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Managing your Distress in the Aftermath of a Shooting

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You may be struggling to understand how a shooting could occur and why such a terrible thing would happen. There may never be satisfactory answers to these questions.

We do know, though, that it is typical for people to experience a variety of emotions following such a traumatic event. These feelings can include shock, sorrow, numbness, fear, anger, disillusionment, grief and others. You may find that you have trouble sleeping, concentrating, eating or remembering even simple tasks. This is common and should pass after a while. Over time, the caring support of family and friends can help to lessen the emotional impact and ultimately make the changes brought about by the tragedy more manageable. You may feel that the world is a more dangerous place today than you did yesterday. It will take some time to recover your sense of equilibrium.

Meanwhile, you may wonder how to go on living your daily life. You can strengthen your resilience – the ability to adapt well in the face of adversity – in the days and weeks ahead.

Here are some tips:

- **Talk about it.** Ask for support from people who care about you and who will listen to your concerns. Receiving support and care can be comforting and reassuring. It often helps to speak with others who have shared your experience, so you do not feel so different or alone.
- **Strive for balance.** When a tragedy occurs, it's easy to become overwhelmed and have a negative or pessimistic outlook. Balance that viewpoint by reminding yourself of people and events which are meaningful and comforting, even encouraging. Striving for balance empowers you and allows for a healthier perspective on yourself and the world around you.
- **Turn it off and take a break.** You may want to keep informed but try to limit the amount of news you take in whether it's from the Internet, television, newspapers or magazines. While getting the news informs you, being overexposed to it can actually increase your stress. The images can be very powerful in reawakening your feeling of distress. Also, schedule some breaks to distract yourself from thinking about the incident and focus instead on something you enjoy. Try to do something that will lift your spirits.
- **Honor your feelings.** Remember that it is common to have a range of emotions after a traumatic incident. You may experience intense stress similar to the effects of a physical injury. For example, you may feel exhausted, sore or off balance.
- **Take care of yourself.** Engage in healthy behaviors to enhance your ability to cope with excessive stress. Eat well-balanced meals, get plenty of rest and build physical activity into your day. Avoid alcohol and drugs because they can suppress your feelings rather than help

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In the Aftermath of a Shooting: Help your Children Manage Distress

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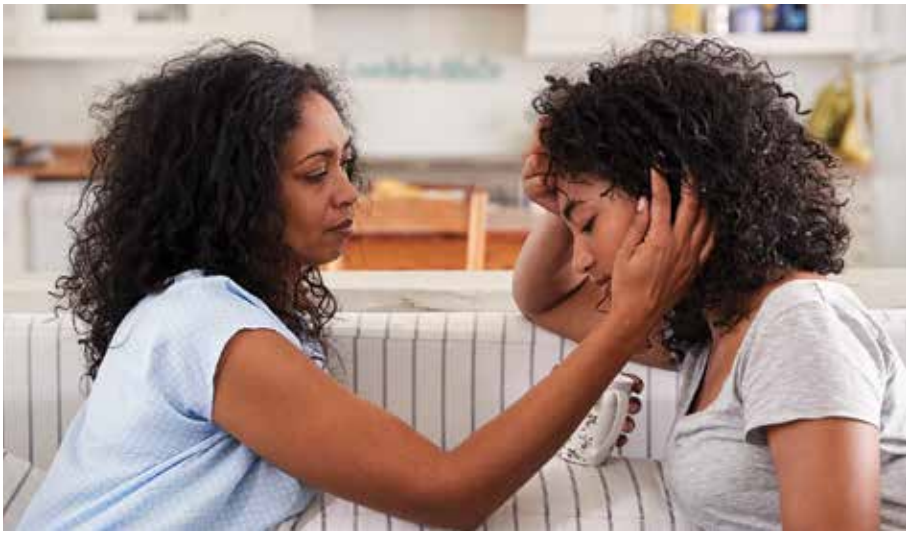
As a parent, you may be struggling with how to talk with your children about a shooting rampage. It is important to remember that children look to their parents to make them feel safe. This is true no matter what age your children are, be they toddlers, adolescents or even young adults.

Consider the following tips for helping your children manage their distress.

