CAPPNews – December 2019

President's Message: Joeanne Gutzwiller, Ph.D., 2019-2020 President

Hello and Happy Holidays! It's a special time of year, and I hope you will all enjoy some down time and celebrations with friends and family. As the year comes to an end, it's also a nice opportunity to reflect on the year that was. As I wrap up my first year of a two-year CAPP presidency, I am very grateful to our dedicated board members and especially our executive coordinator, Laura Wilson, who is truly a gift to CAPP.

Over the past twelve months, CAPP has enjoyed financial stability thanks in large part to our well-attended workshops. We hope to continue to offer excellent programming and learn from our mistakes, when necessary. We rely heavily on feedback from our members and greatly appreciate the feedback we receive at our events. In the next year, we will be offering an ethics workshop, a dinner meeting on the topic of fat shaming, and many more yet to be announced events. As always, we welcome ideas from our members so if you are interested in hearing about a particular topic, please let us know. Your attendance at these events is greatly appreciated as we strive to make CAPP your professional home.

In the past year, we've made a dedicated effort to attract students to our membership and our events. Thanks in great part to Dr. Rachel Sparn, we have our first student affiliate board member, Carly Deremo, from Wright State University. In addition, we've met with students from Xavier University, Miami University and Wright State University. These meetings have been a nice way for students to get to know CAPP; they've also been enlightening for us in terms of the needs and interests of students who will soon become part of our psychology community. As a result of this initiative, we have had several students join CAPP as graduate student affiliates and attend our events.

As we wrap up the year, we say goodbye to two of our board members who have given tirelessly to CAPP: Dr. Sarah Greenwell and Dr. Pete Dillon. Both have served for years and have contributed greatly to CAPP's success. We will really miss them both. Fortunately, we are gaining two new board members this year, Dr. Bailey Bryant and Dr. Amber Stevens. We're excited to welcome them and look forward to the energy and ideas that they will bring to the board. Dr. Bryant will be serving as our representative to OPA and Dr. Stevens will be managing our website.

Lastly, I wanted to thank each and every one of you for your ongoing support of CAPP. We are grateful for your support and look forward to a wonderful 2020!

SAVE THE DATE: Did someone say ETHICS???? April 3! Thomas Heitkemper, Ph.D. , 2019/2020 Chair

Monday–February 3, 2020: Fatphobia: Seeing our higher weight clients as more than a moral and health crisis

2 CEUs for Licensed Psychologists: $55 CAPP members, $65 non-CAPP members, $30 students (no CEUs for student rate; student ID required)

6:00 pm Social…6:20 pm Dinner…7:00-9:00 pm Program

Speaker: Wendy R. Dragon, PhD - Psychologists are expected to have an awareness of how our clients' backgrounds, experiences, beliefs, and values effect their lives. This aspirational goal is an ever-changing construct, as our field recognizes an increasing number of clients' variables that impact their lived experiences. Currently, most psychologists acknowledge the impact of race, ethnicity, sexual orientation, gender identification and religious variables on our clients' lives and experiences. However, we often do not think about how living in a larger body may impact them. If we do recognize the difficulties that our

larger bodied clients have, our response may be to suggest weight management. This response may further isolate and pathologize our clients. This presentation will explore the impact of fatphobia on our higher weight clients' lives and will suggest some better guidelines for psychological care of clients in larger bodies. As part of this conversation, we will discuss diet culture and its impact on us as professionals and as humans.

Objectives: (1) We will discuss weight as an aspect of human diversity; (2) We will review how societal weight stigma impacts our higher weight clients; (3) We will examine how society's stigma around weight may impact our ability to see ourselves and our clients as fully actualized beings; (4) We will consider how we can begin to address our own stigma around weight as a moral and health issue; and (5) We will explore what we need to do to provide better care to our higher weight clients.

Dr. Wendy Dragon currently serves as an associate professor at Wright State University's School of Professional Psychology (WSU-SOPP). She has presented nationally and internationally on issues of size stigma education. She has presented nationally about weight related topics, including treating size as a diversity variable and the impact of stigma on psychological and physical outcomes for our clients. She has also presented on psychological interventions with and advocacy for clients in higher weight bodies. She is the advisor to the Size Acceptance and Body Liberation (SABL) group, a group of WSU-SOPP students interested in advocacy and scholarship about size stigma and client care for larger clients. She serves on and chairs dissertations around size acceptance, body liberation, and size stigma. She currently serves as a co-coordinator for the Sizism Caucus of the Association for Women in Psychology. Her clinical work in this area focuses on health behaviors such as psychological health, balanced nutrition, and joyful movement in an environment of respectful care for clients in larger bodies. She believes that respect, not stigma, leads to better health and quality of life for all clients. In session, she focuses on addressing health without focusing on weight and healing clients' relationships with their bodies. She also assists clients in learning how to care for their marginalized bodies.

FRIDAY - APRIL 3rd 2020* (8:30 AM - 12:45 PM): *Diversity, Trauma, & Ethical Issues in Psychology

Speaker: Dr. Maria Espinola - In this program, attendees will explore trauma-informed techniques, culturally sensitive strategies, and ethical issues relevant to the treatment of diverse clients. The presenter will provide a framework to understand the ways in which trauma and culture intersect and impact clients' behaviors. Attendees will be introduced to the use of trauma-informed, culturally sensitive techniques to increase clients' engagement and response to treatment.

The presenter will discuss case studies of clients from diverse backgrounds who experienced different types of traumas (e.g. sexual violence, childhood abuse). Multiple clinical issues will be reviewed, including case conceptualization, treatment planning, risk assessment, and safety planning. Attendees will have the opportunity to ask questions, share cases with the group, and receive feedback.

