The Pennsylvania Psychologist

Vol. 78, No. 10 OCTOBER 2018 • UPDATE

Parenting Coordination in Custody Cases Returns to Pennsylvania

By: Jeannine Turgeon, Judge[1]

The Pennsylvania Supreme Court recently adopted Rule 1915.11-1 adopting, once again, Parenting Coordination, after having eliminated it several years ago. While many of us were concerned that the proposed new Rule would not include mental health professionals, fortunately it permits both masters or doctorate level mental health professionals to perform the essential and palliative role of a Parenting Coordinator in high conflict custody cases.

This article will outline several of the key components of the Rule and explain some of the components of the Rule in more detail.

The Pennsylvania Supreme Court established several specific educational and training requirements for Parenting Coordinators. Parenting Coordinators must obtain Twenty (20) hours of training prior to their initial appointment and Ten (10) hours of training every two years after the initial appointment.

Highlights of the new Rule 1915.11-1. Parenting Coordination

- Parenting Coordinators are appointed only in cases involving repeated or intractable conflict between the parties affecting implementation of the final custody order, after a final custody order entered.
- Parenting Coordinators may be appointed for up to 12 months, which can be extended.
- Parenting Coordinators must attempt to facilitate/mediate an agreement.
- If unable to reach agreement on the issues(s) then the Parenting Coordinator recommends a resolution to the Court, on a specific form.
- Parenting coordinators, with parties' consent, may contact collateral sources and speak with the child(ren).
- Parenting Coordinators may communicate with parties and their attorneys without the presence of the other party or their attorney, but the parties and their attorneys may not initiate communication with the Parenting Coordinator "ex parte" i.e. outside the opposing party's presence.
- No appointment of a Parenting Coordinator if parties have an active PFA Order or if court finds, a party has been the victim of domestic violence perpetrated by a party to the custody action, either during the pendency of the custody action or within 36 months preceding the filing of the custody action;--or victim of a personal injury crime perpetrated by a party to the custody action, unless the parties consent and appropriate safety measures implemented to protect the participants, parenting coordinator and other third parties.
- Parenting coordinators must issue their written Summary and Recommendations within 2 days after "hearing from the parties" on an issue.
- Parties cannot unilaterally terminate a Parenting Coordinator.
- Parenting Coordinator's Recommendation will be reviewed by a judge, and if parties file no objection within 5 days, the court will approve the recommendation in full or in part. The recommendation however becomes an interim order pending further court order.
- The Court can hold a hearing on issues not approved or remand the case to the Parenting Coordinator for more specific information.

Qualifications of Parenting Coordinators

To become a Parenting Coordinator in Pennsylvania, one must meet the following requisite qualifications as outlined in the new Rule:

- A Parenting Coordinator shall be licensed to practice in Pennsylvania as either an attorney or a mental health professional with a master's degree or higher;

Continued on page 2

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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

Editor — Shannon Len Deets, PhD
PPA President — Nicole P. Quinlan, PhD
PPF President — Williametta S. Bakasa, PsyD, MBA
Executive Director — Ann Marie Frakes, MPA

PARENTING COORDINATION IN CUSTODY CASES RETURNS TO PENNSYLVANIA!

Continued from page 1

- At a minimum, a Parenting Coordinator shall have practiced family law for five years or have five years of professional post-degree experience in psychiatry, psychology, counseling, family therapy, or other comparable behavioral or social science field; and
- A Parenting Coordinator shall have specialized training by a provider approved or certified by the American Psychological Association, Pennsylvania Psychological Association, American Bar Association, Pennsylvania Bar Association, Pennsylvania Bar Institute, or American Academy of Matrimonial Lawyers.

Education and Training Requirements for Parenting Coordinators

The Pennsylvania Supreme Court established several specific educational and training requirements for Parenting Coordinators. Parenting Coordinators must obtain Twenty (20) hours of training prior to their initial appointment and Ten (10) hours of training every two years after the initial appointment. Since the Rule does not take effect until March 2019, those interested in being a Parenting Coordinator placed on a Court of Common Pleas' list of approved Parenting Coordinators, have adequate time to obtain the required training.

The training shall include:

- Five hours in the parenting coordination process;
- Ten hours of family mediation;
- Five hours of training in domestic violence; and
- In each 2-year period after the initial appointment, ten continuing education credits on any topic related to parenting coordination with a minimum of two hours on domestic violence.

As stated above, this training must be approved or certified by the American Psychological Association, Pennsylvania Psychological Association, American Bar Association, Pennsylvania Bar Association, Pennsylvania Bar Institute, or American Academy of Matrimonial Lawyers.

Application to the Court for Placement on Roster of Approved Parenting Coordinator

A Judicial District implementing a Parenting Coordination program must maintain a roster of qualified individuals. If you want to be on the roster in one or more judicial districts (Courts of Common Pleas), you must submit an affidavit attesting you meet the qualifications to the president judge or administrative judge in those Judicial Districts. If approved, you must submit a new affidavit every two-year attesting that you continue to meet the qualifications.

Agreement with the Parties

According to the Rule, Parenting Coordinators must give the parties a copy of their signed Agreement regarding the Parenting Coordinator's qualifications, and information on the parenting coordination process and fees, discussed below. Therefore, it would be wise to include all the requisite training outlined above in addition to your educational background and other qualifications in your standard Agreement.

The Parenting Coordinator must give the parties a copy of their signed agreement regarding matters including the required retainer; hourly rate established by that judicial district; the process for invoices and payment for services; his or her qualifications, and information on the parenting coordination process. Since an agreement is required to contact collateral sources and speak with the children, your agreement should also include those points.

Authority of Parenting Coordinators

While under the prior Rule Parenting Coordinators could initially decide a variety of non-legal custodial issues, under the current Rule, Parenting Coordinators are only authorized to recommend resolutions to the court about issues that include:

- Places and conditions for custodial transitions between households;
- Temporary variation from the custodial schedule for a special event or circumstance;
- School issues, apart from school selection;
- The child(ren)'s participation in recreation, enrichment, and extracurricular activities, including travel;
- Child-care arrangements;
- Clothing, equipment, toys, and personal possessions of the child(ren);
- Information exchanges (e.g., school, health, social) between the parties and communication with or about the child(ren);
- Coordination of existing or court-ordered services for the child(ren) (e.g., psychological testing, alcohol or drug monitoring/testing, psychotherapy, anger management);
- Behavioral management of the child(ren); and
- Other custody issues that the parties agreed to submit to the parenting coordinator, (other than legal custody, primary physical custody and financial issues).

