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Editor's Note: Dr. Joseph Cvitkovic, a long-time advocate for psychology and PPA leader died suddenly on September 4, 2019 at the age of 70. We asked his friend, Dr. Emily Stevick, to share her reflections on this man who had been such a positive influence on the lives of many people.

In Memory of Dr. Joseph Cvitkovic: With Love and Appreciation

Emily Stevick, Ph.D.
Pittsburgh, PA

Dr. Joseph Cvitkovic died suddenly in his psychotherapy office, on September 4. Joe was retired from his job of many years as the Director of Behavioral Health at Jefferson Hospital where he oversaw inpatient and outpatient care. During his years there, he expanded outpatient care with a clinic in Caste Village. He supported women's health issues with seminars focusing on healthy living before similar educational endeavors were easily available. He also served, with care and professionalism, countless people in his private practice in Mt. Lebanon.

From the 1990's Joe was a spokesperson for psychology, serving on insurance advisory committees and visiting state and federal Representatives and Senators. He could be counted on to reach out and go the extra step to lobby and to educate. He was a strong supporter of PennPsyPac where he helped to raise money for local candidates. He also, at the request of the American Psychological Association, traveled to Washington D.C. to testify before Congress. Joe was an active member of the Colleague Assistance Committee for PPA for years, including four years as the Chair which reached out to help psychologists experiencing stresses or showing evidence of potentially harmful behaviors.

In 2002 Joe was honored with the Legacy Award, which he imagined and helped to establish from the Greater Pittsburgh Psychological Association (GPPA). Joe spoke and wrote about the award; his words tell us about who he was as he explains psychologists' need for validation and reinforcement.

Explaining that the idea arose out of the struggle in the 80's that psychology faced, Joe described the situation as being under siege as managed care companies restricted credentialing, potentially eliminating almost 60% of the practicing psychologists in western Pennsylvania. Joe was a leader in organizing GPPA, PPA, and APA to appeal to Highmark and its subsidiary Greenspring to reconsider their approach. His was a reasonable, intelligent and critical voice throughout the struggle. The result was a change in the national criteria for credentialing which transformed the practice of psychologists, especially in western Pennsylvania. He continued for years to be a respected presence on Highmark panels and committees. His voice was part of a dynamic and positive force that assured the valuable participation of psychologists in health care.

It was in this atmosphere that Joe prepared a presentation for the Cancer Survivors Annual Dinner at Jefferson Regional Medical Center. His words follow:

> I was looking for ways to impress upon the group that it is extremely important to be well connected to other people and not become isolated. As we all know, positive psychology teaches us that isolation is not such a good thing for a healing process, as it is healthier for all of us to have support and reinforcement from others.

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IN MEMORY OF DR. JOSEPH CVITKOVIC: WITH LOVE AND APPRECIATION

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> ...I chose to use film clips ...from the Wizard of Oz. This was the scene in which Toto pulls back the curtain and exposes the Wizard as an ordinary man.
>
> ...Remember that the Wizard gave a diploma to the Scarecrow to demonstrate and validate that... he was intelligent. To the Tin Man he gave a clock in the shape of a heart to demonstrate that he indeed did have feelings and a heart, and to the Lion, a badge of honor, validating his courage. And, for Dorothy, he reminded her that the ruby slippers were already in her possession and they could take her home. So, it was not simply that the Wizard reminded each of them that they already had what they wanted. Most importantly, to each, the Wizard gave a sign of validation of their inner strengths and a validation that by their actions, each had demonstrated these inner qualities in ways that made them special and valued by others who appreciated and cared about them.
>
> And so it is, ...there is a need for validation and reinforcement by others who understand our beliefs, our values and our work...I presented this idea of the importance of validation and how enjoyable it could be for all of us to establish an award ceremony to provide this validation.... And so the Legacy Award was born out of love and appreciation of all that we do. It is an appreciation of all that is good and healing in our profession, and a celebration of those who practice it with heart and soul.

There is so much about Joe in the words he wrote about others. And so we grieve, and we celebrate a good man: an excellent psychologist who cared for others with his heart and soul.

An excellent clinician, Joe was the person I referred friends to. He was a healer, warm, available, skilled and knowledgeable. His family described him as someone who could always be counted on to bring joy, laughter, and adventure to the lives of all he knew.

Joe Cvitkovic's obituary: https://www.legacy.com/obituaries/name/joseph-cvitkovic-obituary?pid=193846454

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.

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Berkley Hills–Psychology Position within a Family Medicine Practice in Johnstown, PA: Interviewing candidates for a fulltime Medical Psychology position: Experienced Licensed Psychologist embedded in a family medicine practice. Available Fall/Winter 2019. Due to Federal and reimbursement regulations, the practitioner must: a.) be PA licensed and b.) possess a doctorate in Clinical/Professional Psychology. The candidate should have experience working with a non-mental health medical team of physicians, nurses and other health practitioners. Excellent pay & benefits, including educational and professional expenditure stipend.

For hospital consultations, the clinician must be familiar with a medical model of patient care. All referrals will be from a patient's PCP or attending medical specialist. The selected candidate must be comfortable working on in-patient non-psychiatric medical floors at a local hospital and skilled nursing facility.

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An Introduction to Integrated and Primary Care Psychology

Richard Kutz, Psy.D.
Conemaugh Health System

Integrated Care is an evolution of the "medical home" concept that began in 1968 through the American Academy of Pediatrics and refers to the growing number of healthcare arrangements or settings that provide mental health services alongside traditional medical and other wellness services. The integration of psychology with medical health is happening throughout healthcare settings: rehabilitation facilities, specialty centers, such as those for cancer or diabetes, and in general practice/primary care settings. Primary Care Psychology represents a growing field of sub-specialty of Integrated Care that integrates mental health services into the primary care clinic. This article describes the practice of Primary Care Psychology and its benefits.

Practices Used by Primary Care Psychologists

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a standard framework for integrated care that identified five levels of collaboration for those practices engaged in integrated care. These levels are summarized in Table 1.

This framework establishes integrated care as grounded in collaborative sharing of patients, facilities, systems, and communication along with respect and understanding for the mutual provider roles in healthcare. Thus, in a fully integrated care clinic physicians and psychologists would work together with a mutual respect and understanding for the contribution each has toward a patient's overall health. In this full integration, psychologists and physicians work alongside one another in the same facility, treating the same population of patients, and using shared notes and systems of scheduling, registration, and infrastructure. Physicians and psychologists would collaborate on patient diagnoses, treatment plans, progress, and outcomes.

Primary Care Psychology utilizes a different model within integrated care settings. Patient referrals are generated through physicians within the integrated practice. Utilizing shared space, referrals are often made through a "warm hand-off" technique. This in-person referral process sees the medical provider invite the psychologist into the treatment setting and discuss the referral with both the psychologist and the patient. The doctor-patient relationship is extended to include the

Table One: Levels of Integration

	Level 1: Minimal Collaboration	Level 2: Basic Collaboration from a Distance	Level 3: Basic Collaboration Onsite	Level 4: Close Collaboration / Partly Integrated	Level 5: Fully Integrated
Facilities	Separate	Separate	Shared	Shared	Shared
Systems	Separate	Separate	Separate	Semi-shared	Shared
Patient Sharing	No	Yes	Yes	Yes	Yes
Communi-cation	Rare	Periodic via telephone & mail	Face-to-face	Regular face-to-face, coordinated treatment plans	Regular collabora-tion among routines, conjoined treatment
Reciprocal Influence	Little appreciation of each other's culture	Minimal understanding of each other's culture	Some appreciation of each other's role and general sense of larger biopsycho-social picture	Basic appreciation of each other's role and culture; influence sharing	In-depth appreciation of roles and culture; conscious influence sharing

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psychologist, and the "cold-call" of a referral is replaced instead with the "warm hand-off of a physical introduction." These referrals can address traditional mental health needs such as depression and anxiety and they can also address the behavioral elements present in the treatment of medical illness. Treatment plans emphasize shorter-term behavioral interventions that allow for greater availability to other referrals and collaboration among clinicians.