Talk with your child. Talking to your children about their worries and concerns is the first step to help them feel safe and begin to cope with the events occurring around them. What you talk about and how you say it does depend on their age, but all children need to be able to know you are there listening to them.

- Find times when they are most likely to talk: such as when riding in the car, before dinner or at bedtime.
- Start the conversation. Let them know you are interested in them and how they are coping with the information they are getting.
- Listen to their thoughts and point of view. Don't interrupt – allow them to express their ideas and understanding before you respond.
- Express your own opinions and ideas without putting down theirs. Acknowledge that it is okay to disagree.
- Remind them you are there for them to provide safety, comfort and support. Give them a hug.

Keep home a safe place. Children, regardless of age, often find home to be a safe haven when the world around them becomes overwhelming. During times of crisis, it is important to remember that your children may come home seeking the safe feeling they have being there. Help make it a place where your children find the solitude or comfort they need. Plan a night where everyone participates in a favorite family activity.



Watch for signs of stress, fear or anxiety. After a traumatic event, it is typical for children (and adults) to experience a wide range of emotions, including fearfulness, shock, anger, grief and anxiety. Your children's behaviors may change because of their response to the event. They may experience trouble sleeping, difficulty with concentrating on school work or changes in appetite. This is normal for everyone and should begin to disappear in a few months. Encourage your children to put their feelings into words by talking about them or journaling. Some children may find it helpful to express their feelings through art.

Take "news breaks." Your children may want to keep informed by gathering information about the event from the Internet, television or newspapers. It is important to limit the amount of time spent watching the news because constant exposure may actually heighten their anxiety and fears. Also, scheduling some breaks for yourself is important; allow yourself time to engage in activities you enjoy.

Take care of yourself. Take care of yourself so you can take care of your children. Be a model for your children on how to manage traumatic events. Keep regular schedules for activities such as family meals and exercise to help restore a sense of security and normalcy.

These tips and strategies can help you guide your children through the current crisis. If you are feeling stuck or overwhelmed, you may want to consider talking to someone who could help. A licensed mental health professional such as a psychologist can assist you in developing an appropriate strategy for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living.

Psychologists and Suicide: What If It Happened to Your Patient?

Samuel Knapp, Ed.D.[1]
Director of Professional Affairs

"It was a Sunday night, and I was having dinner at a friend's house. I did not recognize the number that showed up on my phone. As soon as the caller introduced himself as a police inspector. . . I knew what his next words would be." Baba Neal (2017, p. 174)

Suicide is a major health care problem. In 2016, approximately 46,000 Americans died from suicide. Furthermore, the rate of deaths from suicide has increased 20% in the last 15 years, even though deaths from most other diseases are decreasing over the same time. According to the Centers for Disease Control, suicide ranks as the 10th leading cause of death in the United States. Although homicides tend to be well-publicized, they are only half as common as suicides in the United States.

Having a patient die from suicide is an occupational hazard for psychologists. According to Roush et al. (2018), the death of a patient by suicide is the professional event that psychotherapists fear the most. A survey by Pope and Tabachnick (1993) found that well over 90% of psychologists had this fear. Kleespies and Dettmer (2000) found that 25% of psychologists had a patient die from suicide. PPA's own data found that 4% of the members of the Pennsylvania Psychological Association had at least one patient die from suicide in the last year (Leitzel & Knapp, 2017).

The ability of health care professionals to identify suicidal patients is limited. No formula can predict suicide with a high degree of certainty (see for example, Hayes, Janis, Yang, Castonguay, & Locke, 2018). This problem is not unique to psychology. According to Rose's theorem of public health (Khaw, 2008), as many cases of a disease will occur among groups with few risk factors as among groups with many risk factors.[2] Similarly, as many suicides will occur among individuals with few risk factors as among those with many risk factors. Some data supports this. For example, Kessler, Borges, and Walters (1999) found that the 9% of the population that had three or more risk factors for suicide accounted for 55% of all suicide attempts. The other 91% of the population without those risk factors accounted for the other 45% of all suicide attempts. Noted suicidologists Berman and Silverman commented that, "in our legal work, we have encountered too many cases of individuals who had died by suicide who were married with children, were religious leaders . . ., were in treatment with a mental health professional or had future plans" (2014, p. 438).

