The Pennsylvania Psychologist

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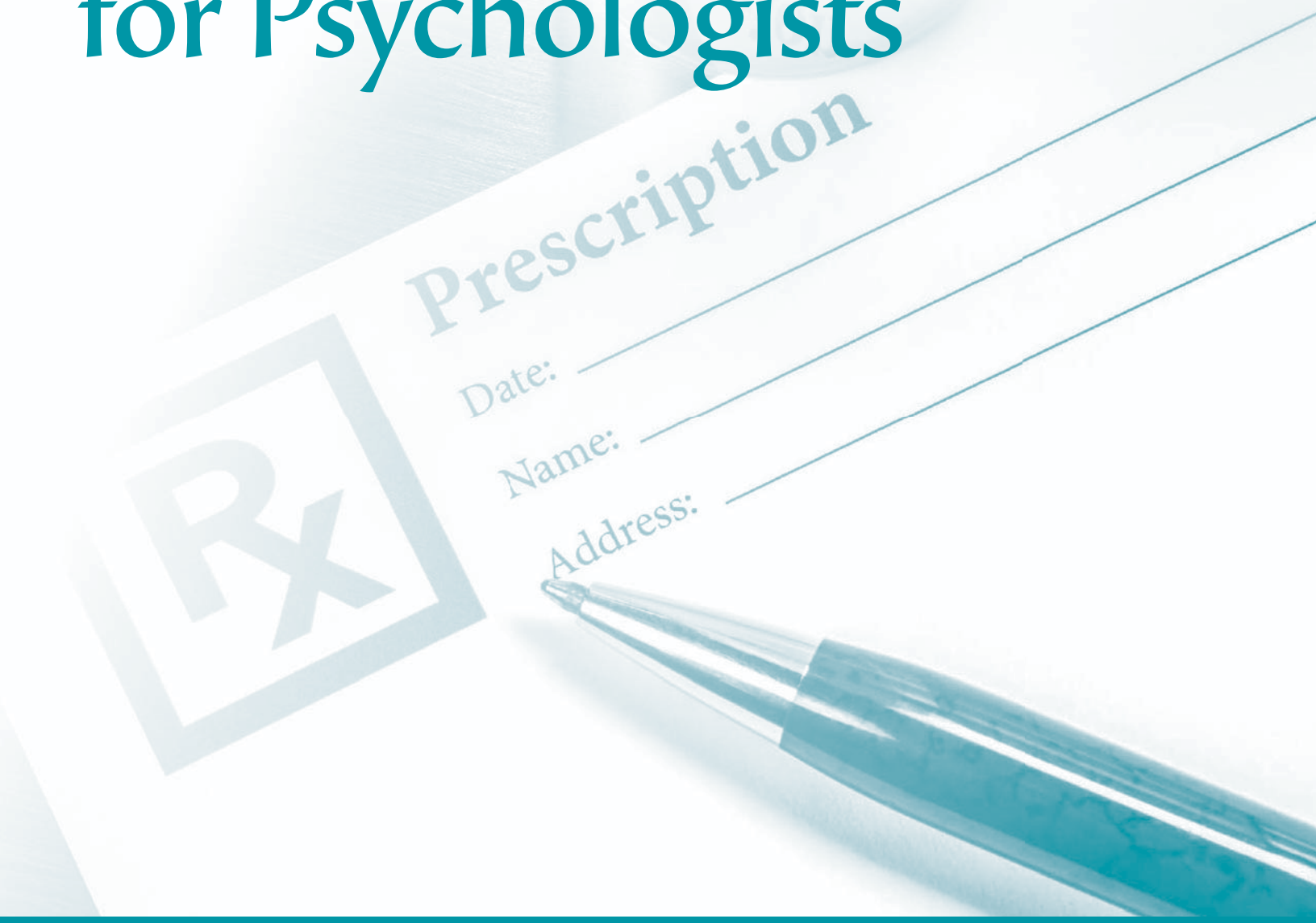
Prescribing Privileges for Psychologists



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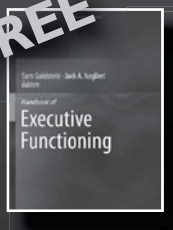

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News, Progress, and Reminders

David L. Zehrung, PhD


Dr. David L. Zehrung

Celebrating Krista Paternostro-Bower

Since my last update, we began the transition to a new executive director. I'd like in this forum to publicly celebrate Krista Paternostro-Bower's 4 years with us and thank her for the many achievements she realized on behalf of PPA. She built a cohesive and top-notch team, updated our electronic infrastructure, transitioned us into our new building, helped make it possible for us to win Association of the Year for the second time, and accomplished many other goals that would take pages to fill if I outlined them all. We appreciate her vision and work and wish her the best in her future endeavors!

Celebrating 85 years

We continue in our 85th year, and I'd like to thank those who have donated to our Aspire 85 celebration! We've listed donors at papsy.org, search Aspire 85. If you don't see your name there yet, make your donation today. We thank you for your generous donation.

In my last article, I introduced you to Florentine Hackbusch, PPA's progenitor. I asked for help finding a photo of her. Molly Cowan, chair of our Ethics Committee, tracked down the photograph that you see by this article. In this photo, Florentine is a young woman teaching in a school before she went to grad school. We also found out that Ms. Hackbusch lived a block or two from PPA's former headquarters on Forster Street, in downtown Harrisburg. Thanks, Dr. Cowan!

I came across a 1940s conference program showing that Florentine and Carl Rogers presented at the same event. We continue researching Ms. Hackbusch's life, so if you have additional information about her, please let me know.

Grant Opportunity

Also since my last update, PPA partnered with James Kimmel and Yale University to apply for a $1.5 million grant to help victims of violent crime. Thank you to Dr. David Rogers for his leadership on this project and to PPA staff for their very hard work to meet a very short deadline! We should hear something soon about whether we will be awarded the grant.

Aspiring Toward Community & Growth

The Aspire task force continues working on selected initiatives that facilitate community and growth – my presidential platform. One such endeavor we are working on is telephone focus groups with our members to learn what you value most in a psychology association. Another is compiling resources to help early career psychologists repay their student loans.

As you know, we are also in the midst of a membership drive. This is one tangible way our wonderful association can grow. The more members you recruit, the more chances you have to win free continuing education! Thank you for helping us toward our goal of 250 new members by our 2018 annual convention, which will be held in King of Prussia!

Thank you, by the way, for your own membership! We are glad that you see value in the professional community that is PPA.

One of the concepts that contributed to selecting *growth* as part of my platform is eudaimonia. Ancient Greeks used eudaimonia to refer to the happy or flourishing life. It was often linked with arete, which means excellence or virtue. The flourishing life is characterized by excellence or full realization of each part of our lives. Positive psychologists build on these concepts. Last year, as I listened to interviews with authors about eudaimonia and arete, I began to think about how to encourage flourishing and excellence within each member and within PPA overall. As the new year approaches, I would love to hear from you about how you are pursuing eudaimonia and arete in your own lives, and about how PPA can continue pursuing these as an association.

Part of my motivation in selecting community as another element to my platform is a longstanding interest in the psychology of *the other*. Jane Elliott's blue eyes/brown eyes exercise crystalized for me observations I'd made growing up. I'd seen poor and rich; male and female; black, white, and Hispanic; young and old; religious and irreligious all judge each other. We all know that in recent years in-group/out-group polarization has been increasing. We experience it in family, friend, social media, classroom, therapy, and sometimes PPA settings. We see the toll in ourselves and in others we care about. Differences will always be important, but commonalities across groups are also important.

In this holiday season, how will we help ourselves, our students, and our clients deal with the out-group person? The first step may be to remember Jane Elliott and apply her lesson to our own views of the other. A second step may be to take a virtue-based approach to help mitigate the fundamental attribution error. What virtue, or value, did cousin Ed emphasize when he chose to vote in a particular way? If we don't understand, we can ask in a truly curious manner. Understanding may then help to strengthen bonds of friendship, increase positive regard between us and the out-group person, and move us closer to becoming a community of mutual respect. De Freitas and Cikara (2017) just published a study along these lines.

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Emergency Involuntary Hospitalizations: Laws and Practical Applications

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


Dr. Samuel Knapp


Rachael L. Baturin


Dr. Allan M. Tepper

Sometimes psychologists will encounter patients who are so dangerous, either to themselves or others, that they need an immediate psychiatric hospitalization. How should psychologists respond if the patient refuses to go to the hospital? Pennsylvania permits the emergency hospitalization of patients against their will under limited circumstances as specified in the Mental Health Procedures Act of 1976 (50 Pa. C. S. A. §7101 et seq.).