Primary Care Psychology is not without limitations. Longer-term treatment plans don't easily fit the primary care model. The medical environment and symbiotic relationship with physicians requires reinforcement of competency boundaries as well as additional training. In 2015 APA published Competencies for Psychology Practice in Primary Care, adding definition to the training and experiences relevant to the different settings and models of integrated care. These competencies center around six domains, (science, systems, professionalism, relationships, application, and education), and identify knowledge, skills, attitudes, and behavioral anchors relative to each domain. In addition, APA has identified directories of doctoral training programs, internship programs, and postdoctoral training programs with specific training in primary care psychology.

The Benefits of Integrated and Primary Care Psychology

The lack of mental health services available to patients has been an ongoing concern. Integrated care presents an opportunity to address these gaps in service availability as it is shown to increase service proximity and provider continuity (Davis et al., 2018). In addition to increased access, integrated care provides health benefits at both primary (prevention) and secondary (treatment) levels. At a primary level, prevention can be advanced through appropriate screening that extends throughout current primary care practices. Secondary level outcomes in treatment can be seen through acute treatments provided directly in the primary care setting. Brief interventions in the primary care setting have been shown to increase access to care and reduce symptoms (Lines, 2019). Further, the inclusion of a psychologist as an interdisciplinary team member through integrated care is related to better outcomes for both mental and physical health. These outcomes show that not only is collaborative care more effective than usual care through improved clinical outcomes, they also show improved patient employment rates, functioning, and quality of life (Unützer et al., 2006).

Cost savings are another benefit associated with integrated care. At a micro-level, individual clinic studies reveal savings in healthcare costs (Ross et al., 2018). At a macro-level, the Milliman Report commissioned by the American Psychiatric Association concluded that $38-$68 billion could be saved annually in healthcare costs through effective integration of behavioral and medical health (Melek et al., 2018).

The Future of Integrated and Primary Care Psychology

Despite the recognition of the skill and service psychology brings to healthcare, work remains to reach levels of integration that represent optimal outcomes. Integration can be confounded through business regulations as well as reimbursement complications. Psychological services billed with Health & Behavior CPT codes are not uniformly reimbursed by CMS or commercial insurance companies. When reimbursed, they can be paid at a lower rate than those of comparable mental health services. Even empirical behavior treatments like those for obesity and insomnia can be denied (LeBlanc et al., 2011).

In September 2018, APA issued a resolution on psychologists in integrated primary care and specialty health care settings. Recognizing the roles and contributions psychology can make to health care, the positive outcomes these contributions can yield, and the challenges that remain through the reimbursement process, APA specified support for a wide range of actions to promote psychologists in integrated care. These actions included the ongoing development of psychology as a professional identity within healthcare, the development of better tools within the healthcare marketplace to better include psychological services, and legislative / legal advocacy to promote adaptive reimbursement and practice guidelines.

The Pennsylvania Psychological Association provides resources regarding integrated care including conference presentations, continuing education opportunities, and information on legal requirements. The Integrated Care Committee meets monthly to discuss and promote integrated care. Interested members can contact committee chair Dr. Julie Radico, ABPP, at juliera@pcom.edu

References

American Psychological Association. (2015). *Competencies for psychology practice in primary care*. Retrieved from http://www.apa.org/ed/resources/competencies-practice.pdf

American Psychological Association. (2018). *Resolution on psychologists in integrated primary care and specialty health care settings*. Retrieved from: https://www.apaservices.org/about/resolution-integrated-care.pdf

Davis, M.M., Gunn, R., Gown, L.K., Miller, B.F., Green, L.A, & Cohen, D.J. (2018). A qualitative study of patient experiences of care in integrated behavioral health and primary care settings: more similar than different. *Translational Behavioral Medicine, 8*(5). 649-659.

LeBlanc, E., O'Connor, E., Whitlock, E.P., Patnode, C., & Kapka, T. (2011). *Screening for and management of obesity and overweight in adults*. US Agency for Healthcare Research and Quality. (USPSTF Report No. 11-05159-EF-1).

Lines, M.M. (2019). Advancing the evidence for pediatric primary care psychology: A call to action. *Clinical Practice in Pediatric Psychology, 7*(2). 179-182.

Melek, S., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018). *Potential economic impact of integrated medical-behavioral health care: Updated projections for 2017*. Milliman Research Report. Retrieved from file:///C:/Users/Sam/Downloads/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf

Ross, K.M., Klein, B., Ferro, K., McQueeney, D.A., Gernon, R., & Miller, B.F. (2018). The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: A prospective, case-control program evaluation. *Journal of Clinical Psychology in Medical Settings, 26,* 59-67.

SAMHSA. (2013). *Standard framework for levels of integrated care*. Retrieved from https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

Unützer, J., Schoenbaum, M., Druss, B.G., & Katon, W.J. (2006). Transforming mental health care at the interface with general medicine: Report for the president's commission. *Psychiatric Services, 57*(1). 37-47.

What Every Psychologist Should Know about Chronic Pain

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Chronic pain, commonly defined as any pain that lasts 3 months or more or beyond the expected time of healing, afflicts about 50 million Americans including about 20 million with "high impact" pain that substantially limits their activities of daily living. The most common types of pain are headache, lower back, cancer, and arthritic pain which includes osteoarthritis (wear and tear around the joints) and rheumatoid arthritis (when the soft tissues around the joints begin to thicken).

Historically physicians assumed a direct connection between the objective indices of bodily damage and the intensity of the pain. Pain was either physiological or psychological. If they could not identify an objective cause of the pain, then they assumed that the pain was psychogenic, and attributed it to the patient's psychological disturbance or malingering. When pain was physiological, it was assumed that the pain increased in proportion to the physical damage to the patient.

That linear model has been replaced by the biopsychosocial model of pain, which considers pain to involve an "interaction among physiological, psychological, and social factors that reciprocally influence one another" (Meints & Edwards, 2018, p. 168). Certain psychological conditions, such as pre-existing anxiety or depression, can increase the risk of chronic pain, and the pain itself can cause anger, hopelessness, and insomnia among persons who had otherwise had good psychological functioning (Meints & Edwards, 2018).

Some patients have chronic pain for which a medical cause cannot be found (called *idiopathic* pain). These patients may feel especially stigmatized and blamed for their own suffering. Other patients have *iatrogenic pain* caused by poor prescribing practices. For example, headache patients may have been overprescribed medication that causes a *medication overuse* headache, or patients taking opioids may develop *hyperalgesia,* or an increased sensitivity to pain (Darnell, 2019).

Cycle of Chronic Pain

Patients with chronic pain can fall into a vicious cycle that can be analyzed on both a neurochemical and behavioral level. The neurochemical activity associated with continued states of anxiety and depression weakens the immune system explaining why certain psychological conditions increase the risk of developing chronic pain. Simultaneously, an over-active immune system, (present in many chronic pain patients) decreases the neurochemicals associated with positive affect and well-being, explaining the reciprocal influence seen through the biopsychosocial model (Schwaiger et al., 2016).

At the behavioral level, chronic pain cycle is sometimes caused when patients avoid activities that cause them pain and then engage in too much activity until pain increases, often resulting in injury. Although health care professionals may recommend an extended rest period to allow the patient to recover from the injury, some patients will increase their activity prematurely to try to return to their baseline activity level. This attempt at increased activity can lead to overdoing it, an increase in pain, and the cycle repeats. This cycle is illustrated in Figure 1. As activity decreases and restricted social contact often increases, depression and anxiety simultaneously increase and exacerbate pain experiences, and so on.

