The Pennsylvania
Psychologist
DECEMBER 2020
VOLUME 80, NUMBER 11

ANTIRACISM

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If you are interested in submitting an article to be published in *The Pennsylvania Psychologist* please contact Publications Chairperson, Jade Logan, PhD, ABPP at *publications@papsy.org*.

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In an article in the September 2020 *Pennsylvania Psychologist* Dr. Edward Zuckerman accurately captured the essence of the work of Dr. Jonathan Haidt on moral foundations and the way that self-identified conservatives and liberals differ in the relative weight that they give to different moral foundations. According to Haidt, neither group is more moral than the others; they just differ in the emphasis given to different moral foundations, and that conversations between liberals and conservatives will be more productive when each group can appreciate the moral foundations of the other (see for example, Haidt & Graham, 2007). Dr. Zuckerman also appropriately noted the importance of talking respectfully to those who have differing opinions on politics and other matters.

Haidt loves discussing controversial topics and there is likely no topic that he finds too dangerous to discuss—if it is done respectfully and with a goal of listening and trying to understand the viewpoints of others (see for example his interview in the libertarian publication *Reason*; Doherty, 2018). Perhaps the greatest hero in Haidt's life has been the philosopher John Stuart Mill who advocated for freedom of speech and the benefit of reaching the truth through a "marketplace of ideas." We could give examples of the many controversial topics that Haidt tackles, but he does not discuss these for shock value, but because he really wants people to examine the foundations of their beliefs. Haidt does a service to all of us- regardless of our political, religious, or social orientation.

However, the example given at the end of the article by Dr. Zuckerman that dealt with how liberals can appeal to conservatives on policy issues gave the impression that only conservatives need to have their beliefs challenged. This presentation was not balanced because, according to Haidt, liberals equally need to have their beliefs challenged as well. No end of the political spectrum has a monopoly on wisdom or knowledge. A respectful dialogue can go both directions, and Haidt's perspective could also be used by conservatives to speak respectfully to liberals by appealing to the values that they hold most dear. We apologize for any implication that only conservatives need to have their beliefs challenged. The lack of balance may have distracted from another wise excellent article that called for respectful conversations. Let us remember that having our beliefs challenged, while it may be unpleasant, can be a benefit to the extent that it causes us to think through our thoughts, correct inconsistencies or falsehoods, and help us become better people. Perhaps now, more than ever, we need these respectful dialogues.

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On the Road to BECOMING AN ANTI-RACIST

DEA SILBERTRUST, PhD, JD

Many years ago, when I was living in Center City, I was robbed at gunpoint on my way home from work. The police located a man who roughly fit the description I had given them, and I remember gazing at him through a window of the police car in which I sat. He was medium height, lean, dressed in loose jeans and an oversized Army jacket. He stood between two uniformed police officers, immobile, with a look between pleading and resignation. It wasn't the man who only an hour earlier held a gun to my head. But I knew that all I had to do was nod my head and this man would be arrested. His skin was dark brown, and mine is white.

This was the first time I recognized the power I held as a white person, a power completely unearned and even, at times, unwanted. Even as a young girl I knew I was privileged and marveled at my good fortune: never wanting for food or shelter, having two loving parents, being born in a time when women had more choice over their careers and lives. But being white was not on that list, it was just a given, something in the background. Looking at that young man through the car window, the power imbalance was undeniable, as was the fact that it was due almost entirely to the difference in our skin color.

I wish I could say that this moment transformed my life. The biggest change it led to was I moved to a better (i.e. whiter) neighborhood. The term White Privilege was unknown to me and I continued to think of racism as something other white people perpetrated. The protests and changes unleashed by the murder of George Floyd has confronted me with my own complacency and the need for all of us to more closely examine ourselves and change our behavior.

The leadership of PPA is determined that this moment does not fade after a few heartfelt messages, but becomes an impetus for lasting changes for us as individuals, as an organization, and as a profession. By the time you read this, you will have elected a Diversity and Inclusion Officer who will join us at our December Board meeting. This is an exciting addition to our leadership at PPA, but we are not waiting for that person to start working on issues of antiracism and diversity.

The Board of Directors and the staff are reading Ibram X. Kendi's book, *How to Be An AntiRacist,* and will be meeting with an outside facilitator to discuss the book and its impact on us as (all white) individuals and our stewardship of this organization. Another group of PPA leaders, including those from the Committee on Multiculturalism, the Antiracism Sub-Committee, and others interested in social justice action have been meeting to re-energize and re-organize our efforts in these areas. If you are not involved in these discussions, but would like to be, please let us know and we will look for an opportunity for you to participate.

No one issue, no matter how important, dominates our lives or the work of this organization. COVID and the need for many of us to work remotely continues to impact our daily lives and PPA remains steady in its support by providing up-to-date resources on the website, answering individual questions on the listserv and by consultation, and through high-quality webinars, home studies and podcasts. If you missed the live workshops offered in November as part of our online CE week, most of them are available on-line, and more are on the way.

In terms of advocacy, Sam Knapp led the charge for us to comment on Medicare's proposal to cut reimbursement by almost 11%. If you were one of the 768 psychologists in Pennsylvania who sent in your comments, Thank You! If not, please consider responding to future legislative alerts. Our efforts do make a difference, and each additional comment or letter strengthens our collective voice. In addition, PPA is laying the groundwork for introducing legislation on prescription privileges for psychologists. This will take time, but our dedicated staff, lobbyists, and volunteers are hopeful this will happen as more and more states move in this direction.

There are more changes ahead. As I write this in mid-October, the election is still three weeks away. Flu season has not yet begun, and cold weather is not yet keeping us indoors. But the need has never been greater for psychologists to provide services, train and mentor the next generation, and serve as role models for the community. Join us as we continue to support and challenge all of us to be better to ourselves and each other.

Email dcsilbertrust@comcast.net or 610-667-5328

CELEBRATE the BRIGHT SPOTS of 2020

ANN MARIE FRAKES, MPA

This year has been full of challenges for everyone, including our members and our organization, but we must reflect on the bright spots and find reasons to celebrate. And this year, despite everything that has happened in the world, there is so much to celebrate. HERE ARE TWELVE bright spots, TWELVE incredible accomplishments by the PPA Board of Directors, PPAGS, other PPA volunteers and the PPA staff, that I would like to highlight for our members. They are listed in no particular order.

1. PPAGS implemented their very first VIRTUAL Internship Fair for Psychology Graduate students this fall! We had almost 30 internship sites participate and approximately 75 students "visit" the sites. Our graduate students appreciate all the assistance we provide as they prepare for a career in psychology.

2. OUR FIRST DIVERSITY AND INCLUSION OFFICER HAS BEEN ELECTED to the PPA Board of Directors. CONGRATULATIONS to Dr. Jade Logan! We look forward to you leading our efforts in making PPA a more welcoming and inclusive organization for all psychologists.

3. To encourage sustained student involvement in PPA, effective July 1, 2020, all psychology graduate students are now receiving FREE PPA membership from the time they enroll in their program until graduation. This was approved by the Board of Directors in March 2020. This is possible because of the continued payment of annual dues by our regular PPA members. Thank you for supporting the future of psychology and assisting in the building of our membership pipeline.

4. A new category of membership was added just for UNDERGRADUATE PSYCHOLOGY MAJORS. Free PPA membership is now available for undergraduate students who have declared psychology as a major. This also helps us to build our membership pipeline for the future. Again, this program is possible because of the continued support of our professional level members.

5. Because of the hard work of our PPA Intern Matt Geisler, our new Mentoring program PPA CONNECT is ready to launch this month. Please sign-up to be a mentor and/or to be mentored! Everyone needs a mentor!

6. Can you believe that **1309** individuals participated in our continuing education WEBINARS from March until November 30th? PPA provided **35** NEW LIVE WEBINARS for our members during this time. Congratulations to all our PPA volunteer presenters and our outstanding PPA staff who made this possible! PPA is committed to providing quality CE for our members in-person or VIRTUALLY!

7. Congratulations to PPA's own Dr. Sam Knapp, the winner of the APA Board of Educational Affairs Distinguished Contributions of Continuing Professional Development Award for 2020. PLEASE JOIN US IN CONGRATULATING SAM on receiving this well-deserved award.