Program Objectives: (1) Discuss therapeutic skills to target trauma symptomatology; (2) Practice techniques to increase attendees' awareness of the multiple factors that shape their own and their clients' cultural identities; (3) Review trauma-informed and culturally appropriate tools to decrease problematic behaviors; and (4) Discuss ethical issues relevant to the treatment of diverse populations.

Maria Espinola, Psy.D. is an Assistant Professor in the Department of Psychiatry and Behavioral Neuroscience at the University of Cincinnati College of Medicine. Her work focuses on the intersection of multicultural issues, gender, and trauma. She was born and raised in Argentina, South America. She studied psychology at the University of Buenos Aires before immigrating to the U.S. in 2001. She completed her doctorate in clinical psychology at Nova Southeastern University, her pre-doctoral internship in multicultural psychology at Boston University School of Medicine, and her post-doctoral fellowship in DBT, women's psychology, and trauma psychology at McLean Hospital and Harvard Medical School. In addition, she completed trainings led by Marsha Linehan. Dr. Espinola received over 20 honors and awards for leadership, diversity initiatives, community impact, academic achievements, and

outstanding performance. Dr. Espinola currently serves as Chair of the Ohio Psychological Association's Diversity Committee, as a member of the Health Policy Institute of Ohio Board of Directors, and as Liaison for the American Psychological Association Presidential Initiative on Deep Poverty.

Treasurer's Report: Alexis Pittenger, Psy.D., 2019/2020 Treasurer

Hello and Happy Holidays! CAPP is ending the year in a solid place financially. However, there are also some challenges that the Board is working hard to address. A number of steps have already been taken to ensure that the net worth of CAPP remains stable, and that we can continue to offer high-quality programs to the community. As you will soon notice, dinner meeting fees are increasing. This is in response to increases in room costs, food, etc. Positively, the last two dinner meetings have been well attended. We were pleased to have a few other professionals join us at the last dinner meeting. Continuing to expand our reach will help to ensure that these meetings are profitable. On that note, we hope to see you at our next meeting in February (more information is on the website)!

We had a number of organizations express interest in advertising in the 2020 Directory, which will help to pay for the costs associated with this. In other news, the Board decided to work with a different website company. Although the monthly fee will increase slightly, this new company will provide many services that hopefully will offset the significant maintenance fees associated with our previous provider.
Sadly, the Board is losing Drs. Dillon and Greenwell. We can't thank them enough for their efforts over the years. We are excited, however, to welcome two new members- Drs. Stevens and Bryant! Adding new faces to CAPP, both via the Board and new members, helps to ensure that CAPP remains a dynamic organization. Of course, CAPP couldn't exist without all of our wonderful members. As a reminder, your 2020 dues are due December 31st. After that, a late fee is assessed. Thank you to all those who have already paid, as this helps us to begin formatting the 2020 Directory. If you haven't paid, please take a moment to do so now.

Membership/Marketing News: Rachel Sparn, Psy.D., 2019/2020 Membership Chair

Our campus visits in October were a positive experience and well received. We've gained two new affiliate members from making these campus connections thus far! We've also recently reached out to several local organizations about the opportunity to advertise in the CAPP directory. We'd like to remind all our members that the directories are sent out every 2 years and advertising your business or organization is always an available option. Please contact me or Laura Wilson (capp@cappnet.org) for further information. Lastly, be on the lookout for CAPP-sponsored tickets to a Cincinnati Reds baseball game this Spring 2020!

Please join us in extending a warm welcome to our newest CAPP members:

Sailee Thakur, Psy.D. - Dr. Thakur received her Psy.D. from Xavier University in 2016. She enjoys working with people across the lifespan, with some of her specialties including anger management, anxiety, and ADHD. Dr. Thakur's contact information can be found on the website.

Megan O'Connor, Ph.D. – Dr. O'Connor received her Ph.D. from Rosalind Franklin University of Science and Medicine and specializes in neuropsychology and traumatic brain injuries. Her contact information can also be found on the CAPP website.

Student Affiliate member, Ameena Ahmed, M.A.
Ameena is currently attending Xavier University's Psy.D. program with an expected graduation date of 2022. Outside of her coursework, she enjoys working with children, adolescents, and teenagers.

Webmaster News: Pete Dillon, Ph.D., 2019 Webmaster

It has been a learning experience and a pleasure to serve on the board for the last two years. I have been honored to work with such an enthusiastic and talented board and gained appreciation for the behind the scenes work that keeps CAPP running so smoothly. I am passing the webmaster torch to the very capable hands of Amber Stevens. I chose the position of webmaster, mainly because I value the resource of the CAPP directory. Of the many advantages of CAPP membership, the online directory and excellent website are near the top of the list. It is a wonderful resource for the community as well, and I frequently refer people to it in order to connect with providers and services. When approached by folks looking for care in a specialized area, a geographical neighborhood, or a specific age group, remember to pass on the website address.

Remember to review and update (if necessary) your listing before the Directory printing. The information for the Directory is taken from the website! If you wish to update your listing with either a photo or a link to your website, send us the information at capp@cappnet.org.

Social Media/Public Relations:

As you likely have heard, CAPP recently created a closed Facebook group (CAPP Cincinnati Psychologists Group) to provide a private forum for CAPP members to seek and share current information with one another. Much like the OPA/APA list serves, members can post referral needs and share resources. If you'd like to join the conversation, sign onto Facebook and search for the group "CAPP Cincinnati Psychologists Group". Once you select "join group", we can add you to the group.

Also, please remember to check out the CAPP Facebook Page to stay up to date on all CAPP events and news:

https://www.facebook.com/CAPPNews/

Insurance Managed Care Committee: Teri Role-Warren, Ph.D., 2019/2020 Chair

The following is a summary from issues recently discussed with the Committee:

The December Insurance Committee meeting reviewed recent listserv topics. There have been some questions on the list serve about allowable charges for Humana Medicare if the psychologist is not a participating provider on that panel. The fee that psychologists are allowed to charge is the Medicare rate, even for psychologists who are not on the Humana panel.