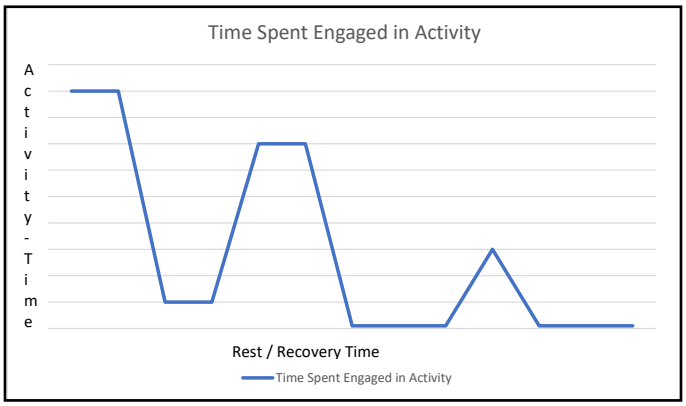

Figure 1: Chronic Pain Cycle

Treatment

Psychological factors influence how patients adhere to the medical regimen, manage their condition, and respond to the psychological sequalae of chronic pain (Darnell, 2019). Effective treatments help chronic pain patients make lifestyle changes to better manage their pain. The optimal interventions will occur in a multi-disciplinary setting that considers a variety of treatment options depending on the needs of the patients. The five categories of approaches for managing chronic pain are: medications (e.g., opioids; non-opioids); restorative movement therapies (e.g., physical and occupational therapy, massage therapy); invasive procedures (e.g., nerve blocks, steroid injections); complementary methods (e.g., yoga, tai chi); and behavioral health interventions (e.g., psychotherapy, relaxation therapies). The ideal treatment program will consider the synergy of these interventions.

Although opioids have been the frontline response to chronic pain for many years, the long turn use of opioid risks addiction and

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What Every Psychologist Should Know about Sleep and Insomnia

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According to sleep experts, adults should obtain seven to nine hours of sleep per day (CDC, 2019). An impressive and growing body of research demonstrates that sleep is necessary for the enhancement, protection and restoration of numerous cognitive and neurobiological processes and systems. Healthy sleep promotes the integrity of memory and learning, decision-making, emotional functioning, appetite regulation and metabolic functioning, neuroplasticity, DNA/RNA synthesis, and genetic, cardiovascular, immune system, and reproductive health (Walker, 2017).

Sleep is a complex process that needs to be understood within the sleep-wake cycle. Two primary and independent determinants of sleep are Process C (circadian rhythms) and Process S (adenosine) resulting in the pressure for sleep, which work in concert to facilitate sleep. Process C is a slightly more than 24-hour cycle that is heavily influenced by light and dark. Process S is primarily influenced by how long we are awake and increases the longer we are awake (Walker, 2017).

Sleep is comprised of a complex succession of movement through non-rapid eye movement (NREM) and rapid eye movement (REM) stages. Process C, Process S and the individual sleep stages are influenced by an array of biopsychosocial factors that can lead to arousal disrupting sleep. These include variables such as, but not limited to, exposure to light, temperature, physical activity, food intake, age, life stress and responsibilities, mental and physical conditions, and chemicals such as medications, alcohol, nicotine and especially caffeine (Sawyer & Weaver, 2010; Walker, 2017).

The human need for sleep changes across the lifespan according to developmental needs and neurobiological changes. Healthy total sleep times for given age groups are listed directly below (CDC, 2019):

0–3 months	14–17 hours
4–12 months	12–16 hours per 24 hours (including naps)
1–2 years	11–14 hours per 24 hours (including naps)
3–5 years	10–13 hours per 24 hours (including naps)
6–12 years	9–12 hours per 24 hours
13–18 years	8–10 hours per 24 hours
18–60 years	7 or more hours per night
61–64 years	7–9 hours
65 years and older	7–8 hours

Notwithstanding these needs, it is estimated that 1/3 of American adults get less than 7 hours of sleep per night (CDC, 2019) and sleep deprivation may adversely affect the well-being of children and teens (Chattu et al., 2019; Gerber, 2014). Inadequate sleep duration and quality is associated with "7 of the 15 leading causes of death in the U.S" (Chattu et al., 2019, p.1) and it has long been established that persons who average 7 or 8 hours of sleep a night tend to have lower all-cause mortality than those who average more than 8 hours or less than 7 hours of sleep (Grandner et al., 2010).

The Influence of Sleep on Cognitive and Emotional Functioning

Sleep has profound effects on cognitive and emotional functioning. Poor sleep quality may decrease attention, quality of working memory, cognitive flexibility, reasoning, problem solving and emotion regulation, and increase unwanted thoughts (Stickgold, 2015; Walker, 2019). REM sleep (deep sleep with dreams) appears especially important in the consolidation of memories. Both the cycles of slow waves and the bursts of brain activity called sleep spindles are involved in transferring memories from the hippocampus to the long-term memory in the prefrontal cortex. Good sleep improves the retention of declarative memories, but evidence suggests it may also have a role in episodic memories.

The quality of episodic memories may be altered if an individual lacks enough sleep. Even encoded memories can be altered by an individual's current life circumstances. "We have evolved memory systems, not so we can reminisce about the past, but so we can use prior experience to enhance our future performance" (Stickgold, 2015, p. 57). A sleep-deprived brain is more likely to remember unpleasant aspects of past events and forget the positive aspects. This process may help explain some of the link between insomnia and depression.

Treatments for Insomnia

Insomnia is among the most common of the sleep disorders included within the DSM 5's category of sleep-wake disorders, all of which are united by the common feature in which disordered sleep leads to "distress and impairment" (American Psychiatric Association, 2013). Insomnia is "difficulty maintaining or initiating sleep, resulting in daytime consequences" (Zuromski, Cero, & Witte, 2017, p. 740). It can involve difficulties in getting asleep and staying asleep, or early waking, and feeling dissatisfaction with the quality of sleep and resulting functional impairment (Titus et al., 2018). About 30% of Americans will have some insomnia during any given year and about 10% will have chronic insomnia.

The most common explanation for insomnia is the ***hyperarousal hypothesis*** which holds that persons with insomnia experience heightened cognitive, emotional or physiological reactivity that prevents

them from having enough good quality sleep (Marques et al., 2016).

Insomnia sometimes occurs alone, but it is usually co-morbid with depression or another mental illness, chronic pain, or other health conditions. When insomnia is a symptom of depression, then one could assume that insomnia will remit when the depression is treated. This assumption is consistent with the finding that worries and rumination are both associated with depression and insomnia.[1] Treatments for depression will often reduce insomnia, although patients with residual symptoms of insomnia are more likely to relapse.

Conversely, some research suggests that the treatment of insomnia may cause symptoms of depression to remit. A meta-analysis by Gebara et al. (2018) found that the treatment of insomnia over these studies led to non-significant improvements in depression. It is possible that a subset of patients treated with insomnia may find a remission of depression due to treatment of the insomnia, but it should not be assumed that it will occur.

About 20% of Americans will take some sleep aid and others will informally medicate themselves for sleep by taking alcohol or other drugs to help them sleep. The commonly prescribed medications, benzodiazepines or antidepressants, may help patients through short-term adjustments to acute stress. In addition, prazosin can be indicated for the treatment of nightmares, such as may occur as part of PTSD (Lipinska et al., 2016). Other than that, the long-term benefits of sleep medication are uncertain.

In a head to head comparison of cognitive therapy for insomnia (CBT-I) and medications, CBT-I did better on sleep onset latency, total sleep time, and waking after first sleep onset (Fox, Nashelsky, & Jack, 2018). Consequently, the American Academy of Sleep Medicine recommends cognitive behavior therapy for insomnia (CBT-I) as the preferred first-line intervention for sleep problems. The accompanying article describes CBT-I in more detail. Evidence is also accumulating that ACT, mindfulness-based treatments, and problem-solving psychotherapies can also reduce sleep problems (Taylor & Dietch, 2018).