8. On May 8, 2020 Gov. Tom Wolf signed Senate Bill 67 (PSYPACT) into law as Act 19 of 2020. Sen. Judy Ward introduced this bill and the purpose was to have Pennsylvania join the Psychology Interjurisdictional Compact (PSYPACT), an interstate compact that facilitates the practice of psychology using telecommunications technologies (telepsychology) and/or temporary in-person, face-to-face psychological practice. This bill addressed the increased demand to provide/receive psychological services via telepsychology across state lines.

   ASPPB is waiving the $400 registration fee for psychologists to join the compact until December 31, 2020. Now is a great time to join the COMPACT!

9. PPA will not be raising dues in fiscal year 2020-2021. We understand that some of our members have experienced a reduction in income because of COVID-19. If you are currently experiencing a financial hardship and cannot afford your PPA dues, please reach out to me directly and we will come up with a plan, so your membership does not lapse. We are also offering a flexible monthly payment option, that includes a minimal service fee for the convenience. This might be a better option for many of our members this coming year.

10. Continuing Education credits will continue to be $20/credit for PPA members until January 1, 2021. On January 1, the cost of a CE credit will be increased to $25/credit for PPA members. Non-member pricing will be at least $50/credit, depending on the program. BUT THE GOOD NEWS IS you can purchase any home study or webinar on-line NOW before the CE credit price increase! You can finish these programs any time before license renewal in November of 2021.

11. Because PPA's gross receipts decreased by more than 50% in 2019 and we were

Continued on page 23

THANK YOU!

MATT GEISLER, *PPA Undergraduate Intern Senior Psychology Major, The Pennsylvania State University, University Park, PA*

My internship here at PPA has provided me with the amazing opportunity to learn more about the professional field of psychology that has helped to guide me as I begin my career in psychology. It is hard to believe that I first learned about PPA my sophomore year at a Penn State alumni panel and I have had nothing but positive experiences with PPA since then.

One of the most valuable experiences I had during my time at PPA was the ability to talk to psychologists and learn about the decisions they made and how they came to where they currently are. One of the reasons I am interested in the field of psychology is that there are many ways to utilize a psychology degree. However, I am learning that one of the challenges is that there are many ways to utilize a psychology degree and finding your specific niche can be challenging. The field of psychology can be very confusing, especially when you do not have the right guidance and I found that the more psychologists I spoke to, the more I was able to understand how I want to proceed and develop my career. One of the most valuable experiences that PPA provides to undergraduate students like me is the ability to attend insightful webinars and other events that many of our professional members use for CE credit. These events have helped me to learn more about what psychologists are doing in the field today and some of the challenges working in the field. By attending these events I feel that I am more informed about what psychologists are doing and I have a better understanding of what it means to be a psychologist as I begin the graduate school application process to school psychology programs. I am also excited that PPA has expanded their membership to include undergraduate students so that more students like myself will have access to these amazing services. The services and connections that PPA provides will help students to learn more about how the information they obtain in the classroom is utilized to help others.

One of the major projects that I have worked on during my time here at PPA was the development of our new mentoring program *PPA Connect*. When Ann Marie brought this idea to my attention, I was very excited. While I have had experiences with many supplemental services such as academic advisors and other mentoring programs, I often found they were focused on the more general tasks such as preparing for an interview or writing a cover letter. While these are valuable skills, I wanted to work with psychologists to learn how to best apply these skills in psychology. Many of the advisors/mentors who I would be assigned to were the people whose jobs were as close to psychology as the program could find, but they didn't have the experiences to help answer my questions. One of the main reasons I was excited for PPA to develop a mentoring program was based on my interactions with many of our members. All the members that I have talked to were very eager to help answer my questions and provided useful advice. I know that many of my fellow undergraduate students also have questions, and with the help of PPA's experienced and eager to help members, I believed that a mentor program would be very successful. Our mentoring program allows members at different levels of their careers, whether students, ECPs, or established psychologists, to come together and share their experiences and advice with the intent of providing the best mental health services to the public that they can. While the program is still new and growing, I am very excited to see how it develops and is utilized for the professional development of our members.

I wanted to thank all the PPA members and staff for supporting me as I continue my pursuit in the field of psychology. I truly feel that my experience here has benefited me significantly especially given the circumstances of this year. I believe that my experience here at PPA is only the beginning and I am excited to see what the future holds.

Congratulations to Dr. Sam Knapp!

Winner of the APA Board of Educational Affairs Distinguished Contributions of Continuing Professional Development Award for 2020

Dr. Knapp is recognized for his contributions to ethical decision-making, risk management and achieving ethical excellence through continuing professional development. Primarily through his work with the Pennsylvania Psychological Association, Samuel Knapp has been part of an informal and extensive network of psychologists, working to develop and implement educational programs and materials to improve the ethical sensitivity and behavior of psychologists. This group of psychologists eschew a legalistic or fear-based approach to ethics education and instead seek to uplift, inspire, empower, and interest learners. Knapp promotes the importance of ethics involving more than just learning the APA Ethics Code or any other disciplinary document. Often, the programs that he conducts and the materials that he utilizes reference the Ethics Acculturation Model, a process designed to encourage ethical self-reflection. These educational programs are designed to promote a sense of community, self-care, self-compassion, and self-reflection.

PLEASE JOIN US IN CONGRATULATING SAM ON THIS WELL DESERVED RECOGNITION!

Join the Colleague Assistance Committee Today!

For all members of our society and especially for health care workers such as psychologists, this is a particularly challenging and stressful time. Our well-being is a major factor in the work that we do whether we are functioning as care-givers, teachers, researchers, or as a combination of these roles. It impacts the quality of care we provide and the help we deliver. Others are more likely to benefit from our efforts as we stay healthy and focused.

WHO ARE WE?

The Colleague Assistance Committee is made up of PPA members who have expressed interest in helping others to have satisfying and rewarding careers and to avoid the damage that can sometimes occur from the inherent stress in the kinds of work we do. The committee is designed to look at self-care and what promotes our best work.

WHAT DO WE DO?

The committee emphasizes self-care in order to help professionals provide ethical, high-quality care. We promote measures to maximize positive professional functioning and career satisfaction and to minimize the negative impacts of the demands and stresses of our work.

If you care about how we fare in doing our work and would like to help us learn more about the promotion of our professional and personal effectiveness through self-care and spreading greater awareness of what impedes versus promotes our wellness, contact us about joining the Colleague Assistance Committee.

If you are interested in joining the Colleague Assistance Committee, please reach out to Dr. Meghan Prato (meghan.prato@me.com) for more information.
Help promote wellness through better self-care!

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Congratulations to PPA's new Diversity and Inclusion Officer!

Jade Logan, PhD, ABPP

Assistant Professor of Psychology, Chestnut Hill College

PPA'S INTERPERSONAL VIOLENCE COMMITTEE IS FORMING

ANTI-RACISM DISCUSSION GROUPS

These groups will be offered in a closed, time-limited format, monthly or bi-monthly for a period of 5-6 sessions. Groups would primarily consist of participants bringing forward new research, discussing approaches, and exploring obstacles they face as they become anti-racist professionals.

Interested in joining one of these discussion groups? Email judy@papsy.org

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

PPA ADVOCATES

for Pennsylvania Psychologists and Psychology Students at the 2020 APA Advocacy Summit on Strengthening Federal Support for Psychology Trainees During COVID-19

RACHAEL L. BATURIN, MPh, JD; *Director of Government, Legal, and Regulatory Affairs*

This fall, the Pennsylvania Psychological Association took part in the 2020 APA Advocacy Summit on Loan Forgiveness. The following individuals represented PPA at the Summit: Adam Sedlock, Chair of the PPA Legislative & Governmental Affairs Committee, Whitney Walsh, PPAGS Past Chair, Maria Tina Benno, PPAGS Diversity Chair, Kalei Mills Programming Chair, Tyshawn Thompson, PPAGS Chair-Elect and Rachael Baturin, MPH, JD. The purpose of this Summit was to advocate for three bills currently before Congress that focused on loan forgiveness or loan refinancing for psychology trainees.