Standards for Commitment

Under Pennsylvania's Mental Health Procedures Act, persons who are seriously mentally disabled may be hospitalized against their consent if they pose a clear and present danger of harm to themselves or others. Clear and present danger is established by showing that, within the past 30 days, the persons have, because of their mental illness, inflicted or attempted to inflict seriously bodily injury to themselves or others and that such conduct will likely be repeated. This requires an overt act or an act in furtherance of a threat. For example, a seriously mentally ill patient who threatens to kill another person could not, based on that threat alone, be subject to an involuntary hospitalization. However, if that patient took actions in furtherance of the threat, such as acquiring a fire arm, then the patient would have acted in furtherance of a threat and would be subject to an involuntary hospitalization. In addition, a commitment could occur if patients seriously neglected their physical well-being or mutilated themselves. Harm to self also can be established by showing that, without adequate intervention, there is a reasonable probability that death, serious bodily injury, or serious physical debilitation will ensue within the next 30 days.

The procedures for implementing the hospitalizations are typically described by referencing the relevant section the law. For example, a commitment pursuant to Section 7302 of the Act becomes a "302" and a commitment pursuant to Section 7303 of the Act becomes a "303."

A 302 commitment requires that a person, referred to as the petitioner, state in writing the facts constituting the grounds by which the petitioner believes the other person is severely mentally disabled and needs treatment. If warranted, an employee of the county mental health system (called a *delegate*) can order the transportation of the individual to an approved facility for an examination by a physician. If the examining physician finds that the individual needs emergency treatment, then the facility can hold that individual for up to 5 days (120 hours). Patients have limited due process protections in this 302 emergency examination. They have no right to counsel, no right to an immediate hearing, and no right to confront witnesses.

The Mental Health Procedures Act also specifies procedures to follow to keep patients longer than the temporary hold permitted under Section 302. If at the end of the initial 5-day (120-hour) emergency detention period, the hospital believes that the patient needs more treatment, it can institute a 303 petition requesting such continued involuntary treatment for up to 20 more days. At this juncture, the patient is afforded more due process safeguards.

A 303 commitment requires a hearing to determine whether the treatment of the patient needs to be extended. Typically, a mental health review officer acts as the judge and decides the case, although a Common Pleas Court judge must affirm the decision. At the 303 hearing, the patient has a right to counsel, a right to present witnesses, and a right to cross-examine witnesses. Following the hearing, the patient has a right to appeal the decision. Counties vary somewhat in how they conduct a 303 hearing and in the type of evidence they permit. Ultimately, all decisions can be appealed to the Pennsylvania Commonwealth Court.

In addition, Pennsylvania has procedures for patients who need more than 20 days of treatment. Also, Pennsylvania has special commitment procedures for children with mental health or drug and alcohol problems who need treatment.

Continued on page 5

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of October 25, 2017

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action	Governor's Action
SB 134	Provides for Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. - Sen. Mario Scavello (R-Monroe)	For	In Education Committee	N/A	N/A
SB 383	Amends the Public School Code, in duties and powers of boards of school directors, providing for protection and defense of pupils. - Sen. Don White (R-Indiana)	Against	Passed 28–22 on 6/28/2017	In Education Committee	N/A
SB 554	Safe Harbor bill for child victims of human trafficking. - Sen. Stewart Greenleaf (R-Montgomery)	For	Passed 50–0 on 4/25/2017	In Judiciary Committee	N/A
SB 599	Provides for Assisted Outpatient Treatment programs in the Mental Health Procedures Act. - Sen. Stewart Greenleaf (R-Montgomery)	Against	In Health and Human Services Committee	N/A	N/A
SB 780	Act providing for telepsychology and for insurance coverage. - Sen. Elder Vogel, Jr. (R-Beaver)	For	In Banking and Insurance Committee	N/A	N/A
HB 414	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	In Human Services Committee	N/A
HB 440	Requires insurers to make their behavioral health benefit no more restrictive than their physical health benefit. - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Insurance Committee	N/A
HB 525	Safe Harbor bill for child victims of human trafficking. - Rep. Mark Rozzi (D-Berks)	For	N/A	In Judiciary Committee	N/A
HB 762	Amends Public School Code, in preliminary provisions, pproviding for study of secondary school start times. - Rep. Tim Briggs (D-Montgomery)	For	N/A	In Education Committee	N/A
HB 1648	Act providing for telepsychology and for insurance coverage. - Rep. Marguerite Quinn (R-Bucks)	For	N/A	In Insurance Committee	N/A
HCO 130	Authorizes licensing boards to expunge disciplinary records for certain technical violations after four years. - Rep. Kate Harper (R-Montgomery)	For	N/A	N/A	N/A

HCO denotes House Cosponsor Memo

LEGAL COLUMN

Continued from page 3

Weighing the Decision to Involuntary Hospitalize a Patient

Most professionals will agree that it sometimes becomes necessary to involuntarily hospitalize patients who present an imminent danger of harming themselves or others. One of the authors (SJK) has involuntarily hospitalized some patients and believed that he saved lives by doing so. Sometimes patients are so psychotic or so dangerous that the decision to hospitalize becomes easy.

In other situations, the decision to hospitalize can be more complex. Although the patient may present some danger, a question is whether an involuntary hospitalization would, in the long run, be in the public interest or the interest of the patient. Take, for example, a patient who has made a threat to kill herself and reports that she is now hoarding sufficient pills to make a successful suicide attempt. In such a situation, it is true that the psychologists may have legal grounds to pursue a 302-commitment hearing. But, unless the need is overwhelming clear, we urge the psychologists to slow down, think the decision through carefully, and consider the following questions:

Will the examining physician agree that the patient presents an imminent danger to self or others? That physician is under a mandate from the Mental Health Procedures Act to secure the least restrictive treatment placement for the patient. If the patient agrees to cooperate with outpatient treatment and appears somewhat rational, it is likely that the examining physician will not agree to an involuntary psychiatric hospitalization. Thus, the patient does not get inpatient treatment but has had an experience that may harm the relationship with his or her treating psychologist.

Has the psychologist considered potential harm to the patient? For some patients, hospitalizations represent great humiliation or resentment. The hospitalization means that the patient may miss work, must scramble to make child-care arrangement, and will be financially responsible for the hospitalization, even if it is involuntary. In addition, involuntarily hospitalized patients will lose their right to own firearms. Resentful patients who are released from the hospital may decide not to cooperate with (or even attend) therapy in the future, thus putting their long-term safety at even greater risk.

Will the hospitalization benefit the patient? Short-term hospitalizations provide a safe environment for patients who need monitoring because of the severity of their suicidal risks. They can also be used to monitor patients' reactions to new medications. However, little therapy occurs within hospitals, and many patients report that their hospital experiences were stressful or even traumatic. We should not expect too much out of a brief psychiatric hospitalization.

Finally, have less intrusive alternatives to treatment been exhausted? Many patients understandably react poorly to the idea of being forced to go to a hospital. However, psychologists should be sure that they have taken the time to explain the purpose of the hospitalization and its expected benefits. In addition, they should carefully consider any reasonable ideas that the patients may have about alternative outpatient avenues to ensuring their immediate safety.

Again, involuntary hospitalizations are sometimes absolutely necessary to save the lives of some patients or to protect the public. But, unless the need for the hospitalization is obvious, we urge psychologists to evaluate the benefits of the involuntary hospitalization carefully and conscientiously consider alternative interventions.

PRESIDENTIAL PERSPECTIVE

Continued from page 2

We are similar and we are different!
I am PPA,
You are PPA
We are PPA!

Reference

De Freitas, J., & Cikara, M. (2017). Deep down my enemy is good: Thinking about the true self reduces intergroup bias. *Journal of Experimental Social Psychology.* https://doi.org/10.1016/j.jesp.2017.10.006

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Questions about this process?
Contact PPA's Professional Development Specialist: judy@papsy.org.

Protracted State Budget Battle Stalls Legislative Agendas

Justin Fleming, Director of Government Affairs, Pennsylvania Psychological Association

Justin Fleming

For the second time in three years, a months-long budget standoff is grinding legislative business at the Capitol to a halt. In late-October, Governor Wolf and legislative leaders put the finishing touches on a Fiscal Year 2017-2018 budget plan which closes a $2 billion shortfall by borrowing from the Commonwealth's tobacco settlement fund, expanding gambling to satellite casinos, and one-time fund transfers.

None of these budgetary solutions offers a consistent source of recurring revenue. However, before the Thanksgiving recess, the PA House began debate on an extraction tax on natural gas. In an earlier version of the budget revenue code bill the PA Senate by a two-vote margin (26-24) approved a tax on natural gas extraction. This action was later rejected by the House which began exploring fund transfers.

