The Pennsylvania

Psychologist

Vol. 76, No. 6

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ALSO INSIDE:

- PPA launches a new public-facing website
- The first On the Personal Side column
- Getting mental health on the presidential candidates' agendas
- A closer look at concentration deficit disorder

The Broad Diversity of Patchwork Found on the Geropsychology Quilt

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The Pennsylvania Psychologist

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REGULAR FEATURES

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SPECIAL SECTION—THE BROAD DIVERSITY OF PATCHWORK FOUND ON THE GEROPSYCHOLOGY QUILT

STUDENT PERSPECTIVE

SCHOOL PSYCHOLOGY SECTION

ALSO INSIDE

Overcoming Interpersonal Violence Throughout the Life Span

PPA Launches New Website: PsychologyCanHelp.com

Beatrice R. Salter, PhD


Dr. Beatrice R. Salter

Nearly a year ago, when I introduced the topic of interpersonal violence as the theme for this year, I could not have anticipated the support and outpouring of energy and ideas that have flowed from our members and staff about this very important issue.

It is impossible to watch the news without being bombarded by images of violence that terrify communities and lead to individuals and families feeling vulnerable and unsafe. Studies have shown that interpersonal violence negatively impacts psychological development, overall mental health, physical health, and economic viability. The impact of violence needs and deserves our attention and resources as mental health professionals, advocates, and educators. We are uniquely trained to address the vestiges of trauma throughout the life span, as well as work with addiction and abuse issues. Psychologists can be even more effective change agents by interfacing with other professionals and their associations and agencies to identify causes that fuel violence and develop tools to remedy these issues in our communities.

PPA reached out to various agencies and associations in the Commonwealth in an effort to establish partnerships around interpersonal violence issues. At the present time, PPA has partnered with the Office of Victim Advocate for the Commonwealth, the Pennsylvania Chiefs of Police Association, the Domestic Violence Services of Cumberland & Perry Counties, the Pennsylvania Coalition Against Domestic Violence, and the Pennsylvania Coalition Against Rape. These relationships will have a positive effect for our citizens and families, as well as for our members.

On April 4, 2016, during our annual Advocacy Day held at the State Capitol, PPA conducted a press conference to unveil our new website, **psychologycanhelp.com**. This website is designed to inform the public about all types of abuse and violence and resources for getting help. Representatives of three of our community partners spoke, pledging their support for this exciting initiative. They were: Jennifer Storm, victim advocate for the Commonwealth; Thomas Gross, executive director, Pennsylvania Chiefs of Police Association; and Dr. Sherry Welsh, executive director of Domestic Violence Services of Cumberland & Perry Counties. Also speaking at the news conference were state representatives Todd Stephens, JD, District 151, and Madeleine Dean, JD, District 153, both from Montgomery County. They also promised their support of this important initiative. All participants pledged to join PPA in the effort to identify, address, and overcome interpersonal violence issues. It was a very exciting day!

> *We are uniquely trained to address the vestiges of trauma throughout the life span, as well as work with addiction and abuse issues.*

Along with this launch, attendees at Advocacy Day visited their representatives and made a pledge to confront interpersonal violence when and where ever it is encountered.

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Welcome to PsychologyCanHelp.com!

Our goal is to establish strategies to help our communities move from cultures of detachment and violence to cultures of cooperation, peacefulness and non-violence. We seek to identify ways to highlight psychology's value in homes, schools, workplaces and our communities at large. We, as psychologists, can become change agents by working with other professionals and agencies to identify causes that fuel violence and to develop concrete tools that address and remedy these issues. Non-violence can be promoted through advocacy and the dissemination of educational tools that reinforce an evolving view of cultural differences, self-awareness, violence and trauma.

What is the Practice of Psychology?

Understand the benefits of psychology in your daily life.

Topics of Interest

Psychology touches all aspects of society. Find topics of interest applicable to your situation here.

How Can I Get Help?

Click here to find a psychologist in your area.

Musings for June on an April Afternoon

Krista Paternostro Bower, MPA, CAE

Krista Paternostro Bower

As I sit down to write this column, I am gazing out of the double window of my newly constructed home office onto the front lawn of the house where all of my fondest adult memories have occurred. This view is something I never anticipated for my life but cherish every day. Over the past five years, I have learned that any perception of control is just that: a perception, not reality.

At the time that my husband Jamie and I decided, way back in the fall of 2014, that we should move to the family farm and add a new addition, it seemed like a long and arduous journey to make it happen. I can tell you with certainty today that my instincts were right. But, we could not be happier with the outcome of this journey, and we feel blessed for the time that we have been given to spend with my mom at the place where our family has over the past 25 years truly transformed a house into a home.

But for now, back to the task at hand. Sitting here today trying to write my column for publication in June is challenging, as so many new stories will likely emerge between now and then, most of which, just like life, we cannot anticipate. However, please join me on a quick look back at 2016 so far:

An 11-person delegation from PPA participated in this year's **APA State Leadership Conference** in Washington, DC, from February 27–March 1. This 4-day training and networking event ended with our annual Hill Day, where delegation members visited with our federal legislators to advocate on behalf of the profession of psychology. PPA would like to thank the organizational leaders pictured in Figure 1 for their participation in the 2016 State Leadership Conference and for their continued dedication to our organization.

Figure 1. *PPA's delegation at the 2016 State Leadership Conference*. Front row (left to right): *Williametta Bakasa, PsyD; PPA president Beatrice Salter, PhD; Jesse Matthews, PsyD*. Back row (left to right): *Justin Fleming; President-Elect David Rogers, PhD; Tim Barksdale, PsyD; Krista Paternostro Bower, MPA, CAE; Rachael Baturin, JD; Samuel Knapp, EdD, ABPP; Adam Sedlock, MS*. Not pictured: *Amanda Katchur, PsyD*.

By the time this article is actually published in June, we will have had four successful CE events under our belt for 2016: two **webinars**, our **Spring Conference**, and **Advocacy Day**! With special thanks to Dr. Sam Knapp, we also recently launched three new home studies that are now available on our website. We are dedicated to providing top-notch and relevant training and professional development opportunities to our members throughout the year.

Looking back on the past quarter, we have experienced some positive momentum for our organization regarding this year's presidential theme. In April, we held a very successful Advocacy Day event at the State Capitol in Harrisburg. The culmination of the effort was the press conference we hosted in the East Wing Rotunda to launch our new public-facing website: psychologycanhelp.com. We invited several community partners, including the Commonwealth Office of Victim Advocate, the Pennsylvania Chiefs of Police Association, and the Domestic Violence Services of Cumberland & Perry Counties to participate in the event by expressing their support for Dr. Beatrice Salter's presidential platform, **Overcoming Interpersonal Violence Throughout the Life Span**. Be sure to read more about this initiative in Dr. Salter's Presidential Perspective article in this issue.

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EXECUTIVE DIRECTOR'S REPORT

Continued from page 3

During the press conference, we also heard bipartisan support for our efforts from State Representatives Todd Stephens (R-Montgomery County) and Madeleine Dean (D-Montgomery County). We carry this momentum forward into our PPA2016 convention event coming up in just a few weeks. I would like to personally thank PPA president Dr. Beatrice Salter and Dr. Bruce Mapes, chair of PPA's Interpersonal Violence Task Force, for their passion and enthusiasm for this initiative. We also thank all of those PPA members who have helped us to populate and build our public-facing website. We could not have done it without your help!

PPA president Dr. Beatrice Salter speaks for the Interpersonal Violence Task Force in April in Harrisburg.

We look forward to seeing our members and colleagues at the **PPA2016 Convention**! If you have not already done so, and would like to pose a question to our PPA leadership team during our Town Hall Plenary at the convention, please submit your question (in video or written format) using the hashtag **#AskPPA** to Justin Fleming at justin@papsy.org.

See you in Harrisburg!

Happenings on the Hill

PPA Making Progress on Modernization of Professional Psychologists Practice Act

Justin Fleming, Director of Government Affairs

Justin Fleming

In the weeks prior to publication of this issue of the *Pennsylvania Psychologist*, PPA learned that Senate Bill 772 will be scheduled for a vote in the House Professional Licensure Committee. After nearly a year of negotiations, PPA and the Pennsylvania Department of Corrections have agreed to language that adds a layer of accountability to the activities of Psychological Services Specialists and Psychological Services Associates. While our legislative journey is not yet complete, we are one step closer to making the first changes to the Professional Psychologists Practice Act in three decades.

A big reason for the movement of our primary legislation can be credited to the more than 50 members of PPA who recently descended upon the State Capitol in Harrisburg to advocate for two bills and a cosponsorship memo that will strengthen the profession of psychology. Those initiatives are the modernization of the Professional Psychologists Practice Act (SB 772), House Bill 706, and SCO 1435. HB 706 and SCO 1435, respectively, would enable psychologists to provide secure telehealth services and, more importantly, mandate that insurance companies pay for those services. Our members visited with more than 40 House of Representatives offices and 30 Senate offices during PPA's annual Advocacy Day.

In the afternoon, Executive Director Krista Paternostro Bower and Board President Dr. Beatrice Salter held a press conference to bring awareness to our presidential theme for this year: Overcoming Interpersonal Violence Throughout the Life Span. PPA was joined by community partners in this endeavor, including: Jennifer Storm, victim advocate for the Commonwealth, Chief Thomas Gross, executive director of the Pennsylvania Chiefs of Police Association, and Dr. Sherry Welsh, executive director of Domestic Violence Services of Cumberland & Perry Counties. In addition, State Representatives Todd Stephens and Madeleine Dean, both of Montgomery County, endorsed the initiative and urged those gathered to bring solutions to the General Assembly that will help to reduce interpersonal violence.

We had a tremendous day of advocacy in Harrisburg, but if you were not able to join us, don't worry. You can still support our efforts in your community! PPA will be glad to send you information that we shared, so you can set up a visit with your legislator in his or her district office. You could also contribute to PPA's Political Action Committee at pennpsypac.org to allow us to provide funds to legislators who support the agenda of psychology and mental health care.

Finally, Governor Tom Wolf signed a state budget for the 2015–2016 fiscal year in March. The $30 billion spending plan provides $200 million more for schools from the Commonwealth. Shortly after the signature dried, economic credit rating agencies chided the state for not doing enough to fix the estimated $2 billion structural deficit present within the budget. As of now, we are in the thick of the budget process once again. We will see if the Governor and legislative leaders can deliver a spending plan by June 30 or if Pennsylvanians should prepare for another protracted budget fight.

