ALSO INSIDE:

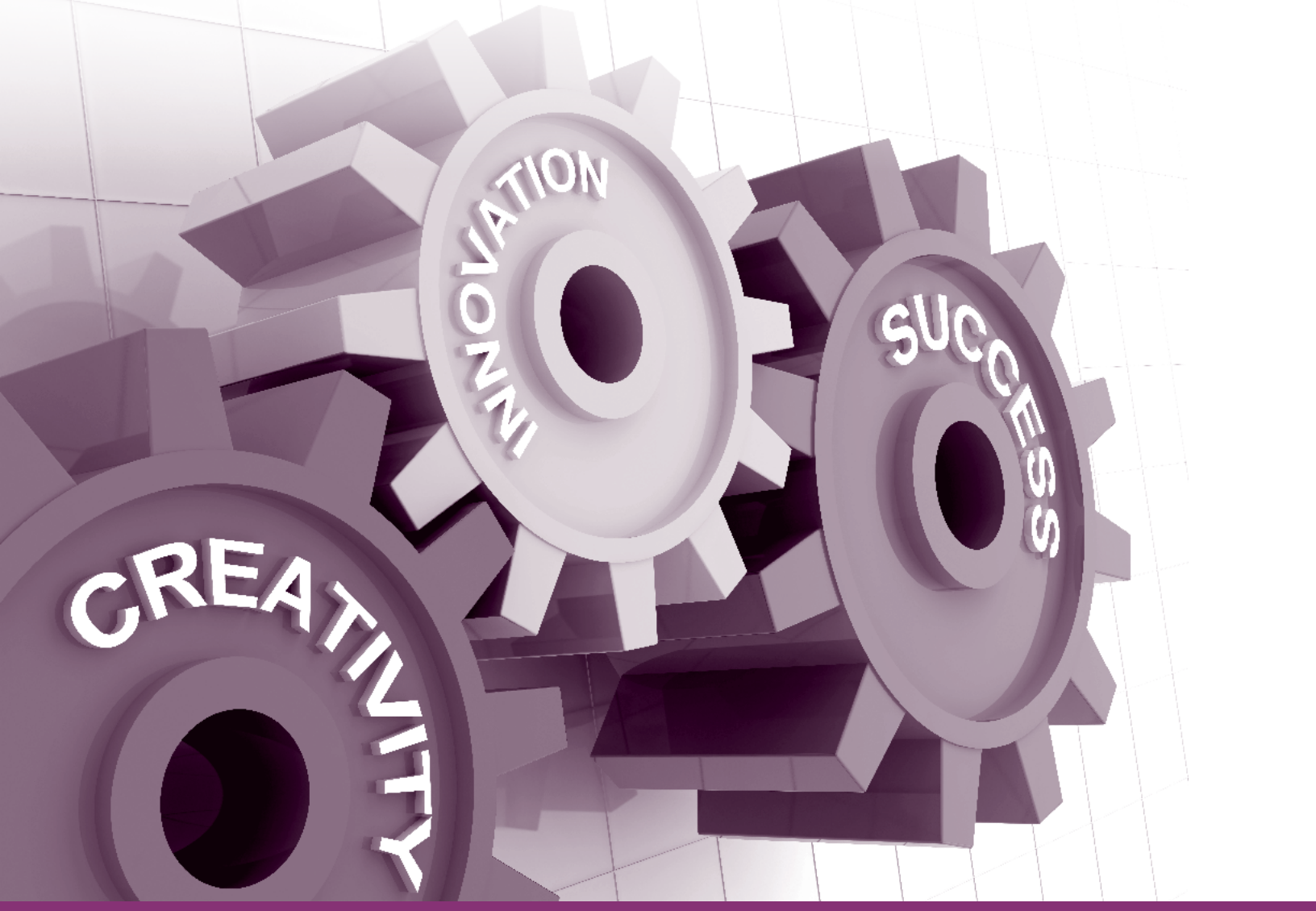
- PPA2017 convention highlights
- Helping first-generation college students succeed
- Educating foster care parents
- Justice for our four-legged friends

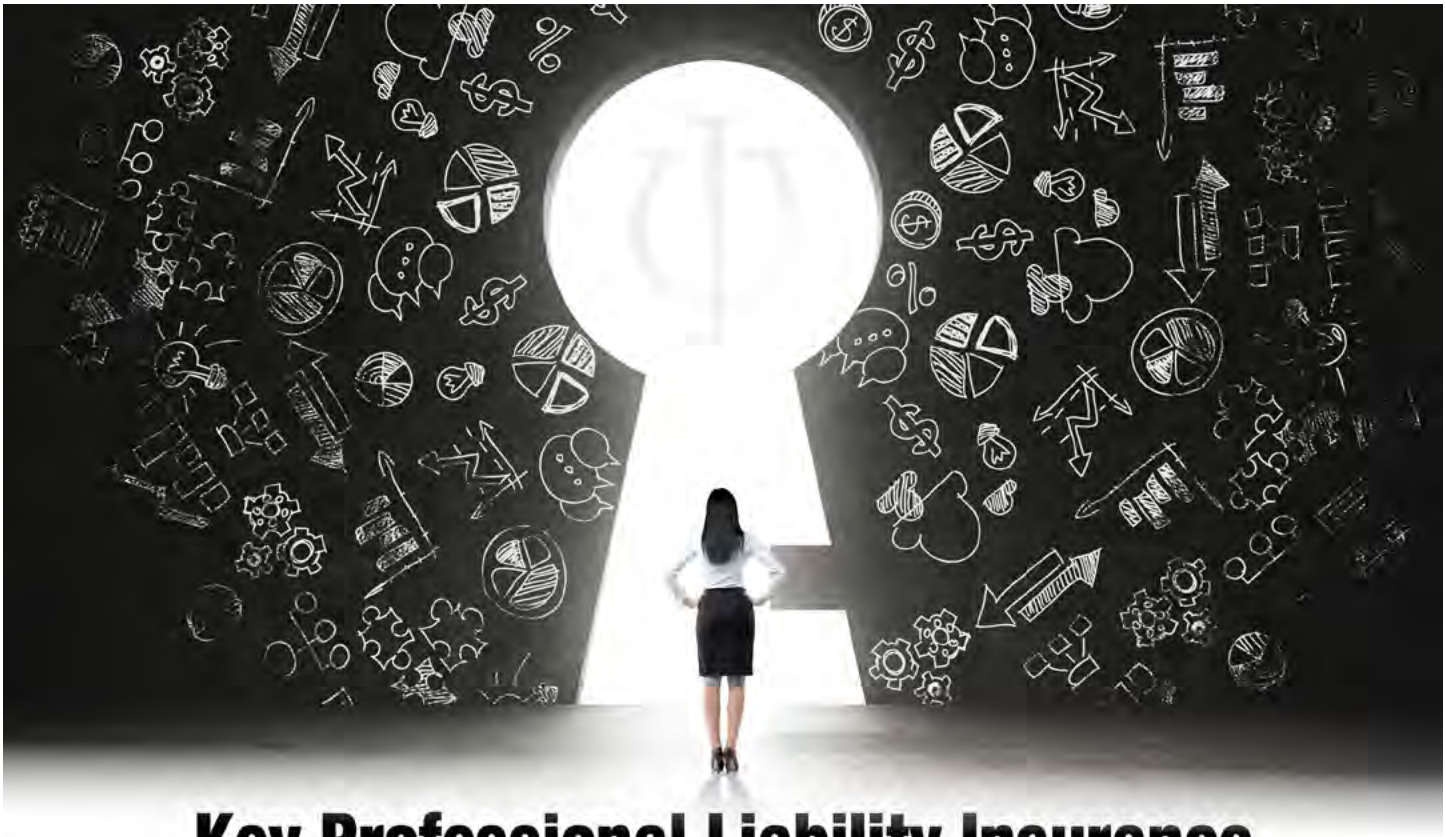
The Pennsylvania Psychologist

Vol. 77, No. 8

SEPTEMBER 2017 • QUARTERLY

INNOVATION and CREATIVITY in Psychological Intervention





Key Professional Liability Insurance Protection Throughout Your Career

Insurance coverage is key to your peace of mind.

Along with your training, experience, and expertise, Trust Sponsored Professional Liability Insurance* gives you the confidence to provide psychological services in a host of settings – across your entire career. Even if you have coverage through your institution or employer, it pays to have your own priority protection through The Trust.

Unlock essential benefits.

Along with reliable insurance coverage, The Trust policy includes useful benefits focusing on psychologists – free Advocate 800 consultations, exclusive discounts on continuing education and insurance premiums, and more. See why so many of your colleagues rely on The Trust for their insurance and risk management needs.

Key features you may not find in other policies:

- Insurance premium discounts including CE, early career, part time, group, and more.
- Broad affordable occurrence & claims-made coverage rated A++ by A.M. Best.
- Unlimited confidential consultations with independent risk management experts.
- No sublimit for defense of sexual misconduct allegations and a free extended reporting period or "tail" to insureds upon retirement.
- Case review process for adverse claim decision by insurance carrier.
- Through TrustPARMA, reduced registration fees for continuing education workshops and webinars.

THE TRUST

trustinsurance.com • 1-800-477-1200

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and its U.S.-based Chubb underwriting company affiliates. Program administered by Trust Risk Management Services, Inc. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit new.chubb.com. Chubb Limited, the parent company of Chubb, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

Vol. 77, No. 8

The Pennsylvania Psychologist

Editor: Tracie Pasold, PhD

September 2017 • QUARTERLY

Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
717-232-3817
papsy.org

PPA OFFICERS
President: David L. Zehrung, PhD
President-Elect: Nicole P. Quinlan, PhD
Past President: David A. Rogers, PhD
Treasurer: Bradley C. Norford, PhD
Secretary: Jeanne Slattery, PhD

APA REPRESENTATIVES
Linda K. Knauss, PhD
Dianne S. Salter, PhD, Esq.

BOARD CHAIRS
Communications: Tracie Pasold, PhD
Internal Affairs: Marie C. McGrath, PhD
Professional Psychology: Vincent J. Bellwoar, PhD
Program & Education: Dea Silbertrust, PhD, JD
Public Interest: Tim Barksdale, PsyD
School Psychology: Susan Edgar Smith, PhD
PPAGS Chair: Jessica M. Dougan, MA

STAFF
Executive Director: Krista Paternostro Bower, MPA, CAE
Director of Professional Affairs: Samuel Knapp, EdD
Director of Legal & Regulatory Affairs:
Rachael L. Baturin, MPH, JD
Director of Government Affairs: Justin C. Fleming
Prof. Development Specialist: Judy D. Smith, CMP-HC
Director of Administration: Iva Brimmer
Member Services Coordinator: Erin Brady

PENNSYLVANIA PSYCHOLOGICAL FOUNDATION BOARD OF DIRECTORS
President: Williametta S. Bakasa, PhD
Secretary-Treasurer: Nicole P. Quinlan, PhD
Joseph Black, PhD
David A. Rogers, PhD
Beatrice R. Salter, PhD
Dianne S. Salter, PhD, Esq.
Jeanne M. Slattery, PhD
David Zehrung, PhD
Krista Paternostro Bower, MPA, CAE, Ex Officio

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in the *Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

The Pennsylvania Psychologist Quarterly is published in March, June, September, and December. The copy deadline is the eighth of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112.

Copy Editor: Karen Chernyaev
Graphic Design: LiloGrafik, Harrisburg

REGULAR FEATURES

2 | Presidential Perspective
3 | Executive Director's Report
5 | Legal Column
6 | Happenings on the Hill
8 | The Bill Box
32 | CE Questions for This Issue

Get 1 CE credit for this issue! Also available online! Page 32

SPECIAL SECTION—INNOVATION AND CREATIVITY IN PSYCHOLOGICAL INTERVENTION

12 | Building New Realities: Expanding the Psychotherapeutic Utility of Virtual Reality Technology
14 | Integrating CBT & Action Interventions: A New Short-Term Group Model for College Counseling Centers
16 | Playing in the Ocean of Awareness: Innovations in Mindfulness Training
18 | Therapeutic Horseback Riding
20 | Mindful Emotional Eating: A Humanistic, Harm Reduction Approach

SCHOOL PSYCHOLOGY SECTION

22 | Dialectical Behavior Therapy—An Additional Potential Resource for School Psychologists?
24 | First-Generation College Students: Common Risk Factors and Strategies for Success

ACADEMICIAN'S CORNER

26 | Justice for Animals: A New Working Group of APA Division 48

STUDENT PERSPECTIVE

27 | Attachment Psychoeducation for Foster Care Parents: A Silver Lining

ETHICS IN ACTION

29 | Gift Giving, Boundary Crossings, and Consultations

ALSO INSIDE

4 | Pennsylvania Psychological Foundation Provides Grant to Pittsburgh Women's Shelter
4 | PPA Member Spotlight
9 | Convention Highlights
28 | Meet Your 2017–2018 PPAGS Board of Directors!
30 | Welcome New Members
31 | Classifieds

We Are PPA!

David L. Zehrung, PhD

Dr. David L. Zehrung

Welcome to PPA's 85th year! Those who attended my talk at the convention may recall that PPA was officially established on June 16, 1933, although at that time we called ourselves the Pennsylvania Association of Clinical Psychologists. The small group of psychologists who met that day in what is now the Forum Building in Harrisburg represented the culmination of three years of organizational efforts by Florentine Hackbusch, a master's-level psychologist, and Mary Vanuxem, a doctoral-level psychologist. I was so intrigued by these intrepid psychologists that I tried to learn more.

Florentine Hackbusch's obituaries wrote of her: "A veritable tower of strength. Tough minded. One of the most vital pioneers. A real person. Truly heroic disregard of her physical handicaps. Warmth and genuineness of feeling. National authority. Loyal to the cause of all mental deficits. Hearty and sometimes brusque exterior. Her name was one to conjure with 'An era has passed with her.'"

Sure, our first president was Lightner Witmer, the founder of clinical psychology, but if given a time machine, and if I had to choose, Ms. Hackbush is who I'd really like to meet. I have not come across photos of either Ms. Hackbusch or Dr. Vanuxem, so if you can find one, please contact me or PPA staff.

I share this history to highlight the context for my platform: community and growth. By virtue of our membership in PPA, you and I are part of an ever-renewing community extending back in time to one remarkable woman. The early 1930s were beset by some grim realities, but that did not stop Florentine Hackbusch from herding psychological cats to form something good for psychologists and Pennsylvanians. She was very growth oriented and never stopped learning.

This year, I'd like us to explore our role in renewing community among Pennsylvania psychologists and in stepping up growth—PPA's growth, our individual professional growth, and our personal growth as human beings. As we do, we will further enhance the well-being of those whom we serve. To organize these aspirations, Dr. Don McAleer is heading up the Aspire Task Force. Lisa May is heading up a subgroup looking at community-enhancing initiatives such as improving member finances by exploring novel ways to pay off student loans earlier, for example. President-Elect Nicole Quinlan is heading up a subgroup looking at ways to further encourage personal and professional growth.

This year, I'd like us to explore our role in renewing community among Pennsylvania psychologists and in stepping up growth—PPA's growth, our individual professional growth, and our personal growth as human beings.

This year, a number of PPA members went on camera to say "I am _____, and I am PPA!" It's been a fun experience, but one that is deeply true. PPA truly *is* its members. We would love to have more video clips, so please record yourself or a group of you saying "We are PPA!" or "I am _____, and I am PPA!" We'd love to incorporate the clips into things like the PPA Minute. We'd also love for you to share photos or video of you engaged in personal growth or challenging activities, for example sports and humanitarian work.

I'd like to conclude by highlighting a fairly new PPA member, Sarah Gates. I met Dr. Gates at our spring conference in Erie, then again at Advocacy Day. She is an ECP who had recently moved with her family from Massachusetts and was energetically setting up a local private practice. Despite her newness to the state, family commitments, and the need to establish a revenue stream in her new locale, Dr. Gates joined PPA and made time to attend the spring conference and Advocacy Day. She expressed interest in becoming more involved in PPA—one of her new communities—and in ongoing professional growth. Kudos, and welcome, Dr. Gates!

