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PRESIDENT'S UPDATE

By Dr. Cathy Fiorello
Temple University

Division 16 had a very successful program at the APA Convention in Washington DC this year. With nine collaborative programs, 13 symposia, and four poster sessions, there were many opportunities to learn (and often earn CE credits) about everything from bullying to systems change to mental health to social justice. We also honored many amazing Division members at our Business Meeting. Cecil Reynolds won the

Nadine Murphy Lambert Lifetime Achievement Award. Vincent Alfonso was presented with the Jack Bardon Distinguished Service Award, and Thomas Power the Senior Scientist Award. Our inaugural Contributions to Practice Award went to Dawn Flanagan. Chris Riley-Tillman was awarded the Tom Oakland Mid-Career Science Award. We presented two Lightner Witmer Awards for outstanding early career research to Keith Radley and Tyler Renshaw. Paige Mission won the Outstanding Dissertation Award. For more information about the Convention and our award winners, including the names of our student Ribbon Walk winners, visit the Division 16 event archive.

The APA Convention next year will be August 9–12 in San Francisco. We certainly hope to see you all there! The call for 2018 APA Convention proposals is out. Collaborative submissions are due by October 13, and regular submissions are due by December 1. Division 16 is accepting proposals for symposia and posters. We are also seeking convention proposal reviewers. Contact Jessica Reinhardt to volunteer.

We also launched our Committee on Professional and Corporate Sponsorship of School Psychology (CPCSSP). The committee, chaired by Cecil R. Reynolds, is raising money to establish a Legacy Fund, a capital endowment campaign that will ensure the future of Division 16. For information about the committee and to ask about purchasing a sponsorship or donating to the Legacy Fund, visit the Division 16 website.

Division 16 is working hard to address the internship shortage, especially as APA moves to requiring APA-accredited internships for students in APA-accredited programs by 2020. We are again accepting applications for the Grant Program for School Psychology Internships (GPSPI). The program, supported by Division 16, CDSPP, NASP, and TSP, is designed to develop new APPIC School Psychology Internship

Dr. Cathy Fiorello

Programs that will eventually obtain APA accreditation. The program provides funds and consultation to University–School partnerships to aid them in developing consortia, building on the strong school-based internships already present in school psychology.

Division 16 has also launched its Webinar series, featuring Dr. Dana Boccio in September speaking about administrative pressure to practice unethically. Keep an eye out for announcements of future offerings!

TEACHERS' PERSPECTIVES OF ACADEMIC ACCOMMODATIONS FOR STUDENTS WITH CONCUSSIONS

By Adam G. Blefari, Psy.D., Duquesne University
Tammy L. Hughes, Ph.D., Duquesne University
Scott L. Graves, Ph.D., Duquesne University
Nathan E. Kegel, Ph.D., UPMC Sports Medicine Concussion Program

A concussion, or mild traumatic brain injury, is diagnosed when a child or adolescent receives a blow to the head or body by an external force (traumatic event) that is followed by one or more symptoms that disrupt their daily life (Collins, Kontos, Reynolds, Murawski, & Fu, 2014). Although different for everyone, the concussion symptoms can present as deficits within the physical, cognitive and emotional domains (McGrath, 2010). There are about twenty-one symptoms commonly experienced after a concussion injury (Collins, Kontos, Reynolds, Murawski, & Fu, 2014). The impact of the hit to the head causes the brain to jar or shake within the skull (Halstead, McAvoy, Devore, Carl, Lee, & Logan, 2013). On a cellular level, this jolt causes efflux of potassium and an influx of calcium that results in the constriction of blood vessels within the brain (Grady, Master,

"Cognitive deficits following concussion can impact long term recall when taking tests, sustain attention when taking notes in the classroom, and the ability to finish work and tests in a timely manner."

& Gioia, 2012; Giza & Hovda, 2014; Collins et al., 2014). These constrained blood vessels make it difficult for blood to flow freely in the brain, causing the brain to need more energy even for routine functioning. Given that concussion is a neuro-metabolic energy crisis, students with a concussion are more likely to have an increase in symptoms when they exert themselves both physically and cognitively (Grady et al., 2012; Halstead et al., 2013; Giza & Hovda, 2014).

Accommodations for Concussions in Schools

Most students recover from a concussion in two to four weeks post-injury (Collins et al., 2014). However, a student who returns to school too early can experience on-going or increased symptoms (Halstead, et al., 2013). For example, headaches may be triggered by environmental sensitivities (light and noise), and may consequently impact cognitive functions including attention/concentration and memory. Dizziness of vestibular origin can present challenges when students make their way through busy environments such as hallways and cafeterias. If the student has light or noise sensitivity symptoms from sustaining a concussion, PowerPoint presentations, movies, computers, fluorescent lights, and crowded and loud places, like lunchrooms, hallways, music class, gym class, or shop class, could exacerbate symptoms of the concussion. Cognitive deficits following concussion can impact long term recall when taking tests, sustained attention when taking notes in the classroom, and the ability to finish work and tests in a timely manner. Finally, sleep disturbance due to concussion, may make it difficult for the student to remember the information taught, cause tardiness or absences, or could cause sleeping in class (Halstead et al., 2013). In classes that build upon past lessons, such as math, a concussion can have a large impact on long-term academic success. By missing two to four weeks of material due to a lack of concentration, fatigue, and memory issues, one may struggle to catch up to their peers.

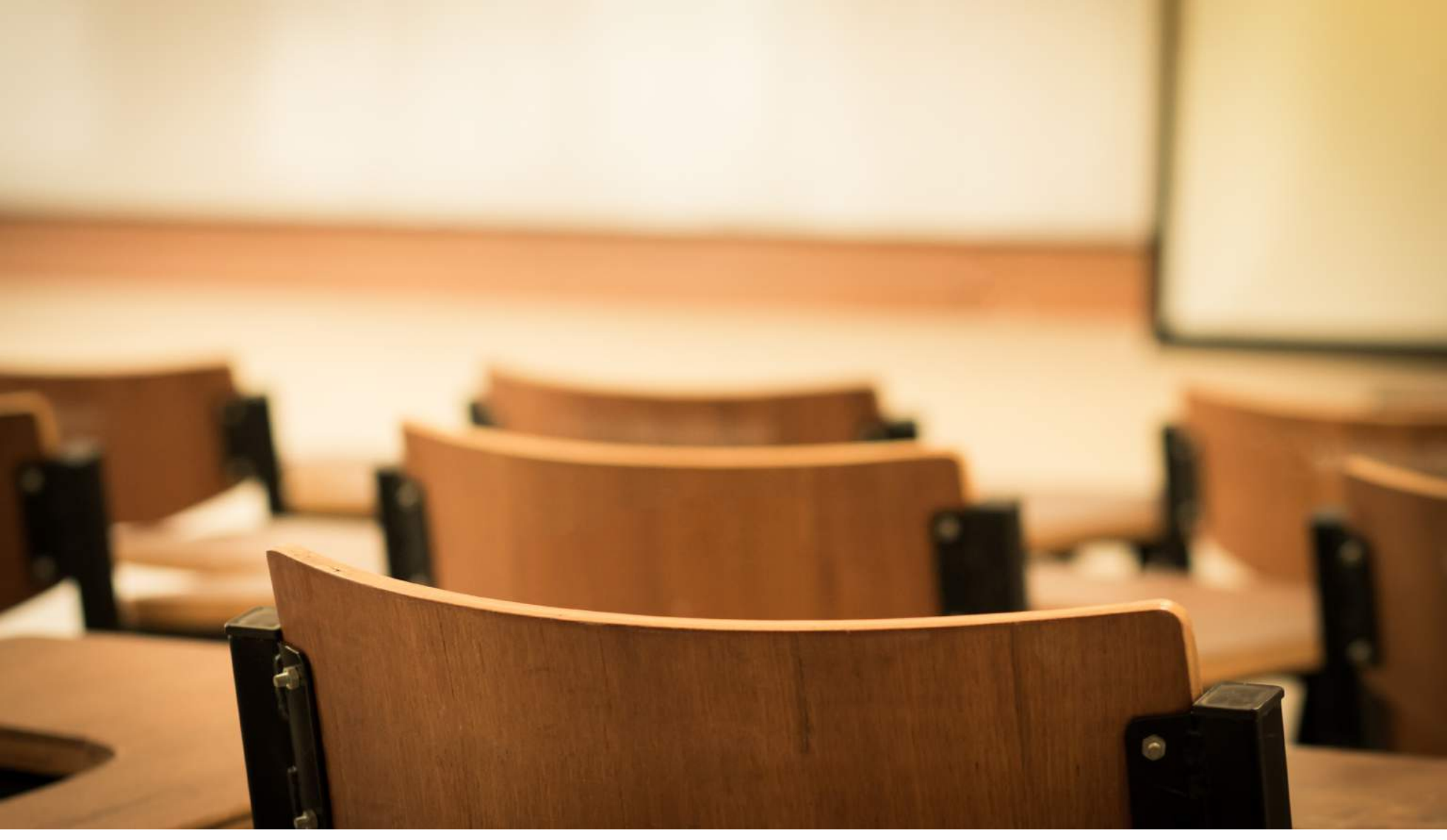
When developing a return-to-school protocol, it is critical to examine evidence-based accommodations. Table 1 summarizes the most common evidenced-based accommodations, fundamental reasoning surrounding the importance of the accommodation, and practical academic accommodation options school psychologists can suggest for children that are concussed. This table was incorporated from a systematic review of accommodations provided to children with concussions. The table was procured from databases such as PsychINFO, PsychArticles, and google scholar by utilizing key terms such as “return-to-learn,” “concussion,” “return-to-school,” and “academic accommodations for concussions.” The citations for each article utilized in the creation of the table were placed in the corresponding box marked “research”.

