ALSO INSIDE:

- A farewell from Dr. David Rogers
- How to form a professional corporation in Pennsylvania
- Prescriptive authority for psychologists
- The rise of reproductive mental health

The Pennsylvania Psychologist

Vol. 77, No. 6

JUNE 2017 • QUARTERLY

The Practice of Working With Diverse Immigrant Populations

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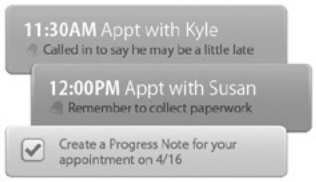

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Vol. 77, No. 6

The Pennsylvania Psychologist

Editor: Tracie Pasold, PhD

June 2017 • QUARTERLY

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

Copy Editor: Karen Chernyaev
Graphic Design: LiloGrafik, Harrisburg

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REGULAR FEATURES

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STUDENT PERSPECTIVE

ETHICS IN ACTION

ALSO INSIDE

A Grateful Epilogue

David A. Rogers, PhD; Hershey Psychological Services

Dr. David A. Rogers

This issue's presidential column marks my final opportunity to address the membership of the Pennsylvania Psychological Association in this particular forum. Though I have other duties ahead of me until I turn this position over to my eminently capable successor, Dr. David Zehrung, I close the page on this one when I type the last word.

What an honor it has been to serve as your PPA president for the past 12 months! In conjunction with my tenure's theme of Interpersonal Violence, I have met with so many interesting and knowledgeable experts employed in a variety of fields including law enforcement, service, and government. As is surely true of all of you, I am committed to lifelong learning. Consequently, these conversations have made me even more socially conscious about the devastating effects of domestic/partner violence, bullying, human trafficking, and campus rape. These components of the theme must concern us all as we continue to treat patients affected by them, read and react to daily articles related to them, and contribute our time and/or money to causes combatting them.

Beyond members of the wider community, it has been a privilege to work with talented and dedicated members of our own profession. I have so much appreciation for those who serve on our Board of Directors and our General Assembly. They have worked tirelessly toward achieving our organization's annual goals and keeping us moving in a positive direction. In addition, I am grateful for the commitment of volunteers—PPA members who spearheaded the committees organized to address the specific components of this year's theme. They have done valuable work and deserve to be applauded for it.

Of course, I would be remiss if I failed to recognize our amazing PPA staff. Krista has guided me thoughtfully and professionally through this year, offering her time and attention to the smallest details. Justin and I have logged many miles together since last June, as we've traveled around Harrisburg and beyond to meet with legislators, professors and students, and employees in the social services. How fortunate we are to have such talented and informed resources as Rachael, Judy, Erin, and Iva; each of them offers gifts that make PPA such a strong and forward-thinking organization.

On a personal note, I want to thank my wife, Nancy. With her own thriving practice and family commitments, she has graciously made this yearlong commitment to PPA easier by making many sacrifices herself. We missed date nights. She endured my participation in long PPA-related phone calls. She offered a listening ear and a gentle hand. I know that she picked up my slack at home more times than I can even count, and for that, along with everything else she brings to my life, I am so blessed.

Beyond members of the wider community, it has been a privilege to work with talented and dedicated members of our own profession.

As we gather in June in Bedford for our annual conference, please take a moment to congratulate our incredible staff upon the receipt of the Outstanding State, Provincial, or Territorial Association Award presented by the American Psychological Association's Division 31. Among the many accomplishments we have to celebrate as an organization, this is one of which we should most certainly be proud.

Writing this epilogue to my presidency has given me the chance to reflect on the many reasons for which I am grateful for this past year. The people I have met, the relationships that I have formed and/or deepened, and the experiences that I have had have brought me immeasurable satisfaction, professionally and personally. Thank you, each and every one who has contributed in any way to this rewarding opportunity. I am sure that Dr. Zehrung will end his term in 2018 with similar feelings of gratitude for and pride in the members and staff of PPA.

I am humbled by the opportunity to have served as your president and honored to be a colleague in this wonderful and glorious profession of psychology.

I leave my post with great respect and warm regard for everyone at PPA.

A Busy First Quarter

Krista Paternostro Bower, MPA, CAE

Krista Paternostro Bower

Water has a way of soothing the soul. I have always believed this but these days, I am reminded of it daily. We are fortunate to have a quaint and inviting creek running through the edge of our property. At night as we sit on our deck, we are serenaded by the sound of nature's symphony as the water gently softens the rocks and provides oxygen to the stream's inhabitants as it passes melodically by our home. On a recent evening, after a moment of quiet conversation, I said to my husband, Jamie, "You know that people actually pay money to hear the sound of water. They use it as a stress reliever. We gain all the benefit free of charge and with out a computer or phone in sight."

On this day, I find myself sitting at a restaurant on the bayfront of Lake Erie on the eve of our **2017 Spring Conference**, and I am reminded of the endless beauty of our commonwealth. The water here is much more expansive and yet a bit more calm, but the view is magnificent and the water's quiet ripple provides a respite from the stresses of the day. This is only my second trip to Erie since starting my position at PPA over 3.5 years ago. I look forward to spending some quality time over the next few days with our friends from Pennsylvania's beautiful Northwest. As I drove here this afternoon, I reminded myself that I need to come back here more often. In addition to a successful spring conference, the first quarter of 2017 has been kind to PPA! Here is a quick recap:

Continued on page 4

PPA Elections Held

PPA is pleased to announce the results of our annual elections, which were held earlier this spring. Please join us in congratulating the following individuals on their recent election to these important leadership posts:

PPA President-Elect
Dr. Nicole Quinlan

PPA Treasurer
Dr. Brad Norford

Communications Board Chair
Dr. Tracie Pasold

Internal Affairs Board Chair
Dr. Marie McGrath

School Psychology Board Chair
Dr. Susan Edgar-Smith

We are very appreciative of the time and effort given by our board and committee leaders throughout each year. We are fortunate to have an engaged Board of Directors working alongside of our professional staff in the best interest of our members.

We look forward to working with each of you, along with our Board of Directors!

EXECUTIVE DIRECTOR'S REPORT

Continued from page 3

- **Practice Leadership Conference in Washington, DC:** A large contingent of PPA members gathered in our nation's capital in early March for APA's annual Practice Leadership Conference. This 4-day training and networking event ended with our annual Hill Day, where delegation members visited with our federal legislators to advocate on behalf of the profession of psychology. In addition to **Pennsylvania Congressman Tim Murphy** receiving **APA's Outstanding Leadership Award**, PPA was also recognized as the **Outstanding State, Provincial, or Territorial Association** by **APA's Division 31**. In addition, I had the pleasure of addressing the Council of Executives of State, Provincial (and Territorial) Psychological Associations (**CESPPA**) about membership retention and recruitment.

Some of the members of the PPA contingent at the APA Practice Leadership Conference included *(back row, from left to right)*: Justin Fleming, PPA; Dr. David Zehrung, PPA President-Elect; Dr. Sam Knapp, PPA; Dr. David Rogers, the now former PPA President; Krista Paternostro Bower, PPA; Adam Sedlock, PPA DRN; Dr. Rosemarie Manfredi, PPA ECP Delegate. *(Front row, from left to right)*: Dr. Linda Knauss, PPA; Dr. Williametta Bakasa, PPA Diversity Delegate.

Next year marks PPA's 85th anniversary, and we are actively considering ways to recognize this important milestone in our organization's history.

- **PPA Elections** have just wrapped up and our winners are listed on page 3. On behalf of the PPA staff, we send our heartfelt congratulations to all of those serving in elected positions, and we look forward to continued success under your collective leadership. Thank you also to the PPA members who took time to cast your important vote and those who made the significant decision to run for office.
- **Member Focus Group:** We were pleased to welcome a handful of PPA members to join us at our office for our first-ever member focus group. Facilitated by Dr. David Rogers, Dr. David Zehrung, and yours truly, this interactive session included feedback on existing PPA initiatives as well as brainstorming and in-depth conversations about new, value-added PPA initiatives. We plan to continue these informal gatherings and even hope to host these events at different locations around the state.
- **Continuing Education:** The first quarter of this year included many opportunities for professional development for our members. We held several successful webinars and continued to offer a variety of home-study options. Our busy CE season begins now with our spring conference, with our capstone event in June, followed by our fall conference next October, with plenty of options in-between to help members meet their CE requirements before the November deadline.

Our **Leadership Academy** event on May 7 and our annual **Advocacy Day** event on May 8 were once again a great success. Advocacy Day culminated with a press conference in the Capitol's main rotunda. The focus of this year's press conference will be to raise awareness of the ills of human trafficking and announce several new initiatives to support statewide, anti-human trafficking efforts.

Looking ahead, please finalize your plans to see your colleagues at our new venue for PPA2017, to be held at the beautiful **Omni Bedford Springs Resort** in Bedford Springs, PA. Our Professional Development Committee has been hard at work preparing for this important event. Members of the committee plan to debut their new lifelong learning initiative, which asks attendees to take a different, deeper look at their own professional development practices.

Next year marks PPA's 85th anniversary, and we are actively considering ways to recognize this important milestone in our organization's history. We will be in touch over the summer to share some ideas and to solicit your thoughts on how to position PPA for an even brighter future!

As I close this quarterly update, my eyes are drawn back to the peaceful waters of Lake Erie. As long as man has inhabited this world, water has been the sustainer of life. For me, I look to the sunset and know that no matter what is happening in the world, from the water's perspective, life is good.

How to Form a Professional Corporation or Obtain a Fictitious Name in Pennsylvania

Rachael L. Baturin, JD, MPH; Director of Legal & Regulatory Affairs


Rachael L. Baturin

In order to set up a professional corporation or a fictitious name in Pennsylvania, psychologists must go through a two-step process: First they must get approval from the State Board of Psychology and then they need to proceed to the Bureau of Corporations and Charitable Organizations in the Department of State. Prior to proceeding through this two-step process, psychologists may call the bureau at 888-659-9962 to make sure the corporation name or fictitious name is available.

Professional Corporation

According to Section 41.26 of the State Board of Psychology regulations, a psychologist licensed by the Board may professionally incorporate with other licensed psychologists or with licensed chiropractors, medical doctors, nurses, optometrists, doctors of osteopathy, pharmacists, podiatrists, veterinarians, dentists, engineers, nursing home administrators, physical therapists, occupational therapists, audiologists, speech-language pathologists, teachers of the hearing impaired, and social workers if the corporation is also authorized by Chapters 5, 17, 21, 23, 25, 27, 29, 31, 33, 37, 39, 40, 42, 45, and 47. However, psychologists who establish a multidisciplinary practice with nonpsychologists must ensure that announcements of services to the public accurately represent the professions of service providers.

