

Perhaps the most innovative and promising development has been looking at self-compassion as a way to reduce self-blame and moral guilt among veterans who harmed or killed others while in military combat, even though their behavior may have been within the standards of conduct prescribed by the military. Guilt does not necessarily imply war crimes or misconduct. Although ideas of moral guilt are commonly associated with religion, they need not be (Bryan, Graham, & Roberge, 2015). The treatment innovation is to foster self-compassion and a search for meaning.

Outstanding Gaps in Knowledge

Despite the very promising developments identified above, my review of the literature suggests several gaps where much more work is needed. Among other questions, we could benefit by a clearer understanding of the relationship of suicide to accidental deaths. We know that accidental deaths are higher among persons with mental illness. Does this represent a decreased care for oneself caused by the mental illness? Or does it represent a disregard for self or well-being so pervasive that it puts individuals at risk to die from an accident?

We could also benefit from a clearer understanding of the relationship between non-suicidal self-injury and suicide? We know that they are statistically linked so that individuals who self-injure have a statistically higher risk of dying from suicide. However, few individuals who self-injure go on to die from suicide. Is there a subset that needs to be watched carefully?

Furthermore, we could benefit from understanding the characteristics of individuals who engage in rational suicide or activities that voluntary hasten death? Some may argue that suicide is never a rational act, others may argue suicide may be a rational act for some persons under some circumstances. But it may help clarify the arguments if we knew more about that small subset of individuals who appear to be making an informed and deliberate choice to die from suicide.

A final glaring gap in research is in the relationship of gun violence to suicide. This occurs largely because Congress has placed substantial restrictions on the ability of the CDC to conduct meaningful gun research (Brazilay, Johnson, & Mohney, 2016). To me this restriction makes no more sense than prohibiting research on the link between diet and diabetes.

Although I am encouraged by the creative research projects and the promising results obtained so far, much more needs to be done.

References

Brazilay, J., Johnson, L., & Mohney, G. (2016 June 16). ABC News. ***Why the CDC has not launched a comprehensive gun study in 15 years.*** Retrieved from http://abcnews.go.com/Health/cdc-launched-comprehensive-gun-study-15-years/story?id=39873289

Brundin, L., Erhardt, S., Bryleva, E. Y., Achtyes, E. D., & Postolache, T. T. (2015). The role of inflammation in suicidal behavior. *Acta Psychiatrica Scandinavica, 112*, 192–203.

Bryan, C. J., Garland, E. L., Georgiou, P. G., Narayaan S., & Baucon, B. R. (2016, August 2). *Technology facilitated assessment of cognitive and behavioral indicators of suicide risk*. Presented at Annual Meeting of the American Psychological Association, Denver, CO.

Bush, N. E., Dobscha, S. K., Denneson, L. M., Hoffman, J. E., Crain, J. E., Crumpton, R., Cromer, R., & Kinn, J. T. (2014). A virtual hope box smartphone app as an accessory to therapy: Proof of concept in a clinical sample of veterans. *Suicide and Life-Threatening Behavior, 45: 1–9*.

Bryan, C. J., Graham, E., & Roberge, E. (2015). Living a life worth living: Spirituality land suicide risk in military personnel. *Spirituality in Clinical Practice, 2*, 74–78.

Connor, K. R., & Simons, K. (2015). State of innovation in suicide intervention research with military populations. *Suicide and Life-Threatening Behavior, 45*, 281-292.

Kiecolt-Glasser J., Derry, H. M., & Fagundas, C. F. (2015). Inflammation: Depression fans the flames and feasts on the heat. *American Journal of Psychiatry, 172*, 1075–1091.

Lindqvist, D., Janelidze, S., Erhardt, S., Träskman-Bendz, Engström, & Brundin, L. (2011). CFS biomarkers in suicide attempters—A principle component analysis. *Acta Psychiatrica Scandinavica, 124*, 52–61.

Randal, J. R., Rowe, B. H., Dong, K. A., Nock, M. K., & Colman, I. (2015). Assessment of self-harm risk using implicit thoughts. *Psychological Assessment, 25*, 714–721.