References

American Psychiatric Association. (2013). *The diagnostic and statistical manual.* (5th Ed.). Washington, DC: American Psychiatric Association.

Centers for Disease Control and Prevention. (2019). *Sleep and Sleep Disorders*. Retrieved from https://www.cdc.gov/sleep/index.html

Chattu, V., Manzar, M. D., Kumary, S., Burman, D., Spence, D., & Pandi-Perumal, S. (2019, March). The global problem of insufficient sleep and its serious public health implications. In *Healthcare,* 7 (1), E-1, doi:10.33901/healthcare.7010001.

Fox, S., Nashelsky, J., & Jack, M. (2018). Can CBT effectively treat adult insomnia disorder? *The Journal of Family Practice, 67,* 446-447.

Galbiata, A., Giora, E., Sarasso, S., Zucconi, M., & Ferini-Strambi, L. (2018). Repetitive thought is associated with both subjectivity and objectively recorded polysomnographic indices of disrupted sleep in insomnia disorders. *Sleep Medicine, 45,* 55-61.

Gebara, M. A. Siripong, N., DiNapoli E. A., Maree, R. D., Germain, A., Reynolds, C. F. . . ., & Karp, J. F. (2018). Effects of insomnia treatments on depression: A systematic review and meta-analysis. *Depression and Anxiety, 35,* 717-731.

Gerber, L. (2014). Sleep deprivation in children: a growing public health concern. *Nursing management, 45*(8), 22-28.

Grandner, M. A., Hale, L., Moore, M., & Patel, N. P. (2010). Mortality associated with short sleep duration: The evidence, the possible mechanisms, and the future. *Sleep Medicine Reviews, 14,* 191-203.

Lipinska, G., Baldwin, D. S., & Thomas, K. G. F. (2016). Pharmacology for sleep disturbance in PTSD. *Human Psychopharmacology: Clinical and Experimental, 31,* 156-163.

Marques D. R., Gomes, A. A., Clemente, V., Dos Santos, J. M., Caetano, G., & Castello-Branco, M. (2016). Neurobiological correlates of psychological treatments for insomnia. *European Psychologist, 21,* 195-205.

Sawyer, A. M. & Weaver, T. E. (2010). Sleep Medicine. In J. M. Suls, K. W. Davidson, & R. M. Kaplan (Eds.), *Handbook of Heath Psychology and Behavioral Medicine* (pp. 442-461). New York, NY: Guilford.

Stickgold, R. (2015 October). Sleep on it. *Scientific American*, pp. 52-47.

Taylor, D. J. & Dietch, J. R. (2018). Integration of cognitive behavioral therapy for insomnia. *Journal of Psychotherapy Integration, 28,* 269-274.

Titus, C. E., Speed, K. J., Cartwright, P. M., Drapeau, C. W., Heo, Y., & Nadorff, M. R. (2018). What role do nightmares play in suicide? A brief exploration. *Current Opinion in Psychology, 22,* 59-62.

Walker, M. (2017). *Why we sleep: Unlocking the power of sleep and dreams*. New York, NY: Simon & Schuster.

Zuromki, K. I., Cero, I., & Witte, T. K. (2017). Insomnia symptoms drive changes in suicide ideation: A latent score model of community adults over a brief interval. *Journal of Abnormal Psychology, 126,* 739-749.

1. Worry and rumination are similar in that both deal with negative emotions that cannot be controlled. They differ in that worry deals with concerns for future events and anticipated threats, whereas rumination deals with concerns for past events and the loss of self-worth (Galbiata et al., 2018).

An Introduction to the Cognitive Behavioral Treatment of Insomnia

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In 2016 the American College of Physicians recommended cognitive behavioral therapy for insomnia (CBT-I) as the first-line treatment for the disorder based on the preponderance of evidence indicating its superiority over pharmacological interventions in terms of sleep duration, sleep quality and maintenance of gains over time, and decreased adverse side effects (Qaseem, Kansagara, Forciea, Cooke, & Denberg, 2016). The effectiveness and efficacy of behavioral treatment of insomnia emerged over time—dating back to the 1970s—as divergent if theoretically-related lines of sleep medicine research were disseminated (Sawyer & Weaver, 2010). Later, the addition of cognitive therapy interventions targeting thought patterns incongruent with sleep onset and maintenance augmented the behavioral paradigm further improving treatment results. The program developed by Perlis, Jungquist, Smith and Posner as summarized in their *Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide* (2006) is generally regarded as the gold standard of CBT-I. This article summarizes this model's sequence, individual components and systematic integration of said components. A brief case example of treating insomnia using a CBT-I approach follows.

CBT-I is a time-limited therapy consisting of eight weekly sessions. The first session is the intake session at which time the clinician formulates diagnostic impressions, determines if CBT-I is appropriate based on presenting problems and sleep pattern while also taking into account contraindications (including, but not limited to, medical illness, psychiatric illness including addiction, effects of medication and life/situational factors) that would rule out this treatment. A detailed clinical history, self-report measures (e.g., Pittsburgh Sleep Scale or the Epworth Sleepiness Scale) and possibly polysomnography and actigraphy data may be utilized. Session two orients the patients to CBT-I components and introduces them to a sleep diary that will be used to track actual sleep time. Sessions three to eight consist of the ongoing review of the sleep diary, the patient's impressions of progress and continued concerns, and application and revision of the component interventions to be discussed below.

CBT-I integrates and includes three primary components—Stimulus Control Therapy (SCT), Sleep Restriction Therapy (SRT), and Sleep Hygiene Education—and two secondary components—Cognitive Therapy and Relaxation Training—that are not always needed (Perlis et al., 2006). Additionally, these authors indicate three possibly effective adjunctive therapies that will be briefly discussed.

SCT was first detailed in 1972 by Bootzin and follows these basic principles (Sawyer & Weaver, 2010):

1. Only go to bed when tired and at the scheduled time.
2. The bed is only used for sleep and intimacy.
3. If one does not fall asleep within 20 minutes or one wakes up and does not fall back to sleep within this time limit, get up and do something non-stimulatory. Return to bed only when tired. Repeat as necessary.
4. Wake up at the same time every day.
5. No naps.

SRT restricts the time allowed in bed and promotes sleepiness and good sleep. It facilitates sleep by decreasing the "mismatch" between time in bed (TIB) and total sleep time (TST) by decreasing anxiety about not sleeping and—via classical conditioning—promotes greater association of the bed with sleep versus non-sleep. Sleep hygiene is a psycho-educational component that includes how other lifestyle factors may impede or improve sleep. Perlis et al. (2006) include a valuable worksheet on sleep hygiene (the authors also provide many other valuable handouts). Some basic sleep hygiene tips include but are not limited to:

1. Remove electronic devices from your bedroom.
2. Regular exercise promotes sleep but don't exercise within three hours of sleep.
3. Reduce caffeine intake and don't drink caffeine after dinner.
4. Do not drink alcohol before bed as it may lead to late-night waking.
5. Don't eat a meal before bed or drink excess liquids, which may lead to waking.
6. Ensure your bedroom is quiet, comfortable (not too hot or cold) and dark.
7. Don't bring your problems to bed as worrying will activate you, not relax you.
8. Turn the clock away from you to avoid getting frustrated about your sleep.

The cognitive therapy component of CBT-I focuses on negative thoughts and beliefs including faulty expectations that are associated with sleep disruption. These interventions are not always necessary and tend to occur in sessions three to eight to assist the patient with understanding how their thinking is interfering with sleep and the implementation of the behavioral interventions. Perlis et al. (2006) offer many typical "dialogues" to assist the clinician with common roadblocks encountered in the behavioral interventions for insomnia.