What this means is that psychologists will have as many patients die from suicide who have few risk factors as they do among patients with many risk factors. Consequently, a psychologist may be blind-sided by a patient suicide. They may accurately say, "She had no risk factors" or "She denied any suicidal thoughts," and so on. No doubt those psychologists who are especially skilled in interviewing will be more likely to identify a patient who has suicidal thoughts. Nonetheless, many patient suicides occur with psychotherapists who did an adequate assessment and provided good quality care.

Having a patient die from suicide is upsetting for all psychologists and catastrophic for others (Wonders, 2011). This loss can be especially difficult for trainees (Gill, 2012). Many psychologists will develop an adjustment disorder following the suicide of a patient, and some developed clinical depression, post-traumatic stress disorder, or another more serious mental disorder. The reaction depends on several factors including the nature and length of the treatment relationship as well as the social support that the psychologist had received (Dransart, Heeb, Gulfi, & Gutjahr, 2015).

The suicide of a patient triggers productive self-reflection in some psychologists and intense self-blame in others. Some psychotherapists reported becoming more structured in their approach to future suicidal patients. Nonetheless, about 10% of psychiatrists stopped treating suicidal patients following the suicide of a patient (Erlich et al., 2017).

I don't know any psychologist who does not fear a phone call about a patient suicide. Perhaps the phone call could come from a coroner, a police officer, or a family member. Sometimes the psychologists can tell me the exact words used: "your patient is dead." Even when peers assure a colleague that they did all that they could it, it can be hard for a psychologist to shake the feeling that they missed something or should have done more.

Often, I am one of the persons that psychologists call following a patient suicide. They may have already spoken to their friends and colleagues about their emotional pain. Often, they call me when they are uncertain about how to respond when the coroner wants information, or the family wants to talk to the psychologist, or if they have worries about their own professional liability. Regardless of the reason they call, I always say, "I am sorry for your loss," recognizing that the psychologists are secondary victims of the suicide. They may not be as impacted as much as a family member or close friend, but they are secondary victims nonetheless.

1 The author thanks Drs. Jeffrey Hayes, Sandy Kornblith and Jeff Sternlieb of PPA's Colleague Assistance Program for reviewing an earlier draft of this article.

2 There are some exceptions to this general rule, such as found in the relationship between smoking and lung cancer.

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MANAGING YOUR DISTRESS IN THE AFTERMATH OF A SHOOTING

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you to manage and lessen your distress. In addition, alcohol and drugs may intensify your emotional or physical pain. Establish or re-establish routines such as eating meals at regular times and following an exercise program. If you are having trouble sleeping, try some relaxation techniques, such as deep breathing, meditation or yoga.

- **Help others or do something productive.** Locate resources in your community on ways that you can help people who have been affected by this incident, or have other needs. Helping someone else often has the benefit of making you feel better, too.

- If you have recently lost friends or family in this or other tragedies. Remember that grief is a long process. Give yourself time to experience your feelings and to recover. For some, this might involve staying at home; for others it may mean getting back to your daily routine. Dealing with the shock and trauma of such an event will take time. It is typical to expect many ups and downs, including "survivor guilt" – feeling bad that you escaped the tragedy while others did not.

Over time, the caring support of family and friends can help to lessen the emotional impact and ultimately make the changes brought about by the tragedy more manageable.

For many people, using the tips and strategies mentioned above may be sufficient to get through the current crisis. At times, however an individual can get stuck or have difficulty managing intense reactions. A licensed mental health professional such as a psychologist can assist you in developing an appropriate strategy for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living.

Recovering from such a tragic event may seem difficult to imagine. Persevere and trust in your ability to get through the challenging days ahead. Taking the steps in this guide can help you cope at this very difficult time.

PSYCHOLOGISTS AND SUICIDE: WHAT IF IT HAPPENED TO YOUR PATIENT?

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Classifieds

The Benefits of Civic Involvement

Molly Cowan, PsyD

Democracies thrive when their citizens vote and otherwise participate in civic life, and democracies wither when their citizens withdraw from public life and allow it to be dominated by political machines or powerful special interest groups who focus only on their specific concerns. But participation in civic life, either through voting or through charitable giving, appears to have benefits for those who vote or give.