The Parenting Coordinator will issue their "Summary and Recommendation" on the specific form, as noted above, within two (2) days after hearing from the parties on the issues and serve a copy of the Recommendation on the parties. the parties have five (5) days after service to file with the Court their objection(s) to the Recommendation and request a hearing before the Court. The Court may approve the Parenting Coordinator's Recommendation, approve it in part and conduct a hearing on issues not approved, or remand it to the Parenting Coordinator for more specific information. If a party makes a timely objection, the Recommendation becomes an interim Order of Court, pending further Order of Court.

Parenting Coordinators' Fees

In accordance with standard practice, of course, the Rule requires the parties to sign a written fee agreement with the Parenting Coordinator concerning the retainer required, your hourly rate and that established by that judicial district, the process for invoices and payment for services, and other matters discussed above.

The Court Order Appointing Parenting Coordinators will provide how the parties will share the Parenting Coordinator's fees. However, the fees may be reallocated by the Court or Parenting Coordinators if a party

Continued on page 12

PPA Responds to Proposed Changes in Intensive Behavioral Health Services

In August, the Pennsylvania Department of Human Services published proposed regulations concerning intensive behavioral health services (IBHS), formerly known as behavioral health rehabilitation services (BHRS). Most of the services for this Medicaid funded program are provided by 200 plus large provider agencies, although many small psychology groups are involved as well. The Commonwealth administers behavioral health in Medicaid largely through five large behavioral health managed care organizations (BMCOs).

Pennsylvania's Department of Human Services proposed these new regulations, in part, because IBHS services are governed by a series of agency policy bulletins and regulations that are nowhere consolidated into one document. In addition, the Department is proposing some major changes in how the system is administered. One of the goals is to ensure that all those delivering the services receive a special facility license from the Department of Human Services.

The proposed regulations cover almost every detail of IBHS services including staffing patterns, qualifications required of staff, record keeping, billing practices, elements required in assessments, standards for administrative staff and much more. Writing regulations is a difficult task that requires much labor and attention to detail. The task for IBHS is especially important considering that the program costs more than 400 million dollars and serves 60,000 children.

The Department of Human Services had been working on these proposed regulations for several years and has given much thought and attention to them. The proposed regulations contained much that was positive and welcomed. Nonetheless, after a detailed review, PPA's Executive Committee recommended that PPA oppose the adoption of the proposed regulations. PPA identified dozens of ambiguities and inconsistencies in the proposed regulations. Most dealt with technical issues that could be corrected with a simple re-write of the proposed regulations. However, PPA also had some substantive differences that prevent PPA from endorsing these proposed changes.

First, the proposed regulations would have required psychologists who deliver applied behavior analysis services under IBHS to receive a second license or second credential before delivering these services. PPA opposed this proposal and insists that applied behavior analysis is part of the practice of psychology. Second, the proposed regulations would have changed the assessment process so that as assessment by licensed professionals would no longer be required for the children to start services (although such as assessment would have been required for the children to continue to receive these services).

Also, PPA noted that the proposed regulations made no provisions for integrating behavioral and physical health care services. Although the Pennsylvania Department of Health and the Pennsylvania Department of Human Services have issued statements urging more integrated health care, these proposed regulations would only perpetuate siloed mental health care services.

First, the proposed regulations would have required psychologists who deliver applied behavior analysis services under IBHS to receive a second license or second credential before delivering these services.

The proposed regulations cover almost every detail of IBHS services including staffing patterns, qualifications required of staff, record keeping, billing practices, elements required in assessments, standards for administrative staff and much more.

In addition, the regulations contained provisions on reimbursement that were ambiguous and could be interpreted to deny providers of fair compensation for services delivered. Furthermore, the regulations contained many provisions that appeared to add administrative burdens

Continued on page 4

PPA RESPONDS TO PROPOSED CHANGES IN INTENSIVE BEHAVIORAL HEALTH SERVICES

Continued from page 3

to providers with no obvious public benefit.

PPA is not opposed to the requirement that providers must become a licensed facility but noted problems how it intended to implement the licensing process. Most specifically, the proposed regulations would allow any agency that currently holds a facility license as a psychiatric outpatient clinic or partial hospitalization program to delay getting an IBHS license until their old license expires. However, no such transition period is allowed for small group psychology practice currently delivering the same services.

Comments to the Department of Human Services' proposed regulations are the first step in the long process of regulatory review.

PPA is not opposed to the requirement that providers must become a licensed facility but noted problems how it intended to implement the licensing process. Most specifically, the proposed regulations would allow any agency that currently holds a facility license as a psychiatric outpatient clinic or partial hospitalization program to delay getting an IBHS license until their old license expires.

The Regulatory Review Process in Pennsylvania

Regulations are laws written by government agencies that expand upon, but which cannot contradict statutes, or laws written by the state legislature. All proposed regulations must go through a detailed process starting with a public comment period following the publication of the proposed regulations in the Pennsylvania Bulletin, the official publication of the Commonwealth of Pennsylvania. The proposed regulations must also go to the relevant committees of the Pennsylvania House of Representatives and Senate which may also comment.

The regulations are also reviewed by the Attorney General's office and the Pennsylvania Department of State. After these reviews are complete and the public comment period ends, the issuing agency must respond to the comments and, if necessary, make changes in their proposed regulations. Then these proposed regulations go to the Independent Regulatory Review Commission (IRRC) which must either accept or reject the regulations in their totality-- they may not modify them at this point. They have very limited reasons for rejecting a regulation including whether it contradicted an existing law. At this stage IRRC cannot reject a proposed regulation simply because they believe it is a bad idea.

The Public Health Challenge of Excess Weight

Samuel Knapp, Ed.D., ABPP

The rates of excess weight in the United States have been increasing substantially in the last 30 years. Currently, two thirds of Americans are either overweight or obese. The categories of "overweight" and "obesity" are determined by body mass index (BMI) which is calculated by dividing weight by the square of one's height in meters. A BMI between 25 and 30 classifies an individual as overweight, and a BMI of more than 30 classifies an individual as obese.

Nationwide the obesity rate is 30%, although there is substantial variation across geographic and demographic groups. Coloradans had the lowest obesity rates (20%) which were almost one-half the rates found in Louisiana. Pennsylvania is at the national average (Lundeen et al., 2008).

Obesity rates for children in the United States increased from 10% in 1988 to 16% in 2004. Since 2004 these rates have leveled off. Among American adults, however, the rates of obesity increased from 24% in 1988 to 32% in 2004 and 36% in 2014. Grade 3 obesity, which is a BMI of 40 or above, increased for adults from 3% in 1988 to 8% in 2014 (National Center for Health Statistics, 2017).

Obesity is linked to an increase in diabetes, cardiovascular problems, hypertension, congestive heart failure, cancer and other medical conditions (Zheng, 2017). Although a higher BMI was especially linked to higher rates of cardiovascular diseases (GBD 2015 Obesity Collaborators, 2017), the cardiovascular BMI link does not appear to apply to mildly obese patients, which is called the obesity paradox (Oktay et al. 2017). As measured by life span, many of the advances in medical treatment made in the last generation may be neutralized by the increase in health care problems related to obesity. As measured by health care costs, the increase in obesity and obesity related disorders (combined with the aging of the American population) will ensure continued sharp increases in health care expenditures.