Florentine Hackbusch was PPA.

Sarah Gates is PPA.

We are PPA.

Reflections & Then Some

Krista Paternostro Bower, MPA, CAE

Krista Paternostro Bower

Four years by any measure is a lot of time. Four years can be the time it takes to meet someone and think about marriage, the time it takes to graduate from high school, or, better yet, the time it takes to complete a bachelor's degree. There is so much that can happen in four short years, yet in all of my measures of time, four years constitutes a very long time. This summer marks the end of my fourth year as PPA's executive director, and I am happy to say "we are doing it." PPA is on the precipice of more greatness, and we are building a first-class organization, rich with outstanding volunteer leaders, to help guide us there.

Even though our official change in leadership happens at the end of June, our ramp-up for the new presidential year happens now. We have been working over the summer to finalize some plans for our continuing education events, and we have already started preparing for PPA2018. But, before I jump ahead of myself, allow me to reflect for a moment upon the last year here at PPA.

This past year, under the outstanding leadership of **Dr. David Rogers**, was another phenomenal success for PPA! If you missed the convention in June, you missed a celebration of the culmination of our second year with a presidential focus on interpersonal violence. We gathered at the beautiful Omni Bedford Springs Resort for a relaxing yet educational program that did not disappoint. We moved the convention out of Harrisburg for the first time in over a decade, and our members were ready for the change. The venue provided just the right backdrop for an engaging and uplifting convention, highlighted by our keynote speaker, **Barbara Amaya**, and our Psychology in Pennsylvania Luncheon speaker, **James Kimmel Jr., JD**. We also recognized some deserving PPA award winners during our Annual Dinner & Awards Banquet. Please be sure to check out the convention highlights and photographs on pages 9–11 of this issue.

Our new PPA president, **Dr. David Zehrung,** will pursue his presidential platform, **Aspire**, with equal vigor. It is exciting for us to move in this new direction alongside of Dr. Zehrung and his vibrant Executive Committee and Board of Directors. Under the capable leadership of **Dr. Don McAleer**, the **Aspire Task Force** will be tackling this year's presidential platform by examining the intersection of PPA membership, professional development, and personal growth and self-care. I join the rest of the PPA staff in saying that we are excited by the endless possibilities offered by this initiative, which has already generated a lot of interest. We enthusiastically welcome Dr. Zehrung to his role as president, and we look forward to working with him during his energetic term as our president. Please take a moment to read Dr. Zehrung's presidential column on page 2 for more details on the specifics of his presidential platform.

There was another important first at this year's convention that I hope you take a moment to read about on page 4 of this issue. The Pennsylvania Psychological Foundation presented its second annual grant in the amount of $7,500 to support the Women's Center & Shelter of Greater Pittsburgh's Empowerment Center Support Groups. This investment by the Foundation speaks to the readiness of psychologists to put money toward a program that is providing a tangible solution to interpersonal violence. It is definitely worth the read.

This coming year marks our 85th year of existence as an organization! To acknowledge this prestigious milestone, PPA is planning several initiatives and offering a few incentives to get our entire membership involved. Be on the lookout for our special 85th anniversary logo, pin, and other exciting ventures to recognize this measure of organizational success. We will celebrate this important milestone during PPA2018 in June of next year.

This coming year marks our 85th year of existence as an organization! To acknowledge this prestigious milestone, PPA is planning several initiatives and offering a few incentives to get our entire membership involved.

There is also a lot of good information in this issue related to our special section topic: Innovation and Creativity in Psychological Intervention. Also, please be sure to read Justin Fleming's update, Happenings on the Hill, to see what our government affairs team has been doing to advocate for health insurance coverage.

Please mark your calendars and plan to join us this fall at our upcoming PPA CE offerings:

- **Various Dates & Times**
  Lunch and Learn Series
  PPA Offices, Harrisburg, PA
- **October 26 & 27**
  Fall Continuing Education & Ethics Conference
  Lancaster, PA

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

Please continue to share your thoughts and suggestions with us. We appreciate your continued membership in PPA and look forward to seeing what the future has in store for all of us.

Pennsylvania Psychological Foundation Provides Grant to Pittsburgh Women's Shelter

The Pennsylvania Psychological Foundation (PPF) does meaningful work within the community of psychologists by providing financial support for a variety of causes, including needs-based assistance to psychology students (through our awards and scholarship program), the underwriting of PPA's Public Education campaign, the Colleague Assistance Program, disaster response personnel training, and other education-oriented public projects that align with our mission. In 2016, the PPF launched a community grant program, which continued this year. The selection process was very competitive, as the selection committee reviewed several highly qualified applicants.

This year's recipient of the $7,500 community grant was the Women's Center & Shelter of Greater Pittsburgh. This community grant will help support the Women's Center & Shelter of Greater Pittsburgh's Empowerment Center Support Groups, which provide direct psychological services to clients who are nonresidents (clients who do not stay in their Emergency Shelter). These groups run for 6 weeks and are designed for survivors at all stages of healing from intimate partner violence (IPV). IPV includes instances in which one person in an intimate relationship exercises power and control over the other through a pattern of intentional behaviors such as psychological, emotional, physical, financial, and sexual abuse. This grant will be used to assist approximately 285 survivors of IPV in Allegheny County.

Left to right: PPF Treasurer Dr. Williametta Bakasa; Rachael Shockey of the Women's Center & Shelter of Greater Pittsburgh; PPA Executive Director Krista Paternostro Bower, MPA, CAE; and 2016–2017 PPA President Dr. David Rogers

We were pleased to present the grant award to Rachael Shockey, development associate, who accepted the PPF 2017 Community Grant on behalf of the Women's Center & Shelter of Greater Pittsburgh at the PPA2017 annual convention in Bedford, Pennsylvania.

PPA Member Spotlight

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

Judith S. Beck, PhD

Congratulations to Judith S. Beck, PhD, who received a promotion to Clinical Professor of Psychology in Psychiatry, Perelman School of Medicine at the University of Pennsylvania. As clinical professor, she will continue to teach second- and third-year psychiatry residents.

Susan Edgar-Smith, PhD

Congratulations to Susan Edgar-Smith, PhD, who was appointed Dean of the College of Education at Eastern University. She will assume her duties this month. Dr. Edgar-Smith also serves as the Chair of PPA's School Psychology Board.

Legal Notice: Ignorance of the Law Is No Excuse

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

Dr. Allan M. Tepper

Dr. Samuel Knapp

Rachael L. Baturin

Three primary bodies of law govern a professional license: statutes, case law, and administrative rules and regulations.

A statute is a written law in which the state legislature drafts and votes upon a proposed bill. If the bill is signed by the governor, it becomes a written statute. One example of a written statute that governs the practice of psychology in Pennsylvania is the Child Protective Services Law, commonly referred to as the Pennsylvania child abuse reporting statute.

At times, a specific legal case applies to licensed psychologists and thus governs the practice of psychology in Pennsylvania. For example, Rost v. State Board of Psychology (659 A.2d 626) is a Pennsylvania Commonwealth court case that outlines the means by which a psychologist must respond to a third-party request for confidential treatment records.

Licensing boards are put into existence by a statute and fall within the area of administrative law. Licensing boards are public protection entities. The Pennsylvania psychology board exists to protect the Pennsylvania public from unqualified psychologists.

As part of the statute that establishes a licensing board, the board is given the power to promulgate rules and regulations necessary to carry out their public protection mandate. The board cannot merely write a new regulation or amend an existing regulation in a haphazard manner. Rather, rule making is a somewhat arduous process that involves different levels of internal, external, and public review. Once a licensing board regulation is finalized, however, it becomes another legal requirement that governs the professional license.

Under the law, there is a concept known as legal notice. There are two types of legal notices: actual notice and constructive notice. Actual notice exists when a psychologist personally reads a specific statute, case opinion, or licensing board regulation. Constructive notice exists when a new statute, case opinion, or regulation becomes effective. Constructive notice does not require that the psychologist have actual notice of the existence of the rule. In both instances, however, the psychologist is bound to follow the rule or requirement in question. A transgression of the rule may result in a licensing board proceeding.

Coupled with this concept of legal notice is a legal axiom known as ignorance of the law is no excuse. What is meant by this legal axiom? Very simply, if a psychologist is accused of transgressing a new or existing rule in which he or she had no actual notice, ignorance of the law is no excuse.

In general, individuals are on constructive notice of all kinds of legal rules with which they have no actual notice. For example, the federal tax code consists of thousands of regulations. The average taxpayer has no actual knowledge of most of these regulations. Nonetheless, if a prior deduction now is disallowed, the taxpayer is on constructive notice of this new rule and is bound to follow the new rule. At the future tax audit, ignorance of the law is no excuse.

Given this somewhat anxiety-provoking issue of constructive notice, how can a psychologist attempt to be on as much actual notice, versus constructive notice, in reference to licensing board requirements? One possibility is to join a national or state professional organization. Often, the state organization is more invested in helping their members stay current about what is happening in their particular state.

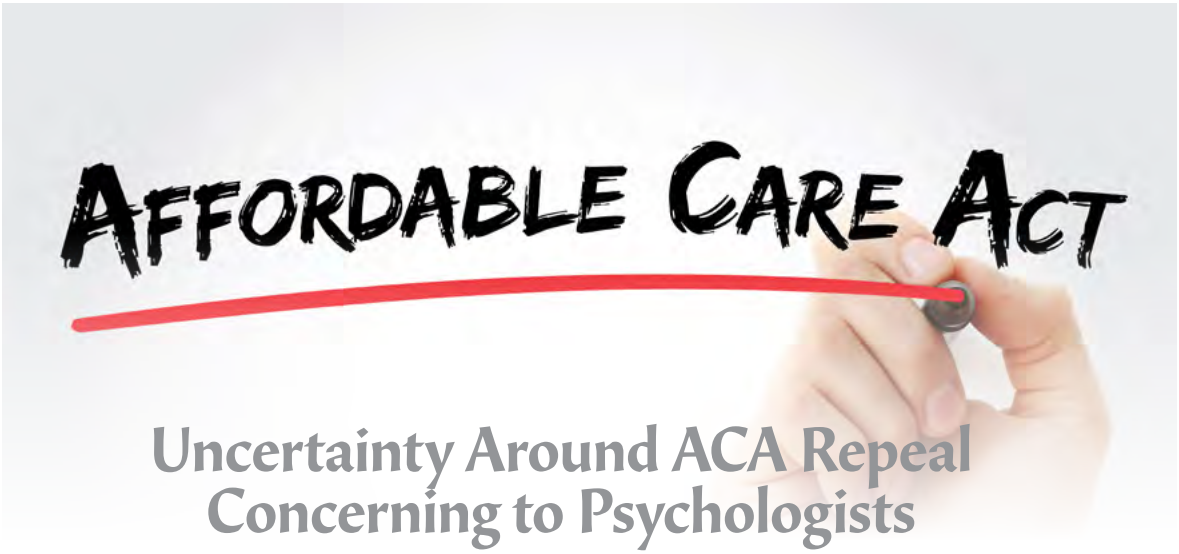
A second way is to dialogue with colleagues or participate in a peer consultation group. Of course, everyone is busy, and the peer consultation group often is a good idea that never comes to fruition. The answer? Pick up the telephone and call a colleague, or organize a group telephone call on a monthly basis.

A third way is to organize trips to the local law library. Of course, despite the exciting nature of this venue, who wants to go to a law library?

A fourth and more practical way to maintain actual notice is via the Internet. More specifically, in Pennsylvania, all of the licensing boards, including the psychology board, have websites.

Question: Other than mailing you a small card every two years reminding you that it is time to renew your license, is the Pennsylvania psychology board sending any other information through the U.S. postal service? Answer: No.

Continued on page 7



Uncertainty Around ACA Repeal Concerning to Psychologists

Justin Fleming, Director of Government Affairs

Justin Fleming

Since the election of Donald J. Trump as the 45th president of the United States, one of the administration's top legislative priorities has been the repeal and replacement of the Patient Protection and Affordable Care Act (ACA). In March, the House of Representatives introduced H.R. 1628 (2017), the American Health Care Act (AHCA). The AHCA was introduced as a budget reconciliation measure, meaning the legislation could pass in each chamber with a simple majority. The bill amends the ACA in several key areas including:[1]

- It eliminates funding after FY2018 for the Prevention and Public Health Fund, which provides for investment in prevention and public health programs to improve health and restrain the rate of growth in health care costs.
- The bill lowers, from 133 to 100% of the official poverty line, the minimum family-income threshold that a state may use to determine the Medicaid eligibility of children between the ages of 6 and 19. In addition, the bill reduces the Federal Medical Assistance Percentage (FMAP) for Medicaid home- and community-based attendant services and supports.
- Health insurers must increase premiums by 30% for one year for enrollees in the individual market who had a break in coverage of more than 62 days in the previous year.
- The bill appropriates $8 billion for the Patient and State Stability Fund to be allocated to states with a waiver to allow premiums to vary by health status in order to [sic] reduce costs for individuals whose premiums increased due to the waiver.
- The bill increases the ratio by which health insurance premiums may vary by age, from a three to one ratio to a five to one ratio. This ratio may be preempted by states.
- Section 204 repeals the penalties for individuals who are not covered by a health plan that provides at least minimum essential coverage (commonly referred to as the individual mandate). The repeal is effective for months beginning after December 31, 2015.
- Section 205 repeals the penalties for certain large employers who do not offer full-time employees and their dependents minimum essential health coverage under an employer-sponsored health plan (commonly referred to as the employer mandate). The repeal is effective for months beginning after December 31, 2015.
- Section 221 repeals the annual fee on branded prescription pharmaceutical manufacturers and importers.
- Section 222 repeals the annual fee imposed on certain health insurance providers based on market share.
- Section 231 repeals the 10% excise tax on the price of indoor tanning services.
- Section 241 repeals a provision that prohibits certain health insurance providers from deducting remuneration paid to an officer, director, or employee in excess of [sic] $500,000.
- Section 251 repeals the 3.8% tax on the net investment income of individuals, estates, and trusts with incomes above specified amounts.

When the CBO had the opportunity to complete its scoring, H.R. 1628 was projected to reduce the deficit by $337 billion over the next 10 years and increase the number of people uninsured by 24 million over the same period. The largest savings would come from reductions in outlays for Medicaid and from the elimination of ACA's subsidies for nongroup health insurance (Congressional Budget Office, 2017).

When the AHCA passed the House Energy and Commerce and House Ways and Means Committees, along party-line votes, the APA and APAPO stated its opposition in a letter to House Speaker Paul Ryan and Democratic Leader Nancy Pelosi. The letter (Puente & Belar, 2017) stated in part:

> As we have previously communicated, we believe that any health care reform

[1]From H.R. 1628, 115th Cong. (2017).

> legislation to repeal and replace the [ACA] considered by Congress should increase the number of Americans with coverage for mental health and substance use disorder services, including behavioral health treatment. Unfortunately, as the recent analysis by the [CBO] concludes, the American Health Care Act would significantly decrease Americans' access to these services, and by 2026 would take coverage away from an estimated 24 million people who would have otherwise been covered under current law, nearly doubling the proportion of Americans without health insurance (para. 2).

The letter (Puente & Belar, 2017) continued:

> We are also concerned about the American Health Care Act's proposed changes to the private health insurance market, including through its reductions in premium supports and elimination of cost sharing subsidies under current law for those most in need of health insurance. CBO's analysis concludes that the American Health Care Act would reduce the quality and reliability of private sector insurance by allowing plans to offer coverage with less actuarial value, increase out-of-pocket costs for lower-income and less healthy Americans, and make it harder to shop for and compare plans (para. 5).