There is a body of evidence to indicate that voting is tied to our health and well-being. According to Barry Burden, the Director of the Elections Research Center at UW-Madison, "Research shows that the healthier you are, the more likely you are to cast a ballot." Additionally, "When a person is involved with civic life, they are more social, efficacious, and participating" (Nerone, 2018). "Social connectedness is really important for physical health, because [people] are active when they're getting out and doing things, and also mental health, because social capital relates to an underlying ideal that can determine health status" (Oliver, as cited in Nerone). In this case, the individual act of voting serves to help us feel more socially connected.

We as psychologists also look for other ways to increase our social connectedness, as evidenced by participation in PPA, networking activities, and the support we seek from others via the PPA Listserv, PPA's social media presence, consultation, and supervision, to name a few. While we are not immune to political disagreements, there are numerous examples of times we come together as a profession to advocate for issues related to our practice needs, helping vulnerable populations, and matters of social justice. PPA's legislative efforts toward a telehealth bill and the Safe Harbor bill are just two recent examples of the importance of using our professional social connectedness to benefit the profession as a whole.

While we are not immune to political disagreements, there are numerous examples of times we come together as a profession to advocate for issues related to our practice needs, helping vulnerable populations, and matters of social justice.

While on the topic of well-being, research has also linked monetary giving to a sense of well-being. Research by William Harbaugh and colleagues at the University of Oregon found that charitable giving activates regions in the pleasure circuit of the brain (Linden, 2011). Additionally, there is also evidence that people who spend money on others—particularly when it satisfies one or more core needs such as relatedness, competence, or autonomy—report greater happiness (Dunn, Aknin, & Norton, 2014). This would suggest that, as psychologists, we may experience the greatest benefit to our well-being by engaging in activities that connect our civic engagement, professional connectedness, and generosity. For example, a recurring or one-time donation to PennPsyPAC helps maximize PPA's ability to advocate for causes to benefit all Pennsylvania psychologists.

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Should I Attend a Patient's Funeral?

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When, if ever, should psychologists attend a patient's funeral? Consider this scenario:

Dr. Verde worked in a facility that treated cancer patients. Some of these patients received intensive psychological services and the psychologist became well known to many of their families. Before her death, a patient asked Dr. Verde to come to her funeral. After her death, the psychologist received a call from a family member asking her to attend the funeral. Should Dr. Verde attend the funeral?

However, consider this other scenario:

Dr. Azul worked as an outpatient psychologist. Despite heroic efforts on her part, Dr. Azul's patient died from suicide. Dr. Azul had worked with this seriously suicidal patient for many years and helped her through several suicidal crises. After the death, Dr. Azul saw a notice for her funeral in the newspapers. Should Dr. Azul attend the funeral?

The APA Ethics Code provides no explicit direction in these circumstances. Attending a funeral would be a multiple relationship, but multiple relationships are not inherently unethical. Rather the consideration is whether the relationship would be exploitative or contraindicated (APA Code of Ethics, Standard 3.04).

Psychologists need to consider both whether to attend the funeral and how they will act if they do attend the funeral. When attending funerals, Koocher wrote, "I seek to convey a message of respect and caring that I hope may bring some measure of comfort (p. 2011, p. 169). So, if psychologists do attend funerals, they should consider how they can convey that caring and respect to the family. Some of the factors to consider are whether the family knew of the treatment relationship? If the family knew of the treatment, then how? Did they participate in family therapy or attend a few sessions as a collateral contact? Did the psychologist simply know the family from brief encounters in the waiting room? Did the family ask the psychologist to attend? How would confidentiality be protected?

Sometimes the situations get blurry. One psychologist received a notification of the patient's funeral because the family member saw the business card of the psychologist among the patient's belongings. Technically, the psychologist was notified and implicitly invited, but there was no indication that the family knew about the relationship.

Psychologists also need to consider their behavior if they were to attend a funeral. What should they say if they are asked, "How did you know. . .?" One psychologist simply said, "We were old friends, I can't remember how we met." Another psychologist recommends saying, "I am a friend of the family" or some other vague response. It may be prudent not to use one's professional title. One should decide whether to write something in the funeral book. Decisions need to be made if the patient is Jewish, whether to make a Shiva call. Instead of attending the funeral, other options might be to send flowers, send a donation to a charity designated by the family, convey written condolences, or take some other step that conveys concern.