TABLE 1

Accommodation	Reasoning	Accommodation Option(s)	Research
Cognitive Rest	• It is important that students are given time to heal following a concussion. One way to do so is by keeping the student's activity below a cognitive level that triggers his or her symptoms (sub-symptom threshold). • However, light activity has been shown to be beneficial because it allows students: o To manage their stress o Keep a regular schedule o Enhance their sub-symptom threshold	• Not going to school • Giving the student a half-day of school • Priority attendance to core classes • Going a full day but given breaks when needed • Having the teacher not give the student homework or school work • Avoid reading, video games, texting, computer time	Halstead et al., 2013; Sady et al., 2011; McGrath, 2010; Master et al., 2012; Moser et al., 2013; Silverberg & Iverson, 2013; Brown et al., 2014; Rose et al., 2015; Arbogast et al., 2013; Gibson et al., 2013; Moser et al., 2013; Brown et al., 2014; Thomas et al., 2015; McCrory et al., 2009; Johnston et al., 2004;
Extensions/ Modifications of classwork	• Students with concussions are at a disadvantage to study for tests and complete assignments compared to their non-concussed peers o Processing speed, memory, and concentration deficits associated with a concussion make it difficult perform optimally on tests o The symptoms also make it uncomfortable to students to take test (having a headache, stomach pains, etc.) • Concussed students often have a slowed cognitive processing speed, resulting in difficulty finishing assignments and tests in a timely fashion • Since stress is found to prolong the recovery of a concussion, teachers should attempt to relieve some stress by not inundating and overwhelming the concussed student	• Extensions on Assignments • Extensions on Tests • Extensions on Projects • Reduce or excuse superfluous homework/projects • Postpone, stagger, or excuse from tests	McGrath, 2010; Sady et al., 2011; Halstead et al., 2013; Harmon et al., 2013; Baker et al., 2014; Popoli et al., 2014; Rose et al., 2015
Reformatting Tests	Due to a slower processing speed and memory difficulties, concussed students are found to have more success on tests when they only have to recognize rather than recall the information	• Reformat Recall Tests to Multiple Choice Tests • Reducing the amount of questions on a test	McGrath, 2010; Sady et al., 2011; Halstead et al., 2013; Harmon et al., 2013; Baker et al., 2014; Popoli et al., 2014; Rose et al., 2015
Notecards	Concussed students with memory deficits can benefit from note cards due to the fact that note cards can help jog their memory of the information that they studied	Allow student notecard with test information during the test	McGrath, 2010; Sady et al., 2011; Halstead et al., 2013; Harmon et al., 2013; Baker et al., 2014; Popoli et al., 2014; Rose et al., 2015

TABLE 1 CONTINUED

Accommodation	Reasoning	Accommodation Option(s)	Research
Limited exposure to stimuli	Stimuli (such as fluorescent lights and lunchroom noise) can put a large demand on the brain to filter and process all the information surrounding the student-athlete	• Turning down the lights • Eating lunch in the library with some friends or with a staff member • Skipping assemblies • Wearing sunglasses in school • Wear a hat in school • Or just letting the student take breaks from the environment when needed	McGrath, 2010; Sady et al., 2011; Halstead et al., 2013; Baker et al., 2014; Popoli et al., 2014; Rose et al., 2015
Lessen the demands during class	• Allows his or her focus to be on learning the new information, rather than focusing on both verbal and visual stimuli • Scribe: Allows concussed student to focus on their thoughts alone rather than writing coherently • Audiobooks: Helpful for students who have issues with visual scanning or have convergence issues o Convergence: eyes are not working together; may cause blurry vision when reading	• Note-taker • Reader • Scribe • Provided notes before class • Audiobooks	McGrath, 2010; Sady et al., 2011; Master et al., 2012; Halstead et al., 2013; Popoli et al., 2014; Rose et al., 2015
Preferential Seating	When testing, it may be an appropriate accommodation to use a smaller, quiet room to reduce distractions and stimulations since concussed students can be easily distracted and are sensitive to light or noise	• Sit away from doors • Sit away from windows • Take tests in a quiet room • Sit close to the teacher	Dykeman, 2001; McGrath, 2010; Popoli et al., 2014; Rose et al., 2015
Tutor	• Since executive functioning skills are often affected when concussed, student-athletes may benefit from checking in and checking out with a guidance counselor or tutor each day • This may allow the student-athlete the opportunity to organize and prioritize their assignments and studying as well as allow the guidance counselor to check the students recovery progress	• Check in, check out • Tutor to help with homework • One-to-one aide	Dykeman, 2001; McGrath, 2010; Master et al., 2012; Popoli et al., 2014



A Teacher's Perspective in Applying Academic Accommodations for Concussions

Although teachers are implementing accommodations for their students with concussions, little to no research has been rendered on a teacher's perspective of the effectiveness/usefulness of academic accommodations for concussions or the practicality/feasibility of academic recommendations given in support of students with concussions. Since teachers are trained in modifying and adapting lessons to fit the learning needs of all their students within their classroom, teachers have a strong knowledge base of the appropriate accommodations for their students. Also, the extant literature has not considered how the teachers describe their management of the needs of the classroom alongside the demands of the recommended accommodations. For example, data in this area is limited to a survey of principals discussing common academic accommodations that teachers could provide (Heyer, Weber, Rose, Perkins, & Schmittauer, 2015). Although it is important to note that most school principals are allowing teachers and school staff to implement academic accommodations for concussions within their school (Heyer et a., 2015), it is difficult to quantify teacher perceptions of the effectiveness/ usefulness and practicality of these accommodations. Implementation of academic accommodations may be compromised if teachers do not believe the accommodations are applicable or feasible. It is important to understand the perspective of teachers when making such accommodations so that health professionals can partner with those who are implementing the accommodations for concussions.

This article examined teachers' perceptions of their schools' policies for addressing children diagnosed with a concussion. The questions included: 1) identifying accommodations that teachers believe are useful and effective in

helping students with concussions and 2) determining how practical and feasible these accommodations are for teachers to implement within their classroom. Given the lack of research in the area, we considered the project exploratory; we did not hypothesize the direction of teacher's perceptions.

Methods

Subjects

Teachers were recruited from 257 schools in western Pennsylvania with the assistance of school principals who were initially contacted for study participation. The principals were asked to contact teachers who had accommodated a student with a concussion in the last 5 years. These schools were selected based as part of a public outreach effort by a local concussion clinic that was aiming to improve the care of the students serviced from their local districts / service area. Initially, 75 teachers began the survey, however information from 7 teachers were excluded because they only responded to consent and the demographic questions. Responses of the remaining 68 participants were utilized in the data analysis of this project.

Procedure

An on-line survey was used to measure teachers' views on the usefulness and practicality of evidence-based academic accommodations commonly used for concussions. This survey solicited the teachers' demographic information such as: years worked as a teacher, information about the location of the school (e.g., urban, suburban, rural), and how many concussion cases the participant has seen in the last 5 years. Since this was a provisional study, the focus was to assess the teacher's perspectives of their student's recovery based off the evidence-based recommendations that the local hospital prescribes. The 5 year time frame was chosen because a) it expanded the potential participant pool for this study and b) teachers working in schools could have received similar guidance for students under return-to-play protocols. Furthermore, it was unlikely teachers would have had any formal requests earlier than that time period. The survey's construction and item selection was selected based on all concussion recommendations commonly prescribed by neuropsychologists in a western Pennsylvania hospital. Although the survey was not piloted, it was peer-reviewed by experts (independent of this data collection) prior to distribution.

The survey also inquired about the teacher's perspective of the usefulness and effectiveness of specific academic accommodations for concussions as well as the participants' belief about how practical and feasible each academic accommodation was within the school setting. Teachers rated each of these accommodations on a 5 point Likert-type scale where 1 signifies that the accommodation is *not* effective / useful / feasible / practical to implement in the classroom and 5 signifies that the accommodation *is very* effective / useful / feasible / practical to implement in the classroom. If teachers had not modified a student's instruction with one of these accommodations they were asked to indicate N/A. This survey took approximately five to seven minutes to complete. The survey is available upon request.

Results

Demographics

Demographic data described the sample based on years teaching, school setting, grade level and experiences with concussed students. While there was a more even distribution of teaching

experiences (e.g., 32.4% for 6-10 years, 22.1% for 11-15 years, 20.6% for 16-20 years) most of the participants were from predominately suburban schools (85.3%), taught high school (45.6%) and had experience with more than 10 students with a concussion in their career (50%).

Specifically, of the 68 teachers that participated in this project, 8.8% of the teachers were in their first 5 years of teaching (n=6), 32.4% of teachers that participated have been teaching for 6-10 years (n=22), 22.1% of teachers have been teaching for 11-15 years (n=15), 20.6% of teachers have been teaching for 16-20 years (n=14), and 16.2% of teachers have been teaching for over 20 years (n=11). In considering school location (e.g. urban, suburban, or rural), teachers that responded to the survey were predominately from a suburban school (n=58; 85.3%), while urban (n=6; 8.8%) and rural (n=4; 5.9%) school teachers infrequently participated. Teachers that participated in the project taught elementary school (n= 11; 16.2%), middle school (n=23; 33.8%), and high school (n=31; 45.6%). Two of the participants did not respond to this question (n=2; 2.9%) and one participant stated that he/she worked with Elementary, Middle, and High School Students equally (n=1; 1.5%). Lastly, in response to how many students with concussions have they taught during their teaching career, five taught one student with a concussion in their career (7.4%), four taught two to three students with concussions in their career (5.9%), eleven teachers taught four to six students with concussions in their career (16.2%), fourteen teachers taught six to ten students with concussions in their career (20.6%), and thirty-four teachers taught more than 10 students with a concussion in their career (50%).

Given that each item was considered separately, Paired Samples t Tests were conducted to assess teachers' perspectives of the effectiveness/ usefulness and practicality/feasibility of evidence-based academic accommodations for concussions. Results showed that classrooms view most of the academic accommodations suggested by neuropsychologists as more effective than practical. That is, of the 24 of accommodations rated, 45% were rated as a 4 or higher in effectiveness/usefulness (the accommodation is effective / useful to implement within the classroom) and 29% were rated as a 4 or higher in practicality and feasibility (the accommodation is practical /feasible to implement within the classroom).