Van Heeringen, K., & Mann J. J. (2014). The neurobiology of suicide. *The Lancet Psychiatry, 1,* 63–72

Westgate, C. L., Shiner, B., Thompason, P., & Watts, B. V. ((2015). Evaluation of veteran's suicide risk with the use of linguistic detection methods. *Psychiatric Services, 66,* 1051–1056

Suicide Training Now Required Every Licensing Renewal Cycle

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

According to Act 74 of 2016, signed into law by Governor Wolf on July 8, 2016, all psychologists, social workers, marriage and family therapists, and licensed professional counselors in Pennsylvania will have to take at least one (1) hour of continuing education in suicide assessment, management, and intervention each renewal period as a requirement for licensing renewal.

This mandate does not increase the total amount of continuing education that psychologists have to have every renewal period. The mandate cannot be carried over from one renewal period to another. The original bill, introduced by Representative William Adolf (R-Springfield, PA), was entitled the Matt Adler Suicide Prevention Continuing Education Act after a constituent of Representative Adolf's who died from suicide.

The bill passed unanimously in both the House and Senate of Pennsylvania. In his remarks in favor of the bill, Representative Adolf stated that

> Many of the professionals are already doing a great job with helping those at risk get the proper treatment. The intent of this legislation is to help strengthen our provider's awareness of the growing problem of suicide and make sure they have current knowledge of best practices and helpful resources on how to best prevent suicide

(*Legislative Journal*—House, June 10, 2016, p. 1006).

PPA did not support this legislation because it believed that the professionals themselves were best qualified to determine what continuing education courses best suited their professional needs. Nonetheless, PPA will work to ensure that its members will have access to quality continuing education that meets this mandate.

To fulfill this requirement, please visit PPA's Home Study page (link) https://papsy.site-ym.com/store/ListProducts.aspx?catid=331312&p=0 and choose a one-hour or three-hour home study entitled "The Assessment, Management and Treatment of Suicidal Patients."

How Well Trained Are Health Care Professionals Dealing With Suicide?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Because suicides are a common mental health emergency and the 10th leading cause of death in the United States, it would seem that all mental health professionals would have received an integrated sequence of didactic training and experience for dealing with patient suicides. The enactment of Act 74 of 2016 in Pennsylvania, reflects a concern that at least some health care professionals are not proficient in dealing with suicidal patients. Consequently, it may be prudent to look at the amount and adequacy of training in suicide that health care professionals actually receive.

My review finds gaps in the training in suicide across mental health professions. Two studies of psychiatric residents found that more than 90 percent of training programs in psychiatry required didactic training in suicide, although the training was often vague, nondescript, and insufficient (see review by Schmitz et al., 2012).

Psychologists did not fare better than psychiatry in their training. Studies of psychology programs in the 1990s found that a minority of doctoral programs provided comprehensive instruction in suicide (see review by Bongar & Sullivan, 2013). A more recent study found that 75 percent of doctoral students received formal training in suicide, although some had received training outside of their formal psychology curriculum (Mackelprang, et al., 2014). In addition, a review of school psychology programs showed that almost all included coursework on suicide in their curriculum, although 10 percent of the program directors agreed or strongly agreed that their programs do a poor job at training their students in suicide (Liebling-Boccio & Jennings, 2013).

Only 25 percent of social work programs included coursework in suicide (Schmitz et al., 2012). However, many social work programs do not purport to train mental health professionals. Instead many are trained to work in housing, service coordination, or other non-mental health work. Nonetheless, we would expect that social workers should have some knowledge of suicide as they are gatekeepers and in a position to encounter suicidal individuals in their work. Training in suicide is a requirement for approved programs for professional counselors, although 16 percent of students reported no training within their program (Douglas & Morris, 2015).

These studies tell us that many professionals have been adequately trained, although gaps in education appear for all mental health professions. However, caution is warranted since all of these studies relied on self-reporting and we do not know much about the quality of the instruction.

