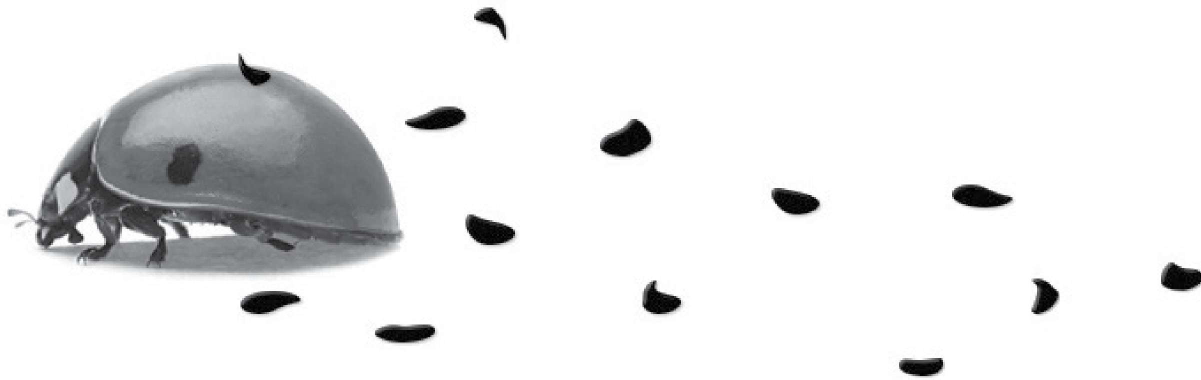
ALSO INSIDE:
- PPA2016 highlights
- Improving the college freshmen experience
- A closer look at childhood traumatic stress
- A call to integrate faith and therapy

The Pennsylvania
Psychologist

Vol. 76, No. 8

SEPTEMBER 2016 • QUARTERLY

Children and Adolescents
Information for Practice



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Pressing Forward on Overcoming Interpersonal Violence

David A. Rogers, PhD; Hershey Psychological Services

Dear Colleagues and Friends:

Dr. David A. Rogers

I trust that you have had a wonderful and refreshing summer. Since the convention, PPA has continued to be quite active as we have proceeded into my tenure as your president. As most of you know, it is the privilege and prerogative for each incoming president to select a Presidential Platform, which becomes PPA's theme and focus during that organizational year. Over the past year as I served as president-elect, I consulted with a number of my predecessors about how they determined their focus or platform. Without exception, their collective perspective was that "it finds you." Well, my search was relatively simple as I almost tripped over my theme. What was quite conspicuous to me was the reality that, under my predecessor's (Dr. Salter's) inspiration, PPA had embarked on a very relevant and successful focus of confronting the tragedy of interpersonal violence. What was also clear was that there is much more to be accomplished. Therefore, I elected to continue the theme with the hope and desire of using the same fundamental "blueprint" and further the effort toward greater completion.

Your Board of Directors will convene a Board retreat in September to renew our strategic plan. It will be within the context of this updated strategic vision that the Presidential Platform will be enacted. Each Board member will be encouraged to activate his or her respective committees to develop tactics that will be used collectively to further our mission and implement this year's focus. Furthermore, in conjunction with the expanded list of community partners, PPA will confront four specific domains of interpersonal violence: domestic violence, campus rape/Title IX matters, cyberbullying, and human trafficking.

We will be looking for volunteers to populate the various subcommittees of the Interpersonal Violence Committee, which is capably led by Past-President Dr. Bruce Mapes. PPA has a unique opportunity to promote and brand itself as a leader in these important areas. Therefore, we will be promoting professional- and community-directed teaching and learning opportunities in these four domains. We are already working closely with legislators who will be examining laws that need to be created or current laws that need enhanced definitions or specifications to help the citizens of this fine commonwealth with the goal to overcome interpersonal violence.

We look expectantly with great anticipation and enthusiasm for what we will accomplish by our next convention. We trust that our direction will inspire many of you to help with this important endeavor. Thank you all for the many ways in which you already exert a knowledgeable and healing presence in each of your communities of influence. We will each do our small part in confronting interpersonal violence but together will accomplish mighty things.

Thank you for the privilege of serving you over the coming months.

Respectfully submitted,

David A. Rogers, PhD
Licensed Psychologist

Here We Go . . . Again!

Krista Paternostro Bower, MPA, CAE

Krista Paternostro Bower

Where does the time go? Just three short years ago, I was eagerly beginning my new role as your executive director. It is hard to believe how much we have achieved together in this short amount of time. I attribute our success to our dedicated and professional staff team and, more importantly, to the phenomenal volunteer leadership team we have in place to ensure our strategic growth in the coming years.

I recently looked back at my article from the *Pennsylvania Psychologist* from September 2014, marking my 1-year anniversary with PPA. The title of the article was "Here We Go." The article addressed the restructuring of some elements of the PPA convention, which had just concluded. I also noted the anticipation of hiring new staff with Sam's impending retirement, as well as some other topics of relevance. I imagine I chose the title to reflect the understanding that September is a busy time for PPA. Two years later and it feels like *"Here We Go . . . Again."*

Even though our official change in leadership happens at the end of June, our ramp up for the new presidential year happens now. We have been working over the summer to finalize some plans for our continuing education events, and we have already been working on PPA2017 preparations. But, before I get into those details, please allow me to reflect for a moment upon the last year here at PPA.

This past year, under the remarkable leadership of **Dr. Beatrice Salter**, was a phenomenal one for PPA! If you missed the convention in June, you missed the summary of the important work of PPA's **Interpersonal Violence Task Force**, chaired by **Dr. Bruce Mapes** and including a cross-section of the PPA membership. The work of the task force helped to shape a relevant and timely convention experience for members, with over 30 continuing education programs offered that aligned with the theme. Please check out the convention highlights and photographs on pages 8–11 of this issue.

The Interpersonal Violence Task Force started as a consequence of Dr. Salter's presidential theme "Overcoming Interpersonal Violence Throughout the Life Span." It has since grown into a standing PPA committee and will span PPA's volunteer leadership terms. The significance of these topics does not dissipate following a presidential term but rather has become part of the fabric of our daily life.

As such, our new PPA president, **Dr. David Rogers**, will continue on Dr. Salter's theme with a slight twist by bringing specific focus to four areas of interpersonal violence: human trafficking, cyberbullying, domestic violence, and Title IX. Dr. Rogers has been passionately working on your behalf all summer long on these topics. We enthusiastically welcome Dr. Rogers to his role as president, and the entire PPA staff team looks forward to working with him on his dynamic term. Please take a moment to read Dr. Rogers's presidential article on page 2 for more details on the specifics of his presidential platform.

There was another important first at this year's convention that I hope you take a moment to read about on page 6 of this issue. The Pennsylvania Psychological Foundation presented its first-ever grant in the amount of $7,500 to support the YWCA of Greater Harrisburg's Violence Intervention and Prevention Program (VIP). This investment by the Foundation speaks to the readiness of psychologists to put money toward a program that is providing a tangible solution to interpersonal violence. It is worth a read.

There is also a lot of good information in this issue related to our special section topic: *Children and Adolescents: Information for Practice*. Also, please be sure to read Justin Fleming's update, Happenings on the Hill, to see what our

The significance of these topics does not dissipate following a presidential term but rather has become part of the fabric of our daily life.

government affairs team has been up to following the successful passage of SB 772 in June.

As mentioned, we are gearing up for a busy fall with our menu of CE programs to include:

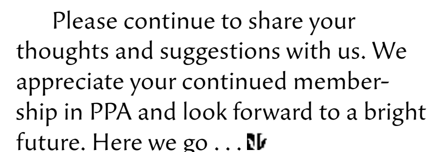
September 14
"Online Reputation Management: Ethical Considerations and Strategies"
Webinar

September 16
Doctoral Summit
PPA Offices, Harrisburg, PA

October 7
Ethics Educator Conference
PPA Offices, Harrisburg, PA

November 4
Fall Continuing Education & Ethics Conference
Valley Forge, PA

If you are interested in learning more about any of these programs, please visit the events calendar on our website. We will be adding additional webinars to the fall calendar, so please be on the lookout for those.



Please continue to share your thoughts and suggestions with us. We appreciate your continued membership in PPA and look forward to a bright future. Here we go . . .

We Did It! How Senate Bill 772 Became Act 53 of 2016

Justin Fleming, Director of Government Affairs

Justin Fleming

More than eight years ago, PPA staff met with members of the State Board of Psychology and worked with committed PPA members on the Legislative & Governmental Affairs Committee and the PPA Board to make long-overdue changes to the Professional Psychologists Practice Act in Pennsylvania. After many meetings and discussions, this effort led to the introduction of Senate Bill 980 on June 3, 2013.

While it was certainly good to finally have the changes in the form of a workable bill, the legislation was never moved out of committee. In January 2015, PPA once again worked with Senator John Gordner to introduce a bill that would make needed, substantive change to the act. Our first order of business was to work with the Association of School Psychologists in Pennsylvania, who had raised questions about the effect of the bill on school psychologists.

Working with Phil Dunn in Senator Gordner's office and Travis Gery, executive director of the Senate Consumer Protection & Professional Licensure Committee, we had successfully allayed their concerns by March of 2015 and were on our way to introducing a bill. Senate Bill 772 was finally introduced on May 1, 2015, just before PPA's Advocacy Day. With the new legislation in hand, many PPA members and students traversed the capitol, speaking to their senators about the importance of SB 772. For our part, PPA also spoke with senators or staff in 48 of the 50 senate offices.

The leadership in the Pennsylvania Senate moved the bill quickly, and on June 9, 2015, SB772 was voted unanimously out of the Senate Consumer Protection & Professional Licensure Committee—we were well on our way! Shortly thereafter, PPA met with the Pennsylvania Department of Corrections (DOC) to discuss concerns related to the elimination of the state exemption in SB 772 and how that would affect people serving as psychological services specialists and psychological services associates within corrections.

PPA had done a lot of due diligence to ensure that we had a bill carefully crafted for easy passage. The revelation that there was opposition to the bill was a surprising setback. In spite of the roadblock, PPA expressed a willingness to work with the DOC in exchange for continued movement of the bill through the Senate. On October 13, 2015, SB 772 passed the Senate 49–0, and it was on to the House of Representatives!

What followed was 8 months of meetings, debate, and discussion with the DOC and the Pennsylvania Department of Human Services in an attempt to reach a compromise with the commonwealth and see our bill move once again. In May 2016, we were finally able to reach an accord. The amendment agreed to by all of the parties removed the blanket state exemption but exempted personnel within DOC and Human Services who provide services of a psychological nature, provided that they do so under the direction of a licensed psychologist.

With that agreement, SB 772 was once again on the fast track. It was reported as amended out of the House Professional Licensure Committee on June 6, 2016, and passed a full House vote 187–4 one week later on June 13, 2016. However, because SB 772 was amended in the House, it had to be sent back to the Senate for concurrence. The Senate voted 49–0 to concur with the amendments in the House on June 15, 2016, and Governor Tom Wolf signed the bill on June 23, 2016, making it Act 53 of 2016!

There are many people to thank for their contributions in seeing the bill pass, but first and foremost, we need to thank Senator John Gordner, the bill's sponsor, who has had a long, fruitful relationship with PPA and is a true friend of the psychology profession. Geisinger Health System is in Senator Gordner's district, and the PPA members there, including Dr. Paul Kettlewell, have cultivated a wonderful relationship with the senator. Next, we thank Phil Dunn, whose expertise in navigating the legislature was critical. We worked with him to develop strategy and specific language in the bill that led to its passage.

We also thank the members of the Senate and House Professional Licensure Committees and specifically the chairs, Senators Robert Tomlinson and Lisa Boscola, and the executive directors of those committees, Mr. Travis Gery and Mr. Stephen DeFrank. Our gratitude also extends to Representatives Julie Harhart and Harry Readshaw and the executive directors in the House, Mr. Wayne Crawford and Mrs. Marlene Tremmel. Additionally, we thank the staff in Senate leadership as well as Senators Jake Corman, Joe Scarnati, and Jay Costa. We thank the leadership in the House of Representatives, beginning with Speaker Mike Turzai and Majority Leader David Reed and Minority Leader Frank Dermody. Special thanks as well to leadership staff in the House of Representatives.