Amendments filed to H.R. 1628 resulted in no decrease in the number of uninsured Americans by 2026 but accelerated those losing health insurance coverage by 14 million in 2018 (Hall, 2017). On May 4, the House passed the American Health Care Act by a 217–213 vote.

Once the U.S. Senate took its turn at health insurance reform in the form of the Better Care Reconciliation Act (BCRA), the outlook improved only slightly per the CBO. Its analysis projected a $321 billion reduction in the federal deficit over the next 10 years, with 22 million fewer Americans being covered by health insurance.

On June 6, the APA and American Psychiatric Association sent a joint letter to Senate Majority Leader Mitch McConnell and Minority Leader Chuck Schumer opposing the changes to Medicaid and health insurance markets under the BRCA. Additionally, in late June, PPA sent letters to Senators Robert Casey and Pat Toomey urging opposition to the bill due to the elimination of mental health coverage as an essential health benefit. We wrote:

> PPA is also opposed to the elimination of the federal requirement that plans cover an essential health benefit package. Before the essential health benefits requirements was enacted, one-third of insurance policies sold on the individual market did not cover for substance use treatments, and almost one in five policies did not cover mental health (para. 3).

The AHCA was introduced on March 20, and the Senate bill was crafted by 13 senators in secret. Since the repeal and replacement of the ACA became a real possibility, APA has insisted that any changes not reduce the number of uninsured individuals and that mental health care remains an essential health benefit. And while a vote to advance a Senate ACA repeal bill failed by a vote of 49–51 on July 28, it is unclear as to whether the issue will be raised again.

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

References

Bower, K. P. (2017, June 29). [Letters to Patrick Toomey and Robert Casey]. Pennsylvania Psychological Association, Harrisburg, PA.

Congressional Budget Office. (2017, March 13). *American Health Care Act*. Retrieved from https://www.cbo.gov/publication/52486

Hall, K. (2017, March 23). [Letter to Paul Ryan]. Congressional Budget Office, Washington, DC. Retrieved from https://www.cbo.gov/publication/52516

H.R. 1628, 115th Cong. (2017).

Puente, A. E., & Belar, C. D. (2017, March 14). [Letter to Paul Ryan and Nancy Pelosi]. APA and APAPO, Washington, DC. Retrieved from http://www.apa.org/news/press/releases/oppose-health-care-act.pdf?_ga=2.22061243.1667110231.1500043288-1457214782.1500043288

LEGAL COLUMN

Continued from page 5

Question: Does the Pennsylvania psychology board promulgate new regulations, amend existing regulations, and post board notices? Answer: Yes.

Question: Where are these new regulations and requirements listed? Answer: The board's website.

Very simply, the Pennsylvania psychology board has a website. The website is updated on a regular basis. There is an expectation that psychologists are aware of the existence of the website. There is an expectation that psychologists are scrolling around the website on a regular basis. Not necessarily every week but at least every few months. Is your time limited? Yes. Is scrolling around the psychology board website an exciting use of your time? No. Is there a better way to spend your Friday nights? Yes. Nonetheless, is it important to visit the psychology board website on a regular basis? Yes. Why? Because ignorance of the law is no excuse.

At times, the legal requirements associated with maintaining a professional license can feel overwhelming. At times, mistakes are made and the world does not come to an end. At other times, however, it is difficult to defend the lack of actual notice of a rule, especially if the rule has been in existence for a period of time. For this reason, take a few minutes, go to your computer, and bookmark the psychology board homepage. Then, spend a little time becoming familiar with the format of the webpage. Click on the various headings. Print out relevant rules or notices. Put a reminder in your calendar to check back in a few months. In this way, you will be informed, stay current, do good clinical work, and maintain actual notice of licensing board rules and requirements.

Remember: Ignorance of the law is no excuse.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of June 8, 2017

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

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

****HCO denotes House Cosponsor Memo**

Legislators who have ideas for bills before they are introduced circulate cosponsor memos. Each memo includes broad strokes about the contents of the bill and seeks to build support for the legislation

PPA2017
Striving to Overcome Interpersonal Violence

Incoming President Dr. David Zehrung and outgoing President Dr. David Rogers

Every June, Pennsylvania psychologists gather for PPA's annual convention, which happened again this year—this time in a new, beautiful, and bucolic setting. We were excited to move PPA2017 to the Omni Bedford Springs Resort in Bedford, Pennsylvania. As usual, the convention featured multiple opportunities for networking, education, meetings, and the presentation of PPA awards.

The backdrop for PPA2017 was different than we've experienced for a convention in quite some time, but we hope that it provided a unique and relaxing atmosphere in which we were able to Live a Little and Learn a Lot. PPA was also able to participate in Omni's Say Goodnight to Hunger program. This program partners Omni Hotel properties with local food banks, and for every group room booked at the Omni during PPA's convention, the Omni Bedford Springs Resort provided a donation to their area food bank. We were so thrilled to be a part of this initiative!

This year's theme, Striving to Overcome Interpersonal Violence, was built upon the previous year's theme, with a specific focus on types of interpersonal violence: human

Continued on page 10

❶ 2016-2017 PPA President Dr. David Rogers with Keynote Speaker Barbara Amaya and PPA Executive Director Krista Paternostro Bower

❷ APA CEO Dr. Arthur Evans addresses PPA2017 attendees at the annual Town Hall.

❸ Psychology in Pennsylvania Speaker James Kimmel Jr., JD, speaks about violence and motive control.

PPA2017 HIGHLIGHTS

PPA2017 HIGHLIGHTS *Continued from page 9*

❶ Convention attendees visit sponsors in the Exhibit Hall.

❷ *Left to right:* Dr. Amanda Sellers, Distinguished Service Award recipient Dr. Cheryll Rothery, and PPA Awards Committee chair Dr. Eric Affsprung

❸ Dr. Arpana Inman accepts the Distinguished Contributions to the Science and Profession of Psychology award.

❹ The Exhibitor Wine & Cheese Reception allows attendees to engage with convention sponsors in a relaxed atmosphere.

trafficking, bullying/cyberbullying, domestic abuse, and campus rape/Title IX. This theme was highlighted in over 15 workshops, as well as in our Keynote presentation, The Cult of Human Trafficking, by now-author Barbara Amaya, a survivor of human trafficking. The theme of Striving to Overcome Interpersonal Violence was also carried through to the Psychology in Pennsylvania Luncheon by speaker James Kimmel Jr., JD, lecturer in the Psychiatry Program for Recovery and Community Health at the Yale School of Medicine. Mr. Kimmel's presentation, Beyond Gun Control to Motive Control, presented a unique view on motives and violence.

PPA staff and leadership are always striving to keep the convention relevant, while also bringing back popular programs and event, and this year was no different. We were honored to recognize donors to PennPsyPAC and the Pennsylvania Psychological Foundation at an afternoon reception on Wednesday. The support of our donors is important to the furthering of these organizations and our charitable giving and advocacy efforts. Thank you to everyone who donated in 2016–2017! We hope that

those who were able to attend the reception enjoyed this new event.

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

Thank you to all of the presenters, exhibitors, and committee members who were responsible for making this event such a success. A lot of work and planning happens behind the scenes, and members of PPA's Professional Development Committee and Proposal Selection Committee deserve special acknowledgment for their hard work and involvement in this process. Special thanks also go to Program and Education Board chair, Dr. Dea Silbertrust.

Lastly, we want to thank everyone who attended PPA2017. Your energetic participation made this year's convention a rousing success. We look forward to bringing this energy and excitement as we move into 2018 and PPA2018. We look forward to seeing you in Valley Forge on June 13–16, 2018!

1. The PPA Donor Reception recognizes members who made financial contributions to the PennPsyPAC and the Foundation in 2016.
2. Drs. Dianne Salter and Kameelah Mu Min enjoying their time at PPA2017.
3. CE session at PPA2017
4. Mary O'Leary Wiley *(back)* with Camille St. James, a member of PPA's first class of Emerging Leaders
5. Dr. Mu Min, winner of the Matthew Small Education Award, with Dr. Rick Small *(left)* and PPF President Dr. Pauline Wallin
6. Brother Bernard Seif *(left)* receives a Presidential Citation from Dr. David Rogers.

Building New Realities: Expanding the Psychotherapeutic Utility of Virtual Reality Technology

William S. Chase II, PsyD, drwilliamchase@gmail.com

Dr. William S. Chase II

At the heart of psychotherapy, we find an intersection between art and science. Psychology's commitment to empirically supported approaches is a clear reminder of the ever-present role of science in our work. However, finding opportunity to express the artistic aspect is, oftentimes, more difficult to tackle. With empirical and ethical standards often relying on replicability and consistency, it can be difficult to find clinically appropriate methods to infuse creativity into practice. Specifically, the critical task of maintaining balance between treatment risk and therapeutic benefit certainly poses its own challenges with regard to working "outside of the box." However, new opportunities have emerged, thanks to modern technology, that may afford a great deal more creative license to psychologists within an empirically supported framework.

One example, quickly proving to be a potentially powerful asset for psychologists, is the ongoing development and advancement of virtual and augmented reality technology (VR and AR, respectively). In VR, an individual is immersed in a simulated, three-dimensional (3-D) audiovisual environment using various types of hardware worn on the head or face. In AR, a device superimposes visual information onto a set of specialized glasses or the screen of a smart device, allowing users to see their current environment fused with the AR content. While once limited to science fiction, VR has now entered an age of photorealism and has been integrated with now ubiquitous smartphones and similar devices.

Despite having been first explored as a potential clinical tool by North and North (1994), it has taken more than three decades for the technology to evolve to a point where it can truly have broad, applied utility. Until now, the technology has been limited to specialized centers or mainly targeted at specific conditions. In fact, early VR applications for treating posttraumatic stress disorder in veterans have been empirically supported for over a decade (Reger et al., 2011). Interestingly, these early applications evolved from mainstream video games to create therapeutically relevant virtual environments. Thus, the novelty isn't in using this technology for psychological conditions; it is in the practitioner's ability to apply entertainment-based VR applications in new, clinically beneficial ways.

This opportunity has not gone unnoticed in the broader mental health community. Earlier this year, the *Harvard Review of Psychiatry* published an overview on the extant research into effective psychotherapeutic uses of VR technology (Maples-Keller, Bunnell, Kim, & Rothbaum, 2017). The review found VR-based applications to be valuable complements to a broad spectrum of treatments. With already broad applications including, but not limited to, exposure therapies, pain management, and addictions work, opportunities to incorporate these methods into practically any practice setting are extensive and gaining empirical backing.

For the first time in history, VR and AR technologies have entered the consumer realm with extensive support from the entertainment industry. The hardware required to create virtual experiences ranges from a basic cardboard cradle that holds a smartphone to more elaborate headsets that connect to a high-end computer for an enhanced experience. With only basic technological know-how, or as little as a few hours of training, users can convert such devices, and the current software they run, from purely entertainment-related technology to therapeutic tools.

Consider for a moment a very basic application that can easily be used in a small, private practice setting. Empirical research shows exposure-based interventions are a gold standard for the treatment of various psychological conditions

For the first time in history, VR and AR technologies have entered the consumer realm with extensive support from the entertainment industry.

(Foa & McLean, 2016). Using little more than an inexpensive cardboard harness (e.g., Google Cardboard or any of the numerous, low-priced alternatives), the client's smartphone, and headphones, a therapist has access to an almost limitless library of web-based content than can be previewed, introduced, and discussed with a client as part of a run of systematic desensitization. Psychologists can now incorporate virtual animals, elevators, crowds, or airplanes, offering a variety and intensity to exposure work never before possible. A client being treated for social anxiety can now be progressively presented with scenes or simulated environments ranging from the familiarity of their therapist's office to standing on the stage of a packed theater. These experiences, enhanced using basic headphones, add a level of immersion that truly blurs the 'virtual' aspect of the experience. Most important, these virtual therapeutic environments can all be created in the safety of the therapist's office.

These technologies also facilitate therapeutic collaboration with clients both in and out of session. The diversity of available VR content allows the therapist to provide richer, more realistic exposure exercises while simultaneously respecting confidentiality and other ethical concerns that accompany in vivo exposure methods. Much of the available content can be accessed for free on websites such as YouTube.com or at low cost from device-specific, digital stores. The use of common relaxation training methods (i.e., deep breathing, imagery, and progressive muscle relaxation) can be potentially enhanced by working with

the client to review free and available online content and selecting materials to incorporate into treatment. For example, it would not be difficult for a therapist to blend a virtual beach experience with a recording of his or her own relaxation training narrative. Given the integration of personal technology, such as smartphones, with day-to-day life, it may be easier to support a client's motivation to follow through with assignments that utilize the devices they are already familiar with. Further, the portability of smart devices might empower individuals to use VR-supported coping or treatment methods in more diverse settings.

More advanced applications are also accessible to practitioners who seek to use the technology more extensively. Currently, several major companies have released head-mounted displays (HMDs) that connect to high-end computers or video gaming systems (e.g., Oculus Rift, HTC Vive, PlayStation VR). These headsets combine with specialized controllers that allow users to interact with their environment in a more natural way, creating a digital representation of hands on the screen that move in sync with users' fingers and hands. While less portable, these systems offer more rich, elaborate VR experiences. The overall effect essentially blurs the virtual aspect of the experience, adding even simulated touch to the equation. Psychologists whose work specializes in disorders such as PTSD can use these devices to potentially grant far greater control over the realism and intensity of desensitization stimuli. Treatment may be enhanced using a software-generated combat zone, or other trauma-related exposure environment, incorporating virtual audio, visual, and tactile components.

Psychologists whose work specializes in disorders such as PTSD can use these devices to potentially grant far greater control over the realism and intensity of desensitization stimuli.

While holding great promise for creative clinical application, VR technology is by no means a panacea. Just as some clients may be eager to embrace another way to expand their use of smart devices, there will certainly be others who maintain little interest in or even apprehension toward the technology. The emotional readiness of a client must also be evaluated due to the realism of the experience. It is important to note that VR, like any other therapeutic tool or intervention, is not without risks. For clients prone to motion sickness, an issue referred to as "VR sickness," the technology can pose a significant barrier. The realistic motion and sensory immersion can cause nausea and disorientation for some individuals (Fernandez & Feiner, 2016). Physical symptoms can also extend to eye strain, headaches, dizziness, accidents, and injury caused by trying to move while wearing a device. Another word of warning is that many of the consumer technology companies responsible for these devices caution against the use of VR devices by children.

With discussion so often directed toward the future of psychotherapy, opportunities to apply current technologies in a way that not only channels our creative nature but also balances the risks and benefits to clients is both exciting and clinically appropriate. In considering VR technology, we are presented with unlimited potential to creatively expand upon empirical foundations and support psychotherapy in a manner both future oriented and 3-D.

References

Fernandes, A. S., & Feiner, S. K. (2016, March). Combating VR sickness through subtle dynamic field-of-view modification. In *2016 IEEE Symposium on 3D User Interfaces (3DUI)*, 201–210. Symposium conducted at the meeting of IEEE, Greenville, South Carolina.

Foa, E. B., & McLean, C. P. (2016). The efficacy of exposure therapy for anxiety-related disorders and its underlying mechanisms: The case of OCD and PTSD. *Annual Review of Clinical Psychology, 12*, 1–28.

Maples-Keller, J. L., Bunnell, B. E., Kim, S. J., & Rothbaum, B. O. (2017). The use of virtual reality technology in the treatment of anxiety and other psychiatric disorders. *Harvard Review of Psychiatry, 25*(3), 103–113.

North, M. M., & North, S. M. (1994). Virtual environments and psychological disorders. *Electronic Journal of Virtual Culture, 2*(4), 37–42.

Reger, G. M., Holloway, K. M., Candy, C., Rothbaum, B. O., Difede, J., Rizzo, A. A. & Gahm, G. A. (2011). Effectiveness of virtual reality exposure therapy for active duty soldiers in a military mental health clinic. *Journal of Traumatic Stress, 24*, 93–96.