Americans now consider obesity to be the most serious health problem facing the nation, tying with cancer (Rosenthal, 2017). Unfortunately, the same survey found that

Americans now consider obesity to be the most serious health problem facing the nation, tying with cancer (Rosenthal, 2017).

respondents identified "lack of willpower" as the most common cause of obesity. Also, social norms concerning weight are changing so that overweight persons are now more likely to describe their current weight as normal or ideal, suggesting that the motivation for decreasing weight may be declining among the population (Burke & Heiland, 2018).

Obesity is caused by a combination of genetic and environmental factors. Because the American genetic pool is relatively stable, the rise in obesity can be attributed to factors in the American lifestyle that promote an imbalance between physical activity and caloric intake. Factors include

- A decline in physical activity
- An increase in pleasurable sedentary activities, such as computer games
- An increase in the need for non-human transportation in urban areas
- An increase in fast foods
- Marketing of fat or sweet laden food and drinks
- An increase in eating out in restaurants in general and especially in fast food restaurants
- Lack of easy access to fruits and vegetables among groups especially vulnerable to excess eating
- A culture of shaming persons with excess weight which paradoxically decreases motivation to lose weight

Although genetics play a factor in excess weight for many persons, the increase in weight is due primarily to environmental factors. One study of the many studies supporting this interpretation dealt with indigenous members of the Pima. Although 60% of the members of the Pima tribe who live in the United States carry excess weight, only 20% of the members of the Pima tribe who live in Mexico do so (Schultz, 2006).

No magic bullet or single intervention will reverse the obesity epidemic. The environmental causes for the increase in obesity are complex and the solutions need to be multifaceted. Some of the population approaches include improving the nutritional value of school lunches, expanding recreational activities for children, increasing the availability of fresh fruits and vegetables, and so on.

In addition, psychologists and other health care professionals can provide individualized weight reduction programs for those carrying excess weight. Many programs can help patients lose weight in the short-term; a major challenge is to keep the weight off over extended periods of time. Our bodies have a complex homeostatic system that resists losing weight in the long run, causing some to consider excess weight to be akin to a chronic disease that needs continual monitoring and periods of more intense treatment (Sharma, Goodwin, & Dunn, 2018). Nonetheless, even small reductions in weight can have significant health care benefits.

Medications have been promoted as one way to lose weight, but their gains are modest, and they should only be prescribed in conjunction with a patient's commitment to undergo lifestyle changes. Bariatric surgery has also increased in recent years, although it is expensive and does involve health risks to undergo. Behavioral health interventions remain the best intervention for reducing weight.

Behavioral treatments typically involve self-monitoring, decrease in calories, and increases in activity levels. The accompanying articles by Drs. Radico and Healey describe successful behavioral programs in reducing weight.

References

Burke, M. A., & Heiland, F. W. (2018). Evolving social norms of obesity: What is the appropriate response? *JAMA, 319,* 221-222.

The GBD 2015 Obesity Collaborators. (2017). Health effects of overweight and obesity in 195 countries over 25 years. *The New England Journal of Medicine, 377,* 13-27.

Continued on page 6

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Fall Continuing Education Opportunities

November 15-16, 2018
Desmond Hotel - Malvern, PA

PPA AND THE TRUST RISK MANAGEMENT SEMINAR
THURSDAY, NOVEMBER 15, 2018

9:00 a.m. - 4:00 p.m.

Sequence VII: Legal and Ethical Risks and Risk Management in Professional Psychological Practice

Daniel O. Taube, JD, PhD
6 CE Credits - This course will cover both Ethics and Suicide Prevention requirements (5 Ethics credits and 1 Suicide Prevention credit)

THE TRUST WORKSHOP REGISTRATION

	Until Oct. 13	After Oct. 13
PPA Members	$175.00	$195.00
Non-Members	$215.00	$235.00

LOCATION AND LODGING

Desmond Hotel Malvern, A DoubleTree by Hilton
1 Liberty Boulevard
Malvern, PA 19355

If you are interested in reserving a room at the discounted rate of $139/night plus tax, contact 610-296-9800 before October 24, 2018.

CONTINUING EDUCATION CREDITS

The **Fall 2018 Continuing Education Conference** is sponsored by the Pennsylvania Psychological Association and will provide up to **9 CE credits**. The Pennsylvania Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. More information is available online.

Daniel O. Taube, JD, PhD is a speaker for The Trust and receives payment for his presentations.

PPA pays an honorarium to Conference speakers. There are no identified conflicts of interest for speakers for the PPA Fall Conference.

Register online now at papsy.org! For more information, contact PPA at ppa@papsy.org or (717) 232-3817.

REGISTRATION RATES

For PPA Fall Conference - Act 31 and Friday, November 16.
Cost is per workshop.

	Until Oct. 13	After Oct. 13
Act 31: PPA Members	$60.00	$80.00
Act 31: Non-members	$110.00	$130.00
Fall Conference: PPA Members	$80.00	$95.00
Fall Conference: Non-members	$130.00	$145.00
Students	$20.00	$35.00
Non-member Students	$45.00	$60.00
Lunch	$50.00	$50.00

CONFERENCE SCHEDULE

Objectives and course descriptions are available online

THURSDAY, NOVEMBER 15

6:00 - 8:00 p.m.
Child Abuse Recognition and Reporting

Rachael Baturin, MPH, JD
2 Act 31 CE Credits - Introductory
This workshop is approved by the Department of Human Services and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement.

FRIDAY, NOVEMBER 16

9:00 a.m. - 12:00 p.m.

W01 - Ethical and Legal Issues When Working with Children
Samuel Knapp, EdD, ABPP
3 Ethics CE Credits - Intermediate

W02 - Effective Skills & Competencies for Clinical Supervision
Kristin Mehr, PhD; Rachel Daltry, PsyD
3 E Credits - Intermediate

W03 -2018 Family Updates for Pennsylvania Psychologists
Jan Grossman, PhD, Esq.
3 CE Credits - Introductory

12:30 - 1:30 p.m. - Lunch

W04 - Ten Ways to Improve the Treatment of Suicidal Patients
Samuel Knapp, EdD, ABPP; Brett Schur, PhD
1 CE Credit - Intermediate

1:45 - 4:45 p.m.