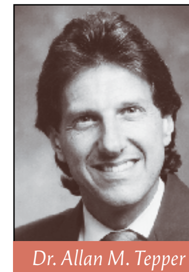
To find information about how Act 53 modernizes the profession of psychology, visit our website, www.papsy.org, click the Advocacy tab and then click the link for Act 53. If you have questions or concerns, feel free to contact me at 717-232-3817, justin@papsy.org, or find me on Twitter @PAPsychGA!

Reporting of 16-Year-Olds Who Have Consensual Sex With Individuals Who Are 4 or More Years Older Than the Minor

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

Dr. Samuel Knapp

Rachael L. Baturin


Dr. Allan M. Tepper

The December 31, 2014, amendments to the Pennsylvania Child Protective Services Law define child abuse, in part, as causing sexual abuse or exploitation of a minor. What constitutes sexual abuse or exploitation of a minor has a specific definition under the Child Protective Services Law. The definition of what constitutes sexual abuse or exploitation of a minor also incorporates a number of offenses contained in the Pennsylvania Crimes Code. At times, this two-pronged definition can be confusing, especially depending upon the age of the individuals participating in the sexual contact, the nature of the sexual contact, and whether the sexual contact was consensual. This article shall focus upon sexual intercourse, defined by the Crimes Code as, in addition to its ordinary meaning, intercourse per os (oral) or anus, with some penetration, however slight.

The first prong of the sexual abuse or exploitation definition, in part, defines child abuse as the employment, use, persuasion, inducement, enticement, or coercion of a child less than 18 years old to engage in actual sexual activity for the purpose of sexual stimulation or gratification. The definition excludes, however, consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within 4 years of the child's age.

Pursuant to this prong of the statute, a report of a 14-year-old patient who is having consensual sexual intercourse with another individual up to the age of 18 would not trigger a mandated report of suspected child abuse. Conversely, under this prong of the statute, a report of a 16-year-old who was coerced into having sexual intercourse with another 16-year-old would trigger a mandated report of suspected child abuse.

This aspect of the sexual abuse or exploitation definition must be compared and contrasted with the criminal offense statutes that are incorporated into the Child Protective Services Law. For example, the Pennsylvania Criminal Code defines rape of a child as sexual intercourse with a child who is less than 13 years of age, regardless of consent and regardless of the age of the other individual. Thus, a report of a 12-year-old child who is having sexual intercourse with another 12-year-old child would trigger a mandated report of suspected child abuse.

The definition of sexual abuse and exploitation includes several different criminal statutes, such as statutory sexual assault or indecent aggravated assault.

The definition of sexual abuse and exploitation includes several different criminal statutes, such as statutory sexual assault or indecent aggravated assault. It is necessary to look at all of these criminal statutes to determine the obligations of a mandated reporter. For example, if one were to look only at statutory sexual assault, it might be possible to conclude that the report of a 15-year-old child who is having sexual intercourse with a 22-year-old individual would not trigger a mandated report of suspected child abuse. However, when looking at other statutes, such as aggravated indecent assault, it becomes clear that a 15-year-old child having sexual intercourse with a 22-year-old individual would be reportable, but a 16-year-old child having sexual intercourse with a 22-year-old individual would not be reportable, unless it involved coercion, enticement, persuasion, or inducement.

The additional criminal offenses that have been incorporated into the Child Protective Services Law contain similar language regarding the age of the child victim, the age of the other individual, the type of sexual contact, and the presence or absence of force or coercion.

We understand that this language can be confusing. It is difficult, therefore, to provide a response for every scenario that might arise when a psychologist receives a report of sexual contact with an individual less than 18 years old.

Continued on page 6

LEGAL COLUMN

Continued from page 5

In such situations, the psychologist may need to gather additional facts and information. The psychologist may need to review the definitions contained in the Child Protective Services Law and in the referenced Pennsylvania criminal statutes. The psychologist may need to obtain outside consultation. In addition, similar to any potential child abuse reporting situation, the psychologist should maintain clear and understandable written records detailing the facts of the case and the decision-making process used in determining whether to file a report of suspected child abuse. A number of scenarios are summarized in Table 1.

Table 1: Age for Reporting Sexual Intimacies of Children

Age of Child	Sexual Intercourse With Person Less Than 4 Years Older	Sexual Intercourse With Person 4 or More Years Older
Less than 13	Yes	Yes
13	Yes	Yes
14 or 15	No	Yes
16 or older	No	Yes, if coercion, persuasion, enticement, or inducement were used

Foundation Awards YWCA of Greater Harrisburg $7,500

Justin Fleming, Director of Government Affairs

As you may have read, the PPA2016 convention theme of Overcoming Interpersonal Violence Throughout the Life Span was supported in a variety of ways. Nearly half of the workshops during the convention were devoted to the theme. The theme was also bolstered through the awarding of a grant from the Pennsylvania Psychological Foundation (PPF) to the YWCA of Greater Harrisburg to support its Violence Intervention and Prevention Program (VIP).

The VIP is the sole state contracted provider of domestic and sexual violence services in Dauphin County. According to Rhonda Hendrickson, director of Violence Intervention and Prevention Services for the YWCA of Greater Harrisburg, the organization will use the grant to enhance existing services and expand their counseling staff.

Left to right: Foundation President Pauline Wallin, PhD, YWCA Director Rhonda Hendrickson, and PPA Executive Director Krista Paternostro Bower.

Following the convention, PPA president Dr. David Rogers convened a meeting with Hendrickson to discuss ways PPA can further support the goals and missions of the YWCA of Greater Harrisburg. As Dr. Rogers explained in his Presidential Perspective column, he is continuing the theme of overcoming interpersonal violence through his presidential year with a specific focus on bullying/cyberbullying, campus rape/Title IX issues, domestic violence, and human trafficking.

To that end, PPA was invited to the South Central Pennsylvania Human Trafficking Response Team Meeting convened by the YWCA of Greater Harrisburg. Nearly 40 people attended from a variety of sectors, including law enforcement, court officers, as well as representatives from advocacy organizations, nonprofit groups, and more. Further, PPA was given an opportunity to address the group about our involvement in helping individuals overcome interpersonal violence. During the meeting, law enforcement officers from the Pennsylvania State Police and the Federal Bureau of Investigation briefed the group on their ongoing efforts to find individuals responsible for human trafficking. One of the more interesting details they reported was that human trafficking is almost always done in conjunction with drug trafficking or drug use. The meeting was especially valuable because PPA made additional contacts we can partner with for training opportunities, advocacy efforts, and other avenues to combat interpersonal violence.

The grant awarded to the YWCA of Greater Harrisburg was well earned, and PPA is extremely thrilled to count them as our newest community partner in the effort to help individuals overcome interpersonal violence.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of July 7, 2016

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action	Governor's 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	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)	N/A
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	N/A
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)	Passed House 6/13/16 (187–4)	Signed by Governor 6/23/16; becomes Act 53 of 2016
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	Passed Senate 6/29/16 (50–0)	Passed House 6/10/15 (188–0)	Signed by Governor 7/8/16; becomes Act 74 of 2016
HB 132	Provides Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. – Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee	
HB 133	Act establishing a bill of rights for individuals with intellectual and developmental disabilities and conferring powers and duties on the Department of Human Services. – Rep. Thomas Murt (R-Montgomery)	For	N/A	Reported as Committed from House Appropriations 9/29/15	
HB 214	Increases oversight and accountability in Home & 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	

Highlights

PPA2016

Overcoming Interpersonal Violence
Throughout the Life Span

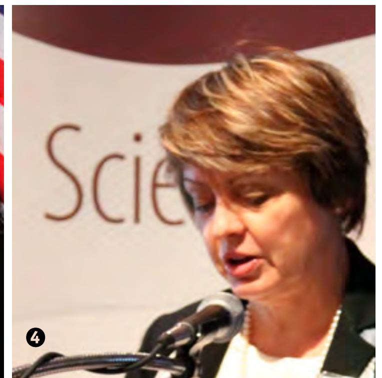
This June again saw Pennsylvania psychologists gather in Harrisburg for PPA's annual convention: PPA2016. The convention featured multiple opportunities for networking, education, meetings, and the presentation of PPA awards.

This year's theme, "Overcoming interpersonal violence Throughout the Life Span," provided a broad and timely topic for presentations and keynotes alike. This theme was highlighted in over 20 workshops, as well as in our keynote presentation, "Knowing Your Rights to Be Free from Gender-Based Violence: An Empowering Lesson From the Law," by Harvard professor Diane Rosenfeld, JD. In addition to giving the keynote presentation, Ms. Rosenfeld spoke at a luncheon for attendees who chose the "all-inclusive" registration. This smaller Q&A session allowed attendees to ask more in-depth questions of Ms. Rosenfeld, who was also featured in *The*

❶ Immediate Past-President Beatrice Salter, PhD, passes the gavel to incoming President David Rogers, PhD, at PPA2016.

❷ Immediate Past-President Beatrice Salter, PhD, enjoys lunch with Samuel Knapp, EdD, and Past-President Dianne Salter, PhD, JD.

❸ Psychologically Healthy Workplace award-winner representative Jeannine Stuart of AREUFIT Health Services *(center)* with Jeanne DiVincenzo, PsyD *(left)*, and Rachael Baturin, MPH, JD.



❹ Psychology in Pennsylvania speaker Susan Sorenson, PhD.

PPA2016 Highlights

Hunting Ground, a documentary film about the incidence of sexual assault on college campuses in the United States. The theme of interpersonal violence was also carried through to the Psychology in Pennsylvania Luncheon by speaker Susan Sorenson, PhD, professor of social policy and of health and societies at the University of Pennsylvania. Dr. Sorenson's presentation, "Gun Violence Through the Life Span: A View From 5,000 Feet," offered a different look at gun violence.

PPA2016 brought back some popular programming, as well as some new opportunities. This year marked the second year that we featured the Foundation and PennPsyPAC in our Give Back Luncheon. This free event featured the opportunity to donate to both of these organizations and to participate in the team-based Jeopardy! game hosted by Justin Fleming, director of Government Affairs.

Thursday evening marked our second annual PPA Banquet & Awards Dinner. We are proud to offer this event to honor the accomplishments of PPA members and community members. Congratulations to all of our award winners!

New this year was the opportunity to earn CE credit while watching the documentary *The Hunting Ground*, followed by a group discussion. This was a successful event, one that we hope to offer again in the future!

Thank you to all of the presenters, exhibitors, and committee members who were responsible for making this event such a success! A lot of work and planning happens behind the scenes, and a special thank-you to this year's Convention Committee cochairs, Dr. Allyson Hall-Galloway and Dr. Molly Haas-Cowan.

Lastly, we want to thank everyone who attended PPA2016. Your lively participation made this year's convention a rousing success. We look forward to continuing this year's theme into 2017 and PPA2017. Stay tuned for exciting news regarding the date and location of PPA2017. We hope to see you there!

❶ PPA Executive Director Krista Paternostro Bower, MPA, CAE *(far left)*, and Immediate Past-President Beatrice Salter, PhD *(far right)*, with PPA award winners. *From left to right:* Hon. John Gordner; Michael Schwabenbauer, PhD; and Paul Kettlewell, PhD.

❷ PPA Public Service Award winner Senator John Gordner *(left)*, with Professional Psychology Board Chair Nicole Quinlan, PhD, and Awards Committee Chair Eric Affsprung, PhD *(right)*.

❸ Immediate Past-President Beatrice Salter, PhD *(left)*, and Past-President Dianne Salter, PhD, JD *(right)*, pose with Keynote Speaker Diane Rosenfeld, JD, in front of PPA's new backdrop!

❹ PPA Executive Director Krista Paternostro Bower, MPA, CAE, addresses the crowd at PPA2016.