Integrating CBT & Action Interventions: A New Short-Term Group Model for College Counseling Centers

Thomas Treadwell EdD, TEP, CGP; Deborah J. Dartnell, MSOD, MA; Ainsley Stenroos, MA

This article combines action interventions and cognitive-behavioral therapy (CBT) techniques in applied group settings. Although both models stress the discovery process through Socratic questioning, the use of certain structured CBT techniques provides additional ways of stimulating the development of self-reflection and problem-solving skills. The cognitive action group therapy (CAGT) model (Treadwell, Dartnell, Travaglini, Staats, & Devinney, 2016) focuses on identifying distressing situations; recognizing distortions in thinking leading to negative interpretations of an event; and activating moods, negative thoughts, and balanced thoughts. CBT techniques, especially those developed by Beck and his colleagues (Beck, 2011; Beck, Rush, Shaw, & Emery, 1979) are recognized as efficacious; incorporating those techniques in an action-oriented environment produces persuasive results. Blending the two models yields a complementary eclectic approach to multiple problem-solving strategies. The CAGT environment provides a safe, supportive climate to practice new thinking and behaviors (Treadwell, Kumar, & Wright, 2004) and has proven to be effective with university students and patients diagnosed with mood, anxiety, personality, or substance use disorders.

Dr. Thomas Treadwell

Deborah J. Dartnell

Ainsley Stenroos

General Guidelines for a Group Therapy Model Integrating Action Theory and Techniques

The preferred size of a group is between 5 and 10 members with sessions lasting 2 to 3 hours. Session one should focus on psychoeducation with action techniques emerging in later sessions. It is important to devote the first two sessions (at least 3 hours each) to educating participants about the CAGT model to create a safe and secure environment in which individuals can share their concerns freely with group members. The initial didactic sessions convey the notion that the group format is, foremost, a problem-solving approach for working through interpersonal, occupational, educational, psychological, and health-related conflicts.

At the outset, the therapist introduces the group members to the Beck Depression Inventory-II, the Beck Anxiety Inventory, the Patient Health Questionnaire-9, and the Burns Anxiety Inventory. Members complete diagnostic instruments on a weekly basis before the start of each session. The forms are stored in personal folders to serve as an ongoing gauge of their progress in the group. In addition to the Beck inventories, group members complete Young's (Young, Klosko, & Weishaar, 2003; Young & Klasko, 1994,) schema questionnaire(s), providing additional data on early maladaptive and dysfunctional schemas/core beliefs. The Social Network Inventory (Treadwell, Stein, & Leach, 1993) or the genogram is utilized to map and quantify participants' relationships with family members, significant others, groups, and organizations. Informed consent and audiovisual forms are distributed. The audiovisual recordings establish an ongoing record of group activities and serve as a source for feedback.

Applying CBT Interventions and Action Techniques

Automatic Thought Record

During the initial sessions, it is important to teach group members how to complete automatic thought records (ATRs) (Greenberger & Padaskey, 1995, 2015). It is central to introduce the ATR as a self-reflection strategy to recognize automatic thoughts that occur within and outside therapy sessions. This is helpful for improving problem-solving and mood-regulation skills. Essential action techniques of role reversal, doubling, self-presentation, interview in role reversal, mirroring, future projection, surplus reality, and empty chair techniques (Moreno, 1934; Kellerman, 1992) can be applied directly to situations indicated in the ATR.

Automatic Thoughts

Automatic thoughts (ATs) are instantaneous, habitual, unconscious, and affect a person's mood containing one or more *cognitive distortions*. The auxiliary egos and the director/therapist/facilitator may help the protagonist discover possible cognitive distortion(s) in the protagonist's stated AT.

Downward Arrow Technique

The downward arrow technique consists of challenging the protagonist by repeatedly asking the questions: "If that were true, why would it be so upsetting?" and "Being upset means what to you?" The technique can be used during any stage of the group process to explore a deeper understanding of the core beliefs/schemas underlying an AT.

The Case Conceptualization Technique

This technique is applied as an ongoing therapeutic tool. Case conceptualization may help the group member reflect on various rules, conditional assumptions, beliefs, and means of coping. Beck (2011) referred to such bias as the negative triad, viewing oneself, one's world, and one's future negatively. The purpose of designing a case formulation is to challenge the patient's distorted views of self, the world, and the future.

Client/Patient Responses

Once taught the basics of the ATR, participants realize this technique yields data that are not threatening. Participants show signs of relief and begin to see that

automatic thinking is what "we" all do. Recognizing core beliefs and schemas that "all" people possess serves to normalize the action behavioral therapy process, permitting group members to feel at ease.

Contraindications

The following exclusions are recommended: (a) Individuals with self-centered and aggressive disorders display strong resistance to group work; they tend to lack spontaneity and are rigid in their portrayals of significant others; and they either insulate or attempt to dominate others in the group; (b) individuals with narcissistic, obsessive compulsive (severe), and antisocial personality disorders, all of whom are more suited to individual therapy; and (c) individuals with cluster A personality disorders and impulse control disorders.

Conclusion

Integrating CBT with action techniques creates a powerful and effective group process enabling participants to address problematic situations with support of group members. Students and clinical populations respond well to the combination and find it helpful in becoming aware of their habitual dysfunctional thought patterns and belief systems that play an important role in mood regulation. Schema-focused techniques coupled with CBT merge nicely within the action framework. Group members begin to see the usefulness of structured CBT and action techniques and adapt accordingly.

The CAGT is data based, enabling group members to track dysfunctional thoughts, depression, and anxiety statistics week to week. The model integrates CBT and action techniques providing a balance between explorations of emotionally laden situations with the more concrete data-based, problem-solving process.

Schema-focused techniques coupled with CBT merge nicely within the action framework. Group members begin to see the usefulness of structured CBT and action techniques and adapt accordingly.

References

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, New York: Guilford Press.

Beck, J. S. (2011). *Cognitive behavioral therapy: Basics and beyond* (2nd ed.). The Guilford Press. Blatner, A. (1996). Acting-In. (3rd. ed.), New York, New York: Springer.

Greenberger, H. & Padaskey, C. (1995, 2015). *Mind over mood: A cognitive therapy treatment manual for clients*. New York, New York: Guilford Press.

Kellerman, P. (1992). *Focus on psychodrama: The therapeutic aspects of psychodrama*. Philadelphia, Pennsylvania: Jessica Kingsley.

Moreno, J. L. (1934). *Who shall survive? A new approach to the problem of human interrelations*. Washington, DC: Nervous & Mental Disease.

Treadwell, T., Dartnell, D., Travaglini L., Staats, M., & Devinney, K. (2016). *Group therapy workbook: Integrating cognitive behavioral therapy with psychodramatic theory and practice*. Parker, Colorado: Outskirts Press Publishing.

Treadwell, T., Kumar, V. K. Stein, S. (1990). A review of psychodramatic action and closure techniques for adolescents and adults. *Journal of Group Psychotherapy, Psychodrama, and Sociometry, 43* (3), 102–115.

Treadwell, T., Kumar, V. K & Wright, J. (2004). Enriching psychodrama via the use of cognitive behavioral therapy techniques. *Journal of Group Psychotherapy, Psychodrama, & Sociometry 55*, 55–65.

Treadwell, T., Stein, S., & Leach, E. (1993). The social networks inventory: A diagnostic instrument measuring interpersonal relationships. *Journal of Small Group Research, 24* (2), 155–178.

Young, J. E., Klosko, J. S., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide*. New York, New York: Guilford Press.

Young, J. E., & Klosko, J. S. (1994). *Reinventing your life*. New York, New York: Plume.

Dr. Thomas Treadwell is a licensed psychologist, trainer, educator, practitioner of psychodrama, and certified group psychotherapist. He is also a clinical associate at the Center for Cognitive Therapy, University of Pennsylvania, and a professor of psychology at West Chester University, where he teaches cognitive group therapy courses and high performance virtual teams in educational and organizational settings.

Deborah Dartnell is an adjunct professor at Philadelphia College of Osteopathic Medicine and West Chester University of Pennsylvania.

Ainsley Stenroos is a CBT-oriented outpatient therapist at TEAMCare Behavioral Health, LLC.

Playing in the Ocean of Awareness: Innovations in Mindfulness Training

Chris Molnar, PhD

Dr. Chris Molnar

I was terrified the first time I paddled out "against" tall ocean waves on a surfboard. Thanks to the skill and guidance of a surfing coach, I shifted from avoidance to approach mode. I was surprised to discover paddling out was great fun as I was lifted up over the wave crests and glided back down into the calm troughs. Many conditions came together to support me in learning to surf both water and fear: I was not surfing big waves. I was paddling out over gentle waves breaking off of a barrier island. The terror was mostly from the mind and how it spiraled into a very tense body that made it more likely that more thoughts of danger would arise. With my coach's guidance, I shifted from an avoid threat to an approach challenge mode that was associated with a more skillful focus of attention. This shift supported me in seeing things as they actually were rather than as I feared they may be. Such a shift is also useful in overcoming anxiety disorders and other extremes of mental and physical experience. As long as we perceive emotions as threatening, we will experience stress physiology and its subsequent narrowing of attention onto danger. As we learn to relate with emotion and the self with compassion, we can shift into challenge physiology with its hallmark coactivation of sympathetic with parasympathetic autonomic nervous system (ANS) divisions (Bernston, Norman, Hawkley, & Cacioppo, 2008; Blascovich, 2008). As well, the positive emotion one can experience while at play learning mindfulness can support a broadened field of attention and awareness that know many possibilities (Fredrickson & Branigan, 2005).

When mindfully surfing waves of all kinds, people can develop skills for weathering stress with what Buddhist monk Suzuki (1970) calls, "Beginner's Mind." Beginner's Mind opens us up to perceiving what is here now in this sensational moment rather than through the lens of the cognitive filters of emotions that can distort reality. As one's relationship with the waves of the ocean change so too can one's relationship with anxiety, uncertainty, and other extreme states of mind and body. What first appear to be menacing waves, internally and externally, can shift into sources of opportunity for growth and can cue new responses. This is possible when one assertively and courageously moves toward the waves. Each wave can lift and support us with its crest and offer a fun glide down into the calm trough on the other side of the peak.

This unexpected good outcome happens both when paddling out over waves and also when catching waves and riding them. This is the experiential manifestation of the "peak and pass" rationale for exposure therapy that I often use with those with anxiety disorders: "Fear peaks and passes like a wave. If you don't avoid and conditions are supportive of learning, you can discover that fear does not destroy you and the outcome is okay. Avoidance is not the reason fear and other unpleasant experiences pass. Avoidance robs us of the chance to learn that discomfort does not last forever and that we can manage outcomes better than predicted." The metaphors and wisdom of mindful surfing and paddling are abundant. This is what first led me to combine it with mindfulness training.

Learning mindfulness on the water can be especially engaging to people who experience extreme states of mind and body such as anxiety and stress-related disorders. Teaching mindfulness in less traditional settings can make it accessible to people who are willing to dip their toes in the water but not necessarily commit to a 2-month long mindfulness-based stress reduction (MBSR) or mindfulness-based cognitive therapy (MBCT) program. About 20 to 25% of people drop out of longer mindfulness training programs due to time demands and extreme states of emotion such as brooding rumination (cf., Hanley et al., 2016). Thankfully, there is evidence that "low dose" or brief mindfulness training programs can produce effect sizes comparable to the longer MBSR and MBCT programs (Carmody & Baer, 2009).

Learning mindfulness on the water can be especially engaging to people who experience extreme states of mind and body such as anxiety and stress-related disorders.

The benefits of combining mindfulness with surfing and other forms of recreation have been described by Jaimal Yogis. He writes about the wisdom that can arise through surfing and being in skillful relationship with fear and the ocean of experiences that are part of this human life in *Saltwater Buddha, The Fear Project*, and most recently, *All Our Waves Are Water*. In *Blue Mind*, Wallace J. Nichols cites a broad range of research about possible mechanisms to explain the healing properties of water. George Mumford's *The Mindful Athlete* is another example of how adapting mindfulness instruction to meet the needs of the student makes its benefits more accessible to a broader range of people. Mumford was inspired to innovate how and where mindfulness is taught by the challenge of coping with great physical and mental pain and to support himself and others in overcoming addiction. His teaching of mindfulness is grounded in both Buddhist philosophy and psychological science about Mihaly Csikszentmihalyi's "flow" construct.

Susan Kaiser Greenland, author of *The Mindful Child* and *Mindful Games*, also describes innovations in mindfulness training to increase its accessibility.

She combines mindfulness and play to support people of all ages to embody compassion and mindfulness in life. One useful exercise any therapist can offer on dry land was inspired by Kaiser Greenland and is part of the brief MBSR (bMBSR) program I developed for making mindfulness accessible to people with anxiety of all ages (Molnar, 2014; Molnar, Marks, Brewer, Gardner, & Klatt, 2012). In bMBSR, the Hoberman Sphere and Switch Pitch balls (see hoberman.com/fold/Sphere/sphere.htm) are used to support attentional broadening when anxiety is severe. The sphere transforms from narrow to broad and contracted to spacious, just like attention must if people are to overcome anxiety and other emotional disorders.

I hold the contracted sphere in front of my face and say, "Anxiety is like this—it prevents us from seeing what is right in front of us sometimes."

People nod in agreement.

I then gradually open and close it in synchrony with my breath as I say, "With mindfulness of simple sensations like the waves of the breath coming and going we can deconstruct anxiety into what it is made of: thoughts, sensations, and urges for behaviors." As I open the sphere wider and wider with each in-breath, I hold it over my head (all ages love this) and introduce three Switch Pitch balls to represent the elements that compose all emotions. I continue: "Just like these Switch Pitch balls change colors, we can use the presence of anxiety thoughts, sensations, and behaviors to cue new responses."

I toss the orange Switch Pitch ball into the air and as it flips into green, I say, "When we deconstruct anxiety into its components any one can become a mindfulness bell and cue a new response. I call it the "Take two, Recue (T2R)." For a classic panic spiral, I may say, "When you notice thoughts like, 'I can't breathe!' and when you feel the sensations of tightness in the torso, you can either let the thoughts or the sensations cue you to sense the feet on the ground or the breath as it expands the rib cage on each side of the torso and as it is released." There are so many skillful T2Rs: Critical self-dialogue cues compassion; narrow attention cues broad; avoidance cues moving toward what is feared with Beginner's Mind.

Once people discover they can be a friendly presence in relationship with others, they realize they can practice such presence in relationship with the self.

The experiential, as opposed to the narrative, mode of Beginner's Mind is associated with a shift from thinking to sensing and activates parasympathetic activity (Jain et al., 2007), which further quells stress physiology and broadens the field of attention. Other research reveals that when both compassion and the state of coactivation of ANS divisions are present for stressful states, parents show reduced reactivity and more skillful interpersonal relating with their children during stressful tasks (Miller, Kahle, Lopez, & Hastings, 2015).

One final innovation in teaching mindfulness in relationship deserves mention. It is a practice of mindfulness that supports the embodiment of ethical and compassionate action called Insight Dialogue (ID) (Kramer, 2007).

Whereas it can be difficult for anxious people to practice in silence, many, including those with social anxiety, discover how to relate with the self with friendliness and acceptance through the ID practice. This involves practicing being a friendly and accepting presence to others and listening mindfully as others speak about a contemplation topic that anchors attention. In bMBSR (Molnar, 2014), contemplation topics such as: "What Beginner's Mind sensations are noticed in the soles of the feet?" and "What internal and external conditions support friendly presence here now in practice with another?" are used. Once people discover they can be a friendly presence in relationship with others, they realize they can practice such presence in relationship with the self. The ID guidelines guide formal mindfulness practice, which is a laboratory for strengthening such presence in life.