I am so privileged to do important advocacy and policy work on behalf of psychologists. If you have questions or concerns, feel free to contact me at 717-232-3817, justin@papsy.org, or find me on Twitter @PAPsychGA!

Sample Authorization Forms in Pennsylvania

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

Dr. Samuel Knapp

Rachael L. Baturin

State and federal laws regulate authorizations to release mental health records. The State Board of Psychology only states that releases of information must be done with the patient's written consent (except for a few mandated situations) but does not specify what elements should be on the written consent. However, HIPAA and the Pennsylvania Mental Health Procedures Act (MHPA) are more specific.

Most providers are covered by HIPAA, and most psychologists would need to have an authorization (or release of information form) acceptable under HIPAA. In Pennsylvania, the MHPA regulates publicly funded outpatient clinics and inpatient services. Psychologists who commonly deal with those entities may wish to have an authorization form that meets their requirements as well. However, unless they work for a publicly funded agency or an inpatient unit, psychologists are not bound by the MHPA and do not have to include all of their requirements in their own release of information forms.

The release of information form on the following page was created to fulfill all of HIPAA's requirements. We also provide information on how forms could be modified to comply with all of the MHPA requirements.

The form is a sample form; not a model form. That is to say, professionals have the option of modifying some of the portions of the form depending on the nature of their practices. We provide several examples of how this could be done. For example, this sample form lists several potential uses for the information (listing the potential uses is a requirement under HIPAA). However, individual psychologists may add more uses than those provided in this sample form. We have included footnotes that give the exact wording for what needs to be included, so psychologists can better understand what is required and what may be altered in these forms.

Also, this sample form can be used for either adults or children. However, some psychologists may find it easier to create separate forms for adults and for children.

In addition, the MHPA has a provision to use when persons are unable to physically sign their names. However, if psychologists have, because of the nature of their clientele, never encountered nor ever expect to encounter patients who cannot sign their names, they may wish to delete this option from their form.

Furthermore, some psychologists include other information in their releases as well. For example, one psychologist notes that the release may permit the release of information related to the HIV status of the patient. Other psychologists include a statement concerning the applicability of federal drug and alcohol laws to releases. Federal drug and alcohol laws, which apply to all licensed drug and alcohol facilities in the state, do not specify the type of information that should be on authorizations to release information, but they do limit the ability of agencies to rerelease information.

Finally, we note two unique requirements under the MHPA. As noted above, psychologists are not covered by the MHPA unless they work in a public agency or an inpatient setting. Nonetheless, they will encounter these two issues on many releases that do attempt to comply with the MHPA.

First, we have seen some releases that include the following statement:

> The information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

The MHPA requires this statement for involuntary releases (releases done without the consent of the patient). Since psychologists in independent practice are very unlikely to use these forms for nonconsensual releases, they may wish to delete this from their release forms.

Second, the MHPA gives patients an opportunity "to inspect materials to be released" (55 PA Code 5100.34 (c)) with some limits. Facilities that must comply with the MHPA will include this in their release forms, although psychologists in independent practices, regulated by the State Board of Psychology, do not have an obligation to allow patients to inspect records before they are sent out.

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SAMPLE AUTHORIZATION FORMS IN PENNSYLVANIA

Continued from page 5

Sample Release of Information Form *(Notes on page 7)*

ABC Psychological Services
Harrisburg, Pennsylvania
717-555-1212

I ____ with the Date of Birth of ____/____/____

Name — Month Day Year

authorize ABC Psychological Services[1] to release/obtain (circle one or both) from

Person or Facility ____[2]

Address ____

City/State/Zip ______________________________ Phone ____________________

The following information (please check the appropriate boxes below)

☐ Discharge summary ☐ Treatment summary ☐ Assessment results

☐ Psychotherapy notes ☐ Other information (please specify) ______________________________[3]

For purposes of

☐ treatment planning ☐ others (please specify) ____________________ ☐ at the request of the individual[4]

The consent will begin on ____________________ and expire[5]

☐ at the end of treatment

☐ other event (please specify) ______________________________ Date __________[6]

I am aware that this information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have a right to cancel this authorization by writing to *ABC Psychological Services at 1000 Forster Street, Harrisburg, PA 17102 (FAX: 717-555-1212)* or by verbally informing a staff member of ABC Psychological Services that I cancel this authorization. However, this revocation will not be effective to the extent to which actions have been taken in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist, health plan, or other covered entity may not condition treatment, payment, enrollment or eligibility of benefits upon my signing the release except a health plan may condition enrollment upon the provision of an authorization to determine underwriting risks, or for creating protected health care information for disclosure to a third party (such as a physical examination as a condition of pre enrollment in a life insurance policy).[7]

I understand that I have a right to inspect the records before they are released., subject to the limitations in 55 PA 5100.33. [8]

I understand the nature of this release

______________________[9]	__________	______________________	__________
Signature of client	Date	Signature of parent or guardian (if legally required)	Date
______________________[10]	__________		
Signature of staff member	Date		

☐ patient has been given a copy of the release [11]

Verbal Consent

I am physically unable to sign the release but below are the signatures of two witnesses who attest that they witnessed that I understood the nature of the release and freely gave verbal consent.

______________________	__________	______________________	__________[12]
Signature of witness one	Date	Signature of witness two	Date

SAMPLE AUTHORIZATION FORMS IN PENNSYLVANIA

Form on page 6

Sample Release of Information Form Notes

[1] HIPAA requires that the release includes "The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure" (45 CFR 164.508 (c) (ii)); The MHPA requires "identification of the agency or persons to whom the records are to be released" (55 PA Code 5100. 34 (f) (2)).

[2] HIPAA requires that the release include "The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure" (45 CFR 164.508 (c) (iii)).

[3] HIPAA requires that the release include "A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion" 45 CFR 164.508 (c) (1). The MHPA requires "a statement of the specific relevant and timely information to be released" (55 PA Code 5100. 34 (f) (4)). Psychologists may add more options if they so choose.

[4] HIPAA requires that the release includes "A description of each purpose of the requested use of disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provider a statement of the purposes" (45 CFR 164.508 (c) (v)). The MHPA requires "a statement of the specific purposes for which the released records are to be used" (55 PA Code, 5100.34 (f) (3)).

[5] HIPAA requires the "signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must also be provided" (45 CFR 164.508 (c) (vi)). The MHPA also requires "A place for the signature of the client/patient or parent or guardian and the date, following a statement that the person understands the nature of the release" (55 PA Code 5100. 34 (f) (5)).

[6] The MHPA requires the signature of a staff person obtaining the consent of the client/patient or parent or guardian and the date. (55 PA Code 5100.34 (f) (6)).

[7] HIPAA requires that "if a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy" (45 CFR 164.508, (c) (4)).

[8] The MHPA requires "a place to record a verbal consent to release information given by a person physically unable to provide a signature and a place for the signatures of two responsible persons who witnessed that the person understood the nature of the release and freely gave his verbal consent" (55 PA Code 5100.34 (f) (7)).

[9] HIPAA requires the "signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must also be provided" (45 CFR 164.508 (c) (vi)). The MHPA also requires "A place for the signature of the client/patient or parent or guardian and the date, following a statement that the person understands the nature of the release" (55 PA Code 5100. 34 (f) (5)).

[10] The MHPA requires the signature of a staff person obtaining the consent of the client/patient or parent or guardian and the date. (55 PA Code 5100.34 (f) (6)).

[11] HIPAA requires that "if a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy" (45 CFR 164.508, (c) (4)).

[12] The MHPA requires "a place to record a verbal consent to release information given by a person physically unable to provide a signature and a place for the signatures of two responsible persons who witnessed that the person understood the nature of the release and freely gave his verbal consent" (55 PA Code 5100.34 (f) (7)).

PRESIDENTIAL PERSPECTIVE

Continued from page 2

Participants signed the pledge, enjoyed cupcakes, and networked with other attendees. One participant stated that this was the most successful Advocacy Day she's attended! Thanks to everyone who participated and made these events possible!

At the PPA Board of Directors meeting held March 12, 2016, the Board voted to make the Task Force on Interpersonal Violence a standing committee. This vote establishes PPA's commitment to address interpersonal violence issues on an ongoing basis. This is an exciting move that provides opportunities for our psychologist members to use their expertise and experience to address this important societal issue. Individuals and families coping with the effects of violence need a face, a voice, and competent treatment, without stigma.

It is with sincere gratitude that I acknowledge Dr. Bruce Mapes for stepping up to chair the task force this year. He has done an amazing job of bringing focus to this project. Also many thanks to all who served on the task force. The energy and vision exhibited has been incredible! Lastly, PPA staff has consistently shown vision and creativity in accomplishing goals set by the task force. They have put flesh on the skeleton of this important issue.

Psychology Can Help. You can, too!!

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of April 8, 2016

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 21	Provides for assisted outpatient treatment programs in the Mental Health Procedures Act. - Sen. Stewart Greenleaf (R-Montgomery)	Against	In Public Health and Welfare Committee	N/A
SB 63 **HB 92**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years. - Sen. Stewart Greenleaf (R-Montgomery) - Rep. Kate Harper (R-Montgomery)	For	(HB 92) In Consumer Protection and Professional Licensure Committee	Passed House 4/21/15 (194–0)
SB 554 **HB 1178**	Amends the Insurance Company Law providing for retroactive denial of reimbursement of payments to health-care providers by insurers. - Sen. Dave Argall (R-Schuylkill) -Rep. Stephen Barrar (R-Delaware)	For	In Banking and Insurance Committee	In House Insurance Committee
SB 772	Updates the psychologists licensing law, eliminates certain exemptions, and modernizes the experience requirements. - Sen. John Gordner (R-Columbia)	For	Passed Senate 10/13/15 (49–0)	Referred to Professional Licensure Committee
HB 64	Requires licensed psychologists to take 1 hour of continuing education in the assessment, treatment, and management of suicide risks. - Rep. William Adolph (R-Delaware)	Against	Referred to Consumer Protection and Professional Licensure Committee	Passed House 6/10/15 (188–0)
HB 132	Provides Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee
HB 133	Act establishing a bill of rights for individuals with intellectual and developmental disabilities and conferring powers and duties on the Department of Human Services. - Rep. Thomas Murt (R-Montgomery)	For	N/A	Reported as committed from House Appropriations Committee 9/29/15
HB 214	Increases oversight and accountability in Home and Community Based Services. - Rep. Mauree Gingrich (R-Lebanon)	For	N/A	In Aging and Older Adult Services Committee
HB 706	Provides for insurance companies to reimburse practitioners for telehealth services - Rep. Mark Cohen (D-Philadelphia)	For	N/A	In House Insurance Committee

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

A Few Words to Our Readers

Elbert M. Saddler, PhD; Chair, PPA Committee on Geropsychology

Dr. Elbert M. Saddler

When I became involved with PPA's Committee for Geropsychology a year ago at last year's convention, I was reminded of how much things have changed since I entered the field of professional psychology a little more than forty years ago. When I studied for my doctoral Prelims, knowing that I would be examined on my knowledge of developmental psychology across the life span, my focus was from Freud's Psychosexual Stages of Development to Piaget's, Kohlberg's, Erikson's, and Levinson's theories on life stages. Back then, the concept of clinical geropsychology was not on my or many other students' radar. Today, the subspecialty of clinical geropsychology incorporates: clinical, developmental, and neuropsychology components, plus elements of many other specialties to assist older adults to improve their lives in their life stage and overcome personal difficulties.