Relaxation training is the fifth component utilized in CBT-I and assists the patient with identifying and managing hyper-arousal that interferes with the aforementioned behavioral interventions to facilitate improved sleep duration and quality. Standard interventions such as progressive muscle relaxation, diaphragmatic breathing, autogenic training and imagery work are briefly discussed. The clinician is advised to select the intervention most relevant to the issue and easiest for the patient to learn and effectively use.

Finally, the authors note three possible therapies to be used to address

particular issues. Phototherapy or light therapy can be used in a behavioral way to take into account circadian rhythm and schedule or situational factors. Sleep compression is distinct from Sleep Restriction Therapy but can be considered a form of "SRT-light" in that it more gradually establishes congruence between TIB and TST by incrementally adjusting bed or wake times. Lastly, the authors also mention the alternative and experimental use of neurofeedback as showing some promise.

Case Example of CBT-I

The following de-identified case example may be considered as a case of moderate complexity with positive results (8 hours of sleep per night regularly over time within 8 sessions). Aaron was a 31-year-old married male, professionally employed who came to treatment for insomnia following a referral from his primary care physician. At intake, he discussed recurrent problems with disrupted sleep over the past two years that had worsened over time. He reported often sleeping well but that increased worry regarding work or life stressors would lead to problems with sleep onset. Aaron noted that having a bad night of sleep resulted in undue worry that this would continue and that subsequently his sleep would be disrupted for four or five nights. This would lead to serious fatigue and negatively impact his work and ability to perform household chores and responsibilities. He acknowledged that he would wake up after several hours and "watch the clock" becoming increasingly frustrated and worrying about how this would negatively impact his next day.

A pleasant and bright man, Aaron had some insight into how over time he had begun to fear not being able to go to sleep, how this resulted in hyperarousal, checking his clock and growing increasingly frustrated, attempting to force himself to go to sleep which only perpetuated a cycle of hyperarousal, frustration and counterproductive attempts to force himself to sleep.

Following the protocol of Perlis et al. (2006), at session two, SCT, SRT, sleep hygiene education and information on the sleep diary and instructions on how to use it were discussed. Aaron was advised to only go to bed when tired, not to bring his problems to bed with him and get out of bed and engage in a boring activity (reading the dictionary) until he was tired and then to return to bed, getting up again and repeating this if he was not able to fall asleep.

At session three, Aaron discussed having great difficulty "shutting of his mind" and a diaphragmatic breathing exercise that also includes an attention-diversion component was introduced and practiced. At session four, Aaron discussed sleeping 7-8 hours per night but that he had been worrying about his upcoming visit to his parents and that he would sleep poorly in their guest room, which would lead to several nights of poor sleep. At this time, cognitive therapy interventions were introduced. We reviewed his progress at home and discussed how cognitive distortions such as "should statements, "all or nothing thinking," "overgeneralization," and "catastrophizing" were involved in his unhelpful appraisals. Specifically, we examined his belief that he should be able to sleep at his parents as well as he does at his home. We also examined how having some sleep difficulty the first night was magnified by his all or nothing thinking, overgeneralization and catastrophizing that led to increased hyperarousal and ruminative worry that adversely impacts sleep onset, duration and quality.

At session five, Aaron reported having a relatively poor night sleep (6 hours) at his parents' home the first night but then was able to use his new understanding about sleep and the tools he had been practicing to get 7.5-8 hours night sleep the two following nights before returning home. At session six, Aaron discussed consistently good sleep (7.5-8 hours of TST) at home but that he had some worry about going away in two weeks and sleeping in a hotel. At session 7, he reported having good sleep (7.5-8 hours of TST) but being apprehensive about sleeping in the hotel the coming weekend. We reviewed his progress and discussed his sleep pattern since beginning treatment as a behavioral experiment that demonstrated excellent progress. At session eight, Aaron reported going to bed later the first night at the hotel and distracting himself doing Sudoko puzzles before going to bed and then sleeping soundly. He reported going to bed at his usual time the second night and sleeping soundly. We scheduled a follow-up session in one month and he was positively discharged at this time.

CBT-I is an evidence-based intervention for insomnia that can assist our patients with their sleep disturbance without the adverse side effects of medications. Interested readers are urged to consult the primary sources to better familiarize themselves with the theory, practice and research base that supports its use.

References

Perlis, M.L., Jungquist, C., Smith, M.T., & Posner, D. (2006). *Cognitive Behavioral Treatment of Insomnia: A Session-by Session Guide.* New York, NY: Springer.

Qaseem, A., Kansagara, D., Forciea, M. A., Cooke, M., & Denberg, T. D. (2016). Management of chronic insomnia disorder in adults: a clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine, 165*(2), 125-133.

Sawyer, A.M., & Weaver, T.E. (2010). Sleep Medicine. In J.M. Suls, K.W. Davidson, & R. M. Kaplan (Eds.), *Handbook of Heath Psychology and Behavioral Medicine* (pp. 442-461). New York, NY: Guilford.

Suicide and Insomnia

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs

Insomnia, or "difficulty maintaining or initiating sleep, resulting in daytime consequences" (Zuromski, Cero, & Witte, 2017, p. 740) is a separate disorder within the DSM-5, but it is also a transdiagnostic symptom of many psychiatric disorders, especially PTSD and depression. It is also identified as a manifestation of the over arousal that occurs with the immediate risk of suicidal behavior (Galynker, 2018; Rogers et al., 2017). Nightmares contribute to suicide risk, even after adjusting for other psychiatric disorders such as anxiety, depression, PTSD, or substance misuse (Titus et al., 2018). Nightmares appear to be more closely linked to suicidal behavior than insomnia alone.

Because insomnia often occurs as a symptom of other disorders, it is unclear how much of the suicidal behavior is driven by the co-morbid disorder and how much is driven by insomnia alone. Nonetheless, Zuromski et al. (2017) claimed that insomnia predicts suicidal behavior, not the other way around. People who have insomnia at one point in time are at a higher risk to develop suicidal thoughts at a later point in time. It is less likely that a person will have suicidal thoughts and then develop insomnia later.

The reasons for the relationship between insomnia and suicide are unclear. Perhaps it is an artifact of the well-established link between insomnia and loneliness, although the loneliness may be a symptom of clinical depression (Hom et al., 2017). According to the interpersonal theory of suicide, suicide is usually accompanied by a perception that one is a burden on others (perceived burdensomeness) or that one is unwanted by a valued social group (thwarted belongingness), both are beliefs could occur with loneliness (Chu et al., 2019).

Another possibility is that insomnia is linked to poor decision making and a diminished ability to control one's emotion. This explanation would be consistent with experimental findings that sleep deprived research participants tend to do poorly on a wide range of cognitive tasks including making decisions or thinking through risks (Perlis et al., 2016). Perhaps this decline in reasoning leads to poor interpersonal decisions causing to or exacerbating interpersonal stressors and loneliness. Or perhaps the sleep loss reduces their ability to regulate their emotions and refrain from impulsive decisions.

The clinical implications are that: (1) psychologists should assess for insomnia and nightmares when working with any patient because insomnia can predict many future problematic behaviors including suicide and (2) psychologists should target insomnia and nightmares when working with suicidal patients. One of the first questions to ask about insomnia is total sleep time ("How many hours do you sleep in the average night?"), followed up with more specific questions about quality of sleep, feeling fatigued during the day, and nightmares or bad dreams.

Effective treatments include cognitive behavior therapy for insomnia and imaginal rehearsal therapy and prazosin for nightmares. Cognitive therapy can decrease suicidal behaviors as well as insomnia, cognitive rigidity, and hopelessness (Roberge et al., 2019). Changes in sleep patterns preceded reductions of suicidal beliefs. Improvements in cognitive flexibility might account for these findings.