Health and Behavior billing codes will change in 2020. There is a crosswalk on APA's website and a free webinar on the changing codes and how to use them.

The committee reviewed telepsychology issues, such as conditions under which telepsychology is billable and reimbursable. APA offers an online telehealth certification to train psychologists about medicare rules for telepsychology.

Some psychologists are unclear about how to bill for psychological testing and what constitutes psychological testing. Dr. Broyles reported that his research shows that insurance companies require that more than one psychological test be given in order to constitute testing, for example. Additional questions can be researched on the OPA insurance committee website or by posting questions to the listserv.

Payment for psychology post-doctoral residents was also discussed. The State of Ohio requires psychologists to notify the insurance company if a supervisee is providing services. Not all clearinghouses and EMR's put that information through to the insurance company automatically. In addition, psychologists must adhere to the requirements of each insurance company. Psychologists should look at their contracts or call the insurance company in question.

Regarding credentialing, turn-around times with Medicare and Cleveland Clinic have improved. Aetna said their panel is "closed" even though they have group contract. If changing practice addresses, insurance companies are legally required to complete the change of address within 90 days.

The OPA insurance committee is redesigning its webpage to make it easier and more efficient for psychologists to navigate.

Please feel free to contact CAPP's chair, Teri Role-Warren with any questions. Contact info found on our website. www.cappnet.org

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News from the Ohio Psychological Association (OPA): Sarah Greenwell, Psy.D., 2019 OPA Representative

OPA has teamed up with APA to be one of a few state associations to offer a Pain Management Training Program for psychologists. On Friday January 24, 2020 OPA and APA will present a Summit on Psychological Pain Management Services course. OPA will kick-off this partnership with APA at the Ohio Statehouse on January 23, 2020. There will be an hour presentation with a reception to follow.

Senator Theresa Gavarone (District 2 in Toledo, OH) has expressed interest in introducing the PsyPACT (Psychological Interjurisdictional Compact) Bill, though not until early next year. OPA continues to lobby for the introduction of this bill as several states have already passed a similar telehealth bill to allow temporary face-to-face practice of psychology across jurisdictional or state boundaries. House Bill 323-Prescription Privileges for Psychologists is still in the House Health Committee and is sponsored by Representatives Manning and Seitz. OPA continues to monitor 16 other bills related to Conversion Therapy, Culturally Competent health care workers and the Ohio Fairness Act. Go to the OPA Bill Box on the OPA website for more information.

Finally, after 9 years, I have resigned from the CAPP Board and as the OPA Regional Representative. I have enjoyed every minute of being a part of OPA and CAPP. OPA is a strong organization as noted recently in one of Michael Ranney's weekly updates outlining a year of OPA accomplishments:

- **$4,625** in scholarships and awards were provided to High School and Graduate students
- **6,272** "Find a Psychologist" searches were initiated on the OPA website last year
- **61** OPA workshop opportunities offering **129** CE hours were attended

I will continue to work on OPA Committees, but Bailey Bryant, PsyD will be taking over as OPA Regional Representative on the CAPP Board in 2020. Please feel free to contact your new OPA representative at BaileyBryant@drbbryant.com with any further questions about OPA.

Save the Date:

- January 23, 2020 from 2:00-3:30pm, kick-off to Psychological Pain Management Services Summit at the Ohio Statehouse Atrium, with reception immediately following.
- April 23-25, 2020 OPA Annual Convention: *Today's Psychology: Practice, Research, and Emerging Trends* in Columbus, OH. Online registration and convention brochure will be posted January of 2020 on the OPA website.

Program Reviews: James Dahmann, Ph.D. 2019/2020 Secretary

In our recent program on social media and adolescents' "new digital reality," some participants asked for more data on these issues. As Stephen Smith indicated, the research is mixed. Here is a small sampling of research on media violence. Note that these issues are not new. Recall that Albert Bandura was blackballed for his research (including his 1963 paper by him and two colleagues titled Imitation of Film-Mediated Aggressive Models, which espoused the Social Learning paradigm as an explanation for aggression behavior):

On Albert Bandura being blackballed in the 1970s for his research finding an adverse impact of television violence on children's behavior:

https://books.google.com/books?id=-tZsBQAAQBAJ&pg=PA214&lpg=PA214&dq=albert+bandura+blackballed+by+network&source=bl&ots=SK3BTyohGm&sig=ACfU3U287KdrsMi2Ra8DMvh-sCMTSXvAiA&hl=en&sa=X&ved=2ahUKEwihuO_dgIjmAhWk1VkKHdl1CTMQ6AEwCnoECA0QAQ#v=onepage&q=albert%20bandura%20blackballed%20by%20network&f=false

Other more current research includes:

The effect of violent video games on aggression: Is it more than just the violence?
https://www.sciencedirect.com/science/article/pii/S135917891000073X

The role of media violence in violent behavior
https://www.annualreviews.org/doi/full/10.1146/annurev.publhealth.26.021304.144640