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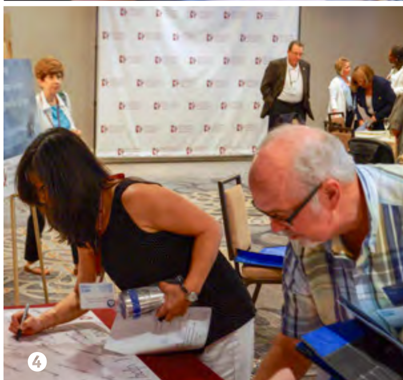
PPA2016 Highlights

PPA2016 HIGHLIGHTS
Continued from page 9



❶ PPA2016 attendees view posters and interact with the presenters during the Research Poster Session.

❷ Attendees respond to questions asked during workshops at PPA2016.

❸ PPA members pose for a group shot at PPA2016. *From left to right:* Past-President Donald McAleer, PsyD; Past-President Dianne Salter, PhD; President-Elect David Zehrung, PhD; Ashley Milspaw, PsyD.

❹ Signing PPA's pledge calling for psychologists to do their part to help overcome interpersonal violence.

❺ Those who registered at PPA's all-inclusive rate had the opportunity to attend a special Q&A luncheon with Keynote Speaker Diane Rosenfeld, JD. Also on the panel were Past-President Bruce Mapes, PhD, and Cathy Petchel, MA *(not pictured)*.

PPA2016 Highlights

❶ Rex Gatto, PhD, engages in conversation with PPA2016 attendees during lunch.

❷ Representing Erie in central PA! Thanks to everyone who traveled to Harrisburg for PPA2016!

❸ Attendees enjoying one of over 53 workshops at PPA2016.

❹ PPA Director of Government Affairs, Justin Fleming *(right)*, networking during the Research Poster Session.

❺ Engaging presentations were abundant at this year's convention!

Sleep: An Important Topic for Education and Educators

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Dr. Gail R. Karafin

Adolescents have a unique internal clock that acts as a form of delayed sleep phase disorder. Their circadian rhythms do not enable sleep habits for a 9:00 p.m. bedtime. The melatonin secretion, which induces sleepiness, starts much later, about midnight. It is difficult, therefore, for teens to fall asleep much earlier than 11:00 p.m., and the problem is compounded when they must wake at about 6:00 a.m. to be able to arrive to school on time, often omitting breakfast. Although some people believe that 7 hours of sleep is sufficient, the reality is that teens are sleep deprived about 10 hours per week, and research in this area suggests that this chronic sleep deprivation creates a type of perpetual jet lag, also known as "short sleep." Moreover, this chronic sleep deprivation is associated with a number of cognitive, educational, emotional, physical, athletic, and safety problems, as well problems related to equity for economically disadvantaged students. The National Sleep Foundation (2000) reports that teenagers worldwide require an average of 9¼ hours of sleep each night. As a result, middle and high school early start times are counterproductive to our children's developmental needs and educational successes.

The National Sleep Foundation (2000) and many pediatric sleep specialists recommend the following amount of sleep nightly relative to a child's age:

Age of Child in Years	Needed Hours of Sleep
1–3	12–14
3–6	10–13
6–11	9½ –12
11–18	9–9½

Recent developments have occurred nationally where state and federal legislations are studying the impact of school start times as a way of raising student achievement and improving school performance. They are reacting to the plethora of evidence-based research on children's need for sleep; circadian rhythm changes in adolescence; and the physical, emotional, and educational consequences of sleep deprivation.

The American Academy of Pediatrics (2014) published a study stating that middle and high schools should begin no earlier than 8:30 a.m. to allow teenagers to get enough sleep to improve student academic performance and overall well-being. Many high schools in the United States start around 7:30 a.m. and sometimes earlier. Additionally, the Centers for Disease Control and Prevention (CDC) conducted a study and reported in an August 2015 press release that "Insufficient sleep is common among high school students and is associated with several health risks including being overweight, drinking alcohol, smoking tobacco, and using drugs, as well as poor academic performance."

Owens, Drobnich, Baylor, and Lewin (2014) prepared an in-depth examination of school start-time issues in school districts in the United States. They studied approximately 40 school districts of varying sizes from multiple states. The benefits and costs associated with later bell changes indicated increased daily attendance, reduced tardiness, improved standard test scores, and improved grades. Cost savings were attributed to increasing the busing tiers. There were no reported problems associated with traffic patterns or a reduction in student involvement in extracurricular activities. Complicating issues that required community outreach included parent and teacher work schedule changes.

The Maryland Department of Health and Mental Hygiene (2014) issued a study detailing the research on sleep and sleep deprivation. Based on their review of national and local data, the Maryland State Department of Education's recommendation was to "encourage the Maryland State Board of Education to use its authority to advise

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local school systems of the benefits of later start time policies and encourage them to conduct feasibility studies regarding the implementation of school starting times of 8:00 a.m. or later" (p. 22).

Petroni (2015) reported that the Framingham School Committee voted to submit a resolution to the Massachusetts Association of School Committees that proposes a start time of 8:30 a.m. or later for high school students throughout the commonwealth. The aim of the later start is to provide students with more time to get sufficient sleep and is based on published information regarding the benefits of adequate sleep and later school start times for adolescents. The resolution states that policies that promote academic success should be implemented in every school and district.

Arne Duncan, former U.S. Secretary of Education, stated on Twitter that it is "Common sense to improve student achievement that too few have implemented: let teens sleep more, start school later" (UPI, 2013, para. 5).

Benefits of Adequate Sleep

Following are some of the known benefits of adequate sleep:

Cognitive Benefits

- Improved school achievement
- Improved reaction time
- Improved attentiveness
- Improved memory
- Improved information processing
- Improved time on task
- Improved reaction to response shifts
- Improved executive functioning

Educational Benefits

- Reduced sleepiness in class
- Reduced tardiness to school and to class
- Reduced absenteeism
- Increased motivation
- Reduced discipline problems
- Increased grades
- Reduced drop-out rates
- Reduced visits to school nurse

Emotional Benefits

- Reduced incidence of depression
- Reduced incidence of anxiety
- Improved motivation
- Reduced drug and alcohol experimentation
- Reduced suicidal thoughts
- Reduced irritability

Physical Benefits

- Reduced incidence of diabetes
- Reduced incidence of high blood pressure
- Reduced incidence of obesity
- Improvement in immune system effectiveness
- Reduced headache
- Reduced cardiometabolic disease
- Improved metabolic functioning
- Reduced food cravings

Safety Benefits

- Reduced incidence of car crashes
- Reduced incidence of accidents for drowsy students walking to bus

Athletic Benefits

- Improve speed and reaction time
- Improved shooting accuracy
- Reduced risk of injury
- Improved benefit of technique/film study

Equity Consequences of Short Sleep

Early school hours disproportionately affect disadvantaged students. Privileged families can more easily counter the negative consequences by choosing private schools with later starts, hiring tutors to boost achievement, and driving their children to school later to maximize morning sleep. Later school start times have shown increased school performance for economically disadvantaged students (National Science Foundation, 2010).

How Did We Get Here?

During the 1960s, the baby boomers were reaching school age, and educators were looking for ways to deal with problems of overcrowding. In the 1970s, many school districts were dealing with decreased tax revenues, reduced oil supply at the pumps, and both inflation and recession. Also in the 1970s, court-ordered busing was mandated in some districts to desegregate schools. In 1974, daylight saving time was extended over a 42-week period in an effort to conserve energy, leading to concerns about younger students waiting in the dark for their buses. As a result of these many factors, cuts in transportation costs became a partial solution to the problems, and the staggered, three-tiered systems were adopted so that schools could move more students with fewer buses. With little or no sleep science available at that time, the earliest start times were instituted for high school students. Volumes of subsequent research on adolescents and sleep suggest that this decision has had deleterious effects.

The Pennsylvania Psychological Association approved a motion to adopt the following position statement in June 2014:

> Current research and practice related to adolescent circadian rhythm patterns and developmental needs indicates that sleep deprivation resulting from excessively early school start times negatively impacts students' cognitive functioning, physical health, emotional status, behaviors/discipline in the classroom, grades, and school performance, school attendance and arrival times, and the likelihood of auto accidents. In addition, early research suggests that excessively early school start times have greater negative impacts on economically disadvantaged youth. In view of these research findings, the Pennsylvania Psychological Association supports efforts to educate school administrators and other stakeholders about the risks of adolescent sleep deprivation, and to engage in advocacy for moving to later high school start times at the state and local levels.

Summary

In summary, as educators and child advocates, we should not allow any child to walk or drive to school sleep deprived in the dark. Consider that the Individuals with Disabilities Education Improvement Act guarantees that all students with an impairing disability (e.g., delayed sleep phase disorder) can expect accommodations to optimize their performance in the learning environment. It is our duty as educators and health care professionals to advocate for children's needs.

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Given that a main focus of education is to maximize students' potential, it is imperative that we provide a learning environment that takes into account the biology of the learner (Carskadon, 2011). We as educators and child advocates need to embrace these challenges before us.

Addendum

Since the writing of this article, there have been several exciting developments. In June 2016 the American Medical Association issued a press release adopting the position that no middle or high school should start before 8:30 a.m. In addition, in May 2016, the Commonwealth of Pennsylvania

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Treating Eating Disorders in Children and Adolescents

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Dr. Karyn L. Scher

Concerns about children, adolescents, and eating disorders have changed significantly since Sigmund Freud, in 1905, first observed that anorexia was a disorder of young girls with an aversion to sexual development (Freud, 1962). By the latter third of the 20th century into the first decade of the 21st, obesity (defined as "excess body fat") in children, particularly children of poverty, had reached nearly epidemic proportions, although not classified as a mental disorder within the *DSM-5* (APA, 2013). Obesity has more than doubled in children and quadrupled in adolescents in the past thirty years, with more than one third of children and adolescents currently overweight or obese (CDC, 2012). The stressors on young people who go on to develop anorexia nervosa and bulimia are typically quite different from those whose excessive weight has become risky to their present and future health, though many in each subgroup may seek help from psychologists. This article intends to cover the risk factors for each group, including youths with the relatively new diagnosis of binge eating disorder (BED), which can occur in all weight ranges and categories, and current approaches to treatment.

Risk Factors for Binge Eating Disorder, Anorexia, Bulimia

Unlike its predecessor, the *DSM IV*, the *DSM-5* does not place "Feeding and Eating Disorders" in a developmental sequence and does not categorize them as disorders of children. Nevertheless, anorexia nervosa and bulimia nervosa typically make their first appearance in adolescence and, more frequently, among "tweens." Though they continue to be most prevalent among females, eating disorders impact individuals across age, gender, and ethnicity. The prevalence of anorexia among young women is 0.4% of the population. Often, a triggering event or a prodromal period of anxiety or obsessional traits could increase the risk for an adolescent onset of anorexia. The diagnosis in children and teens is made, in part, by utilizing the World Health Organization's BMI percentiles to determine low body weight, which is then indicated by a specifier to be mild, moderate, severe, or extreme. The clinician also specifies whether the presentation is restricting subtype or a binge-eating/purging subtype. Fear of gaining weight or becoming "fat," disturbances in self-assessment of size, and excessive emphasis on body weight on self-evaluation are key additional criteria.

> *Because of the short- and long-term health risks associated with . . . eating disorders, it is absolutely critical for the mental health professional to collaborate with medical and nutritional experts on an integrated multidisciplinary treatment team.*

A key feature of bulimia, which occurs in 1%–1.5% of the young female population, is the sense of lack of control over consuming large amounts of food (compared with other individuals' consumption and pace), accompanied by inappropriate compensatory behaviors that may include purging, excessive exercise, laxative/diuretic abuse, or severely restrictive eating. Weight is within the normal range or above as those who present as underweight would be classified as having anorexia. In both diagnostic categories, excessive concern about body weight influencing self-esteem is a preoccupation, which is thought to be largely a function of sociocultural factors that overemphasize thinness or fitness.