A psychologist seeking to form a professional corporation must: (1) File a copy of the articles of incorporation and registry statement of the proposed corporation with the State Board of Psychology for review and approval prior to submitting them to the Bureau of Corporations and Charitable Organizations; (2) fill out the State Board of Psychology application for approval of corporate or fictitious name (phone 717-783-7155); and (3) must identify all parties with an ownership interest in the business and all licensed or unlicensed professional staff. If the name of the corporation limits the practice of psychology to a particular area of psychology—for example, neuropsychology, clinical psychology, or biofeedback—the State Board of Psychology will need additional documentation of training sufficient to establish the credentials in that area of the relevant service providers. Once this information is received by the State Board of Psychology, the Board must approve it prior to its use.

Corporate names that contravene the ethical principles set out in §41.61 (relating to the Code of Ethics) or that, when regarded in their entirety, are false, misleading, or deceptive, will be disapproved by the Board. For example, a psychologist cannot call the corporation "International Psychology Services" unless the corporation is really international. When the State Board of Psychology approves the name of the corporation, the psychologist may then proceed to file the articles of incorporation, docketing statement, and letter from the State Board of Psychology approving the use of the name with the Bureau of Corporations and Charitable Organizations.

If at some point the psychologist who creates the professional corporation retires and wants to transfer the corporation to another professional, it is important to note that at least one of the new partners must be a psychologist. This is especially true if the word "psychology" or "psychological" is used in the name of the corporation.

Fictitious Name

According to §41.27 of the State Board of Psychology regulations, a psychologist practicing as a sole proprietor or in association with other psychologists in a business form other than a professional corporation may do business under a fictitious name. The process for getting a fictitious name approved parallels the process for forming a professional corporation. A psychologist seeking to form a fictitious name must: (1) File a copy of the fictitious name registration with the State Board of Psychology for review and approval prior to its submission to the Bureau of Corporations and Charitable Organizations; (2) fill out the State Board of Psychology application for approval of the corporate or fictitious name; and (3) identify all parties with an ownership interest in the business and all licensed or unlicensed professional staff.

If the name of the corporation limits the practice of psychology to a particular area of psychology . . . the State Board of Psychology will need additional documentation of training.

If the fictitious name limits the practice of psychology to a particular area of psychology, the State Board of Psychology will need additional documentation of training sufficient to establish the credentials in that area of the relevant service providers. Once this information is received by the State Board of Psychology, the Board must approve it prior to its use.

Names that contravene the ethical principles set out in §41.61 (relating to the Code of Ethics) or that, when regarded in their entirety, are false, misleading, or deceptive will be disapproved by the Board. When the State Board of Psychology approves the fictitious name, the psychologist may then proceed to file the application for registration of fictitious name and letter from the State Board of Psychology approving the use of the name with the Bureau of Corporations and Charitable Organizations.

Following Advocacy Day Success, PPA Seeks Input on Prescriptive Authority

Justin Fleming, Director of Government Affairs


Justin Fleming

Thanks to the 60 members and students who came to Harrisburg to advocate for issues important to psychologists and patients, PPA hosted yet another successful Advocacy Day!

PPA leadership also held a press conference announcing initiatives to help individuals overcome being a victim of human trafficking. We are working with officials in the public and private sectors to distribute posters raising awareness about human trafficking and directing people to get help. In addition, several PPA members have expressed interest in providing services to victims of human trafficking to help break the trauma bonds that develop.

During Advocacy Day, PPA members and students spoke to legislators and staff about telepsychology, mental health parity, and other critical issues. However, the PPA Board wants to gather feedback from members on another issue that will affect the future of psychological practice—prescriptive authority for psychologists.

According to the American Psychological Association, Idaho became the fifth state to allow prescriptive privileges for psychologists in April 2017, joining New Mexico (2002), Louisiana (2004), Illinois (2014), and Iowa (2016). The U.S. Department of Defense also allows psychologists to prescribe medication.

Supporters of prescriptive authority for psychologists often cite the difficulty patients have in accessing psychiatrists as a justification to pass legislation authorizing psychologists to prescribe. Pennsylvania is a large state and access to psychiatrists in rural areas is extremely difficult for those who need medication as part of their mental health treatment.

In states where the law has passed, prescribing psychologists must receive additional education (usually a master's degree in pharmacology) and enhanced professional development training. Those opposed to prescriptive authority for psychologists cite a lack of education/training, and a fear that psychology will evolve from talk therapy and shift more toward an emphasis on prescribing medicine, as it has with psychiatry.

PPA is looking for your help in deciding whether to pursue the issue of prescriptive authority for psychologists. Please take a brief survey and tell us your thoughts. The link can be found here: https://www.surveymonkey.com/r/P2DHNB7. Preliminary data suggests that 76% of respondents support prescriptive authority for psychologists in Pennsylvania, but we would like to increase the sample size to gain more confidence in the data.

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

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of April 29, 2017

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action	Governor's Action
SB 134	Provides for Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. – Sen. Mario Scavello (R-Monroe)	For	In Education Committee	N/A	N/A
SB 554	Provides safe harbor for child victims of human trafficking. – Sen. Stewart Greenleaf (R-Montgomery)	For	Passed 50-0 on 4/25/2017	In Judiciary Committee	N/A
HB 525	Provides safe harbor for child victims of human trafficking. – Rep. Mark Rozzi (D-Berks)	For	N/A	In Judiciary Committee	N/A
SB 599	Provides for Assisted Outpatient Treatment programs in the Mental Health Procedures Act. – Sen. Stewart Greenleaf (R-Montgomery)	Against	In Health and Human Services Committee	N/A	N/A
HB 414	Act establishing a bill of rights for individuals with intellectual and developmental disabilities and conferring powers and duties on the Department of Human Services. – Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee	N/A
HB 440	Requires insurers to make their behavioral health benefit no more restrictive than their physical health benefit. – Rep. Thomas Murt (R-Montgomery)	For	N/A	In Insurance Committee	N/A
HB 762	Amends Public School Code, in preliminary provisions, providing for study of secondary school start times. – Rep. Tim Briggs (D-Montgomery)	For	N/A	In Education Committee	N/A
HCO 130	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years. - Rep. Kate Harper (R-Montgomery)	For	N/A	N/A	N/A
HCO 601	Act providing for telepsychology and for insurance coverage. – Rep. Marguerite Quinn (R-Bucks)	For	N/A	N/A	N/A
SCO 570	Act providing for telepsychology and for insurance coverage. – Sen. Elder Vogel Jr. (R-Beaver)	For	N/A	N/A	N/A

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

*SCO denotes Senate Cosponsor Memo
**HCO denotes House Cosponsor Memo
Legislators who have ideas for bills before they are introduced circulate cosponsor memos. Each memo includes broad strokes about the contents of the bill and seeks to build support for the legislation.

PennPsyPAC
MINDING WHAT MATTERS

2016–2017 PennPsyPAC Donors

The following individuals have shown their dedication to the field of psychology with donations to the PennPsyPAC during the PPA fiscal year from July 1, 2016, through publication. They, as well as donors to the Pennsylvania Psychological Foundation, will be recognized at a special donor appreciation event during the PPA2017 annual convention in Bedford, Pennsylvania, from June 14–17.

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Documenting Trauma for Asylum Seekers

Judy Eidelson, PhD, Adjunct Fellow, University of Pennsylvania, Center for Public Health Initiatives , judyeidelson@gmail.com


Dr. Judy Eidelson

I met Maria[1] while she was detained at Berks Family Residential Center along with her 7-year-old son, Carlos. Maria had fled Honduras with Carlos after his 13-year-old brother was killed by gang members because he refused to join them. Previously, Maria had been raped by gang members in front of her sons.

Maria's aunt borrowed money from several relatives to pay a "*coyote*" who helped Maria and Carlos cross the border from Honduras to Guatemala, then into Mexico, and finally into Texas. Soon after they crossed the U.S. border, Maria and Carlos were stopped by Customs and Border Protection agents. With the few English words she knew, Maria told the CBP policeman that she was afraid to go back. For this reason, she and her son were put in a holding pen that the migrants call a *hielera* (cooler) or *perrera* (kennel) because it's kept very cold and feels like a cage. From there they were transferred to a privately run Immigration and Customs Enforcement (ICE) detention center in Dilley, Texas, and then to the Berks County Family Residence in Leesport, Pennsylvania, the only facility where ICE holds immigrants with children for up to a year or more while they await disposition of their cases.

Maria's pro bono attorney asked me to evaluate Maria in order to document her trauma history and its impact on her current functioning. I interviewed her with the assistance of a Spanish-speaking interpreter and was able to administer standardized assessment tools in Spanish as well. The results of this assessment indicated that Maria was suffering from PTSD, related to her sexual assault and the murder of her older son, as well as major depressive disorder. In accordance with the Istanbul Protocol (UN OHCHR, 2004), in my report I was able to note that Maria's reported and observed symptoms were highly consistent with the history of persecution that she had described. I was also able to give examples of specific symptoms, such as Maria's flashbacks to the look on the face of the man who raped her, which were triggered by a guard's expression of contempt.

Why Do Asylum Seekers Need Psychological Evaluations?

For immigrant survivors of human rights abuses, healing requires the establishment of physical safety. Asylum seekers flee to the United States seeking protection—either from government forces or from abusers their governments cannot or will not protect them from, such as violent gangs. The road to safety, justice, and a new life is often blocked by the asylum seeker's inability to talk openly and convincingly about what are often extremely humiliating traumatic experiences. Psychologists can play a crucial role in helping trauma survivors describe the events that form the basis for their asylum claims. We can also explore and document the specific ways in which a particular survivor was affected by trauma. The reports that we write become evidence in immigration proceedings, where the survivors themselves are often too frightened, numb, or confused—i.e., traumatized—to present their experiences in the ways immigration officials would most like to hear them.

While documentation for immigration cases takes some specialized training, the most important skills are those that qualified psychologists possess and use every day. We know how to be present and listen empathically. We know how to validate and normalize distress. We know how to be a calm and soothing presence. We take these qualities for granted, but they are sorely lacking from other aspects of the immigration process, where asylum seekers are often treated like criminals.

Maria and Carlos have been granted asylum and they've begun to build a new life with the assistance of a supportive church community and a Spanish-speaking trauma therapist. Their attorney felt that the psychological evidence played a crucial role in this case by uncovering aspects of the trauma history that Maria had been reluctant to disclose and by explaining aspects of Maria's demeanor that appeared counterintuitive to laypersons.

The road to safety, justice, and a new life is often blocked by the asylum seeker's inability to talk openly and convincingly about what are often extremely humiliating traumatic experiences.

How Can You help?

When I first started doing this work, almost 15 years ago, I was worried that I didn't know enough about other cultures and world politics to write reports about asylum seekers. I was also intimidated by the thought of legal proceedings and the specter of possible testimony in an immigration hearing. While cultural humility is crucial, the reality is that we don't have to be experts in the specific conflicts our clients have been affected by in order to document their trauma. Furthermore, oral testimony is rarely required. It can usually be done telephonically, and it becomes relatively routine with experience. Overall, this work has been a source of tremendous professional and personal satisfaction to me.