This edition of the *Pennsylvania Psychologist* will give just a small glimpse of how geropsychologists tackle the diverse scope of their work. I am so pleased that the Committee for Geropsychology (GPC) has this issue's special section to focus attention on this emerging area of psychological practice.

One of the GPC's goals this year is to encourage psychologists to actively participate in efforts to better serve this ever-growing population of older adults. APA standards for the performance of geropsychological services were first established in 2003. We are hoping that by taking our CE offerings, psychologists may be inspired to incorporate this specialty into their clinical practice and acquire the training and background that qualifies a practitioner.

I want to thank my colleagues for their contributions to this edition and for offering CE opportunities this year. I hope the readers will appreciate and take full advantage of them.

Sexual Consent Capacity in Long-Term Care Settings

Jennifer Hillman, PhD, ABPP; jhillman@psu.edu

Dr. Jennifer Hillman

The majority of nursing home residents, with and without dementia, ascribe at least moderate importance to sexual activity, including holding hands, hugging, kissing, fondling, having intercourse, and masturbating (Roelofs, Luijkx, & Embregts, 2015). According to the World Health Organization (2010), sexual expression that respects the rights of others represents a basic human need, regardless of advanced age or disability. The primary ethical issue is to balance a resident's right to autonomous sexual expression with the institution's duty to protect residents from harm (Wilkins, 2015). Residents with various disorders (e.g., Parkinson's disease, Alzheimer's dementia, delirium) may also display hypersexuality and disinhibition (e.g., impaired decision-making skills) (Hillman, 2012). Fortunately, psychologists are in a unique position to provide an assessment of sexual consent capacity.

Distinctive Features

Sexual consent capacity functions on a continuum; an older resident may be capable of making an independent decision about participating in sexual activity such as hugging and kissing but not heavy petting or intercourse. Unlike medical and financial consent capacity, sexual consent capacity must also be determined in the moment and not by a surrogate decision maker or proxy (e.g., a living will or power of attorney) (ABA & APA, 2008). One reason for this qualification is that decisions about participation in sexual activity are often made privately, without the assistance of professionals and family members that often accompanies medical decision making. A resident's sexual consent capacity also should be reassessed when changes occur in the older adult's mental status (e.g., via dementia, delirium, or depression) or environment (e.g., moving to a private room).

An Approach to Assessment

Although no national guidelines are available to determine an older adult's sexual consent capacity, the ABA and APA (2008) and other professionals (Wilkins, 2015) offer various recommendations. First, an interdisciplinary team should be assembled that includes psychologists, physicians, social workers, occupational and physical therapists, nursing staff, and family members as appropriate. Family members should be educated about the process, and the older resident prepared for the assessment, including a discussion of consent or assent, limits of confidentiality, and possible outcomes.

A psychologist should then administer a screening instrument for cognitive functioning such as the MMSE (Folstein, Folstein, & McHugh, 1975). The presence of cognitive impairment indicates the need for a more extensive evaluation, particularly in relation to executive functioning (e.g., ability to plan, problem solve, and make decisions). The next step is a semistructured interview designed to assess the resident's *knowledge* of the sexual activities and related, potential risks (e.g., risk of coercion, gossip or rejection from others, STDs) and the *capacity* to make decisions about engaging in sexual activity based upon those risks and personal values. The interview also assesses the *voluntariness* of participating in sexual activity, devoid of persuasion. Embedded within these constructs are issues of personal safety, the privacy of others, and the verbal or nonverbal ability to say "no."

The results of the interview are then shared with the team. Spouses and partners, adult children, and legal guardians are included, particularly when a resident is cognitively impaired or unable to communicate his or her own wishes. Interdisciplinary team members provide vital information about a resident's medical status, potential functional limitations, social history, religious beliefs, and everyday behaviors that can give clues to assent or coercion.

Case Example

Mr. C, a 72-year-old widower of 10 years with advanced Parkinson's disease, and Ms. F, a 68-year-old divorced woman with Alzheimer's dementia, appeared to strike up a romantic relationship in their assisted living facility. Both residents often maneuvered their wheelchairs (indicating voluntariness) so they could sit next to each other in the lobby, hold hands, and occasionally kiss on the cheek. The mood of both residents brightened after spending time together (indicating assent).

> *According to the World Health Organization (2010), sexual expression that respects the rights of others represents a basic human need, regardless of advanced age or disability.*

Two weeks later, Mr. C's adult daughter came to visit and was distraught upon seeing him hold hands with Ms. F. Mr. C's daughter called for an immediate staff meeting "to discuss this terrible turn of events." Mr. C's daughter insisted that "in his right mind, my father would never be with another woman because he loved my mother [his deceased wife] so much!" In response, the staff psychologist included her in the interdisciplinary team tasked with Mr. C's sexual consent capacity evaluation. Mr. C had no other relatives, and Ms. F's adult children approved of the relationship.

On the MMSE, Mr. C scored 14 and Ms. F scored 17. Even though he showed evidence of cognitive deficits, the results of the semistructured interview and further testing (cf. Hillman, 2012; Wilkins,

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The Joys and Challenges of Treating Older Adults in Private Practice

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Dr. Rise Kass

Fourteen years ago, I became a Medicare provider in order to treat two very sweet older women who were seeking therapy. My solo private practice had been an eclectic mix, but I had seen no one, up to that point, over the age of 65. These women, one 86 and the other 70, were dealing with compelling real-life stressors—the impending death of a beloved spouse and a painful divorce in later life. To my surprise, I found them among my most interesting and likeable patients. I shortly thereafter discovered that not only was I one of the few clinical psychologists in private practice in my area who accepted Medicare but that the older adult population was very underserved in the private practice context.

Listing myself as a Medicare provider on my *Psychology Today* website and informing primary care physicians and geriatricians in the area that I accepted Medicare resulted in a steady stream of older patients. Today, older adults represent more than half my practice and, except for the stressful PQRS reporting requirements that Medicare providers face, it has been a real joy to treat this population. I have found that older adults are extremely motivated to come for therapy, rarely cancel except when ill or due to bad weather, are available to come in for daytime appointments, and, most important, benefit greatly from brief and ongoing psychotherapy. The rewards are great for both patient and therapist.

Older patients who seek therapy in an outpatient setting face many critical issues and challenges:

- Grief due to death of spouse, friends, children, or grandchildren
- Loss of friends due to relocation
- Reduced social opportunities as a result of loss of significant others or issues of illness or physical mobility
- Financial concerns due to fixed income, high medical expenses
- Adjustment to changes in physical abilities due to normal aging, injury, disease, or disability
- Adjustment to retirement
- Relationship issues, such as divorce, chronic marital unhappiness, raising grandchildren, conflict with adult children
- Addiction issues
- Anxiety and depression
- Suicidal ideation
- Trauma, such as elder abuse, emotional abuse, life-threatening experiences (e.g., near death experiences, heart attack), injury, and illness
- Fear of death
- Difficulties related to medications
- First-time episodes of psychiatric illness
- Regrets, loneliness, and unresolved emotional issues

Examples in my practice of some of the above cited issues include an 83-year-old man, healthy and cognitively sharp, who experienced his first episode of significant anxiety and depression when his beloved wife had an 11-day hospitalization for a medical procedure. His wife recovered, but my patient required antidepressant medication and several months of psychotherapy before he too made a full recovery. I have been treating a 69-year-old woman for several years who has struggled with the sudden and unexpected death of her 38-year-old son. Another patient, a 70-year-old man and his wife, are raising their 9-year-old grandson after the death of their daughter and are dealing with grief and resentment. I am treating several older adults who struggle with cognitive changes and aphasia and many who struggle with medical illnesses such as postpolio syndrome and cancer.

Prior to becoming a clinical psychologist, I was a medical social worker, and I have found my medical background to be particularly helpful in dealing with this population. It is essential that the treating psychologist obtain a complete list of the patient's illnesses and medications, communicate with the primary care physician, and endeavor to learn about the condition(s) so as to better understand the totality of the patient's life experience. I have found that primary care physicians are very interested in my feedback as I see their patients on a much more frequent and ongoing basis and can provide much useful information.

> *I shortly thereafter discovered that not only was I one of the few clinical psychologists in private practice in my area who accepted Medicare but that the older adult population was very underserved in the private practice context.*

I believe it is important to rule out an organic or medical issue prior to determining that a problem is only or mainly psychological. Therefore, I often refer the patient back to their physician for an evaluation. For example, what appears to be anxiety is sometimes a thyroid problem. When one of my longtime patients, a bright and engaging 71-year-old woman, came in for a session and didn't seem cognitively "herself," I sent her to the emergency room as I suspected that she was having or had just had a stroke. She was indeed found to have had a stroke and happily made a good recovery, but that experience highlighted not only the importance of being attuned to medical issues in an older population but the valuable contribution a therapist can make as a result of being a frequent observer of the patient.

It is important, too, in dealing with older patients to involve family members in treatment when relevant or to obtain additional information. This is especially useful when the patient has cognitive issues, but it is also helpful in broadening

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JOYS AND CHALLENGES OF TREATING OLDER ADULTS IN PRIVATE PRACTICE

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one's understanding of the patient's life at home.