Traditionally longer mindfulness training programs and practices can be inaccessible for reasons ranging from limited resources such as time and attention to the presence of extremely distressing and distracting emotional states (see Molnar et al., 2012, for a review). There is nothing like an approaching wave to inspire a skillful focus of attention. To surf powerful waves of water and stress to a life free from harm, and even fun, requires that one land attention in the sensational moment and respond compassionately and based on what is actually true right now. Ultimately that must happen off of a meditation cushion if mindfulness is to enhance wellness.

References

Bernston, G. G., Norman, G. J., Hawkley, L. C., & Cacioppo, J. T. (2008). Cardiac autonomic balance vs. cardiac regulatory capacity. *Psychophysiology, 45*(4), 643–652.

Blascovich, J. (2008). Challenge, threat, and health. In J. Y. Shah and W.L. Gardner (Eds), *Handbook of Motivation*. New York, New York: Guilford Press.

Carmody, J., & Baer, R. A. (2009). How long does a mindfulness-based stress reduction program need to be? A review of class contact hours and effect sizes for psychological distress. *Journal of Clinical Psychology, 65*, 627–638.

Fredrickson, B. L., & Branigan, C. (2005). Positive emotions broaden the scope of attention and thought-action repertoires. *Cognition and Emotion, 3,* 313–332.

Hanley, A. W., Abell, N., Osborn, D. S., Roehrig, A. D., & Canto, A. I. (2016). Mind the gaps: Are conclusions about mindfulness entirely conclusive? *Journal of Counseling and Development, 94*, 103–113.

Jain, S., Shapiro, S. L., Swanick, S., Roesch, S. C., Mills, P. J., Bell, I., & Schwartz, G. E. R. (2007). A randomized controlled trial of mindfulness meditation versus relaxation training: Effects on distress, positive states of mind, rumination, and distraction. *Annals of Behavioral Medicine, 33,* 11–21.

Kramer, G. (2007). *Insight dialogue: The interpersonal path to freedom*. Boulder, Colorado: Shambhala Publications.

Miller, J. G., Kahle, S., Lopez, M., & Hastings, P. D. (2015). Compassionate love buffers stress-reactive mothers from fight-or-flight parenting. *Developmental Psychology, 51*(1), 36–43.

Molnar, C. (2014). Generalized Anxiety Disorder. In L. Grossman & S. Walfish (Eds), *Translating research into practice: A desk reference for practicing mental health professionals*. New York, New York: Springer Publishing.

Molnar, C., Marks, D., Brewer, J., Gardner, F., & Klatt, M. (2012, November). *How much is enough? Designing "low-dose" mindfulness-based stress reduction programs for crowded schedules and busy lives*. Presented at the 46th Annual Conference of the Association for the Advancement of Behavior and Cognitive Therapy (ABCT), National Harbor, MD. Retrieved from meta4stress.com

Suzuki, S. (1970). *Zen mind, beginner's mind*. New York, New York: Weatherhill.

Therapeutic Horseback Riding

Judy Hendrickson, Founding Director, Reins of Life; reinsoflife@verizon.net

Judy Hendrickson

Reins of Life was established in 1993 as a 501(c)(3) nonprofit corporation and is well recognized as a successful therapeutic riding program for children and young adults with special needs. The program has helped hundreds of children and young adults with diverse types of disabilities make tremendous strides in improving the quality of their lives through therapeutic horseback riding. At Reins of Life, we strive to achieve physical development, socialization, and learning through fun equine activities and riding as we instill a great sense of success, confidence, and accomplishment in our riders. We are committed to serving each of our unique riders and their families in a caring, close-knit community. Our instructors and volunteers, along with myself, grow quite close to our riders and their families and celebrate the accomplishments of their therapy.

History of Therapeutic Riding

Horses have been utilized as a therapeutic aid since the ancient Greeks used them for those people who had incurable illnesses (Bizub, Joy, & Davidson, 2003). The benefits of therapeutic riding have been dated back to 17th-century literature, where it is documented that it was prescribed for gout, neurological disorder, and low morale (Willis, 1997). The modern term "therapeutic riding" was originally used in Germany to address orthopedic dysfunctions such as scoliosis (Benda, Fredrickson, Flanagan, Zembreski-Ruple, & McGibbon, 2000). The physician would engage a physical therapist and a specially trained horse and instructor to address a patient's strength and orthopedic dysfunction for one year, after which the patient was discharged. The physical therapist worked with the physician and the patient to attain the patient's goals, and the instructor was responsible for the horse. In the United States, this later became known as hippotherapy (American Hippotherapy Association, n.d.).

Therapeutic riding techniques used today started with Lis Hartel from Denmark. Her legs were paralyzed from polio but with therapy she was able to win the silver medal for dressage in the 1952 Olympic Games. The first riding centers in North America began in the 1960s, and the North American Riding for the Handicapped Association was launched in 1969 (PATH, 2014).

Exercises Involved in Therapeutic Riding

Therapeutic riding involves a wide range of activities and exercises the individual engages in while on and interacting with the horse. Some of these include:

- Sitting on the horse using proper posture
- Holding arms outstretched forward and then overhead, with pole or stick grasped with both hands
- Rotating the trunk with arms outstretched
- Turning side to side while sitting
- Lying back on horse's back, then returning to sitting position
- Advanced: riding without stirrups, riding independently, cantering, maneuvering the horse in a pattern, trotting over poles

Benefits Derived From Therapeutic Riding

The amount of benefit gained through therapeutic riding differs from person to person based on many factors, such as the type of disability, severity of disability, motivation of the rider, and connection between horse and rider. Unlike exercise machines that only focus on one muscle group at a time and do not use natural body movements, riding forces the rider to make use of the entire body to steer, control, adjust the horse, and maintain balance. Because physical and cognitive skills are required for achievement, riding reveals the strengths and weaknesses of the rider. While most traditional therapeutic techniques often reach a plateau where the patient may lose motivation, the pleasure and excitement of riding acts to encourage patients to work through the challenges associated with their physical or psychological condition. A multitude of psychological/psychiatric (Bennington-Castro, 2014) and physical (PATH, 2014) conditions can benefit from therapeutic riding. Some of these include:

Because physical and cognitive skills are required for achievement, riding reveals the strengths and weaknesses of the rider.

Psychological/Psychiatric Conditions

- ADD/ADHD
- Depression
- Anxiety
- PTSD
- Eating disorders
- Attachment, relationship issues
- Behavioral problems
- Learning disabilities

Physical Disabilities and Other Physical Conditions

- Traumatic brain injury
- Spinal cord injury
- Stroke
- Multiple sclerosis
- Muscular dystrophy
- Cognitive defects
- Autism
- Cerebral palsy
- Spina bifida
- Intellectual disability
- Orthopedic conditions

Safety Considerations

Many people might ask whether it's safe for someone with poor motor and communication skills to ride a horse. As with any intervention strategy, risks exist. Providers should fully inform themselves

of this method of intervention. Every precaution should be taken in implementing therapeutic horseback riding. For example, side walkers are utilized to help stabilize the rider and the horse is matched to the rider's ability level.

Proponents argue that the benefits of therapeutic riding far outweigh the risks. Despite its broad and beneficial effects, therapeutic riding may not be the appropriate therapy for some people with disabilities. A medical history and the health-care provider's statement of approval and recommendations are necessary before an individual can participate in therapeutic riding activities. Health-care information enables the riding instructor(s) to prepare for an individual's needs, plan supervision, and ensure rider safety.

Reins of Life Client Testimonials

Therapeutic horseback riding can be a viable component in comprehensive treatment of a range of physical and psychological issues when implemented by professionals trained in this mode of intervention. Clients of Reins of Life have experienced positive results. A few of the reported benefits include:

- Physically improved posture and muscle strength
- Gained social and verbal skills, along with feelings of accomplishment and pride
- Increased self-assurance and self-confidence that carries over into daily life
- Lots of laughter and smiles

Physical therapists are consistently surprised with the improved body strength, attributing it directly to horseback riding. During his first year, a client diagnosed with spastic quadriplegia cerebral palsy focused on increasing his head control and grew from being hunched over to sitting up straight on the horses. His overall physical strength, core abdominal strength, and tone improved, as well as his gait.

References

American Hippotherapy Association. (n.d.). Use of hippotherapy in occupational therapy, physical therapy and speech therapy. Retrieved from http://www.americanhippotherapyassociation.org/wp-content/uploads/2015/02/Final_Present-Use-of-HPOT-3-8-2017.pdf

Benda, W., Fredrickson, M., Flanagan, S., Zembreski-Ruple, J., & McGibbon, N. H. (2000). Animal-assisted therapy: A highly versatile modality. *Complementary Medicine for the Physician, 5*(6), 41–48.

Bennington-Castro, J. (2014). How horses help with mental health issues. Retrieved from https://www.everydayhealth.com/news/how-horses-help-with-mental-health-issues/

Bizub, A. L., Joy, A., Davidson, L. (2003). It's like being in another world: Demonstrating the benefits of therapeutic horseback riding for individuals with psychiatric disability. *Psychiatric Rehabilitation, 26*(4): 377–384. dx.doi.org/10.2975/26.2003.377.384

Professional Association of Therapeutic Horsemanship International (PATH). (2014). Learn about EAAT. Retrieved from https://www.pathintl.org/resources-education/resources/eaat/27-resources/general/194-eaat-benefits

Willis, D. A. (1997). Animal therapy. *Rehabilitation Nursing, 22*(2): 78–81. dx.doi.org/10.1002/j.2048-7940.1997.tb01738.x

Mindful Emotional Eating: A Humanistic, Harm Reduction Approach

Pavel Somov, PhD; www.drsomov.com

Dr. Pavel Somov

Emotional eating is misunderstood and often unnecessarily demonized. However, emotional eating—that is, eating to feel good, often termed "compulsive eating"—isn't the problem. It's emotional overeating and mindless emotional eating that can be both psychologically and physically unhealthy. Emotional eating works as a coping strategy and stress reliever if approached with mindfulness and moderation. I first wrote about mindful emotional eating in 2008 in my book, *Eating the Moment*. I have since continued to pilot and fine-tune my clinical approach to this problem and have had a chance to describe it in my most recent book, *Mindful Emotional Eating*.

Emotional Eating Is Inevitable

Whether you eat or overeat, whether you eat mindfully or mindlessly, one thing is clear: People only eat what they like to eat. How a particular food tastes is a fundamentally emotional consideration. Let's face it: Your body doesn't give a hoot whether you eat something that tastes good or not so good, as long as the food isn't rotten. Taste is the business of the mind—a matter of pleasure. Bottom line: Everyone eats for pleasure, so emotional eating is inevitable.

Emotional Eating Is Coping

Aside from eating to feel good, some of us also eat to cope—that is, to reduce emotional distress. Eating for pleasure or eating to reduce daily stresses are two sides of the same coin, but our all-or-nothing minds divide this indivisible coin in half. On one hand, we are encouraged to slow down and enjoy the food we eat. On the other hand, we are told by popular culture to never eat for emotional reasons. If this sounds like hypocrisy, it is. Any pursuit of well-being is simultaneously a reduction of distress.

Why Emotional Eating Works

There are several good reasons why emotional eating is so appealing as a coping strategy:

- Eating is oral coping: From day one, feeding has been a default parenting intervention and the pacifier our first coping tool. Eating to relieve oral tensions—for example, after quitting smoking—is an intuitive soothing choice.
- Feeding is caring: Many cultures explicitly equate feeding with caring. Remember Grandma's home-baked chocolate cookies after a hard day at school?
- Meal time is support time: Family meals are a family ritual, and at their best are a time of togetherness, an opportunity for social relating and belonging, and a means to emotional well-being.
- Eating is grounding. Eating is a ritual, and as such, it's comforting in its predictability. Eating is a sensation-rich, unambiguously physical activity. As such, eating is an effective reality check at a time of uncertainty or confusion, a behavior that grounds and centers a busy or overworked mind.
- Eating is relaxing. From the physiological perspective, a choice to eat can be seen as an attempt to directly manipulate the nervous system by switching on the part of our wiring that is associated with relaxation and rest.

Leveraging More Coping per Calorie

Given the fact that we all eat emotionally on some level or another, here are a few suggestions for making your meals more mindful, effective, grounding, relaxing, and nutritionally beneficial:

1. Accept emotional eating as a legitimate coping choice, not a coping failure.
2. When eating to cope, have an appetizer of relaxation first. Take a few moments to notice your breath and smell your food. Preload on the fullness of the moment.
3. Follow a predictable eating ritual, with clear starting and ending points. Begin with breathing, focus on your food throughout your meal, and end with a healthy dose of self-acceptance.
4. Use pattern-interruption techniques (such as eating with a nondominant hand or using the wrong utensils) to keep your mind aware, guessing, present, and focused during the mindful emotional eating episode.
5. If you want to binge or "veg out," or regress into a bit of a mindless "hand-to-mouth" trance, then consider a harm-reduction strategy: Mindfully choose what you will mindlessly eat. Instead of "inhaling" a bag of M&Ms, fill up on carrot sticks. The objection that carrot sticks don't taste as good as M&Ms is irrelevant here. Remember, this "hand-to-mouth" trance isn't about taste after all but about the soothing activity of self-feeding.
6. Know your comfort foods. Mindful emotional eating is an attempt at self-care. So, if you are going to try to self-medicate with food, you might as well use the right "medicine." Allow yourself to have exactly the experience of pleasure that you seek. Or risk filling up on what you don't want to eat and then feeling doubly disappointed.
7. Indulge on quality, not quantity. Mindful emotional eating is not about meeting your caloric quota or about how much you eat but about how much you enjoy this moment of

Eating for pleasure or eating to reduce daily stresses are two sides of the same coin, but our all-or-nothing minds divide this indivisible coin in half.

eating. So, as you purchase your comfort foods, pay the premium price and get the top-shelf foodstuffs. This additional financial investment will likely intrigue your tongue and help you slow down to mindfully notice this moment of self-care.

8. When you eat to cope, just eat. The suggestion of "eating when you eat" is the backbone of all mindful eating know-how. It is particularly important when it comes to mindful emotional eating. When you sit down to eat to cope, turn off the TV and put the reading aside. Or risk missing out on the very self-care moment you have so courageously allowed yourself to have. So, when you eat to cope, then just cope. If food is your therapist at this moment, then you have to show up for this session with yourself.

Building a new habit is a process. Give mindful emotional eating a try. Fine-tune this self-care strategy until you find the sweet spot of moderation. As with most life-modification plans, self-acceptance is a healthy place to start. Remember: Emotional eating doesn't have to lead to emotional overeating.

Pavel Somov, PhD, is a licensed psychologist in private practice in Pittsburgh. He is the author of seven mindfulness-based self-help books and speaks internationally on the topics of mindfulness. Dr. Somov is on the Advisory Board of the Mindfulness Project (London, UK). Several of his books have been translated into Dutch, Chinese, and Portuguese.

Dialectical Behavior Therapy—An Additional Potential Resource for School Psychologists?

Timothy L. King, PhD, drkingtesting@gmail.com

Dr. Timothy L. King

Last year, I submitted an article in response to a discussion amongst members of PPA's Board of School Psychology regarding potential "outside the box" roles of school psychologists, such as emergency responders or providers of brief therapy interventions such as solution-focused therapy. In a similar vein this year, I felt it might be helpful to present a brief overview of some potential school-based applications of dialectical behavior therapy (DBT), a cognitive-behavioral therapeutic approach based upon Marcia Linehan's extensive research and experience in treating borderline personality disorders (BPDs), as well her biosocial theory and principles of emotional dysregulation (Linehan, 1993). According to Linehan, the approach aims to: (a) reduce suffering, increase happiness; (b) increase the ability to control the mind; and (c) experience reality as it is. Thus, Linehan (1993) notes that DBT's central goal is to promote an individual's desire to live by building a life worth living. She explains further that the dialectical component of the approach essentially attempts to help individuals to incorporate two things that may seem like they are opposites—accept who they are yet feel motivated to initiate new activities to find more happiness in their lives.