Can the Act 74 requirement of one-hour of CE in suicide per renewal period substantially improve the quality of services provided to patients? Many professionals are up-to-date on their skills and the mandate would constitute a reminder or refresher for them. The one-hour program may also be sufficient for professionals who do not treat patients, but who may nonetheless, through the course of their work, have the option of identifying and referring suicidal patients. However, one hour of training will not be sufficient for mental health professionals who currently lack proficiency in working with suicidal patients. For those professionals I hope that the one-hour requirement will prompt them to seek additional training and supervision.

Proficiency generally occurs through an organized sequence of training that includes both didactic and experiential components. It is impossible to identify a specific number of hours of training required to bring a professional up to the level of adequate proficiency. Much depends on the quality of their overall training. However, a number of sources, including Cramer et al. (2013) and Rudd et al. (2008) have identified areas of core competency that professionals or supervisors can use to monitor their progress toward proficiency.

References

Cramer, R. J., Johnson, S. M., Rausch, E. M., McLaughlin, J., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology, 7*, 1–11.

Douglas, K. A., & Morris, C A. W. (2015). Assessing counselors' self-efficacy in suicide assessment and intervention. *Counseling Outcome Research and Evaluation, 6*, 58–69.

Liebling-Boccio, D. E., & Jennings, H. R. (2013). The current status of graduate training in suicide risk assessment. *Psychology in the Schools, 50*, 72–86.

Mackelprang, J. S., Karle, J., Reihl, K. M., & Cash, R. E. (2014). Suicide intervention skills: Graduate training and exposure to suicide among psychology trainees. *Training and Education in Professional Psychology, 8*, 136–142.

Rudd, M. D., Cukrowicz, K. C., & Bryan C. J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. *Training and Education in Professional Psychology, 2,* 219–228.

Schmitz, W. M., Allen, M. H., Feldman, B. N., Gutis, N. J., Jahn, D. R., Kleespies, P. M . . . . (2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in U. S. mental health training. *Suicide and Life-Threatening Behavior, 42*, 292–304.

Managing the Switch to ICD-10

Ed Zuckerman, PhD

Dr. Ed Zuckerman

To make the transition from ICD-9 to ICD-10 somewhat easier, no deletions, additions, or wording changes were allowed to the ICD-10 formalized several years ago. However, the moratorium has run its course and changes to the diagnoses and code numbers to be used for documentation and billing for services rendered after October 1, 2016, were recently finalized by NCHS/CDC.

Recall that DSM5 adopted about half of the codes (numbers) available in the ICD's F-codes (the familiar symptom-based disorders) although the APA changed the names of nearly a dozen. Now all the changes to ICD for 2017 are wordings adopted from the DSM-5.

The good news is that there are fewer than twenty of these and their names have been widely discussed (e.g. disruptive mood dysregulation disorder, excoriation disorder, social pragmatic communication disorder. Hoarding disorder was already in ICD). Do note that ICD-10 retained and still retains many of the older diagnoses from ICD-9 such as Conduct disorder and Asperger's)

The bad news is that more than a hundred of DSM5's wordings for substance use, abuse, dependency, etc. diagnoses have now been added to the diagnoses already in ICD. I am not an expert in this area but based on my reading of the DSM's wordings I do not see any meaningful improvement by their addition.

I do not see any added information, important distinctions, or clarity of concepts in them. They simply expand the bulk of the text file. They are not improvements because DSM's concepts are often muddled and not an improvement over the traditional and familiar wordings of ICD. For example, does DSM's "mild" equal or improve on ICD's "uncomplicated" substance abuse?