W05 - Making Ethics Come Alive through Self-Reflection
Jeffrey Sternlieb, PhD; Samuel Knapp, EdD, ABPP
3 Ethics CE Credits - Intermediate

W06 - Things About Family Law Every Psychologist Should Know
Steven Cohen, PhD; Marolyn Morford, PhD; Kathryn L. Vennie, DBH, MS; Ashley Milspaw, PsyD
3 CE Credits - Introductory

W07 - Psychological First Aid (1:45 - 5:45 pm)
Shari Kim, PhD
4 CE Credits - Introductory

THE PUBLIC HEALTH CHALLENGE OF EXCESS WEIGHT

Continued from page 5

Lundeen, E. A., Park, S., Pan, L., O'Toole, T., Matthews, K., & Blanck, H. M. (2018). Obesity prevalence among adults living in Metropolitan and nonmetropolitan counties- United States, 2016. *Morbidity and Mortality Weekly Report, 67* (23).

National Center for Health Statistics. (2017). *Health, United States, 2016 with chartbook on long-term trends in health.* Hyattsville, MD: United States Department of Health and Human Services.

Oktay, A. A. et al. (2017). The interaction of cardiorespiratory fitness with obesity and the obesity paradox in cardiovascular disease. *Progress in Cardiovascular Disease, 60,* 30-44.

Rosenthal, R. J. et al., (2017). Obesity in America. *Surgery for Obesity and Related Disorders, 13,* 1643-1651.

Schultz, L. O. et al. (2006). Effects of traditional and western environments on prevalence of type 2 Diabetes in Pima Indians in Mexico and the U.S. *Diabetes Care, 29,* 1866-1871.

Sharma, A. N., Goodwin, D. L., & Dunn, J. C. (2018). Conceptualizing obesity as a chronic disease: An interview with Dr. Arya Sharma. *Adapted Physical Activity Quarterly, 35,* 285-292.

Zheng, Y. (2017). Association of weight gain from early to middle adulthood with major health outcomes later in life. JAMA, 318, 255-269.

In Memoriam

Dr. Rodney (Rick) Schall

Emmaus, Pennsylvania
August 12, 2018
http://www.heintzelmancares.com/obituary/dr-rodney-rick-schall

Dr. Michael A. Palmer

Mansfield, Pennsylvania
September 2, 2018
http://www.legacy.com/obituaries/tiogapublishing/obituary.aspx?n=michael-h-palmer&pid=190121207&fhid=10135

When you know of a PPA member's passing, please contact Ann Marie Frakes at annmarie@papsy.org so we may include the information in monthly editions of *The Pennsylvania Psychologist*.

Motivational Interviewing to Treat Obesity

Julie Radico Psy. D., ABPP
Department of Family and Community Medicine, Penn State Milton S. Hershey Medical Center

Many patients presenting to primary care are told by their providers that they need to lose weight. This makes sense based on the prevalence of overweight, obesity, and severe obesity in the United States as noted in Dr. Knapp's introductory article. As a psychologist working with medical students, residents, and attending physicians in Family Medicine I have a front row seat to the provider's frustration when their patients come for a return visit and have not lost weight (but gained!) or their hemoglobin A1C has increased. In coaching these providers and when treating patients, it is important to engage the patient in conversations about lifestyle changes in a way that puts them in the role of director of their own health activities.

One such strategy, which has a growing body of evidence for its use in primary care settings, is Motivational Interviewing (MI). It is described as a patient-centered and directive approach to counseling for behavior change, which emphasizes individual autonomy and a collaborative relationship between patient and provider (Miller & Rollnick, 2002). MI has been shown to improve patients' general health status or well-being, promote physical activity, help develop healthier nutritional habits, reduce problematic substance use, boost self-efficacy in their ability to make health-related behavioral changes, and manage chronic conditions such as mental illness, hypertension, hypercholesterolemia, obesity, and diabetes (Lundahl et al., 2013; VanBuskirk & Wetherell, 2014). There is some variability in the effectiveness of MI for obesity in primary care, with a systematic review by Barnes and Ivezaj (2015) demonstrating effects in a range from no, to small, to significant weight loss. It is hypothesized that since many of the MI studies did not use manualized approaches more research is warranted to identify the specific applications of MI which result in the most beneficial patient outcomes.

Nevertheless, MI: has been shown to be efficacious in primary care settings, the higher the credentials of intervention deliverer have been found to significantly moderate effect size in treatment, and as few as one MI session may be effective in enhancing readiness to change and action directed towards reaching health behavior-change goals (VanBuskirk & Wetherell, 2014). Therefore, psychologists working and teaching in health care settings are well positioned to teach other providers how to deliver this care.

The following outlines specific MI strategies and examples described in Rollnick, Miller, and Butler's (2008) Motivational Interviewing in Health Care: Helping Patients Change Behavior.

1. Providers are encouraged to act as a Guide to their patients, rather than as Directors or Followers. The authors describe that a good Guide is like a tutor, in that the student (i.e. patient) directs you to the area in which they need help (i.e. exercising) and you know what is possible and show the student alternatives from which to choose. If you take one side (e.g. "you need to lose weight") the patient will naturally take the opposite side.

- The more the patient verbalizes reasons against changing the behavior the more committed they become to staying the same.
- We believe what we hear ourselves say.

2. Since the patient is the Director it is important to elicit Change Talk from them. The Change Talk statements you collect from the patient are like little weights placed on the "pro-change" side of a balance. Helping patient's voice pro-change arguments gradually tips the balance in the direction of change.

Examples of Change Talk prompts can be remembered with D.A.R.N. and the following questions can be asked to have your patient begin using language stating their desire, belief in their ability to, reasons for, and need to change (e.g. lose weight).

- **Desire:** "Why might you want to make this change? What do you want, like, wish, hope?"
- **Ability:** "What is possible? What can or could you do?"
- **Reasons:** "What would be some specific benefits to this change? What risks would you like to decrease?"
- **Need:** "How important is this change? How much do you need to do it?"

3. Another way of eliciting change talk is by having the patient rate how strongly they feel about the change, their readiness, the importance they place on the change, and their confidence. (Of these four, Importance and Confidence are of critical importance.)

- How important would you say it is for you to start exercising? On a scale from 1 to 10, where 1 is 'not at all important' and 10 is 'extremely important?'
- How confident are you that you could start exercising? On a scale from 1 to 10, where 1 is 'I'm certain I could not' and 10 is 'I'm certain I could?'

If a patient responds, "5 out of 10," using MI you could ask: "A 5 out of 10. I'm curious, why not a 1?" Asking the patient to tell you why they did not rate their confidence or importance lower elicits from them change talk (e.g. a patient's response may be, "well I know it's not good for my heart to weigh this much.")

Of note: Patients who are high on importance but low on confidence will need encouragement that change is possible and some specific ideas about how to do it (remember to guide not direct!). Patients who are low on importance but high on confidence may need to you to roll with resistance by opening the pathway for future conversations (e.g. "would it be okay if we talk about this again at our next appointment?").