Desensitization to media violence: Links with habitual media violence exposure, aggressive cognitions, and aggressive behavior - This study examined the links between desensitization to violent media stimuli and habitual media violence exposure as a predictor and aggressive cognitions and behavior as outcome variables. Two weeks after completing measures of habitual media violence exposure, trait aggression, trait arousability, and normative beliefs about aggression, undergraduates (*N* = 303) saw a violent film clip and a sad or a funny comparison clip. Skin conductance level (SCL) was measured continuously, and ratings of anxious and pleasant arousal were obtained after each clip. Following the clips, participants completed a lexical decision task to measure accessibility of aggressive cognitions and a competitive reaction time task to measure aggressive behavior. Habitual media violence exposure correlated negatively with SCL during violent clips and positively with pleasant arousal, response times for aggressive words, and trait aggression, but it was unrelated to anxious arousal and aggressive responding during the reaction time task. In path analyses controlling for trait aggression, normative beliefs, and trait arousability, habitual media violence exposure predicted faster accessibility of aggressive cognitions, partly mediated by higher pleasant arousal. Unprovoked aggression during the reaction time task was predicted by lower anxious arousal. Neither habitual media violence usage nor anxious or pleasant arousal predicted provoked aggression during the laboratory task, and SCL was unrelated to aggressive cognitions and behavior. No relations were found between habitual media violence viewing and arousal in response to the sad and funny film clips, and arousal in response to the sad and funny clips did not predict aggressive cognitions or aggressive behavior on the laboratory task. This suggests that the observed desensitization effects are specific to violent content. (PsycINFO Database Record (c) 2016 APA, all rights reserved)
https://psycnet.apa.org/ (You'll have to go to this site and search for the article)

Stephen Smith did make the point that increasing screen time may be having an adverse impact on our children. Again, this remains a contentious area:
https://doi.org/10.1001/jamapediatrics.2019.4559

But research is finding an impact of screen time on children's brains Here's the "public" article:
https://amp-usatoday-com.cdn.ampproject.org/c/s/amp.usatoday.com/amp/4156063002
And here's the actual article link: https://doi.org/10.1001/jamapediatrics.2019.3869

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10/25/19 - OUR AGING BRAINS - Dr. Wes Houston returned by popular demand to present a half-day workshop about age related neurocognitive disorders. This was felt to be a pertinent topic giving the aging of the general population (as well as some of the attendees, including yours truly!).

Norms for Older Adults

The first thing we learned is that we don't know much about changes in the elderly, because many of our norms don't go beyond 90 years. With people living longer this is becoming problematic--it is no longer unusual to see people in their upper 90's presenting for a cognitive assessment. People are staying independent much longer than in the past, but because we tend to see only the ones having problems, we may be biased in our view of older adults as having cognitive problems when, in fact, most do just fine. People do have more medical problems as they age, but those having many medical problems and

those having a few are quite different populations and our normative data doesn't separate this out--important, as many medical problems negatively impact cognitive functioning. As the population ages, the variation varies quite widely (the standard deviation becomes very large), so that on some tests it is difficult to end up in the impaired range.

One's culture and educational level also plays a major role in how one's functioning is viewed. As an example of variability in cultural norms, Dr. Houston noted how, when he moved to Iowa, he discovered that it was not uncommon for people with 8th grade educations to be running multimillion dollar farms—a much different norm than most of us are used to.

Changes with Age - Brain changes and thinking changes are not necessarily linked. We know, for example, that brain shrinkage occurs throughout adulthood, probably starting in the 20's. The cells are not really dying, but are shrinking in size and so are less efficient. In addition, there is a decline in neurotransmitters, and the connections between neurons are withering away. Looking at brains of healthy older adults we find there are plaques and tangles as seen in Alzheimer's Disease, even though these people functioned just fine. Proportions of grey matter/white matter/cerebral spinal fluid reflected in brain images can help determine brain health. However, it doesn't tell us what the problem is, only that there is a problem.

HAROLD Model - The Hemispheric Asymmetry Reduction in Older Adults (HAROLD) model has found that prefrontal cortex activity is no longer as symmetrical in older adults as in younger adults. The brain is compensating and working harder by using both sides to function at the same level, and we can see this on brain scans. Older people who do not do this, staying on one side of the brain, do not function as well. When we are no longer able to use other areas of the brain we start to see declines. There is increasing evidence for plasticity in the brain—growing new neurons, etc.

Normal vs. Abnormal Cognitive Aging - Mild cognitive impairment (MCI) refers to the transitional stage between normal and the earliest clinical signs of dementia. It is the middle part of a cognitive continuum from normal to dementia. It incorporates memory as well as other cognitive impairments (attention problems, speech problems, etc.) and does not always progress to dementia. Is just one domain affected, or are multiple domains affected? MCI can have memory problems, or not have them, as brain imaging can show. People with genetic risks convert from MCI to AD much faster. Within MCI clinicians must particularly attend to those who are worried about the cognitive impairment.

Dementia - Alzheimer's Disease was first described by Alois Alzheimer in 1906, initially called Pick's Disease (which is actually a more focused disorder). From the 1920's to 70's the name AD was not mentioned, rather the term "senility" was used. In the 80's we returned to the use of AD as well as Primary Progressive Aphasia for those with language problems with other terms introduced since. Dementia can be caused by stroke, brain trauma, or Alzheimer's. Disease

Symptoms are a decline in cognitive capacity from a previous level, in a minimum of two cognitive domains, and impaired functioning in normal daily activities. Usually dementia is irreversible. It is not *caused* by aging (though risk increases with age) but caused by a brain dysfunction. Cortical Dementia symptoms are prominent amnesia, poor recall and recognition, aphasia, apraxia, agnosia, motor and sensory deficits. Subcortical Dementia symptoms are memory retrieval deficits (recognition leads to recall), motor/cognitive slowing, poor attention and working memory, executive dysfunction, and personality or mood changes.

Dementia Diagnosis by Initial Symptoms - If the initial symptoms are memory deficits, think Alzheimer's; if language deficits, think primary progressive aphasia; if executive function deficits, think frontotemporal dementia. Visuospatical/attention deficits suggest. dementia with Lewy bodies; variable pattern of deficits think vascular dementia. Reversible kinds of dementia are normal pressure hydrocephalus, hypothyroidism, nutritional deficiencies, depression, sleep disordered breathing e.g. apnea.