It has been my experience that older patients are uniformly grateful for the opportunity to come for therapy to address the many issues with which they struggle. Of course, the fact that Medicare and their secondary insurance provide payment does help them a great deal, as many are on fixed and limited incomes and most could not seek help if it were not covered by their insurance. Therapy offers this group much relief, comfort, and the ability to work out problems and issues in a safe context. For those who are the most isolated, it provides a valuable connection. Some have been in therapy before but many have not and come for the first time at the suggestion or insistence of their primary care physicians. All my older patients seem very glad to be in treatment, which is not always the case with my younger patients.

> *For the therapist, the rewards are just as great, if not greater. I have learned much of value about life from my older patients and am continually impressed by their wisdom and their resilience.*

For the therapist, the rewards are just as great, if not greater. I have learned much of value about life from my older patients and am continually impressed by their wisdom and their resilience. Older patients can serve as role models to younger therapists for adaptation and optimism in the face of serious life-altering challenges. The diversity of issues that this population faces makes treatment extremely interesting and exciting. It's wonderful to experience their gratitude and appreciation and gratifying to see their growth. For some, the therapist is among the few individuals in their lives who really listen to them. I am very glad that 14 years ago I decided to treat older patients, and I highly recommend that more therapists in private practice consider expanding their practices to include this special population.

SEXUAL CONSENT CAPACITY IN LONG-TERM CARE SETTINGS

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> *Even though the ethical issues related to Mr. C's sexual consent capacity were appropriately assessed and addressed, influences beyond the team's control ended the residents' relationship.*

2015) led the team to believe that Mr. C could consent to holding hands and kissing but not to fondling or intercourse. Mr. C identified Ms. F as "his new friend" and not his deceased wife, indicating his knowledge of the relationship. Because the residents never attempted to engage in additional sexual activities (e.g., fondling or intercourse) and they reported that they enjoyed spending time together (signifying voluntariness and assent), the team recommended that the relationship be allowed to continue. Monitoring was deemed essential; another assessment would be conducted if the residents' activities, mood, or cognitive status changed.

The psychologist discussed the situation with Mr. C's daughter, who was unable to separate her wishes from those of her father's. Two weeks later, Mr. C's daughter moved him from the facility. Because the assisted living center was pay-for-service, no one could prevent the move. Even though the ethical issues related to Mr. C's sexual consent capacity were appropriately assessed and addressed, influences beyond the team's control ended the residents' relationship.

A Call for Advocacy

Cognitive deficits or dementia should not automatically preclude a resident from sexual expression. Because less than 25% of nursing homes have a sexual consent policy and related staff training (AMDA, 2013), psychologists can be encouraged to engage in related advocacy and education. Facing the complex issues and challenges related to sexual consent capacity is necessary to protect the rights of all older residents in long-term care.

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Brain Health and Psychology

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Dr. Paul D. Nussbaum

The single greatest miracle ever designed sits between our ears. Weighing 3 pounds, comprised of 60% fat, and demanding 25% of the blood from each heartbeat, your brain is the origin of your every thought, emotion, movement, and dream. In short, your identity is the product of your brain, and it is the brain that builds and holds your life story, the most precious gift you have.

Neuroscience has taught us more about the structure and function of the human brain in the past 20 years than at any time in our history. We have been reintroduced to "neural plasticity," which refers to a brain that is highly dynamic, constantly reorganizing, and malleable. From neural plasticity, we are able to generate new brain cells (neurogenesis) in a structure called the hippocampus that is so critical for memory and new learning (Eriksson et al., 1998); we can build brain resilience (Wilson, 2011) that helps the brain delay onset of clinical symptoms associated with different diseases; and we can understand the importance of living a lifestyle that proactively promotes brain health (Nussbaum, 2003, 2010).

Brain Health

Since the 1950s, we have known that the environment is critical to brain development in rodents (Diamond & Hopson, 1999). Indeed, physical activity (walking on a wheel), socialization (living with other rodents), and mental stimulation (playing with toys) were three factors critical to the "enriched environment" and this lead to increased cortical volume and new brain cell development (neurogenesis). It was not until 1998 that we learned neurogenesis also occurs in the human brain (Eriksson et al., 1998) and in the same region, the hippocampus, as was found in rodents.

This transformed our understanding of the human brain and with a reinvigoration of neural plasticity, the concept of brain health for humans gained momentum around 2002. More specifically, we have the ability to shape our brains for health across the life span. The importance of the environment in the shaping of the human brain is now well studied, and the idea of brain health is now well known by the general public (American Society on Aging, 2006). Interestingly, the same three critical factors so important to brain development in rodents now form part of my Brain Health Lifestyle® (Nussbaum, 2010) for humans. Environment matters and the types of activities we choose to engage in on a daily basis have both a structural and functional consequence to our brains.

Lifestyle Interventions

In a recent advance online publication in *The Lancet*, Philip Scheltens and colleagues (2016) opined, "Ultimately, there will be a future in which specific anti-Alzheimer's therapy will be combined with lifestyle interventions targeting brain health to jointly combat the disease."

It is well known the United States is experiencing a swell in the number of adults over 65 and that the leading risk for dementia, including that caused by Alzheimer's disease (AD), is advanced age. Add to this the consistent finding of surveys that adults are most concerned about loss of memory or mind, and we have the ingredients for a call to action.

There is plenty of research on the positive effects of lifestyle on general health (Kvaavik, Batty, Ursin, Huxley, & Gale, 2010) and more recently on brain health (Barnes & Yaffe, 2011; Krell-Roesch et al., 2016; Nussbaum, 2011). Underscoring the need for starting early and remaining proactive with our healthy lifestyle is a finding that cognitive decline including memory loss may occur in the 40s, far earlier than previously thought (Manoux et al., 2012).

In my own work (Nussbaum, 2003, 2011), I have reviewed the research on lifestyle and brain health and published a Brain Health Lifestyle®. This lifestyle is built from the idea that every consumer should be empowered with the basic knowledge of his or her brain, how it functions, and the power of plasticity to encourage them to engage in a lifestyle that promotes health. Such a proactive approach to brain health is not meant as a clinical intervention, since we have no cure or even prevention for neurodegenerative diseases. However, research indicates lifestyle can help to build brain resilience that not only reflects a healthier brain but might delay onset of neurodegenerative diseases (Wilson, 2011).

> *In short, your identity is the product of your brain, and it is the brain that builds and holds your life story, the most precious gift you have.*

I believe any healthy brain lifestyle should include five major domains, or "slices of a brain health pie" (see brainhealthctr.com) that include:

- Physical activity
- Mental stimulation
- Nutrition
- Spirituality
- Socialization

A consumer-friendly detailed overview of this Brain Health Lifestyle® was published recently (Nussbaum, 2010). In addition, a more research-based review on the merits of such a lifestyle as authored by leading clinical scholars in each of the five domains was published in a special journal edition dedicated to the topic (Nussbaum, 2011).

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BRAIN HEALTH AND PSYCHOLOGY

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The Role of Psychology

There is a need for direct application of what neuroscience and research is teaching us about the positive effects of a living a life that promotes brain health. We now know that regular physical activity, socialization, proper nutrition, mental stimulation, and spirituality are important aspects of such a lifestyle. An environment that enables exposure to "novelty and complexity" is also critical to shaping our brains for health and development. Perhaps most important is the need to empower individuals to proactively engage in activities that promote a healthy brain at the earliest stages of life. While the survey on brain health published by the American Society on Aging (2006) suggested the primary care physician is the person best able to promote such a lifestyle, I believe psychologists are best positioned to implement the personal and national changes necessary to create a brain health culture.

Psychologists are experts at behavior and on ways to change behavior. The profession of psychology is well schooled on the importance of lifestyle and overall wellness that is not well defined from a clinical standpoint. Psychologists are also well suited to help apply such lifestyle changes into the very fabric of society, the places where humans go on a daily basis. Brain health needs to grow in childcare, parenting classes, schools, business and corporate wellness programs, restaurants and grocery stores, religious institutions, retail, media, and indeed in the health-care system, including medical and clinical curricula. This effort reflects a wellness orientation that is proactive and health promoting and less reactive or disease managing. While not the only profession needed in this effort, I do believe psychology can lead in both ongoing research and implementation to the general public, where health and economic benefits can be significant.

Policy Considerations

1. Set a national strategic emphasis on making the United States a nation dedicated to brain health across the life span. This can include an ambitious goal of studying the energy of the human brain that might help regulate and even heal the body. (I refer to this as "neural energy.")
2. Allocate financial investment in the continued study of how a Brain Health Lifestyle® benefits the structural and functional development of the brain.
3. Integrate education on the basics of the brain and how lifestyle can shape the brain for health into elementary schools.
4. Empower each parent-to-be with the education of what he or she can do to help shape the baby's brain while in the womb and upon birth.
5. Include consumer-friendly information on menus and in grocery stores so the general public can choose foods believed to be best for the brain.
6. Integrate brain health curricula and application into corporate wellness programs.
7. Integrate brain health into all health-care payer wellness programs and benefit packages.
8. Incentivize inclusion of brain health and lifestyle into the medical school and ancillary clinical education. This certainly includes psychology.
9. Integrate brain health programs into older adult care (Area Agencies on Aging, Medicare) and establish an annual cognitive screen for all beginning at age 40.
10. Incentivize use of mobile and virtual technology to advance brain health and continue the development of Brain Health Centers (see brainhealthctr.com), where the general public can work on brain health from a holistic perspective.

It is time our nation recognizes we are in need of a better and more cost-effective approach to slowing down the major chronic diseases and causes of death. To date, we have not done well despite the fact we spend more on heath care per capita than any other nation on the planet. I believe we need to heed the advice Grandma gave and focus on health and health promotion: exercise, eat healthy, socialize, stay mentally stimulated, and be spiritual. There is a tremendous opportunity for psychologists to lead this paradigm shift.

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Website Resource

The Brain Health Center (brainhealthctr.com)

A Hidden Disorder: Compulsive Hoarding in the Older Adult Population

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Dr. Shawn K. Pritchett

"Where is that checkbook? I know I put it right here," remarked Mrs. L, a widowed 90-year-old who lives alone. Mrs. L's search took her on an odyssey through her jam-packed house. Like many hoarders, Mrs. L appears to know the whereabouts of every item, although it might be under a pile of trash.

Upon entering the modest home, the most noticeable feature is its 2-foot wide walkway that rambles through a sea of junk. Visitors must clear a way to find a place to sit, eat, or sleep. Mrs. L sleeps and eats in a recliner. Throughout the house, including the kitchen and bathroom, is the odd assortment of yellowed magazines, dried rotted yarn, hotel towels, expired medications, and spoiled food.