With the latest budget stalemate behind us, PPA looks forward to pursuing important legislative priorities to support psychologists.

Here is a sampling of legislation that PPA is fighting for, and a forecast on our ability to get these bills passed.

HB 762, SB 780, and HB 1648

Of all the pieces of legislation we are supporting, I think HB 762 has the best chance of passing the House and Senate and being signed into law. This bill would have the Pennsylvania Department of Education study the efficacy of high school students starting school later. If the data confirm what other research from groups such as the American Academy of Pediatrics and others claim about the benefits of later start times for secondary students, it will allow us to advocate for the issue on a more localized basis. Given Pennsylvania's status as a Commonwealth with 501 separate and unique school districts, change on this issue will only come at the local level.

SB 780 and HB 1648 would authorize insurance companies to pay for telemedicine services, including telepsychology. Currently, some insurance companies are reimbursing for telepsychology services, but these bills would mandate payment from insurers. A disappointing aspect of these bills from our perspective is that there is no language that guarantees payments are on par with that of in-person services. So far, these bills are stuck in the Senate and House Insurance Committees, respectively, and the issues are still being looked at by leadership in the chambers.

SB 780 and HB 1648 would authorize insurance companies to pay for telemedicine services, including telepsychology. Currently, some insurance companies are reimbursing for telepsychology services, but these bills would mandate payment from insurers.

PPA is enthusiastic about these and other legislative proposals that, again, support psychologists and the patients you serve!

It remains a great honor and privilege to serve the association and you as a member! If you have questions or wish to aid us in our advocacy efforts, feel free to contact me at 717-510-6349, justin@papsy.org, or find me on Twitter @PAPsychGA!

About Prescribing Psychologists

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John is worried. In fact, he's so worried, it's distracting him from his job, family and responsibilities. His son has recently been diagnosed with depression and is in desperate need of both psychological treatment and medication. The boy has a good relationship with the psychologist in their town, but it seems as though therapy alone isn't enough, and that the proper medication would significantly help control his son's disease. The psychologist, who is unable to prescribe the appropriate medicine, had to refer John to the nearest child psychiatrist—a three-hour drive away. John's son trusts his psychologist and is wary of seeing someone else. John wants to provide his child with the best care possible, but it seems that the easiest route is the only one he can't take.

In most states, John and his son don't have many options. But in Illinois, Louisiana and New Mexico, the family would have a different option. In those states, appropriately trained psychologists can be granted the right to prescribe medications. Patients are able to work with one health care provider for psychotherapy and medication management, if needed.

Most medications to treat mental disorders are prescribed by primary care physicians. However, they have not received extensive training in the diagnosis and treatment of mental health disorders, unlike psychologists.

Psychologists trained to prescribe can also un-prescribe, ensuring that patients receive the proper combination of therapy and medication when they need it. Simply put, a prescribing psychologist offers an integrated and comprehensive approach to care that can save time and money.

What Does It Mean to Be Appropriately Trained as a Prescribing Psychologist?

All licensed psychologists are highly trained, health care professionals holding a doctorate (PhD or PsyD) and extensive training in the diagnosis and management of mental illness. Graduate school for psychologists takes an average of seven years, with coursework that includes the biological basis for human behavior.

Psychologists trained to prescribe can also un-prescribe, ensuring that patients receive the proper combination of therapy and medication when they need it.

After receiving his or her doctorate, a psychologist must complete between 1,500 and 6,000 hours of supervised clinical practice and take a national examination in order to become licensed (rules vary by state). In some states, a jurisprudence exam is also required. While each state develops its own educational requirements, the training for a licensed psychologist to prescribe is rigorous in all the proposed legislation.

- In Louisiana, psychologists must complete a post-doctoral master's degree in clinical psychopharmacology.
- New Mexico requires a minimum of 450 hours of didactic instruction along with a 400-hour supervised practicum as part of its eligibility criteria.
- In Illinois, psychologists seeking prescriptive authority must complete advanced, specialized training in psychopharmacology as well as full-time practicum of 14 months of supervised clinical rotations in various settings such as hospitals, community mental health clinics and correctional facilities.
- Psychologists must pass a certified exam in psychopharmacology.
- After completing their formal training, psychologists must coordinate care with a patient's primary care physician.
- Psychologists are also trained to know when to refer patients for the evaluation of other health problems.
- When all the training—doctoral and post-doctoral—is completed, prescribing psychologists have more training in diagnosing, treating and prescribing for mental health disorders than primary care physicians.

History of the Prescribing Psychologists' Movement

The movement to grant psychologists the right to prescribe psychotropic medication took root in the late 1960s when the APA identified psychopharmacology as a discipline of psychology.

- 1991-1997: The Department of Defense begins a six-year trial program to train 10 psychologists to prescribe medication at assigned military bases. The program was successful, demonstrating that psychologists can be taught to prescribe safely. Some of the psychologists are still prescribing and appropriately trained psychologists may now be credentialed to prescribe in the Defense Department, the U.S. Public Health Service and the Indian Health Service.
- 2002: New Mexico becomes the first state to enact a law allowing appropriately trained psychologists to prescribe psychotropic medications.
- 2004: Louisiana passes legislation providing prescribing rights to psychologists.
- 2014: Illinois enacts legislation granting prescriptive authority to licensed psychologists with additional specialized training in psychopharmacology.
- 2016: Iowa passes legislation granting licensed psychologists who are trained in psychopharmacology with prescriptive authority.

The need is great and the evidence is clear: Allowing prescribing rights for psychologists is an essential step to providing thousands of patients with access to comprehensive mental health care.

Measuring Health-Care Employee Attitudes Regarding Prescription Privileges for Psychologists

ENS Julia von Heeringen, MA; Richard Kutz, PsyD; Thomas Simunich, MS, MBA

The number of practicing psychiatrists has been in decline, and the remaining psychiatrist population is unable to meet demands for mental health care. Telepsychiatrists, primary care physicians, and nonphysician prescribers are increasingly called upon to meet the need for psychiatric services, particularly in rural regions. In response to this national shortage, some states have passed legislation that allows psychologists, after receiving additional training in psychopharmacology, to prescribe psychotropic medication. The prescribing psychologist movement (RxP) provides an option of combating the psychiatric shortage. Minimal research has been conducted regarding health-care employees' attitudes about psychologists obtaining prescribing rights. Research of this nature is essential to fully assess the feasibility of utilizing RxPs within health care (Crary, 2015).

Telepsychiatrists, primary care physicians, and nonphysician prescribers are increasingly called upon to meet the need for psychiatric services, particularly in rural regions.

Literature Review

The RxP movement came to prominence in the mid-1980s. Currently, five states (Idaho, Iowa, Illinois, Louisiana, and New Mexico), in addition to the Department of Defense, U.S. Public Health Service, and Indian Health Service, allow appropriately trained psychologists to prescribe psychotropic medication (APA, 2017). Proponents of RxP argue that appropriately trained psychologists are fully capable of engaging in safe and effective prescribing practices (Walters, 2001). Opponents of the movement maintain that, even with advanced training, psychologists are not equipped to provide safe and effective medication management (Pollitt, 2003; Robiner, Tumlin, & Tompkins, 2013).

The current study completed at Conemaugh Health System aimed to expand upon existing research by evaluating the attitudes of health-care employees from a variety of backgrounds, including those with prescription privileges. A convenience sampling of 104 health-care professionals within the Conemaugh Health System responded to an anonymous, online survey assessing attitudes about professional collaboration with psychologists within the RxP movement. Sample demographics included: 32 physicians, 44 nurses (40 RN), 4 psychologists, 4 pharmacists, 3 social workers, and additional staff, including technicians, caregivers, and physical/occupational therapists.

Julia von Heeringen *Dr. Richard Kutz* *Thomas Simunich*

Hypotheses and Results

H_1: The survey would reveal overall support for the RxP movement among health-care providers in general.

Question	Positive Response (Agree; Strongly Agree	Neutral Response	Negative Response (Disagree; Strongly Disagree
I would feel *comfortable referring* a patient to a prescribing psychologist for psychotropic medication.	*59.6%*	27.9%	12.5%
I would feel *comfortable collaborating* with a prescribing psychologist on medication selection.	*61.5%*	17.5%	21.0%

H_2: Support for the RxP movement would be moderated by level of contact with patients receiving psychological treatment. No statistical significance was found and therefore the null hypothesis is accepted.

H_3: Support for the RxP movement would be moderated by knowledge of the training and requirements necessary for participating psychologists. The statement "I would feel comfortable referring a patient to a prescribing psychologist for psychotropic medication" was posed before and after educational text describing typical requirements for earning RxP privileges. Using the Friedman Two-Way Analysis of Variance by Ranks, responses were found to be significantly different ($p=0.011$) before and after the educational text.