This is a moment in history when the willingness to use our unique qualifications to explain psychological phenomena, such as reactions to trauma, can make the difference between life and death for vulnerable immigrants.

To learn more about refugees and asylum seekers, and for information

Continued on page 11

[1]**Names and other identifying information have been changed to protect confidentiality.**

Acculturation Unveiled

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Nearly 1 million new immigrants have entered the United States every year since 1990. Over 40 million U.S. residents are foreign born. Of these, approximately 18.1 million are naturalized citizens, 11 million are authorized noncitizens, and another 11 million are undocumented (APA, 2013). Immigrants often come to the United States to seek humanitarian refuge, reunite with family members, and search for work. When immigrants enter the United States, they begin the process of acculturation. Acculturation refers to changes that take place as a result of contact with culturally dissimilar people, groups, and social influences (Gibson, 2001). In this case, it involves changes in various aspects of immigrants' lives (e.g., cultural and ethnic identity, language, attitudes, and values).

Latin Americans and Asian Americans comprise the two largest and fastest growing ethnic groups in the United States (U.S. Census Bureau, 2010). Research indicates that transitioning to a new culture may have detrimental effects on one's mental health (Sodowsky & Lai, 1997). Factors such as separating from country of origin, family members, and familiar customs; exposure to a new physical environment; and navigating unfamiliar cultural contexts contribute to mental health challenges. The acculturation model may provide a useful paradigm for understanding the psychological stresses of immigrant clients (Lang, Munoz, Bernal, & Sorensen, 1982) and enhance our ability to be more responsive to their mental health needs.

Models of Acculturation

Acculturation was originally conceptualized as a unidimensional process whereby retaining the heritage culture and acquiring the host culture were on opposing ends of a single continuum (Gordon, 1964). According to this model, as migrants gained the values, practices, and beliefs of their new homeland, they abandoned those from their cultural heritage.

In 1980, Berry developed the Fourfold Model of Acculturation Strategies, in which acquiring the host culture and retaining the heritage culture are independent dimensions. These two dimension intersect to create four acculturation categories: *assimilation* (an immigrant adopts the receiving culture and discards the heritage culture); *separation* (an immigrant rejects the receiving culture and retains the heritage culture); *integration* (an immigrant adopts the receiving culture and retains the heritage culture) and; *marginalization* (an immigrant rejects both the heritage and receiving cultures). Some research has found Berry's integration category (also known as *biculturalism*) to be associated with the most favorable psychosocial outcomes, especially among young immigrants. For example, bicultural individuals tend to be better adjusted (e.g., show higher self-esteem, prosocial behaviors, and lower depression; Schwartz, Unger, Zambaoanga & Szapocznik, 2010).

Although Berry's model offers a more complex understanding of acculturation, it has received a number of criticisms. For example, the validity of the marginalization category has been questioned as there is a low likelihood that a person will develop a cultural sense of self without drawing on either the heritage or receiving culture (Schwartz et. al., 2010; Del Pilar & Udasco, 2004).

Expanding on Berry's model, Schwartz and his colleagues (2010) developed a multidimensional biculturalism model. Whereas Berry's acculturation model primarily focuses on cultural practices, the multidimensional biculturalism model incorporates cultural practices, values, and identifications. For instance, a Latin American immigrant in the United States might be fluent in both English and Spanish, endorse individualistic values in some contexts (e.g., at work), and collectivistic values in other contexts (e.g., at home), and identify with both the United States and with his or her country of origin (Schwartz et al., 2010).

The acculturation model may provide a useful paradigm for understanding the psychological stresses of immigrant clients and enhance our ability to be more responsive to their mental health needs.

Generational Differences and Acculturation

Clearly, acculturation is a complex phenomenon. It is a process that may involve several moderator variables such as generational status, education and income, age, years of residence in the United States, ethnic density of neighborhood, country of birth, job skills, religion, kinship structures, circumstances and purpose of immigration, language fluency, and encounters with racial discrimination (Sodowsky, Lai, & Plake, 1991; Bulut & Gayman, 2016). These factors may significantly impact immigrants' sense of well-being and belonging (APA, 2013).

In terms of the impact of generational status on acculturation,

Sodowsky et al. (1991) found that first-generation Latin and Asian immigrants perceived significantly more prejudice, were significantly less acculturated, and used significantly less English than those who were second, third, and fourth generations. A meta-analysis by Liu (2015) explored the impact of acculturation mismatch (incongruence between collectivism in traditional heritage culture versus individualism in American culture) on intergenerational cultural conflict and mental health outcomes of offspring of Asian and Latin Americans. Liu (2015) found that discrepant cultural values and practices within an immigrant family pose greater acculturative stress for Latin and Asian immigrants and disrupt family cohesion. Furthermore, greater intergenerational cultural conflict within Asian and Latin American families was related to poorer psychological functioning among offspring. Adult groups tended to experience greater intergenerational conflicts with their parents in comparison to adolescent groups, and conflicts focused on the offspring's adoption of adult roles (e.g., career choices, ethnicity of future spouses, and family responsibilities), which were incongruent with their parents' cultural expectations. For immigrant adolescent offspring, intergenerational conflicts may be a combination of cultural mismatch or simply normative parent-adolescent discord. The resulting negative family environment created by the intergenerational dissonance may have a deleterious effect on the offspring's mental health and adaptation.

Clinical Implications

When working with immigrants, it is important to understand acculturation and its relation to mental health. This entails accounting for factors including culture of origin, level of acculturation, subgroup characteristics, individual characteristics, and values. For example, among Latino immigrants, subgroup values such as *familism* (importance of the family unit), *machismo* (masculine pride), and *simpatia* (agreement and harmony in relationships) may be crucial (Cano et al., 2016). Similarly, among Asian immigrants, values such as filial piety (respect for parents, elders, and ancestors), family recognition, and emotional self-control may be important (Park & Kim, 2008).

Awareness of the possible connection between acculturation mismatch and intergenerational cultural conflict may help clinicians identify the sources of family conflict and distinguish development-based from cultural-based conflicts. Intergenerational conflict among adult immigrant offspring may indicate longer-lasting, culture-specific conflict due to acculturation mismatch, whereas intergenerational conflict among adolescent offspring may be a combination of both or simply normative conflict between adolescents and parents (Liu, 2015).

Clinicians are encouraged to think beyond traditional treatment approaches and incorporate acculturation factors and sociocultural and psychological perspectives.

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about how to volunteer your services, please explore these websites:

Pennsylvania Immigration Resource Center (York): pirclaw.org

Hebrew Immigrant Aid Society (Philadelphia): hiaspa.org

Nationalities Service Center (Philadelphia): nscphila.org

Friends of Farmworkers (Pittsburgh, Philadelphia): friendsfw.org

US Committee for Refugees and Immigrants (Erie): refugees.org

International Service Center (Harrisburg): isc76.org

Catholic Social Services (Scranton, Allentown): cssdioceseofscranton.org

HealthRight International (National Network): healthright.org

Physicians for Human Rights (National Network): physiciansforhumanrights.org

For training resources:

Center for Victims of Torture: cvt.org

National Partnership for Community Training: gulfcoastjewishfamilyandcommunityservices.org

Physicians for Human Rights: physiciansforhumanrights.org

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A Refugee/Asylee Client in Therapy: Challenges and Rewards

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Dr. Carol A. Gantman

In May 2015, an attorney at HIAS Pennsylvania, a nonprofit organization providing legal assistance to newcomers to the United States, requested therapy for a female client. The woman from Congo sought asylum due to persecution resulting from her political activism. The client arrived in the United States in January 2015 and, according to the attorney, her medical and psychological conditions were worsening. I agreed to see her in therapy pro bono.

Prior to our first meeting, I learned that Grace[1], the client, had been a deputy leader of the opposition party in her country, having spoken out forcefully against the president. Her activism resulted in her business being demolished and her home being invaded by government soldiers. During a night attack in her home, Grace and her 15-year-old daughter were raped. She fled to safety in the United States, forced to leave her children behind with friends in neighboring Guinea.

What to Expect When Seeing Immigrant/Refugee Clients

As therapists, we know that seeking professional support requires a belief in the efficacy of the process. For an immigrant, still unfamiliar with her adopted country, Grace's seeking out therapy was a display of serious determination to reduce her suffering. Most often, though, for those who arrive without documentation, legalizing immigration status is their initial priority.

Even when a client's legal immigration status is obtained, the medical and psychological challenges do not abate. Indeed, the mental health challenges/struggles become more manifest after the legal battle is won. It is at this time that the immigrant has the opportunity to attend to health problems and/or psychological distress lingering from the violence, persecution, or trauma experienced in the country of origin and from the immigration process itself.

What could I expect from Grace, the outspoken activist raped by a group of men sent to silence her? A woman desperately missing her children, who remained in Africa. In this time of need, displacement, depression and isolation, what could I offer? These questions plagued me as the first session approached. Within minutes, it was clear that what I offered was what worked with clients throughout my career. Providing a safe, caring environment enabled Grace to express what was necessary to heal. My role was to listen attentively and respectfully, allowing her to share, for the first time, out loud, what she had kept secret since the traumatic events occurred. From the time of the trauma to the present, she experienced tremendous guilt and shame for what happened to her and to her children. While in this country, she suffered in isolation. Over months, Grace explored all that had happened to her and its lingering psychological impact on her. During this time, Grace processed the PTSD symptoms, learning to utilize healthy coping strategies, as needed. She emerged from her suffering to re-experience herself as the capable and competent woman she was prior to the trauma of 2014.

What Are the Risk Factors that Clients Are Likely to Present?

When immigrants arrive in this country as a result of persecution, they are experiencing the aftermath of this inhumane treatment, along with the separation from their home, family, and culture. Following their arrival, they are confronted with the tasks of establishing a sense of safety and community; providing a residence for themselves, and, often, family members; learning a new language; and establishing a means to earn income. They often face discrimination and the stigma of being different. They must learn new skills to succeed in the United States. They need to struggle against a sense of isolation and loss, disillusionment, and challenges to self-esteem (Snell, 2006).

> *Providing a safe, caring environment enabled Grace to express what was necessary to heal.*

Newcomers arrive desiring a better life for themselves and their families. During the early days of being an immigrant, there can be significant hardship. Within therapy, a client can learn what is realistic to expect of herself and her new life. Within the safety of each session, a client experiences the attentive presence of another, someone who listens actively, offers positive feedback, and praise. Once rapport is established, trust builds and hope renews. Through this work, my client, Grace, reconnected with her competence, determination, and courage. Critical was her ability to revise an image of herself as the capable person who is strong and has the tenacity necessary to seek a better life in the United States.