No room or closet is immune to clutter. Every cabinet is full so that it is impossible to find anything. A dip in the ceiling hints at the weight of the attic's contents. The clutter is so pervasive that routine household cleaning is impossible.

Attempts by family to assist Mrs. L with the disposal of unneeded items are met with resistance and anger. Mrs. L's reasoning is simple—she or someone else may need something. When Mrs. L cleans, she moves items from one place to another without discarding anything. Mrs. L does not see a problem with her home's condition. Her need to acquire and save is deeply embedded and has progressed as she has aged.

Clinical Presentation

Compulsive hoarding is the inability to discard possessions resulting in excessive clutter so that a person's living spaces cannot be used for their intended purpose (Frost & Hartl, 1996). Unlike collectors, who derive pleasure from their pursuits, hoarders experience significant impairment and distress in their daily lives. Additionally, it is the hoarder's inability to act and make decisions regarding possessions that sets him or her apart from a hobbyist. Hoarding, traditionally considered to be a subset of obsessive-compulsive disorder (OCD), is now a distinct disorder (*DSM-5*, 2013).

In clinical populations, the prevalence of hoarding ranges from 2 to 5% (*DSM-5*, 2013). These figures may be inaccurate as most hoarders do not see their behavior as problematic and, consequently, do not seek treatment. Items typically saved include books, magazines, unopened mail, and knick-knacks, to name a few. In extreme cases, animals and bodily fluids have been removed from homes.

Hoarding, which can go largely undetected and untreated for years, can present as a serious psychological, safety, or health issue for many people. Among older adults, hoarding is especially problematic because the excessive clutter can lead to falls, fire hazards, and unsanitary living conditions (Kellum, 2012). Typically, hoarders are discovered when there is an emergency where firefighters, police, emergency medical services, community nursing, or Adult Protection Services are needed.

Unlike collectors, who derive pleasure from their pursuits, hoarders experience significant impairment and distress in their daily lives.

In 2010, the aging population (65 and over) in the United States comprised approximately 40 million people, or 15.1% percent of the total U.S. population (U.S. Census Bureau, 2010). It is projected that this number will increase through 2029, when all Baby Boomers will have reached aged 65. Thus, it is likely there will be an increase in the number of hoarding cases among the elderly.

Hoarding can appear as early as childhood. However, most people report their hoarding to have begun in adolescence or early adulthood, with females having an earlier onset than males. Most relate their hoarding behavior and clutter to have grown increasingly worse and debilitating as they aged (Winsberg, Cassic, & Koran, 1999). Many hoarders report having at least one first-degree relative who compulsively hoards (Frost & Gross, 1993). In fact, the familial link is so strong that genetic markers have been identified to be associated with the disorder (Saxena, 2011). Additionally, there is no evidence to suggest that hoarders were materially deprived as children.

As the brain ages, there is a decline in executive functioning. Current research has found that elderly hoarders have greater difficulty with time management, memory, task shifting, and decision making, all processes directed by structures within the cerebral cortex that modulate executive functioning and emotions (Steketee & Frost, 2003). Because these structures of the brain are affected, it is no surprise that hoarders have significant difficulty with decision making and planning that is colored with strong emotions.

It appears that the indecisiveness surrounding the disposal of possessions stems from erroneous beliefs about the need for and use of them. Even with therapeutic assistance, a hoarder spends an inordinate amount of time deciding which items to discard, if any at all. Furthermore, when confronted with sorting tasks (i.e., whether to keep an item or where to store it), hoarders, unable to remain focused, tend to switch between tasks before fully completing one (Steketee & Frost, 2003).

Hoarders appear to be strongly connected to and emotionally comforted by their possessions. Anecdotal accounts obtained by Steketee, Frost, and Kyrios (2003) further reveal that hoarders accord sentimental and personal

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Psychology's Role in Creating a Longer, Healthier Life With Lower Health Costs

Jeanne M. Slattery, PhD


Dr. Jeanne M. Slattery

My parents are getting older. My mother has recently been diagnosed with cancer, and my father is legally blind. As a result, my siblings and I have begun considering our parents' future, raising questions that are often difficult and uncomfortable.

Our parents live in Texas, long plane rides from each of us. We'd like it if they were to move back to Chicago where my sister lives. There's good health care and a large airport available; they still have friends in Chicago despite having moved away more than twenty-five years ago. My father, in particular, has resisted our suggestions that they move north. He is independent in Texas and believes he would be homebound throughout Chicago's long winters, fearing a fall on the ice. He is still writing and doing research with colleagues and, although most of his work is done virtually, he wonders whether he would be able to collaborate effectively if he moved.

In the last year I've read three books that, together, have helped me consider the ways I respond to the dilemmas raised by my parents' aging: Atul Gawande's (2014) *Being Mortal*; Jerome Groopman's (2007) *How Doctors Think*; and Jo Marchant's (2016) *Cure*. These books offer much useful information.

While our health-care system has focused on drugs and surgery to maintain or increase health, both Gawande (2014) and Marchant (2016) suggest in their books that there may be more effective, less expensive, and less invasive strategies than those typically used. For example, nursing home residents who were given a plant and attended a lecture on the benefits of taking responsibility for their well-being appeared more alert, active, and lived longer (Langer & Rodin, 1976). Gawande described a study examining the residents of two nursing homes. Residents of one had dogs, cats, parakeets, chickens, an active garden, and on-site childcare. Their drug costs were only 38% of the comparison nursing home. Prescriptions of drugs such as Haldol that decrease agitation dropped significantly. The death rate dropped by 15%.

> *While our health-care system has focused on drugs and surgery to maintain or increase health, both Gawande (2014) and Marchant (2016) suggest in their books that there may be more effective, less expensive, and less invasive strategies than those typically used.*

Marchant (2016) described a range of low-cost, high-impact interventions, many of which will be unsurprising to psychologists. Some interventions are firmly rooted in psychology but surprising nonetheless—especially to those of us who have not considered the role of psychology in recovery from physical disease. Hypnosis helps patients maintain low levels of pain throughout the day and decrease the need for narcotics. Patients receiving Comfort Talk (just as it sounds) during surgeries required lower levels of sedatives and had fewer complications. People doing yoga and meditating have less stress, depression, and anxiety, less inflammation and physical damage from stress, and slower declines in cognitive performance with age. Similarly, people with strong social networks live longer and healthier lives. Early research suggests that people with transplants can use classically conditioned placebos to safely reduce their immunosuppressants, receive similar health benefits, and avoid their toxicity.

Why doesn't the medical system emphasize such interventions more frequently? Marchant (2016) repeatedly suggests that one difficulty is that the medical system tends to think dualistically—either mind or body—rather than recognize the importance of both systems. Further, because pharmaceutical companies cannot profit from treatments like Comfort Talk, they aren't promoted, and researchers have difficulty obtaining grants. One clinician interviewed said that although Comfort Talk has a range of health benefits, she now talks about its economic benefits rather than health outcomes with hospital administrators: "That's what [they're] interested in" (p. 123).

Psychologists can recommend simple and straightforward changes. Groopman (2007), for example, suggested patients ask questions to help physicians make better diagnostic and treatment decisions: "What else could it be?" "Is there anything that doesn't fit with this diagnosis?" "Is it possible I have more than one problem?" "What body parts are near where I am having my symptom?"

Similarly, when physicians are stuck, they might attempt to break their cognitive set by saying, "Tell me the story again as if I'd never heard it—what you felt, how it happened, when it happened."

Psychologists can make a meaningful difference in the care of an older population. As Gawande (2014) described, people seen by a geriatrics team were 25% less likely to become disabled and half as likely to become depressed. They were 40% less likely to require home health services. Why do such interventions help? People need more than safety and protection; they need lives full of purpose and meaning. The interventions described in the three books discussed in this article help people experience a sense of control, connection, meaning, and purpose.

My mother's treatment team has made her an active member of the

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team. Her surgeon put in her port while singing, "I've got you under my skin," probably not only because he loves to sing. We've been impressed by the warmth and support she's receiving at this large cancer center—and from her friends, who've been disconnecting her port at home, thus avoiding the need for long stays out of town. We're encouraging her to take control of her treatment as much as possible (e.g., considering how she wants appointments scheduled, making behavioral and dietary changes to help treatment).

Because our parents are still pretty healthy, my siblings and I are helping them identify strategies to retain their autonomy as long as possible. My father is using large monitors and fonts to continue to write; Uber helps him get around town. We are taking turns flying to Texas for my mother's chemotherapy, knowing our support helps maintain her spirits. She's using AnyList (an iPhone app) to keep her questions—and as she's shared the app with us, we follow her questions and answers to stay involved in her treatment. When she feels well, she is going to the gym and doing yoga. We want our parents to maintain as normal a life as possible and retain their sense of meaning and purpose, even during this period.

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A HIDDEN DISORDER: COMPULSIVE HOARDING IN THE OLDER ADULT POPULATION

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qualities to their belongings. One reason for affective attachment, according to their research, is the level of depression and anxiety associated with the compulsion. These researchers posit that older adult hoarders form strong bonds with their belongings because they lack social contact with others.

Among the hoarding population, avoidance behaviors are used to escape feelings of loss, guilt, or grief (Steketee & Frost, 2003). Unlike OCD, these avoidance behaviors are not nonsensical or intrusive; they are purposeful and goal directed. Acquisition and saving allow the hoarder to avoid negative feelings associated with his or her self-concept. Possessions become an extension of the self. Therefore, discarding unneeded items means throwing away a part of a hoarder's identity.

Treatment Strategy & Prognosis

Pathological hoarding is a social, neurological, and biological disorder that is distinct from OCD. Given its complex nature, the research indicates that this disorder does not respond well to typical OCD behavioral treatment or medication. There are several reasons, both biological and behavioral, cited in the research for the lack of efficacious treatment for compulsive hoarding.

With the damage to the cerebral cortex, hoarders do not respond well to selective serotonin reuptake inhibitors (SSRIs) and other antiobsessional medication as do people with OCD (Saxena, 2011). Saxena recommends prescribing cognitive-enhancing medications that treat dementia and stimulants that treat attention-deficit/hyperactivity disorder (ADHD). These medications influence neurotransmitters involved in cognitive functioning and attention.

The ego-syntonic nature of pathological hoarding is also an impediment to treatment. Compulsive hoarders have poor insight, low motivation to change, and more reasons than not to save. Thus, when identified, most hoarders refuse treatment.