In addition, the statement "Prescribing psychologists do not have the level of training necessary to safely prescribe medication" was also made before and after the aforementioned educational text. The Friedman test identified a significant difference ($p=0.020$) between the responses before and after the educational text.

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RxP Battle: Prescriptive Authority for Psychologists May Not Be Worth the Cost

Charles M. Lepkowsky, PhD

Prescriptive authority for psychologists (RxP) has become a controversial topic. It is the focus of time and energy for many state psychological associations. The greatest challenge to RxP is opposition by physician groups, based on the perceived encroachment of professional psychology on psychiatry. Psychiatry has all but abandoned talk therapy, largely over reimbursement. The criterion issue remaining that separates psychiatry from psychology is prescription authority.

Pursuit of prescriptive privilege validates the perception that professional psychology is encroaching on psychiatry. It deepens the rift between us and physicians. This seems especially unwise in the context of shrinking resources and growing pressures for integrated care.

The facts and figures of experts show that professional psychology can only contribute a tiny fraction of what medical groups contribute to lobbying efforts. This further adds to concern that going to war with the medical profession over prescriptive privilege is unlikely to be successful. From political and practical standpoints, pursuing prescriptive privilege seems unwise. From a medical safety standpoint, it may also be unwise.

Unlike many psychologists, I have a substantial basic science training background. I took biochemistry, organic chemistry, zoology, physiology, physiological psychology, did research in physiological psychology and taught graduate psychology courses in physiological psychology. I have worked full time in a hospital, have been on hospital staffs for 30 years and have chaired a hospital department. I have been in and around medical settings for most of my 35 years in the field of psychology.

I have had thousands of patients on psychoactive medications and would venture to say that I know a fair amount about them, their chemical structures, mechanisms of action, common and uncommon side-effects. I would even say that I have a passing familiarity with many non-psychoactive prescriptive medications, including beta blockers, cholesterol medications, diabetes medications, pain medications and heart medications.

I know exactly enough to know that the major and minor effects of prescriptive medications are not fully understood or entirely reliable, nor are their interactions with other prescriptive or OTC drugs or medical conditions which may or may not appear relevant.

Medical science is already functioning on the bare edge of its comprehension of the human body and its functions. For psychologists with a couple of years of ancillary training to prescribe medications of any kind seems to be getting in way over our heads. The potential medical-legal liability issues are enormous.

According to the logical principles employed by attorneys and legislators, the argument that general practitioners, physician assistants, nurse practitioners and even some psychiatrists know as little or less than psychologists do about psychoactive medications ("they do a lousy job, so we are likely to do no worse") derives from an indefensible position. Psychologists—as 'non-medical' professionals—are likely to be held to a higher standard by licensing bodies.

There is also a psychotherapeutic concern about the difference in relationship dynamics between psychotherapist and prescriber. Many of the discussions we have with patients on Rx medication have to do with their ambivalence about Rx's, their compliance or noncompliance with the Rx and general feelings about being on medication. We encourage them to share these concerns with the prescriber, but it is notable that they first bring such concerns to someone else (the non-prescribing psychologist).

I am not an opponent of RxP, but I do see potential difficulties with the agenda and believe that it might be premature to rush headlong into political efforts to win prescriptive privilege. Just because we can do something does not mean that we should do it.

In my state, California, much attention is being given to the pursuit of RxP. The California Psychological Association (CPA) supports this effort. I am told by our county psych association representatives to CPA that the greatest challenge to the psychologist license in California is, of course, the California Medical Association (CMA).

They say CMA has launched repeated campaigns in the state legislature to eliminate the psychology license, limit the scope of the license, lump our license in with MFTs by collapsing the Board of Psychology into the Board of Behavioral Science Examiners (BBSE, which licenses MFTs and LCSWs) which almost succeeded and keep psychologists from practicing in hospitals (despite CAPP v Rank).

On the other hand, desperation is in the air. Professional psychology is scrambling for a foothold—in an ever-meaner economic environment. Due in large part to our failure to join with other professions with whom we share common interests—the CMA and the California Association of Marriage and Family Therapists—our influence in the state legislature (much less the Congress) is marginal.

We are an easy target. Our reimbursement continues to dwindle, and more unreimbursable documentation is required of us each year. Psychologists are casting about for a way to make a living. Coaching? Mindfulness workshops? Maybe yoga instruction.

So, it may come as no surprise—if psychologists ever are awarded prescriptive privilege in California—that I am one first in line to get such a credential. After all, a person has to pay the bills.

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H^4: Support for the RxP movement would be moderated by prescriptive authority: those with prescription privileges would have different levels of support for the movement contrasted with those who do not have prescription privileges. A delta function revealed a difference between prescribers' and nonprescribers' overall criterion variables. Overall, a 12.7% between-group difference was noted with regard to support of the RxP movement.

Discussion

Overall support for RxP within the Conemaugh Health System was found to be consistent with previous studies about rural health-care providers (Shearer, Harmon, Seavey, & Tiu, 2012). Potential factors affecting that support are suggested through the study results. Specifically, level of education about RxP and presence of prescriptive authority were seen to be significant moderators of RxP support. Further research is needed to verify and expand on these issues. Perhaps providers in rural areas have a greater familiarity with the paucity of psychiatric resources based on increased contact with patients engaged in those resources and this yields greater support for RxP as an additional resource. Nearly 83% of respondents indicated "agree" or "strongly agree" that the RxP model would increase patient access to mental health treatment. However, support for RxP among providers with high-use patients was greater among nonprescribing providers than among prescribing providers. This difference between prescribing providers and nonprescribing providers was seen throughout all responses, with the majority of the support for RxP coming from nonprescribing providers, (nurses, social workers, medical office assistants). When asked the open-ended question, "What level of training is appropriate for prescription rights?" one self-identified physician responded: "complete medical school and a residency program." Perhaps there are significant increased medical concerns associated with prescribing that require complete medical training; however, this doesn't address physician's assistant models or certified nurse practitioner models. And while 64% of respondents "strongly agreed" or "agreed" with the statement that RxP trained psychologists can safely prescribe medication, that percentage of agreement is moderated by prescription rights. Only 20% of respondents who prescribe indicated "agree" or "strongly agree" to the statement that RxP training psychologists can safely prescribe. This is an important distinction in understanding the support and resistance for the RxP, even if we recognize such opinions can be challenged empirically.

Longitudinal studies through the Department of Defense and among prescribing psychologists have shown equivalent and increased efficacy and safety outcomes (Muse & McGrath, 2010; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000; Van Winkle, 2010). The Conemaugh Health System study supports previous research showing support for RxP in rural service areas. In addition, it suggests that support is affected by contact with patients who would utilize RxP services and by overall education about the RxP model. The study also suggests that while some of our colleagues who prescribe are supportive, most support for the movement comes from nonprescribing medical professionals.

Longitudinal studies through the Department of Defense and among prescribing psychologists have shown equivalent and increased efficacy and safety outcomes (Muse & McGrath, 2010; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000; Van Winkle, 2010). The Conemaugh Health System study supports previous research showing support for RxP in rural service areas.

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RxP: A Day in the Life of an RxP Student

Tracy E. Ransom, PsyD

"What antidepressant is the best for me, if any?"; "What are the side effects of the medications I am on?"; "I'm on different medications, and I'm concerned about how they interact—can you help?"

How often have we heard these types of questions in our clinical practice? Clinical psychopharmacology (RxP) is a field of study that prepares clinical psychologists as well as pharmacists in the complex field of psychotropic medication management and consultation. Like neuropsychology, rehabilitation psychology, geropsychology, and other specialties, RxP is a fast-growing specialty practice. Allowing prescribing rights for psychologists is an essential step to providing thousands of patients with access to comprehensive mental health care. The current state of psychiatric practice includes an average of a 3–4 month outpatient appointment wait time; only 6,000 psychiatrists who completed residency programs between 2014 and 2017; many unfilled psychiatry residency appointments; and 59% of all psychiatrists currently over the age of 55 (Association of American Medical Colleges, 2015). The need for highly skilled clinicians in the field of psychotropic management is large, and this is why I chose to complete a master's degree in psychopharmacology.