References

Barnes, R. D., & Ivezaj, V. (2015). A systematic review of motivational interviewing for weight loss among adults in primary care. *Obesity Reviews, 16*(4), 304-318.

Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. *Patient Education and Counseling, 93*(2), 157-168.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: preparing people for change* (2nd Ed.). New York: Guilford Press.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: helping patients change behavior.* New York: Guilford Press.

VanBuskirk, K. A., & Wetherell, J. L. (2014). Motivational interviewing with primary care populations: A systematicreview and meta-analysis. *Journal of Behavioral Medicine, 37*(4), 768-780.

Cognitive Factors and Interventions for Weight Loss/Management

Sean Healey, Psy.D.
Allegheny Mental Health Associates

The costs of obesity and excess weight on individual health and the healthcare system are severe and behavioral interventions remain the best course of treatment available to assist clients with weight management concerns, as Dr. Knapp reminds us in his introductory article. For mental health practitioners the standard course of treatment to assist our patients with weight reduction has been an approach based on learning theory that seeks to reverse high caloric intake and sedentary behavior with lower caloric intake and more physical activity via interventions such as stimulus control and improved self-monitoring. Research supports that this approach is effective for many during treatment but that weight gains all too often occurs post-treatment (Faulconbridge & Wadden, 2010). As a clinician who conducts psychological assessments for bariatric surgery candidates and provides treatment and consulting services for weight management, I have frequently encountered the frustration that clients and fellow healthcare professionals experience.

One important line of research into improving the effectiveness of psychotherapy for sustained weight management focuses on the role of cognition in human behavior related to weight loss (e.g., more healthy eating and physical activity level). Contemporary cognitive therapy is a diverse set of psychotherapies that while sharing a focus on the role of thought in human behavior is also marked by considerable debate. It is, of course, well beyond the scope of this brief article to provide even an introduction into the many varieties of "cognitive therapy." Instead, this article briefly reviews some empirically-supported interventions of the two camps: 1) the traditional model that emphasizes the role of the content of human thought on behavior via cognitive restructuring; and 2) the newer generation that focuses on the process of thinking on human behavior via psychological distancing from thoughts to facilitate more goal-congruent behavior (e.g. managing weight).

That the more traditional cognitive therapy can complement behavioral interventions and improve adherence to healthier eating and greater activity has limited support in the research literature. For example, Werrij et al. (2009) found that at follow up a group receiving cognitive therapy in addition to dietetic interventions demonstrated decreased negative and counter-productive thoughts, decreased impulsive eating and maintained weight loss, whereas the control group receiving only dietetic interventions regained 25% of weight. Perhaps the most well-known weight management program deriving from cognitive therapy is Judith Beck's The Beck Diet Solution (2007), which cites research supporting cognitive therapy in sustained weight loss. The program is not a stand-alone treatment guide but is designed to augment a healthy diet by focusing on the identification of and adaptive response to self-defeating thoughts, beliefs and expectations about food, dieting and the challenges inherent in dieting and sustained weight loss.

Basic but effective cognitive techniques such as Socratic questioning, the Downward Arrow (Burns, 1999), and the Thought Record can be readily applied and can be effective in assisting clients with identifying and challenging negative thoughts and beliefs that sabotage healthy eating and behavior. Socratic questioning entails not informing or lecturing clients on the impact of negative thoughts but guiding the patient in identifying and challenging unhelpful inferences he/she makes about his/her weight loss struggle(s). A sample transcript dealing with a lapse in treatment plan adherence follows:

- Therapist: "Let's start with your thought, 'I have no willpower, I am never going to be able to lose weight. It's hopeless.' What question could you ask yourself to challenge this thought?"
- Client: "Do I have any evidence for this thought?"
- Therapist: "Yes. What would be your next step?"
- Client: "Actually, I could remind myself that I have lost 15 lbs. Or that I have quit smoking. I guess I can do hard things."
- Therapist: "Very true! How does that make you feel about your misstep now?"

The Downward Arrow is another standard technique that promotes insight into how thoughts may reflect deeper-seated beliefs that can be then worked with rather than allowing them to manifest into maladaptive behavior adversely impacting weight loss/management. It is based on discovering how thoughts reflect more core beliefs that compromise weight management. The therapist assists the client by discovering the latter's inferred meaning of what happened and what it means to him or her. An example is provided:

- Client: "I have only lost 2 lbs. since last week." Therapist: "What does that mean to you?"

- Client: "I won't be able to reach my target weight and go to the beach this summer." Therapist: "And what that does mean to you, or about you?"

- Client: "I'm disgusting, my kids are ashamed of me."

The Thought Record is another technique that can be utilized to assist the client with understanding how their thoughts, feelings and behavior are interrelated and how challenges in weight management can become demotivating. A typical example is included at the top of the next page:

Situation	Mood/Feeling	Sensation	Unhelpful Thought	Alternative Thoughts	What Can I Do	New Mood
Woke up late and ate fast food breakfast	Guilty Frustrated	Bloated	I have no willpower I will never lose weight	I made a mistake I woke up late, was rushed and did not follow my plan that was working	I can go to bed on time and wake up on time, so I can better follow my plan	More hopeful

As mentioned above, new-generation cognitive therapies and techniques examine how the process of thinking directly influences human behavior. Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999), Metacognitive Therapy (Wells, 2011) and an array of approaches utilizing mindfulness are considered variants of these more novel approaches. These therapies share the assumption that thoughts are frequently identified by clients as valid representations of reality—cognitive fusion—rather than as simply cognitive phenomenon that are distinct from and cannot adequately represent the complexity and totality of human experience—cognitive defusion (Blackledge, 2018). Research supports the effectiveness of these treatments on a wide range of clinical concerns including weight management (Blackledge, 2018; Lillis & Kendra, 2014).

Due to the complexity and need for initiation and practice of approaches such as ACT or mindfulness-based approaches, two Metacognitive techniques that are readily usable when we encounter a patient with unhelpful thoughts involved in compromising weight loss are presented. Wells suggests using metaphors that allow the individual to gain some psychological separation from unhelpful thoughts. His Recalcitrant Child metaphor emphasizes that our negative thoughts are like an attention-seeking child, the more we pay attention to him/her the more likely that further attention is demanded. Thus, by ignoring certain patterns of our negative thoughts, we minimize our propensity to attend to them and thereby decrease their power over us. His Runaway Train metaphor is another technique that contends that thoughts take us to a psychological "place," and that when we actually travel we want to know our destination. By practicing this technique, we can assist our patients with NOT "traveling" to unwanted, unhelpful "destinations."

Cognitive therapy techniques can be helpful when we are working with clients whose thoughts are adversely impacting their adherence to their weight management plan. Interested readers are urged to consult the primary sources to better familiarize themselves with the theory, practice and research base that supports their use.