Below is a brief description of the three bills:

Protecting Access to Loan Forgiveness for Public Servants During COVID-19 Pandemic Act (H.R. 7761)

This bill would ensure that for any borrower enrolled in Public Service Loan Forgiveness (PSLF), and employed in full-time public service before the declared national emergency related to COVID-19, student loan payments that are suspended as a result of the pandemic are counted towards PSLF eligibility, even if the borrower's employment is disrupted due to the coronavirus.

Frontline Health Workers Act (H.R. 6720)

This bill would forgive the student debt of frontline health workers, including psychologists, providing care for those impacted by COVID-19 or conducting research related to the pandemic. This loan forgiveness would apply to all federal and private student loans and the bill ensures that any canceled debt is not considered taxable income. Both paid and volunteer workers, including current trainees, who served for any period during the qualifying emergency related to COVID-19, would be eligible.

Bank on Students Coronavirus Emergency Loan Refinancing Act (H.R. 7449/S. 4141)

This bill would allow both federal and private student loan borrowers to refinance their loans at the new, historically low interest rates that went into effect on July 1, 2020. The bill would also provide current federal benefits and protections to borrowers who refinance their private loans and ensure that any refinanced loans remain eligible for repayment programs, such as Public Service Loan Forgiveness (PSLF).

After being briefed on the issues, the representatives from PPA met with the members of Congress from Pennsylvania to discuss and explain these issues to them. In addition, after the Summit, PPA sent out an Action Alert to all members of PPA asking them to contact their Representatives in Congress to ask them to support these bills. If you have not contacted your member of Congress yet on these issues, please write or call them and ask them to support these bills.

If you have any additional questions regarding these bills, please feel free to reach out to Rachael Baturin at Rachael@papsy.org

the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF OCTOBER 27, 2020

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
SB 67	PSYPACT Legislation.	Sen. Judy Ward	Support	Passed Senate 202-0	Passed House 49-0	Enacted into law Act 19 of 2020 May 8, 2020
SB 90	Adding a provision for Extreme Risk Protective Orders.	Sen. Thomas Killion	Support	Referred to Senate Judiciary Committee	N/A	
SB 621	Training for those who carry guns in schools.	Sen. Mike Reagan	Support	Passed Senate 32-17	Passed House 116-83	Enacted into Law Act 67 of 2019 July 2, 2019
SB 706	Loan Forgiveness Program for Graduates Entering the Mental Health Intellectual Disability and Drug/ Alcohol Treatment Professions.	Sen. Scavello	Support	Referred to Senate Education Committee		
SB 857	Act relating to telemedicine; authorizing the regulation of telemedicine by professional licensing boards; and providing for insurance coverage of telemedicine.	Sen. Vogel	Support	Passed Senate 47-1 Senate concurred House Amendment 29-21	Passed House, Amended in the House 111-77	Vetoed by the Governor Veto No. 4 April 29, 2020 Laid on table with Governor comments May 6, 2020
HB 672	An act enabling certain minors to consent to medical, dental and health services, declaring consent unnecessary under certain circumstances," further providing for mental health treatment and for release of medical records.	Rep. Jason Ortitay	Support	Referred to Senate Health & Human Services Committee	Passed out of House with vote 195-0	
HB 872	Legislation Establishing Telemedicine Law for Pennsylvania.	Rep. Gary Day	Support	N/A	Referred to House Insurance Committee	
HB 1075	Extreme Risk Protective Orders- Providing Due Process for Gun Owners and Reducing Firearms Deaths by Temporarily Disarming People in Crisis.	Rep. Todd Stephens	Support	N/A	Referred to House Judiciary Committee	
HB 1293	Bans Conversion Therapy for children under 18.	Rep. Brian Sims	Support	N/A	Referred to House Health Committee	
HB 1397	Presumption of Joint Custody.	Rep. Susan Helm	Oppose	N/A	Referred to House Judiciary Committee	
HB 1415	Trauma Informed Education Initiative.	Rep. Ryan MacKenzie	Support	N/A	Referred to House Education Committee	
HB 1500	Amends school code to include licensed school social worker.	Rep. Dan Miller	Oppose	N/A	Referred to House Education Committee	
HB 1525	Providing for more access to mental health professionals in schools.	Rep. Tarah Toohil	Support	N/A	Referred to House Education Committee	
HB 1566	Permitting Licensed Professionals to Receive Advice From Licensing Boards.	Rep. Bill Kortz	Support	N/A	Removed from Table April 29, 2020	
HB 1820	An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in school health services, providing for seizure recognition and related first aid training.	Rep. Chris Quinn	Support		Laid on the table, Sept. 11, 2020	
HR 193	Shortage in Mental Health Workforce.	Rep. Jeanne McNeill	Support		Adopted June 4, 2019 196-0	
HR 345	Assess ACES in Schools.	Rep. Mike Sturla	Support	N/A	Referred to House Education Committee	

DIGNITY, RANKISM, and the Practice of Clinical Psychology

RALPH JAFFE, M.S.W., Psy.D.

These days, we are confronted almost daily with instances where power is abused. Racism, sexism, and homophobia are prominent examples. In this brief piece, I introduce a model that may help us understand the abuse of power and move toward greater egalitarianism. I want to discuss the ideas of Dr. Robert W. Fuller, physicist, and former president of Oberlin College, from his 2008 book, "Dignity for All – How to Create a World without Rankism."[1]

Dr. Fuller postulates that human beings long for dignity; having our dignity and worth acknowledged is essential to our well-being. Dr. Fuller describes dignity as including the following elements:

- "Respect."
- "Worthiness."
- "A sense of belonging, of inclusion, of being valued…"

Diminished dignity results in extreme distress and prompt attempts to self-soothe through drugs and alcohol or manifest as mental health disorders.

The need for dignity is, in my view, based in biology. Confronted with the contempt of another, someone who perceives us as less-than, of unworthy of belonging to the group, we will feel our dignity diminished. Stephen Porges's polyvagal theory helps us understand our physiological response in this situation. Porges suggests that evolution has hardwired our brains to determine whether we are accepted and safe in relationships or social groups. Because people cannot survive by themselves, knowing this information is crucial to determining whether we will live

long enough to reproduce.

The vagal system is essential in "deciding." If we perceive the social environment as supportive, our bodies and brains regulate, permitting us to learn, heal, socialize, and love. However, if the vagal system determines that we are unsafe, it will trigger a sympathetic fight-or-flight response or a vagal freeze response. Inflammation increases as our bodies prepare for the possibility of injury. In other words, the painful experience of diminished dignity is inextricably tied to a biological system designed to help us survive. Therefore,

1 Fuller, R. W., Gerloff, P.A. (2008). *Dignity for all: How to create a world without racism*. Berret-Koehler.
2 Ibid. p. 10
3 Liao, K. Y-H., Kashubeck-West, S., Weng, C.-Y., & Deitz, C. (2015). Testing a mediation framework for the link between perceived discrimination and psychological distress among sexual minority individuals. *Journal of Counseling Psychology,* 62, 226–241

chronic attacks on our dignity are not only destructive to us emotionally and spiritually but physically as well.

Dr. Fuller also introduces the concept of *rankism,*[2] which he defines as "abuse of power attached to rank." Rankism will be familiar to anyone who has worked under a toxic supervisor. While he never heard of the word *rankism,* my father understood the idea well; I remember him telling me, "The boss may be nasty because he is in a bad mood – but *you* are *never* allowed to be in a bad mood."

Rankism always diminishes another person's dignity. Once you understand the concept, you start to notice rankism everywhere – in relationships, families, graduate programs, and workplaces.

Some examples of rankism are clear. There is no basis, for example, for one group to have privileges denied to another group because of differences in skin color, gender, or religion. Sometimes, however, it is not so apparent whether rankism exists. From Dr. Fuller's perspective, power differentials do not necessarily mean that rankism exists. Most of us would agree, for instance, that in a surgical team, the surgeon – not her staff – ultimately makes the critical decisions. However, if the surgeon also used her authority to demean or bully the nurses, that would represent rankism.

Rankism is also related to the concept of micro-aggressions.[3] For example, we might maintain a different posture or speak differently with people over whom we hold power or are perceived as less than ourselves. The effect, intended or not, is to diminish or demean those with whom we are communicating. Dr. Fuller posits that rankism is a superordinate category that includes other "isms" such as racism, sexism, and homophobia. However, I am not implying that we can replace those terms; different forms of rankism have unique implications for those affected.