BED shares many features with bulimia but without the postintake compensatory follow-up behaviors. Moreover, compared with bulimic patients, those with BED may also have a higher frequency of distress and negative affect. Compared with anorexia and bulimia, the gender ratio in BED is far less skewed, affecting many more males. Although onset for BED, as with other eating disorders, may be in adolescence, individuals who seek treatment tend to be older than the individuals with anorexia or bulimia, perhaps because BED seems to run in families and does not present an urgent health risk. That being said, the correlation between obesity and BED is high and may precipitate a referral for treatment among children and adolescents, particularly from concerned pediatricians.

Being female in America poses a risk factor for developing eating disorders in adolescence, as teens are exposed to societal pressure from the media, family, or peers to be thin and to equate a thin body with success and happiness. Dieting, which for many teens is part of a "rite of passage," increases the risk of disordered eating, as healthy bodily processes are disrupted by cycles of restricted eating and overeating. Children in families with histories of substance use disorder, obsessional traits, or mood disorders have genetic predispositions that contribute to a higher risk of eating disorders.

Importance of Medical-Nutritional Team and Family Involvement

Because of the short- and long-term health risks associated with each of the above eating disorders (e.g., amenorrhea, low bone density, electrolyte imbalance, diabetes, respiratory problems), it is absolutely critical for the mental health professional to collaborate with medical and nutritional experts on an integrated multidisciplinary treatment team. While necessary, this involvement can favor compliance with treatment, especially for families that are motivated, but, conversely, may induce resistance to treatment, as young patients and their parents confront denial, minimization, and difficulty making long-term changes in eating and activity patterns. Nevertheless,

in discussing treatment with children and adolescents, in most cases, family motivation for adherence to health and psychological recommendations is a necessary condition for behavior change.

It should be noted that it is desirable for the psychologist to function as the de facto "team leader," since the psychologist is often the key professional who has the most frequent and regular face-to-face encounters with the child or adolescent patient and family. This role can be challenging in terms of establishing rapport with a young person by maintaining sufficient boundaries around confidentiality to allow the patient to feel safe about sharing feelings, conflicts, and setbacks while simultaneously facilitating team collaboration and communication. Transparent "ground rules" at the outset of treatment can be helpful in maintaining this delicate balance. The psychologist may also be called upon to be a "child/adolescent advocate," while avoiding splitting, in the capacity of helping young people recognize, label, and express the feelings that underlie the eating symptoms. Thus, psychologists must manage another balancing act by helping with the patient's affective expression, while also being firm about the necessity of following unwanted recommendations to achieve health. Early on in the history of eating disorder treatment, Levenkron (1982) coined this the "nurturant/authoritative" posture.

Evidence-Based Treatment

Available treatment options have been expanding over the past decade. The bad news is that our current tools don't have a sterling empirical track record for recovery from eating disorders. Only one third make full recovery in terms of maintaining a healthy weight through regular and diverse meals, learn to minimize negative body image, and maintain positive work and personal relationships (ANRED, 2016). The good news is that this is a time rich in research projects testing online techniques, acronym approaches [e.g., CBT, DBT (Safer, Telch, & Chen, 2009), ACT, MB-EAT (Kristeller, Wolever, & Sheets, 2012)], and group support. Locally, University of Pennsylvania and Drexel University are conducting research with a variety of age groups and diagnoses. These recent initiatives provide hope for young people and their treating psychologists for tools for effective recovery from eating disorders.

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proposed a Bill in the House of Representatives, HB 2105, introduced by Rep. Tim Briggs, requesting that the Department of Education conduct a study of the issues, benefits, and options related to instituting a later start time to the school day in secondary schools. This bill has bipartisan support and is cosponsored by members of the Children and

Please contact your representative in Harrisburg and register your support for HB 2105.

Youth, Education, and Transportation Committees. Please contact your representative in Harrisburg and register your support for HB 2105. I quote Judith Owens, MD, director of the Center for Pediatric Sleep Disorders at Boston Children's Hospital: "To do nothing in this situation is to do harm" (Rees Shapiro, 2014, para. 12).

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Thriving in College While Coping With Anxiety and Stress

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Dr. Lynne Siqueland

There are many examples in the press and in all communities of healthy, highly competent, and generous college and college-bound students making academic contributions and giving back by participating in and even creating philanthropic programs. Quite a number of these same young adults are coping with anxiety and depression at the same time. For others, anxiety and depression, usually untreated, is stalling or even stopping their progress on these important developmental stages of transition to college or work.

Overall, 31% of college students have experienced debilitating depression in the last year, and 50% have faced academic hardship due to overwhelming anxiety. Sixty-four percent of young adults who did not complete their degree cite mental health as the primary reason. Fifty-two percent of those seeking mental health services had severe mental health issues and 8% showed impairment in functioning that led to withdrawal from college. But the good news is that even many of those (44%) with severe illness could continue in college with support (Gruttarado & Crudo, 2012).

For years, college counseling centers have reported an increase in students seeking services and have valiantly and creatively tried to meet the need. Of those students seeking counseling at college counseling centers, 50% have been in counseling before and 33% have taken a psychiatric medication. The students are at risk, though, with 25% having self-injured; 33% having seriously considered suicide; and nearly 10% having made a suicide attempt. Indeed, 10% have been hospitalized for psychiatric reasons (Center for Collegiate Mental Health, 2016). There are challenges for students and colleges to maintain student well-being.

Many of the students who struggle have anxiety disorders that are unrecognized or untreated. Good psychological treatment of various orientations can lower distress and lead to improvement in functioning. Clearly, treatment prior to college is the best option and even needed to allow students to be successful. For more severe anxiety disorders and obsessive-compulsive disorders, cognitive-behavioral therapy (CBT) to begin with is usually recommended with medication added if necessary. All anxiety treatments involve facing fears in some way and building competence through increasing knowledge and then confidence by doing.

For years, college counseling centers have reported an increase in students seeking services and have valiantly and creatively tried to meet the need.

In CBT, clients and their families are given a lot of information about how anxiety works so they can separate experiences of anxiety from their identity or sense of self. Understanding that they think, feel, and act differently when anxious helps this process. When clients can recognize that they are thinking certain thoughts because they are anxious—and knowing that it is not them and not the truth—they can make a fair and balanced interpretation of their experience and the world around them, which helps them to cope. Anxiety takes its biggest toll in how much distress there is in anticipating and preparing for being anxious. In addition, those people who struggle with anxiety exhaust themselves with trying to get rid of anxiety and making sure it does not happen. Perhaps most important is learning how not to be frightened of anxiety. This allows a young person to either self-soothe or ride out the anxiety experience.

Exposure to or practice doing certain tasks is often the real cure by offering the person opportunities to experience doing things with less anxiety than anticipated or by managing it. This different relationship with anxiety allows practice to happen. In therapy, the client and therapist create hierarchies of graded intensity and do lots of practice (from calling for a pizza to discussing paper topics with a professor). Young adults with anxiety often have chosen or been allowed to avoid and not practice skills such as talking to teachers, coaches, making calls, and other independence tasks. They are less competent because they have not had the chance to practice. Parents have done it for them so they don't know they do not know how to do it or that they can do it. The only way you can believe you can do something is by doing it. Often this means breaking things into steps because the task seems impossible. But it also means taking risks. A big part of handling anxiety and stress, whether on one's own or in therapy, is learning to be okay about being uncertain or not knowing.

Some students need to apply for appropriate accommodations at their college. It is helpful to think of accommodations as being temporary (unless learning difficulties require them) and in the service of growth. For example, we might work early in treatment the first month or two to ask teachers not to call on a student as they learn the skills to cope with their anxiety. However, we do not want students excused from participation or not required to give presentations for any length of time because that increases their anxiety and limits their future competence. Other young adults and their parents are not making sure that they have adequate therapeutic support on campus. Everyone hopes therapy in college is not needed as they want to

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Treating Children and Adolescents With Mild-to-Moderate Autism Spectrum Disorder

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Dr. Bradley C. Norford

Children and adolescents with mild-to-moderate autism spectrum disorder (ASD) present frequently to psychologists in outpatient settings. While the breadth of challenges may seem overwhelming, the training and expertise of psychologists lend themselves quite well to effectively treating more-focused referral issues (e.g., specific phobias, being bullied, parenting challenges), as well as providing expertise to parents in the larger picture of assessing and treating ASD. Following are 10 considerations for psychologists seeking a framework for psychological assessment and intervention with families with a child with ASD. Cognitive-behavioral skill sets are especially beneficial in implementing effective day-to-day intervention.

1. Get off to a good start: Youths with ASD generally make up their minds very quickly about whether they like someone—including their new psychologist. Having a sense of humor, being affable and flexible, using a low-key approach, valuing their special interests, and connecting with them over the acute issue(s) with which they want help (e.g., being bullied by a classmate) are determining factors. Likewise, in terms of therapeutic alliance, parents of children and adolescents with ASDs can be quick studies of professionals, as many have considerable experience interfacing with various providers by the time they reach a psychologist in an outpatient setting.

To best accomplish a favorable start, I recommend that the initial evaluation/intake appointment be conducted with parents only. Meeting the child/adolescent separately in the second visit means that the bulk of the history will have already been dispensed, and the therapist can prioritize rapport. It is helpful to invite the child or adolescent to bring one of his or her passions (e.g., drawings, collections, writings) to the following session to help facilitate connection around their talents and interests.

2. ASD diagnosis: When a child comes with a prior diagnosis of ASD, it is important for the psychologist to lend his or her expertise regarding that diagnosis after reviewing prior assessments and considering new information from the family, teachers, and the child to confirm the diagnosis, assess comorbidities, and field questions the family may have. Parents often wonder why their child has received an ASD diagnosis when attention-deficit/hyperactivity disorder, anxiety, or educational issues seem more prominent in daily life. Clarification of how a diagnosis of ASD may encompass several comorbidities and related behavioral, emotional, sensory, and neurological problems is often helpful. Prior to providing a diagnostic impression to parents that their child may have ASD, it may be beneficial to seek consultation from an experienced professional about optimal ways to present this oftentimes "heavy" and sensitive information.

3. Assessing school support, especially through the IEP/504: Individualized Education Plans and 504 plans as well as the Evaluation Report used to generate them should be reviewed so that at the very minimum the psychologist can ensure that the plan fits the most-significant needs the child (and parent) experience at school. The quality of the goals and objectives can range from thorough to minimal. Parents often need guidance as to how to advocate with school personnel if the plan is lacking essential accommodations required for their child to access his or her education and experience progress in academic attainment. Some parents need support to speak up more and others need to hear how to modulate their tone and establish a better partnership with the school.

4. Activating hope and positive energy: Parents with children and adolescents with ASD value professionals who notice their child's talents and suggest ways to parlay those skills into adaptive functioning. Briefly studying their favorite areas of focus (such as aircraft, computer coding, global warming, anime) in advance of sessions can go a long way toward cementing rapport and valuing their passions. It is similarly beneficial to be cognizant of reinforcing parents for their hard work at home and in therapies, and reminding them that their advocating for their children has likely favorably altered their child's developmental trajectory.

While the breadth of challenges may seem overwhelming, the training and expertise of psychologists lend themselves quite well to effectively treating more-focused referral issues.

5. Assessing need for other services and resources: It is helpful for the psychologist to assess the overall picture of the child's needs and services to determine whether any indicated services such as occupational therapy, physical therapy, speech therapy, social skills groups, and/or psychiatric consultation are missing or whether any inappropriate treatments are being considered. Develop a list of specific vetted resources to have at your disposal; this resource list can include community support groups and parent networks, appropriate ASD websites, local conferences for parents, executive functioning tutors, educational advocates, and specialized camps for children on the spectrum. Lastly, it is beneficial to recommend an easily consumed comprehensive handbook geared toward parents with children with ASD, such as Ozonoff, Dawson, and McPartland (2015) or Attwood (2015).