Specifically, Paired Samples t Tests comparisons showed that teachers rated the effectiveness of ten concussion accommodations higher than their practicality. This indicated that teachers believed many of these academic accommodations were more useful than practical to implement in their classroom. Specifically, for the *no school* condition teachers rated this intervention as significantly more effective ($M = 3.49$, $SD = 1.29$) than practical ($M = 2.67$, $SE = 1.41$; $p < .001$;$d = .61$), for the *modified days of school* condition teachers rated this intervention as significantly more effective ($M = 3.44$, $SD = 1.29$) than practical ($M = 2.89$, $SE = 1.33$; $p < .00$;$d = .41$), for the *full days of school with breaks throughout the day* condition teachers rated this intervention as significantly more effective ($M = 3.97$, $SD = 1.20$) than practical ($M = 3.67$, $SE = 1.17$; $p < .05$; $d = .26$), for *extensions on tests* condition teachers rated this intervention as significantly more effectives ($M = 4.16$, $SD = .920$) than practical ($M = 3.88$, $SE = 1.23$; $p < .05$; $d = .26$), for the *no tests* condition teachers rated this intervention as significantly more effective ($M = 2.52$, $SD = 1.41$) than practical ($M = 1.93$, $SE = 1.16$; $p < .05$; ; $d = .45$), for the *staggered tests to avoid taking several tests on the same day* condition teachers rated this intervention as significantly more effective ($M = 4.07$, $SD = .936$) than practical ($M = 3.37$, $SE = 1.26$; $p < .001$; $d = .$

For four concussion accommodations, teachers also rated practicality higher than effectiveness/usefulness: allowance of snacks, preferential seating, wearing a hat, and wearing sunglasses.

63), for the *reformatting of recall tests to multiple-choice tests* condition teachers rated this intervention as significantly more effective (M = 3.37, SD = 1.20) than practical (M = 3.06, SE = 1.28; p=. 049; d = .24), for the use of *audio books* condition teachers rated this intervention as significantly more effective (M = 4.07, SD = 1.24) than practical (M = 3.17, SE = 1.61; p< .001; d = .63), for the *limited computer work* condition teachers rated this intervention as significantly more effective (M = 4.10, SD = 1.04) than practical (M = 3.62, SE = 1.18; p< .001; d = . 43), and for the *shutting the lights off* condition teachers rated this intervention as significantly more effective (M = 3.49, SD = 1.20) than practical (M = 2.40, SE = 1.35; p< .001; d = .85).

For four concussion accommodations, teachers also rated practicality higher than effectiveness/usefulness. This indicated that teachers felt these accommodations were easy to implement in their classroom but were not as useful for the student. Specifically, for the *allowance of snacks* condition teachers rated this intervention as significantly more practical (M = 3.96, SE = 1.20) than effective (M = 3.45, SD = 1.18; p= . 001; d = .43), for the *preferential seating* condition teachers rated this intervention as significantly more practical (M = 4.68, SE = .725) than effective (M = 4.40, SD = .850; p= .003; d = .35), for the *wearing a hat* allowance teachers rated this intervention as significantly more practical (M = 3.89, SE = 1.40) than effective (M = 3.18, SD = 1.48; p= .001; d = .

49), and for the *wearing sunglasses* allowance teachers rated this intervention as significantly more practical ($M = 4.34$, $SE = .990$) than effective ($M = 3.85$, $SD = 1.20$; $p < .001$; $d = .45$).

Discussion

Based on the results of this preliminary project, teachers seem to believe that cognitive rest (e.g., *no school, modified days of school, full days of school with breaks throughout the day, extensions on tests, no tests*) is an effective set of accommodations for concussions. However, the practicality of implementing cognitive rest accommodations was generally more difficult (lower scores on practicality) than their perceived effectiveness. It is possible that this is because teachers would have a more difficult time teaching concussed students if they are not in the classroom throughout the entire period. That is, while various cognitive rest accommodations are being applied, students are missing instruction and would then require re-teaching. Modifying tests, schoolwork or the environment was also perceived by these teachers to be more effective than practical when accommodating concussed students. One could hypothesize that this could be because teachers have limited resources and time. It may be very challenging to completely modify or reschedule tests, develop different assignments, or readily access resources for concussed students. For example, many schools do not have available copies of audio books across all educational content areas; teachers may find it difficult to generate alternative assignments with the available resources in the school.

When considering the accommodations teachers found more practical than effective (i.e., allowing for snacks, preferential seating, wearing hats, and sunglasses), one can see that these accommodations are easily accomplished (i.e., changing a student's seat), and likely facilitated by parents (i.e., bringing in a hat, snacks, sunglasses). That is, these accommodations generally do not disrupt how their classroom is run and require minimum instructional allowances.

Implications for Practice

Health professionals depend on the schools to implement academic accommodations. If teachers feel that these accommodations are not practical in their classroom, they may not implement them with fidelity, if at all. Based on the results of this project, which requires additional investigation and replication, teachers with experience helping children with concussions in the classrooms view most of the academic accommodations suggested by neuropsychologists as both adequately effective and practical. However, when considering accommodations individually, only four were deemed practical for them. As such, there is a clear need to help teachers find more accommodations practical. This may be possible by providing direct support to teachers through release time to adjust tests formats or consider the child's school/test schedule. Or it may require in-service training around the need to make accommodations to facilitate healing. Since most students heal within two-four weeks, it is unlikely that parents would have time to secure a 504 plan to indicate accommodations are required. However, without adequate support early, which could result in an exacerbation or prolonging of concussive symptoms, a 504 plan, or even an IEP, may be the next steps in ensuring accommodations (Halstead et al., 2013; Popoli et al., 2014; Chesire et al., 2015; Rose et al; 2015). These are steps that the school team can avoid by understanding the need to effectively implement return-to-learn plans.

Schools should implement a concussion management plan for each student with a concussion. This return-to-learn policy should: a) assess the needs of the student (i.e., symptoms, triggers,) b) implement the accommodations set by the neuropsychologist with fidelity and seek remediation if there are obstacles in implementing these accommodations c) progress monitor the students' symptoms and accommodations (BrainSTEPS, 2015). It is important that schools collect both baseline and post-injury data on all students within the district. This could be accomplished through routine Tier 1 universal screenings (e.g., district benchmarks, DIBELS, etc.). It would be beneficial for schools to implement ImPACT testing or other neurocognitive screeners at the beginning of school each year (e.g. as addition to universal screenings) to obtain baseline data. Some athletic programs offer neurocognitive testing to assess the student's visual and verbal memory, attention, concentration, reactions time, processing speed, and response accuracy as these are often are weakened when concussed (McGrath, 2010). Comparing pre-injury scores to post injury scores provides one piece of valuable information to help determine recovery status of the concussed student (McGrath, 2010). These scores allow schools to determine with little uncertainty when they can reduce accommodations and begin increasing demands on students with concussions.

Developing a gradual, individualized plan for each student re-entering school after a concussion injury is critical for recovery (McGrath, 2010; Sady et al., 2011; Master et al., 2012; Halstead et al., 2013; Baker, Rieger, McAvoy, Leddy, Master, & Lana, 2014; BrainSTEPS, 2015; Center of Disease Control and Prevention, 2015). Researchers have shown that students and schools without a return-to-learn protocol often attempt to return-to-learn too quickly causing intensified symptoms (Master et al., 2012). Although it is impossible to develop a plan that fits the needs of every student, managing each member's defined roles can help the school stay organized and effectively manage each concussion (Sady et al., 2011) and accommodate students appropriately based on concussion severity (Master et al., 2012).

The following are some considerations and roles for stakeholders managing students with concussions:

- *Teachers*: consistently observe symptom progression and implement accommodations.
- *School Psychologists*: help identify, progress monitor, and help teachers implement appropriate services/accommodations.
- *School Principals*: help with scheduling changes and ensure adequate communication between the medical services and the school.
- *School Nurses*: progress monitor the student's symptoms, be a liaison between staff, parents, and medical services, and educate staff.
- *Students*: share their thoughts on their progress and symptom management.
- *Parents*: follow the guidelines set by the school and hospital at home and advocate for their student at school (Center of Disease Control and Prevention, 2015).

Conclusions

In regard to limitations in this study, it is important to note that although we had a moderate sample size (i.e., 68 participants), the assumptions of the homogeneity of variance and normality were violated due to a skew in who participated in the project. Although we hoped for a large sample size based on the volume of schools that were sent this survey, it is not known if this sample is representative of the population of teachers. Furthermore, it is impossible to know how many

teachers have seen concussions within each of the 257 schools solicited, therefore it is not possible to accurately determine a response rate (e.g., the total possible participants responding as compared to the total solicited, is not known). Lastly, the terms effectiveness/usefulness and practicality/feasibility could have been better defined. Teachers were asked how useful or effective an accommodation was when implemented for a student with a concussion and how feasible or practical was the accommodation to implement within their classroom. However, it is possible that teachers may have construed questions about the classroom as considering the student or teacher point of view. As such, it is difficult to assess if these, or any other, factors played a role in the perceptions of the teachers.

Overall, it is critical that more school practitioners become aware of the need to consider return-to-learn policies with the same importance afforded to return-to-play policies. It is imperative that more research is completed on return-to-learn policies and procedures so that schools can help students with concussions return quickly to academic endeavors. Also, parents need to be informed that their children can, and should, receive the same procedural safeguards in school as they do for sports.

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SEXTING: SCHOOL RESPONSE TO A POTENTIAL CRISIS

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In 2008, 18-year-old, Jessica Logan, sent nude pictures to a boyfriend. After they broke up, her boyfriend sent the photos to other high school girls and the photos went viral. This resulted in Jessica being persistently harassed and called names, including “slut” and “whore.” The impact of this harassment took its toll, and Jessica committed suicide after graduation; just months after the photos went viral. Jessica’s story is one of many in which the implications of technology, decision-making, and harassment reached a crossroads of crisis. The devastation of this situation highlights the need of schools to understand the implications of sexting and to begin thinking of an appropriate response (Angelides, 2013).

Smart phones, social media sites, and Wi-Fi are omnipresent in many US households and society. In fact, 78% of teens between the ages of 12 and 17 years have a cell phone and 48% of those are smartphones (Madden, 2013). The rise of smartphones has undoubtedly correlated with a rise in online and social media activity, as 92% percent of teens report going online daily; 24% say they go online “almost constantly” (Pew Research Center, 2015). As of 2015, Facebook was the most widely used social media website for teens, though recent data has shown that Instagram and Snapchat have taken the lead with 76% and 75% of teens using then, respectively (NORC at the University of Chicago, 2017). However, 71% of teens report using more than one media outlet, including the aforementioned as well as Twitter, Google+, Vine, Tumblr, Periscope, and YouTube. Given the constant changes in social media applications, however, these percentages and the use of programs is constantly changing. In addition to general communication, these sites also have capacity to share videos and photos with “friends,” groups, and other members to some extent.