We can utilize the two concepts of dignity and rankism to become better people, improve our organizations, and even enhance our psychotherapy psychotherapeutic work. As individuals, we can ask ourselves questions such as

- How has my dignity been enhanced or diminished in childhood?

Rankism always diminishes another person's dignity.

- Do the people and institutions in my life enhance or diminish my dignity?
- Do I perceive myself as worthy of dignity?"
- Do I enhance or diminish the dignity of others?
- Where do I unconsciously practice rankism? (Hint: Sometimes, we can be brave and ask the people how we affect them.)

In our organizations, we can create policies that enhance the dignity of everyone and minimize rankism. In my first paying job in 1971, I worked at Camp Ramapo, a camp for children coping with various mental health disorders. At the staff orientation, the camp director explained their policy,

> In most organizations, administrators are the most important people, followed by the workers, and then those the organization is supposed to serve. In our camp, we practice what we call "reversed importance." This means that the children are the most important people here. As the individuals directly helping the children, you are second-most important. As administrators, we are the least important people here; our job is to help you do your job better and to take care of all the crappy jobs so that you don't have to do them.

That policy helped the counselors work 100-hour weeks with joy and enthusiasm. Many large corporations would do well to emulate that wonderful place.

In psychotherapy, we must do everything we can to enhance the dignity of our clients. We can teach them about dignity and identifying the rankism in their families and organizations. We need to validate clients when they are injured by those who diminish their dignity. We should also teach clients how to respond to institutions, social groups, or individuals who perpetrate rankism. We can challenge clients when they diminish the dignity of others.

I encourage psychologists to pay attention to rankism and enhance their clients' lives by incorporating an understanding of rankism and the importance of dignity into their practices.

MICROAGGRESSIONS in the WORKPLACE: Working from Home

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Although Covid-19 has forced Americans to change their routines, it is no surprise that this pandemic has highlighted the reality of microaggressions towards minority groups (Devakumar et al., 2020; Tessler, 2020). Microaggressions are brief indignities towards marginalized groups that communicate hostile, derogatory, or inappropriate attitudes (Nadal, 2014; Sue et al., 2007). These comments and behaviors can be intentional or unintentional and are directed towards People of Color or other minority groups.

Research on microaggressions suggest they have lasting psychological impacts as evidenced by increased stress, anxiety, and depression as well as decreased productivity and performance (Nadal, 2014; Sue, 2010; Sue et al., 2007). Odongo et al. (2017) found that working from home increased the risk of online harassment through work laptops and cell phone devices as coworkers are connected well beyond work hours. This experience of harassment is difficult to escape when the workplace is completely online (Tenório & Bjørn, 2019).

What do microaggressions look like online?

1. Microassault: Easiest to identify as they are the most obvious in nature and are seen as "old-fashioned racism." A racial slur, stereotype, or expression of ableism would be considered a microassault (Torino, et al., 2018).
2. Microinsults: Small race-related insults. These may include commenting on a Person of Color's English-speaking skills, not attempting to learn their name because it is unfamiliar, and questioning a person's intelligence (Torino et al., 2018).

3. Microinvalidation: Includes mistaking people of the same race, neglecting to consider the cultural implications of minorities, lack of representation, colorblindness, and disregard for preferred pronouns (Torino, et al., 2018).

Minority groups are struggling to be accounted for in online workplaces. In a recent survey, 1 in 5 women reported feeling "overlooked" by coworkers since working from home (Edelman Intelligence, 2020). Mothers also reported scaling back their online work hours at a rate of 4.5x the rate of their male partners (Collins et al., 2020), suggesting a greater gender gap in online workplaces since Covid-19.

Racial divides are prevalent amongst

those that can and cannot work from home. Only 30% of people from the US can work from home, the differences amongst race and ethnicity are apparent. Approximately 20% of African Americans and 16% of Hispanic workers can work from home. Asians are the highest minority group able to work from home, at 37%. Approximately 30% of Whites were able to work from home (Gould & Shierholz, 2020; US Bureau of Labor Statistics, 2019).

Lack of representation in the workplace is considered an environmental (micro) invalidation (Torres-Harding et al., 2012). Environmental invalidations, as identified in the Racial Microaggression Scale (Torres-Harding et al., 2012) include lack of leadership with a similar background, being the only minority (representative), and seeing few people of minority status in your chosen career. As women reduce their work hours and People of Color have limited access to work from home, environmental microaggressions are now occurring *at home.* Many minorities may be the only Person of Color, gender, or sexual orientation in their field or position. Lack of representation is believed to reduce productivity and increase stress (Jones, 2017). Environmental microaggressions experienced at home may have a similar impact on productivity and stress for minority workers.

What does it mean to experience a microaggression in your own home? Microaggressions experienced in people's homes create an environment of harassment that is inescapable (Tenório & Bjørn, 2019). The blurring of boundaries between workplace and home increases the responsibility on employers as well, if microaggressions are perpetuated through employer-sponsored devices (Tenório & Bjørn, 2019).

I recently had an experience during a phone-call in which a male colleague continued to speak over me. I felt confused by the matter, wondering if it was just a connection issue or if he was truly dismissing my comments. It happened another two times on the same phone-call. I felt confused by his behavior, as we both have the same education and are of the same ethnicity. This confusion is common following a microaggression as the incidents are typically ambiguous in nature (Sue et al., 2007). I brought this experience up to him and received invalidating comments suggesting that what I experienced was not what happened, I was thinking too much into it, and "it must have been your phone- did you check if you were unmuted?" My concerns about this microaggression were validated by a female colleague who shared a similar invalidating experience.

Because this happened in my own home, throughout the day I continued to feel uncomfortable about being "at work." Working from home elicited a different and more complicated response to microaggressions as the boundaries between the work and home were difficult to maintain (Basile, & Beauregard, 2016) and the safe-space of my home felt invaded (Furedi, 2020). I associated the invalidating comments with the space in which I experienced them and not the workplace.

How do we manage workplace microaggressions online?

1. **Acknowledge that it happened.** Identify the experience that has occurred and work towards addressing or accepting it (Cohn, 2016; Harwood et al., 2015).
2. **Speak up!** Working from home is a new experience. We need to identify and discuss how microaggressions are manifesting in the digital world. Eschmann (2020) suggests online platforms to discuss microaggressions that occur online, may be helpful.
3. **Ask leadership to take a lead.** Leadership needs to play an active role in reducing microaggressions and creating an environment in which employees thrive. They might include more minority groups in meetings, have representation from different levels of the workforce, include conversations around biases, be empathic towards employees during a time of racial unrest, and highlight the benefits of diversity regularly (Cohn, 2016; Harwood et al., 2015).
4. **Check in with your biases.** Notice thoughts, perceptions, and belief patterns. In order to reduce the experience of microaggressions, we must be aware of our biases around race, gender, sexual orientation, and age (Sue et al., 2007).

Now what?

1. **Take a break:** Give yourself time to process the nature of the comment and how you want to proceed. Confusion about microaggressions is common (Hernandez et al., 2010; Nadal, 2014; Sue et al., 2007).
2. **Tell someone:** Speak to a friend or another colleague about what happened. Having validation around the incident can be helpful to reduce the stress and anxiety that may follow a microaggression (Hernandez et al., 2010).
3. **Bring it up:** Whether you are the victim of the microaggression or you witnessed one occur, bring it up in a meeting, discuss it as a group, or inform the workplace (Eschmann, 2020; Hernandez et al., 2010; Nadal, 2014).
4. **Maintain some sense of normalcy.** Try to incorporate boundaries where you can to differentiate between work responsibilities and home responsibilities. Change your clothes, turn off your notifications, give yourself frequent breaks (Harwood et al., 2015; Hernandez et al., 2010).
5. **Do something kind for yourself:** This does not have to be luxurious. A simple affirmation, a nice meal, or a phone call to a friend may contribute to reducing the psychological impact of microaggressions experienced in-person or online (Hernandez et al., 2010; Nadal, 2014).