A review of the literature revealed a few treatment options specifically designed for elderly hoarders. In general, the preferred methods of treatment include cognitive-behavioral group and individual therapy, home visits, family involvement, and a multidisciplinary approach (Ayers et al., 2013; Frost, Steketee, & Greene, 2003) for hoarders of all ages. Even after treatment, in some cases up to 17 months post treatment, compulsive hoarders continued to have difficulty in overall functioning, especially in the reduction of clutter (Steketee, Frost, Wincze, Greene, & Douglass, 2000). What is generally agreed upon for the elderly is long-term, ongoing mental health and support services that address not only the acquisition and retention of things but also the unique mental issues and age-related limitations that affect this population.

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Politics in 2016: Why the Candidates Should Be Discussing Mental Health

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Nicole Fleischer, MS

As November 8 looms closer, it is important to look at how infrequently potential candidates are mentioning mental health reform and increasing community mental health resources. While news stations are all too keen to discuss mental health problems, this only seems to be pertinent when discussing violence; purporting that violent acts were committed solely because the aggressor was mentally ill. Yet, the media and presidential candidates fail to bring up more important facts and statistics. For instance, 20% of homeless individuals are struggling with a mental illness. Furthermore, the most common reason for absenteeism in the workplace is depression. These are real problems that face everyday Americans yet are rarely brought up by our current and previous presidential candidates. As our leaders continue to place mental health concerns on the backburner, the stigma associated with mental health continues to prevent people from seeking care.

As someone who has worked in inpatient and outpatient mental health settings, I have seen clients with a variety of problems. In some cases, these problems include access to adequate mental health resources. Whether the resources are unavailable or patients are unaware of their availability, many people suffering from mental health issues have nowhere to go and, thus, do not get their mental health needs met. Many of my inpatient clients were admitted because of extreme psychosis; situations that could have been mitigated or avoided altogether with community resources. Patients felt ashamed being in an inpatient facility; the stigma of mental health weighed heavily on them, sometimes interfering with their recovery. It was this shame that often led to a hesitation when seeking care.

Specifically, I remember sitting in on a court session with a patient. She had just met her lawyer for the first time. Her lawyer was there to defend her against a judge and prosecutor pushing to extend her involuntary commitment. This patient was suffering from severe delusions and opted to deny her right to an attorney and to defend herself. She could not see her mental health problems and did not understand why her court case was even happening. During the trial, her lawyer attempted multiple times to remind her of her right to remain silent. She did not heed this advice and continued to argue her case. Every time this interaction occurred, I witnessed the lawyer roll his eyes and sigh heavily. During this trial, my heart went out to the patient, and my frustration grew toward this situation. I was not necessarily angry at the lawyer but more so the culture by which he was surrounded; a culture that shows a lack of understanding toward mental health care. Although I was not aware of the specific details of her original involuntary commitment, it may have been addressed by preventive or early care.

In some cases, preventive and early care are available, but potential clients are unaware of these services. The facility where I completed my master's level internship had plenty of funding for individuals and families with low income. Yet, many people I talked to within the community were unaware of these opportunities. Group therapy, individual therapy, family therapy, and partial hospitalization programs were available to anyone regardless of insurance. In many cases, the county would pay for these services, but the funding was not always used. Whether this was due to ignorance or shame was unclear; yet the facts are still there—mental health care services are underutilized.

In another case, an outpatient client of mine was attending therapy to cope with bullying. However, one of the bullies was her mother. Her mother was opposed to her seeing a therapist and attributed her symptoms to "attention seeking." Even after discussing the instances of bullying with her guidance counselor, I heard similar rhetoric of placing blame on my patient for the bullying rather than addressing the perpetrators. While therapeutic goals included coping skills and dealing with bullying, treatment would be easier with the help of her mother and guidance counselor. As a result of this negativity, my client often felt ashamed of her depression.

> *The shame and stigma associated with mental health needs to be addressed by the potential leaders of our country.*

The shame and stigma associated with mental health needs to be addressed by the potential leaders of our country. While there are many important issues involved in running a country, the domestic health and welfare of its citizens should be a high priority. As we vet the potential candidates for our best leader, it is important to question where they stand on reforming mental health care. How much funding will go toward creating and improving community mental health care? How much emphasis will be placed on treating homeless citizens for mental health and substance abuse issues? As I continue to gain experience in the field and discuss these issues among colleagues, I hope to raise awareness of the importance of government funding for mental health problems.

Concentration Deficit Disorder/Sluggish Cognitive Tempo: Considerations for Practitioners

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Sluggish cognitive tempo (SCT) is a condition characterized by cognitive and motor features that overlap somewhat with the diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD); however, research suggests that it also has features that are distinct from ADHD and that it may therefore be useful to conceptualize SCT as a separate but related condition. Although the term sluggish cognitive tempo has been used since the 1980s, Barkley (2014) suggests that it may be considered pejorative in addition to being misleading, as the neurocognitive dysfunction underlying this condition is not yet well understood and the term "sluggish" may carry negative connotations. Instead, he has suggested that concentration deficit disorder (CDD) be used. Because the term SCT remains prevalent in the literature, CDD(SCT) will be used in this article.

Relationship Between ADHD and CDD(SCT)

At present, there are no official criteria available in major diagnostic taxonomies, such as the DSM-5, for CDD(SCT); however, several characteristic features have been identified by researchers. These include slow completion of tasks; lack of persistence/fading effort during task completion; frequent daydreaming; appearing withdrawn, apathetic, lethargic, and/or drowsy; sluggish movement; anxiety; and social difficulties (Penny, Waschbusch, Klein, Corkum, & Eskes, 2009). While some of these symptoms are similar to those identified in the DSM-5 diagnostic criteria for the predominantly inattentive and combined subtypes of ADHD, which define inattention as "wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized" (APA, 2013, p. 61), the motoric, affective, and social components of CDD(SCT) are not well represented in current diagnostic criteria for ADHD.

It has been estimated that 30 to 50% of individuals currently diagnosed with ADHD-predominantly inattentive subtype (ADHD-PI) also present with symptoms of CDD(SCT) (Garner, Marceaux, Mrug, Patterson, & Hodgens, 2010). However, CDD(SCT) symptoms do not appear to be uniquely tied to ADHD; research suggests that a subset of individuals who present with attentional difficulties demonstrate CDD(SCT) symptoms without meeting full criteria for any ADHD subtype. Additionally, a study examining CDD(SCT) symptoms in a sample of pediatric survivors of acute lymphoblastic leukemia and their siblings found that the survivors demonstrated significantly more CDD(SCT) symptoms but did not necessarily meet ADHD criteria (Reeves et al., 2007). There appear to be some demographic differences between the groups affected by ADHD and CDD(SCT), with boys and girls more equally impacted by CDD(SCT) than by ADHD; however, more research is needed to more fully examine potential demographic links to CDD(SCT).

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Although few studies have examined the neuropsychological differences between ADHD and CDD(SCT), those that do exist suggest differences between ADHD, particularly the hyperactive/impulsive and combined subtypes, and CDD(SCT). Barkley (2013) suggests that executive functioning deficits are the primary neurological issue underlying ADHD symptoms. However, CDD(SCT) symptoms may also be related to selective attention or information processing and have been linked to lower motor speed and variability in spatial memory performance. Patterns of comorbidity also differentiate individuals with CDD(SCT) and ADHD. CDD(SCT) symptoms appear to be related to higher rates of internalizing symptoms, such as withdrawal, anxiety, and depression, and are negatively associated with externalizing disorders, such as oppositional defiant disorder (ODD) (Lee, Burns, Snell, & McBurnett, 2014). In contrast, individuals with ADHD are up to 11 times more likely to exhibit symptoms of ODD than the general population (Barkley, 2013). Barkley (2014) noted that over 200 times as many articles on ADHD, as compared to CDD(SCT), appear in the research literature (with approximately 50 articles available on CDD(SCT) and 10,000+ on ADHD at that time); therefore, significantly more research is needed to elucidate the similarities and differences between these conditions.

Considerations for Practitioners

The lack of empirical inquiry regarding CDD(SCT) extends to treatment options for the condition, though research to identify assessment practices and interventions specific to CDD(SCT) is ongoing. Currently, assessment and intervention techniques validated for use with individuals with ADHD, social anxiety, and other related disorders are often used. Behavioral observation is a useful

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CDD(SCT): CONSIDERATIONS FOR PRACTITIONERS

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component of assessment; however, given the internalizing nature of several significant CDD(SCT) symptoms, it cannot be used alone. Clinical interviews and standardized ratings should be completed with the individual being assessed, as well as other informants, as appropriate (e.g., parents, teachers).

Omnibus scales that target internalizing, externalizing, and ADHD + CDD(SCT) behaviors (e.g., BASC, CBCL, Conners CBRS), as well as single or limited construct scales, including ADHD- and executive functioning–focused scales by Barkley and others (e.g., Barkley Deficits in Executive Functioning Scale; BRIEF) and measures of alertness (e.g., the Epworth Sleepiness Scale) may also be helpful. Rating scales that examine CDD(SCT) in particular are currently in development. It may also be helpful to directly assess a variety of cognitive abilities and constructs, including: response inhibition/impulse control, sustained attention/persistence, selective attention, processing speed, working memory, rate of learning/retrieval, and academic skill acquisition and application.

Little is known to date about the efficacy of medication in treating CDD(SCT) symptoms. Methylphenidate, recommended as a "first-line" pharmacological treatment for ADHD by the American Academy of Child and Adolescent Psychiatry, has shown mixed results in pilot studies. There is some evidence that atomoxetine (Strattera) is more useful in treating individuals with ADHD and comorbid internalizing disorders; a trial examining atomoxetine for treatment of CDD(SCT) is currently underway. Barkley (2014) suggests that antinarcoleptic medications may also hold promise for treating symptoms related to alertness; however, research in this area is lacking.

For children and adolescents who present with CDD(SCT) symptoms that impact their functioning in school, eligibility for services under IDEIA (i.e., provision of special education services, including specially designed instruction and other supports) or Section 504 (i.e., provision of accommodations and supports eliminating barriers to participation) should be considered. Research suggests that 20% of students diagnosed with ADHD are also identified with learning disabilities and may require more intensive instruction targeting skill deficits (Spiel, Evans, & Langberg, 2014); while the extent to which CDD(SCT) is comorbid with learning disabilities is unclear due to lack of research in this area, it is likely that children and adolescents who present with symptoms of both will also demonstrate increased levels of need in the classroom. Identification of academic skill versus performance deficits is important in order to target intervention appropriately. Preliminary research suggests that CDD(SCT) is more predictive of academic difficulty, and is more strongly associated with internalizing symptoms, than ADHD is among college-aged students (Becker et al., 2013); older students may therefore require more intensive supports.