Under some circumstances attending the funeral of a patient could be intrusive and awkward. Under other circumstances it could offer great comfort for the family. One psychologist attended the funeral of a child patient who died from cancer. The death was anticipated, and the psychologist had worked with the family and the child in preparing the funeral. In their last family session together, the 9-year-old identified things she wanted in the funeral including the dress she would wear. The family openly identified him to other attendees as the psychologist who helped their daughter so much.

Another psychologist attended the funeral of a patient who died from suicide. "The family greeted me with considerable warmth and it was very emotional. They knew how much I cared and how hard I had tried" (Heller, 1997). But sometimes family members do not know the treating professional well (or at all) and may blame them for the death of their loved one (Ward-Ciesielski, Wielgus, & Jones, 2015).

No simple rule can apply to every situation. The behavior of psychologists regarding funerals or other death rituals needs to balance obligations to the deceased and the family with their personal needs and professional responsibilities.

1 The author thanks Dr. Steven Cohen for his review of a previous version of this article.

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Suicide and Professional Liability

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Data from PPA's annual survey shows that 87% of PPA members reported treating a suicidal patient in 2016. In addition, 23% of PPA members had a patient attempt suicide while in treatment and 4% had a patient die from suicide (Leitzel & Knapp, 2017). The death of a patient by suicide is perhaps the worst professional event that a psychologist will experience. For a few psychologists the tragedy will be compounded by an accusation that they were negligent in the treatment of the patient.

Malpractice suits against psychologists are rare compared to other health care professions, although lawsuits for patient suicides are among the top reasons why a psychologist may be sued (Knapp, Younggren, Harris, VandeCreek, & Martin, 2013). Lawsuits for inpatient suicides are more common than lawsuits for outpatient suicides. When patients are being treated in a hospital, the hospital can monitor them more closely, has more control over their activities, and assumes greater responsibility for their behavior. In contrast, when a patient is being treated as an outpatient, the outpatient psychotherapist has less ability to monitor them, less control over their activities, and therefore has less legal liability in the event of a patient death by suicide.

Nonetheless, malpractice suits for outpatient suicides do occur. The standards for malpractice are that the psychotherapists must: (1) have a professional relationship with the patient (duty of care); (2) the patient must have suffered a severe harm (the patient experienced damage); (3) the psychotherapist must have violated a profession norm of conduct (deviated from standards of care); and (4) the deviation from the standard of care directly caused the harm to the patient (direct cause) (Simon, 1992). Psychologists who deviate from standards of care are considered negligent.

Malpractice courts have other rules that they must follow which can become complex at times, such as those dealing with statute of limitations, the concept of contributory negligence, and so on. However, this article will focus on the element that is most under the control of psychologists, which is adhering to the appropriate ***standard of care.*** The term standard of care is flexible, but generally refers to "what most reasonable psychologists under similar circumstances do" (Sobelman & Younggren, 2016, p. 257). That quotation paraphrases the criteria used in Pennsylvania for determining negligence, except in cases involving involuntary psychiatric hospitalizations where the standard is ***gross negligence,*** which is an even lower standard of conduct. This lower standard was adopted in cases involving involuntary psychiatric hospitalizations because, in the chaos that often surrounds involuntary psychiatric hospitalizations, it is often impossible to confirm to ordinary standards of professional conduct.

In any given trial, the court would determine the standard of care by relying on expert opinions. Although experts may vary somewhat in what they declare to be the standard of care, they usually agree on essential points because they rely upon a generally common core of learned texts, scientific studies, guidelines of professional associations, and so on to make these determinations. Although media accounts tend to play up "the battle between experts," such battles are relatively rare and typically involve complex issues where reasonable experts may disagree.

When it comes to treating suicidal patients, psychotherapists can ensure that they are acting in accordance with professional standards if they demonstrate competencies as delineated by learned authorities such as the American Association of Suicidology's which has developed 24 competence statements (combined into 7 domains; American Association of Suicidology, n.d.) or Cramer's reformulation of those statements into 10 domains (Cramer, Johnson, Rausch, McLaughlin & Conroy, 2013). The home studies that PPA offers use these domains of competence as guide to content. Cramer et al.'s domains are listed in Table One with slight modifications by the author.