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RACIAL INEQUITY in the Criminal Justice System: How it Works and What Can be Done

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As a psychologist working in the criminal justice system, I have seen the devastation wrought on individual lives by laws that unfairly target young males, particularly those of color, who make up the largest portion of those incarcerated in America. The statistics are alarming. As of June 2020, the United States has the largest rate of incarceration per capita in the world, at 655 per 100,000 (approximately 2,000,000) followed by Ecuador (590), Turkmenistan (552), Thailand (541), Palau (522), Rwanda (511), Cuba (510), the Maldives (499), the Northern Mariana Islands (482), and the Virgin Islands (UK) (482). No other major industrialized country is even in the top twenty. (Statistica.com, 2020) Add to this the 840,000 people on parole, and the extraordinary 3.7 million on probation and the overall correctional population, including probationers and parolees, approaches 7 million, or one in every 33 Americans (Wagner & Rabuy, 2017).

The rate of incarceration in the United States has risen dramatically since the 1970's. As per the National Research Council, in 1971, 161 individuals were incarcerated per 100,000. By 2007 this rate reached a peak of 767 per 100,000 in 2007, a figure four times higher (Travis et al., 2014). The per capita number has since fallen in 2020 to 655, but is still the highest in the world.

Mass incarceration has a greater effect on communities of color than on white communities. Racial disparities exist in rates of incarceration at both the federal and state level. Whites make up 60% of the population but only 40% of those incarcerated. Blacks make up 16% of the overall population but 39% of the incarcerated population. Hispanic figures are 13% and 19% respectively. In short, blacks are incarcerated at six times the rate of whites, and for Hispanics the rate is double that of whites. In several states the ratio is more than 10 to 1 Black vs. White, and 4 to 1 Hispanic vs. White. While this data represents the extremes, there is no state where whites are incarcerated at a greater ratio than blacks. The state with the lowest ratio of black to white incarceration is Hawaii, at 1.9 to 1, with the District of Columbia having the highest ratio at 19 to 1 (Maurer & King, 2007).

The effects of incarceration on the families of those incarcerated are severe. As Gladwell notes, "Having a parent incarcerated increases a child's chance of juvenile delinquency between 300 and 400 percent; it increases the odds of a serious psychiatric disorder by 250 percent" (Gladwell, 2013, p. 245). In addition, long-term effects on the incarcerated and their families include negative impacts on future employment and economic wellbeing, physical and mental health, and marginalization from civic and community life. (Travis et al., 2014)

What Led to This Increase?

The dramatic increase in incarceration from 1970 to 2000 was driven by several factors, many of which fell more heavily on minority and inner city populations. The "War on Drugs," begun officially in 1971, declared drug abuse to be "public enemy number one." The Drug Enforcement Administration (DEA) was subsequently created in 1973. The Reagan administration greatly increased this effort by focusing on incarceration over treatment for drug offenders. Incarcerations for non-violent drug offenses subsequently

increased from 50,000 in 1980 to 400,000 in 1997 (History.com Editors, 2019).

The Anti-Drug Abuse Act of 1986 established mandatory minimums for drug offenses, and led to a minimum of five years for possession of five grams of crack cocaine, while it took possession of 500 grams of powder cocaine to elicit the same sentence. It was estimated that 80% of crack users were African American, leading to a great increase in arrests and incarceration of inner city blacks. Subsequent laws have reduced the difference in sentencing from 100 to 1 to 18 to 1. Nonetheless, by 2014, nearly half of inmates in federal prison had been incarcerated on drug related charges. In 2018 the largest single category of nationwide arrests at 1,654,282 was for drug abuse violations (Stellin, 2019).

A 1994 law enacted in California imposed a life sentence for almost any crime if the defendant had two prior convictions for crimes defined as serious or violent (subsequently known as "three strikes and you're out"). In 1989, 76 thousand people were imprisoned in California. Five years later, largely because of three strikes, that number had doubled (Gladwell, 2013). The Federal Government followed suit with The Violent Crime Control and Law Enforcement Act of 1994 that mandated life sentences for criminals convicted of a violent felony after two or more prior convictions. The 1994 federal law also provided 8.7 billion for prison construction for states that enacted "truth in sentencing laws" requiring people convicted of violent crimes to serve at least 85% of their sentences. Prior to this the percentage of time served was 55%. (Farley, 2016). This law incentivized states to enact harsher sentencing laws to obtain federal funding. These laws and others like them have fueled the tendency toward mass incarceration that began in the 1970's. The effectiveness of these policies in reducing the use and sale of drugs has been minimal at best (Brewley-Taylor et al., 2005).

What Can We Do?

Legislative action could help reduce the extent and effects of mass incarceration and help turn current protests into actionable policy initiatives. The War on Drugs has resulted in clear inequities for minority populations. The differential between sentences for crack cocaine and powder cocaine should be eliminated. Laws against marijuana possession for personal use, which are all too slowly being eliminated, should be completely erased. The federal law categorizing marijuana as a Schedule 1 drug, making marijuana illegal at the federal level, needs to change. Legalizing marijuana at the state level (nine states have already done so) leaves unsolved the problem of financial institutions and businesses that are unwilling to finance or be engaged in an activity that violates federal law.

The intensive policing of minority communities, resulting primarily in arrests for drug offenses, can be rolled back with changes in the drug laws. Mandatory sentencing should be eliminated to allow judges the discretion to apply appropriate and proportionate sentences relative to the context and individual circumstances of a crime. Thirty states still have a "three strikes" policy that can be repealed or made more just by ensuring that minor infractions do not lead to life in prison. Re-examination of state and local statutes regarding qualified immunity laws pertaining to police use of force could reduce impulsive or prejudicial actions that can help restore a balance between officer and citizen.

The inequity of mass incarceration is only one reflection of racism in America. The measures suggested will not eliminate racism or prejudicial behavior, but can improve the lives of tens of thousands by helping to ensure more equal justice and social equity for minority populations.

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ANTIRACISM COMMITTEE SPOTLIGHT

This past Spring, in the wake of George Floyd's murder, of Breonna Taylor's, of Amy Cooper's confrontation of Christian Cooper while he was quietly bird watching, members of the Interpersonal Violence Committee decided that we needed to do something. That led to the birth of the Antiracism Subcommittee.

We do not consider ourselves racists, but we know that we are part of a racist system — one where our friends, our colleagues, and clients are afraid of being stopped by the police, where they are traumatized by news reports and worry about their children, their family members, their friends, where they are perceived differently than we are when doing the same things.

We do not want to be silently nonracist but to actively challenge the systemic racism that our friends, our colleagues, and clients face. In the language of Ibram X. Kendi, we choose to be antiracist.

As ethical Psychologists, it is our duty to educate ourselves about how race and racism impact our clients on a daily basis. We want to promote self-reflection and awareness about these issues, become advocates, and be part of the change.

We are a young committee, but we are looking for ways to make a difference. We have begun writing articles, offering webinars and podcasts, and contributing materials to PPA's social media outlets. We have been talking about ways to support each other: book clubs and support groups.

We are both People of Color and Whites. Together, we can make a difference. If you want to be part of this change process, contact Whitney Robenolt <drwrobenolt@gmail.com> or Jeanne Slattery <jslattery176@gmail.com>

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PPA Leadership & Staff
Would Like to
Wish our Members
a Holiday Season
Filled with Peace & Love
and
a Happy & Healthy
New Year!

Building A Culturally Responsive TELEHEALTH TREATMENT to Combat Health Inequalities Faced During COVID-19

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The level of discrimination against racial and ethnic minorities, coupled with health disparities of the COVID-19 pandemic, have unfortunately magnified existing wounds in minority populations. With the rise of COVID-19 cases in the U.S., individuals from racial and ethnic minority communities are at a greater risk for contracting the virus, especially if access to healthcare is very limited. In areas where health care is provided, the quality is poor and the population is underserved. The Centers for Disease Control and Prevention (2020) reported that Black, Indigenous, and Other People of Color (BIPOC) are experiencing higher hospitalization and death. According to the CDC reports, it is evident that race and ethnicity plays a major role in COVID-19 deaths. Although telehealth services are offered to racial and ethnic minorities to help address these challenging experiences, it may be adding to the health disparities of this population due to issues related to social determinants of health. These included but are not limited to income level, educational opportunities, racial segregation, access to housing, food insecurity and inaccessibility of nutritious food choices, and occupation.