References

Beck, J. S. (2007). *The Beck Diet Solution: Train your brain to think like a thin person.* New York, NY: Oxmoor House.

Blackledge, J.T. (2018). Cognitive Defusion. In S. C. Hayes & S. G. Hoffmann (Eds.) (2018). *Process-Based CBT* (pp.351-362). Oakland, CA: Context Press.

Burns, D. (1999). *Feeling good: The new mood therapy.* New York: Harper Collins.

Faulconbridge, L.F. & Wadden, T.A. (2010). Managing the Obesity Epidemic. In J M. Suls, K. W., Davidson, & R. M. Kaplan (Eds.), *Handbook of Heath Psychology and Behavioral Medicine* (pp. 508-526). New York, NY: Guilford Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy.* New York, NY: Guilford Press.

Lillis, J., & Kendra, K. E. (2014). Acceptance and Commitment Therapy for weight control: Model, evidence, and future directions. *Journal of Contextual Behavioral Science, 3*(1), 1-7.

Wells, A. (2011). *Metacognitive therapy for anxiety and depression.* New York, NY: Guilford Press.

Werrij, M. Q., Jansen, A., Mulkens, S., Elgersma, H. J., Ament, A. J., & Hospers, H. J. (2009). Adding cognitive therapy to dietetic treatment is associated with less relapse in obesity. *Journal of Psychosomatic Research, 67*(4), 315-324.

Healthy Weight in Pennsylvania: Education and Income Levels Major Predictors of Health-Related Behaviors

Samuel Knapp, Ed.D., ABPP

Some areas of the United States, such as Utah, Colorado, the New England States and the Pacific Coast states have healthier weights than other parts of the country, especially the South. These differences are due to many factors. For example, the rate of obesity in Colorado is one-half that of Louisiana (Lundeen et al., 2018).

Income or educational levels may be factors. There may be a social selection process whereby persons with serious health problems are unable to work or hold well-paying jobs. On the other hand, there may be a social benefit process whereby persons with more education or higher incomes have better access to health care services and they know more about the health implications of their behavior and thus engage in activities more likely to protect or improve their health.

Within Pennsylvania excess weight is more common in the poorer counties in Southwestern and Southcentral Pennsylvania, while less common in affluent Philadelphia suburban counties (Montgomery, Chester, and Delaware Counties). The following tables shows Pennsylvania-specific data on various high-risk behaviors according to educational and income levels, based on data from the Pennsylvania Department of Health (2016). As readers can see, self-rated health, lack of physical activity, obesity, and incidence of diabetes consistently become better as one goes up the education or income ladders of society.

Education

	Self-Rated Health As Poor or Fair	No Physical Activity	Obese	Diabetic
Not high school graduate	32%	36%	35%	21%
High school graduate	20%	31%	35%	13%
Some College	15%	19%	30%	10%
College Graduates	6%	10%	22%	7%

Income

	Self-Rated Health As Poor or Fair	No Physical Activity	Obese	Diabetic
Less than $15,000	40%	36%	35%	15%
15,000 to 25,000	30%	33%	35%	18%
25,000 to 50,000	18%	25%	34%	13%
50,000 to 74,000	10%	21%	34%	11%
75,000	6%	12%	25%	6%

Correction

An article in the July/August Pennsylvania Psychologist ("More Questions about Insurance, Billing, and Other Office Practice Policies, Part I") referred to the evaluation of police officers in Pennsylvania as falling under Act 235. This was an error. The evaluations of police officers in Pennsylvania fall under Act 120.

Life Style and American Health

Samuel Knapp, Ed.D., ABPP

Public health initiatives within the United States have changed considerably in the last century. At the turn of the last century (around 1900), infectious diseases (TB, influenza, measles, small pox, etc.) were common health concerns of Americans and the average life expectancy was around 50. Foods were often contaminated. Industrial accidents were common and safety procedures for most industries were minimal. For example, coal miners almost invariably acquired black lung disease and textile workers frequently got brown lung disease.

Public health advances have greatly reduced those risks. Nutritious food is more plentiful, and food processing is now monitored to ensure minimal standards of safety; sewage systems and other improvements have led to a cleaner water supply; vaccinations prevent many diseases; and antibiotics effectively treat many infectious diseases. The creation of the FDA has led to a substantial decrease in contaminated foods. Family planning is far more available, and most expectant mothers have access to prenatal care. Drinking water is fluoridated in most localities and dental health has improved substantially (CDC, 1999).

Now, the most serious threats to public health are linked with life style behaviors such as smoking, failing to exercise, not eating fruits or vegetables, the abuse of alcohol and other drugs, over exposure to ultraviolet sun rays, failures to get preventive care, including preventive dental care, and high risk sexual behavior. A review of the most common sources of death in the United States shows that many of them have causes linked to life style behaviors (See Table One).

Table One: Top Ten Causes of Death

1	Heart disease[1]	23%
2	Cancer[2]	22%
3	Lower respiratory disease	6%
4	Unintentional injury[3]	5%
5	Stroke	5%
6	Alzheimer's Disease[4]	3%
7	Diabetes[5]	3%
8	Influenza and pneumonia	3%
9	Kidney disease	2%
10	Suicide	1.6%

1 Heart disease can be prevented, or the impact of heart disease can be reduced through good diet, exercise, and abstaining from smoking or drinking in excess.
2 Lifestyle issues (excess weight, poor diet, lack of exercise, excessive exposure to sunlight, smoking tobacco, etc.) accounts perhaps one third of all cancers.
3 Human error accounts for most accidents.
4 Cognitive decline can be slowed through regular exercise, good diet, an active social life, and involvement in cognitive activities, such as reading, doing puzzles, or solving problems.
5 Diabetes is strongly associated with excess weight. Weight reduction programs have the promise of reducing the prevalence of diabetes.

(Data from National Center for Health Statistics, 2017)

Excess weight, is especially important because excess weight is associated with increased risks of heart disease, cancer, diabetes, arthritis, dementia, and other ailments. It is also associated with an increased risk of death or disability. This problem is so serious among children that the current generation of young Americans may be the first to have a shorter life expectancy than the previous generation.

Disability rates among Americans declined in the last two decades of the 20th century due primarily to improvements in the overall health of the population, but there are indications that it might be increasing due to increases in health problems associated with excess weight such as diabetes, heart attacks, or decreased mobility.

References

Centers for Disease Control (1999). Ten great public health achievements– United States, 1900-1999. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm

National Center for Health Statistics. (2017). *Health, United States, 2016 with chartbook on long-term trends in health*. Hyattsville, MD: United States Department of Health and Human Services.

Continued from page 2

has disproportionately caused the need for the services of Parenting Coordinators.