Although there are some positive aspects to the increase in technology, the rise in social media and smartphone use has contributed to some youth engaging in risk taking behaviors, such as disseminating sexually inappropriate content and pictures of themselves, or in other words engaging in “sexting.” The National Center for Missing and Exploited Children (2009) defines sexting as “youth writing sexually explicit messages, taking sexually explicit photos of themselves or others in their peer group, and transmitting those photos and/or messages to their peers.” Results from a survey conducted by the National Campaign to Prevent Teen and Unplanned Pregnancy (2008) indicate that 20% of adolescents ages 13 to 19 have sent or posted nude or semi-nude pictures of themselves; 71% of adolescent females and 67% of adolescent males who have sexted sent the content to their significant other; and 38% of adolescent females and 39% of adolescent males reported having seen messages originally intended for someone else. The increased engagement in sexting behaviors is a potential crisis affecting parents, schools, and the courts. Sexting can have serious legal ramifications depending on the age of the receiver and the sender. Considering that high schools can have a significant number of students over the age of 18, child pornography laws may be applicable in some instances compelling the sexting participants to register as a sex offender (Russo, Osborne, & Arndt, 2011). Students may face both short and long term consequences, such as being excluded from extracurricular activities and jeopardizing higher educational opportunities (National Center for Missing and Exploited Children, 2009). Lastly, the inappropriate photos may fall into the hands of child predators and could potentially be in the cyber world indefinitely (Aldridge, Davies & Arndt, 2013).

Psychosocial Implications

According to research, sexting is a new type of sexualized behavior in youth that is associated with many risks (Ahern & Mechling, 2013; Benotsch, Martin, Snipes, & Bull, 2013a; Draper, 2012; Hua, 2012; Judge, 2012; Korenis & Billick, 2013; O'Keeffe, Clarke-Pearson, & Council on Communications and Media, 2011). In a meta-analysis of 50 empirical studies between 2009 and 2013 retrieved from PsycINFO and PubMed databases, the majority (79%) address sexting as a problematic and unhealthy behavior in minors (Döring, 2014). Some of these unhealthy behaviors include risky or inappropriate sexual acts, promiscuity, practicing unsafe sex, and sexual infidelity. Youth’s impulsivity, poor judgment, sensation seeking, and problematic

"Dake, Price, Maziarz, and Ward (2012) found significant correlations between sexting and sexual behaviors (41%-74%), substance use (50%), and mental health issues (29%-52%) in middle and high school students."

alcohol and drug use are all contributing factors in sexting behavior (Dir, Cyders & Coskunpinar, 2013). There is also concern regarding a link between sexting and sexual objectification as well as between sexting and sexual violence. Sending sexual images is regarded as unhealthy objectification, especially of teenage girls that can be harmful (Jewell & Brown, 2013; Maurović & Knežević, 2012) and can put minors at risk for sexual abuse by peers or adults (Fontenot & Fantasia, 2011; Hua, 2012).

In a recent study examining the relationship among sexting, depression, impulsivity, and substance use in teens, results indicate that sexting is unrelated to depression; however, it is linked with impulsivity and substance use (Temple et al., 2014). Dake, Price, Maziarz, and Ward (2012) found significant correlations between sexting and sexual behaviors (41%-74%), substance use (50%), and mental health issues (29%-52%) in middle and high school students. In this study, sexting was associated with mental health issues such as being depressed, considering or attempting suicide in the past year, being hit by a boyfriend or girlfriend, and being coerced into having sex. It is posited that depressed youth could use sexting as a way to gain acceptance; some may also feel compelled to send a sexually explicit image and fear the consequences of not complying (Dake et al., 2012). Ybarra and Mitchell (2014) also concluded that youth who send explicit photos of

themselves are more likely to use substances and less likely to have high self-esteem. While the research on the psychosocial implications of sexting suggests an association between sexting and mental health, a causal relationship is difficult to determine.

Legal Implications

Growing up with new and rapidly changing technologies poses a threat to adequate supervision of adolescents in their use of social media. Often, youth have greater facility and knowledge of the functionality of social media than adults. In order for parents and adults to maintain current knowledge on new technologies and media, it is an arduous process at best or a complete conundrum at worst. This problem in understanding and remaining current with technology is also an issue facing middle and high schools across the nation, especially when these media are used inappropriately. One dilemma for schools regarding sexual misconduct across technology is the decision either to report the misconduct to the local authorities with the possibility of criminal charges occurring or to deal with the incidences within the confines of the school district. Either of these responses have possible legal implications for not only the school, but also the students involved. In the case of Jessica described earlier, her parents filed a lawsuit against the school for not addressing and preventing the harassment (Celizic, 2009), which illustrates the potential consequences for schools that do not act responsibly and attempt to prevent sexual harassment according to Title IX of the Education Amendment of 1972 (Meyer, 2009). This prompts the need for schools to have specific policies and procedures for handling these incidents.

With regard to students, the legal repercussions could be life altering. When involved in sexting with underage children and adolescents, the person in the photo, the person taking the photo, or anyone who forwards the sexually explicit image can have charges filed against them. In some states, transmitting a seminude or nude photo of oneself, a friend, or another student in a private message could result in a criminal case of child pornography.

In order to illustrate the legal complexities that can occur from texting incidents, we briefly want to review a high profile case from Pennsylvania. This legal case involved consensual sexting of three 13-year-old girls in which teachers discovered topless photos of the girls on the cellphones of male students in the Tunkhannock School District in 2008 (Miller v Skumanick, 2009). The Wyoming County district attorney determined that these self-taken images (e.g., selfies) were suggestive, and therefore, the girls were accessories and collaborators in the production of child pornography, which is a felony charge. In addition, the district attorney threatened felony charges against the students who had these images on their cell phones unless they participated in an education and counseling remediation program, probation, and drug testing. Incarceration and a permanent criminal record would have been the penalty for these charges. While those who disseminated the photos completed the remediation program, the three girls depicted in the photos did not, and their case went on for 2 years to the United States Court of Appeals that upheld that the teenage girls could not be prosecuted under child pornography laws solely for appearing in the cell phone images (Miller v. Mitchell, 2010).

Albeit that the teenagers in this case were not ultimately charged with a felony, the extensive legal proceedings in this case illustrate the serious and potential life changing consequences that can occur from a quick act of sharing an inappropriate photo. There are obviously significant and long-term consequences of a

felony charge of child pornography between consenting teenagers. As this charge seems unacceptably harsh, prosecutors and other policymakers nationwide have looked for alternatives for addressing this issue. Some jurisdictions are prosecuting sexting as a lower-grade offense and others are choosing to address the issue with more education through a diversion program and community support (Levick & Moon, 2010). Several legislatures, uncomfortable with charging and prosecuting youth for sexting with a child pornography offense, have sought to create a new criminal offense that is specific to sexting (McEllrath, 2014). The state of Connecticut differentiated between felony child pornography and underage sexting by creating a misdemeanor for certain acts of sexting or acts involving electronic child pornography by persons 13 to 15 years of age for transmission and 13 to 17 years of age for possession (Connecticut Public Act 10- 191, 2010). In Nebraska, it is now legally permissible for persons under the age of 19 to possess a sexually explicit visual depiction of another youth who is at least 15-years old if that youth voluntarily shared the image and the image was not further disseminated (Nebraska Legislative Bill 97, 2009). However, not all states are so progressive, as for example, in Washington State, juvenile sexting is still subject to child pornography laws (Washington Rev. Code 9.68A.050, 2012). A number of legal

"Several legislatures, uncomfortable with charging and prosecuting youth for sexting with a child pornography offense, have sought to create a new criminal offense that is specific to sexting."

cases exist regarding sexting and youth, and we encourage readers and schools to be familiar with these cases, as well as the laws in your state. This knowledge is needed to understand the expectations and rules that must be followed in your state, such as being a mandated reporter, and as such, this information can help drive policies for schools to handle these situations.

Recommendations for Schools

The increasing use of social media and its inappropriate use such as sexting are a recent phenomenon that schools face and must plan to address. To date, there are no empirically supported "sexting prevention" programs or research on a specific targeted plan for schools to use. There have been online sexting risk-prevention campaigns, though these programs primarily rely on scare tactics, stress the risks of bullying and criminal prosecution, engage in female victim blaming, and recommend complete abstinence from sexting (Döring, 2014). Scare tactics are rarely effective with adolescents (Witte & Morrison, 1995), and therefore, addressing the potential crisis of sexting needs a more planned and comprehensive approach. We suggest that schools consider three aspects in addressing sexting – Policy, Prevention, and Intervention – and schools should tie these with already existing programs or policies in the school.

Policy

Sexting and other inappropriate uses of technology are often conducted off school property, yet have serious repercussions for the youth involved in their school. Unfortunately, many schools focus on policies that are "don't do that" approach. This can be reminiscent of the "Just Say No" policies of the past. When schools have policies that focus on "don't sext," we risk victim blaming and ultimately the effectiveness of the policy in helping youth. Take for instance a female student who consensually sent a seminude photo to her boyfriend, who then forwarded it to others. With a punitive policy in place, what is the likelihood of her coming to a counselor or principal to obtain assistance for being a victim of a privacy violation? Therefore, we endorse that schools have clear rules and explanations of policies are outlined in the student handbook under code of conduct that focus on the harm that can occur – harassment, privacy violations, etc. – rather than whether or not a situation of sexting occurred. The behaviors of sexting are better addressed as part of the prevention and intervention process, whereas the policies should focus on the actions to hurt others. We advocate for a team approach in policy development, which should include school personnel (e.g., administrator, school psychologist, counselor, and teachers), as well as someone from the technology department, a parent, and a law enforcement representative. The policies regarding sexting can be integrated with other existing policies, such as bullying/cyberbulling, use of digital media on school grounds, and laws regarding possession and/or dissemination of child pornography (Segool & Crespi, 2011). However, there also needs to be policies regarding how to instruct students in the risks of digital media, the steps that school staff should take if sexting or a privacy violation is suspected, and how to obtain services for student victims of such situations (Segool & Crespi, 2011).