Diagnosis by course of illness

Acute onset: (delirium)
Neurodegenerative (loss of neurons): Suggestive of Alzheimer's Disease. Frontotemporal dementia, primary progressive aphasia, and dementia with Lewy bodies.

Slowly progressive or stable: deficits suggest vascular dementia, Parkinson's dementia, or alcohol-related dementia
Rapidly progressive dementia suggests Prion disease, atypical presentations of common neurodegenerative diseases

Alzheimer's Disease Diagnosis
Abnormal results on cognitive screening and neuropsychological testing and/or history
Deficits in two or more spheres of cognition
Not explained by delirium or psychiatric disorder
Insidious onset and progressive over time
Amnestic vs. nonamnestic presentations
No prominent features of other neurologic diseases

Alzheimer's starts in middle part of temporal lobe and then moves out. Those with the genetic risk factors (four possible genes) have an earlier onset (as early as the 30's or 40's,in the 50's is common). The more factors, the higher the risk. People who know their risk factor report more memory problems than those who do not know.

Other Disorders

Frontotemporal Lobar Degeneration Dementia (FTLD) is a degeneration of frontal and/or temporal lobes, with more lateral damage. Early onset dementia symptoms are prominent changes in social behavior, personality, language skills (i.e. aphasia), and/or motor signs/symptoms. Etiology is genetic. There are three subtypes. Degeneration in left temporal lobe (Broca's area) leads to language problems; degeneration in the right temporal leads to difficulties understanding emotions in others, but usually damage is on left side. Behavioral changes are seen before imaging changing. Managing frontotemporal dementia is difficult, as we have few options other than caregiver support and patient safety. Modest support using SSRI's for behavioral problems; benzodiazepines can lead to a decline in memory and psychomotor skills which may not be reversible. Cholinesterase inhibiters are not helpful. Atypical antipsychotics in low doses can help with aggressive and compulsive behaviors.

Primary Progressive Aphasia (PPA) Most prominent feature is language problem, causing impairment in daily functioning. Aphasia is most prominent initially and early in the disease. There are three types: Nonfluent/agrammatic, Semantic , and Logopenic Progressive Aphasia which is Alzheimer's Disease (has plaques and tangles) but with language rather than memory impairment. There is a degenerative ability to produce language (e.g. describing a picture), naming articles, and sentence repetition, word retrieval difficulty make slow down language production.

Normal pressure hydrocephalus is common in older adults. Gait problems are usually first symptoms, such as difficulty getting foot off ground (magnetic gait); Gait problems, cognitive impairment, and urinary incontinence constitute the diagnostic triad. However, these conditions can also be caused by peripheral neuropathy secondary to diabetes, prostate enlargement, etc. There may be excess cerebral spinal fluid, due to a production or an absorption problem. This leads to ventricular enlargement—3-4 times the usual size. Since the accumulation happens slowly, sometimes over years, you don't seen the pressure increase as you do with obstructive hydrocephalus (when a tumor or other problem interferes with cerebral spinal fluid absorption) which is a medical emergency requiring draining of fluid. In this case, gait is the best indicator of improvement after the surgery (number of steps and time to walk a fixed distance).

Dementia with Lewy bodies : Alzheimer's like dementia with Parkinsonian features. Both cortical and subcortical symptoms. Antipsychotics contraindicated due to extrapyramidal sensitivity. Problems with executive functions such as multitasking, problem solving, use of forethought. Fluctuating cognitive abilities (over hours). Cholinesterase drugs may help. Can have visual hallucinations that are well defined. Less memory impairment than with Alzheimer's. These can also be side effects of some of the drugs used to treat Parkinson's motor skill problems. Tests: circle all the A's, copy a complex figure. inability to remember information (e.g. list of words or drawing a figure).

Vascular Dementia: Not a neurodegenerative disorder. Caused by repeated insults to the brain (e.g. subcortical strokes), and progresses in a stepwise fashion. We all accumulate tiny strokes over time.

Deficits based on location of damage. In multi-infarct dementia, cognition declines gradually over time. Symptoms include cognitive and psychomotor slowing, decreased attention, concentration, and executive functioning, and depression. Cognition problems with focal cortical strokes are aphasia, apraxia, amnesia, and visuospatial deficits.

Delirium: Also called acute confusional state. Generally a medical emergency. There is an acute onset, with a fluctuating course. Cognitive dysfunction. Can be agitated, restless, and combative; may have hallucinations. Like an acute brain failure. Hyperactive type (30%), hypoactive type (25%) and mixed (45%). Post-operative delirium is very common. Usually delirium is reversible. Extremely common among nursing home residents (estimates as high as 60%), 80% get it near death. Many cases go undetected. High mortality rate afterward. Causes: drugs, perceptual difficulties, low oxygen, infection, urine retention, dehydration, poor nutrition, sleep deprivation.

Treatment of Cognitive Problems

Treatment is geared to prevention and assessment.

Prevention involves five key things: Exercise, Diet, Stress Reduction, Social Activity, and Mental Activity. Most strategies have to do with minimizing medical risk factors for cerebrovascular disease: managing blood pressure, quitting smoking, lowering /LDL and HTN, maintaining healthy weight, managing/preventing diabetes, Mediterranean diet, controlling stress, and getting regular exercise. Cognitive activity of any kind works—new things are what matters, not the specific activity (e.g. drive to work a different way). Frequently engage in leisure activities. While there is no substantial evidence that cognitive training can prevent Alzheimer's Disease, it can delay decline in healthy older adults.