COVID & Health Disparities

In the state of Pennsylvania, race and ethnicity plays a significant factor in COVID-19-related deaths. Blacks contribute to 114.4 per 100,000 COVID-19-related deaths compared to Latinos (47.6 per 100,000) and Whites (55.2 per 100,000) (Egbert et al. 2020). Philadelphia has the highest number of COVID-19-related deaths than any other city. Blacks in Philadelphia constitute 39% of COVID-19 deaths while Whites make up 29% of deaths (Briggs & Feldman, 2020).

Nationally, cases for Black Americans are 2.6 higher than Whites, while Hispanics and Latino Americans have a 2.8 times higher COVID-19 case rate than Whites (CDC, 2020). In predominantly Black counties in the U.S., there were 90% identified cases, and 49% deaths reported in comparison to 81% cases and 28% deaths in all other counties (Millet et al., 2020). As of September 2020, there are 18.2% cases and 20.9% deaths in the Black population, while there are 29.1% cases and 16.5% deaths in the Latino population (CDC, 2020). Adjusting for age, Black, Indigenous, Pacific Islander, and Latino Americans all have three times or more COVID-19- related deaths than White Americans (Egbert et al. 2020). These statistics are alarming, especially since Black Americans have experienced 21.5% of all COVID-19 deaths than any other race but represent only 12.4% of the total U.S. population (Egbert et al. 2020).

Overall, racial and ethnic communities are impacted more by COVID-19 and face increased challenges in comparison to Whites because of ongoing social determinants of health that have yet to be resolved in the U.S. In contrast to Whites, BIPOC are more likely to have a lower SES, less education, underlying health conditions; as well as, more likely to be uninsured, which all negatively shape health outcomes, including COVID-19-related outcomes (Artiga et. al. 2020).

Telehealth Advantages and Disadvantages for Ethnic and Racial Minorities

With the rise of COVID-19 cases in racial and ethnic minority populations, particularly in Black Americans, telehealth would be an ideal solution to increasing healthcare access for these populations. However, telehealth has its drawbacks. According to George, Hamilton, and Baker (2012), even though increased and immediate access to clinicians are endorsed as advantages of telehealth by ethnic and racial minorities in low income urban communities, Black Americans shared more concerns about confidentiality, privacy, and lack of physical interaction with providers. Black Americans generally have low levels of trust in the healthcare system due to historical experiences of marginalization and oppression dating back to slavery. The

footprints left by past abuse by healthcare systems such as the Tuskegee study of untreated syphilis (Alsan & Wanamaker, 2016) might explain the lower level of trust in healthcare innovations compared to their immigrant Latino counterparts who do not share a similar historical background.

Further, it can be difficult to adequately conclude telehealth treatment's effectiveness for Black Americans due to limited literature. However, among the available literature with findings highlighting satisfaction with telehealth, there remains skepticism around receiving care that is culturally competent (Fraser et al., 2017; George et al., 2012). On the other hand, for ethnic and racial minorities, telehealth services reduced transportation barriers related to mental health treatment accessibility. However, services may increase health disparities for racial/ethnic minorities in lower SES due to barriers associated with the absence of technological equipment, reliable internet, and limitation in digital literacy (Mehrotra, 2020; Nouri, Khoong, Lyles, & Karliner, 2020).

Culturally Responsive Telehealth Treatment for Racial and Ethnic Minorities

An overall theme found with telehealth treatment among racial and ethnic minorities is that its effectiveness is contingent on promoting trust and providing culturally competent and safe treatment. Campbell and Khin (2020) noted that it is essential to acknowledge and empathize with the most impacted communities and address the need for culturally sensitive treatment. Recognizing this population's challenges will help develop a telehealth treatment that has a healing dynamic. Culturally responsive treatment would need to address barriers created by telehealth, such as the SES disparity that impacts this populations accessibility to technological connectivity including accessibility to optimal devices for telehealth treatment. Clinicians must engage in a collaborative approach with this specific population. Telehealth treatment outcomes will improve for ethnic and racial minorities when using a community-oriented approach that will help reduce the disparity in mental health services. Understanding each population's specific needs instead of focusing on the implementation of typical interventions will be essential. Treatment would need to be flexible to provide services that may include case management due to this population's present needs. In addition to addressing the diverse needs of racial and ethnic communities that will be served through telehealth, healthcare professionals need to be ethnically and racially diverse. Diversity in all health professions, including psychiatrists, psychologists, physician assistants, medical doctors, nurses, and other allied healthcare professionals, is essential in improving health outcomes for minorities (Ongera, 2019).

Clinicians who work with these populations need to be competent in providing culturally sensitive treatment around grief and loss. They need to address the emotional process and help them find new rituals to honor the numerous people who have died in their family from this disease. Elderly people in the ethnic and racial minority community are an essential part of the family structure. Losses in these families can be incredibly impactful in three-generational families under the same room (Falicov, Nino & D'Urso, 2020).

In this time of COVID-19 and the widespread use of telehealth treatment, bridging the gap in health disparity for ethnic and racial minorities rests on creating culturally sensitive and safe modalities that are technologically accessible and having professionals that are diverse and practice from a multicultural and racially equitable lens.

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Addressing PANDEMIC-RELATED ANXIETY in Older Adults through Telehealth Service

ANNA ZACHARCENKO, PsyD

The COVID-19 pandemic has dramatically altered our daily lives and created a time of uncertainty. As psychologists we have been challenged to modify our service delivery to preserve the emotional health of our patients. We have rapidly shifted to using telehealth platforms and in some cases a hybrid model of telehealth and in person services. Given their age-related risk factors combined with prolonged isolation and disruption in support systems, older adults may be referred for psychological services by their primary care providers. In addition, seniors may independently request services to address pandemic related anxiety. Most recently, researchers have been examining factors correlated with COVID-19 related anxiety as well as developing a tool to assist in screening for this anxiety (Lee, 2020; Milman, Lee, & Neimeyer, 2020). Their efforts are a testament to the importance of addressing the profound psychological impact of our current pandemic. Currently, telepsychology services may yield benefits for the older adult including: promoting treatment continuity and providing flexibility in scheduling of appointments to times when the patient is less fatigued. In transitioning to telepsychology services, there may be a learning curve for both the patient and the psychologist. It may be best to do a little homework beforehand and to consider the following items.

Perceived Barriers. Researchers have identified several predictors that play an important role in the perception as well as acceptance of telehealth services. Of these, computer anxiety has been found to be the most consistent predictor carrying a negative impact on attitude and intention to use technology (Cimoerman, Makovec, Bren, Trkman, & Stanonik, 2013). Computer anxiety refers to a negative affective reaction toward computers such as a fear of using computers. Prior to initiating telepsychology services with an older adult, a psychologist may wish to engage the patient in a discussion regarding computer anxiety. This can be achieved through a phone call before the patient's scheduled telehealth appointment. APA guidelines suggest providing technological support prior to the appointment. This may entail a telephone contact with the older adult to review verbal instructions and to test the telehealth platform. Concise written instructions typed in a larger font size may be forwarded to the older adult along with screen shots of each step of the process of logging onto the platform (APA Committee on Aging, 2020; Greenwald, Stern, Clark, & Sharma, 2018; O'Hanlon, Bond, Knapp, et al. 2010). When possible, support staff may be assigned to the above-mentioned tasks.

Modifications necessary to compensate for possible age-related sensory challenges.

Older adults may experience changes in sensory functions such as impaired hearing or vision. The psychologist may wish to consider (6;11):

1) Visual presentation modifications such as screen illumination to offset challenges experienced due to decreased visual acuity., and
2) Auditory enhancements which may include adjusting volume settings, offering closed captioning options with enhanced text size or using headphone sets.