Learning to trust others is essential in the immigrant journey and in therapy. Early screening for psychological issues followed by therapeutic intervention has been found to lower emotional distress, improve postmigration adjustment, and prevent further psychological crisis. (Johnson-Agbakwu, Allen, Nizigiyimana, Ramirez, & Hollifield, 2014). The therapist becomes the catalyst enabling the client to heal and achieve life-enhancing objectives.

What Challenges Does a Therapist Encounter?

The desire to help, to alleviate the suffering of the immigrant, is palpable when

[1]The client's name and identifying information have been changed to protect confidentiality.

clients have experienced such hardship in their countries of origin and/or after displacement. The challenge and opportunity that presents itself is to appreciate and respect the differences between the client and clinician, while at the same time, celebrating and embracing the commonalities. An immediate need that emerges is to maintain clear boundaries, to recognize what the limits are to being an effective therapist. One needs to resist becoming overly involved in problem solving and/or intervening beyond what allows an individual to develop self-sufficiency. A client complains of being hungry, that her family has abandoned her, refusing to send money to support her. How does a therapist listen compassionately without offering food and/or money? When a client has to cancel sessions because she has no tokens to public transportation, does a therapist assist her compliance with her weekly appointment by offering to buy bus tokens?

A client's experiences in his or her country of origin are often incomprehensible to us living in the United States. The tragic circumstances of the lives of our clients are difficult to hear and challenging to process. It is our therapeutic responsibility to provide a safe venue, be a caring listener for their narrative, and respectfully accept what they bring and share with us. This can become burdensome and affect us beyond the therapy session. Learning how to care for ourselves, as we care for our clients, is essential to this work. Finding means to accomplish this is fundamental to maintaining our involvement with these clients. Avoiding compassion fatigue allows us to maintain the therapeutic presence necessary for the client's well-being, as well as our own.

What Are the Rewards of This Work?

Listening as my client shared the narrative of hardship experienced before immigration was difficult. What occurred after the initial sharing, though, was the opportunity to work with her. Grace was able to learn to accept this horrific personal history without being defined by it. Therapy enabled her to reconnect with her own strength, courage, and hope. Participating in this process brought rewards that were, at moments, profound and inspiring. Bearing witness as she examined her tragic past and then eventually climbed out of the pit of despair, depression, and hopelessness was a daunting task. If, at the end, a client is able to renew a view of herself as the person capable of being successful in this country, the benefits of the work are palpable and heart filling.

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Explorations in Racial Awareness, White Privilege, and White Guilt

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Dr. Janet Etzi

Dr. Francien Dorliae

In these times of intense social change, I have become increasingly aware of my own personal development in regard to racism, diversity awareness, and the emotions stirred up in my work with clients and students as I try to understand others' experiences and cultural contexts. One benefit from this self-reflection has been the recognition of an underlying discomfort that I have experienced when working with people of color who often endure various forms of social injustice as a matter of everyday reality. (The pronoun "I" refers to Janet Etzi in the first half and very end of this essay; Dr. Francien Chenoweth Dorliae contributed to the discussion on implications for clinical work.) Two concepts, *white privilege* and *white guilt*, are helpful in provoking thinking regarding the biases and blind spots of white psychologists.

The words of Baldwin (1972) validate my private struggle with being white in America, and my reward has been deeper connections with my clients and my community:

> I have always been struck, in America, by an emotional poverty so bottomless, and a terror of human life, of human touch, so deep, that virtually no American appears able to achieve any viable, organic connection between his public stance and his private life. This failure of the private life has always had the most devastating effect on American public conduct, and on black-white relations. (p. 53)

Until we, that is, white people, start thinking about being white as racialized instead of as the standard against which all other races are judged, we will continue to believe that it is not necessary to understand our white heritage (Coates, 2015). While different white ethnic groups have a myriad of histories and heritages, being white is the history that we share and that has brought us to the present racialized context in which we work and live today. Since race is a social construct and not based in any biology besides skin pigmentation, white is as much a race as black. So we must comprehend what it means to be white and the history of being white. For example, while we have much research and literature showing the effects of slavery on black psychology, including the effect of trauma, there is almost nothing on the effects of slaveholding on white psychology. This is an important omission that only serves to keep us in a psychological fog regarding the effects of white privilege on others and of white guilt on ourselves.

White privilege allows us to remain unaware of and indifferent to racialized existence. We usually do not notice or even think about our whiteness; whereas people of color are constantly reminded of their color. We have had the luxury of taking for granted prereflectively that we are *of* our cultural surround and that it has always been this way. In this sense, white privilege is experienced as an implicit givenness, and we render our whiteness invisible to ourselves.

White guilt consists of a complex and amorphous mix of shame, guilt, anxiety, and awareness/unawareness (Jacobs, 2014). It manifests itself in attitudes, behaviors, projections onto others, and defensiveness, to name a few. In answer to the understandable question, *What am I guilty of?*, Steele (1998) has pointed to our willingness to comply with injustices suffered by people of color, our indifference to human suffering and denigration, and our capacity to abide injustice for our own benefit and in defiance of our own sacred principles. So while I may not be personally guilty for any specific actions or behaviors, my whiteness situates me socially in a privileged position.

Implications for Clinical Work

Becoming aware of the feelings, cognitions, and attitudes associated with *white guilt* provides opportunities to recognize our own discomfort and confusion, and the defenses against this awareness, as they arise in the therapy session with our clients of color. Guilt can be viewed in two ways: (1) guilt that leads to shame and fear about one's hoped for innocence and a compulsion to quickly escape toward feeling innocent; and (2) contained guilt that leads to genuine concern. If I am preoccupied with restoring my sense of innocence, I am more likely to use my client to help me feel innocent, and then she remains invisible to me. I may burden her with my need to feel that my work is adequate and that I am an effective, multiculturally competent clinician. In a session with an African American client, I may go through a checklist of appropriate questions to ask in order to ensure that I am acting in a culturally sensitive manner, all the while ignoring my own immediate feelings and thoughts regarding interactions with this client. It is for this reason that I deem it

Since race is a social construct and not based in any biology besides skin pigmentation, white is as much a race as black. So we must comprehend what it means to be white and the history of being white.

necessary to uncover my own personal biases and blind spots regarding my socialization as a white person and more importantly that I prevent my biases from causing me to remain disconnected from my clients.

White privilege and *white guilt* prevent clinicians from thoroughly connecting to our culturally diverse clients by creating a colorblind racial ideology, meaning denial of racial differences by focusing and asserting sameness. It is not uncommon for many white clinicians to deny that being "white " is accompanied by privileged status or automatic advantage because of skin color. This denial creates defensiveness. Defensiveness is manifested by disavowing being "white" or by expressed anger/frustration at being unfairly blamed for racism (Sue, Rivera, Capodilupo, Lin, & Torino, 2010). White privilege and white guilt allow us to make automatic assumptions about our clients of color and their experiences and to react to them in stereotypical ways that are consistent with our worldview. Automatic assumptions and stereotypical approaches are reflected in the ways that we question our clients, conceptualize their symptoms, and provide interventions. Constantly making automatic assumptions and stereotypical interactions with culturally diverse clients can lead to mistrust in the therapeutic relationship similar to the relationship that the clients may have with society at large.

Ongoing acknowledgment of white privilege and white guilt, while difficult, permits clinicians to entertain the experience of clients of color that may be different from our own. It helps white clinicians move away from victim blaming and fear of clients of color and it increases ethnocultural empathy. Burkard and Knox (2004) found that psychologists who hold high levels of colorblind racial ideology reported lower levels of empathy and were more likely to hold African American clients more responsible for finding solutions to their problems than those with lower colorblind racial ideology. Increasing awareness further nurtures the white clinician's ability to authentically connect with clients of color.

While these personal reflections involve emotional discomfort and even pain, the rewards include deeper connections, better understanding of clients' experiences, and joy in discovering so many people whom I encounter every day who are eager to share their experiences, sorrows, and joys with me.

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Multicultural Competencies and Conducting an Immigration Evaluation for U.S. Citizenship

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Immigrants seeking U.S. citizenship must meet certain requirements, including the ability to read, write, speak English, and have knowledge and understanding of the fundamentals of U.S. history and government. Severe mental and physical symptoms prevent many immigrants from adequately retaining and retrieving information to pass the English and civics tests (also known as the naturalization test). These mental health issues include memory problems, trauma, depressive and anxiety symptoms, and written and expressive language problems.

Immigrants applying for citizenship are provided a study guide booklet of 100 questions and answers (this booklet is also available on the Immigration and Naturalization Service [INS] website) and are expected to study for the test. Examples of these questions are: What does the constitution do? What is an amendment? What is one right or freedom from the first Amendment? What stops one branch of government from becoming powerful? During the naturalization interview, an immigrant is asked up to 10 questions from a list of 100. The immigrant passes the test if 6 out of the 10 questions are answered correctly and he or she is able to spell basic words verbalized by an immigration officer.

Immigrants who are diagnosed with a psychological or physical disorder that affects the ability to pass the naturalization test can obtain a disability waiver. The waiver form is called N-648. The N-648 form can be obtained from the INS office or website. Only a licensed psychologist or a medical doctor can complete the N-648.

A psychologist or medical doctor is required to demonstrate how the immigrant's medical or psychological impairments severely affect his or her ability to learn English or demonstrate English proficiency and knowledge of U.S. history and government. With the waiver, the immigrant with a mental health diagnosis or medical condition can have the citizenship test waived and the citizenship interview can be conducted in his or her language with an interpreter.

In most cases, by the time an immigrant schedules an appointment with me for a psychological evaluation, he or she has been retraumatized by the threat of losing income and fears of facing an immigration officer who might deny his or her petition for citizenship.

I have completed many N-648 forms mostly for elderly immigrants. Many of these older adults came to the United States as refugees or political asylees. They were traumatized by war or the threat of persecution and imprisonment or death in their country of origin. In order to complete the N-648 form, a comprehensive psychological evaluation has to be completed. During a psychological evaluation, a female refugee with traumatic experiences similar to many of the immigrants I see in my practice shared that she witnessed militants torturing and stabbing her husband to death because he refused to join a militant group. She walked in a forest for at least two to three days from her country to a neighboring country without food. She slept in the dark forest at night, ate whatever looked like fruits or vegetables, and drank from creeks or rivers along the way. This woman was separated from her family for many years. She was relocated to the United States by the United Nations after living in a refugee camp for 5 or more years. She has been in the United States for approximately 10 years without her family. The whereabouts of her family is unknown. This female refugee experiences episodes of trauma symptoms such as depression, memory problems, headaches, nightmares, and sleep and appetite disturbances. She also had a mild stroke. Her medical problems include acid reflux, hypertension, and undiagnosed body aches.