Prevention

The National Center for Missing and Exploited Children endorses educating students and staff members about the risks of sexting as one of the most important factors in preventing and changing the behavior (National Center for Missing and Exploited Children, 2009; Aldridge, Davies & Arndt, 2013; Siegle, 2010; Russo, Osborne & Arndt, 2011). However, we suggest that prevention must go beyond simply discussing the risks of sexting. Schools and

school psychologists have an opportunity to develop and coordinate comprehensive prevention efforts that can meet far greater goals.

First, prevention efforts should start with providing education on safe and thoughtful digital media use. It is important for discussions to go beyond the risks of sexting briefly also to include building skills such as critical thinking, judgment, and forethought. As part of this, the topic of sexting and social media use can be incorporated and discussions should occur around case studies or real examples to have students begin thinking about what they might do if faced with a similar situation and to problem solve through options. This approach layers the education regarding risks of sexting with the more important skills of problem solving to help students develop a plan of how they might respond. These discussions can be part of existing health or wellness programs or could be incorporated in other school-wide mental health or character building efforts. In addition, researchers have reported that 51% of adolescent girls and 18% of adolescent boys indicate that peer pressure influenced their decision to engage in sexting (Sex & Tech, 2008). This brings to the forefront another area of prevention that is needed – *assertiveness*. This is not simply building self-esteem, but instead, is to build confident behavior that leads to self-efficacy or the students' belief that they can succeed in a specific situation. Again, this does not require schools buying a new program or curriculum, as assertiveness can be incorporated into already existing school programs. School psychologists can be an excellent resource in helping to select assertiveness techniques that could have benefit for all students and then how to use these in situations of peer pressure regarding inappropriate social media use.

Second, prevention efforts must also address the impact of bullying, cyberbulling, shaming, and sexual harassment. Many schools already have in place bullying prevention programs or efforts, though schools need to be sure that issues of sexual harassment and sexting are addressed in these programs. For those schools using formal programs for bullying prevention, discussions of sexting and sexual harassment can be incorporated into those programs as a means of providing additional education. However, the bullying prevention aspect of prevention must also involve having in place a policy and procedure of the steps that will be taken should an issue of sexting arise. Aldridge, Arndt, and Davies (2013) discuss having a "sexting prevention team" that not only helps with needs assessments and curricula planning, but also develops a crisis plan that can be used with a sexting incident occurs to respond appropriately and prevent further negative outcomes.

Intervention

Despite our efforts in policy development and prevention, the reality is that sexting will likely continue to occur. When incidents do arise, having solid policies on the steps that need to be taken will help guide a process of handling the situation. However, there remain the social and emotional implications that follow such an incident. Students at risk for social and emotional issues include those in the photos or exchanges (e.g., victim and perpetrator), as well as those students who may have reported the situation. School psychologists and other mental health providers should provide an initial screening of these students to provide appropriate assessment of need and triage to services.

Once student needs are determined, then a specific plan regarding appropriate interventions can be developed. Although a number of

intervention-models exist that can be incorporated in a school-based mental health program in the aftermath of a sexting incident, we recommend the use of cognitive-behavioral interventions (see Mennuti, Christner, & Freeman, 2012). There are no specific cognitive-behavioral interventions for sexting itself, yet CBT (Cognitive Behavior Therapy) has been shown to be effective with a number of issues that may follow a sexting incident, such as anxiety, depression, anger, trauma response, shame, etc. (Friedberg & McClure, 2015; Mennuti, Christner, & Freeman, 2012; Ollendick & King, 2004). School psychologists trained in CBT interventions are ideal to spearhead the use of this approach in school settings and they can work directly with other mental health providers for the best interest of the students.

Conclusion

The concept of sexting behaviors is complex and has many variables from understanding technology, to legal implications, to social and emotional consequences. In today's growing world of technology and social and digital media, situations of sexting and inappropriate use are inevitable. However, we feel that it is incumbent on schools and school psychologists to have the knowledge and skills to help combat or at least mitigate the potential negative consequences of sexting. As such, we encourage all school psychologists to work with their schools to improve policies and procedures around incidents of sexting to have a response to is legally sound but also that builds a school climate and community that avoids victim blaming. Moreover, school psychologists have an opportunity work with schools to enhance current prevention efforts in schools by incorporating information on sexting to not only educate students on potential risks, but also to build necessary life skills that might aid in prevention such as assertiveness, critical thinking, and problem solving. It is necessary not to assume that knowledge of these skills generalizes to

sexting, and schools must have direct case examples in place for students to work through how they might handle or respond to a sexting request or incident. Finally, despite our efforts to educate and prevent, sexting is likely to happen. School psychologists and schools must be prepared to provide psychologist screening, triage, and intervention as needed in order to have appropriate response to social and emotional needs. Although we recognize other possible approaches, we advocate here for school psychologists to gain skills in CBT to help with intervention planning and implementation.

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DID YOU KNOW?

Division 16 has developed a Grant Program for School Psychology Internships (GPSPI) to assist in the predoctoral internship crisis in the U.S. The GPSPI is supported by Division 16, Council of Directors of School Psychology Programs (CDSPP), National Association of School Psychologists, and Trainers of School Psychologists.

GPSPI's primary aim is to provide funds and consultation for developing new APPIC School Psychology Internship Programs that will eventually obtain APA Accreditation. Internship programs that accept doctoral students from more than one doctoral program are preferred (non-captive programs). GPSPI also may provide funds and consultation for expanding existing APPIC School Psychology Internship Programs that will eventually obtain APA Accreditation.

Those interested in learning more—or submitting an application—will find details here.

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THE EARLY CAREER PROFESSIONAL WORKGROUP PRESENTS

SCHOOL PSYCHOLOGY AND INTEGRATED HEALTH

By Rachel Stein, University of Colorado Denver
Nicholas W. Gelbar, University of Connecticut
Jacqueline A. Brown, University of Montana

Integrated health is a model of service delivery that incorporates behavioral health professionals and medical providers in a shared setting with a shared patient population (Huang et al., 2014). These services may be co-located or integrated. In a co-located model, each specialty makes separate appointments with patients. This differs from an integrated model, where patients see specialists from multiple disciplines within the same visit. Within either of these models, behavioral health specialists may provide a variety of services, including: helping individuals cope with life stress, crisis intervention, supporting somatic

symptom presentations, working on health behavior change, and engaging in preventative care (e.g., typical developmental guidance; Huang et al., 2014).

The drive for more integrated care service delivery stems from the realization that medical settings are often where individuals first bring concerns and questions. In particular, primary care settings are a location where many mental health and behavioral questions and concerns are first brought to light (Blount, 2003). Indeed, research has found that 50-80% of pediatric medical appointments include topics related to emotional, behavioral, psychological, or educational functioning (Cooper, Valleley, Polaha, Begeny, & Evans, 2006). Yet, pediatricians generally report feeling less competent and less comfortable during visits that focus on these concerns (Adams et al., 2016). Furthermore, pediatric providers often have no or little specific training in addressing emotional, behavioral, psychological, or educational questions and challenges (Campo et al., 2005).

This article aims to elucidate some of the ways in which school psychologists are using their training backgrounds to work with families in pediatric primary care environments. First, some tenets of school psychology training that are easily transferable to pediatric primary care settings are outlined. Next, a few school psychologists share examples from their own work in pediatric primary care. Finally, some of the challenges and future directions for school psychologists in primary care settings are described.

School Psychologists in Primary Care

School psychologists are professionals with appropriate training to help fill the need for behavioral health services within primary care. Although pediatric psychologists also have the professional background to provide support within medical settings, school psychologists have training and experiences that make them uniquely poised to support children and families within primary care pediatric settings. In particular, school psychologists' training in mental health, development, understanding of systems/school systems, and experience working within interdisciplinary settings is readily transferable to pediatric primary care. Research has shown that better services are provided when collaboration, communication, and cooperation takes place between school and pediatric settings (Adams et al., 2016). However, this is much more effective when it is done by professionals who are able to understand each of these settings and how to navigate them effectively. Although some pediatric and clinical psychologists have a background understanding of both of these systems, school psychologists have often worked across settings. Training in child development and systems-based work, in addition to individual mental health support, offers school psychologists the opportunity to successfully integrate into pediatric primary care settings. Finally, experience with indirect service provision (e.g., consultation) and interdisciplinary teams are extremely helpful skill sets that school psychology training brings into pediatric primary care environments.

Case Examples

Case Example One

Rachel works part-time in an interdisciplinary pediatric care office. Within the framework of a general pediatric medical office, Rachel and her colleagues provide a variety of different supportive services to children and families. Through the Healthy Steps Program, they provide developmental guidance and

preventative support for children ages zero to three years. In addition, providers frequently approach the team when there are concerns related to post-partum mood disorders, child development, behavior, and mental health concerns. Also embedded within the clinic are social workers and community health navigators. The clinic primarily services a diverse population of low-income families within an urban center. In addition, the clinic is affiliated with a medical training program, so medical trainees are able to learn about integrated behavioral health as part of their training rotation.

Case Example Two

Rachel spends one day per week as part of an interdisciplinary team supporting children with cleft lip/cleft palate. Other individuals on this team including ear, nose, and throat doctors, plastic surgeons, speech and language pathologists, occupational therapists, a dental team, and an outreach coordinator. Within this setting, psychological support is offered to help families adjusting to their child's cleft lip/cleft palate, to support families with challenges related to cleft lip/cleft palate (e.g., creating a cleft story, dealing with bullying), and provide mental health care coordination.

Case Example Three

Nick works part-time in an interdisciplinary outpatient center that supports children and adolescents with Autism. This center has the following services represented: psychology, psychiatry, developmental/behavioral pediatrics, speech/language pathology, occupational therapy, and marriage/family therapy. In addition, a nurse provides care coordination. Although the clinicians have individual appointments with children and families, they often refer to other disciplines and collaborate to align services. Each clinician also regularly provides information to the child's pediatrician so that the center serves as an extension of the child's medical home. The American Academic of Pediatrics indicates that a medical home is: "delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care." This center was the first patient-centered specialty practice for Autism to be recognized by the National Committee for Quality Assurance (NCQA), the most widely adopted medical home model in the country. The medical home concept is analogous to the concept of "wrap-around services" in the education literature and provides many opportunities for Nick to coordinate his recommendations for treatment with other disciplines, the child's pediatrician, and the school.