RxP Programs

Currently there are five master's degree programs that offer training in RxP: the University of Hawaii, Nova Southeastern University, Alliant International University, New Mexico State University, and Fairleigh Dickinson University. Each program must adhere to specific, rigorous criteria developed by the American Psychological Association's Proposed Uniform Criteria for Privileging Psychologists to Prescribe in Federal Agencies, which was established in 2010. These criteria include:

- A postdoctoral master's degree in psychopharmacology from a regionally accredited and/or APA-approved graduate program; a master's degree in psychopharmacology earned during the pursuit and completion of a doctorate in psychology from an accredited graduate program; or a postdoctoral certificate in psychopharmacology that meets APA recommendations prior to a specified year (grandfather clause).
- Passage of the Psychopharmacology Exam for Psychologists or other national certifying examination recommended by APA.
- Documentation of 1 year of supervision by a licensed prescribing psychologist, board-certified psychiatrist, or other board-certified physician with specific knowledge of psychotropic medications in a community, state, or federal setting.
- Proof of having provided pharmacotherapy to a minimum of 100 patients during the supervisory period.
- Current licensure from a state permitting psychologists to prescribe or obtaining such a license within 2 years of being privileged in a federal agency to prescribe.
- A statement indicating that medications typically used to treat psychiatric disorders are within the standard formulary of RxPs.
- A statement regarding the expectation of ongoing competence, continuing education in psychopharmacology, and participation in quality management such as peer supervision (Shearer, Moore, & Park, 2015).

Program Structure and Cost

Most programs are structured to be completed within 2 years and typically require between 30 and 34 credit hours in addition to practicum and residency requirements. The Fairleigh Dickinson Program, which I currently attend, includes the following format:

- Biological Foundations of Pharmacological Practice I and II (3 credits each)
- Neuroscience (3)
- Neuropsychopharmacology (3)
- Clinical Pharmacology (3)
- Professional Issues and Practice Management (3)
- Treatment issues in psychopharmacology: affective disorders (3)
- Treatment issues in psychopharmacology: psychotic disorders (3)
- Treatment issues in psychopharmacology: anxiety disorders (3)
- Treatment issues in psychopharmacology: other disorders (3)
- Clinical lab/test prep (optional)
- Clinical Practicum elective

Costs for training for the different programs usually averages between $15,000 and $20,000 for the entire program. The American Psychological Foundation offers several national scholarship opportunities for students who are studying clinical psychopharmacology.

The Inside Line on Training

Training in psychopharmacology is rigorous and challenging. Typically, a student will spend anywhere from 10 to 20 hours per week on course work, and most of the programs are offered online with residency requirements. There is required reading, completion of direct study questions, online testing, and semester projects (such as completing a draft of a physical on a patient with recommendations for psychological treatment or a critical review of sources opposing the use of psychotropic medications and intended use of medication in one's own practice).

I often am asked why I am devoting such time and energy to a program in Pennsylvania, which currently does not have prescribing privileges for psychologists. There are many reasons for my devotion. In particular, there

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RxP: A Chronology

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- 1984: At the Hawaii Psychological Association Convention, Sen. Daniel Inouye, D-Hawaii, challenges psychology to seek prescriptive authority (RxP) as a way to address the needs of underserved populations.
- 1985: Hawaii Psychological Association introduces the first bill seeking to grant prescriptive authority for psychologists.
- August 1989: APA staff joins the Department of Defense Blue Ribbon Panel to create the curricula for the Psychopharmacology Demonstration Project (PDP).
- 1991: The Department of Defense PDP begins training two Navy psychologists.
- August 1995: The APA Council of Representatives adopts a resolution on prescription privileges for appropriately trained psychologists. The resolution reaffirms that physical interventions are part of the practice of psychology and supports the APA seeking prescription privileges for psychologists.
- August 1996: The APA Council of Representatives approves the Model Legislation for Prescriptive Authority and the Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges as APA policy.
- June 1997: The fourth and final PDP class graduates. By the conclusion of the PDP, it has successfully trained 10 military psychologists to prescribe psychoactive medications.
- December 1999: The territory of Guam, overriding a gubernatorial veto, passes the Collaborative Practices Act, granting psychologists limited prescriptive authority.
- September 2000: The APA College of Professional Psychology's Psychopharmacology Examination for Psychologists (PEP) becomes available for states and provinces to use in granting prescriptive authority to psychologists.
- March 6, 2002: In New Mexico, Gov. Gary Johnson signs into law a bill that grants prescriptive authority to psychologists who have met certain educational and training requirements.
- May 6, 2004: Louisiana's Gov. Katherine Blanco signs the RxP bill into law, granting appropriately trained medical psychologists to prescribe psychotropic medications and emphasizing a collaborative relationship between prescribing psychologists and patients' primary care physicians.
- 2007: The Hawaiian legislature passes an RxP bill. Unfortunately, the bill was ultimately vetoed by Gov. Linda Lingle on July 10, 2007, and the legislature was unable to override the veto.
- 2010: On Feb. 24, the Oregon Legislature passes RxP legislation. The bill is subsequently vetoed by Gov. Ted Kulongoski on April 8.
- June 25, 2014: Illinois Gov. Pat Quinn signs the prescriptive authority bill into law, authorizing licensed Illinois psychologists who have additional specialized training in psychopharmacology to prescribe certain medications for the treatment of mental health disorders. This makes Illinois the third state to grant prescriptive authority for properly trained psychologists.
- 2016: Iowa passes legislation granting licensed psychologists who are trained in psychopharmacology with prescriptive authority.
- 2017: Idaho Gov. C.L. "Butch" Otter signs legislation which grants prescriptive authority to Idaho licensed psychologists who have completed a postdoctoral master of science degree in clinical psychopharmacology, a supervised practicum in clinical assessment and pathophysiology, and passed a national examination.

RXP: A DAY IN THE LIFE OF AN RXP STUDENT

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is a need for skilled consultation with my medical colleagues in formulating recommendations for specific patient cases, which ties in directly to my obligation to provide the highest quality of care. I am fortunate that my organization recognizes the importance of integrating physical and psychological aspects of care to provide lower cost and convenience to our patients. I am also grateful for the support my management provides in pursuing RxP training to promote this integration. Currently, psychologists can make recommendations to physicians but not directly to patients. By having the skills training, I will better serve my medical colleagues and can offer specific, thoughtful recommendations for medications or removal of medications. In addition, this training offers hundreds of hours of continuing education units. Having just entered the second year of the program, I can advocate that I am utilizing the information learned in the program in my current clinical practice to a great degree.

Five states currently offer prescribing rights for psychologists (Louisiana, New Mexico, Illinois, Iowa, and Idaho, as well as Indian Health Services and all branches of the US military), and 17 other states are either pursuing legislation or have groups actively advocating for psychologist prescribing rights. I am confident that Pennsylvania will support and promote this essential opportunity for specialty practice to help meet the underserved mental health needs of our Commonwealth.

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Serving Students With Pediatric Acute-Onset Neuropsychiatric Syndrome

Maura A. Miglioretti, MSEd, Ara J. Schmitt, PhD, and Amy Tiberi, MSEd


Maura A. Miglioretti


Dr. Ara J. Schmitt


Amy Tiberi

Pediatric acute-onset neuropsychiatric syndrome (PANS) is a disorder that has gained recent attention in the fields of pediatric psychiatry and psychology. PANS impacts an estimated 1 in 200 children and is theorized to account for 25% of childhood obsessive-compulsive disorder (OCD) cases (PANDAS Physician Network, 2016). PANS is a chronic condition that has lasting effects on the social, emotional, and cognitive development of children. Children with PANS commonly experience deleterious effects at school, including executive functioning deficits, handwriting difficulties, impairments in mathematics, and a multitude of anxiety-related effects. Anecdotal evidence suggests that children with PANS experience significant difficulties in gaining support at school due to lack of familiarity with the disorder (Alleman, 2015). The prevalence of the disorder suggests that most school personnel will work with one or more students with PANS during their career (Doran, 2015).These facts serve as a call to action for school psychologists to gain awareness and understanding of the disorder, along with how to best serve children and families impacted by PANS.

What Is PANS?

In the 1980s, researchers at the National Institute of Mental Health (NIMH) identified a subset of children with OCD who displayed a sudden onset of emotional and behavioral symptoms following typical childhood bacterial or viral infections (Allen, Leonard, & Swedo, 1995). Existing evidence shows that children with PANS display obsessions and compulsions, motor dysfunction, hyperactivity, emotional lability, and a multitude of other neuropsychiatric symptoms (Murphy & Pichichero, 2002; Snider & Swedo, 2004). PANS has a rapid onset and a relapsing-remitting course and is classified as an autoimmune disorder. In PANS, the body's immune system mistakenly attacks the basal ganglia, an area of the brain also implicated in OCD and Tourette syndrome that is responsible for motor control and associative learning (habit learning).

OCD is the most common neuropsychiatric manifestation of PANS; however, 1 in 5 children with PANS have a primary presentation of an avoidant/ restrictive food intake disorder rather than OCD (PPN, 2016).