Courts implementing a parenting coordination program must also establish Parenting Coordinators' hourly fees. How each court determines these rates will likely vary from county to county considerably. I believe it is very important that all mental health professionals providing their services to custody litigants should immediately contact their local Family Law Bar Section to assist them and the courts on this challenging issue. Certainly, standard hourly rates differ depending upon the education and experience of each professional, whether a mental health provider or lawyer.

For low-income or in Forma Pauperis (IFP) parties, the Rule requires each court establish a "sliding fee scale" for those approved to serve as Parenting Coordinators. Some counties such as Allegheny and Lackawanna have programs that may serve as a model for the new fee schedule for Parenting Coordinators under the recent new rule.

As I understand it, Allegheny Family Court's Generation Program operates under a sliding fee scale for psychologists and mediators for IFP and low-income litigants to provide custody evaluations, psychological evaluations, and mediation. The county has contracts with those professionals. Some other counties also have similar contracts with mental health professionals. Most, however do not. Therefore, in accordance with standard practice, of course the rule requires the parties to sign a fee agreement with Parenting Coordinators concerning the retainer required, your hourly rate and that established by that Judicial District, the process for invoices and payment for services.

Conclusion

The entirety of the new Rules concerning Parenting Coordinators, including the form for Parenting Coordinators' recommendations, can be found at http://www.pacourts.us/assets/opinions/Supreme/out/Attachment%20%20103653532640942566.pdf?cb=1

1 The Honorable Jeannine Turgeon has served as a judge handling criminal, civil and family matters in the Court of Common Pleas of Dauphin County since 1992: In 2013, her goal of establishing a Family Court was realized and she assumed the role of managing a separate "division" of family law matters. She is the Vice-Chair of the Pa. Supreme Court Suggested Standard Civil Rules Committee and has served as Member and Chair of the Supreme Court Domestic Relations Rules Committee, The Pa. Statewide Parenting Coordination Task Force, The Pa. Sentencing Commission, and other Boards and Committees.

2 The Form required is as follows:

SUMMARY AND RECOMMENDATIONOF THE PARENTING COORDINATOR

The undersigned, the duly appointed parenting coordinator in the above-captioned matter, pursuant to the Order of Court dated _____, 20__, after submission of the issue described below and after providing the parties with an opportunity to heard on the issue, the parenting coordinator sets forth the following:

SUMMARY OF THE ISSUE(S)

1. Description of the issue(s):

_____

_____

2. The respective parties' position on the issue(s):

_____

_____

RECOMMENDATION-

_____

_____

Within five days of the date set forth below, a party may object to this recommendation by filing a petition with the court and requesting a record hearing before the judge as set forth in Pa.R.C.P. No. 1915.11-1(f)(3). The undersigned parenting coordinator certifies that this Summary and Recommendation of the Parenting Coordinator has been served on the court and the parties or the parties' attorneys on the date set forth below.

3 Ex parte" is a Latin phrase meaning "on one side only; by or for one party." An ex parte communication occurs when a party to a case, or someone involved with a party, talks or writes to or otherwise communicates directly with a Parenting Coordinator, Hearing Officer, Master or Judge about issues in a legal case without the other parties' presence or knowledge.

4 "Personal injury crime." is one that constitutes a misdemeanor or felony under any of the following, or criminal attempt, solicitation or conspiracy to commit criminal homicide, relating to assault, relating to kidnapping, human trafficking, sexual offenses, arson and related offenses, robbery, victim and witness intimidation, homicide by vehicle, and accidents involving death or personal injury.

5 The Rule provides as follows:

TERMINATION/WITHDRAWAL OF PARENTING COORDINATOR:

(a) The parties may not terminate the parenting coordinator's services without court approval.

(b) A party seeking the termination of the parenting coordinator's services shall serve the other party or the party's attorney and parenting coordinator with a copy of the petition for termination.

(c) If the parenting coordinator seeks to withdraw from service in a case, the parenting coordinator shall petition the court and provide a copy of the petition to the parties or the parties' attorneys.

6 The complete procedure under the Rule is, as follows: A party objecting to the recommendation shall file a petition for a record hearing before the court within five days of service of the Summary and Recommendation of the Parenting Coordinator form. The petition must specifically state the issues to be reviewed and include a demand for a record hearing. A copy of the recommendation shall be attached to the petition. In accordance with Pa.R.C.P. No.440, the objecting party shall serve the petition upon the other party or the party's attorney and the parenting coordinator.

7 In my opinion, parties may agree to appointment of an Arbitrator to co-ordinate parenting, instead of a Parenting Coordinator under this Rule, agreeing the Arbitrator will have the authority to make decisions on various parenting issues if an agreement cannot be reached by the parties on matters other than legal custody and changes regarding primary physical custody. That decision could be appealed to the Court; however, it at least provides a "decision" the parties must operate under pending hearing. See: What's in a Judge's Toolbox for Children in High-Conflict Families Without Parenting Coordinators? Co-authored with Hon. Katherine B.L. Platt, Pennsylvania Family Lawyer, 35 PA Family Lawyer Issue No. 3 (September 2013).

Classifieds

Court Conciliation and Evaluation Service is seeking licensed mental health professionals to complete custody evaluations in Bucks County, PA. Work out of your own office, no court appearance/ testimony required. Family and Child experience necessary, forensic experience preferred. Send resume and inquiries to rbrookspsych@gmail.com.

OFFICE SPACE AVAILABLE: BALA CYNWYD – Attractive, furnished windowed offices include Wi-Fi, fax/copier, café, free parking, flexible hours weekdays and weekends. Perfect for therapy and evaluations. 610-664-3442.

Camp Hill private practice interested in licensed psychologists, LPC, or LCSW willing to rent furnished office space or do fee-for-service evaluations and outpatient therapy. Office is located next to Cedar Run Creek in Camp Hill, PA with quick access to Rt. 15, 83, and 581.

Creek-side location is ideal for play therapy with children ages 2-99. Newly renovated building, all offices have windows and natural lighting. Off-street parking and security system. Part-time or full-time availability. Anyone interested please call the Clinical Director, Dr. Ashley Milspaw, at 717-745-7095.