Challenges and Future Directions for School Psychologists and Integrated Behavioral Health

Integrated behavioral health is a growing field that includes a range of interdisciplinary specialists. Amongst these individuals, school psychologists have the appropriate training background for pediatric settings because of our experience working within systems, collaborating with different disciplines, and understanding a range of mental health and environmental impacts on children and adolescents. Yet, school psychologists face a variety of challenges entering these work environments and being seen as valuable contributors.

Perhaps the biggest challenge faced by school psychologists offering behavioral health services in integrated medical settings is funding (Adams et al., 2016). Indeed, payment and insurance reimbursement is one of the biggest hurdles that has held back the expansion of behavioral health

service provision within medical settings. Given the changing and uncertain landscape of healthcare payment modalities, the method of payment for behavioral health services within integrated settings will likely continue to unfold. Although it is unclear whether current models are sustainable over the long term, the intricacies of billing and reimbursement for behavioral health services will likely remain uncertain until a more stable insurance and medical payment system is in place.

School psychologists face an additional challenge in integrated care settings due to the demand for appropriately trained individuals (Adams et al., 2016). Although oftentimes school psychologists may be well suited for the interdisciplinary systems-based work that takes place in pediatric medical settings, their relevant training may not be recognized by individuals without familiarity of school psychology training. In addition, there is a general shortage of school psychologists (Castillo, Curtis, & Tan, 2014), which may limit professionals seeking work across settings.

Conclusion

Ultimately, the goal of school psychology is to support children and families' health and wellbeing. Although schools are the traditional setting for this work, and an extremely impactful environment, this work also takes place in other domains. In particular, pediatric settings offer the opportunity to engage with a wide range of children and families, even prior to the age at which they are likely to encounter the school setting. Finally, school psychologists' training and expertise provides an important opportunity to continue to think about how best to support children and families, which includes pediatric medical settings.

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THE EARLY CAREER PROFESSIONAL WORKGROUP PRESENTS

PROFESSORS IN PRIVATE PRACTICE: AN OVERVIEW OF THE BOARD CERTIFICATION PROCESS

By Jessica S. Reinhardt, University of Denver
Anisa N. Goforth, University of Montana-Missoula
Sarah Valley-Gray, Nova Southeastern University

In this installment of *Professors in Private Practice*, we introduce early career faculty to issues related to board certification with the American Board of Professional Psychology (ABPP) In our previous article, the third in our series, (Vol. 71, Issue 1), we explored the advantages and disadvantages of the enrolling in Medicaid as a provider for early career faculty. We extend this discussion of issues related to being a professor in private practice by first introducing the ABPP and discussing the process of becoming board certified**.** In addition to state credentials, as school psychologists, we are eligible to seek out a range of nationally recognized credentials (e.g., National Certification of School Psychologists [NCSP]) and licenses (e.g., licensure through Boards of Psychologists), and it is important

that early career faculty, in particular, recognize and understand an additional certification that may support their private practice.

What is the American Board of Professional Psychology?

The American Board of Professional Psychology (ABPP) is the country's oldest and largest credentialing body for psychologists. Developed with the support of the American Psychological Association (APA), the organization was incorporated as a separate organization in 1947 (Bent, Packard, & Goldberg, 1999). It serves to protect consumers by examining and certifying competency among psychologists in one of 15 defined areas of specialty practice (Tansy, Edgar, Radico, & Skilings, 2017). Although discussion of the specialty area of school psychology began in 1953, formal recognition did not occur until 1968 (Bent, Packard, & Goldberg, 1999). School psychology is the fourth specialty area, with clinical, industrial organizational, and counseling psychology being the first three areas to grant board certification (Bent, Packard, & Goldberg, 1999).

School psychology is one of the smaller specialty areas recognized by ABPP. This is due, in part, to the fact that school psychology is the smallest of the three branches of psychology that lead to licensure. Furthermore, there are a number of other variables within graduate education that further diminish the numbers of psychologists who hold board certification in school psychology. First, given that national certification requires that practitioners complete 600 hours at the doctoral internship level in a pre-school through grade 12 setting, many doctoral level school psychologists may complete the entirety of their internship in a school setting, which may result in the completion of 1600 hours, rather than the requisite 2000 hours required by the majority of state licensure agencies. In contrast, those doctoral students who complete a 600-hour internship in the schools frequently apply for an internship accredited by the American Psychological Association (APA) or that is in compliance with the Council of Directors of School Psychology Programs (CDSPP) internship guidelines in a setting combined with or outside of the schools, such as a hospital or community agency. Consequently, many of these individuals find that their professional affiliation evolves to an identity as a pediatric or clinical psychologist. Moreover, school psychologists who plan to seek employment in a school setting or as a faculty member at a university may not complete the requirements for licensure, such as a 2000-hour internship, a post-doctoral residency, or the Examination for Professional Practice in Psychology (EPPP), required by most states for licensure as a psychologist. As a result, there are fewer numbers of individuals eligible for board certification.

Why Seek ABPP as a Professor in Private Practice?

Consistent with psychologists in each of the specialty areas, there are numerous benefits associated with board certification, including: 1) opportunities for increased academic rank, 2) financial incentives, 3) expectations within hospitals that psychologists seek out certification similar to our physician colleagues, 4) requirements by health insurance companies, 5) increased marketability, 6) mobility of licensure across states, and 7) consumer protection. Attainment of the credential demonstrates competency in a specialty area. For the private practitioner, attainment of board certification facilitates inter-jurisdictional license and practice mobility across states. Over 35 states recognize the ABPP as a route to licensure (Tansy, Edgar, Radico, & Skillings, 2017). In fact, attaining board

"These benefits are important for faculty members, but there are also a number of benefits specifically for professors who also participate in private practice."

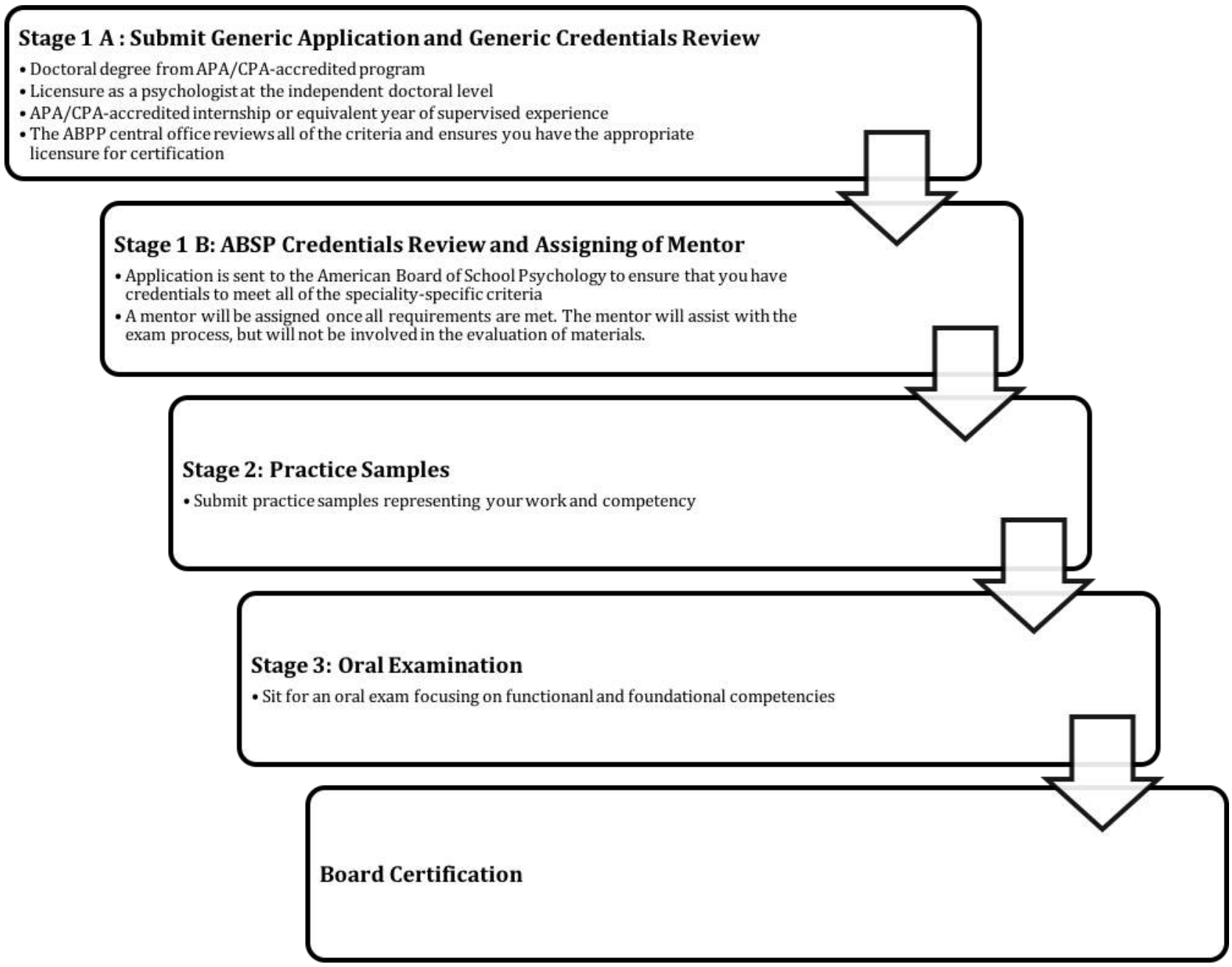
certification supports licensure renewal as ten continuing education (CE) credits are awarded by the American Board of Professional Psychology upon earning the credential.

These benefits are important for faculty members, but there are also a number of benefits specifically for professors who also participate in private practice. The first benefit is recognition as a board-certified practitioner in a number of directories including but not limited to ABPP academy directories, the APA membership directory, and the National Register of Health Service Providers in Psychology (Tansy, 2013). As a professor, recruitment and marketing of one's private practice is often challenging (e.g., smaller practice). Board certification can thus increase exposure to potential clientele and prestige of one's practice. A second benefit would be increased opportunities for continuing education and professional development through Fellowship in the American Academy of School Psychology and receipt of the *Journal of Applied School Psychology (JASP)* and *The Specialist*. Access to relevant clinical training allows part time practitioners to improve service provision. Third, some professional liability insurance companies offer reduced rates for those with board certification. Finally, for faculty members, board certification serves as an opportunity for powerful modeling for one's students. Attainment of the diplomate can be crucial in helping students to understand the value of board certification, demystify the process, and provide motivation to seek out the credential.