Neurobehavioral Consequences of PANS

OCD is the most common neuropsychiatric manifestation of PANS; however, 1 in 5 children with PANS have a primary presentation of an avoidant/ restrictive food intake disorder rather than OCD (PPN, 2016). Other symptoms include severe separation anxiety, general anxiety, irritability, aggression, emotional lability, or depression (Swedo et al., 1998; Murphy & Pichichero, 2002; Swedo et al., 2015). Due to the broad range of symptoms PANS students may exhibit, diagnosis can be difficult and at times frustrating. Academic decline often accompanies the presence of PANS (Swedo, Leckman, & Rose, 2012). Many children experience developmental regression during symptom exacerbation. This can be seen in school through exhibition of poor planning abilities, difficulty with peers, poor handwriting, difficulty in mathematics, hyperactivity, and concentration difficulties (Candelaria-Green, 2015). Teachers may also notice an increase in absenteeism or tardiness related to frequent medical appointments or behavioral problems, making school attendance challenging. Children with PANS may also experience involuntary episodes of crying or laughing that are mood incongruent, temper tantrums/ rage episodes, speech regression, selective mutism, or stuttering. Sexual or violent thoughts and impulses can be seen in children with PANS, as well as self-injurious behaviors (Frankovich, Thienemann, Rana, & Chang, 2015). School psychologists commonly evaluate students for referral concerns that are similar to the above symptoms. Developing a greater understanding of PANS, as well as an evaluation plan that includes acquiring robust medical, developmental, and neuropsychological data are critical to ensure school psychologists are positioned to identify PANS, select evidence-based interventions, and make special service eligibility determinations in the schools.

Treatment of PANS

Medical treatments for PANS include intravenous immunoglobulin (IVIG), plasmapheresis, prednisone, and antibiotics (Stagi et al., 2014).

However, some children are resistant to pharmacological interventions (Nadeau et al., 2015), and it is believed PANS can be worsened by psychotropic medications in some cases. Intensive cognitive-behavioral therapy (CBT) is a first-line treatment option for children with PANS. Children with PANS have attenuated behavioral impulse control, which results in difficulty inhibiting a behavioral response to anxiety and habituation to subjective distress. Therapy tailored to breaking this stimulus-response pattern provides a promising behavioral intervention for the psychiatric effects of the disorder.

Roles of the School Psychologist

School psychologists may play multiple roles in the identification and treatment of PANS. As school-based mental health providers, they can serve as a consultant for classroom teachers; provide interventions for students struggling socially or emotionally as a result of their illness; monitor a child's performance in the classroom to identify areas of needed support; and provide a psychoeducational evaluation for a child with academic impairments related to the illness.

The breadth and depth of the PANS symptoms profile points to several potential protections that students are eligible for under Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA, 2004).

1. A child demonstrating marked learning or social-emotional/behavioral difficulties in school as a result of a health condition requires a comprehensive psychoeducational evaluation by the school psychologist. We argue children with PANS might be considered for special education eligibility under the category of Other Health Impairment (OHI) due to the etiology of the presenting problems.
2. Even when not demonstrating significant educational impairments, children with PANS could be considered for accommodations under Section 504. School psychologists might argue that despite the waxing and waning nature of PANS symptoms, these children might benefit from having a Section 504 plan in place so that educators may respond proactively during periods of symptom increase.

The breadth and depth of the PANS symptoms profile points to several potential protections that students are eligible for under Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act.

It's important to remember that any impairment that is in remission or episodic in nature, as is PANS, is still considered a disability under the law if it would substantially limit a major life activity when in an active state (U.S. Department of Education, 2015).

Furthermore, school psychologists have a unique skill set that equips them to intervene with children with social, emotional, behavioral, and academic difficulties. They have been trained to:

1. Evaluate for the presence of impairments using psychodiagnostic and psychoeducational assessment tools
2. Create modifications and accommodate learning through behavior plans, assistive technology, or extended time to complete assignments
3. Provide counseling or therapy services related to emotional and behavioral symptoms
4. Assess the efficacy of intervention strategies through progress monitoring
5. Take on a consultative role with classroom teachers to provide them with information and resources about the disorder

In conclusion, the training of school psychologists makes them an invaluable resource to parents and children while undergoing the diagnostic and treatment process. Through evaluation, the development of education or accommodation plans, consultation, and multidisciplinary collaboration, school psychologists can support students with PANS.

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Are You Asking About Social Media?

Courtney L. McLaughlin, PhD, NCSP
Dana Elmquist, MEd

Social media is a predominate, primary communication tool. According to the Pew Research Center (2015), 92% of adolescents report daily use of social media with 24% saying they are online "almost constantly," and 71% of adolescents use more than one social networking site. Not surprisingly, adolescents and adults use social media to interact with their worlds, from online shopping to coordinating a party or checking in on a loved one. How adolescents and adults use social media has the potential to provide a lot of meaningful information. In fact, the professionals who write the coding for many of the social media sites agree. For example, advertisements and articles about a topic being searched begin popping up online everywhere, which provides evidence that IP addresses are monitored as people search online to gather data about their interests, shopping habits, and other information.

While social media can tell a lot about a user, it also has the powerful ability to influence a user. Although social media users are in control of the content they choose to read, follow, and share, some of the content is suggested to users based on prior searches, pages being followed, or content that was shared or created. This can create an over representation of specific content for a user, or create what's been termed a "social bubble."

An example of a social bubble is when someone who is struggling with depression uses social media to find information about depression and sees an abundance of other users' negative coping strategies. By having an over representation of these negative coping strategies, users may interpret that "everyone" is coping this way and that these feelings/experiences are "normal." Some sites, such as Buzzfeed, recently launched an initiative termed "Outside Your Bubble," which intentionally


Dr. Courtney L. McLaughlin


Dana Elmquist

pushes messages associated with different perspectives and/or experiences on a topic for users to get exposure beyond what they are seeking. This strategy may be helpful to minimize the social bubble, especially for users who are struggling with mental health problems.

Given that social media is a primary tool used to communicate with the world about oneself and can influence one's perceptions, mental health professionals need to think critically about how engaging clients in discussion about social media may assist in evaluations, case conceptualization, and counseling. One simple way to begin is to consider incorporating the discussion of social media as a semistructured interview. For school psychologists, this may be at the beginning of an evaluation when interviewing an adolescent. For counseling purposes, discussing social media use may be a more ongoing discussion and/or may be associated with goals the client is working toward.

In an effort to assist professionals to incorporate social media questions into their discussions with clients, Elmquist, McLaughlin, and Thompson (2017) developed the Social Media Interview for Adolescents (SMI-A) to help guide professionals when asking questions about social media use. The SMI-A provides brief descriptions of popular social media sites (i.e., Facebook, Twitter, Instagram, Snapchat, Tumbler, Whisper, Periscope, Pinterest) and provides the user with vocabulary specific to those sites (i.e., tweet, like, follow, share). The semistructured interview guides the user through more general questions about use to specific questions about content the adolescent is "likeing," sharing, following, or creating, and the impact or influence social media use has on his or her life. In addition, the semistructured interview includes questions about accessing resources. To view the semistructured interview, please use the QR code below.

In conclusion, social media has emerged as a dominant tool in our society. Thoughtfully and intentionally asking clients questions about social media may assist professionals in gaining a better understanding of them from their perspective. For researchers, more investigation is needed to gain a better understanding of how individuals with various disabilities and diagnoses interact (or do not interact) with social media. For example, which social media sites are preferred? What types of posts are more common? As researchers learn more about these patterns of behavior, interventions will be more strategically targeted to assist adolescents and adults in obtaining the help and resources they may need.