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6. Treating comorbidities and related problems: Anxiety, including phobias, obsessive-compulsive disorder, and social anxiety, is the highest comorbidity for those with ASD—ranging from 40%–80% in various studies, while ADHD is the second most common at 30%–55% (Mannion, Brahm, & Leader, 2014). Executive functioning issues, problems with sleeping or eating, and unhappiness are other related problems requiring therapeutic attention beyond the expected presentation of ASD-related behaviors such as socialization problems, emotion dysregulation, and noncompliance.

These challenges can be treated in a manner similar to that used to treat non-ASD youths with psychological problems. However, navigating cognitive inflexibility and modifying existing rigid behavior are unique and essential aspects of treating youths with ASD. Frequently, cognitive inflexibility emanates from a specific worry that is helpful to first clarify and address if the psychologist is to help the young person to progress. Sohn and Grayson (2005) offer excellent insight on the central role of anxiety in inhibiting appropriate responses by youths with ASDs and highlight the benefit of resolving the reason "why" change is in their best interest over utilizing rewards and consequences when it comes to increasing motivation to change.

Parents and psychologists should be mindful of assessing for and cultivating reasonable habits in three common problem areas—poor sleep regulation, excessive electronics usage, and picky eating. Unfortunately, left intact, these problem areas often become entrenched and interfering, affecting socialization, getting to school on time, parent-child relationships, and even health. Psychologists are advised to develop proficiency in modifying behavior in these realms.

7. Enhancing social cognition: Social cognition, also referred to as social pragmatics or understanding "unwritten social rules," involves how a person conceives of social situations, including interpreting the actions of others and adjusting one's actions based on the reactions of others. Developing these capabilities is both elusive and essential to most successful interventions with children and adolescents with ASD. Garcia-Winner (2007, for example) is the most prolific author on approaches to enhance social cognition—many of which employ a cognitive behavioral perspective. Excellent examples of strategies to enhance social cognition include:

a) Write customized social stories (Gray, 2015) for teaching how to handle challenging social situations (e.g., a story explaining why joining peers at recess is recommended and how to accomplish this goal).

b) Preview expectations shortly before the child enters a social situation and outline each step in the social interaction.

c) Use visual cues (checklists, drawing social dilemmas and thought bubbles on a marker board, colors to indicate feelings, counting down to a consequence by holding up fingers) to enhance verbal communication whenever possible.

d) Utilize humorous role plays to provide social guidance. Video record role plays to enhance effectiveness by creating a visual story (to accompany the social story), especially as many children with ASD enjoy acting.

e) Model thinking out loud. For example, "I am writing a short e-mail to my friend to thank her for the book she gave me. It will only take me two minutes. This way she will know that I appreciate her friendship.")

8. Key points of intervention involving parents: While there are many strategies for addressing challenges faced by parents of children and adolescents with ASD, a few critical considerations are highlighted below. Psychologists' expertise in tailoring interventions to fit the particular child's needs and the capabilities of the parents can be especially effective.

a) Family system: It is not uncommon to treat families with a child with ASD in which one parent is overfunctioning and one is disengaged. The whole family benefits from addressing this dynamic as well as balancing the needs of all the children in the household. In two-parent families, involving both parents in initial assessment and ongoing intervention facilitates these expectations. Helping to connect a disengaged parent with their child with ASD through areas of mutual interest, assignment of parenting tasks in which the parent is likely to be successful, and offering suggestions to improve parenting effectiveness are solid places to start.

b) Navigating "transitions": Transitions are a challenge for nearly all youths with ASD due in large part to cognitive rigidity and poor emotion regulation. Parents can be counseled on the value of utilizing patience, a calm voice, verbal and physical humor, expressing a clear and agreed upon plan, and gently "motoring" the child in the direction in which he or she needs to go. Children with ASD respond well to a negotiated transition time on a digital clock within their view.

c) Social relationships: Parents of children and adolescents with ASD nearly always need to be involved in facilitating peer relations to a greater extent than other parents. Improving the social realm involves teaching parents effective strategies for helping their child to establish and maintain friendships, reduce behaviors that turn peers off, cope with bullying incidents, and advocate with school staff and coaches when needed for support.

d) Daily routines: Many therapy sessions focus on helping parents in need of guidance in establishing reasonable, mutually agreeable morning, after school (i.e., homework and electronic management), mealtime, and bedtime routines. Navigating the cognitive inflexibility and poorer self-management capabilities is dependent on ASD-sensitive steps such as visual reminders, parents maintaining a calm tone, parents learning the essentials of contingency management, and the child agreeing to all aspects of the plan in advance.

e) Nurturing talents: While sports are common activities for mainstream youths, children with ASDs are far more likely to find compatibility and talent with art, instruments, nature, science and technology, acting, Legos and other building toys, writing/drawing, and programs/classes/camps focusing on any of the above. In the interest of building competencies and enhancing self-esteem, parents should be encouraged to expose their children to these areas and to create opportunities for enjoyable development if their child shows interest.

f) Self-advocacy: Vital to success beyond high school is the ability to ask others for assistance with concerns about academics, employment, social relationships, and so forth. Self-advocacy, a challenge for nearly all youths with ASD, is established through ongoing, gentle, step-by-step guidance from parents, teachers, and professionals with an eye toward independent living in adulthood.

9. Key skills to build in children and adolescents with ASD:

a) How to better regulate emotions and behavior
b) Specific skills and steps for managing anxiety
c) How to make a friend, communicate with that friend, and maintain a friendship
d) How to deal with bullying behavior by peers
e) Specific skills for self-advocacy
f) Specific skills to improve executive functioning sometimes through the IEP or a tutor
g) How to value and develop their strengths

10. The question of youths knowing their diagnosis: First, discuss pros and cons with parents and then how best to introduce the topic. Refrain from using the word "disorder" and rather talk about Asperger's or being on the "autism spectrum." I often share a book (with parents' permission) called *All Cats Have Asperger Syndrome* (Hoopmann, 2006) when introducing the diagnosis. Not infrequently youths with ASD respond with, "Yep, that's like me." Most have heard the label before and some already have considered it personally without their parents realizing.

After exploring reactions, I explain that it is only a part of who they are, and how it is related to some their challenges, which is why their parents bring them to see me. Youths with ASD often find it interesting how some of their talents (if applicable) may be related, such as: remarkable memory, strong academic skills, great visual thinking that helps with puzzles and building, good compliance with rules, and having strong passions for topics such as science, nature, and transportation.

Conclusion

This article provides an overall framework for a psychologist treating families with a child or adolescent with a mild-to-moderate ASD. Youths with ASD and their families are often a joy to work with in therapy, and each presents with a different set of puzzles to work though.

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THRIVING IN COLLEGE WHILE COPING WITH ANXIETY AND STRESS

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be a "normal college student." Sometimes entry to college is a good time to explore whether continued services are needed. It helps to establish a contact and know the options on campus before they are needed. It is often good to strongly suggest that students make an appointment early on with the college counseling center when they do not need the services so they meet someone and know how counseling works. Finally, it is a disservice to young adults to pretend they do not need help when current behavior shows otherwise. The therapist or parent can say clearly why they think treatment is needed and ultimately the student decides. Many therapists continue to work with college students while they are away at college, providing booster sessions if needed.

On the other hand, without treatment, parents and young adults together can help increase competence and independence and create a healthy mind-set. Nothing shrinks anxiety like avoiding avoidance. Parents can ask young adults, and young adults can be willing to practice, practice, practice. If they are not doing it already, young adults should be sending those e-mails, making those phone calls, going regularly into bookstores, asking directly for information, or calling their admissions or academic departments. Many college-bound students do have at least a mental list of what they want to be able to do to feel competent or independent. Many are doing this already but, if not, teach them to use a checkbook or debit card, do laundry, grocery shop, and navigate a train station or airport alone. Parents can help to teach and then provide assistance if needed initially but then let the individual do it independently.

Young adults are not anxious; they are young adults with anxiety. These disorders do not have to define or limit a person's dreams and goals. Anxiety can make life harder at times for sure. If anxiety is acknowledged, accepted, and managed adequately, life can be full and joyous even if stress or anxiety come along for some of the journey.

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Promoting Adequate Sleep and Self-Regulation in Children

Barbara C. Gelman, PhD

Dr. Barbara C. Gelman

In fall 2015, approximately 50.1 million students attended public elementary and secondary schools (National Center for Education Statistics, n.d.). Each year, an estimated 3%–6% of students are referred for psychological evaluation due to chronic academic or behavioral difficulties (Algozzine, Christenson, & Ysseldyke, 1982). Estimates, when including students deemed at risk for emotional problems, are higher (Dryfoos, 1994). Children referred for psycho-educational evaluation typically experience chronic underperformance and in most of these cases, prior to testing, their progress has been monitored. The evaluating psychologist reviews grades, attendance records, and standardized test results before beginning testing, but what do we know about sleep and its impact on student performance?

The American Academy of Pediatrics recommends 9–12 hours of sleep for children ages 6–12 years and 8–10 hours of sleep for children ages 13–18 years (Paruthi et al., 2016). Inadequate sleep can cause inattention and difficulty with emotional regulation, which can lead to impulsive behavior. Regardless of IQ, tired students may be set up to receive negative messages and consequences from teachers, which makes learning and instruction harder. Inadequate sleep can exacerbate symptoms of attention-deficit hyperactivity disorder; these children, as a result of the disorder, already have difficulty with self-regulation and their sleep patterns can be erratic.

Parents can try to approximate sleep guidelines by taking into account individual differences, though striving for 8–9 hours of sleep on regular basis should be a goal. Recommendations for developing good "sleep hygiene" include having a consistent bedtime every night, keeping a child's bedroom cool and quiet, using low lighting, and reading at bedtime. Younger children can be read to and children able to read can be encouraged to read a book, even for 15 minutes, before lights-out. It is strongly recommended not to place a television in a child's bedroom, as nighttime television watching can be overstimulating and interfere with sleep. Of course, in this day and age, parents also need to control "screen time" of mobile phones, laptops, and tablets. A general rule of thumb is to turn off all screen usage 30–60 minutes before lights-out (Paruthi et al., 2016). Parents can allow children to sleep in on weekends but not for more than an hour later than the usual wake-up time on school days. This avoids the problem of children staying up late Sunday nights, which causes a sleep deficit and difficulty getting up Monday mornings.

Putting these recommendations into practice can be hard for typical families where both parents work. It is understandable parents want time to wind down in the evenings after homework and dinner, though there is not much time before readying for bedtime begins. Families need to embrace the sleep schedule during the school years with the understanding breaks from adhering to a schedule come on weekends, holidays, and in summertime.

The goal is for children to begin self-regulating their sleep and activity schedules in the early teen years. Before age 10, they need help doing this. A simple "to-do list" for three activities—such as homework, reading, and bath time—is an easy way to self-monitor. For young children, parents can use stickers and colorful pencils to track progress.

As children progress through adolescence, they can develop their own to-do list, including a homework schedule perhaps broken down by subjects and time slots for each, reading, chores, shower, and packing their book bag. The goal of including reading in the to-do list, beyond what is assigned in school, is to build the reading stamina necessary for developing vocabulary and writing skills. It is easiest to stick with a simple plan: A to-do list should have no more than five items. With older children, parents can discuss progress at the end of the week. How did the list go, what was easy to follow, which tasks were harder? What changes in the household (i.e., earlier dinner, completing homework in a different room, earlier bedtime) might help?

The goal is for children to begin self-regulating their sleep and activity schedules in the early teen years. Before age 10, they need help doing this.