Steps to Becoming Board Certified with the ABPP

To become a board-certified school psychologist through the American Board of Professional Psychology (ABPP), there are three stages: 1) an initial application to the ABPP central office, 2) a specialty application to the American Board of School Psychology, and 3) the oral examination.

FIGURE 1: STAGES OF BOARD CERTIFICATION



Stage 1: Application and Generic Credentials Review. The first stage in the process is to complete an initial, online application for ABPP board certification. In this application, there are some basic requirements, including a doctoral degree from an APA-accredited program, licensure as a psychologist at the independent doctoral level, an APA/CPA-accredited internship or equivalent year of supervised experience, and endorsement from two board certified school psychologists. The interested reader is referred to the ABPP website for more complete details. The ABPP credentials review board will review the application and notify you of the status of the application in 6 to 8 weeks, depending on the time of the year. Changes will be made to this process beginning in 2020, the interested reader is again referred to the ABPP website and future issues of *The School Psychologist* for a timely overview of changes.

At present, once the ABPP central offices ensures that you have met all of the requirements, the American Board of School Psychology (ABSP) will review the application and ensure that your credentials meet all of the specialty-specific criteria for school psychology (Figure 1. Stage 1 B). Notification will then be sent to confirm that you've met the credentials and a mentor will be assigned to assist you through the rest of the examination process. The role of the mentor is to provide feedback and support as you go through the examination; he or she is not involved in the evaluation or examination itself.

Stage 2: Peer-Reviewed Practice Samples. Once the ABSP has reviewed and approved your credentials, you may then complete the professional statement and practice samples. The professional statement includes the candidate's curriculum vitae as well as a personal statement in response to a series of questions. In addition, two video recorded practice samples and accompanying narratives are submitted as part of the application, which are described in detail below.

There are eight options for the video recorded practice samples, which include: 1) assessment, 2) intervention, 3) consultation, 4) research/ evaluation, 5) supervision, 6) teaching, 7) management/administration, and 8) advocacy. There is also an accompanying narrative with each video recording that asks the candidate to describe the client, context, background events, issues of diversity, and how it represents the candidate's practice. Each candidate can choose which two practice samples to complete, depending on the nature of the candidate's work. For example, as a faculty member, your work may be comprised primarily of teaching, research, and service/administration, and thus you may choose to focus on those aspects of your work. On the other hand, if you have a private practice in addition to your work as a faculty member, you may choose to record a treatment session with a client (i.e., intervention practice sample) or a Conjoint Behavior Consultation with a teacher and parent in a school (i.e., consultation practice sample). The mentor can assist you in selecting which practice samples best represent your work.

Stage 3: Oral Examination conducted by the American Board of School Psychologists (ABSP). Once the practice samples have been reviewed and approved by the ABSP, an oral examination is scheduled with the candidate. Generally, the examination is comprised of an examination of the curriculum vitae and professional statement, followed by an examination of the competency domains (including the practice samples submitted): professionalism, reflective practice/self-assessments/self-care, scientific knowledge and methods, relationships, individual and cultural diversity, ethical and legal standards and policy, and interdisciplinary systems.

Fees

There are a number of fees associated with each of the three stages of the application process. The application fee for the review of credentials during Stage I is $125. It is important to note that the $125 application fee is waived for training directors from doctoral programs accredited by the American Psychological Association (APA), APA-accredited or Association of Psychology Post-doctoral and Internship Centers (APPIC) member internship sites, or APA accredited post-doctoral fellowship/residency programs. The fee for the review of the professional statement and practice samples is $250. Following review and approval by the Specialty Board, the candidate moves to Stage III, the oral examination stage. The oral examination fee is $450.

Early Entry

In addition to the standard process to obtain board certification, ABPP also has an early entry program at the pre-licensure level that allows graduate students, interns, or residents to begin the board certification process without committing to an area of specialty. Students can bank their credentials for a $25 application fee, which is a significant savings compared to the usual fee of $125. In fact, some graduate education programs choose to pay this reduced application fee to encourage their students to complete the

board certification process. Oftentimes, the comprehensive examination process utilized by doctoral programs is similar in nature to the oral assessment required for board certification.

The American Board of Professional Psychology recently modified its application process for early entry applicants. Through a partnership with the Association of State and Provincial Psychology Boards (ASPPB), the Credentials Bank will collect and verify an applicant's graduate education and applied experiences. This information is stored by ASPPB and forwarded to ABPP for review at no charge.

Conclusion

Overall, the purpose of this article was to introduce early career faculty to the function and process of obtaining certification with the American Board of Professional Psychology. Our field is comprised of a number of licenses and credentials (e.g., NCSP, licensure as a psychologist), and it is important that early career faculty have knowledge about the differences between these options. Not only does board certification potentially provide increased marketability and portability of licensure for private practice, but it demonstrates identification with and competency in an approved specialty area. Most importantly for faculty members, you have the ability to serve as a powerful role model and ultimately a mentor for graduate students.

This installment concludes the four-part series of *Professors in Private Practice* for early career faculty curated by Jessica Reinhardt and Anisa Goforth. The present series covered: an overview of considerations for professors in private practice, becoming credentialed with insurance panels, becoming credentialed with Medicaid, and this final article covering board certification.

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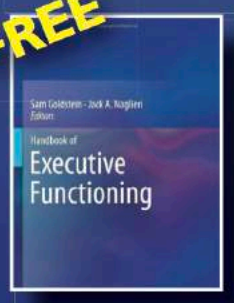

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BUILDING A RESILIENT SCHOOL PSYCHOLOGICAL WORKFORCE

EARLY INTERVENTION TO PROMOTE MENTAL WELLNESS AMONG GRADUATE STUDENTS

By Aria E. Fiat, M.A., University of Minnesota
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School psychology graduate programs – of which over 240 exist in the United States alone (NASP, 2017) – have the duty of preparing future school psychologists for the challenges that accompany serving children, families, schools, and communities in the 21st century. Given the stressors associated with the profession and the high rates of burnout among school psychologists (Huebner, 1993), trainees should enter the workforce already equipped with effective self-care and coping strategies (Corey, Corey, Corey, & Callanan, 2014). Moreover, research suggests that self-care practices adopted during graduate school extend to one's professional career. To that end, it is

critical for training programs to actively promote graduate student mental health and well-being as a form of early intervention, and for students to prioritize their own self-care strategies (Bamonti et al., 2014). This article will provide a brief review of the common challenges to mental wellness among graduate students. Then, using Multi-Tiered Systems of Support (MTSS) as a guiding framework, this article will outline strategies for program faculty and students can undertake to maximize mental wellness in school psychology training programs.

Challenges to Optimizing Graduate Student Mental Wellness

While psychology graduate students may themselves be well-versed in mental health promotion in the context of their work, research suggests they are no more immune to mental health difficulties than members of the general population (Gilroy, Caroll, & Murra, 2002; Kleespies et al., 2011). Graduate school in general is ridden with challenges that may threaten students' mental health if not met with deliberate efforts to maximize well-being (Toews et al., 1997). For example, the compound stress of increasing academic demands with financial, family, and work-related responsibilities can significantly compromise graduate student well-being (Furr, Westefeld, McConnell, & Jenkins, 2001). In fact, in a survey of 387 psychology graduate students, 70% of them reported experiencing stress that interfered with their functioning (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). Additionally, some graduate students may experience limited social and/or academic support as they operate in an environment that provides significantly less structure and guidance relative to the school experience of undergraduate students (Peters, 1997), with research indicating that feelings of isolation in doctoral programs is one of the primary factors linked to attrition (Ali & Kohun, 2006). Moreover, the time and energy needed for success during graduate school can lead students to sacrifice self-care activities (e.g., spending time with loved ones, physical exercise, healthy sleeping and eating habits, etc.) that are integral to maintaining well-being for practitioners/clinicians (Cushway, 1992). Finally, students who require extra support to cope with the challenges of graduate school may face barriers to accessing mental health services including lack of available in-network providers, financial limitations, time/scheduling constraints, and stigma (Hyun, Quinn, Madon, & Lustig, 2006).

Recommendations for Graduate Programs

For trainers of psychologists, attending to graduate student mental health and well-being has ethical, professional, and logistical/financial implications (Bamonti et al., 2014). Upon completion of their training, the majority of school psychology trainees transition to a career as school psychologists whose professional activities can be very stressful and result in mental health issues that negatively impact professional effectiveness (Shapiro, Brown, & Biegel, 2007). Some of the consequences associated with harm to professional effectiveness include loss of concentration, compromised decision-making skills, and reduced ability to establish strong relationships with others (Shapiro et al., 2007). It has long been recognized that self-care habits of psychologists are part of a trajectory that should begin in graduate school (Corey et al., 2014). Consequently, efforts to promote graduate student well-being are critical to ensuring a stable, competent, and resilient school psychological workforce. In addition, graduate student well-being directly impacts school psychology training programs. Research

indicates that graduate students who practice adequate self-care and have better mental health are more productive, show greater program engagement, matriculate as planned, and contribute to a better overall program climate (Goncher, Sherman, Barnett, & Haskins, 2013). In contrast, graduate programs characterized by high levels of student stress and burnout may be required to invest more time and resources on the backend to repair program climate and matriculate students. To address these concerns, training programs might consider utilizing a MTSS framework, with particular emphasis given to universal prevention.

Numerous ideas for Tier I interventions to promote graduate student well-being and prevent mental health concerns have been proposed in the literature. At the most basic level, trainers of school psychologists should explicitly teach the importance of maintaining psychological wellness at all stages of one's career (Goncher et al., 2013). This includes underscoring the awareness of and attention to one's mental health as foundational to being a competent, ethical school psychologist (Barnett & Cooper, 2009). Taking this a step further, Corey et al. (2014) advised embedding self-care education into graduate programming from the start of students' graduate careers. Self-care education is a multi-faceted construct that ideally involves building a culture of self-care within the graduate program (Goncher et al., 2013), explicitly instructing feasible, acceptable, and appropriate self-care strategies (Newsome, Waldo, & Gruszka, 2012), and having faculty model self-care attitudes and practices (Barnett & Cooper, 2009). Some school psychology graduate programs have embraced the idea of self-care education by requiring students to participate in seminars about enhancing well-being/resilience, or inviting students to participate in group wellness activities such as "Mindfulness Mondays" and gratitude practices (C. Cook, personal communication, June 26, 2017).