Screening to identify and measure the severity of Covid-19 related anxiety. During an infectious disease outbreak, individuals may experience clinically significant levels of anxiety. Sheltering in place coupled with disruption in previous activities and loss of significant relationships may lead to feelings of isolation, fear, boredom and frustration. Milman, Lee and Neimeyer studied factors correlated with COVID-19 related anxiety and developed a tool to assist in screening for this anxiety (9;10). The coronavirus anxiety scale (CAS) is a 5 –item self-report mental health screener of dysfunctional anxiety associated with the coronavirus crisis. The CAS was developed to assist clinicians and researchers in identifying cases of individuals functionally impaired by coronavirus-related anxiety. The diagnostic properties of the scale are comparable to the Generalized Anxiety Disorder 7 scale. To encourage its use in clinical assessment and research, the CAS has been placed in the public domain. Psychologists who wish to learn more about the psychometric properties, scoring and interpretation of the CAS may access the scale through the following link: https://www.phenxtoolkit.org/toolkit_content/PDF/Coronavirus_Anxiety_Scale_CAS.pdf

Selection of interventions easily adaptable for use within a telehealth platform. Demonstrating utility and efficacy, telephone psychotherapy has emerged thus changing the landscape of treatment for psychological disorders (5;10;11;12;13;14). Telepsychology protocols using cognitive behavioral and other interventions have shown promise and may lend themselves to addressing pandemic related anxiety. Older adults may report a disruption in their support systems as well as a cessation of deeply valued activities. A reoccurring theme which may be expressed is the violation of the belief that one is safe in the world. Interestingly in a study examining COVID-19 related anxiety, exercising control and restricting travel was identified as a factor buffering against the emergence and intensification of anxiety. As the older adult may perceive a loss of control during the pandemic, psychologists can recommend implementing structure through activity scheduling (7). This would be preceded by a discussion guiding the older adult patient into identifying viable activities which are meaningful to the individual. Another intervention which has been correlated with increased positive affect is generating a daily gratitude list (3). Recommendations for the selective use of the internet and social media have also been generated. Creating virtual communities can offset feelings of isolation. Older adults may have family members such as grandchildren whom they miss visiting. Encouraging facetime with family members and friends can enhance feelings of social support. In contrast, when the older adult reports experiencing increased distress following exposure to the media, limiting this exposure may be considered. Last, addressing the physiological manifestations of anxiety is an important facet in treatment. The psychologist may wish to consider introducing diaphragmatic breathing, progressive muscle relaxation as well as mindfulness-based strategies.

Summary

As we continue to navigate the challenges of our current pandemic, psychologists may be called upon to provide increasing psychological support and services to older adults. Through the introduction of telehealth services, we have the opportunity to reach a vulnerable population and help to decrease their emotional suffering.

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COVID CHAOS, a.k.a. Testing in 2020

CHRISTOPHER ROYER, PsyD

I'm a neuropsychologist. For 25 years, I have tested. That's what I do. In my private practice I would see ten people a week for in person and technician-administered lengthy batteries, and see many more for shorter dementia evaluations. In February of this year, things got a little tense. As COVID-19 spread around the world and then across our country, a shut-down became unavoidable. In March we closed for seven-weeks.

In Pennsylvania, client care and insurance advocacy necessarily became about telehealth. With some pain most psychologists shifted to doing psychotherapy via telehealth platforms for many clients. On the testing front it was a different story. There are contraindications and barriers to telehealth testing: issues with test security, standardization, adapting measures to video formats, incompatibility with video administration and my favorite, having to learn new tests!

Fortunately, insurance reimbursement for telehealth testing came quickly due to the thoughtful and energetic efforts by APA nationally and PPA locally and by testing-centered organizations such as the National Academy of Neuropsychology. However, some types of evaluations, even working with these issues, simply do not allow remote assessments. Legal cases, custody evaluations, Act 235 evaluations and the like depend upon the standardization of measures and tight test security to conform to forensic standards.

The pandemic is making change happen. The wheels of digital innovation in the field of assessment are getting an opportunity to turn. Major testing companies quickly adapted the stimulus materials to digital formats. Batteries such as the *Test My Brain* (TMB) Neuropsychological Battery have been made available for free use, and we

are learning to cope with the challenges of assessing the variance introduced by distance administration and weighing and integrating these factors into our reports.

For psychologists, digital administration of tests creates some thorny problems. First, we were taught that standardization is the cornerstone of making good inferences about results. With digital administration, we have little control of the client's environment. For example, we say five digits clearly but the client's wifi is stone age and they only hear three. Should we repeat the sequence (our standardization superego says, "no way!")? Or we send out an MMPI and our client asks her spouse "I'm not depressed, am I?" before responding. And you know the story of a cat walking across your keyboard? Well I've had that happen to a client during testing. Obviously, this can cause problems with our data.

Another issue that some may not admit to is that we are very attached to our batteries. We do swap tests to keep up with current content and norms, but we

really don't even like doing that. We really know our tests, we have researched them, are aware of their weaknesses and their strengths.

Digital administration comes with new tests that may be less in tune with what we like to measure, and are sometimes less well-researched. Our referral sources also like our test batteries, they like what they get from our reports, and they know what to expect. And there are some tests that just are not adaptable to digital distance administration.

My personal adaptation involves digital administration only to clients with accessibility to developed technology (e.g. not a cell phone), the availability of a helper if needed, and serving high health risk clients whose staying at home lowers their risk. Forensic cases and evaluations with similar needs for specific and standardized administration of tests had to wait until we went Green.

With the "opening" of the State to the Green phase, I wanted to remain a good steward of the health of my clients, my employees and myself. After reviewing CDC guidelines, PA Department of Health information and after discussions with several physicians, this has become my formula for testing in person:

- Clients are initially interviewed via telehealth including attention to their telehealth situation.
- Where the potential administration issues allow, any emotional/personality inventories are administered via telehealth.
- Clients are permitted in the office if they have not been exposed to individuals with COVID-19, if they do not have concerning symptoms (see CDC) and if they are able to wear a mask during their time in the office. Individuals with medical reasons why they cannot wear a mask are asked to reschedule to a later date or proceed with full telehealth assessment.
- In the office we try to minimize lobby congestion. Clients are met at the front door and taken directly to the testing room. If multiple clients are scheduled on the same day, arrivals are staggered. Only one person may wait in the lobby for a client, and, if the client can tolerate it, others are encouraged to leave the office and return at the end of testing.
- In addition to the usual informed consents we require a written acknowledgement that although we do everything we can, there are no guarantees.
- We wear scrubs (which can be removed at the end of day and washed) and masks. We use plexiglass screens with three-inch openings between the evaluator and the client.
- All surfaces and test materials are disinfected between testings.
- Clients put their test response booklets in a basket and these materials are only handled 24 hours later.
- Feedback sessions are done via telehealth.

While somewhat cumbersome, these guidelines have allowed clients to return to the office for testing in a manner that promotes safety and hopefully reduces anxiety.

I hope this has been useful. I have found the *PPA Listserv* and the *Testing Psychologist Community* on Facebook to be excellent resources for discussion of these issues.

CELEBRATE THE BRIGHT SPOTS OF 2020

Continued from page 4

financially able to continue to employ our entire staff team, PPA was eligible for the federal employee retention credit, which resulted in **a refund of approximately $30,000.00**. Thank you to our accounting team at Boles Metzger Brosius & Walborn PC for making us aware of this opportunity and jumping on it!

12. Congratulations to Rachael Baturin on her successful grant submission to APA for their support of our grassroots advocacy efforts. **PPA has been awarded a $10,000 GRANT** from APA to move our PRESCRIPTIVE PRIVLEGES FOR PSYCHOLOGISTS legislation forward in Pennsylvania.

Thank you for your dedication to and continued support of PPA. Everything we do, we do for our members. Please find a bright spot of 2020 and be thankful! Find some time for your own self-care this month.

We wish you HAPPY HOLIDAYS and only the BEST in 2021! As always, if you want or need to discuss anything related to PPA and how we might do things better, please send an email message to annmarie@papsy.org or call me on my cell phone at 717. 614.5095. BE SAFE. BE WELL.

EQUITY "FILL-UP" FOR SCHOOL PSYCHOLOGISTS:

Anti-racisim and Educational Equity Efforts in Pennsylvania

NIKOLE HOLLINS-SIMS, EdD, LAUREN KAISER, PhD, NCSP

In these unparalleled times, the term equity has become a word that is consistently used in numerous contexts. In educational spaces, the term equity is one that cannot be understated. Educational communities are charged with providing an experience for all learners to be successful. It has become clear amid a global pandemic, as well as current civil unrest in our nation, intentionality in equity and anti-racism is paramount to fully create educational conditions that are emotionally, psychologically, and physically safe. School psychologists serve in an invaluable role in supporting students, families, and other educators in developing and sustaining equitable school climates.