Physical activity has shown positive results on cognition and also helps reduce falls in the elderly, but overall the evidence for prevention of dementia is mixed but likely does indirectly reduce risk by reducing other cognitive risk factors. Dr. Houston suggests we treat our retirement as we treat our job. In general, maintain mental (e.g. cognitive training) and social stimulation. Psychotherapy can assist with the emotional reactions to cognitive impairment.

With dementia, maintain safety and independence at home; eventually may need assisted living environment and transition to full time care setting. Maintain mental and social stimulation and engagement. Acting out behavior is usually due to some negative factor in the environment—find and fix the problem rather than drug up the patient. Set meaningful, realistic goals and practice reutilized, well-learned preserved abilities.

Cognitive Screening

Cognitive domains needing assessment are orientation, attention, language, visuospatial skills, memory, and executive functioning. Patient self-reports are unreliable. Screening provides a quick, brief assessment of current cognitive functioning, can be the first step in making the distinction between normal cognitive functioning and cognitive dysfunction, and can indicate whether a patient would be able to participate in a more comprehensive evaluation (e.g. are they cooperative?). These can be administrated by a variety of healthcare professionals but have limited sensitive to mild cognitive difficulties and cannot be basis of a definitive diagnosis. They can also be biased by patient demographics including age and education.

Screening Tools

Among the screening tools Dr. Houston mentioned were:
MMSE Mini mental status exam.
MoCa: Montreal Cognitive Assessment: Free, well-researched, has alternate forms including one for the blind, is available in multiple languages, has a basic one for people who are illiterate or intellectually deficient, balanced measurement of cognitive domains, and is highly sensitive—but variable results depending on administer have now required you to get certified to use it. Can yield false positives
Mini-Cog—three word recall, clock drawing, takes only seconds to administer but you need training to interpret.
ADAS-Cog

CDR Clinical Dementia Rating must be certified and trained to administer
DRS-2: Has very low floor.
CERAD:
RBANS:
SLUMS (in public domain) Free, well known, sensitive to brain dysfunction, useful for visually impaired, English only. Good balance in measuring cognitive domains.

We thank Dr. Houston for his very informative workshop that will help our patients, and help us, as we all grow older.

Houston, W. (2019) Age related neurocognitive disorders. Presented to Cincinnati Academy of Professional Psychology, October 25, 2019.

9/25/19 – THE SPECTRUM OF GENDER NON-CONFORMITY – We were treated to a presentation by Sarah Painer World, MS, MSW, LISW-S on the spectrum of gender non-conformity. The presenter noted there is a shortage of therapists who deal with issues of gender non-conformity, so this could be a fruitful area to gain expertise in.

Definitions: Gender is a spectrum between male and female, and the definitions are fluid and constantly changing. Some examples are:

Cisgender : not trans, lives as same sex as identified when born.
AMAB/AFAB: Assigned male/female at birth
Trans: out of date term
Non-binary: don't identify as male or female.
Queer: at one time used in a negative fashion until the queer community embraced it. Means nonconforming in terms of gender identify/orientation and is acceptable to use.

Gender involves identity, expression/presentation, sex assigned at birth, sex attracted to, and sexual behaviors with. Gender is who one is, sexual orientation is choice of sexual partner. The percentage of gender non-conforming in the population is unknown but one estimate, probably low, is 5%. The etiology is a combination of factors: genetic, biological brain differences, hormonal, but *not* environmental. There is no evidence that parenting style, abuse, or other environmental events influence sexual orientation/gender.

LGBT kids come out most commonly to their close friends and classmates; rarely to their doctors. It is important to create a safe environment for them: office décor, language and terminology you are using, pamphlets, posters, forms, etc. You should NEVER out them or expose them without their consent. They have reasons for not coming out which need to be explored. A safety net should be in place for them should parents reject them. Ask them their preferred name/pronoun and use them. Use of the child's chosen name and pronoun by treatment providers and family is critical to prevent problems. "The little purple backpack" is a good web resource for college bound kids.

Gender Dysphoria - This diagnosis is no longer looked at as something being wrong (it is no longer a "disorder") with the brain/person. Rather, the key is that gender issues cause the person distress. (By contrast, gender *euphoria* can occur with acceptance and being addressed in the desired name/pronoun.)

Problems Faced: Child - Trans have a 41% suicide attempt risk, and 45% for ages 18-24. 57% have experienced family rejection and 60% health care provider rejection. 69% have been homeless. The suicide risk is *strongly* related to family rejection. The Family Acceptance Project has good materials for the family. Rejection also increases depression, illegal drug use, and unprotected sexual intercourse. Acceptance protects against all these things and also promotes self- esteem, social support, and overall health. Sometimes the rejection is subtle but perceived by the young person as such—e.g. "maybe it's a phase." 90% feel unsafe at school and hear derogatory remarks. They are often mistreated in school, are bullied, skip school because they feel unsafe. 25% have been physically attacked. 50% have seriously thought of suicide and 50% will attempt suicide in their lifetime.

Problems Faced: Parents - Parents may feel rejection is the right thing to do. We must recognize the parents struggle with this and assist them. They may feel their world is falling apart. Comments they make are not meant to harm the child, but instead to "not encourage" them. There is typically a period of concealment by the parents—but when the kid comes out, eventually the parents must come out also.

This can be embarrassing, scary, etc. for them. Parental disparity in the level of acceptance may further destabilize the family. Unfortunately, this happens at the same time the child needs parental support the most. Families typically become less rejecting over time.