While DBT was originally developed for adults, Mazza, Dexter-Mazza, Miller, Rathus, and Murphy (2016) have utilized DBT principles to focus on problematic realms determined to be the most common amongst middle and high school students: (1) difficulty managing emotions; (2) confusion about self/distraction; (3) impulsive reactions; and (4) interpersonal problem-solving skills. The approach the authors developed, entitled DBT STEPS-A, is described as "not a therapy program. Rather, it is a skills training component of DBT modified for students of middle and high school age, to be delivered as a universal social-emotional learning curriculum. The goal of DBT STEPS-A is to help youth develop their own tool boxes of effective strategies to regulate emotions, solve problems, improve relationships and enhance their lives" (p. 4).

Mazza et al. (2016) break the mindfulness intervention down further, into practice activities designed for students at middle and high school levels.

Thus, the authors teach students modified DBT techniques, divided into several modules covering the following realms:

- The emotional regulation module focuses on helping students improve their skills for naming emotions, decreasing unpleasant or distressing emotions, and increasing positive emotions;
- The mindfulness module assists students in developing their skills in becoming more observant and attentive to their environment, as well as developing an appropriate use and attentiveness to the concept of "wise mind"—a balance between the rational and emotional components of the mind;
- Distress tolerance teaches students techniques to cope with emotional distress without reacting impulsively and making matters worse for themselves; and
- Increasing interpersonal efficiency/effectiveness helps students develop and maintain better interpersonal relationships by using techniques to improve assertiveness, reduce conflict, and increase self-respect (Mazza et al., 2016).

Since many psychologists in private practice, as is the case with the author, are more inclined to use individual techniques of DBT (versus the entire approach) and many school psychologists are unlikely to have the time and/or opportunity to implement the entire DBT STEPS-A program, the focus of this article is to present selected techniques from the approach that could have a potentially broad application for middle and high school students and could potentially be used by psychologists consulting to or directing activities in special education emotional support programs.

For example, DBT practitioner Lane Pederson (2012) noted that: "Mindfulness is the foundation of DBT skills. It allows us to gain awareness into our feelings, thoughts, behaviors, relationship and environment . . . Neuroscience research shows that mindfulness makes positive and lasting changes to our brains" (p. 27). Pederson (2012) outlines a guide, very suitable for an adult population, for understanding and applying some of the principles of mindfulness in the publication.

Mazza et al. (2016) break the mindfulness intervention down further, into practice activities designed for students at middle and high school levels. For example, the first mindfulness activity focuses on a specific type of observation (e.g., focusing their sense of smell on a scented candle). Students are then instructed to assume the traditional mindfulness position and follow the leader's guidance for pacing their breathing and then focus on a specific entity for 2 minutes. Practice activities are then

assigned, and the students are encouraged to use "diary cards" to monitor their use and response to the intervention.

Similarly, the DBT techniques Pederson (2012) and Fox (2015) recommend to distract adults from disturbing and sometimes even self-destructive thought patterns could easily be taught, as Mazza et al. (2016) note, to troubled teenagers as "distress tolerance" strategies. The authors teach such strategies to teenagers (in a group session of standard class time, initiated with a 5-minute mindfulness activity) with the goal of helping them "get through a bad situation without making it worse" (p.103) by using distracting techniques encompassed by the acronym ACCEPTS:

- **A**ctivities—do something like call, email, or visit a friend
- **C**ontributing—contribute to or do something nice for a friend or help a sibling with homework
- **C**omparisons—compare how you are feeling now to a time when you felt more troubled and then think about others who may be coping less well than you
- **E**motions—watch a funny program or do something to get active, if you are sad
- **P**ushing away—leave the uncomfortable thought patterns mentally by building an imaginary wall or creating an image of putting the thoughts in a box and placing it on a shelf far away
- **T**houghts—replace your thoughts by engaging in activities such as reading a book or doing puzzles
- **S**ensations—intensify other sensations by engaging in activities such as holding an ice cube, petting a dog, or exercising

[I]n a time of shrinking school budgets, yet indications that ample numbers of at-risk or emotionally troubled teenagers will continue to populate school districts across the state, school psychologists may wish to utilize the references below to explore the principles and applications of DBT.

Students are then asked to select at least two specific ACCEPTS skills to practice in the upcoming weeks, keep track of what they did on their diary cards, and then present the results at the following meeting.

In closing, it seems important to note that the above brief overview was, as suggested previously, intended only to support school psychologists seeking to potentially explore additional interventions they may use with teenagers they are asked to see for a diagnostic consultation or may already be working with in emotional support programs in their districts, not as a replacement for additional training or more intensive researching or studying of the approach. Further, DBT is a well-researched clinical, therapeutic approach with a track record of efficacy for individuals with BPD (Linehan, 1993), that, as noted above, can be adapted to aid "typical" teenagers in coping with a variety of emotional and interpersonal concerns (Mazza, et al., 2016).

However, it seems equally important to mention that concerns about the DBT methodology have been raised. For example, critics noted that comprehensive use of the approach is difficult to implement, requires considerable ongoing training and supervision, and that client improvements in such areas as emotional regulation have often not been well defined (Fox, 2014). However, even taking into account the above concerns about DBT, it is the author's opinion that, in a time of shrinking school budgets, yet indications that ample numbers of at-risk or emotionally troubled teenagers will continue to populate school districts across the state, school psychologists may wish to utilize the references below to explore the principles and applications of DBT and determine whether the approach, or selected components of it, have merit for the work they are doing with teenagers in their respective districts.

References

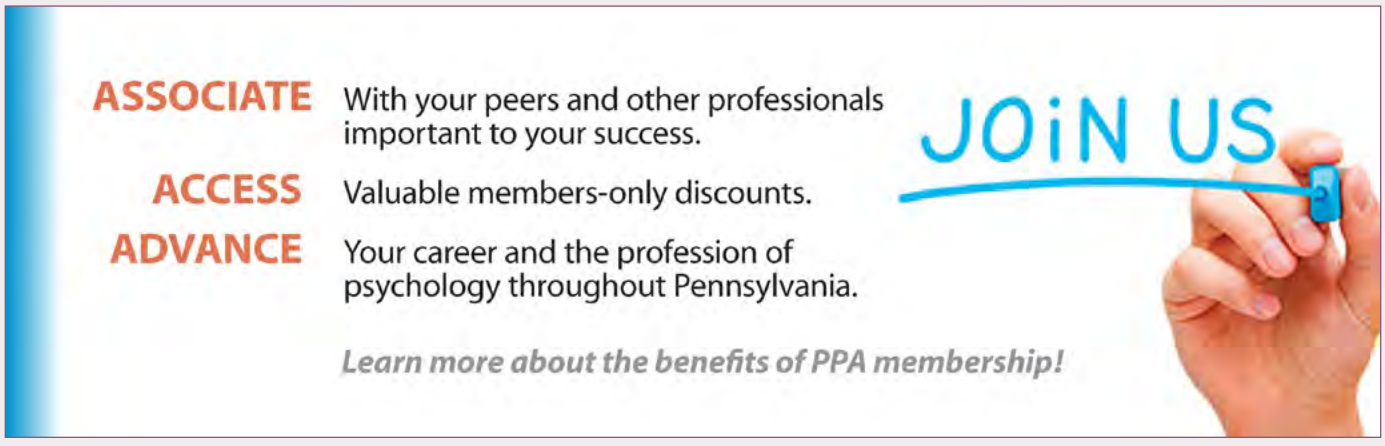
Fox, D. (2014) *Diagnosis and treatment of personality disorders: DSM-5 updates*. Eau Claire, WI: PESI, Inc.

Fox, D. (2015). *Treatment strategies for cluster B personality disorders*. Eau Claire, WI: PESI, Inc.

Linehan, M. (1993) *Cognitive-behavioral treatment of borderline personality disorders*. New York: Guilford Press.

Mazza, J., Dexter-Mazza, E., Miller, A., Rathus, J. & Murphy, H. (2016). *DBT skills in schools: Skills training for emotional problem solving for adolescents (DBT STEPS-A)*. New York, NY: Guilford Press.

Pederson, L., (2012) *The expanded dialectical behavior therapy skills training manual*. Eau Claire, WI: PESI, Inc.



First-Generation College Students: Common Risk Factors and Strategies for Success

Jessica Reinhard, MA, and Marie C. McGrath, PhD, Department of Psychology and Counseling, Immaculata University

Jessica Reinhard

Dr. Marie C. McGrath

In the United States, attainment of a college degree yields many benefits. Individuals who pursue postsecondary education are more likely to gain and maintain steady employment and financial security. While these trends are long-standing, they appear even more pronounced among millennials (Pew Research Center, 2014). Educational attainment is also associated with enhanced well-being. College graduates experience higher levels of autonomy, prestige, and satisfaction in the workplace; longer life spans; lower rates of divorce; and higher rates of civic engagement than peers without degrees (Pascarella & Terenzini, 2005; Trostel, 2015). Given the benefits associated with college completion, it is not surprising that postsecondary enrollment has increased by approximately one third since the year 2000 (National Center for Education Statistics, 2013).

First-generation college students (FGCSs) represent a large portion of the postsecondary student population; of the approximately 4 million students who enrolled in postsecondary programs for the first time in 2011–2012, 58% reported that neither parent held a bachelor's degree, and 31% reported that neither parent attended college at all (NCES, 2016). FGCSs are less likely to enroll in 4-year colleges and universities, more likely to enroll at institutions with higher student loan default rates, more likely to attend school part-time, and less likely to graduate within 6 years than non-FGCS peers (Postsecondary National Policy Institute, 2015; Cahalan, Perna, Yamashita, Ruiz, & Franklin, 2016). Thus, many aspiring FGCSs will struggle to attain the benefits associated with college completion, while still incurring the costs (i.e., debt, deferred job market entry). This article reviews factors that place FGCSs at risk for postsecondary difficulties and the strategies that can be implemented in secondary and postsecondary settings to increase the likelihood of postsecondary success for FGCSs.

Risk Factors and Stressors Commonly Experienced by FGCSs

In addition to issues that impact college students from all backgrounds, FGCSs experience specific stressors that place them at risk for college noncompletion and other negative outcomes, including:

Acculturative difficulties. Acculturation is the process of adapting to expectations and behaviors of another (typically dominant) cultural group (Birman, 1994). For FGCSs who are more likely to come from lower supplemental educational services, ethnic minority, and/or linguistic minority backgrounds than non-FGCS peers, postsecondary acculturation difficulties can cause stress. Once at college, FGCSs may feel pressure to choose between cultural and familial expectations and collegiate demands (Hodge & Mellin, 2010; Orbe, 2004), which can create anxiety and feelings of isolation. FGCSs may also lack knowledge of institutional support structures (e.g., academic support services, networking events) that may benefit them both personally and professionally. FGCSs may not attribute difficulties adjusting to college to acculturation factors and may blame personal deficits instead (Kingston, 2000).

Academic gaps. K–12 experiences may leave FGCSs underprepared for postsecondary education. High school academic rigor is associated with a variety of postsecondary academic outcomes, including GPA and degree attainment. For a variety of reasons (e.g., lack of secondary school resources, inadequate advisement), FGCSs tend to take less challenging high school courses than non-FGCS peers; as a result, they are more likely to be required to take non-credit remedial courses as prerequisites to credit-bearing courses, which can delay graduation and increase financial burden.

Family knowledge and expectations. Parental expectations of and support for college attendance are positively related to FGCS decisions to pursue postsecondary education (Bradbury & Mather, 2009). FGCS odds of postsecondary enrollment increase when topics related to educational achievement in general, and college attendance in particular, are discussed in the home (Perna & Titus, 2005). Overall, increased parental support facilitates both enrollment and psychological adjustment for FGCSs. Hodge and Mellin (2010) found that FGCS parents tended to offer general support for their children's college plans but were much less likely than non-FGCS peers' parents to be able to provide concrete assistance with specific college preparation tasks (e.g., college visits, financial aid applications).

Lack of financial resources. While education-related debt is a major concern for FGCSs and non-FGCSs alike, FGCSs tend to experience more financial stressors overall. Level of accumulated debt, including student loan debt, has been associated with decreased persistence for FGCSs. FGCSs are also more likely than non-FGCSs to live off campus and hold either part- or full-time employment during the school year to pay for tuition and living expenses; reallocating time and energy from one's studies to one's job may negatively impact FGCSs' academic performance and reduce time

and availability to participate in campus-based activities that enhance a sense of belonging (Hottinger & Rose, 2006).

Strategies to Combat Risk Factors and Increase FGCS Success

The risk factors described above may make it more difficult for FGCSs to experience postsecondary success. Interventions addressing these risk factors can ease FGCS transition into postsecondary education settings, including:

Role of secondary school staff. Long before students begin applying for college, K–12 school staff can help familiarize future FGCSs and their families with college planning processes. K–12 schools can partner with national organizations such as Advancement Via Individual Determination (AVID; avid.org), Career and College Clubs (careerandcollegeclubs.org), College Advising Corps (advisingcorps.org), College for Every Student (CFES; collegefes.org), and Project GRAD (projectgrad.org). These organizations provide traditionally underrepresented students with a variety of supports known to increase performance and graduation rates by offering college and financial aid application assistance, visits to college campuses, instruction in study and organizational skills, and mentors who can help FGCSs to build knowledge and skills that will be useful to them in postsecondary settings.

Role of postsecondary psychologists. Once FGCSs have matriculated, psychologists in postsecondary settings can help implement programs that address academic and socio-emotional risk factors specific to FGCSs (Stephens, Hamedani, & Destin, 2014). The difference-education model (Stephens et al., 2014), in which a diverse group of rising seniors speaks with FGCS and non-FGCS freshmen during orientation about how social class differences impacted their adjustment to college, is a brief and efficient intervention. FGCSs who participate in difference-education programs are more likely to believe that students from similar backgrounds can be successful in college; seek out support resources during freshman year; and achieve GPAs commensurate with those of non-FGCSs (when controlling for race, ethnicity, gender, income, SAT score, and high school GPA) (Stephens et al., 2014).

Stressors experienced by FGCSs may cause anxiety, depression, and other adjustment difficulties. Psychologists who provide counseling or related services in the college setting should be aware of the unique stressors that may affect this population, including potential feelings of isolation from one's old and new communities and self-blame for acculturative difficulties, so that they can address these factors as needed.

In addition to issues that impact college students from all backgrounds, FGCSs experience specific stressors that place them at risk for college noncompletion and other negative outcomes.

Interventions to address academic gaps can also help to reduce risks of poor academic performance and/or dropout among FGCSs. Establishing FGCS-specific learning communities, first-year experience programs, advising programs, and/or course clusters incorporating general education content and study skills can help to enhance FGCS academic performance while strengthening their ties to peers from similar backgrounds. Postsecondary psychologists can advocate for and/or help to implement such programs on their campuses.

In summary, FGCSs face a variety of risk factors and barriers to academic success. Understanding those factors can help staff in K–12 and postsecondary settings implement interventions to mitigate these factors, reduce FGCS-specific stressors, and increase the likelihood that FGCSs will attain the full range of benefits associated with postsecondary education.

References

Birman, D. (1994). Acculturation and human diversity in a multicultural society. In E. Trickett, R. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 261–284). San Francisco: Jossey-Bass.

Bradbury, B. L., & Mather, P. C. (2009). The integration of first-year, first-generation college students from Ohio Appalachia. *National Association of Student Personnel Administrators, 46*(2), 258–281.

Cahalan, M., Perna, L., Yamashita, M., Ruiz, R., & Franklin, K. (2016). *Indicators of higher education equity in the United States: 2016 historical trend report*. Washington, DC: Pell Institute for the Study of Opportunity in Higher Education, Council for Opportunity in Education and Alliance for Higher Education and Democracy of the University of Pennsylvania.