Table One: Ten Essential Competencies

Assessment

1. elicit suicidal ideation and behavior;
2. elicit risk and protective factors
3. make a clinical judgment as to risk; and
4. integrate assessment data into the management and treatment plans.

Management

5. set up a monitoring plan for the patient;
6. motivate the patient for treatment;
7. implement means restriction counseling; and
8. create an effective crisis intervention plan.

Treatment

9. develop and implement a treatment plan that addresses the co-existing mental illness while keeping patient safety and management principles in place.

Documentation

10. document assessment, management, and treatment

Modified from Cramer et al. (2013)

Adhering to these standards, competent service is the best risk management strategy that psychologists can adopt. After all, the best risk management strategy is to deliver and document good care (Knapp et al., 2013). Effective risk management strategies promote good patient care and are based on overarching ethical principles. So, the best risk management strategies are to: avoid harming the patient (non-maleficence), promoting patient well-being (beneficence), involving patients in their treatment (respecting patient autonomy), keeping promises to patients (fidelity), and treating patients fairly (justice).

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SUICIDE AND PROFESSIONAL LIABILITY

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Any purported risk management strategy that fails to promote the well-being of a patient or violates an overarching ethical principle, qualifies as ***false risk management strategy*** and should be questioned. False risk management strategies purport to protect psychotherapists from malpractice, but do not. Often these false risk management principles are based on dichotomous or simplistic thinking about complex clinical and ethical issues. Frequently they are peppered with absolutist terms such as "always" or "never."

For example, some well-meaning psychotherapists may claim that they will "do everything they can" to help a suicidal patient. On the surface that sentiment seems noble, but a closer evaluation could lead to questions about its wisdom. It may be implemented in a clinically contraindicated defensive manner that undercuts good clinical care. "Doing everything they can" could, for some psychologists, mean sending every patient to an emergency room for an evaluation, having all patients sign a pre-written no-suicide contract, or immediately notifying family members of the patient's suicidal thoughts without the consent of the patient. However, not all emergency rooms are well equipped to deal with suicidal patients and a referral to an emergency room may simply mean that the patient will spend hours in a stressful environment to get a subpar evaluation that contributes nothing or little to their well-being. Of course, it can be indicated to send some patients to an emergency room. But the decision needs to be based on the unique needs of the patient; and not a routine measure done simply to show that one has done "everything they can."

No-suicide contracts can be off-putting and there is no evidence that they reduce suicides. Informing the family members without seeking the consent of the patient or learning enough about the family members to make the information sharing meaningful, may alienate patients, lead them to lose trust in their psychotherapist, and deter them from seeking or cooperating with further treatment. Informing family members should, except in extreme cases, be done with the consent and participation of the patient. If done the right way, it can save a patient's life. If done the wrong way, it can alienate the patient and increase their risk of suicide.

Sometimes psychologists are warned to "cover your asses" (CYA) when they work with suicidal patients. Dr. Donald McAleer (personal communication April 20, 2017) suggested that CYA could also mean: "Can you articulate?" or can you describe the clinical reasons for your decisions?