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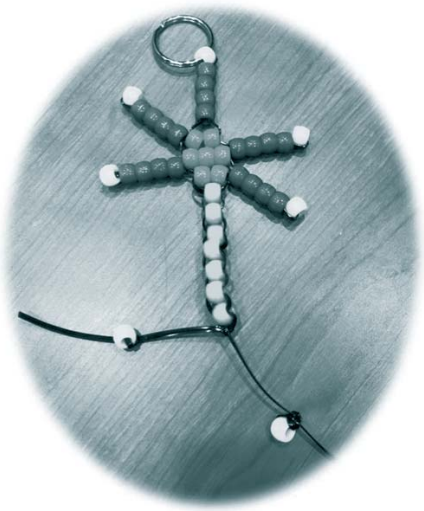
Beads and Biopsychology for Introductory Psychology Students

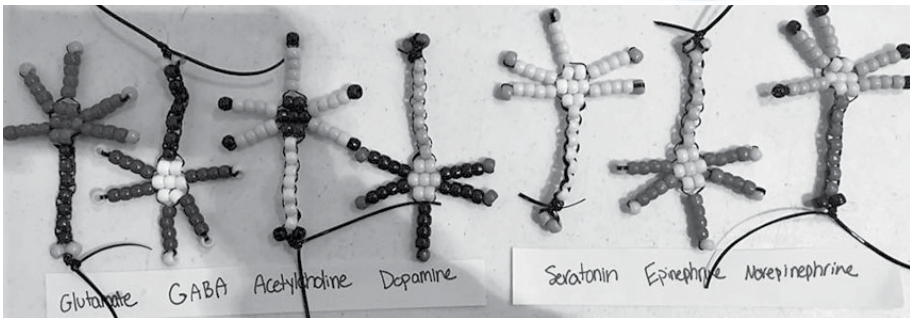
Kristel M. Gallagher, PhD

At the heart of the prescriptive authority movement for psychologists is the coupling of psychological training with biological training. Ideally, if we are moving in a direction where all clinical psychologists receive advanced training in psychopharmacology, we should aim to expose undergraduate psychology students to these topics as early as possible in their education.

In an introductory psychology course, this exposure typically happens in the biopsychology unit. Unfortunately, biopsychology is often one of the more challenging units for students to master. Unlike many of the other topics covered in a typical introductory course, biopsychology is not as intuitive or as easy to "see" in everyday life. More specifically, neuron anatomy and neural communication are concepts that many students struggle to fully understand. As the foundation for the field of psychopharmacology, it is essential that students in introductory psychology have at least a working knowledge of the parts of the neuron and how neurons function.

Thus, it is especially important for instructors of introductory psychology to incorporate hands-on and/or active learning techniques into their discussion of these tougher concepts. One such activity I adapted from the Neuroscience for Kids website is to build a neuron. For this activity, students channel their inner "summer camp kid" by using plastic beads and lacing to build a replica of a neuron (that also doubles as a nifty keychain!). Students complete the activity during half of a regular class period, guided by the instructor and a handout of instructions. The efficacy of this project was evaluated to determine whether, in fact, building the neuron keychain significantly enhances student learning of the basic anatomy and function of a neuron, as well as retention of the knowledge gained.





Students in the two Spring sections of the course who built neuron keychains in the first quarter of the course were compared to students in the three Fall sections who did not. The Spring "neuron builder" sections outperformed the Fall "nonbuilder" sections on both the unit test covering biopsychology (77.9% vs. 61.6%; $t(90)=2.27$, $p=.02$) and in a surprise assessment at the end of the semester (68.6% vs. 56.3%; $t(61)=1.84$, $p=.07$). Predictably, the largest effects were observed in the anatomy subsection of the assessment (unit test – 92.4% vs. 69.9%; surprise assessment – 79.5% vs. 60.0%).

Within the neuron builder sections, scores on the surprise assessment at the end of the semester were significantly higher than on a preassessment completed before the biopsychology chapter ($t(67)=-4.36$, $p=.00$). Students retained an increase of 27%, suggesting a true gain in understanding of the material. Though small (and expected) losses were observed from the unit test to the surprise end of the semester assessment, none were significant (p's$>.12$). Overall, a loss of just 9% was observed from the unit test to the end of the semester.

Together, these results highlight how a simple class activity can be an effective tool for enhancing students' understanding of, and comfort with, important biopsychological concepts. As we prepare future psychologists for advanced training in psychopharmacology so that they may eventually gain prescription privileges, the undergraduate psychology curriculum should become rich in these types of hands-on experiences.

Multiple Relationships in Small Communities

Jeanne M. Slattery, PhD, and Linda K. Knauss, PhD

This vignette is part of a regular series looking at clinical dilemmas from an ethical standpoint. In addition to the two of us, the respondents to this vignette included Drs. Francine Fettman, Claudia Haferkamp, Julie Jacobs, Deb Kossmann, Bruce Mapes, Don McAleer, Jeff Pincus, and Geoffrey Steinberg.

> *Dr. Marion Small is a psychologist working with a small community of gays and lesbians in a larger city. Many of her clients are referred by other clients, who are members of this community. Because Dr. Small is also a member of this community, her clients believe that she understands them especially well, but she also frequently ends up at gatherings that have one or more clients present. Her friends and family often have her clients as friends both in real life and on social media. What should she do?*

We laughed when Dr. McAleer asked whether this case was a real-world dilemma. Although we live and work in different contexts, it's clear that these sorts of incidental and often discomforting encounters are experienced by all of us. Dr. Slattery has had such experiences in her small community of 5,300 but so has Dr. Steinberg in his New York City practice. Dr. Knauss, having served on a number of ethics committees, said that we'd be amazed at what is real!

Dr. Haferkamp observed that these boundary issues aren't just related to the size of the community. Some subcultures, like many GLBTQ+ communities, tend to be more cohesive to protect themselves from the "domineering cultures" with which they often come into contact. Such groups often look within the group to find professionals, leading to the kinds of interactions that Dr. Small experienced in this vignette.

Dr. Pincus described a colleague, a gay psychiatric nurse with a history of addiction, who struggled with how to handle this work/life balance. Should he come out as gay? Where could he safely go to 12 Step meetings? How could he create a space for himself? This nurse wanted to be a good role model to the young gay males in the community, who often had difficulty finding partners in places other than bars but also wanted to maintain his privacy.

Several people talked about how they handle these often-tricky interactions. In some cases, it was clear that consulting and referring elsewhere made sense. Dr. Kossmann, for example, described a colleague who worked with two people with different last names in two different cities—only to discover that they were married. After requesting a consult from his supervisor, this psychologist ended treatment with both parties, citing a conflict of interest.

Dr. Pincus described a colleague, a gay psychiatric nurse with a history of addiction, who struggled with how to handle this work/life balance. Should he come out as gay? Where could he safely go to 12 Step meetings? How could he create a space for himself? This nurse wanted to be a good role model to the young gay males in the community, who often had difficulty finding partners in places other than bars but also wanted to maintain his privacy. When would he choose to wear his "therapist hat" and when could he just be himself? Ongoing consultation with Dr. Pincus helped this nurse resolve the complicated issues raised by being a therapist in a very small "community."

Dr. Kossmann talked about preventing problems proactively. Dr. Jacobs, for example, discussed how she attempts to resolve incidental interactions as part of her typical informed consent procedure by letting clients know that if she sees them in public, it will be up to them to acknowledge her first. Dr. Steinberg noted that such discussions are part of a larger

process of orienting clients to the therapy process. However, he described the often-ridiculous lengths that some people take in order to avoid such interactions (e.g., one psychologist who hid when he saw clients).

Misconceptions

A number of people described some of the misconceptions around multiple relationships. Dr. Steinberg observed, for example, that many clients believe they need to protect the confidentiality of the people in their own lives. This interferes with the therapy process and can make it difficult to identify unexpected multiple relationships.

Dr. Knauss noted that many psychologists think you cannot have multiple relationships under any circumstances; however, the ethics code does not say that multiple relationships are unethical. The APA Ethical Principles of Psychologists and Code of Conduct says, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (APA, 2017, p. 6). Often, determining whether a relationship could impair a psychologist's objectivity requires consulting with colleagues or supervisors. Everyone emphasized the importance of such consultations.

When considering entering into a multiple relationship, it is also important to discuss that decision with the client and consider the alternatives and potential consequences of such relationships. If the client is unwilling to do so, Dr. Knauss suggested that the contemplated relationship should not proceed.

Ethical Acculturation Model

Dr. Haferkamp focused our discussion on the ethical acculturation model (Handelsman, Gottlieb, & Knapp, 2005). Some people may attempt to resolve ethical dilemmas by primarily considering personal ethics (Separation) or professional ethics (Assimilation). However, the ethical acculturation model encourages us to maintain a balanced perspective guided by both personal and professional ethics (Integration), rather than making our treatment decisions solely from a fear of disciplinary action, to protect the therapist's privacy, or to meet the client's needs. In the course of our decision-making process, we should weigh the degree and probability of harm and benefit to the therapist and the client that could be reasonably expected from incidental encounters such as those that Dr. Small experienced.

Because reasonably predicted harm and benefits vary across therapists and clients, there are no hard and fast rules, and this makes many people anxious. Dr. Pincus suggested that we see the ethics code as a resource or a safety net. Navigating ethical issues well often requires flexibility and good humor. Rather than thinking about the ethics code as a restrictive and punitive set of rules, we can use it as a resource to navigate difficult situations. Supervisors and consultants can help others begin to see the code in this manner.