The social issues experienced by those with CDD(SCT) are different than those experienced by other students (e.g., individuals with autism spectrum disorder, individuals with externalizing behaviors) who may receive social skills instruction or support in school; specifically, social *skills* are likely to be intact, but *performance* may be affected by anxiety or lack of motivation. Socioemotional interventions for CDD(SCT) that focus on reduction of social anxiety may therefore be more appropriate than traditional social *skills* instruction. Access to counseling or other therapeutic services to address other internalizing symptoms associated with CDD(SCT) may also be helpful.

Finally, a variety of behavioral strategies and accommodations may be useful, including: use of reinforcers to support on-task behaviors; provision of directions in multiple formats; checks for recall and understanding; cuing prior to transitions; "think aloud" modeling; self-cuing and self-monitoring strategies; provision of discreet external cues to avoid embarrassment; and frequent home-school communication.

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Solution-Focused Counseling: An Option for School Psychologists?

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At the last meeting of PPA's Board of School Psychology, one of the many topics of discussion included the nature and types of services or roles that school psychologists in public schools provide. Participants reviewed some crisis intervention approaches being developed in selected school districts. In a previous issue of the *Pennsylvania Psychologist*, Barrett (2014) described a tiered service delivery model. She noted that: "Within such a model, school-based support staff /personnel (i.e., school psychologists, school social workers and school counselors) can develop, coordinate and/or provide increasingly intensive levels of mental health interventions/treatment" (p. 1). While noting many of the benefits of the model, the article goes on to note that "much is still needed to improve the delivery of services to address the emotional and mental health needs of students" (p. 2).

However, any practicing school psychologist who is seeking to expand the nature and types of services he or she provides knows that the seemingly never-ending challenge is: finding time. Speaking from more than 20 years' experience as a school psychologist, this author is quite aware that every day in a school setting appears to be a never-ending list of: assessments and classroom observations to be completed, reports to be written, MDE's and IEP's to attend, and so forth. Thus, the purpose of this article is to provide a brief overview of solution-focused counseling, a therapeutic intervention with established merits, which is brief, highly structured, and able to be implemented effectively in a school setting (Brasher, 2009).

Assumptions and Basic Principles of Solution-Focused Counseling

Brasher (2009) outlines the reality that the approach is based on principles of Milton Erickson, which guide psychologists to view students in need as already holding the key elements of the solutions to their problems. Thus, school psychologists utilizing this approach are encouraged to view their role as assisting individuals in discovering their past successes, resources, and strengths in order to create solutions. The central emphasis of the approach is on the present and future, not the past. Brasher (2009) also notes that the approach emphasizes small rather than large changes, noting that the former can actually lead to more substantive and more meaningful changes. Finally, the aforementioned author offers that practitioners of the approach are encouraged to use words and methods that conform to the needs of students rather than require them to use one or more specific techniques.

Strengths and Limitations of the Approach

Solution-focused counseling was found to have merit for such issues as: academic concerns, time management, and dealing with behavioral and personal concerns. It can be relatively simple to use, but its effectiveness relies on the skill of the practitioner using it (Murphy, 2008). The approach is short-term, goal-oriented, and time sensitive. Some practitioners of the approach in school settings advocate that if progress is not made in three sessions that the student should be referred elsewhere for longer term intervention. The approach has also not been found to be helpful for students with chronic or severe disorders (Brasher, 2009).

Important Questions for Practitioners of Solution-Focused Counseling (Birdsall & Miller, 2002)

Coping Questions

Coping questions are used to help students focus on the positive steps they have taken and actions they have implemented (or have considered) to help them survive difficult situations in the past. Such questions can help build confidence and motivation to try again to initiate change. They include questions such as: "What have you found helpful (or tried) so far?" "How did that work?" ''What have you thought about trying but haven't tried?" "What will it take to try i t?"

> *[A]ny practicing school psychologist who is seeking to expand the nature and types of services he or she provides knows that the seemingly never-ending challenge is: finding time.*

Exception Questions

Exception questions are utilized to determine times when a student functioned better or when a problem was not as severe. A typical exception question would be, "Have there been times when the problem did not happen or was less severe?" Once the exception is identified, the counselor or therapist focuses on the components of the exception (i.e., who, what, when, and where) rather than on the problem itself.

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In some instances, videotape questions (i.e., "What did that look like when it happened?") may be helpful.

Miracle Question

This is a future-oriented question that requires students to brainstorm possibilities. It encourages students and their counselors or therapists to focus on solutions or goals, not problems. Skylar (2005) suggests asking these questions in the following format: "Consider the possibility that while you are sleeping tonight, the problem you presented today is solved in your sleep. When you awake, how will you know that a miracle has occurred and that your problem is solved?" He notes that this type of question can often motivate the student to formulate positive, realistic goals for the future rather than dwell excessively on a problem-ridden past. If students drift backward in their discussion, they should be redirected to focus on the differences in their life that will occur when the miracle takes place.

Scaling Questions

Scaling questions can be used for a variety of purposes including: setting realistic and effective goals in the early sessions; in later sessions, they can serve as vehicles for monitoring the progress a student has made or the outcomes of interventions. Examples from John Murphy (2008) include: "On a scale of 0 to 10, with 10 being the very best that things could be and 0 being the very worst, where would you rate things in your science class (at home, in the relationship with your father, etc.) right now?" "What would the next highest number look like?" "If I videotaped you after you moved up one point from where you are right now, what would I see?" "How will your parents/teachers know when you have moved up one point?" "How will you be able to tell that things are different (or, moved up one point)?"

> *In conclusion, it is this author's hope that the above brief outline of solution-focused counseling will serve as an impetus for school psychologists to consider expanding their role in addressing the mental health needs of the students they serve*

Task Development Questions

These types of questions are aimed toward directing students to develop specific tasks that are realistically achievable and will give them confidence that they can develop new or alternative behaviors that will help them solve future problems. Murphy (2008) notes that they can be fashioned as practical, small steps to achieve success rather than fostering a belief that they must achieve 100% success immediately. They can begin with asking students to do more of what has been working for them to address a certain problem; asking students to notice or keep track of what happens when things are better during a certain class, at home, etc. When a useful activity is discovered, students are asked to do it more and make a list of what happened (or the opposite—chronicle what happens when they do less of an activity). Students can also pretend their "miracle" is happening one day and make notes of their feelings and experiences.

In conclusion, it is this author's hope that the above brief outline of solution-focused counseling will serve as an impetus for school psychologists to consider expanding their role in addressing the mental health needs of the students they serve.

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Concussion Management Teams: Helping Students Return to Learn in Pennsylvania

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Public awareness of the neuropsychological impact of concussions has significantly increased in recent years. The National Football League and other professional sports leagues have instituted concussion management protocols. The days of returning to play immediately after a "bell ringer" or "ding" are gone. As required by the Safety in Youth Sports Act of 2011, coaches, athletic trainers, and athletic directors in Pennsylvania have instituted return-to-play procedures. For students, the return-to-learning process following a concussion also requires the oversight of interdisciplinary professionals.

As a result of sustaining a concussion, a student may experience difficulties with emotional functioning, thinking, memory, sleep patterns, and physical functioning. Psychologists' expertise in the areas of learning, mental health, and educational intervention is critical to Concussion Management Teams (CMTs) and needed to support students' recovery after sustaining a concussion. To assist students in their return to learning, psychologists should familiarize themselves with the regional teams (i.e., BrainSTEPS) and school-based, return-to-learn CMTs.

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Regional Resource: BrainSTEPS

Each year, over 24,000 children in Pennsylvania sustain traumatic brain injuries ("About BrainSTEPS," n.d.). As these children return to learn, they may benefit from various types of supports to address symptoms that arose after, or were exacerbated by, their brain injury. BrainSTEPS (Strategies Teaching Educators, Parents, and Students) is a Pennsylvania-based organization that was created by the Pennsylvania Department of Health in 2007 and is jointly funded by the Pennsylvania Department of Health and Pennsylvania Department of Education's Bureau of Special Education via the Pennsylvania Training and Technical Assistance Network (PaTTAN). BrainSTEPS is implemented by the Brain Injury Association of Pennsylvania and has created a leading national framework for the return-to-school process. BrainSTEPS is "a brain injury school re-entry consulting program" (para. 1) that serves students with newly acquired brain injuries as well as students with lingering effects from past brain injuries, and provides an array of services to schools, families, and other stakeholders ("About BrainSTEPS," n.d.).

BrainSTEPS's services are provided by 31 BrainSTEPS teams located across Pennsylvania and are housed in every Intermediate Unit (IU) in the state. Teams are comprised of individuals from a variety of settings and disciplines, including educators, rehabilitation specialists, counselors, medical providers, and parents, as well as school and licensed psychologists ("About BrainSTEPS," n.d.). These individuals facilitate BrainSTEPS's key services, including dissemination of acquired brain injury student information, consultation, and training. In order to distribute information related to brain injury and the return to learn process, teams present to educational and medical providers as well as to community groups. Teams also utilize a consultation framework to assist schools and families with school re-entry planning and accommodation development ("About BrainSTEPS," n.d.). Additionally, BrainSTEPS provides training to schools to help them establish district-level CMTs. To date, BrainSTEPS has trained over 1,000 CMTs (BrainSTEPS, 2015). These teams are located within school districts and are the first line of response after a student sustains a concussion. If a student's symptoms do not resolve after 4 weeks, the CMT makes a referral to BrainSTEPS, which then provides more intensive support and consultation to the school team and family and monitors the student until graduation.

Local Resource: School-Based, Return-to-Learn Concussion Management Teams

In recent years, CMTs have been used by schools across the country to provide a framework that educators can follow as they assist students in returning to learn after sustaining a concussion. A CMT communicates and collaborates with stakeholders such as the student's parents, health-care professionals, and educators. Through this communication

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Rx: Survive a Life-Threatening Experience

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Dr. Jeffrey L. Sternlieb

How would you live differently if you found out that you had a limited time to live? This is one of those questions we sometimes ask, but usually in a theoretical context. Fourteen years ago, I came face to face with that question. I arrived at University of Pennsylvania hospital via a Life Flight helicopter, and, after 8 hours, survived an operation to repair a dissecting aortic aneurysm. My surgeon later told me that a few hours later, he might not have been able to help me. I had been given extra time to live, totally changing the nature of that question. The changes in my professional functioning have felt so dramatic that I somewhat flippantly suggest everyone ought to have a life-threatening experience that they survive. Clearly, it's not that simple—so what was it that made such a difference?