Mental health provider role - Review the APA Guidelines to help you deal with this population, but be aware standards of care are changing. Help individuals live as their true gender self. Help them discover the gender that feels most authentic and develop resiliency. Model acceptance, making no attempt to ward off a transgender or gender nonconforming outcome. Be mindful of own biases and beliefs related to gender identity etc. Assess, diagnose, educate, and discuss treatment options. Assess the environment the child is in: e.g. challenges at school, church, being bullied, etc. With kids understand the family system and provide family support to help them accept and understand the child. Address any coexisting mental health concerns. Refer for medical intervention as appropriate (e.g. puberty suppression, which is totally reversible and does not interfere with other development). Most kids do not figure out their gender identity until puberty or even later Help parents value diversity over conformity; to deal with their grief, sadness, anxiety, fear, denial, guilt, anger, confusion, and shame. Keep in mind parents love their kids and want to do the right thing for them. When transitioning the mental health provider can assure the client is making an informed decision regarding medical care.

Resources - Children's Hospital sees people aged 5-25; if under 18 Children's is the ONLY local resource. For adults, medical providers are often full. A few endocrinologists, OB-GYN's and surgeons are available. Surgeons will want a letter from a mental health professional before proceeding. A new clinical group out of Columbus is coming to Cincinnati—perhaps next year—for ages 18 and over.

12/9/19 – SOCIAL MEDIA AND ADOLESCENTS - At our December dinner meeting, Stephen Smith, M.Ed. presented on the life of kids today with social media. As he pointed out, the "neighborhood" kids live in today is vastly different than the kind most of us grew up in. For kids, the online social media neighborhood is just as real as the physical neighborhood's parents are more familiar with--only unlike our parents, today's parents do not know what is happening in their childrens' "neighborhood" of social media. Apps send kids things the app developers think the kids SHOULD be interested in. The influence now is not only parents, teachers—but also the algorithms feeding them. Mr. Smith presented some correlational data that seems to warrant additional investigation and study.

This is happening to kids at a younger and younger age—some first graders now have smart phones now. This may not be a good idea (Steve Jobs wouldn't let his kids have one). Kids are isolating themselves from their parents, texting and driving is epidemic, and kids ride in the back of the car with earbuds in instead of talking to parents. 75% of kids are allowed to take their phones into their bedrooms. Some are on their phones at 2 or 3 AM even though they are very young (not good for their sleep patterns) and can make contact with dangerous people (e.g. pedophiles). They need to get away from their phones regularly (as do the parents). Parents need to control the app store password so kids cannot download inappropriate apps. 21% of middle school kids hide their photographs and chats from their parents. This may be perfectly innocent, or something very dangerous for the child. Mr. Smith suggests parents and kids sign a mutual contract clarifying the roles and responsibilities of having a phone! Incidentally, it is illegal for a child younger than 13 to use a free social media app! Who knew?

Mr. Smith suggested Bark and Teen Safe as being good apps for monitoring children's online behaviors and keeping them safe.

How does the misuse of today's technology impact the child? There are multiple problems.
1) This is the first generation that will be judged by people who have never met them. Starting in the 8th grade, some college coaches look at EVERYTHING a child posts on social media. One coach looks at years 8 and up and drops anyone posting anything negative e.g. racial comments, etc. Business is doing the same thing—social media is routinely checked, artificial intelligence does interviews and can also create a facial recognition database, then searches the interview and can match up the face at any age.

2) This is the first generation that has 24 hour access to the world and the world to them. Knowledgeable people are able to get a good amount of information about someone through technology--even just messaging can reveal a significant amount of information. Everything you do on a free app is recorded, analyzed, and sold. This is why TikTok, Instagram, Snapchap, etc. should be used with some caution. You must be on an app at least 20 minutes for the company to make money, so the apps are

programmed to keep you on it. For example, Instagram holds back "likes" to keep you coming back to check the app. Instagram and Facebook have 98 datapoints that they collect on each user. It is parents' responsibility to keep this programming from controlling their children. A recent CNN study claims kids spend 7 hours/day on their screens, other studies range from 4-9. Nobody knows for sure.

There are 1.5-1.7 million apps available to kids and parents, kids primarily use about 70 of them. Most common: YouTube, Netflix, Instagram, Snapchat, and Twitter. Thirteen to fourteen year old boys like Fortnite, which exceeds all other video games for this age group. Nothing on these apps ever disappears--even if you delete them. For example, prosecutors can get *all* information from your SnapChat account. The photographs do not disappear just because you delete them. Note: There is no such thing as a private account (on ANY app). It only means the general public cannot access it.

Mr. Smith did a survey of 2500 kids and 80% of kids reported that they felt social media pressured them to act in a certain way. The awareness of this increased with age. 78% girls said social media had made them feel poorly about themselves; 58% of kids acknowledged cyberbullying was an issue at their school. Children's Hospital has seen a 70% increase in kids with mental health issues since kids started getting smartphones. (Not all of this is attributable to social media, of course, and Mr. Smith's survey was just that—correlational only, not a scientific study.)

There has always been parental distraction, but Mr. Smith believes parental distraction started increasing in 2007-2008. Parents have gotten so immersed in their devices that they have been distracted from bathing small children and so forth. Teens are also distracted: 58% of teen crashes involve distracted driving, mostly due to texting and driving. (Editor's note: there is some data suggesting older adults text and drive more than the kids do!)

While many parents are aware of YouTube, Snapchat, and other apps mentioned above, some apps not on parents' radar that kids are using were discussed:

Secret Calculator (which hides things like photos and messages, popular with middle school girls);

omegle (lets you talk to strangers!) which is actually a website where strangers ask about anything and is often used by sexual predators, who use sextortion techniques with young women (e.g. 7th grade).

Instagram is the app of choice for many predators. Once they get the child's attention and trust they move them over to an encrypted app.

TikTok: This is owned by a Chinese corporation. It gives the Chinese email addresses, locations, etc. on millions of U.S. and European kids. TikTok has used embarrassing behavior in global advertising and is legally allowed to do so by terms of the user agreement.

twitch: while famous gamers display their abilities on this site, it also has about 100 "girls of twitch" who will do things for payment from a stranger- e.g. pushups in their negligee.