References

Chu, C., Hom, M. A., Hirsch, J. K., & Joiner, T. E. (2018). Thwarted belonginess and perceived burdensomeness explain the relationship between sleep problems and suicide risk among adults identifying as sexual and/or gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 6,* 22-33.

Galynker, I. (2018). *The Suicidal Crisis.* New York, NY: Oxford University Press.

Hom, M. A., Hames, J. L., Bodell, L. P., Buchman-Schmitt, J. M., Chu, C., . . . Joiner, T. E. (2017). Investigating insomnia as a cross-sectional and longitudinal predictor of loneliness: Findings from six samples. *Psychiatry Research, 253,* 116-128.

Perlis, M. L., Grander, M. A., Chakravorty, S., Bernert, R. A., Brown, G. K., & Thase, M. E. (2016). Suicide and sleep: Is it a bad thing to be awake when reason sleeps? *Sleep Medicine Reviews, 29,* 101-107.

Roberge, E. M., Bryan, C. J., Peterson, A., & Rudd, M. D. (2019). Variables associated with reductions in insomnia severity among acutely suicidal patients receiving brief cognitive behavioral therapy for suicide prevention. *Journal of Affective Disorders, 252,* 230-236.

Rogers, M. L., Chiurliza, B., Hagan, C. R., Tzoneva, M., Hames, J. L., Michaels, M. S., Hitchfield, M. J., . . . Joiner, T. E. (2017). Acute suicidal affective disturbance: Factorial structure and initial validation across psychiatric outpatient and inpatient samples. *Journal of Affective Disorders, 211,* 1-11.

Titus, C. E., Speed, J. J., Cartwright, P. M., Drapeau, C. W., Heo, Y., & Nadorff, M. H. (2018). What role do nightmares play in suicide? A brief exploration. *Current Opinion in Psychology, 22,* 59-62.

Zuromski, K. L., Cero, I., & Witte, T. K. (2017). Insomnia symptoms drive changes to suicide ideation: A Latent difference score model of community adults over a brief interval. *Journal of Abnormal Psychology, 126,* 739-749.

WHAT EVERY PSYCHOLOGIST SHOULD KNOW ABOUT CHRONIC PAIN

Continued from page 5

related problems.[1] Drug overdoses have increased substantially within the United States, primarily as a result of the overuse of opioid or its derivatives. Furthermore, opioids are seldom effective for managing long-term pain. Since awareness of the problems associated with opioid prescriptions have become known, the number of opioid prescriptions has decreased by nearly one-third between 2010 and 2017.

Non-opioid options include acetaminophen, a non-aspirin pain reliever, for mild to moderate pain. Other pain relievers are non-steroid anti-inflammatory drugs (NSAIDS) such as ibuprofen, naproxen, and aspirin. In addition, anti-depressants, muscle relaxers, buspirone and hydroxyzine may help some patients as well. Medical marijuana is sometimes prescribed for chronic pain, although more evidence is needed before it could be considered a front-line treatment, and marijuana combined with opioids presents medical risks (Yanes et al., 2019).

Other interventions, such as acupuncture, massage therapy, physical therapy, yoga, or tai chi among others, can help many patients. Some of these interventions, such as yoga, have not been subject to long-term or rigorous evaluation. Nonetheless, the available data suggests that they are safe, cost-effective and often helpful.

Effective behavioral treatments for chronic pain patients include cognitive behavior therapy, acceptance and commitment therapy (ACT), mindfulness-based stress reduction, biofeedback and relaxation therapy. A person need not have a diagnosable mental illness to benefit from behavioral interventions. Even negative affect at a subclinical level can influence the perception of pain (Edwards et al., 2016).

The active ingredients of these interventions often include instruction about the link between emotions and pain, methods of self-distraction, reduction of unpleasant emotions that can exacerbate the sensation of pain, and activity pacing. Treatments might not always help patients control or reduce the pain, but often they help patients to develop more productive responses to pain (Edwards et al., 2016). Good treatments often address catastrophizing which involves magnifying the pain sensation, ruminating about the pain, and helplessness. Patients may say things such as "this is the worst pain I ever felt" (magnifying), "I can't stop thinking about it" (ruminating), or "I can do nothing to stop this pain" (helplessness).

Hybrid approaches address quality of life issues as well as the management of the pain (Tang, 2018). This could, for example, assist patients with insomnia, one of the common sequalae of chronic pain, or address strained interpersonal relationships or depression caused by or exacerbated by the lack of mobility.

Patients face many obstacles when they try to access state of the art care in pain management. Many physicians receive little education in pain management, and it is often difficult to find qualified persons, including qualified psychologists, who can deliver non-medical pain interventions.

References

Darnell, B. D. (2019). *Psychological treatments for patients with chronic pain*. Washington, DC: American Psychological Association.

Edwards, R. R., Dworkin, R. H., Sullivan, M. D., Turk, D. C., & Wasan, A. D. (2016). The role of psychosocial factors in the development and maintenance of chronic pain. *The Journal of Pain, 17*, T70-T-92.

Meints, S. M., & Edwards, R. R. (2018). Evaluating psychosocial contributions to chronic pain outcomes. *Progress in Neuropsychopharmacology & Biological Psychiatry, 87*, 168-182.

Pace, B. (2000). Managing pain. *Journal of the American Medical Association,* 283, p. 1778.

Tang, N. K. Y. (2018). Cognitive behavioral therapy in pain and psychological disorders: Toward a hybrid future. *Progress in Neuro-psychopharmacology & Biological Psychiatry, 87*, 281-289.

Schwaiger, M., Grinberg, M., Moser, D., Zang, J. C., Heinrichs, M., Hengstler, J. G. . . , & Kumsta, R. (2016). Altered stress-induced regulation of genes in monocytes in adults with a history of childhood adversity. *Neuropsychopharmacology, 41*(10), 2530-2540.

Yanes, J., McKinnell, Z. E., Reid, M. A., Busler, J. N., Michel, J. Pengelianan, M. M. . . , & Robinson, J. L. (2019). Effects of cannabinoid administration for pain: A meta-analysis and meta-regression. *Experimental and Clinical Psychopharmacology, 27, 370-382*.

1. In preparing this article, we ran across a "Patient Page" from the *Journal of the American Medical Association* in 2000 which stated that "even though the use of these painkillers [opioids] has increased, the rate of abuse of these prescription drugs is surprisingly low" (Pace, 2000, p. 1778).

Psychology Licenses Expire at the End of November 2019!

All the licenses of Pennsylvania psychologists will expire on November 30, 2019. Licensed psychologists will receive an EMAIL notice from the State Board of Psychology instructing them on how to renew their licenses. Renewal notices are only being mailed to those licensees for whom the Board does NOT have an email address on file. Psychologists who have not received their notices by October 15, 2019 should contact the State Board of Psychology (ST-PSYCHOLOGY@pa.gov) and inquire about the status of their licensure renewal. At the time of licensure renewal, psychologists will be required to attest that they have fulfilled their continuing education mandates. **All 2019 license renewals must be completed online.**

Continuing Education Requirements for Licensure Renewal

Licensed psychologists in Pennsylvania who wish to renew their licenses must complete a minimum of 30 contact hours of continuing education between December 1, 2017 and November 30, 2019. Psychologists may carry up to 10 contact hours in excess of the 30 required from one renewal period to the next; however, psychologists may not carry over continuing education hours in ethics, suicide, or child abuse training.

The State Board of Psychology will accept a continuing education course if it is (1) a course from an accredited college or university corresponding to the scope of practice of psychology and generates semester or quarter hour credit; (2) given by an APA approved CE provider; (3) given by a sponsor approved by the American Medical Association and the course is related to the practice of psychology and has learning objectives and assesses the extent to which those learning objectives are met; or (4) given by a provider specifically recognized by the Pennsylvania State Board of Psychology as a CE provider for Pennsylvania psychologists.