One wake-up call was my awareness that I had always assumed I would be long lived. My great-grandparents lived into their 90s as did my paternal grandparents. I felt as if there were always one or more generations ahead of me—an invisible protective wall between me and mortality. I clearly had to change that story. I almost died at age 54! I still may have longevity in my future, but I know now that there truly are no guarantees.

A second jarring awareness came after reading on the insurance company explanation of benefits that it literally cost more than one-quarter of a million dollars to save my life (in 2002). That number created a palpable feeling of owing a debt. Not a literal money debt, but I had been given more life—time added. It's an unknown amount of time. But this was extra time, bonus time, a gift; and it felt like an obligation came with this gift. The obligation was an expectation to do something meaningful with the time. There was no formula that accompanied this feeling—no guide, no criteria, and no measure. Just a sense that I couldn't or shouldn't just carry on as I had.

Coincidentally (or not), I had just started a new job as a behavioral scientist at a family medicine residency program, where medical school graduates were being taught how to talk with patients, how to do brief counseling focused on life issues related to their illness, and how to become more self-aware and reflect on their experiences in providing patient care. Most significantly, they were undergoing a transformation in their identity and in their sense of themselves as a healer, not just a medical technician.

For most of my career, I had been providing psychotherapy for children, adolescents, and families. This had certainly been meaningful work. I was told I did this well, but chose to leave this work when a family tragedy left me emotionally devastated and with a greater need to take care of myself than my patients. I left my practice with a profound sense of loss. I experienced great satisfaction from helping people with personal difficulties or at a crisis point in their lives, and this role provided for me a true sense of place in the community. But I knew that I could not effectively or ethically continue that work while I was in greater need of my own healing.

The shift to a teaching role presented a different set of challenges. This population was young, healthy, and eager to learn. They arrived at this residency with a calling to serve, and the program valued what a psychologist had to offer. There were regular structured self-reflection activities centered on patient care, and there was attention to self-care and the recognition of the impact that patient care had on the doctors themselves. And finally, it was clear that each of these graduating physicians would be taking care of thousands of patients in the course of their years of practicing medicine. After watching several years' worth of graduating residents begin their work, I realized that my impact on six residents each year would be multiplied by the thousands of patients they would see in the course of their careers. An additional bonus involved opportunities to teach other behavioral scientists through conference presentations and journal articles about this work.

> *I felt as if there were always one or more generations ahead of me—an invisible protective wall between me and mortality. I clearly had to change that story. I almost died at age 54! I still may have longevity in my future, but I know now that there truly are no guarantees.*

One more ingredient contributed to addressing this obligation—writing. I began to keep a personal journal at least two crises (and 15 years) ago. I went through an earlier time filled with an explosion of emotion, mostly hurt and pain, and releasing this pent-up emotion through journal writing was life changing. I wrote ferociously. I couldn't get the thoughts and feelings out fast enough. And, invariably, when I read what I wrote, the learnings included a lot about all that I had been holding in just below the surface, the truth of what I wrote, and an appreciation of the value of putting my thoughts and feelings into words. Through this process, I began to focus more than ever on the parts of my life experiences that are sub- or unconscious.

So, it seems like thriving came from a combination of re-examining my assumptions of longevity, recognizing the gift that my life is, having an opportunity to touch so many lives directly and indirectly, and the inclination to put my thoughts and feelings into words—written and spoken. I have also taken professional risks I never would have considered previously. Receiving a rejection of a journal article submission or a conference proposal no longer has a big impact.

Finally, in my presentations and celebration of my surviving and thriving, I have become keenly aware that not everyone who experiences a life-threatening event survives whole and intact, physically, emotionally or mentally. It took me several months to work at regaining most of my physical strength, at least a year to have an identity other than a survivor of this episode, but a bit longer to recognize those whose wounds do not heal.

How would you live differently if you found out that you had a limited time to live? I hope you know that you do!

Classifieds

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CONCUSSION MANAGEMENT TEAMS

Continued from page 23

and collaboration, the CMT identifies the student's concussion-related symptoms and needed educational accommodations. Once a student returns to school, the CMT monitors the student's symptom presentation and educational progress.

A CMT core team must be well equipped to address the student's concussion symptoms, academic progress, and any mental health difficulties that may arise; and therefore, a school nurse, school counselor, and school psychologist often serve as the core members of the CMT.

A school nurse typically serves as the Symptom Monitor and assesses the status of the student's physical, cognitive, emotional, and sleep symptoms. A school counselor frequently is the Academic Monitor and tracks the student's educational progress. A school psychologist consults with other CMT team members and further refines the student's educational accommodations as needed. The monitoring data are regularly shared with stakeholders.

After a brief period of cognitive rest, students can typically begin a stepwise return to cognitive activity (Thomas, Apps, Hoffman, McCrea, & Hammeke, 2015). However, there is currently a paucity of research on effective interventions for return to learn following a concussion; and therefore, recommendations are generally based on expert opinion (AAP, 2013). The present state of the research underscores the importance of CMTs working closely with stakeholders to individualize educational accommodations to address a student's unique symptom constellation and to monitor the student's response to those accommodations. For instance, if a student is experiencing headaches and fatigue, then the student may benefit from scheduled breaks to rest and extra time to complete in-class work and homework. Academic and symptom monitoring data can be used to determine the efficacy of such accommodations for the student. When the student's symptoms have subsided, teacher reports are unremarkable, and health-care providers have cleared the student for physical activity, the CMT coordinates the discontinuation of educational accommodations and ends symptom and academic monitoring.

A psychologist providing outpatient services for a student who has recently had a concussion can assist the student in returning to learn by helping the student cope with stress related to the transition and consulting with the CMT in the student's school. In addition, if the student's concussion symptoms have persisted for more than 4 weeks, a psychologist providing outpatient services may consider referring the student to the BrainSTEPS team at the IU that provides services for the student's school district.

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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.

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

Hillman

1. Which of the following is true about sexual consent capacity among older adults?
   a. It can be determined by proxy or surrogate.
   b. It can be determined ahead of time.
   c. It functions on a continuum.
   d. It cannot be determined for someone with dementia.

2. The semistructured interview of a sexual consent capacity evaluation is designed to assess which of the following?
   a. Knowledge of sexual activities and the potential risks
   b. The voluntariness of participation in sexual activities
   c. The capacity to make decisions about sexual activity based upon risks and personal values
   d. All of the above

Kass

3. A 75-year-old man comes in for an initial evaluation with the chief complaints of anxiety, heart palpations, and nausea and a description of significant interpersonal and environmental stressors. What should the therapist not do at the first appointment?
   a. Discuss interpersonal and environmental stressors at length
   b. Get a list of the patient's medications and review medical history
   c. Definitively diagnose the patient with a panic disorder
   d. Suggest a future conjoint session with relevant family members
   e. Refer the patient to his primary care physician for evaluation of his physical symptoms

Nussbaum

4. *Neurogenesis* refers to new brain cell development. In 1998, what structure in the human brain demonstrated neurogenesis?
   a. Thalamus
   b. Hippocampus
   c. Cerebellum
   d. Adrenal gland

Pritchett

5. When a person with hoarding disorder is forced to discard things, the patient experiences
   a. OCD symptoms
   b. Grief-like distress
   c. Anxiety-type distress
   d. Withdrawal symptoms

Slattery

6. People in a nursing home who were encouraged to take responsibility for their well-being were:
   a. More like to die early
   b. More frustrated and felt pushed by the nursing staff
   c. Less likely to need medications such as Haldol
   d. Visited by family members more frequently

7. Psychologists can become better health advocates for themselves by:
   a. Recognizing the role of mind and body in their health care
   b. Asking their physicians questions that will encourage them to break cognitive set and consider other diagnostic or treatment options
   c. Engaging in health-promoting activities such as yoga, regular exercise, and meditation
   d. All of the above

Hessler & McGrath

8. Which of the following symptoms is more commonly seen in individuals with ADHD hyperactive/impulsive subtype than in individuals with CDD(SCT)?
   a. Anxiety
   b. Defiance
   c. Depression
   d. All of the above

9. Social skills support that focuses on ________________ can be beneficial for individuals with CDD(SCT).
   a. Teaching specific social skills
   b. Reducing externalizing behaviors
   c. Reducing social anxiety
   d. None of the above

King

10. Some practitioners of solution-focused counseling advocate that if the approach has not been effective after three sessions, the student should be referred elsewhere.
    True
    False

11. "Scaling questions" are interventions in solution-focused counseling that can be used for progress monitoring.
    True
    False

Carlson

12. At what point in time during a student's recovery from a concussion should a referral to BrainSTEPS be considered?
    a. 1 week
    b. 8 weeks
    c. 4 weeks
    d. 3 months

13. What school professionals are likely to be part of a core CMT?
    a. Principal, school counselor, and teacher
    b. Assistant principal, school nurse, and teacher
    c. Teacher, director of student services, and principal
    d. School counselor, school nurse, and school psychologist

14. To assist with a student's return to learning following a concussion, Concussion Management Teams (CMTs) collaborate with the following:
    a. Parents
    b. Community health-care professionals
    c. Educators
    d. All of the above

Continuing Education Answer Sheet

The Pennsylvania Psychologist, June 2016

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

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

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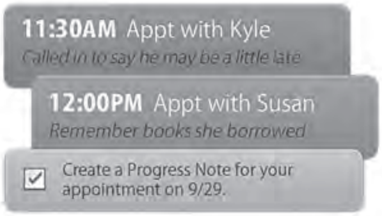

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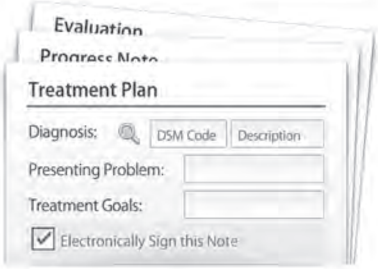

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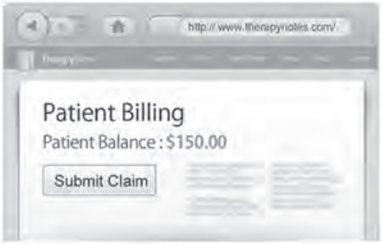

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