Yubo: This app is a friend finder. Kids post their profile on line. A pedophile might say "I'm looking for a female who lives in Loveland:. Use is restricted to ages 13-17 but of course the pedophiles mask their age. The FBI calls it "Tinder for teens."

Big mouth: very sexually provocative music videos.

Deepface: Can replace a face on somebody else's body in a video. This allows you, for example, to place a child's face on the body of a porn star.

Pic-to-Map: Shows on a map exactly where a photo on your phone was taken. Using this, a predator can find exactly where a kid lives, as an example of how it can be misused.

Any sexting of explicit photos is illegal and can result in a child having to register as a sex offender. Very often it is 13-14 year olds doing this. Even if never prosecuted, the information is in the cloud and available forever. (Incidentally, adults do this also.)

Porn uses up more bandwidth than Amazon online. But much of our media is highly sexualized. If kids are exposed to this from age 3-4, what is their idea of what a man/woman going to be? (Women are more often sexualized than men.) 89% of kids say watching it is prevalent (but that doesn't mean 89% of kids are doing it). Porn stars are now being digitized and inserted into video games.

Mr. Smith recommends NEVER using (or letting your kids use) a public wifi network. Many criminals have "pineapples" (cost about $100) that lets them create a wifi that looks like a nearby store's legitimate one. They can use this to steal data from your phone.

One final peace of information. If you have an Ohio driver's license or state ID card, the State of Ohio has your facial recognition and other data. The bad part: the state has been caught selling it. (Dr. Heitkemper found information verifying and explaining this further at https://www.cleveland.com/open/2010/07/ohio_collects_millions_selling.html)

We continue to look for speakers who can present on topics which are of broad interest to our membership and to all psychologists throughout the area. Contact us if you know of (or are!) an engaging speaker who would be willing to present for CAPP!

Board Happening Highlights: James Dahmann, 2019/2020 CAPP Secretary

You make a referral to another CAPP member, only to discover they are not taking new patients or do not accept the patient's insurance. Frustrating, right? In response to a CAPP member asking about this, the Board has developed a closed Facebook group for CAPP members to inquire about referrals needed. Specifics on guidelines have been emailed to all members.

The Board was concerned about backup storage for our information. CAPP is a paperless office with backup stored on Laura's PC. In the event of a disaster the files could not protected. Therefore, Laura investigated off-site storage. The first one we tried didn't work as promoted and was returned; we are now using Microsoft One Drive at a low cost of $60 per year. Paper copies of tax documents and other financial instruments which must be kept indefinitely (as we are a non-profit) are physically stored by the Treasurer.

We now have a student representative on the board! Carly Deremo is from Wright State University in Dayton, and will be attending all board meetings as a non-voting member. In addition, Dr. Sparn and Dr. Gutzwiller have presented at Xavier and Miami Universities and Dr. Sparn at Wright State. The Board hopes to make outreach contacts to other area universities as well in our never-ending attempt at growing CAPP's membership and offering our wonderful community to early career folks.

The OPA Colleague Assistance Program is looking for providers to volunteer (pro bono). This program aims to destigmatize a psychologist asking for help for his or her own difficulties. Contact howardfradkin@me.com if you are interested.

To help meet increased expenses, the Board reluctantly voted to raise dues. *2020 Dues* were set by the Board at $160 for members; $130 for early career members. These levels are still quite low for membership in a professional organization, and we will continue to keep them as low as possible. We are also changing our website support company to reduce maintenance costs. As an example, Dr. Dillon noted a problem with the map feature which was requiring him to input the actual longitude and latitude for new members, and the provider was going to charge to repair this issue. The new company's pricing offers services that are included with our monthly fee so we can better budget vs. dealing with issues as they arise.

It should be noted that OPA finished the year with a deficit due to declining enrollment. Thus, it is a very positive note that our membership--including our new student membership category--is increasing. We are particularly pleased to have students become involved in our organization, since they are the future of psychology and of CAPP.

We also were forced to raise fees for dinner meetings slightly due to lost revenue tracked over the past 3 years. Room costs, food costs and speaker costs have all increased, and we have consistently lost

money on these over the past three years. We simply can't afford to keep losing at the same rate. Many ideas were discussed on how to reduce costs, and this topic will continue to be explored. In the meantime, new pricing is set at $55 for CAPP members, $65 for non-members, $45 for program only, and $30 for students. Please note that the higher the attendance, the lower the costs per person, so if we can increase attendance, we hope to reduce the price again. We carefully track the attendees' opinions of our dinner meeting and workshop presentations, and those who DO attend these meetings consistently give high praise to the quality of the presentations, so if you do not attend, you are really missing out!

2020 is a Directory year (it is published biannually). To reduce costs, printed copies will be mailed only to referral sources since they indicate they use them frequently, and each member who requests one will get one printed copy with an opt out for members as well. Additional copies will be available at $5 plus S&H, or can be picked up at a program event (to save postage costs). Members and others may purchase ad space to help defray the costs.

The Board is changing its meeting location. The new location is 3665 Erie Avenue (corner of Erie and Saybrook, enter from Saybrook).

Complete board minutes can be viewed on the CAPP website.

CLASSIFIEDS:

OFFICE SPACE AVAILABLE: *Office Rental or Purchase Opportunity:* Rent space (full time or shared) or purchase ownership in an established professional building. Terrific Kenwood location that is close to I-71 and the Kenwood Towne Centre. Collegial atmosphere, excellent potential for referrals, secretarial services available. ***Contact: Gary Schneider, Ph.D., Tom Kalin, Ph.D., Leslie Swift, Ph.D. (513) 791-8849.***

Please remember to visit www.cappnet.org for updates/events, etc.!