Some parents want their children exposed to and involved in many outside activities; however, this can defeat the goals of adequate rest and interfere with self-regulation. A rule of thumb is no more than one extracurricular activity per week. A student with many interests can rotate activities midyear by playing a fall or spring sport or doing art in the fall and drama in the spring. It is important to ensure participation in after-school activities does not interfere with completing homework because this can delay bedtime and lead to sleep deficit. Older children, if parents listen, will tell their parents when they are overwhelmed and need more time at home. It is understood that many children are encouraged to participate in after-school activities because parents are not home from work until evenings. An accounting of how family members use their time can help set priorities and open

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Trauma Impacts School Functioning

Helena Tuleya-Payne, DEd

Dr. Helena Tuleya-Payne

Consider the following scenarios: Amy, a model third-grade student, was brought to the school nurse by her teacher, who complained that she was not paying attention or completing her work. A second student, John, is a fourth grader who is constantly in trouble at school and is having difficulty grasping fourth-grade material. Through further assessment, you learn that Amy reported seeing her cat hit and killed by a car. She was sad and frightened and was having nightmares. John's mother describes that violence is pervasive in their home and neighborhood and that John has endured physical assaults from his father and witnessed gun violence in the neighborhood. What hypotheses might you draw about key factors involved in both sets of behaviors? This article will explore the impact of trauma on a child's development and school performance. The approach of trauma-sensitive schools will also be discussed.

The scenarios regarding Amy and John come from the National Child Traumatic Stress Network (NCTSN) as examples of children who might be viewed as having experienced trauma, which is defined as "an experience that threatens life or physical integrity and that overwhelms an individual's capacity to cope" (NCTSN, 2008). Specific events identified by NCTSN that may be traumatic include physical or sexual abuse, neglect, the death of loved one, an automobile accident, and witnessing domestic violence. Baker, Overstreet, and Whalen (2016), in a National Association of School Psychologists podcast, distinguish between "large T's," or traumatic events such as witnessing a violent death, and "small t's," or chronic events such as food insecurity and living in a dangerous neighborhood. Both contribute to child traumatic stress. The impact of events is subjective, depending on factors such as the child's developmental level and culture. Not all individuals have the same reaction to these events; what is traumatic for one child is not necessarily traumatic for another.

> *Through ACE research, a conceptual framework emerged that links stress reactions evoked by trauma to disrupted brain development leading eventually to social-emotional cognitive impairment and adoption of health-risk behaviors.*

Childhood traumatic stress can have immediate and long-ranging impacts. In the late 1990s, the Centers for Disease Control and Prevention (2016) and Kaiser Permanente conducted the landmark Adverse Childhood Experiences (ACE) Study, with over 17,000 adult HMO participants from Southern California completing a confidential survey where they indicated whether, during their first 18 years, they had experienced any of the 10 listed ACEs. The ACE score, a total sum of the different categories of ACEs reported by participants, is used to assess cumulative childhood stress. As it turns out, ACEs are common. Almost two thirds of study participants reported at least one ACE. A graded dose-response relationship exists between ACEs and negative health and well-being outcomes across the life course; the more exposure to traumatic situations, the greater the impact. About 12% earned a score of 4, and this number of adverse childhood experiences was associated with a higher rate of negative outcomes, including alcoholism, depression, chronic obstructive pulmonary disease, and suicide attempts in adults. Through ACE research, a conceptual framework emerged that links stress reactions evoked by trauma to disrupted brain development leading eventually to social-emotional cognitive impairment and adoption of health-risk behaviors. Ultimately this trajectory can lead to disease, disability, social problems, and early death.

Links between trauma and school-related outcomes have been identified. Perfect, Turley, Carlson, Yohanna, and Saint Gilles (2016) reported three major areas of impact on student functioning: cognitive functioning (memory, attention, and language); academic functioning; and teacher-reported social-emotional behavioral functioning. Baker et al. (2016) described a study conducted with school-aged children that found an ACE score of 1 to be associated with a 3% increase in problem behavior and learning behaviors, while children earning a score of 4 or more had a 50% increase in maladaptive educational functioning not associated with a disability or disorder.

Garro, Brandwein, Calafiore, and Rittenhouse (2011) cite empirical support for childhood stress associated with trauma yielding neuropsychological and endocrine changes that manifest in externalizing and internalizing disorders. Children who are suffering from traumatic stress may exhibit "fight or flight" reactions manifested by a state of heightened alert. These children respond to situations by "freezing" or by acting out. In the scenarios presented earlier, Ann is showing evidence of internalizing behaviors while Jack would be described as demonstrating externalizing behaviors. Garro et al. (2011) caution that school psychologists may mistakenly identify children as demonstrating ADHD or other externalizing disorders

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up more time for homework and evening preparation. Summer break is an ideal time to expand interests and try new activities without the pressure of schoolwork.

Children are works in progress. While demands during the school years can seem endless, taking time to help young children develop good sleep and work habits can pay off with increased stress management skills in the teen years and beyond.

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when, in fact, the "problems are rooted in trauma" (p. 21).

The impact of trauma on children's functioning was vividly brought alive in a panel discussion sponsored by National Public Radio affiliate WITF (LaMar, 2016). The presentation brought community members and experts together to discuss the impact of poverty on children. What became salient throughout the evening was the greater prevalence of childhood traumatic experiences in underserved populations. Dr. Roy Wade Jr., a pediatrician and researcher from Children's Hospital of Pennsylvania, talked passionately about how trauma impacts the mental health and educational outcomes for children. I was struck by the comment of a mother on the panel who is raising children while in poverty. She recounted her first encounter with other mothers and their children on the playground of the low-income housing into which she was moving. She reported that almost all of the children on the playground (including preschoolers) were on medication for ADHD. She wondered along with the panel whether these children were engaged in problem behaviors due to trauma, not ADHD.

Given the pervasiveness of trauma, large T and small t, the case for trauma-informed schools is being made. Ahlers, Stanick, and Machek (2016) described how a recent lawsuit in California shed an important light on the impact of trauma exposure on children and their teachers, citing both primary effects from direct trauma for children and secondary effects for teachers. The plaintiffs are seeking relief that includes implementation of school-wide trauma training for all adult staff. A guiding framework suggested by Ahlers et al. (2016) was school-wide positive behavior support. At the first tier, schools would apply universal strategies involving the training of staff as well as screening of students for significant exposure to trauma. An overarching goal of a trauma-informed school, according to the NCTSN, is for staff to better understand how students experience trauma and how distress can linger over time.

Baker et al. (2016) are working with six schools in the New Orleans area to measure the effectiveness of trauma-sensitive practices. They echoed the importance of a systems-level positive approach where the first task is to get organizational buy-in. They engage in a two-day in-service with staff members, educating them on the impact of stress on the developing brains and bodies of children and how to recognize stress reactions, as well as providing them with teaching practices they can implement. Monthly professional development follows. To enhance essential leadership support, they formed a collaborative with representatives from across the schools. Preliminary pre- and posttest results are encouraging in demonstrating the effectiveness of the two-day training in changing attitudes and finding trauma-sensitive interventions acceptable. One challenge reported by Baker et al. (2016) is achieving policy changes such as those involving discipline. They stress that a positive approach is key to avoid retraumatizing children with physical and harsh punishment.

There is a clear role for school psychologists in support of trauma-informed schools. They may assist in the selection of a model that best meets the needs of the school district. At the universal level, they might assist in the training of staff and screening for trauma. At secondary and tertiary levels, they can be a resource for evidence-based interventions. Trauma-informed schools would benefit all children and staff as in the words of Baker et al. (2016), a trauma-sensitive approach is really about creating "compassionate schools."

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What's Troubling Our College Freshmen?

How University Psychologists Can Help Improve the Freshmen Experience in That Decisive First Semester

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Almost 30% of freshmen who attended 4-year public institutions in the fall 2014 semester failed to return to the same university in fall 2015 (National Student Clearinghouse Research Center, 2016). Student attrition impacts a university's bottom line, cutting into revenues expected from sources such as tuition, fees, housing, and meal plans. Not surprisingly, student retention has been studied at length over the last half century, resulting in a vast body of research. Despite all the research, we have not made much progress in reducing attrition (Tinto, 2006–2007). Based on our experience with the project described below, we would like to suggest that university psychologists can play a crucial role in exploring the unique causes of attrition at their universities and implementing retention programs tailored to address the specific needs of their students.

The authors work as psychologists at California University of Pennsylvania (Cal U). In the fall of 2015, the first author administered the Student Adaptation to College Questionnaire (SACQ; Baker & Siryk, 1984) to 34 first-time college freshmen (24 females and 10 males) in the 3rd week of the semester. The SACQ is a self-report questionnaire designed to measure adjustment to college. All of the students were between 18 and 20 years old and lived on campus. The SACQ was readministered to 23 (19 females and 4 males) of the original students in the 11th week of the semester. (Surveys were administered a third time in March, but the return rate was too low to be considered here.) Students were offered $10 for each survey they took.

The students in this study were not randomly selected from all incoming freshmen, making generalizability of our findings less certain. Seven (6 females and 1 male) of the 34 students, all living in the same residence hall, volunteered to take part in an 8-week "Hive" support/activity group focused on adjustment to college and fostering bonds with other freshmen. The other 27 (18 female and 9 male) students volunteered to serve as control subjects, filling out questionnaires at the same time as students in the Hive. There were not enough students in the Hive to

University psychologists can play a crucial role in exploring the unique causes of attrition at their universities and implementing retention programs tailored to address the specific needs of their students.

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make meaningful comparisons between their adjustment and that of the controls. Although no statistically significant differences were found between the two groups on the SACQ full-scale or sub-scale scores at either administration time, it's unknown whether differences would have emerged with a larger sample size.

Looking at the first semester adjustment scores of the 34 subjects (Hive group and controls) as a whole at Time 1 (the 3rd week) and Time 2 (the 11th week) revealed some interesting findings:

1. **There was extreme variability in how well these incoming freshmen adjusted to college in their first semester.** At both Time 1 and Time 2, scores on the Full-Scale SACQ ranged from the 1st percentile to the > 99th percentile.
2. **These freshmen were especially worried about their college expenses.** Out of all the SACQ items associated with poorer adjustment, "I worry a lot about my college expenses" was endorsed most highly at both Time 1 and Time 2. (By offering a small payment for participation, we may have recruited a higher percentage of students with financial concerns than would be found in the general freshmen population.)
3. **The 11th week of the first semester appears to be a vulnerable time for Cal U freshmen (see table below)**. From Time 1 to Time 2:

- There was a significant drop in students' intention to stay at Cal U for a bachelor's degree [t(22) = 2.79 (p=.01)].
- There was a significant drop in the "Personal-Emotional Adjustment" subscale [t(22) = 2.17 (p=.04)]. This subscale assesses symptoms such as tension, moodiness, trouble thinking, fatigue, worry about college expenses, and not sleeping well.
- There was a marginally significant drop in "Academic Adjustment" [t(22) = 1.79 (p=.09)]. This subscale includes items related to academic motivation, behaviors, performance, and satisfaction with the academic environment.
- There was a marginally significant drop in the "Attachment" subscale, which measures attachment to college [t(22) = 1.81 (p=.08)]. This subscale assesses happiness with the decision to go to college and to attend their college in particular, as well as their intention to finish a bachelor's degree.

Limitations of this study include a small sample size and lack of random sampling from the general freshmen population. In addition, at Time 2, 7 of the 23 students assessed had completed programming aimed at adjusting to college, adding to generalizability concerns. More research would need to be done to determine whether the findings of this study accurately represent the adjustment of freshmen at Cal U. If the findings of this study are replicated, possible interventions could include:

- Administering an adjustment scale to all incoming freshmen and offering special programming for low-scoring students focused on their areas of difficulty
- Considering instituting a fall break for Cal U students
- Educating freshmen about the lifetime financial benefits of a college degree, managing their loan payments, and federal debt-reduction programs
- Offering programming to encourage healthy lifestyle choices and teach stress reduction techniques

More research would need to be done to determine whether the findings of this study accurately represent the adjustment of freshmen at Cal U.

In addition, research on peer-led social support group interventions have shown them to be beneficial for freshmen (Mattanah, Ayers, Brand, & Brooks, 2010). All of the students who participated in the Hive program reported that they were happy they had joined the group. We suggest that similar freshmen programming be considered on every campus.