References

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct.* Retrieved from http://www.apa.org./ethics/code/ethics-code-2017.pdf

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice, 36*, 59–65.

Would you like to be involved in future discussions of vignettes? Email Dr. Slattery at jslattery176@gmail.com and let us know!

PPA Member Spotlight

Welcome to the PPA Member Spotlight feature in the *Pennsylvania Psychologist*. Among the items we will include are new positions or practice openings, awards and recognition related to the practice of psychology, peer-reviewed journal publications, and more. The Member Spotlight is not designed for self-promotion or the advertising of products and services.

Congratulations to **Paul Kettlewell, PhD, ABPP,** who was recently elected to serve as a Board member on APA's Committee for the Advancement of Professional Practice (CAPP)! Dr. Kettlewell will begin serving a 3-year term on Slate 2: Experience in Health-Care Policy for CAPP in 2018.

Happy Holidays!

One of the real joys this holiday season is the opportunity to say "thank you" and wish you the very best now and always. Warmest thoughts and best wishes for a wonderful holiday and a very happy New Year!

Your PPA Staff
Iva, Rachael, Justin, Judy, and Erin

Nominate a Deserving Colleague for a PPA Award

Do you know of a colleague who has distinguished himself or herself as an outstanding professional psychologist? If so, we invite you to nominate that person for a PPA award! These awards, will be presented at the PPA2018 annual convention at the Doubletree Valley Forge in King of Prussia, PA.

The award for **Distinguished Contributions to the Science and Profession of Psychology** is to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications.

The **Distinguished Service Award** is to be given to a PPA member for outstanding service to the Pennsylvania Psychological Association.

The **Public Service Award** is to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the Association.

To nominate a deserving psychologist by December 15 or for more information, contact Professional Development Specialist Judy (Smith) Huntley at 717-232-3817 or judy@papsy.org.

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

Office to share West Chester. Bright, spacious single office, beautifully furnished, private waiting room. Professional building. Free parking. Handicapped accessible. 2-3 days per week. Please call 610-436-1611.

OFFICE SPACE – BUCKS COUNTY Neuropsychology practice has handicap accessible professional office space available for lease. Private office is approximately 8x10, with access to reception area, conference room and kitchenette . Ideal for solo practitioner or satellite office. As LHG no longer provides treatment services, this could represent a good opportunity for the right clinician. Monthly fee of $590 includes utilities, internet.
Office located in Langhorne, easy access to Phila and NJ. E-mail interest to: libertyhealthgroup@gmail.com.

Office space available in prime location of Center City Philadelphia: The available office is part of a gracious suite with other therapists and psychiatrists. Break room includes a kitchen, use of computer, copier and fax. Easily accessible by train or bus. Reasonable rent for part time or full time use. Email Estelle at eprice8225@gmail.com, or call my cellphone, 617-320-1865.

Join PPA's Listserv!

The listserv provides an online forum for immediate consultation with hundreds of your peers. Sign up for FREE by contacting:

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Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between August 16 and November 8, 2017!

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Philadelphia, PA

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Philadelphia, PA

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Philadelphia, PA

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Pittsburgh, PA

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Malvern, PA

Suzette Madanat, MS
Malvern, PA

Sophie Manevich, BS
Philadelphia, PA

Samantha Marino, MA
West View, PA

Madeline R. Meade, MS
Gwynedd Valley, PA

Lindsey M. Nicholson, BA
Hanover, PA

Karen Owens, MA
Phoenixville, PA

Vincent A. Pietropaoli, MS
Pittsburgh, PA

Bethany Roche, MS
Shillington, PA

Amanda Rose, Psy.M.
Fairview, PA

Brooke A. Roseman, MA
Exton, PA

Samantha C. Ryland, MA
Pittsburgh, PA

Aalia Saleem, BS
Philadelphia, PA

Anna L. Schimmelpfennig, MA
Hershey, PA

Stephanie Sema, MA
Exton, PA

Lindsay Shima, MA
Media, PA

Katherine Solomon, BA
Elizabethtown, PA

Danielle Stepien, BS
Philadelphia, PA

Abigail Torres, BS
Lancaster, PA

Tara N. Toscano, MA
Royersford, PA

Lauren Truskey, MS
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CE Questions for This Issue

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

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

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

Allow one to two weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before December 31, 2019.

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.

Zehrung

1. Which two words describe the Greek term for a "happy or flourishing life" and "excellence or virtue"?
   a. Shalom, chai
   b. Eudaimonia, arete
   c. Hakuna, matata
   d. All of the above

Fleming

2. What is the purpose of HB 762?
   a. Study the efficacy of high school students starting school later in the day
   b. Promote healthy aging resources in local communities
   c. Authorize insurance companies to pay for telemedicine services
   d. Earmark additional funding for drug and alcohol programs
3. Which piece of legislation does the author anticipate being most likely to be passed by the House and Senate and be signed into law?
   a. SB 780
   b. HB 1648
   c. HB 762
   d. All of the above

Knapp, Baturin, & Tepper

4. In a 302-emergency examination, which of the following is true:
   a. Patients maintain their rights to counsel, an immediate hearing, and confronting witnesses.
   b. Patients may leave the facility so long as they sign Against Medical Advice.
   c. Patients have no right to counsel, no right to an immediate hearing, and no right to confront witnesses.
   d. There are no prescribed rules for a 302.
5. Which of the following conditions must be met for involuntary hospitalization:
   a. A verbal threat to harm someone else
   b. An act of furtherance such as acquiring a firearm or an overt act such as harming oneself in a way that shows reasonable probability of death or serious bodily injury within the next 30 days
   c. Self-harm that occurred no less than 30 days and no more than 120 days from the date of the session
   d. None of the above

Von Heeringen, Kutz, & Simunich

6. In the Conemaugh Health System study, support for the RxP movement is shown to be:
   a. Greatest among physicians
   b. Equal across health-care providers
   c. Present across health-care providers but stronger among prescribers
   d. Present across health-care providers but stronger among nonprescribers

Lepkowsky

7. This author suggests that which of the following is true:
   a. Pursuing prescriptive authority is a wise endeavor for psychologists.
   b. Going to war with medical professionals over prescriptive privilege is unlikely to be successful.
   c. Medical/legal liability issues will be easily addressed as psychologists begin prescribing.
   d. Psychologists will likely not be held to a higher standard by licensing bodies.

Ransom

8. Each of the five master's degree programs that offer training in RxP must adhere to specific, rigorous criteria developed by:
   a. The American Psychiatric Association's Prescribing Privileges for Psychologists Criteria established in 2007
   b. The American Psychological Association's Psychopharmacology Extension Program established in 2014
   c. The American Psychological Association's Proposed Uniform Criteria for Privileging Psychologists to Prescribe in Federal Agencies established in 2010
   d. No specific criteria have been developed to date

Miglioretti, Schmitt, & Tiberi

9. Which of the following is a common symptom of PANS?
   a. OCD
   b. Emotional lability
   c. Hyperactivity
   d. All of the above

10. The authors of this article argue that children with PANS should not be considered for special education eligibility under the category of Other Health Impairment.
    a. True
    b. False

Slattery & Knauss

11. The ethical acculturation model suggests that the most ethical way of approaching ethical dilemmas is to consider:
    a. Professional ethics only
    b. Personal ethics only
    c. Both personal and professional ethics
    d. Neither personal nor professional ethics but agency guidelines

12. When considering a multiple relationship:
    a. Consider the impact on the client
    b. Consider whether it would impair your objectivity
    c. Consult with colleagues or a supervisor
    d. All of the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist Update*, December 2017**

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

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

Satisfaction Rating

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

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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I verify that I personally completed the above CE test.

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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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The Pennsylvania Psychologist

December 2017 • QUARTERLY

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2017/18 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

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

February 21
PPA Webinar Series
1:00 p.m.–2:00 p.m.

March 3, 2018
ECP Day
PPA Office
Harrisburg, PA

April 13, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar
Harrisburg, PA

April 20, 2018
Spring Continuing Education Conference
Sheraton Station Square
Pittsburgh, PA

May 11, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar
Harrisburg, PA

June 13–16, 2018
PPA2018—PPA's Annual Convention
Doubletree Valley Forge
King of Prussia, PA

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

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

Home Study CE Courses

Act 74 CE Programs

Assessment, Management, and Treatment of Suicidal Patients—1 CE

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

Assessment, Management, and Treatment of Suicidal Patients (Podcast)—1 CE

Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

Competence, Advertising, Informed Consent, and Other Professional Issues—3 CEs

The New Confidentiality 2018—3 CEs

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

For all Home Study CE courses above, contact: Judy (Smith) Huntley, 717-232-3817, judy@papsy.org.