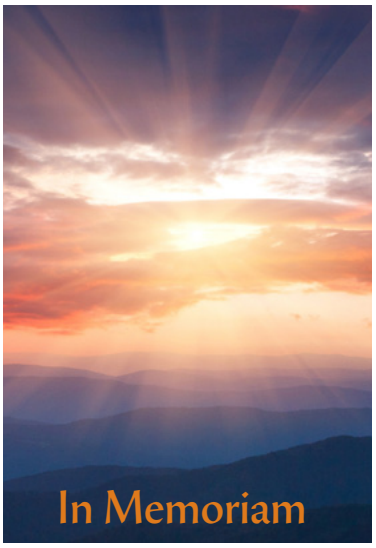
As context to understanding what this adoption means, recall that ICD is simply the results of a multinational, multi-cultural, and historical survey of which diagnostic labels are in actual use by clinicians of different backgrounds, training, and experience around the world. Its main purpose is to document practice and so it does not contain diagnostic criteria, epidemiological data, or other discussions present in DSM. In contrast, DSM claims to document real disorders (not diseases) and that their etiology and dynamics are at least partially known and offered. The ICD is international and not just American in its concepts, language, and private sponsorship. Having the World Health Organization adopt DSM language into ICD guarantees DSM's use (sales) and influence around the world. It is American hegemony if not imperialism.

This "harmonization" of two quite differently designed and purposed sets of diagnoses is, at its base, a power grab by the APA. In the absence of a diagnostic manual for the ICD, the APA has integrated enough of DSM's language into the ICD so that the book will now become the necessary reference for understanding the meanings of the diagnostic labels. I don't need to restate for this audience the significant scientific failings of the DSM5.

What to do now

The good news is that this does not change the codes (numbers) to be used in our records and billing. Use your

Continued on page 10



Dr. Steve Anderer

Dr. Steve Anderer, a psychologist and attorney, died suddenly while participating in a triathalon in New Jersey on August 28, 2016. He is survived by his wife, Dr. Susan Anderer, and their three children. Dr. Anderer graduated from the joint J.D./Ph.D. Program from Villanova University and spent most of his professional career in domestic law, especially child custody litigation.

He helped organize several workshops on best practices in child custody through PPA and the Pennsylvania Bar Association. He served on committees and task forces looking at ways to improve the welfare of children involved in domestic court, including the use of parenting coordination as a dispute resolution process in Pennsylvania.

Dr. Anderer had multiple professional publications on child custody evaluation and the law. He gave generously of his time to his professional communities and did so with a generous and genial spirit. He will be missed by his friends, colleagues and community.

MANAGING THE SWITCH TO ICD-10

Continued from page 9

current ICD codes for services you provide up until the end of September. Use them even if you bill for those services after that date. For services you provide (and bill for) after October 1, 2016, use the changed codes described here.

If you need to add the diagnostic labels for your documentation, there is no guidance as to using the older ICD language or the now added DSM language – or both – sorry. Perhaps our friends at the managed care companies will tell us what they want. In my opinion, you can't go wrong with the ICD words as they are from the US government approved list.

You can hack your copy of the DSM-5 to include the newly introduced diagnoses. This idea was suggested by Todd Finnerty, PsyD and his list is on his website at: http://psychology.news/news/2016/05/15/a-step-by-step-guide-to-vandalizing-your-dsm-5/

I will soon be incorporating all changes to ICD in the version I sell on my website and will offer some way to update copies you have bought from me.

One final point: the new diagnoses are only to the F-codes (chapter 5 of ICD-10). No changes were made to any of the S, T, R, or Z codes, all of which I believe should be considered in creating any comprehensive biopsychosocial case formulation.

Ed Zuckerman, PhD, is a clinical psychologist, licensed in Pennsylvania and the author of the *Clinician's Thesaurus* whose eighth edition will come out in the spring and of *The Paper Office for the Digital Age* whose fifth edition (co-authored with Keely Kolmes, PsyD) will be out this fall. He has offered for sale a more functional and handy version of the ICD-10 at his website (www.TheCliniciansToolbox.com) for the last three years along with some informative handouts about ICD and DSM.