Hodge, A. E., & Mellin, E. A. (2010). First-generation college students: The influence of family on college experience. *The Penn State McNair Journal, 7,* 120–134.

Hottinger, J. A., & Rose, C. P. (2006). First-generation college students. In L. A. Gohn & G. R. Albin (Eds.), *Understanding college student subpopulations: A guide for student affairs professionals* (pp.115–134). Waldorf, MD: National Association of Student Personnel Administrators.

Kingston, P. W. (2000). *The classless society.* Stanford, CA: Stanford University Press.

National Center for Education Statistics. (2013). *Digest of education statistics, 2012.* Retrieved from https://nces.ed.gov/pubs2014/2014015.pdf

National Center for Education Statistics. (2016). *First-time postsecondary students in 2011–12: A profile.* Retrieved from https://nces.ed.gov/pubs2016/2016136.pdf

Orbe, M. P. (2004). Negotiating multiple identities within multiple frames: An analysis of first-generation college students. *Communication Education, 53*(2), 131–149.

Pascarella, E. T., & Terenzini, P. T. (Eds.). (2005). *How college affects students* (Vol. 1). San Francisco, CA: Jossey-Bass.

Perna, L. W., & Titus, M. A. (2005). The relationship between parental involvement as social capital and college enrollment: An examination of racial/ethnic group differences. *Journal of Higher Education, 76*(5), 485–518.

Pew Research Center. (2014). *The rising cost of not going to college.* Retrieved from http://www.pewsocialtrends.org/2014/02/11/the-rising-cost-of-not-going-to-college

Postsecondary National Policy Institute. (2015). *First generation students in higher education.* Retrieved from https://pnpidotorg.files.wordpress.com/2015/08/2017-first-generation-students.pdf

Stephens, N. M., Hamedani, M. G., & Destin, M. (2014). Closing the social-class achievement gap: A difference-education intervention improves first-generation students' academic performance and all students' college transition. *Psychological Science, 25*(4), 943–953.

Trostel, P. (2015). *It's not just the money: The benefits of college education to individuals and to society.* Retrieved from https://www.luminafoundation.org/files/resources/its-not-just-the-money.pdf

Justice for Animals: A New Working Group of APA Division 48

M. L. "Candi" Corbin Sicoli, PhD; mlcorbin@verizon.net

"In relations of man and the animals, with the flowers, with all the objects of creation, there is a whole great ethic scarcely seen as yet, but which will eventually break through into the light and be the corollary and the complement to human ethics."

— Victor Hugo

Dr. M. L. "Candi" Corbin Sicoli

Historically, we have placed the value of animals in terms of their utility to humans. Seldom have animals been valued in their own right and understood from their own perspective. We see animals but don't usually understand how they see us. A new perspective is emerging in which we seek to understand and value animals' experience of reality, independent of their utility to humans.

In the fall of 2016, I founded a group called Justice for Animals, as a working group of the American Psychological Association's Division 48 (Society for the Study of Peace, Conflict, and Violence). I contacted Frank Farley, president of Division 48, and with his help, 24 psychologists signed on to Justice for Animals Working Group (JAWG). The mission of JAWG is to be a source of inspiration, education, research, and community for psychologists working to make the world a more peaceful place for all by seeking to understand the complexities of human-animal interactions and securing the welfare and rights of animals, our companions on earth. JAWG members believe that there are strong links between violence to humans and violence to animals.

JAWG presented our inaugural symposium at APA in August. It was entitled Justice for Animals: Multiple Perspectives on Making the World a More Peaceful Place for Animals. Topics presented in this APA symposium included:

- How do we extend the concept of justice to animals?
- Animal welfare from a global peace perspective: Rights and responsibilities
- First do no harm: Why plant-based living is apropos to peace in our
- time

In terms of relevance to psychologists who are practitioners, many benefits can be found in the nexus of human-animal interactions. These do not need to involve harm to the animals or invasive experimentation upon them. Consider at least three examples.

First, programs exist to help children to cope with medical illnesses (Amiot, Bastian, & Son, 2016), such as animals visiting children in hospitals and helping students relax while they are trying to decode words when struggling to read (Winerman, 2017), as well as the equine programs that foster confidence in children's abilities to cope with challenges (Cumella & Simpson, 2014). Next, animals can help adults to cope with the devastating effects of PTSD, especially soldiers traumatized by war (Stecker, 2011). Last, animals may also be able to help the elderly by lowering their respiration rate and blood pressure (Cherniack & Cherniack, 2014) and by countering the effects of social isolation by offering companionship to the lonely (Friedmann, Thomas, & Son, 2011).

The movement toward employing animals as therapeutic agents, such as therapy dogs, has recently gained in popularity. However, much more research needs to be done to study the cost-benefit ratio for people and animals. We must bear in mind that this is again part of the idea that animals have value only in so far as they can assist humans. Much care should be taken in realizing the stress that these endeavors can cause animals, such as the seeming depression of dogs utilized in searching for bodies at Ground Zero after 9/11 or in some military operations. The possible problems animals might encounter when helping humans should be addressed (Amiot et al., 2016).

We welcome psychologists and psychology students to join us in helping to make the world a more just and peaceful place for all sentient creatures.

For more information, contact M. L. "Candi" Corbin Sicoli, PhD, at mlcorbin@verizon.net or visit peacepsychology.org/jawg, our APA page.

References

Amiot, C., Bastian, B. & Son, H. (2016). People and companion animals. *BioScience, 66*(7), 552–560.

Cherniack, E. P. & Cherniack, A. R. (2014). The benefits of pets and animal-assisted therapy to the health of older individuals. *Current Gerontology and Geriatrics Research*, 2014, Article ID 623203, 9 pages. dx.doi.org/10.1155/2014/623203

Cumella, E. J., & Simpson, S. (2007). *Efficacy of equine therapy: Mounting evidence.* Wickenburg, AZ: Remuda Ranch Center for Anorexia and Bulimia. Retrieved from https://www.researchgate.net/publication/228793576_Efficacy_of_equine_therapy_Mounting_evidence

Friedmann, E., Thomas, S. A., & Son, H. (2011). Pets, depression and long-term survival in community living patients following myocardial infarction. *Anthrozoös, 24*(3), 273–285. dx.doi.org/10.2752/175303711X13045914865268

Stecker, T. (2011, July 30). Why dogs heal PTSD. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/survivors/201107/why-dogs-heal-ptsd

Winerman, L. (2017). Allies, sidekicks and pals. *Monitor on Psychology, 48*(6), 51–56.

Attachment Psychoeducation for Foster Care Parents: A Silver Lining

Gina Rossitto, MA, grossitto@m.marywood.edu

Gina Rossitto

Jake sat quietly in the principal's office for the third time this week, waiting for his foster mom, Cindy, to pick him up. This time Jake was in trouble for stealing his fifth-grade classmate's lunch. Cindy bustled into the office with a sad look of exhaustion upon her face. She looked at Jake, sighed, and despairingly whispered, "Again?" Cindy is at the end of her rope. Jake's therapist recommended the use of a token economy in order to help reduce his behavior problems. Yet Jake is utterly indifferent as to whether he receives or loses a token. This is Jake's sixth foster placement, and he has lasted with Cindy for a record 5 months. But at this point, Cindy is contemplating how much longer she can allow Jake to stay with her family. Cindy has two biological children, and Jake is constantly engaging in physical altercations with them. She truly cares about Jake, but she has to think about the safety of her children and her own sanity.

Jake was born to a mother addicted to heroin and to a father who abused his mother, his three older siblings, and Jake himself. Child Protective Services eventually intervened when Jake was 7 years old, assigning him and his siblings to foster homes. He has not seen his siblings in over two years. The first seven years of Jake's life is beyond many of our own imaginations. Jake has never had the chance to form any attachment, let alone a secure attachment, with his biological or foster parents. He views others and the world as dangerous and unreliable, and he views himself as unworthy to receive love or affection.

Does this seem like a child who could be expected to care about receiving a token for good behavior? Tokens have no value to him. Jake's childhood left him angry, confused, and largely apathetic. It is no wonder that he is constantly acting out at home and at school. Yet Cindy cannot be expected to inherently understand the intricacies of Jake's difficulties. She does not have knowledge of attachment theory or attachment styles. Nonetheless, Jake's lack of a secure attachment style is the root of his adversity and the driving factor behind his behavior problems.

The improvement of our foster care system and the treatment of foster care children are vast issues requiring multiple levels of integrated corrective efforts.

How can we expect Cindy to help Jake thrive if she is not well versed on the nature of his struggle? Before we can expect Jake to care about receiving a token, we must help him to develop a secure attachment style. Before we can encourage this development, we must educate Cindy on this topic so that she may cultivate a greater understanding of Jake and ultimately the development of a secure attachment with him. The improvement of our foster care system and the treatment of foster care children are vast issues requiring multiple levels of integrated corrective efforts. One small yet significant step in this process is providing attachment psychoeducation for foster parents.

The Role of Attachment in Adjustment

Insecure attachment styles and attachment disorders are related to numerous negative outcome variables. For example, research has shown that, as compared to adolescents with secure attachment styles, adolescents with insecure attachment styles are less positively adjusted as evidenced by higher aggression and depression scores and lower sympathetic scores (Laible, Carlo, & Raffaelli, 2000). Additional research has found correlations between attachment insecurity and lower perceived social support among first-year college students (Shahyad, Besharat, Asadi, Alipour, & Miri, 2011) and between attachment insecurity and behavior problems as evidenced by externalizing symptoms among adolescents (Lacasa, Mitjavila, Ochoa, & Balluerka, 2015). The existing literature has also illuminated links between attachment styles and well-being, such that insecure attachment styles are related to reduced physical well-being (McWilliams & Bailey, 2010; Puig, Englund, Simpson, & Collins, 2013) and reduced psychological well-being (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998; Kafetsios & Sideridis, 2006).

Taken together, previous research has indicated that attachment insecurity is related to maladjustment, lower perceived social support, behavior problems, and reduced physical and psychological well-being (Diehl et al., 1998; Kafetsios & Sideridis, 2006; Lacasa et al., 2015; Laible et al., 2000; McWilliams & Bailey, 2010; Puig et al., 2013; Shahyad et al., 2011). Moreover, research shows that foster care children are particularly susceptible to attachment insecurity. For instance, a particular study found that foster care children exhibit significantly higher reactive attachment disorder (RAD) symptomatology scores as compared to children not involved with foster care (Minnis, Everett, Pelosi, Dunn, & Knapp, 2006). This is not surprising considering

Continued on page 28

ATTACHMENT PSYCHOEDUCATION

Continued from page 27

the early environments and experiences endured by foster care children.

Attachment Education

Given the unfavorable correlates of attachment insecurity and the prevalence of attachment insecurity among foster care children, it is quite logical to assume that foster parents are provided with exposure to this topic. Yet this is not the case. As a routine training practice, foster parents are not provided with psychoeducation about attachment styles or how attachment insecurity is affecting their foster children. This is a clear gap in the training of foster parents. Psychologists may help to bridge this gap both by intervening in the existing training model and incorporating attachment psychoeducation for foster parents into the treatment of foster children.

Behavioral intervention is highly efficacious as a treatment modality. However, as psychologists, it is our duty to go beyond behavioral interventions under these special circumstances. Before we can expect foster children to respond to behavioral interventions, we must help them to develop secure attachment styles and subsequently build upon that foundation. In order to do so, we must provide psychoeducation for foster parents about attachment insecurity as it pertains to their foster children.

Cindy has tried everything. Let's give her some new tools before Jake is forced to move on to his seventh placement. Jake's childhood has been far from favorable, but we can provide a silver lining via attachment psychoeducation for Cindy. Jake deserves the chance to thrive, and Cindy deserves the chance to help him do so. Attachment psychoeducation is a key that can unlock the door to these opportunities, and it is time we start putting this key to good use.

References

Diehl, M., Elnick, A. B., Bourbeau, L. S., & Labouvie-Vief, G. (1998). Adult attachment styles: Their relations to family context and personality. *Journal of Personality and Social Psychology, 74*(6), 1656–1669.

Kafetsios, K., & Sideridis, G. (2006). Attachment, social support and well-being in young and older adults. *Journal of Health Psychology, 11*(6), 863–875.

Lacasa, F., Mitjavila, M., Ochoa, S., & Balluerka, N. (2015). The relationship between attachment styles and internalizing or externalizing symptoms in clinical and nonclinical adolescents. *Anales De Psicología, 31*(2), 422. dx.doi.org/10.6018/analesps.31.2.169711

Laible, D., Carlo, G., & Raffaelli, M. (2000). The differential relations of parent and peer attachment to adolescent adjustment. *Journal of Youth and Adolescence, 29*(1), 45–59.

McWilliams, L., & Bailey, S. (2010). Associations between adult attachment ratings and health conditions: Evidence from the National Comorbidity Survey Replication. *Health Psychology, 29*(4), 446–453.

Minnis, H., Everett, K., Pelosi, A. J., Dunn, J., & Knapp, M. (2006). Children in foster care: Mental health, service use and costs. *European Child & Adolescent Psychiatry, 15*(2), 63–70. dx.doi.org/10.1007/s00787-006-0452-8

Puig, J., Englund, M. M., Simpson, J. A., & Collins, W. A. (2013). Predicting adult physical illness from infant attachment: A prospective longitudinal study. *Health Psychology, 32*(4), 409–417. dx.doi.org/10.1037/a0028889

Shahyad, S., Besharat, M. A., Asadi, M., Alipour, A. S., & Miri, M. (2011). The relation of attachment and perceived social support with life satisfaction: Structural equation model. *Procedia: Social and Behavioral Sciences,15*, 952–956.

PPAGS Highlights

Meet Your 2017–2018 PPAGS Board of Directors!

Chair
Jessica Dougan, MA, Marywood University

Chair Elect
Jessica Reinhard, MA, Immaculata University

Past Chair
Amanda Sellers, PsyD, Chestnut Hill College

Communication Focus
Whitney Walsh, MS, Chestnut Hill College

Diversity Focus
Kameelah Mu'Min Rashad, MS, MEd, Chestnut Hill College

Programming Focus
Camille St. James, MS, Chestnut Hill College

State Advocacy Coordinator
Karishma Lalchandani, BS, Widener University

Representative from PPA Board of Directors
Marie McGrath, PhD, Immaculata University

A note from the PPAGS Board of Directors

We are excited to serve the students of PPAGS and look forward to the upcoming year. Please keep an eye out for upcoming events and information starting with the internship fair this fall!

About PPAGS

The Pennsylvania Psychological Association of Graduate Students (PPAGS) is the voice of student concerns within PPA. Student members of PPA are automatically members of PPAGS. Check out papsy.org for a list of accredited internship sites in Pennsylvania, a calendar of student events, more information about PPAGS, and how to become more involved.

Gift Giving, Boundary Crossings, and Consultations

Jeanne M. Slattery, PhD; Linda K. Knauss, PhD; and Deb Kossmann, PhD

This vignette is part of a regular series looking at clinical dilemmas from an ethical standpoint. In addition to the three of us, the respondents to this vignette included Drs. Fran Fettman, Don McAleer, and Ed Zuckerman.

Dr. Shelter has seen Mr. Gifter for about 10 years, first in her outpatient practice, then in assisted living. Over this period of time, Mr. Gifter has lost his vision and is now in a wheelchair. His Seeing Eye dog, Leia, is very attentive but no longer "working." Mr. Gifter has become increasingly concerned about Leia and has asked Dr. Shelter to take her in the likely case that he is moved to a nursing home. Although he has checked out other options, they aren't workable. Knowing that Leia would be cared for would give Mr. Gifter real peace of mind.

Dr. Shelter loves Leia even though she is not really a "dog person" and could use her as a therapy dog in her office. She is concerned, however, about the boundary issues raised here and wonders how she should handle this difficult situation.