The onset of her psychological symptoms started prior to entering the United States and exacerbated at various times in the United States. However, she never sought treatment nor did she share her experience with anyone for fear of negative stigma and superstitious beliefs attached to mental illness. Mental illness is viewed negatively in her country of origin. To further intensify the psychological symptoms of some elderly immigrants, the Social Security Office that issues a monthly income of roughly $300–$400 usually shortly upon arrival due to the refugee or asylees status, terminates their monthly income if they have been in the United States for more than 7 years without becoming a U.S. citizen.

In most cases, by the time an immigrant schedules an appointment with me for a psychological evaluation, he or she has been retraumatized by the threat of losing income and fears of facing an immigration officer who might deny his or her petition for citizenship. For many elderly immigrants, Social Security is their only source of income for food and shelter.

Multicultural Counseling Competencies and Immigration Evaluations

Racial minority immigrants represent a significant and fast-growing population in the United States. As of 2007, approximately 12% of the entire U.S. population, or 38.1 million individuals, were born abroad (American Community Survey Reports, 2010). Psychologists providing counseling with immigrants as well as conducting INS evaluations for citizenship must be multiculturally competent. It has been suggested that minority

clients' poor treatment outcomes and high therapy dropout rates may be a consequence of multiculturally inappropriate services (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Research found that racial minority immigrants are more likely to experience discriminatory practices by health-care providers and lack access to culturally competent health-care providers (Lauderdale, Wen, Jacobs, & Kandula, 2006; Remy, 1995). Sue and Sue (2008) defined a competent helping professional as one who is actively developing ways of becoming aware of his or her own assumptions about human behavior. Multicultural counseling has been conceptualized as having three components: beliefs and attitudes, knowledge, and skills (Sue et al., 1982). A multiculturally competent psychologist conducting immigration evaluations must demonstrate the following competencies:

1. Actively becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, and personal limitations.
2. Actively making efforts to understand the worldviews of the immigrant.
3. Actively practicing and engaging in appropriate intervention strategies and skills when working with immigrants.

Competency One: Psychologist Awareness of One's Own Assumptions, Values, and Biases

A psychologist completing an N-648 evaluation must be aware of his or her own assumptions about immigration policies and issues. An unexamined attitude toward immigration issues can be manifested in transference and countertransference, thereby making it difficult to conduct the evaluation as well as to write the report. Psychologists must become aware of how their own values and biases might affect immigrants. Many immigrants experience biases related to their accent. Reportedly, when immigrants are interacting with nonimmigrants, nonimmigrants tend to tune out immigrants due to their accents and categorize immigrants as uneducated. Consequently, most immigrants report feeling unheard. A psychologist conducting an immigration evaluation who harbors biases or negative attitudes due to his or her intolerance for non-American accents may produce an immigration evaluation that leans more toward negative conclusions about an immigrant's ability to demonstrate proficiency in English and knowledge of U.S. history as opposed to comprehensively assessing whether the immigrant has mental health issues that may or may not impact his or her ability to demonstrate English and knowledge of U.S. history.

A psychologist doing an immigration evaluation does not have to subscribe to the worldviews of the immigrant; however, the psychologist must be open to accepting the worldviews of the immigrant in a nonjudgmental way.

Competency Two: Understanding the Worldviews of Culturally Diverse Clients

Understanding the worldviews of immigrants is crucial to the immigration evaluation process. In my practice, many of the clients seeking an N-648 evaluation have experienced trauma due to a war that has perhaps influenced their worldview. A psychologist doing an immigration evaluation does not have to subscribe to the worldviews of the immigrant; however, the psychologist must be open to accepting the worldviews of the immigrant in a nonjudgmental way. Sue and Sue (2008) emphasized cognitive empathy. Cognitive empathy involves the psychologist acquiring practical knowledge concerning the scope and nature of the immigrant's experience with war, living in a refugee camp, immigration process to the United States, current living situation, and current and prior level of psychological functioning.

Competency Three: Developing Appropriate Intervention Strategies and Techniques

Developing appropriate interventions and strategies and techniques is also key to conducting an effective N-648 evaluation. Many immigrant clients present psychological symptoms in ways that are different from westernized perceptions of health, which may lead to inaccurate conceptualizations and ineffective intervention. For example, many immigrant clients might experience psychological trauma as psychosomatic complaints such as headaches, dizziness, and stomachaches. A psychologist conducting an immigration evaluation who may not be aware of the cultural manifestation of psychological symptoms might not explore the trauma symptoms but rather focus on physical symptoms. Consequently, the psychologist might feel incompetent to complete the N-648 or feel that the physical symptoms manifestation is out of a psychologist's scope of practice. Many immigrants in my practice may not seek psychological services except in situations such as getting an evaluation for citizenship. Most immigrants feel like an outsider and having a mental health diagnosis is even more stigmatizing. Many immigrant clients in my practice tend to report having a physical problem that had never been diagnosed by a medical professional perhaps due to the psychosomatic nature of their complaints.

With immigrants increasingly representing a large portion of the U.S. population, psychologists are likely to provide psychological services to immigrants. Enhancing multicultural competencies is instrumental for providing effective clinical service to immigrants to the legal system.

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Supporting Immigrant Students and Families in Politically Uncertain Times

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Dr. Marie C. McGrath

First- and second-generation immigrants comprise a large and growing segment of the U.S. student population. It is estimated that approximately 4.7 million foreign-born students are enrolled in preschool, K–12, and postsecondary programs in the United States, representing 6% of the total student population (U.S. Department of Education, 2017). Almost 5 times that number are second-generation immigrants whose parents were born outside the United States (U.S. Department of Education, 2017). While research suggests that immigrant students often academically outperform socioeconomically matched U.S.-born peers (e.g., McDonnell & Hill, 1993), they may also face challenges related to acculturation and English language acquisition that can hinder academic and social success. Undocumented immigrants and refugees, who comprise small subsets of the immigrant student population, may face additional challenges and needs related to their previous experiences and immigration status.

Undocumented Immigrants

Individuals are considered undocumented immigrants if they have either entered the country without legal authorization or initially entered the country legally (e.g., on a temporary nonimmigrant visa) but stayed beyond the legal entry period. Approximately 1.4% of the K–12 student population are undocumented immigrants, and 6.9% of K–12 students have at least one parent who is an undocumented immigrant (Passel & Cohn, 2014). While most undocumented immigrant students reside with their families, hundreds of thousands have journeyed to the United States on their own; during fiscal year 2016 alone, almost 60,000 unaccompanied minors were apprehended entering the United States via its southern border (U.S. Customs and Border Protection, 2016). In addition to acculturative and linguistic challenges, undocumented immigrants may face additional hardships, including stress related to their and/or their family members' undocumented status, as well as socioeconomic challenges due to reduced employment opportunities.

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Refugees

Section 101(a)(42) of the Immigration and Nationality Act defines a refugee as "any person who is outside any country of such person's nationality . . . because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." Approximately 3 million refugees have been admitted to the United States since the passage of the Refugee Act of 1980 (Krogstad & Radford, 2017). The specific number admitted annually fluctuates in response to geopolitical conditions and governmental policies but unsurprisingly tends to be highest in times of global unrest; in FY 2016, 84,995 refugees were admitted to the United States via the federal Refugee Resettlement Program, the highest number since the Kosovo crisis in the mid- to late 1990s (Krogstad & Radford, 2017). Of this group, 3,219 refugees were resettled in Pennsylvania during FY 2016 (Krogstad & Radford, 2017), which represents the ninth-highest total nationwide. It is estimated that 35%–40% of all refugees resettled in the United States are children (Bridging Refugee Youth & Children's Services, 2017). These numbers do not include individuals who seek asylum after arriving in the United States (in contrast to refugees, who must undergo vetting and approval through the Refugee Resettlement Program before arriving in the country). Students who are refugees or asylum seekers are much more likely than their peers to have experienced significant traumatic events, including separation from family members; deprivation of food, water, and other basic needs; and indirect and/or direct experience with violence (NASP, 2015; Ruiz, Kabler, & Sugarman, 2011). These experiences place them at increased risk for mental and behavioral health issues. Additionally, refugee students are likely to have experienced gaps in their education due to infrastructure breakdown in their communities of origin and/or lack of access to schooling during the migration process, which can lead to postresettlement academic difficulties (NASP, 2015).

Considerations for School-Based Practitioners

U.S. policies and procedures related to immigration and refugee resettlement have received much attention from politicians and the public in recent months. Heated public policy debates and high-profile incidents of violence and intimidation have caused many immigrants, refugees, and their families to feel vulnerable and uncertain about the future, potentially exacerbating the stressors described above. While school-based practitioners have little control over the external political climate, there is much that they can do to make the

schools in which they work safe, supportive, and welcoming settings for students and families. In addition to more general strategies designed to facilitate positive school climate, several suggestions for enhancing service provision to this population are provided below.

- *Decreasing linguistic barriers:* Immigrant and refugee students may require English Language Learners (ELL) program supports, and their need for these services should be assessed as soon as possible after enrollment. Additionally, parents/guardians of ELLs are likely to require language support themselves to effectively communicate with school personnel. The use of trained interpreters and translators—preferably those who are not only fluent in the language spoken by the family but also familiar with their cultural background—to facilitate oral and written communication between school staff and families is recommended.
- *Understanding and respecting cultural differences:* Immigrant and refugee families may hold beliefs regarding education and mental health that differ from those held by majority-culture individuals. Understanding families' perspectives on these issues and addressing differences in a respectful manner can help to facilitate communication and build rapport between families and school staff.
- *Increasing cultural competence:* Learning about students' and families' cultures of origin can help to increase the quality of services provided to students and families. Cultivating links with culturally diverse community members who are willing to serve as school and community liaisons can help school staff to increase not only their cultural awareness but also their ability to connect families with supportive community members and organizations. Actions that increase multicultural visibility in schools (e.g., routinely displaying objects and images associated with different cultures; discussing and celebrating diverse cultural events) may help students and families to feel that differences are accepted and valued.
- *Addressing the impact of trauma:* Because immigrant and refugee students are more likely to have experienced trauma than their classmates, it is important for school staff to be able to recognize symptoms of trauma in children and adolescents, including behavioral manifestations and cognitive symptoms, and to provide appropriate assessments and/or psychological services to address students' needs in this area (and/or referrals to community-based providers who specialize in the treatment of trauma).
- *Adhering to laws and regulations that protect the rights of immigrant and refugee students:* Regardless of one's personal political beliefs regarding immigration, it is important for school personnel to be aware of and affirm current laws and policies that protect the rights of immigrant and refugee students and families. (While a comprehensive overview of relevant laws and regulations is beyond the scope of this article, readers are encouraged to access the *U.S. Department of Education Resource Guide*. See "Useful Resources.")

Useful Resources

U.S. Department of Education Resource Guide: Supporting Undocumented Youth. This Department of Education publication summarizes K–12 and postsecondary schools' legal obligations toward undocumented immigrant students and families; provides tips that schools can use to create safe and welcoming environments for all students and their families, including those who are undocumented immigrants; and contains extensive links to other resources. It is available at https://www2.ed.gov/about/overview/focus/supporting-undocumented-youth.pdf.