Ashley Milspaw, PsyD
Gallant Psychological and Forensic Services
3803 Cedar Ave. Camp Hill PA 17011
717-745-7095
www.gallantpsychological.com

UPCOMING WORKSHOPS ON PARENTING COORDINATION

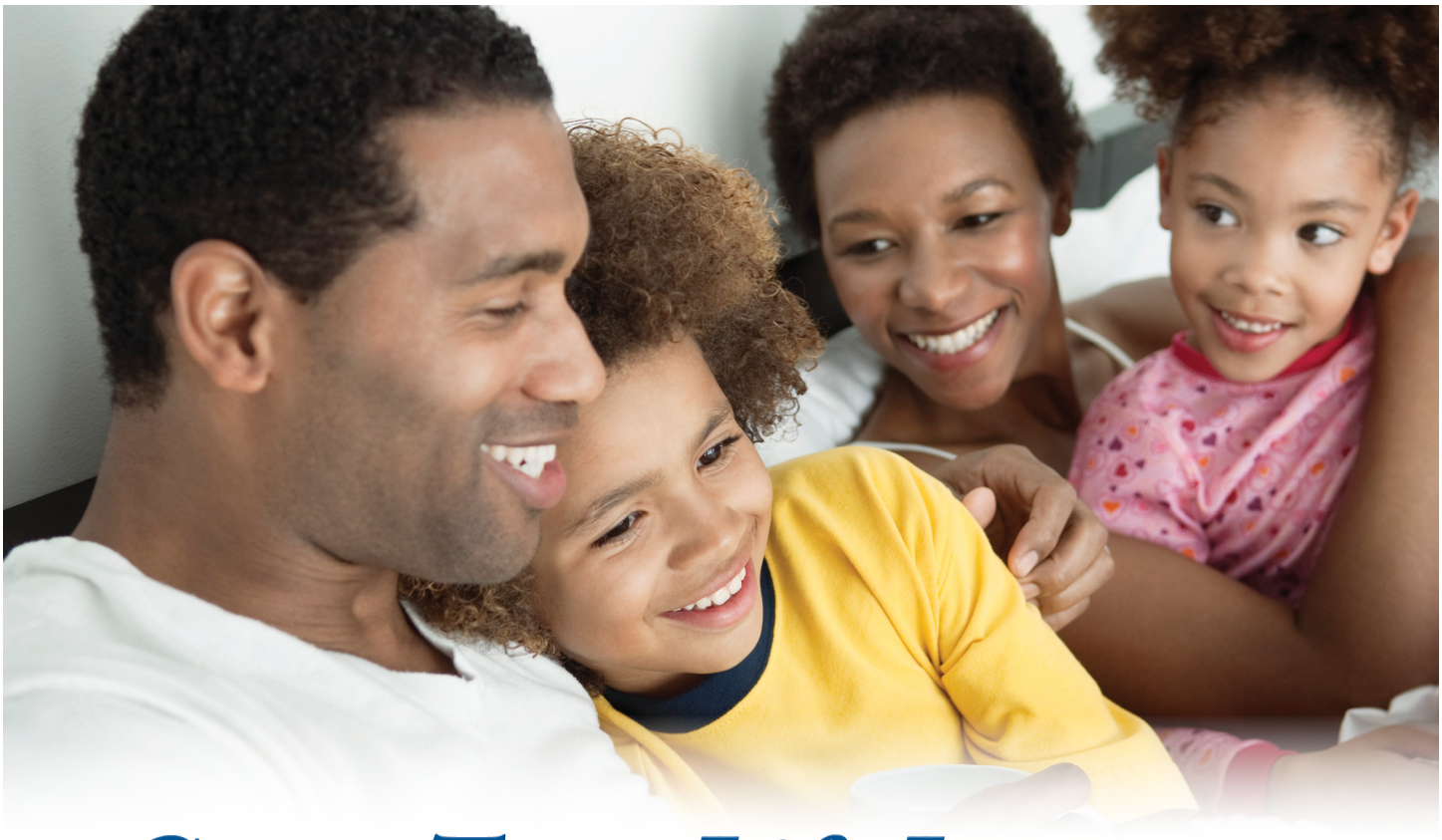
November 2, 2018
8:30 am to 10:30 am
Parenting Coordination- How Will We Create Dauphin County's Protocol?
November 12, 2018
9:00 am to 11:00 pm
Parenting Coordination 2.0: The New Parenting Coordination Rule and Implementation of that Rule

Click on each workshop title for more information and registration.

Please join the PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION for happy hour in PITTSBURGH on Thursday, October 11, 2018. Come meet our current PPA President, Dr. Nicole Quinlan and learn about our exciting plans for the 2019 PPA Convention in PITTSBURGH. We have lots of ideas how you, your colleagues, interns and students can get involved in the convention and we can't wait to tell you all about it! PPA will provide some snacks and your first beer or glass of wine!

Thursday, October 11, 2018
6:00 PM- 7:00 PM
LOBBY BAR at SHERATON STATION SQUARE
300 W Station Square Drive, Pittsburgh, PA 15219
(412) 261-2000

Please feel free to extend this invitation to our PPA and PPAGS members and non-member psychologists in the Pittsburgh metro area! Please RSVP to ***annmarie@papsy.org***.



Group Term Life Insurance

Essential financial protection for the ones you love.

If you were to die prematurely, would you leave enough assets to ensure that your surviving family could avoid financial hardship? **Affordable Trust Group Term Life Insurance*** can ease their burden and continue to cover many of the expenses you covered so well in life.

Knowing your options not only gives you peace of mind; it is sound financial planning. Even if you have coverage, The Trust can help you decide whether you have enough to meet changing life needs... and whether you are currently paying too much.

Use our calculator to quickly estimate your premium, get insurance plan details, and instantly download everything you need to apply — all at **trustinsurance.com**.

Watch the Q&A video *What You Need to Know About Life Insurance* at trustinsurance.com.

Term coverage at affordable premiums:

- Available to psychologists and related individuals, regardless of association membership.
- Great supplement to your existing or employer-provided coverage.
- Added protection during child-raising years.
- Includes Living Benefits, Disability Waiver of Premium, and options for Inflation Safeguard and Accidental Death and Dismemberment.

THE TRUST

www.trustinsurance.com
1-800-477-1200

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

2018 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.

October 3 & 10, 2018
PPA Webinar Series: Promote Psychology & Social Justice via News Media: It's our Ethical Duty
12:00 – 1:30 pm
Virtual Webinar

October 18-19, 2018
Erie Ethics, Suicide Prevention, and Advocacy Program
Sheraton Erie Bayfront Hotel
Erie, PA

November 15, 2018
The Trust Risk Management CE Program
Sequence VII: Legal and Ethical Risks and Risk Management in Professional Psychological Practice
The Desmond Hotel
Malvern, PA

November 16, 2018
PPA Fall Continuing Education Conference
The Desmond Hotel
Malvern, PA

March 2, 2019
ECP Day
PPA Office
Harrisburg, PA

March 8, 2019
Preventing School Shootings
Milton Hershey School
Hershey, PA

April 4-5, 2019
PPA Spring Continuing Education Conference
Holiday Inn Grantville
Grantville, PA

June 19-22, 2019
PPA2019 – PPA's Annual Convention
Sheraton Station Square
Pittsburgh, PA

Home Study CE Courses

Act 74 CE Programs

The Essentials of Managing 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

Essential Competencies When Working with Suicidal Patients—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 a full listing of our home studies, download our catalog here, or visit our online store.

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

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