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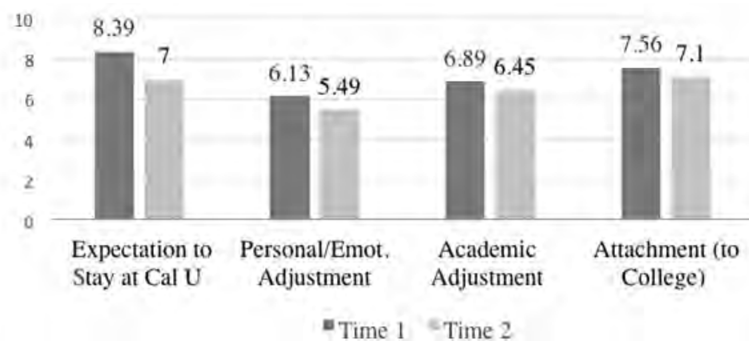
Average Item Scores* at 3rd Week (Time 1) and 11th Week (Time 2) of First Semester for Hive and Control Participants Combined



**Note that these are the adjusted means generated by paired sample t-tests*

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The Need to Integrate Understanding of Christian Faith in Clinician Training

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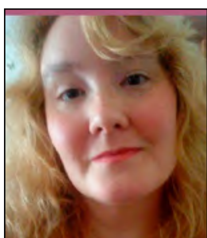
Stephanie Riley

Several factors come into play when discussing the need for therapists to have an understanding of Christian faith, which can be integrated into psychotherapy treatment plans for clients. First, the benefit of faith incorporation with health management has been highly documented as improving well-being and overall health and quality of life (Ellison & Levin, 1998; Dossey, 1993; Jarvis, 1987). Second, as a sample size increases, the *mean* becomes more reflective of the entire population as posed by the probability theory's law of large numbers. Third, drawing from several sources, including a recent poll by ABC News based on the 2010 Religion Census by *Encyclopedia Britannica,* it must be noted that more than 80% of the American population affiliates itself as belonging to the Christian faith (with the remainder listed as "no religion" (13%) and Jews, Buddhists, Muslims, and "other unspecified" (4%) (ABC News, 2016; *Encyclopedia Britannica*, 2016). Based on these three points, it becomes logical to suppose that the average therapist or clinician will see a majority of patients who will belong to the Christian faith. We may note that, though a client's *level of commitment* to this faith may widely vary, it will nonetheless *affect his worldview and subsequent behaviors* to some degree. Some believers will live their lives defined completely by their faith, while others may only use it as a light moral framework. Whatever the level of commitment, should a Christian seek psychological counseling, it may be expected that the role of faith in the healing process should come into question if not direct use.

Harris (2011) studied a large group of clinicians to see whether they treated patients-of-faith any differently than those patients who had no religious convictions. The study found that the clinicians treated all clients the same without regard for their faith characteristic. While this seems positive under the lamp of equality, there is an aspect to it that is disconcerting given that faith plays such an integral role in human behavior. The fact that the clinicians tested did not alter their behavior or advice to suit the clients with strong faith takes on the appearance of religion as a trait being ignored. The clinicians made no use of the faith element in treatment planning, which has been shown to improve treatment outcome (Shafranske, 2005; Worthington & Sandage, 2001). So one must ask, Was that lack of use because many clinicians were not adequately trained in the Christian faith enough to be able to utilize this beneficial client quality? Carlson, McGeorge, and Toomey (2013) state that this may be the precise problem: "Therapy training programs are not adequately preparing students to address spiritual and/or religious beliefs as a resource for change in therapy [even though] . . . spiritual self-exploration is associated with increased use of interventions that integrate spirituality into therapy" (p. 310). Shafranske (2005) and Worthington and Sandage (2001) suggest that spirituality and religion have a legitimate place in psychology and that this dimension of human experience *should be included* in theory, research, training, and practice, including psychological assessment (Adams, McMinn, & Thurston, 2014).

As there is an established need for the integration of faith in psychotherapy treatment, there is also logically a need to have learned clinicians who can work within the structure of this common worldview (Canning, Pozzi, McNeil, & McMinn, 2000; Suite, Rollin, Bowman, & La Bril, 2007). Hence, it makes sense to educate future clinicians on the basics of biblical Christianity while they are still in their graduate programs in order for them to best serve what is likely to be the majority of their clientele over years of practice. Again, based on the numbers, many of the clinicians themselves may be part of the Christian sect; however, it is still beneficial for all clinicians to become familiar with the basic tenets of biblical Christianity for the dual purpose of:

a) gaining a clear understanding of the moral guardrails and worldviews these clients live within (without bias); and
b) learning about the level of faith clients have in God to possibly put it to use in the treatment plan, which has been indicated in research as a key to success (Ellison & Levin, 1998; Dossey, 1993; Jarvis, 1987).

We may note that, though a client's level of commitment to this faith may widely vary, it will nonetheless affect his worldview and subsequent behaviors to some degree.

On a personal note, in my experience over the last 8 years, I have witnessed several times the verbal badgering of Christian students by non-Christian professionals who have asked the same accusatory question: "As a *Christian*, are you capable of counseling someone who is *not* a Christian, such as an atheist or member of the LGBTQ community without personal bias or judgment and without trying to sway the client toward your Christian worldview?" Though I understand the concern, I believe that this type of personal attack is ethically beneath those professionals who demand a politically correct answer from student clinicians. In recent research, Carlson et al. (2013) suggest that Christian students *are trained* in their programs to understand cultural norms and handle *minority* sensitivity

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THE NEED TO INTEGRATE UNDERSTANDING OF CHRISTIAN FAITH IN CLINICIAN TRAINING

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with relative ease. I have noted, however, that no similar learning requirement is offered or made of non-Christian counselors and therapists to be educated in the central aspects of Christianity, which is, again, the population that is likely, based on the numbers, to be the majority of their clientele. So the question that has so often been put to Christian students about their counseling capabilities *must* be flipped back around onto the non-Christian students and professionals: "Can you as a *non*-Christian properly counsel a Christian without bias or judgment and without trying to sway the client toward your *non*-Christian worldview?"

I believe that just as the Christian student clinician is capable of working with non-Christian clients successfully, the same can be said of non-Christian counselors, as evidenced by decades of therapist interventions. However, since our goal is not merely to counsel or treat but to improve quality of life, should we not do that to the best of our ability? That said, counseling professionals should have a working knowledge of the fundamentals of the Christian faith to create a more holistic and gourmet treatment plan for the success of all clients who sustain a Christian faith. Certainly, additional college courses may be taken while one is a student, but in the event none are readily available, self-study is recommended for all levels of professionals through local churches or pastors who are typically willing to share their knowledge.

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Dr. Daniel Schwarz

As psychologists, we have a responsibility to assess patients for suicide risk and to help clients and their families take steps necessary to prevent self-harm of any kind. In my previous article, "What Psychologists Can Do to Prevent Gun Violence" (Schwarz, 2016), I cited some grim statistics on our country's suicide rate. Statistics released by the Centers for Disease Control and Prevention (CDC) since that article was written indicate that there were 42,773 completed suicides in the United States in 2014 (Drapeau & McIntosh, 2015). Suicide deaths, including those committed with a firearm, rose slightly from 20,000 in 2013 to 21,334 in 2014. Suicide deaths from guns accounted for 50% of all suicides, with the second leading cause of suicide being from suffocation/ hanging (11,407 or 26.7% in 2014). Both of these forms of suicide were greater than the 10,945 deaths from homicide in 2014. According to Cerel, McIntosh, Neimeyer, Maple, and Marshall (2014), an estimated 18 people are bereaved after a suicide (also called suicide loss survivors). That means that an estimated 769,914 people in the United States were affected by suicide in 2014 alone.

Access to a firearm, the most common method of suicide for all age groups, is considered one of the most lethal risk factors associated with suicide. At our PPA2016 convention, Sorenson (2016) presented on the epidemiology of gun violence and what psychologists can do to address the issue of suicide. She was clear in stating that "suicide can be prevented" and that psychologists and other health care providers are in a unique position to help clients to stay safe by asking them whether there is a gun in the home. She pointed out that if a suicide is not completed, more than 90% of those who attempt it never repeat the attempt. She provided research indicating that decreasing access to guns decreases rates of suicide. In response to the Orlando shootings, the American Psychological Association's president and its interim CEO sent an e-mail to members on What You Can Do Now (McDaniel & Belar, 2016). The American Medical Association voted for the first time to declare gun violence a "public health crisis" (Ferris, 2016).

Risk Factors for Suicide

What are the risk factors for suicide? As mentioned above, access to a firearm is one of the biggest risk factors. Females have a higher rate of suicide ideation and suicide attempts than males, although males have a higher rate of suicide completion, likely due to their greater access to guns. Hispanic females are at especially high risk, as are American Indian and Alaskan Native youths. Youths who are lesbian, gay, bisexual, transgender, or questioning their own sexual orientation or gender identity are 2 to 3 times more likely to complete suicide than their peers. Although youth suicide is on the rise and ranks as the second leading cause of death for 15- to 24-year-olds, the highest rates are among adults over age 50. Adults age 65 years and older have the highest rates of gun ownership in America as well as the highest prevalence of depression and suicide. Dementia and functional limitations can add to suicide risk. Members of the military and veterans, especially those returning from Afghanistan and Iraq, may suffer from mental illness, such as PTSD, or substance use disorder, increasing their risk of suicide. Ninety percent of suicide victims have a mental illness at the time of their death. The presence of mental illness is associated with an increased risk for suicide; a lifetime history of depression more than doubles the risk. Depression and substance use disorders are the conditions most likely associated with suicide attempts and completion. Gun safety is an increasing public health concern. Suicidal patients can be both suicidal and homicidal.

Warning Signs

Warning signs are more specific than risk factors and consist of symptoms or behaviors that are acute or subacute in nature and are an indicator for a more acute risk for suicide. Bono and Amendola (2015) list the following warning signs for medical providers and family members to consider:

- Suicidal threats in the form of direct and indirect statements: "Everyone would be better off without me"
- Talking of or mentioning dying, disappearing, jumping, shooting oneself, or other types of harm
- Suicide notes and plans
- Prior suicidal behavior
- Making final arrangements, such as planning one's funeral, writing a will, giving away prized possessions
- Preoccupation with death
- Change in personality: sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
- Change in behavior: cannot concentrate on school, work, or routine tasks
- Loss of interest in friends, hobbies, and activities the person previously enjoyed
- Feelings of no hope for the future: believing that things will never get better and that nothing will change
- Low self-esteem: lack of self-confidence; feelings of worthlessness, shame, overwhelming guilt, self-hatred
- Going through a relationship breakup, legal trouble, or other setbacks
- Increased use of alcohol or drugs

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SUICIDE AWARENESS, ASSESSMENT, AND PREVENTION

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Barriers to Suicide Assessment

Evidence indicates that primary care physicians (PCPs) rarely assess patients for suicide risk even if the patient is known to be depressed and even though antidepressants were prescribed. Several factors that deter PCPs from suicide risk assessment include uneasiness about starting such a conversation, time constraints, lack of knowledge about suicide risk assessment, and lack of confidence in treating those at risk. Clearly, medical providers and gun shop owners need to be trained in screening and referring at-risk patients or customers. Winterstein (2010) showed that PCPs educated on assessing patients for suicide risk are more likely to screen, deter and refer at-risk patients. The New Hampshire Firearm Safety Coalition initiated a collaborative effort to engage gun shop and range owners, employees, and customers in preventing suicide (Shute, 2016; Vriniotis, Barber, Frank, & Demicco, 2014). The initiative resulted in a significant decrease in gun-related suicides and accidental gun deaths.

Suicide Assessment Training and Tools

No universally adopted national guidelines or standardized screening tests exist for suicide assessment, specifically in primary care. However, numerous training methods and assessment tools have been developed to identify depression and other suicide risk factors. A screening instrument should be used for all patients with depression, especially youths, older adults, and those with comorbid medical conditions or multiple doctor and emergency department visits for vague physical complaints. Brief assessment tools for PCPs include the Beck Depression Inventory-II, the Patient Health Questionnaire 9, SAFE-T, and the Zung Self-Rating Depression Scale. The Columbia Suicide Severity Rating Scale provides both training and a brief screening. Other training programs include SafeTALK, ASIST, QPR Gatekeeper Training for Suicide Prevention, Connect, Safety Planning Intervention, Lifelines Trilogy, and Stop a Suicide Today.