Up to 15 of the required contact hours may be in home study programs offered by an approved sponsor. A continuing education program offered via the internet (Webinars) "will be considered home studies unless the participants are able to interact with the instructor in real time" (State Board of Psychology, 2016a).

Up to 15 hours can be acquired by teaching an approved workshop or college course. However, an individualized course may be credited to an instructor only once every 4 years. One clock hour of instruction equals one contact hour of CE. If the course has multiple instructors, the Board will determine the hours of continuing education granted to a psychologist/instructor by dividing the number of continuing education hours by the number of instructors. For example, a psychologist with two co-presenters who presents a three-hour workshop through an APA approved provider would receive one contact hour of CE.

Up to 10 hours may be obtained by writing an article in a journal abstracted in PSYCHLIT, or a book chapter or a book published by a commercial publisher or by a psychological association. The hours of continuing education granted to a psychologist/writer will be determined by dividing 10 by the number of co-authors. For example, a psychologist with one co-author who wrote an article published in a peer review journal abstracted in PSYCHLIT would receive credit for 5 hours of continuing education. For more information about CE requirements in Pennsylvania, visit: http://www.papsy.org/index.php/ce/ce-licensure-requirements.html.

Continuing Education Mandates

The State Board of Psychology has three mandates in continuing education for licensing renewal.[1] First, all psychologists must take at least three hours of ethics every renewal period. This can be either in the form of a home study, a course taught, an approved publication, or attendance at a live program. PPA offers home studies on ethics which can be found on the PPA website and ethics programs will be offered at PPA's fall conference.

Second, per Act 74 of 2016, all licensed psychologists must complete at least one hour of continuing education in the assessment, treatment, or management of suicide. The Pennsylvania State Board of Psychology will accept any CE program that otherwise meets the criteria for licensing renewal if "the word 'suicide' or a derivative of the word 'suicide' is contained in the title." If the word "suicide' or a derivative of the word "suicide" does not appear in the title, "the approved provider of the course program must indicate on the certificate of attendance/completion of number of hours of suicide prevention continuing education earned." This continuing education requirement may not be used to fulfill the ethics requirement (State Board of Psychology, 2016b). PPA offers home studies on suicide prevention that can be found on the PPA website. The State Board of Psychology does not require any special paperwork for licensees who fulfill the ethics or suicide continuing education requirement. Instead, their compliance will be monitored through the random audit to which all licensed psychologists are subject (see section on auditing of CE programs below).

1. A fourth mandate applies only to those psychologists who are primary supervisors of post-doctoral trainees (psychology residents). This mandate does not apply to any other psychologists or any other supervisor. Psychologists who supervise psychology residents (post-doctoral trainees) must either have had a course in supervision in their doctoral programs or have taken or taught a three-hour continuing education course in supervision.

Third, all health care professionals licensed in Pennsylvania must take a two-hour course in child abuse recognition and reporting which has been approved by the Pennsylvania Department of Human Services and the Pennsylvania Department of State. The Pennsylvania Psychological Association offers that home study which can be found on its website. In addition, the course will be offered at PPA's Fall Conference. The State Board of Psychology may not renew a license unless the provider offering continuing education in fulfillment of Act 31 requirements has submitted documentation to the Department of State (the oversight body for the licensing boards in Pennsylvania) that the psychologist has completed the coursework.

Audits

In 2020 the State Board of Psychology will conduct a random audit of licensed psychologists. Psychologists who are audited must forward copies of their transcripts as documentation for attending and completing the required contact hours for the renewal period in question. According to the regulations of the State Board of Psychology psychologists should "retain for at least two bienniums, certificates, transcripts or other documentation showing completion of the prescribed number of contact hours" (49 Pa Code §41.59 (c)). Psychologists who carry over hours from one renewal period to the next need to ensure that they keep all the continuing education documentation needed to justify their decision to carry over credits.

Psychologists should be sure that they meet the continuing education requirements in all the states where they are licensed. Several psychologists have been disciplined because they did not realize that courses that met the CE requirements in one state did not necessarily meet the requirements in another state.

References

State Board of Psychology. (2016a). "Is a webinar considered home study?" Retrieved from http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Documents/Special%20Notices/PsychSN%20-%20Webinar.pdf

State Board of Psychology. (2016b). Suicide Prevention Continuing Education. Retrieved from http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Documents/Special%20Notices/PsychSN%20-%20Suicide%20Prevention%20Continuing%20Education.pdf

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Fall Continuing Education Conference

November 7-8, 2019

DoubleTree Valley Forge - King of Prussia, PA

CONFERENCE SCHEDULE

Click here to register NOW!

Course descriptions are available online

THURSDAY, NOVEMBER 7

8:00 - 11:00 a.m.

W01 - Advanced Risk Management: An Ethically Informed Approach
Samuel Knapp, EdD, ABPP
3 CE Ethics Credits - Advanced

W02 - An Affect-Based Approach to Understanding Anger
Brett Schur, PhD
3 CE Credits - Introductory

11:15 a.m. - 1:15 p.m. - Lunch

W03 -Act 31 Child Abuse Recognition and Reporting
Rachael Baturin, MPH, JD
2 CE Credits - Introductory

1:30 - 4:30 p.m.

W04 - My Suicidal Patient Isn't Going to The Hospital – What Do I Do Next?
Samuel Knapp, EdD, ABPP, Brett Shur, PhD
3 CE Ethics Credits - Intermediate (Act 74)

W05 - Traumatized Patients/Traumatized Psychologists: Can Positive Psychology Help with Current Events?
Karyn Scher, PhD
3 CE Credits - Intermediate

CONTINUING EDUCATION CREDITS

The Fall 2019 Continuing Education Conference is sponsored by the Pennsylvania Psychological Association and will provide up to 15 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.

PPA's Act 31 program is approved by the Department of Human Services (formerly the Department of Public Welfare) and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement. PA CE Provider Number: CACE000007

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

REGISTRATION RATES

(Per workshop)	Until October 15	After October 15
PPA Members	$80.00	$95.00
Non-members	$130.00	$145.00
Student Members	$20.00	$35.00
Non-member Students	$45.00	$60.00
Thursday Lunch (2 CE)	$75.00	$75.00
Friday Lunch (1 CE)	$50.00	$50.00

FRIDAY, NOVEMBER 8

8:30 - 11:30 a.m.

W07 - Understanding the APA Ethics Code-Intermediate
Molly Cowan, PsyD; Linda Knauss, PhD; Randy Fingerhut, PhD
3 CE Ethics Credits - Intermediate

W08 - Developing an Ethical Lens: Transforming Ethical Desire into Ethical Action
Samuel Knapp, EdD, ABPP; Jeff Sternlieb, PhD
3 Ethics CE Credits - Intermediate

9:30 - 11:30 a.m.

W09 - Psychologist Prescriptive Authority - the Latest on Legislation, Practice and Training
Tracy E. Ransom, Psy.D., BCB, MSCP; Jennifer M. Collins, Psy.D.
2 CE Credits - Introductory

12:00 - 1:00 p.m. - Lunch

W10 - Working with Suicidal Patients: The Therapist Experience
Samuel Knapp, EdD, ABPP, Brett Schur, PhD
1 CE Credit - Intermediate (Act 74)

1:30 - 4:30 p.m.

W11 - Understanding the APA Ethics Code-Advanced
Molly Cowan, PsyD; Sam Knapp, EdD; Linda Knauss, PhD; Randy Fingerhut, PhD
3 Ethics CE Credits - Advanced

W12 - Exploring Blind Spots in Doctor-Patient Relationships: Balint Group Process
Jeff Sternlieb, PhD
3 CE Credits - Intermediate

W13 - Addressing the Psychological Treatment Needs of Seniors
Anna Zacharcenko, Psy.D.; Rise Kass, PhD; Christopher Catalfamo, MA
3 CE Credits - Introductory

LOCATION AND LODGING

The 2019 Fall Conference will be held at the DoubleTree Valley Forge: 301 W Dekalb Pike, King of Prussia, PA 19406. PPA has a block of rooms reserved at the discounted rate of $124/night plus tax. If you are interested in reserving a room for the Fall Conference please contact the hotel at (610) 337-0200 before October 15, 2019.