Pennsylvania Department of Education Refugee Education Program. This program helps schools provide comprehensive school-based and community supports to refugee students and families. Grants to support these initiatives are also available. More information can be found at http://www.education.pa.gov/K-12/Refugee%20Education/Pages/default.aspx.

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Pennsylvania Migrant Education Program: Effectively Assisting At-Risk Children and Youths

Helena Tuleya-Payne, DEd


Dr. Helena Tuleya-Payne

One of my memorable experiences as interim dean of the then School of Education at Millersville University (MU) was attending the annual statewide ceremony held in Harrisburg for migrant youths graduating from high school. These students represented numerous ethnic backgrounds each with their native tongue, including Chin, Burmese, Nepali, and Spanish to name a few. What they had in common was that each one of them had received services provided by the Pennsylvania Migrant Education Program (PA-MEP). In this article, I will describe the program, highlight the benefits to students and their families, and suggest how aspects of this model might inform our work in education.

The following is a definition of the term "migrant child": "A migrant child is defined as a child age 3–21 who has moved across a school district line with/or to join a migrant parent or guardian, or on their own, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing" (Pennsylvania Department of Education [PDE], 2015, p. 2). As might be gleaned from the definition, this group of children is at risk for poor educational outcomes due to instruction interruption and other factors that often include low socioeconomic status as well as language differences and cultural barriers. In 1966, the U.S. Congress recognized the special needs of this population and established the MEP program as part of the Elementary and Secondary Education Act in order to assure that "all migrant students achieve challenging academic standards and graduate with at high school diploma (or complete a GED), and upon graduation are prepared for responsible citizenship, further learning, and productive employment" (U.S. Department of Education, 2015).

According to 2013–2014 Pennsylvania Department of Education data, Pennsylvania is home to 2,874 migrant families and 5,343 migrant children. Of the children enrolled in the PA-MEP, 100% receive free or reduced lunch and 16% are considered homeless, moving on average 5–10 times a year. Of migrant families being served, 75%–90% have a combined income of $10,000 or less and 80%–97% of migrant parents do not have a high school diploma (PDE, 2016a).

Children and youths enrolled in this program come from nine project areas of Pennsylvania. These areas are further organized into five service areas. MU houses the area that serves children and families from Lancaster, Berks, Northampton, and Lehigh counties. The director, Mr. Damaso Albino, is a retired urban high school principal with a passion for serving migrant children and youths. Under his leadership, his service area has seen substantial growth, meaning more children having access to services that include tutorial programs, after-school extended hours, summer programs, in-home programs, health and social support services, language arts, and enrichment.

As Mr. Albino's university supervisor, I learned of the extensive efforts made by PA-MEP staff to serve migrant children. Eligible children have access to preschool programs and arrangements are made with local schools and churches to find space for the programs. Most recently,

Of migrant families being served, 75%–90% have a combined income of $10,000 or less and 80%–97% of migrant parents do not have a high school diploma.

MU has allocated space within the education building that not only serves the children but supports interaction with MU faculty and students. School-aged children have access to after-school programs, summer camps, and leadership institutes. I was impressed with Mr. Albino's advocacy and commitment to using evidenced-based curricula. At the secondary level, youths participate in the Diploma Toolkit Project, where program staff works with students and their families to educate them about what is needed to graduate from high school and to help plan for postsecondary education (PDE, 2013).

Recently, PA-MEP has collaborated with MU to bring the College Assistance Migrant Program (CAMP) to the institution through a 5-year grant from the Office of Elementary and Secondary Education (U.S. Department of Education, 2017a). This program provides financial aid, academic services, and family support to migrant children who received MEP services at some point in their pre-K to 12 experience and are accepted to the institution. Both the Millersville CAMP director and a future recruiter are former MEP students and graduates from CAMP programs. An essential component of the MEP program is family involvement. Parents and

caregivers are included in every phase of student delivery. MEP counselors go directly to the homes to provide services and to connect families with community-based organizations. Each project area has an elected Parent Advisory Council whose members participate in capacity building activities to enable them to represent parent concerns, attend statewide meetings, and evaluate the program (PDE, 2016b).

The keys functions of MEP staff are to identify, recruit, and serve. Identifying and recruiting eligible children requires building relationships with employers who hire migrant workers. Staffers go the employment sites, often out to the fields or on the factory floor, to find migrant workers with children (U.S. Department of Education, 2017b). These migrant workers are not asked about U.S. citizenship as the services that are being provided through the PA-MEP are educational and directed to children. Mr. Albino did report, however, for certain pockets of workers geographically closer to the Washington, DC, area who are undocumented, there has been a scattering of workers as Immigration and Customs Enforcement (ICE) has targeted this group. He also indicated that Lehigh County status as a sanctuary county may be challenged with recent Executive Office decisions.

The successful outcomes of the MEP program point to factors that we have long recognized as important to education, particularly for at-risk students. Family support, early education, and connection to community resources are key tenets.

The successful outcomes of the MEP program point to factors that we have long recognized as important to education, particularly for at-risk students. Family support, early education, and connection to community resources are key tenets.

The MEP fills the gaps of educational needs that often outstrip the resources of school districts. Not only are families invited to participate in their children's education; they are actively recruited in this endeavor through at home visits and the PACs. I wonder how such focused service delivery would work with other at-risk students such as English Language Learners whose parents' employment status would not make them eligible. This brings me back to the graduation ceremonies. A student from each service area is selected to tell his or her story. Their experiences often include refugee camps, challenging relocation experiences in Pennsylvania, and the importance of the PA-MEP and their public school educators to support their future aspirations of postsecondary education. The resilience and potential for future excellence exemplified by these students is inspiring, despite overwhelming odds.

I am a strong advocate of the MEP and am paying close attention to future federal budget allocations. We cannot afford to lose a program that provides such benefit to some of our most vulnerable constituents.

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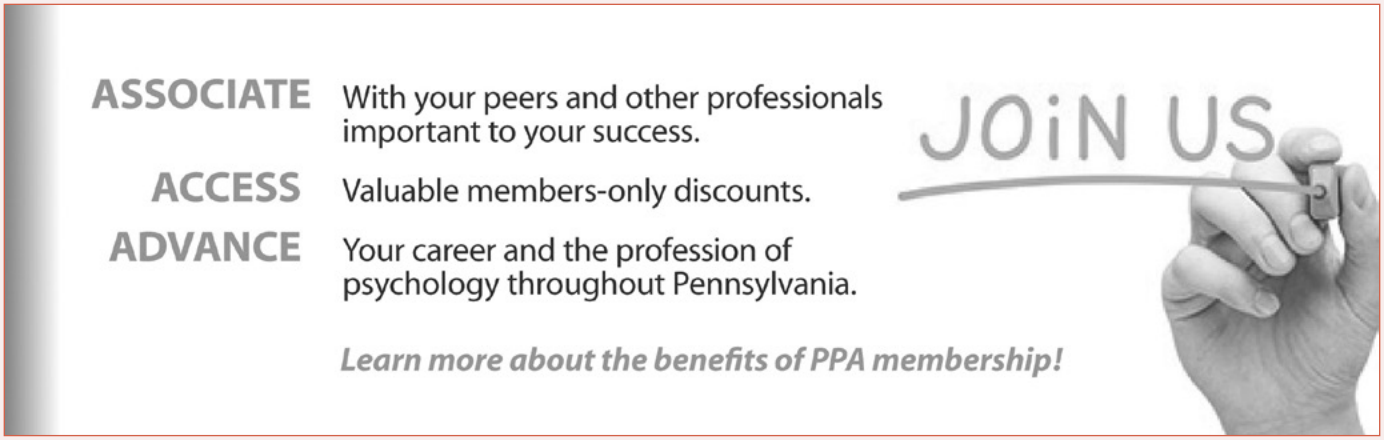

What Can School Districts and Psychologists Do About Bullying?

Matthew A. Carlson, PsyD, ABPP; Brooke E. Zumas, PsyD, NCSP; and David E. Ramsey, MA, NCSP

The impact of bullying has garnered significant media attention in recent years. Addressing bullying within schools and the community is important to establish a safe climate and culture for learning for all students. Fundamental to institutions' prevention programs is the consideration that bullying impacts all students including perpetrators, victims, and bystanders. In addition, the responsibility of schools enacting bullying prevention programs was heightened upon the U.S. Department of Education's Office of Civil Rights issuance of a Dear Colleague Letter (Lhamon, 2014), which framed some instances of bullying as a civil rights violation and a possible denial of a free appropriate public education (FAPE) for students with disabilities.

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While prevention is of the utmost importance, schools must have procedures in place to intervene when bullying occurs.

Psychologists working in schools and psychologists working with children and adolescents in clinical practice are uniquely positioned to provide leadership and consultation to stakeholders to address bullying. Via system-wide consultation and program evaluation, psychologists can assist students, educational professionals, and community members to accurately define bullying, implement evidence-based programs, and create best practice policies (Cornell & Limber, 2015).

What Can School Districts Do?

One of the most important steps that educators can take to address bullying is to implement an evidence-based, school-wide process that focuses on preventing bullying and building a positive school climate. *School-Wide Positive Behavioral Interventions and Supports (SW-PBIS)* and the *Olweus Bullying Prevention Program (OBPP)* are two commonly used evidence-based, systemic interventions that reduce bullying and promote a positive school climate (See Olweus Bullying Prevention Program, n.d.; Positive Behavior Interventions and Supports, n.d.).

SW-PBIS and the *OBPP* have several similarities. For instance, both approaches require that a school-based committee be trained by a consultant. The committee coordinates the implementation of the system-wide intervention and trains all of the school staff in the approach. *SW-PBIS* requires that the committee create behavior expectations for students (e.g., "Respect yourself, others, and property."), and the *OBPP* prescribes specific rules for students to learn and follow (e.g., "We will include others who are left out."). For *SW-PBIS*, teachers provide specific lessons to teach students the school's behavioral expectations. Similarly, for the *OBPP*, teachers hold class meetings to facilitate dialogue about how students and staff can create a positive school climate. Both system-wide interventions include a kick-off celebration at the beginning of the year to create a positive tone and set expectations for the year. *SW-PBIS* and the *OBPP* have data collection methods to assess the current status of behavioral difficulties in the school. *SW-PBIS* uses an office discipline referral process to obtain data about behavioral difficulties, and the *OBPP* uses the Olweus Bullying Questionnaire to obtain data specifically about bullying issues in the school. These data are used to further refine the implementation of the system-wide intervention.

There are some differences between *SW-PBIS* and the *OBPP*. For example, *SW-PBIS* includes a system for recognizing and praising students for demonstrating behavior that is consistent with the school's expectations. The *OBPP* has specific procedures for on-the-spot intervention when bullying is witnessed by staff and procedures for following up with a student who has been bullied and the student who engaged in bullying behavior. Because of the differences between these programs, schools sometimes integrate the two approaches.