Faculty advisors can also play a critical role in enhancing the well-being of graduate students.

One straightforward but often overlooked approach is to build positive and supportive relationships with advisees, which can lead to more competent and confident professionals (Schlosser, Lyons, Talleyrand, Kim & Johnson, 2011). More positive advisor-advisee relationships – comprised of better rapport and a stronger working alliance – has been associated with greater student satisfaction, higher self-efficacy, and better progress on program milestones (Faghihi, 1998; Schlosser & Kahn, 2007). Research indicates that positive advisor-advisee relationships are characterized by mutual respect, clear communication, good conflict resolution, and alignment of values (Knox et al., 2006).

While the aforementioned strategies provide an excellent starting point for meeting the mental health needs of most graduate students, graduate programs should be prepared to offer additional Tier 2 and Tier 3 supports for students who are at-risk of developing or already experiencing mental health concerns. The demands of graduate school can be particularly taxing for students with significant responsibilities outside of school (e.g., familial, financial). Therefore, training programs might consider offering accommodations and/or greater flexibility for students who may be struggling to maintain a healthy work/life balance for various reasons. One possibility is to facilitate small group meetings among graduate students to provide additional academic and social support. Bruno et al. (2017) introduced a modified Check-In Check-Out (Hawken & Horner, 2003) for graduate students and found positive effects in the areas of well-being and productivity. Additionally, programs should take the time to make *all* students aware of resources within the university or surrounding to community to promote mental health and facilitate work/life balance. While some programs may view such initiatives as outside their scope of practice, they are crucial to preparing trainees for ethical and competent practice.

Recommendations for Graduate Students

The APA Ethics Code mandates that psychologists, trainees, and students "be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA 2002; p. 1062). In other words, as psychology graduate students, we have an ethical obligation to engage in ongoing self-care, whether or not self-care education is emphasized within our graduate programs (Goncher et al., 2013). The literature points to several important practices to maximize well-being while in graduate school. These include scheduling time to do things you enjoy, getting an adequate amount of sleep, maintaining a nutritious diet, exercising regularly, prioritizing relationships with family, friends, and mentors, and setting ambitious but reasonable goals for oneself (Cook et al., 2016). Mindfulness practices and values clarification offer additional approaches to increase resilience and reduce the negative impact of stress (Cook et al., 2016). In addition to these preemptive approaches, the APA ethics code also requires psychologists and psychology students to proactively address mental health issues when they do arise (Standard 2.06, Personal Problems and Conflicts). Keep in mind that fulfilling this duty might involve cutting down on work, seeking consultation from an advisor, or obtaining appropriate treatment (Barnett & Cooper, 2009).

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PEOPLE & PLACES

Edited By Ara J. Schmitt, Ph.D.
Duquesne University

Frank Farley, Ph.D., the Carnell Professor of Psychological Studies in Education at Temple University, Fellow of Division 16 and former APA President, has been elected President-elect of APA's Division 3, the Society for Experimental Psychology and Cognitive Science, and Representative to the APA Council of Representatives for Division 48, the Society for the Study of Peace, Conflict and Violence.

The University of Colorado Denver School Psychology Program is excited to announce the hiring of Dr. Rachel Stein as an assistant clinical professor. Dr. Stein received her Ph.D. from the combined Counseling, Clinical & School Psychology program at the University of California Santa Barbara. She is joining current faculty members Dr. Franci Crepeau-Hobson and Dr. Bryn Harris.

Indiana State University is pleased to welcome a new Assistant Professor, Dr. Chavez Phelps. Dr. Phelps received his Ph.D. in Guidance & Psychological Services, School Psychology from Indiana State University in 2011 and has since been an active school psychologist, private practitioner, and internship supervisor in New Orleans, LA. Dr. Phelps joins Dr. Carrie Ball.

The School Psychology Program at the University of Massachusetts Boston is pleased to announce the recent hire of Drs. Stacy Bender and Brian Daniels, both joining the faculty as assistant professors. Dr. Bender received her Ph.D. from Michigan State University and most recently served as an Assistant Professor in the School Psychology Program at Alfred University in New York. Dr. Daniels received his Ph.D. from Northeastern University and most recently served as Project Director for a multi-year project funded by the Institute of Education Sciences. The program faculty is thrilled to welcome both to the team!

The University of Montana School Psychology Program has a number of exciting announcements. The Specialist in School Psychology Program recently received full re-approval from NASP to 2024. Dr. Greg Machek, Associate Professor of Psychology, was awarded a sabbatical for the 2017-2018 academic year. Dr. Anisa Goforth, Director of the School Psychology Program, was awarded tenure and promotion.

Eleazar Cruz Eusebio, Psy.D., NCSP has been appointed Chair of the Department of School Psychology at The Chicago School of Professional Psychology in Washington, D.C. He joins the D.C. campus after seven years as an associate professor and core faculty in their inaugural program in Chicago.

Effective this past August 16th, Keith Radley, who was promoted earlier this year to Associate Professor and was the co-recipient of the 2017 Lightner Witmer Award at the recent APA conference, took over as training director of the Ph.D. program at the University of Southern Mississippi (USM). Radley is a 2011 graduate of the University of Utah and has been with USM since 2012. He takes over from Dan Tingstrom, Professor, who served 19 years as director (1992-2005 and 2011-2017). Tingstrom plans to retire from USM May 31st at the end of this academic year after 32 years. Other program faculty include Brad Dufrene, Evan Dart, and Joe Olmi (also chair of Psychology Department), and a special welcome to Lauren McKinley, a 2016 graduate of the University of

Cincinnati, who joined our faculty in August in a split position between the school psychology program and the Master's program in applied behavior analysis as a Visiting Assistant Professor.

William M. Reynolds (Bill) retired (sort of) in August after 40 years of university teaching (SUNY Albany, University of Wisconsin-Madison, University of British Columbia, and Humboldt State University). Bill received his Ph.D. from the University of Oregon in 1976 in School Psychology and has been a Fellow of APA Division 16 for 30 years (1987). Bill looks forward to relaxing on the California coast, walking his dog, Cookie, and completing several large-scale assessment projects. Cheers.

Dr. Brea M. Banks recently joined the school psychology program at Illinois State University. Dr. Banks received her training in school psychology from Illinois State University's APA- accredited and NASP-approved program. She completed an internship in pediatric psychology at the University of Nebraska Medical Center's Munroe-Meyer Institute. Her research centers around the cognitive impact of race-based microaggressions. Clinically, she has assessment and intervention expertise that are not limited to the following presentations and concerns: attention-deficit/hyperactivity disorder, autism spectrum disorder, anxiety disorders, conduct problems, depression, experiences related to racism and oppression, intellectual disability, and learning disorder. Dr. Banks is a licensed clinical psychologist and is pursuing certification as a Nationally Certified School Psychologist.

Dr. Marlene Sotelo-Dynega will take over the role of program director for the specialist and PsyD programs at St. Johns University (NY). Dr. Sotelo-Dynega has been with SJU since 2007.

Dr. Erin McDonough has been hired as a Clinical Assistant Professor in the School Psychology program of the Applied Department in the Graduate School for Applied and Professional Psychology at Rutgers University. In this role, she will serve as Practicum Coordinator, Director of the Rutgers School Psychology Internship Consortium, and supervisor of school psychology students in beginning and advanced practicum. Dr. McDonough is currently co-editing *Contemporary Intellectual Assessment, Fourth Edition* with her colleague, Dr. Dawn Flanagan.

See Yourself & Colleagues Here!

Please send items for next issue's "People & Places" to Ara Schmitt. Suitable information includes personal accomplishments within the field, such as hires, professional awards, and other recognitions. Similarly, let us know about the accomplishments of your program or institution (e.g., gaining accreditation status). Finally, please let us know about relevant program creations—such as training programs, internship sites, post-doctoral positions, and so forth.

DIVISION 16 EXECUTIVE COMMITTEE

The following elected officials have been selected by Division 16 membership to serve leadership roles for the specified terms.

Office	Term	Name	Contact Information
President	2017-19	Cathy Fiorello	Temple University Email: catherine.fiorello@temple.edu
Past-President	2017-19	Lea Theodore	College of William & Mary Email: ltheodore@wm.edu
Vice President for Convention Affairs & Public Relations (VP-CAPR)	2017-19	Rik D'Amato	The Chicago School of Professional Psychology Email: rdamato@thechicacgoschool.edu
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Council Representative	2016-18	Samuel Y. Song	University of Nevada, Las Vegas Email: sam.song@unlv.edu

AUTHOR'S INSTRUCTIONS & PUBLICATION SCHEDULE

Division 16 of the American Psychological Association publishes *The School Psychologist* as a service to the membership. Three PDF issues are published annually. The purpose of TSP is to provide a vehicle for the rapid dissemination of news and recent advances in practice, policy, and research in the field of school psychology.

Article submissions of 12 double-spaced manuscript pages are preferred. Content of submissions should have a strong applied theme. Empirical pieces conducted in school settings and that highlight practical treatment effects will be prioritized. Other empirical pieces should have a strong research-to-practice linkage. Non-empirical pieces will also be reviewed for possible publication, but are expected to have a strong applied element to them as well. Briefer (up to 5 pages) applied articles, test reviews, and book reviews will also be considered. All submissions should be double-spaced in Times New Roman 12-point font and e-mailed to the Editor. The manuscript should follow APA format and should identify organizational affiliations for all authors on the title page as well as provide contact information for the corresponding author. Authors submitting materials to *The School Psychologist* do so with the understanding that the copyright of published materials shall be assigned exclusively to APA Division 16..

For more information about submissions and/or advertising, please e-mail or write to:

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To be considered in an upcoming issue, please note the following deadlines:

Winter Issue: Approximate publication Date - February 1st; Submission Deadline - December 15th
Spring Issue: Approximate publication Date - June 1st; Submission Deadline - April 15th
Fall Issue: Approximate publication Date - October 1st; Submission Deadline - August 15th