What you need to know about license renewal

Psychologists in Pennsylvania must earn 30 CE credits per biennium. Biennia run from odd year to odd year. For example, December 1, 2017 – **November 30, 2019**

Credits for psychologists must come from:

- An APA approved provider/course
- An AMA approved provider/course
- A provider approved by the State Board of Psychology
- An accredited college or university with semester hours, related to the practice of psychology

Webinars: Live vs. Home Study

Live, interactive webinars happen in real time, when the speaker is able to interact with the attendees.

A webinar is considered *live* when "Instructors and participants can see, interact, and discuss information in real time" - If all three of these do not occur, then a webinar is considered to be a home study.

Pennsylvania Psychology License Renewal Checklist

30 credits required

- No more than 15 credits can be from distant learning workshops
- 3 Ethics - The word "ethics" must be part of the title, or the certificate must state that the credits apply for ethics credits
- 2 credits for Child Abuse Recognition and Reporting - Act 31
- 1 credit for Suicide Prevention

Call 717-232-3817 to request a PPA Home Study Catalog today!

For more information check out our Continuing Education Fact Sheet at *www.papsy.org*

CE Questions for This Issue

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

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:

Continuing Education Programs
Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112

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 three to six 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 October 31, 2021.

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.

Kutz

1. Outcomes for integrated and primary care psychology tend to show
   a. Reductions in health care costs
   b. Better physical and mental health
   c. Increased access to behavioral health services
   d. All the above

Knapp & Kutz

2. According to the biopsychosocial model, pain is
   a. Increased in proportion to the physical damage to a patient
   b. Caused by an interaction of biological, psychological, and social factors
   c. Primarily psychogenic
   d. All the above

3. Hyperalgesia is an example of
   a. Psychogenic pain
   b. Idiographic pain
   c. Idiopathic pain
   d. Iatrogenic pain

4. Effective behavioral treatments for pain include all the following EXCEPT
   a. ACT
   b. Mindfulness based medication
   c. Cognitive therapy
   d. Exposure therapy

Knapp & Healey

5. According to Process C, sleep is influenced by
   a. Circadian rhythms
   b. The amount of adenosine in the blood
   c. Exposure to light, sound, and especially caffeine
   d. All the above

6. The transfer of memory from the Hippocampus to long term memory occurs when there are
   a. Bursts of brain activity known as sleep spindles
   b. Traces of adenosine in the brain
   c. Process S activities taking place
   d. Reductions in delta waves

7. According to the hyperarousal hypothesis
   a. Nightmares always precede insomnia
   b. Circadian rhythms interfere with sleep
   c. Heightened cognitive, emotional, or physiological reactivity can interfere with sleep
   d. Sleep spindles interrupt the REM cycle

Healey

8. Going to bed at the same time every night is an example of
   a. SCT (Stimulus Control Therapy)
   b. SRT (Sleep Restriction Therapy)
   c. Relaxation
   d. None of the above

9. Reducing caffeine intake during the day is an example of
   a. SCT (Stimulus Control Therapy)
   b. SRT (Sleep Restriction Therapy)
   c. Sleep Hygiene
   d. None of the above

10. Challenging negative thoughts and relaxation treatment are always essential elements in any CBT-I treatment program
    True
    False

Knapp

11. Suicide may be linked to insomnia because
    a. Sleep loss may reduce a person's ability to regulate their emotions and refrain from impulsive decisions
    b. Sleep deprived persons tend to do poorly on thinking through decisions
    c. Both insomnia and depression are associated with loneliness
    d. All the above
12. The author claims that psychologists should routinely screen patients for insomnia or frequent nightmares.
    True
    False

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, October 2019**

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

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

Satisfaction Rating

Overall, I found this issue of the Pennsylvania Psychologist:

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Please print clearly.

Name _____

Address _____

City _____ State _____ Zip _____ Phone ( ) _____

Signature _____ Date _____

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

Now available online, too! Purchase the quiz by visiting our online store at papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

PSYCHOLOGY LICENSE RENEWAL IN PENNSYLVANIA

QUICK TIPS ABOUT THE PROCESS FROM YOUR FRIENDS AT PPA

Renewal notices from the ***State Board of Psychology*** have been sent out to licensees via EMAIL for 2019. This email will include the link to renew your license, your user ID, and your personal Registration Code. The text of the notice is included below.

Dear Licensee,

Your renewal is available and can be processed at ***www.pals.pa.gov***. Please follow the instructions below to renew your license.

Instructions to renew your license - PS000000

- Renew your license at ***www.pals.pa.gov***
- Login using the same user ID below
  - Your User ID: xxxxxxxxx
    - Please note: For security reasons we cannot send your password in this email. If you do not remember your password, visit ***www.pals.pa.gov/recover*** to recover your password.
- If you hold more than one license (including facility ownership), use your registration code and the "Link License" functionality located in the "Professional Details" banner on your PALS dashboard to combine all of your licenses with the Bureau of Professional and Occupational Affairs into one login.
  - Your Registration Code is: xxxxxxx
- To renew your license, click the "Renewal" toolbox at the top of your PALS home page. You will be directed to the renewal application.

You will receive confirmation via email when your license has been renewed. If you have already attempted to renew your license but there is a renewal hold on the record, you will need to address the renewal hold as directed in the emailed discrepancy notice before your license can be renewed.

We recommend your prompt attention to this matter to ensure that your license does not expire on November 30, 2019.

All 2019 license renewals must be completed online, there is no opportunity for a paper renewal application.
Renewal notices are only being mailed to those licensees for whom the the Board does NOT have an email address on file. Psychologists who have not received their notices by October 15, 2019 should contact the State Board of Psychology (ST-PSYCHOLOGY@pa.gov) and inquire about the status of their license renewal.

Additional Information:

- In the Yes/No answer section of the renewal form: there is a requirement to upload documentation for any questions answered 'YES'. It appears that for the LAST question in regards to Continuing Education Requirements, you do not need to provide documentation if you answer 'YES' to this question.
- In the Professional Details section: if you have an NPI (National Provider Identifier), this number can be found through your biller/online billing account or CAQH. If you do NOT have an NPI number, you do not need to provide one.
- Please note that the web pages may be slow to load - please be patient and allow yourself at least 30 minutes to complete the license renewal process.

Additional questions should be directed to the State Board of Psychology:
(717) 783-7155 or ST-PSYCHOLOGY@pa.gov

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

The PA State Board of Psychology is a government entity responsible for licensing and disciplining psychologists in the Commonwealth. PPA is a membership organization that is separate and apart from the State Board of Psychology.
This resource is a member-benefit of your membership with PPA

2019 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2019, 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.

November 7-8, 2019
Fall Continuing Education Conference
DoubleTree Valley Forge
King of Prussia, PA

November 11, 2019
Current Topics and Trends in Neuropsychology
PPA Office
Harrisburg, PA

April 3, 2020
Spring Continuing Education Conference
Hotel Monaco
Pittsburgh, PA

June 17-20, 2020
PPA2020 Annual Convention
Lancaster Marriott at Penn Square
Lancaster, PA

June 23-26, 2021
PPA2021 Annual Convention
Kalahari Resort & Convention Center
Pocono Manor, PA

Home Study CE Courses

Act 74 CE Programs

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

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Ending the "Silent Shortage" in Pennsylvania through RxP (Webinar)—1 CE
Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each
*Introduction to Ethical Decision Making**—3 CEs
*Mental Health Consent and Confidentiality When Working with Children**—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.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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.