While prevention is of the utmost importance, schools must have procedures in place to intervene when bullying occurs. When a student has been bullied by peers, the educational team should consider creating a plan that will reduce the likelihood that the bullying will continue. In some cases, it may be helpful to create a written individualized bullying prevention plan. The educational team, the student, and the student's parents should be active participants in the development of the plan. One educator should be assigned to be the point of contact for the plan. The point of contact should ensure that all relevant educators, the student, and the student's parents are

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The Rise of Reproductive Mental Health

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Allison D. Abraham

"Just relax, and you'll get pregnant." "When are you having kids?" "Have you tried _____?" These statements imply that people with infertility has control over the fact that they cannot conceive. There is an unfortunate assumption that infertility is caused by psychological processes, such as stress or anxiety. I write this article because I am passionate about changing societal perceptions about infertility. The first step in this process is offering education on what it actually means to be infertile. Spoiler alert: Infertility has nothing to do with control and everything to do with a sense of powerlessness.

One in 8 couples are infertile, meaning that they experience difficulty getting pregnant and sustaining pregnancy (Centers for Disease Control and Prevention, 2015). Infertility, a medical disease that results in the abnormal functioning of the reproductive system, affects men and women equally. The psychological devastation that ensues following an infertility diagnosis—a blend of feelings such as anxiety, sadness, shame, anger, and inadequacy—is something that men and women experience in the infertility journey. When someone's body denies him or her the opportunity to conceive, this creates an invisible trauma. One of the most basic aspects of our selves is our ability to reproduce. When our bodies do not function the way they are supposed to, the "what ifs?" about what this could mean for one's sense of self, relationships, and future plans become incredibly consuming.

We live in a fertility normative society. Pregnancy is all around us. For infertile individuals, pregnancy is a reminder of a profound joy that they might never experience. They often have to distance themselves from friends who are pregnant or have young children. They miss baby showers and first birthday parties because it is excruciating for them to experience yet another person's dream come to fruition as theirs fades away. As they distance themselves from these emotional triggers, they often experience tremendous social strain in their relationships. This strain often ensues when important people in their lives do not understand and empathize with the struggle of infertility. When family and friends lack understanding for the infertility experience, the infertile individual might choose to avoid seeking support for fear of becoming invalidated or criticized by important figures in their lives (Mattson & Hall, 2011). This is the crux of why I believe infertility and reproductive mental health warrant more clinical attention. If emotionally distressed individuals are living in a society where what they so deeply desire is constantly surrounding them and they cannot reach out to others, how do they receive support?

I write this article because I want people to understand and empathize with this painful experience. I want clinicians to be mindful and more aware of how prevalent reproductive mental health issues are in our world.

When I began my doctoral program, I became interested in maternal mental health, including postpartum and attachment issues, as well as parenthood transitions. About a year into my training, I found myself wondering about the women who do not get to become mothers. I started to think about why it had taken so long for me to reflect on the experience of infertility rather than fertility. I eventually realized that there was so much silence and stigma in the infertile community. The invisibility of infertility was the very reason it had taken me so long to discover it. I learned that men tend to be even more silent surrounding infertility. As a psychodynamic thinker, I felt strongly that I would incorporate men into my research as well. I would not perpetuate their invisibility by not including them in infertility discussion.

I write this article because I want people to understand and empathize with this painful experience. I want clinicians to be mindful and more aware of how prevalent reproductive mental health issues are in our world. As clinicians, we have the beautiful gift of empathy to offer our clients. We have the potential to offer a corrective emotional experience for those who have been unheard and unseen by others in their lives. The discussion surrounding reproductive mental health is starting to blossom. People do not want to be silent any longer. I hope that we, as therapists, can hear them.

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Supervision: Who's Responsible for an Intern's Gaffe?

Jeanne M. Slattery, PhD, and Linda K. Knauss, PhD

This vignette is part of a regular series looking at clinical dilemmas from an ethical standpoint. In addition to the two of us, the respondents to this vignette included Deb Kossmann, Sam Knapp, and Don McAleer. The following vignette is followed by discussion on managing the presenting issue.

> *Dr. Proctor is supervising a number of psychological interns and postdocs. He often finds himself stretched thin. He had heard a number of complaints about one intern (e.g., rudeness, swearing) but was not sure how seriously to take these complaints, as he had also heard high praise. After the election, however, these complaints escalated in intensity, including at least two clients complaining about the intern making unsolicited and unwanted comments about their preferred candidate. This same intern was perceived as making racist and sexist comments in the course of supervision. What should Dr. Proctor do?*

The respondents to this case first discussed how the intern's actions could harm his clients. As a result, his clients may become uncomfortable disclosing in treatment, refuse to come back, or fail to seek additional treatment, even though they may still need it. Behaviors "on the ethical rim" (e.g., swearing, tacky advertisements, and informal name choices) can be problematic and interfere with treatment (Knapp, VandeCreek, Handelsman, & Gottlieb, 2013).

We discussed several variants on this case. Dr. Slattery noted that one of her African American clients, who had been upset by the outcome of the 2016 presidential election, had a psychiatrist born in India who had made pro-Trump comments to her on her first two appointments following the election. She had just begun seeing him, and they still had a tenuous relationship, although

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she agreed he had been helpful. She felt threatened by his unsolicited comments, however, and couldn't protect herself from them—and he didn't seem aware that she would be offended by his comments or that his actions might interfere with their relationship. Was he acting out his election-related feelings–that particularly surprised his client, as they were both brown-skinned—or did they reflect his own racist attitudes or his poor social skills? Our response to an intern behaving in such a manner would depend in part on our assessment of the problem.

Psychologists and their interns can easily err in either political direction, however. Dr. Knapp described a case where a student had been insistent that the therapy group she led should talk about their anger and fears following the election. As Dr. Knauss observed, this would have been appropriate if it had been consistent with the group's goals or had been suggested by a group member—neither of which had been the case. Dr. Knapp wondered whether the student had been acting out her own psychological issues or, perhaps with good intentions, her own white privilege (e.g., "I know best and should step in and help my clients deal with their anger about the sexism and racism that I saw rampant throughout the election").

While the discussion started here, we also wondered about the context of supervision. Did Dr. Proctor respond at a good place in the course of supervision or, because of his own issues (e.g., problems in assertiveness or failing to set appropriate limits on his time), wait until problems had escalated to a point where they became difficult to resolve? Did Dr. Proctor hold attitudes that made it difficult to recognize such behaviors as problematic? Could he see discussions of such problems as possible learning opportunities that might foster skill growth? Dr. Knapp wondered whether Dr. Proctor had created a supervisory relationship that fostered the sort of trust that would allow his interns to be vulnerable and share their "failings." Did Dr. Proctor encourage the kinds of self-reflection that would help his interns learn to recognize these attitudes and behaviors?

We wondered whether the intern's response was an acute issue stemming from a significant stressor or more of a characterological issue. Drs. McAleer and Kossmann wondered whether the intern's rudeness might reflect a shift in the larger culture, with social media making a greater bluntness and "acting out" apparently more acceptable.

Dr. McAleer wondered whether these weren't only individual issues—intern and supervisor—but reflected a need for systemic change at the agency level. Should there be a better supervisor/supervisee ratio? Should the agency focus more on self-care in general and, perhaps, especially following the election (aware that the election might acutely impact people's emotional competency)? Or should they have set aside time following the election for some debriefings about their reactions before staff met clients throughout the week?

We also wondered about how previous sites and the doctoral program responded and whether they had forwarded an applicant who should have been weeded out of the field at an earlier point. Dr. Knauss described this as "much more common than we think . . . that there is a reluctance at all levels to address issues and dismiss students." Dr. Knapp pointed out that accredited doctoral programs are required to do yearly evaluations of students. Dr. Kossmann

wondered whether the internship site needed better tools for screening interns during the interview process.

Drs. McAleer and Kossmann both talked about the converse side of the issues raised by the Proctor case: clients who are rude and make racist statements to their therapists and agency staff. Dr. Kossmann described working with such a client and observed that it had been difficult but noted how her supervisor had helped her stay with and empathize with her client's pain, which they had hypothesized as leading to the acting out in session. She noted, "It was horrible, yet he softened." Dr. McAleer described, on one occasion, refusing to treat a client who made racist comments to a staff member, while in another case, staff were informed of what was happening with a client who had frontal-temporal dementia and difficulty inhibiting offensive and inappropriate statements (e.g., about staff members' large breasts). As Dr. Knauss observed, however, such decisions need to be directly related to clients' treatment goals.

In sum, we saw Dr. Proctor's intern making a variety of mistakes, which might reflect a problem with emotional competency (or perhaps multicultural competency), as well as failing to act to reduce harm (nonmaleficence). However, we also saw these issues more systemically and questioned whether the supervisor, agency, doctoral program, and even previous practica sites had behaved ethically: by (a) failing to foster a climate of self-care, respect, and trust (beneficence); or (b) inadequately intervening with problems in a timely manner and, when needed, dismissing trainees poorly suited to the field (technical competency). We concluded that "it takes a village" to train clinically competent and ethically sensitive psychologists.

Would you like to be involved in future discussions of vignettes? Let us know by emailing jslattery176@gmail.com

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WHAT CAN SCHOOL DISTRICTS AND PSYCHOLOGISTS DO . . .

Continued from page 22

aware of the plan and any changes to the plan that are made after the plan is initially implemented. The plan should outline locations where the bullying is likely to occur to ensure that close supervision is provided at those locations. The plan should also identify the administrator who will investigate future bullying incidents and educators who can support the student. The plan should describe strategies, supports, and resources that can be used to reduce the likelihood of bullying (e.g., peer buddy system, change of seating in classroom, cafeteria, or on bus). An example of an individualized bullying prevention plan can be found via the following link: https://goo.gl/cy3cXR.

Psychologists should also consider directly reaching out to parents and schools to share information across settings and stakeholders.

What Can Psychologists Do?

Psychologists in private practice who work with children and adolescents may come across those impacted by bullying, whether they are victims, bystanders, or perpetrators. One of the most basic steps psychologists can take to ascertain whether a client is experiencing bullying is to ask about peer relationships. In this process, it is important to be aware that, although bullying may be impacting the client, children and adolescents may not disclose bullying or recognize that it impacts them. Victims, bystanders, and perpetrators may face shame and embarrassment, feel that bullying is commonplace, and believe it is destined to continue, resulting in nondisclosure (deLara, 2012).