Classifieds

PHILADELPHIA Center City, Fitler Square. – Four beautiful designer-decorated offices, three waiting rooms. fireplaces, decks, garden, a/c, cathedral ceiling, skylight, kitchen, Wi-Fi, fax, buzzer for each office. Over bridge from U/Penn. Psychiatrists and learning disabilities specialist on premises. Parking option. Flexible arrangements: Full time, day, hour. Reasonable rent. 215-546-2379, marlabisaacs@gmail.com

FOR SALE – Former Location of Psychology Practice in Hershey, PA. Dually zoned (commercial/residential) house with prestigious Chocolate Avenue address that served as a solo practice for ten years. Live and work at this location (no commute!) or convert to multiple offices. ADA compliant. 3 bedroom, 2.5 bathroom with office and waiting room. Large garage and parking lot. Owner is retiring. $249,000. 717-649-8022, rmlafo@comcast.net.

PSYCHOLOGISTS – Contact us regarding part-time opportunities to provide services in nursing and rehab centers. We offer training and ongoing support as you deliver a unique and valuable perspective to the interdisciplinary team. www.goldenwoodservices.com.

Assesses a wide range of **social, emotional, behavioral,** and **academic concerns and disorders** in youth aged 6 to 18 years.

CONNERS
Comprehensive Behavior Rating Scales™

Updated to include a new scoring option for the DSM-5 Symptom Scales.*

*DSM-IV-TR scoring still available for online and software options

A multi-informant tool that assesses youth across academic, school, and social settings. The Conners CBRS® assists in the diagnostic process, development and monitoring of intervention plans, and the identification of students for potential eligibility in special education programs.

- Direct and clear links to the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) and the individuals with Disabilities Education Improvement Act 2004 (IDEA 2004)
- Straightforward administration, scoring, and reports available in online and software formats
- Excellent reliability and validity
- Spanish versions are available for parent and self-report forms

Earn Continuing Education (CE) Credits with the Conners CBRS.

It is easy to earn CE credits quickly and online. Just study the manual, pass the online questionnaire, and a certificate is created for you!

Learn more at MHS.com/CE

MHS.com/ConnersCBRS

MHS ASSESSMENTS

Multi-Health Systems Inc.
USA Tel: 1.800.456.3003 / CAN Tel: 1.800.268.6011
mhs.com • customerservice@mhs.com

2016/17 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. Now, and moving into 2017, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

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

2016 Fall Continuing Education and Ethics Conference

November 4, 2016
9:00 a.m.–4:30 p.m.
DoubleTree by Hilton
Valley Forge, PA

2017 Spring Continuing Education and Ethics Conference

April 27–28, 2017
Sheraton Erie Bayfront Hotel
Erie, PA

PPA2017–PPA Annual Convention

June 14–17, 2017
Omni Bedford Springs Resort
Bedford, PA

Webinars and Home Studies

Available year-round!

Podcasts

Podcasts for CE credit by Dr. John Gavazzi are 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.

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

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.**

For all Home Study CE Courses above contact:
Judy Smith, (717) 510-6343, judy@papsy.org.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

What does Act 74 mean for Psychologists?

Act 74, signed in 2016, requires all psychologists to complete one (1) CE credit on suicide prevention per biennium. This requirement will go into effect for the current biennium, meaning that psychologists must complete at least one (1) hour of suicide prevention CE before November 30, 2017.

NEW Mandatory Requirement

What does this mean for you?

PPA is here to help! Dr. Sam Knapp has developed two home studies to meet this new requirement. These home studies are currently available through PPA - both online and hard copy. Click below to access these new home studies!

You can also join us for Dr. Knapp's **live presentation** at the Fall Continuing Education and Ethics Conference on Friday, November 4 from 12:15 - 1:15 pm. This lunchtime presentation is only $40 and includes the cost of your meal.

Have questions regarding this new requirement? Contact Rachael Baturin, JD, MPH at (717) 510-6340 or rachael@papsy.org.

The Assessment, Management, and Treatment of Suicidal Patients: 1 CE

The Assessment, Management, and Treatment of Suicidal Patients: 3 CE

Live at the Fall Conference: W04- Patients at Risk to Die from Suicide: Assessment, Management, and Intervention