As we talked our way through this case, we kept shifting our perspectives. Most of us, including Drs. Fettman and Zuckerman, started by thinking about issues of beneficence and nonmaleficence. We considered the potential good that could come of such a gift giving and also initially saw little harm. In fact, Dr. Knauss saw this as an opportunity for basic human kindness, which could itself be therapeutic, and an opportunity for Mr. Gifter to control his fate and that of Leia's.

Dr. Jeanne M. Slattery

Dr. Linda K. Knauss

Dr. Deb Kossmann

Because this is an ethics vignette, however, it felt like a trick question. Clearly this can't be so easy! Dr. Kossmann spoke for all of us in acknowledging that this gift is a boundary crossing but not clearly a boundary violation (Guthiel & Gabbard, 1993). She considered this instance of gift giving from a less pejorative stance than is often proposed—as simply stepping outside the typical roles of therapy—and as a place where we should be more thoughtful as we do so (Brown, 1994).

Dr. Slattery observed that gift giving can shift roles in therapy. Both she and Dr. Kossmann described a variety of ways that their clients had used gift giving: to curry favor, to demonstrate how important we are to them, to feel worthy of our time and attention, and perhaps even to be "taken home"—as the gift is—after therapy is over. Sometimes a cigar is only a cigar, though. As gift giving is a typical part of most relationships, even relationships that superficially appear similar to therapy, some gifts may only indicate social skills and an adherence to cultural norms.

Dr. McAleer's first response was a practical one: Does Dr. Shelter really want to take care of the dog? If there's no real potential for harm, Dr. Shelter should at least have a choice in this situation. Dr. Fettman asked whether Dr. Shelter even had the skills and interest to accept this long-term responsibility.

Dr. McAleer's second reaction, though, was about what it would be like to give a "child" to someone else. We are animal lovers, so this comparison struck home: Our dogs and cats really are our children. What would happen if Leia died in Dr. Shelter's care? What if Dr. Shelter didn't care for Leia as Mr. Gifter believed should be the case (e.g., crating Leia when her presence was inconvenient)? His practical question, "What could go wrong?" helped us consider the possible benefits and costs accruing from any decision.

It seems that these concerns would continue to follow Dr. Shelter even after Mr. Gifter's death, although Mr. Gifter would not know how Leia was being cared for. Dr. McAleer suggested that at this point it might cease to become an ethical issue and more of a practical one. Would Dr. Shelter feel she had betrayed Mr. Gifter and his dog?

Even if there is no damage to Mr. Gifter or this relationship, would it create an appearance of impropriety? How would other residents in the assisted living facility perceive this? How about in the larger community and in what ways, positively and negatively, might they perceive psychologists as a result of this decision?

Process Issues

We were each curious about our process during this discussion. We started by not immediately seeing harm—and maybe there would be none—but gained different perspectives through hearing other people's perspectives. Dr. McAleer, for example, wondered to what degree our initial responses might be some sort of internal bargaining or justification to do the very things that we wanted to do. If

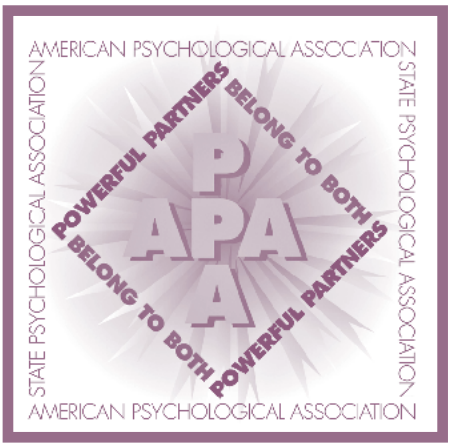
Continued on page 31

Would you like to be involved in future discussions of vignettes? Let us know by emailing

jslattery176@gmail.com

Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between May and August 15, 2017!



NEW MEMBERS

Isaac Brandt, PhD
Lewisburg, PA

Sue-Ellen Brown, PsyD
Volant, PA

Sierra Brown, PhD
Hershey, PA

Linda Brownback, MA
Allentown, PA

Carol Campbell, EdD
Flourtown, PA

Christine Castillo, PhD
Spring Grove, PA

Amy Cohen, PhD
Bethlehem, PA

Thomas Condon, PhD
Philadelphia, PA

Christopher Connacher, PhD
Lewisburg, PA

Kate Connolly, PsyD
Philadelphia, PA

Heidi Dalzell, PsyD
Newtown, PA

Benjamin Daniels, PsyD
Philadelphia, PA

Karen DeKleva, MA
Pittsburgh, PA

Kelly Donohoe, PsyD
Pittsburgh, PA

Anne Eaton, MEd
Bloomsburg, PA

Nancy Farber, PhD
Hershey, PA

Linda Filetti, PhD
Thornton, PA

Jill Fuini, PhD
Bethlehem, PA

Ellen Halpern, PhD
Flemington, NJ

Samantha Holt, PhD
Lewisburg, PA

Sandra Jaffe, PhD
Pittsburgh, PA

Paul Jones, PhD
Bryn Mawr, PA

Elizabeth Kleber, PhD
Haverford, PA

Nicole Lavertue, PsyD
Duncannon, PA

Julie Learn, PsyD
Homer City, PA

Nancy Lee, PhD
Philadelphia, PA

Bryce Lefever, PhD
York, PA

Jaclyn Levy, PsyD
Bear, DE

Debra Luther, PhD
Pittsburgh, PA

Thomas Mack, PhD
Collegeville, PA

Nadine Metro, PsyD
West Chester, PA

Meg Miller, PhD
Wynnewood, PA

Terry Murphy, PsyD
Philadelphia, PA

Amy Neeren, PhD
Havertown, PA

Michael John Niewiecki, PhD
Philadelphia, PA

Jessica Parrillo, PhD
Collegeville, PA

Jane Pile, PhD
Allentown, PA

Anthony Ragusea, PsyD
Key West, FL

Noah Rahm, PsyD
Sewickley, PA

Jordan Rood, PsyD
Pittsburgh, PA

Margarita Saenz, PsyD
Philadelphia, PA

Shiri Sella, PsyD
Cherry Hill, NJ

Shannan Smith-Janik, PhD
University Park, PA

MaryAnne Spencer, PsyD
Cranberry Township, PA

MaryAnn Sutton, PhD
Harrisburg, PA

David Swisher, MS
Huntingdon, PA

Jenna Tinker, PsyD
Drexel Hill, PA

LeeAnn Trudel, PhD
Wilmington, DE

Julia Vahlsing, PsyD
Wynnewood, PA

Linda Veronie, PhD
New Castle, PA

Stacey Wettstein, PhD
Pittsburgh, PA

STUDENT TO MEMBER

Devon Dautrich, PhD
Wayne, PA

Amanda Sellers, PsyD
Allentown, PA

Chesha Simon, MA
Morton, PA

Kristine Spano, PsyD
Philadelphia, PA

NEW STUDENTS

Leah Bowden, BA
Philadelphia, PA

Patrick Breen, BS
Scranton, PA

Tiara Brock, MA
Philadelphia, PA

Elisa Brown Fuller, MA
Philadelphia, PA

Amara Chukwunenye, BS
Scranton, PA

Ariel Cohen, MA
Conshohocken, PA

Mackenzie Crawford, MEd
Indiana, PA

Brienna-Rae Cruz, BS
Jermyn, PA

John DeHart, MS
Lonaconing, MD

Raquel Emdur, MA
Philadelphia, PA

Jessica Flores, MS
Philadelphia, PA

Marcus Garrido-Balanzategui, BS
Malvern, PA

Felicity Gazowsky, MS
Newark, DE

Lara Gross, MS
Conshohocken, PA

Jennie Harrigan, BA
Philadelphia, PA

Zachary Heimbuck, MA
Philadelphia, PA

Stephanie Herlitz, BA
Verona, PA

Ashley James, BS
Philadelphia, PA

Kathleen Jones, BA
Blakeslee, PA

Joanna Kaye, MS
Philadelphia, PA

Asher Kline, MS
Elkins Park, PA

Karmen Koesterer, MEd, MA
Lititz, PA

Kara Manning, BA
Philadelphia, PA

Gabrielle Massi, BS
Perkasie, PA

Corrine McCarthy, MA
Philadelphia, PA

Emily Melhorn, BA
Scranton, PA

Kayla Meyer, BS
Macungie, PA

Katerina Michaels, BA
Philadelphia, PA

Alysha Morehouse, BA
New Tripoli, PA

Molly Norman, BA
Philadelphia, PA

Kyle Osbourne, MA
Elkins Park, PA

Natalie Palermo, BS
Glen Mills, PA

Alexandra Pappas, MS
Philadelphia, PA

Fiona Purcell, MS
Bala Cynwyd, PA

Jessica Rutkowski, BA
Hanover Township, PA

Nicole Ryan, MS
Philadelphia, PA

Laura Salciunas, MS
Ardmore, PA

Kelsey Sanner, BS
Philadelphia, PA

Sarah Schwartz, BS
Scranton, PA

Hider Shaaban, BA
Philadelphia, PA

Regina Silvestrini, MA
Lansdale, PA

Katlyn Sodon, BA
Perkiomenville, PA

Jenna Steinmiller, MA
Philadelphia, PA

Bianca Stern, BA
West Chester, PA

Falynn Strohl, MA
Allentown, PA

Beth Ann VanVleet, BA
Mount Ephraim, NJ

Francesca Varischetti, BS
Brockway, PA

Shannon Walsh, BA
Farmingdale, NJ

Letricia Whitfield, BA
Philadelphia, PA

Kennedy Wong, BA
Philadelphia, PA

Emily Young, MS
Philadelphia, PA

Yetianyi Yu, BA
Scranton, PA

Tomasz Zuk, BA
Easton, PA

GIFT GIVING

Continued from page 29

we liked and wanted Leia, would we frame our questions differently than if we didn't want her?

The strength of consulting is that engaging in it caused us to take a step back and consider some of the issues that we initially hadn't thought as much about. Dr. McAleer observed that decisions made in haste are more open to error, while Dr. Knauss observed that this was an example of the value of having or obtaining multiple opinions. And, as we should always conclude, Dr. Kossmann reminded us to document our decisions and our decision-making process.

References

Brown, L. S. (1994). Boundaries in feminist therapy: A conceptual foundation. In N. K. Gartrell (Ed.), *Bringing ethics alive: Feminist ethics in psychotherapy practice* (pp. 29–38). New York, NY: Haworth.

Guthiel, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk management dimensions. *American Journal of Psychiatry, 155*, 409–414.

Classifieds

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

1,227 SF OFFICE CONDO FOR SALE IN BALA CYNWYD! Ample parking, immediate access to Route 76 and City Ave. 3 private offices, waiting area, kitchenette, bathroom, and elevator access. For more information, please contact Tess Scott at 610-401-3453.

THERAPY OFFICE TO RENT, MAIN LINE, HAVERFORD—Sunny 1st floor furnished office available. Monday, Wednesday, Thursday, Friday. Shared attractive office suite/waiting room, in building with other psychologists, psychiatrists, LCSW offices. Hi Speed Wi-Fi. Well-lighted parking lot. $50 per day/evening. carole@mstherapist.com or 610-649-9964.

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 in to 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 September 30, 2019.

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

Chase

1. One of the earliest clinical applications of VR technology was:
   a. An assistive device for hypnotherapy
   b. Part of exposure-based treatment for PTSD
   c. Social modeling for young children with autistic spectrum disorder
   d. A training tool for interns in a psychological services center

2. VR technology has been shown to be generally safe to use with clients from all age groups.
   True
   False

Treadwell

3. The cognitive experiential group therapy (CAGT) model can be applied by any professional who has a background in psychology training.
   True
   False

4. The automatic thought records are to be used to identify core beliefs and maladaptive schemas.
   True
   False

Molnar

5. Several "low-dose" or brief mindfulness-based training programs have been developed that evidence comparable effect sizes to those found in research with the traditional but longer MBSR and MBCT training programs.
   True
   False

6. When stressful situations are perceived as challenging verses threatening, both the sympathetic and parasympathetic divisions of the autonomic nervous system can be activated in a state called coactivation that one study by Miller and colleagues showed was associated with reduced reactivity in parenting behaviors during a stressful task.
   True
   False

7. Positive emotion, such as that occurring during play, expands the field of attention and builds resilience according the Fredrickson's (2005) Broaden and Build theory and findings.
   True
   False

Hendrickson

8. Horses have been utilized as a therapeutic mode of intervention dating as early as:
   a. The 1980s
   b. The early 1900s
   c. Ancient Greek times
   d. The cowboy era

9. Therapeutic riding is being used as an intervention tool as part of treatment of physical and psychological issues.
   True
   False

Somov

10. Mindfulness-based, harm-reduction technologies can be used to leverage more coping per calorie and thus optimize emotional eating as a coping choice.
    True
    False

King

11. DBT STEPS-A offers elementary school students interventions that may help them address common problems they experience.
    True
    False

Reinhard & McGrath

12. Which of the following experiences may negatively impact how FGCSs function in postsecondary environments?
    a. Acculturation-related stress
    b. Academic underpreparedness
    c. Lack of family support
    d. All of the above

13. Difference-education interventions appear to increase FGCS _____.
    a. GPA
    b. Willingness to access support services
    c. Beliefs that they can succeed in college
    d. All of the above

Sicoli

14. Traditionally, animals are seen as having value to the extent that they can be useful to humans.
    True
    False

15. JAWG is a working group of the Pennsylvania Psychological Association.
    True
    False

Rossitto

16. Studies have shown that attachment insecurity is related to which of the following?
    a. Behavior problems and lower perceived social support
    b. Reduced physical and psychological well-being
    c. Maladjustment
    d. All of the above

Slattery, Knauss & Kossman

17. Clients can use gift giving to:
    a. Curry favor
    b. Demonstrate how important we are to them
    c. Feel worthy of our time and attention
    d. All of the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, September 2017**

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

1.	a	b	c	d	**10.**	T	F		
2.	T	F			**11.**	T	F		
3.	T	F			**12.**	a	b	c	d
4.	T	F			**13.**	a	b	c	d
5.	T	F			**14.**	T	F		
6.	T	F			**15.**	T	F		
7.	T	F			**16.**	a	b	c	d
8.	a	b	c	d	**17.**	a	b	c	d
9.	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

Comments or suggestions for future issues _____

_____

Please print clearly.

Name _____

Address _____

City _____ State ____ZIP _____ Phone ( ) _____

I verify that I personally completed the above CE test.

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!

Vol. 77, No. 8

The Pennsylvania Psychologist

September 2017 • QUARTERLY

PRSRT. STD.
U.S. POSTAGE
PAID
Harrisburg, PA
Permit No. 1059

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

2017/18 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2017, 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.

September 15, 2017 • noon–1:30 p.m. (1.5 ethics credits)
Patient Focused Risk Management: An Ethical Approach
Rachael Baturin, JD, MPH—PPA Office

October 20, 2017 • noon–1:30 p.m. (1.5 ethics credits)
How to Ethically Respond to a Subpeona or Court Order
Rachael Baturin, JD, MPH—PPA Office

October 26–27, 2017
Fall Continuing Education Conference
Eden Resort Inn, Lancaster, PA

October 30, 2017 • noon–1:30 p.m. and
November 6, 2017 • noon–1:30 p.m.
The Darker Side of Ethics and Morality in Psychological Practice
John Gavazzi, PsyD, ABPP—PPA Webinar

November 17, 2017 • noon–1:30 p.m. (1.5 ethics credits)
When to Ethically Break Confidentiality
Rachael Baturin, JD, MPH—PPA Office

April 2018
Spring Continuing Education Conference
Pittsburgh Area

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

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

Home Study CE Courses

Act 74 CE Programs

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

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

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

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

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

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

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

*Introduction to Ethical Decision Making**—3 CEs

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

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

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