As psychologists, we are in a unique position to provide education and training on suicide assessment to PCPs, colleges and universities, gun shop owners, and the general population. The integration of psychologists into primary care is an important avenue in this regard. My hope is that our state psychological association will take on this initiative as a part of the Interpersonal Violence Committee within primary care; schools, colleges, and universities; and gun shops. Providing patients and potential gun owners and gun shops with the phone number for the National Suicide Prevention Lifeline (800-273-TALK) is a first step. We must also advocate for improved training, assessment, education, and communication within the medical community and in our society so that talking about suicide will become the norm and lives will be saved.

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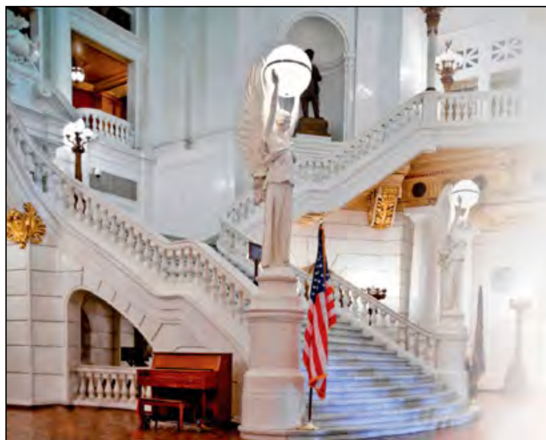

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Remembrance of Dr. Edward S. Shapiro

Helena Tuleya-Payne, DEd

In March 2016, the field of school psychology lost an important voice and change agent for transforming schools. Dr. Edward S. Shapiro, professor of school psychology and director of the Center for Promoting Research to Practice at Lehigh University, passed away at 64 years of age.

Is it possible for a mentor to be younger than you? Dr. Edward Shapiro was such a presence in my professional life. Although younger in years, his vision and cutting-edge skills were a powerful shaper in my professional development and that of my students.

I first encountered Dr. Shapiro in the mid-1980s, when the Lancaster-Lebanon Intermediate Unit (IU) #13 brought him in to present a workshop on a new assessment technology—curriculum-based assessment (CBA). I remember sitting in the room thinking, "This approach makes so much sense!" It was one of the epiphanies in my professional development.

I also remember Dr. Shapiro as being a confident presenter, despite some skeptics in the room of school psychologists. Shortly after that presentation, the IU contracted Dr. Shapiro to provide me one-on-one instruction in this technology so I could disseminate this approach to my fellow educators at the IU. I won't lie: Being a pupil of one with Dr. Shapiro as an instructor was intimidating. I was grateful that he could not read minds. But my skills developed, and I became and remain an enthusiastic disseminator of CBA as an approach to understanding the learning needs of children and interventions that would maximize basic skill acquisition.

Dr. Shapiro's contribution continued to inform my work when I became a trainer of school psychologists at Millersville University. The core preparations my advanced assessment students receive are his Academic Skills Problems textbooks and accompanying workbooks. This last year, I added his text on Response to Intervention (RTI), coauthored with Drs. Joe Kovaleski and Amanda VanDeeHeyden.

It would be hard to overestimate Dr. Shapiro's influence on legions of school psychologists, trainers, and students over his illustrious career. He has received numerous recognitions from such organizations as the American Psychological Association, where he received both the Lightner Witmer Award and Senior Scientist Award. In 2007, I was fortunate to present him with PPA's Distinguished Contribution to School Psychology award. In February 2016, Dr. Shapiro received the School Psychologist Outstanding Contributions to Training Award from the Trainers of School Psychologists at the National Association of School Psychologists (NASP) Annual Convention.

Amy Smith, former president of the NASP, recalls that she chose Drs. Shapiro and Kovaleski to be the Distinguished Lecturers at the 2013 national convention, the highest honor a NASP president can bestow, for their work in promoting school psychologists as leaders in the Response to Instruction and Intervention (RtII) approach. Ms. Smith called his contributions to school psychology "immeasurable" and wrote to me in an e-mail: "Being around him made you raise your game; we're all better for having worked with him".

In a related e-mail, Dr. Kovaleski wrote, "I first met Ed in 1980, when he came to Pennsylvania to direct Lehigh's School Psychology Program. We worked together on a number of projects, most notably when we were coprincipal investigators for PaTTAN's rollout of the Response to Instruction and Intervention Initiative. His contributions to our field, both nationally and here in Pennsylvania, were unparalleled. He was indefatigable and always had a new idea in the works. Amazingly, in spite of his enormous productivity, he had a rich personal life as a husband, father, and community member (he was a great youth baseball coach). He was my go-to guy on any question about school psychology. We are all the poorer for his passing but the better for having known him."

There was much to admire about and be inspired by Dr. Shapiro, including his energy, prolific scholarship, excellent communication skills both oral and written, and his tenacity in formulating and promoting best practices in education. What I particularly admired is the excellence with which he prepared his students. When I attended a conference, I would check the presentations to see where Dr. Shapiro or his students were presenting, and I would advise my students to do the same. Dr. Shapiro's students were well prepared, knowledgeable, and exuded a confidence that comes with thoroughly commanding the material. Dr. Shapiro was typically in the audience, supporting his students, and, it was clear to see, feeling justifiable pride in their accomplishments.

Dr. Shapiro's commitment to the preparation of his students is measured by their successful careers as researchers and academics. Dr. Amelia Lopez, my colleague at Millersville, recalls the serendipity of meeting Dr. Shapiro in the hallways of Lehigh, where she had gone to inquire about a doctoral program in another educational field. Dr. Shapiro invited her instead to learn about the field of school psychology, and she never looked back.

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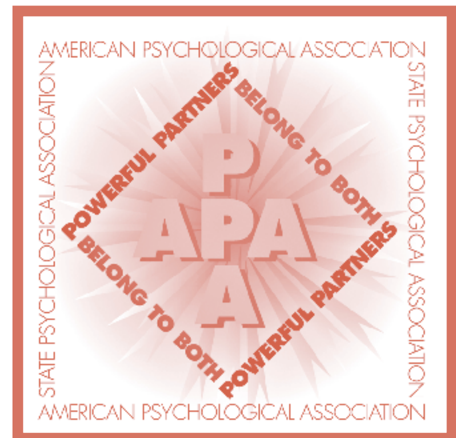
Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between May 13 and August 14, 2016!



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DR. EDWARD S. SHAPIRO

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Dr. Lopez credits Dr. Shapiro with being a superb mentor who at times believed in her more than she believed in herself.

Attending the memorial service for Ed (somewhere along the way, I dropped Dr. Shapiro) in April affirmed for me the tremendous respect he had from his colleagues, students, and friends. Even with short notice, people came from across the country and abroad to pay their respects. I was particularly touched by the remembrances from his two adult sons. Their tributes were heartfelt and genuinely delivered. The passion Ed engendered in his professional work was evidenced in his devotion to his family. In the latest edition to his Academic Skills Problems text, he wrote poignantly on the acknowledgment page to his sons and his wife: "To Sally—my life partner—for the hopes of health and a long life together."

We wished a longer life for Ed, but we are so grateful and amazed for what he accomplished in the years he was given.

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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.

Karafin

1. Sleep deprivation in teens is associated with:
   a. Reduced physical and mental health
   b. Reduced athletic performance
   c. Reduced school and educational functioning
   d. Increased accident and injury
   e. All of the above

2. The Maryland Department of Health and Mental Hygiene conducted a study in 2014 and concluded that the Board of Education:
   a. Needs to mandate more appropriate school start times.
   b. Should advise local school systems of the benefits of later start-time policies and encourage implementation of school starting times.
   c. Does not need to take any action.

Sher

3. The male/female gender ratio in binge eating disorder shows a higher prevalence of males than it does for anorexia or bulimia.
   True
   False

Siqueland

4. Exposures, or practice for anxiety, require clients to address all aspects of the feared situation at the same time to be effective.
   True
   False

Norford

5. Studies indicate that the two highest comorbidities of autism spectrum disorder are:
   a. Anxiety and depression
   b. Schizophrenia and anxiety
   c. Refrigerator mothers and immunization toxicity
   d. Anxiety and ADHD

6. Social cognition is also known as:
   a. A new theory for conceptualizing relationships
   b. Social pragmatics or understanding "unwritten social rules
   c. A form of group therapy that benefits people with ASD
   d. SC

Gelman

7. Parents of school children should monitor:
   a. Television watching
   b. Laptop usage
   c. Amount of nightly sleep
   d. All of the above

8. Problems associated with inadequate sleep can include the following except:
   a. Poor study habits
   b. Difficulty concentrating
   c. Artistic ability
   d. Impulsive behavior

Tuleya-Payne

9. Trauma-informed schools benefit from a _____________ approach of service delivery.
   a. Systems-level
   b. Grassroots
   c. Top-down
   d. Bottom-up

10. Which of the following is true?
   a. The impact of trauma dissipates over time.
   b. To date, school models do not exist to address trauma.
   c. Schools can initiate responses to trauma through screening and training of staff.
   d. Large T's have a greater impact on children than small t's.

Academician's Corner

11. The freshmen in this study showed improved adjustment to college on all SACQ subscales from the 3rd to 11th week of the first semester.
    True
    False

12. In the third and 11th weeks of the first semester, freshmen most highly endorsed:
    a. Feeling they'd prefer to be at home instead of college
    b. Wishing they were at another university
    c. Feeling lonely at college
    d. Worrying about college expenses

Schwarz

13. Which of the following is not a risk factor for suicide?
    a. Youth between 15 and 24 years old
    b. A history of drug or alcohol abuse
    c. A family history of depression or past suicide attempt
       Military combat
    d. Access to a firearm
    e. Adults aged 50 and older
    f. Marriage

14. Which of the following is an example of an instrument that provides both suicide training and brief screening?
    a. Beck Depression Inventory
    b. Zung Self-Rating Depression Scale
    c. Columbia Suicide Severity Rating Scale
    d. Patient Health Questionnaire 9
    e. All of the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, September 2016**

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

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

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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A check or money order for $20 for PPA members ($35 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

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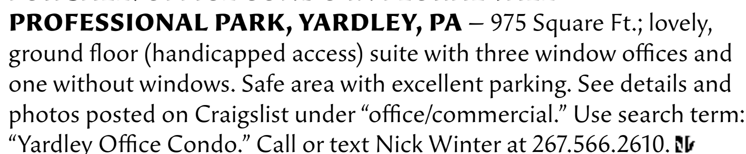

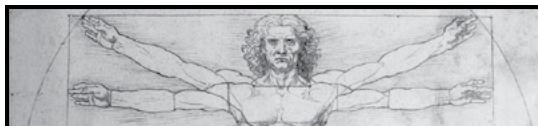

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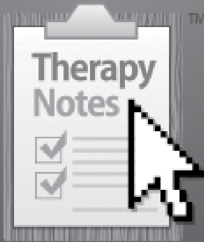

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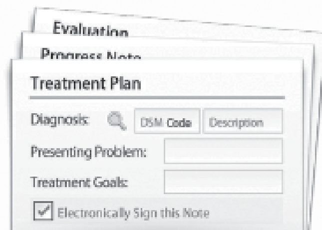

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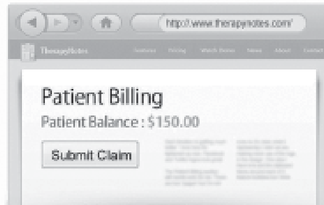

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September 14, 2016
noon–1:00 p.m.

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November 4, 2016
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DoubleTree by Hilton
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Spring 2017 Continuing Education and Ethics Conference
April 27–28, 2017
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