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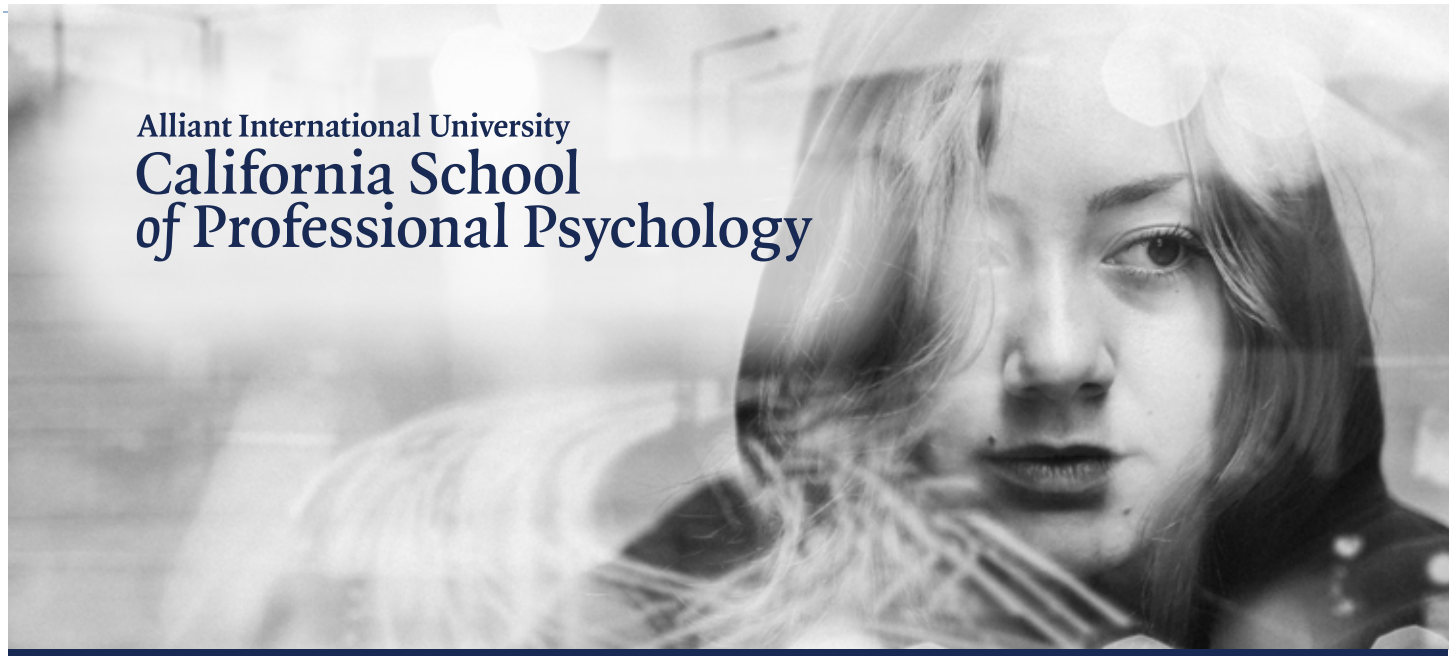

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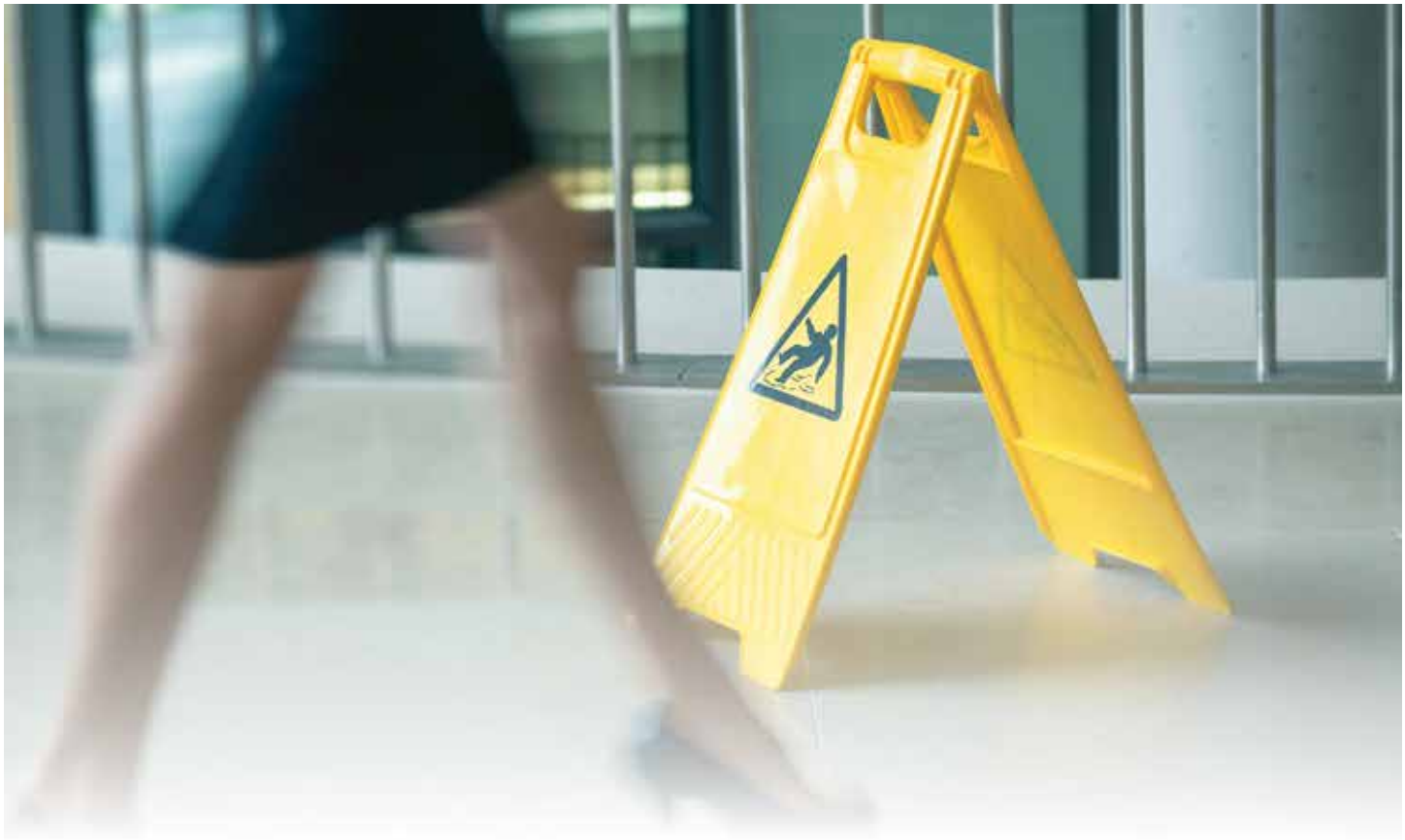
Not all programs are available online or to residents in all states. Programs vary by location and modality; see the Academic Catalog for detail. Alliant is a private university accredited by the WASC Senior College and University Commission (WSCUC). We are an equal opportunity employer and educator. For more information about our graduation rates, the median debt of students who completed the program, and other important information visit alliant.edu/consumer.