Once it is determined that an individual is impacted by bullying, various therapeutic strategies can be utilized. With victims of bullying, in whom anger, anxiety, and isolation may be observed, utilizing interventions that focus on teaching social skills, emotion regulation, and how the student can report bullying may be appropriate (Cook, Williams, Guerra, Kim, & Sadek, 2010). Group therapy can also be beneficial but should be carefully considered so that victimization patterns are not perpetuated. For those engaging in bullying acts, interventions that focus on building problem-solving skills and addressing negative feelings toward self and others may be incorporated (Cook et al., 2010). In all cases, psychologists must be prepared to work with victims as well as those who bully, while recognizing that a single individual can take on multiple roles.

Psychologists should also consider directly reaching out to parents and schools to share information across settings and stakeholders. In work with parents, psychologists can encourage them to examine the school's bullying prevention policy and program and provide psychoeducation regarding how to build collaborative relationships with educators to address bullying issues. When bullying is a presenting issue, parents should participate in their child's therapy to learn how to help their child with bullying (Cook et al., 2010). Additionally, when psychologists contact school personnel, pertinent information can be obtained, which may inform treatment goals and avenues for therapeutic intervention and focus.

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Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between February 8 and April 30, 2017!

NEW MEMBERS

Heidi Baldacci, PhD
Lancaster, PA

Kaleigh Bantum, PhD
Evans City, PA

Cynthia Bartok, PhD
Gaithersburg, MD

Kaycee Beglau, PsyD
Philadelphia, PA

Matthew Burke, MEd
Seattle, WA

Shelley Carroll, PhD
lords valley, PA

Michael Cawley, PhD
State College, PA

Adam Clarke, PsyD
Lucinda, PA

Michelle Coleman, PhD
Reading, PA

Andrea Croom, PhD
Pittsburgh, PA

Jane Darton, MEd
Moorestown, NJ

Linda Dench, PhD
Allentown, PA

Taylor DiGravina, PsyD
Philadelphia, PA

Jennifer Dorau, PsyD
Lebanon, PA

John Falbo, PhD
Bethlehem, PA

Ann Frankel, PsyD
Jenkintown, PA

Justin Griffith, EdD
Cranberry Township, PA

Brad Isserman, PhD
Newtown, PA

Jason Jaegly, PsyD
Hillsborough, NJ

Kathryn Jones, PhD
Schuylkill Haven, PA

Jeb Jungwirth, PhD
Pittsburgh, PA

Tanya Kindel, MS
Nanty Glo, PA

Margaret King, PsyD
Lancaster, PA

Hallie Kushner, PhD
Philadelphia, PA

Marion Lindblad Goldberg, PhD
Philadelphia, PA

Viviana Lucabeche, PhD
Kutztown, PA

Stephanie Marasti-Georg, PsyD
Pittsburgh, PA

Kelly Mason, BS
West Lawn, PA

Carrie Massura, PhD
Danville, PA

Danielle Mink, PsyD
McAlisterville, PA

Murray Jay Moses, PhD
Philadelphia, PA

Karen O'Brien-Maynard, MA
Easton, PA

Rebecca Preiser, PsyD
Swarthmore, PA

Stephon Proctor, PHD, ABPP
Philadelphia, PA

Heidi Ramsbottom, PhD
Shillington, PA

Diana Robins, PhD
Philadelphia, PA

Nancy Rosenberg, PsyD
Elkins Park, PA

Hannah-Lise Schofield, PhD
Philadelphia, PA

Alan Schwartz, PsyD
Bala Cynwyd, PA

Molly Scott-Anthony, PsyD
Pittsburgh, PA

Jessica Sevecke, PhD
East Stroudsburg, PA

Richard Shillabeer, PsyD
Duryea, PA

David Silbermann, EdM
Elkins Park, PA

Robert Slawinski, MA
Lansdale, PA

Lindsay St Thomas, PsyD
Clarks Summit, PA

Geoffrey Steinberg, PsyD
Philadelphia, PA

Tara Studley, PsyD
Conshohocken, PA

Elana Szczesny, PhD
Philadelphia, PA

Amy Taylor, PsyD
Hanover, PA

Jessica Temple, PsyD
Elizabethtown, PA

Tamika Thomas, PsyD
Philadelphia, PA

Jane Thompson, PsyD
Downingtown, PA

Keith Williams, PhD
Lititz, PA

NEW STUDENTS

Leeann Allagas, BS
Edinboro, PA

Keisha April, AB
Philadelphia, PA

Janelle Ardrey, MS
Philadelphia, PA

Patrick Baldwin, MA
Philadelphia, PA

Katherine Beattie, MA
Pittsburgh, PA

Madelon Bohdal, BS
Pocono Lake, PA

Magdalene Bracken, MA
Danville, PA

Daniel Bross, BA
Sinking Spring, PA

Anthony Cavalier, BS
Yardley, PA

Samantha Clemo, BA
Phoenixville, PA

Jennifer Dasti, BA
Whitehall, PA

Naomi Gemmill, BS
Port Deposit, MD

Andrea Genello, BS
Scranton, PA

Shalonda Griffin, MS
Willingboro, NJ

Laura Guzy, BA
Collegeville, PA

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Jacquellyne Hengst, MS
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Kristine Hernandez, MS
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Jennifer Irizarry, BS
Lancaster, PA

Jessica Lawson, MA, MS
Danville, PA

Jenna Marx, MS
Danville, PA

Continued on page 27

Check Out PPA's Exciting Upcoming Events

PPA has some great events for our members on the horizon. Hopefully you can join us for one or more of these exciting CE programs!

Wednesday, June 14–Saturday, June 17: PPA2017 Annual Convention
Visit the gorgeous Omni Bedford Springs Resort for the PPA2017 Annual Convention, where we make it our goal to help you Live a Little and Learn a Lot! At this year's convention we will have many workshops and sessions promoting the theme *Striving to Overcoming Interpersonal Violence*. We hope you join us for PPA's premiere event!

Thursday, October 26–Friday, October 27: PPA Fall Continuing Education Conference
The deadline for licensure renewal is November 30, 2017. Join us at the Eden Resort in Lancaster, Pennsylvania, for this 2-day opportunity to earn CE credit as you head into the homestretch for renewing your license!

NEW MEMBERS

Continued from page 26

Megan McDonnell, MA
Scranton, PA

Maria Miller, BS
Philadelphia, PA

Jeff Moody, MA
Ephrata, PA

Jessica Murakami, MA
Danville, PA

Dan Murphy, BA
Indiana, PA

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Melissa Platt
Carmel, NY

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Mountain Top, PA

Rachael Stethers, BA
Downingtown, PA

Leslie Taylor, BS
Clifton Heights, PA

Paul Tullis, MA
Wyomissing, PA

Ian Weiser, BS
Bristol, PA

Monica Whitehead, MS
Danville, PA

Brittany Williams, MA
Danville, PA

Classifieds

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

CE Questions for This Issue

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

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

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

To purchase and complete the test online, visit our online store at papsy.org. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before June 30, 2019.

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

Eidelson

1. Which of the following is true?
   a. Psychologists evaluate asylum seekers to see if they should be granted citizenship.
   b. Immigrants are only detained while awaiting a hearing if they have committed crimes.
   c. Asylum seekers are detained in the state where they request asylum.
   d. Psychologists can often testify by telephone in asylum hearings.

Bakasa

2. Which of the following categories are included in Berry's Fourfold Model of Acculturation?
   a. Assimilation
   b. Marginalization
   c. Separation
   d. Integration
   e. All of the above
   f. a, b, and d

3. Sodowsky and his colleagues found that first generation Latin and Asian immigrants perceived significantly more prejudice, were less acculturated, and used less English than those who were second, third, and fourth generations.
   True
   False

Gantman

4. Maintaining clear therapeutic boundaries can be a challenge when seeing these clients.
   True
   False

Etzi

5. Defensiveness, as it relates to white guilt, is manifested by:
   a. Disavowing being "white" or by expressed anger/frustration at being unfairly blamed for racism
   b. Defending the client against wrongdoings
   c. Being protective of the client's feelings
   d. None of the above

Dorliae

6. Multicultural counseling has been conceptualized as having three components:
   a. Beliefs and attitudes, knowledge, and skills
   b. Person, acculturation, and empathy
   c. Support, empathy, and acculturation
   d. None of the above

McGrath

7. Which of the following experiences may negatively impact the academic and/or behavioral functioning of refugee students after resettlement?
   a. Exposure to violence
   b. Malnutrition
   c. Gaps in education
   d. All of the above

Tuleya-Payne

8. The Migrant Education Program is primarily for:
   a. Migrant children and youths aged 3–21
   b. Migrant workers seeking educational activities
   c. College-aged students
   d. Preschool children

9. Components of the MEP program that are relevant to the education of at-risk children as a whole include:
   a. Involvement of parents
   b. Early childhood services
   c. Connection with relevant community organizations
   d. All of the above

Carlson

10. In a "Dear Colleague" letter, the U.S. Department of Education's Office of Civil Rights provided guidance that bullying:
    a. Is indicative of a disability
    b. May result in a denial of a free appropriate public education
    c. Should be handled exclusively by law enforcement
    d. None of the above

11. Similarities between *SW-PBIS* and the *OBPP* include all of the following except:
    a. A school-based committee must be trained by a consultant
    b. Rules/expectations for students must be developed
    c. Specific procedures for on-the-spot intervention when staff witness bullying
    d. Data collection methods to assess behavioral difficulties in a school

Abraham

12. According to a 2015 CDC survey, 1 in 8 couples experiences infertility.
    True
    False

Slattery

13. Slattery and Knauss conclude that ethical supervision of interns includes:
    a. Offering supervisees needed training and supervision
    b. Fostering a climate where self-care and respect are valued
    c. Intervening with supervisees when needed
    d. All of the above

14. Knapp and his colleagues might describe the rudeness in the Dr. Proctor case as:
    a. Immoral
    b. On the ethical rim
    c. Clearly demonstrating poor boundaries
    d. Breaking confidentiality

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, June 2017**

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

1.	a	b	c	d		
2.	a	b	c	d	e	f
3.	T	F				
4.	T	F				
5.	a	b	c	d		
6.	a	b	c	d		
7.	a	b	c	d		
8.	a	b	c	d		
9.	a	b	c	d		
10.	a	b	c	d		
11.	a	b	c	d		
12.	T	F				
13.	a	b	c	d		
14.	a	b	c	d		

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

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

Comments or suggestions for future issues _____

_____

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A check or money order for $20 for PPA members ($35 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

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Vol. 77, No. 6

The Pennsylvania
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2017/18 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2017, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

PPA2017 Annual Convention
June 14–17, 2017
Omni Bedford Springs Resort, Bedford, PA

2017 Fall Continuing Education & Ethics Conference
October 26–27, 2017
Eden Resort & Conference Center, Lancaster, PA

PPA2018 Annual Convention
June 13–16, 2018
DoubleTree by Hilton-Valley Forge, King of Prussia, PA

Webinars and Home Studies
Available year-round!

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

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

Home Study CE Courses

Act 74 CE Programs

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

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

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