Income Protection Insurance

Helps you pay the bills while you get back on your feet.

Becoming disabled during your working years happens more than you might imagine. If you are seriously injured or become ill and cannot work, can your loved ones continue to pay the bills and still live comfortably?

Trust Endorsed Income Protection (Disability Income) Insurance* is the key to providing you and your family with income and financial stability while you get well and get back to what you do best.

Apply for this coverage with rates often lower than similar insurance available to the general public. If you already have disability insurance, compare the rates of The Trust's Income Protection Plans against what you already own at **trustinsurance.com**. You may achieve substantial savings.

Choose the plan that fits your needs!

Sample rates: $2,500 Monthly Benefit – LifeStyle 65 Plan, 90 Day Waiting Period

Age	Quarterly Premium
35	$55.25
40	$70.50
45	$103.00
50	$121.25
55	$141.00

THE TRUST

1-800-477-1200

Watch the Q&A video *What You Need to Know About Income Protection Insurance* at trustinsurance.com.

* Coverage is individually underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of Liberty Mutual Group. Plans have limitations and exclusions. For costs and complete details, call The Trust or visit www.trustinsurance.com

2018 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

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

November 16, 2018
PPA Fall Continuing Education Conference
The Desmond Hotel
Malvern, PA

December 10, 2018
Movie and Discussion: Alcoholism & Addiction
Chestnut Hill College
Philadelphia, PA

March 2, 2019
ECP Day
PPA Office
Harrisburg, PA

March 8, 2019
Preventing School Shootings
Milton Hershey School
Hershey, PA

April 4-5, 2019
PPA Spring Continuing Education Conference
Holiday Inn Grantville
Grantville, PA

June 19-22, 2019
PPA2019 – PPA's Annual Convention
Sheraton Station Square
Pittsburgh, PA

Home Study CE Courses

Act 74 CE Programs

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

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

Essential Competencies When Working with Suicidal Patients—1 CE

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

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

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

*Introduction to Ethical Decision Making**—3 CEs

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

*The New Confidentiality 2018**—3 CEs

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

For a full listing of our home studies, download our catalog here, or visit our online store.

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

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