The Context and Need

COVID-19 and the murders of Black Americans in high-profile incidents has propelled many into an intense focus upon equity issues, however most of these issues have been long-standing for centuries. It is important to recognize the vast history of systemic oppression that has affected not only schools, but community structures, healthcare, and housing. An intentional focus on equity in Pennsylvania schools has been a key tenet of Pennsylvania Secretary of Education, Pedro Rivera's administration, since 2015.

This focus was further exemplified in November 2016, following the presidential election, where several Pennsylvania schools experienced racial incidents resulting in national media attention. The Pennsylvania Department of Education (PDE) was resolute in providing schools with resources and supports to address tensions as well as steps to prevent, respond and recover from these types of incidents. At this time, Governor Wolf shared in a letter to the educational community the following sentiment:

> "My administration is committed to creating a culture of inclusiveness at all schools, where students are made to feel welcome and valued, and we'll continue to work with schools and communities to help them create these supportive settings that celebrate diversity and teach the importance of respect for self and others." (Equity and Inclusion Toolkit, 2017, p. 4)

In the summer of 2020, Secretary of Education Pedro Rivera, after the murders of George Floyd, Breona Taylor, and the subsequent civil unrest in the country, offered the following:

"Our education system is not without fault in perpetuating the systemic inequities and institutional bias that many of our communities have accepted as normal. As a leader in our education system, I'm taking my outrage and using it to fuel my commitment to right these wrongs, correct the injustices, dismantle the systemic barriers, and ensure every student has access to the opportunities to learn and achieve regardless of their skin color. Educators are change agents and community leaders." (Rivera, 2020, p. 1)

As change agents, school psychologists' understanding the current state of educational experiences for students from varying backgrounds is important to begin the equity journey. For example, Riddle and Sinclair (2016) described county-level risk ratios in the United States regarding disciplinary actions taken in schools (e.g. suspension, expulsion). When viewing Pennsylvania data, the numbers are staggering, with some counties displaying risk ratios between 4.5 and 7.0. This may translate into Black students being 4.5 times more likely to receive suspension/expulsion as compared to their white peers. Although this is one example of the need for equitable practices, it is not isolated to disciplinary processes. Inequities in special education identification, access to Advanced Placement courses, gifted placements, and digital access are each important areas of concern.

When school psychologists present this type of information to members of the educational field, it is sometimes met with resistance. For many, there is a perception that there is not a real issue to consider, and blame is placed on the students, families and communities. In other cases, due to other competing priorities, the educational systems have not yet tackled these issues in a systemic way. In reality, many educators need explicit education around topics related to systemic racism, oppressive policies, and bias to see the need to change their educational

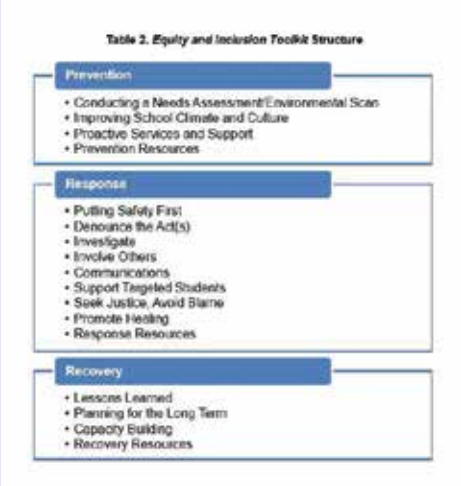
infrastructure. The work connected to this level of professional learning and growth is not a "one-size-fits-all" approach and requires intentionality and long-term commitment.

Progress in Pennsylvania

The needs seen throughout the Commonwealth of Pennsylvania cannot be ignored. PDE has demonstrated a commitment to ensuring equitable practices are being promoted throughout statewide educational entities. In Pennsylvania, equity has been defined as "every student having access to the educational resources and rigor they need at the right moment in their education across race, gender, ethnicity, language, disability, sexual orientation, family background and/or family income (CCSSO, 2017). With these definitions in mind, the PDE Equity and Inclusion Toolkit (2017) specifically supports schools and districts in the areas of: Prevention, Response and Recovery (see Figure 1).

Figure 1

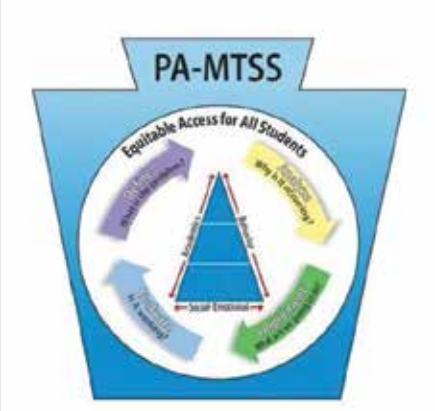
PDE Equity and Inclusion Toolkit Structure



Since the release of the Equity and Inclusion Toolkit (2017), the educational field requested more content that addressed all types of educational inequities and not solely in response to bias incidents, harassment or discrimination in schools. As a result of the feedback, PDE and other statewide educational training arms began to connect the equity work with Multi-Tiered Systems of Support (MTSS, see Figure 2). MTSS serves as an overarching framework to ensure students are receiving appropriate supports based on their specific needs or skills. This further promotes the universal approach necessary for equity and dismisses the idea of equity being a program or specific curriculum for only certain students.

Figure 2

Pennsylvania's MTSS Model



The most recent release from PDE to effectively support schools and districts was the Equitable Practices Hub (2020). The purpose of the resource hub is to establish a coherent collection of resources that an educational community may use in promoting intentional equity in their communities (Pennsylvania Department of Education, 2020). The resource hub is also aligned to the newly developed PDE Equity Pillars of Practice, which include: (1) General Equity Practices (2) Self-Awareness (3) Data Practices (4) Family/Community Engagement (5) Academic Equity and (6) Disciplinary Equity. The goal of the Equitable Practices Hub is intended to provide a "one stop shop" to support educators embarking on the equity journey.

School Psychologists Role in Equity for Diverse Populations

School mental health practitioners (e.g., school psychologists, school counselors, school social workers) are uniquely positioned in schools to address these equity issues. Specifically, the National Association of School Psychologists (NASP) practice model places Equity for Diverse Populations as a core foundational domain of practice for school psychologists (NASP, 2020). A key component of using an equity lens in practice begins with self-awareness, with regards to cultural proficiency, and unpacking bias, power and privilege. As school mental health practitioners continue the course towards equitable practices, their abilities to analyze academic and disciplinary data is imperative to detecting disproportionality and inequity in supports. Additionally, their ability to authentically engage with families, communities, and other educators through consultation is a skill set primed for stakeholder input to shape systems-level change.

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TELESUPERVISION: Promising Directions and Ongoing Considerations

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As we are very much settled into the fall 2020 semester, those of us involved in teaching and training students are likely engaging online with students and trainees at a higher frequency than we did prior to the COVID-19 pandemic. While there is a great deal of literature and training for online teaching, there is limited information on telesupervision (Jordan & Shearer, 2019; Martin et al., 2018). What do we know about telesupervision? Is this truly a viable option for our trainees during the COVID-19 pandemic and in the future? For those psychologist academicians providing telesupervision to trainees, what ongoing considerations should we have in place?

Background

APA's Commission on Accreditation's (CoA) Standards of Accreditation for Health Service Psychology (2015) defines telesupervision as "supervision of psychological services through a synchronous audio and video format where the supervisor is not in the same physical facility as the trainee" (p. 27). While CoA recognizes the benefits of in-person supervision (and required at least 50% of trainee supervision had to be delivered in person prior to the COVID-19 pandemic when they relaxed this limit), CoA also recognizes that "accredited programs may utilize telesupervision in their program curriculum" (p. 20).

What Does the Research Say?

Psychologists engaging in telesupervision at this time, whether entirely remote or blended with some in-person supervision, may wonder if we are truly meeting our trainees' needs. The research in this area is predominantly based on the trainees' perspectives, and trainees are likely to perceive it as helpful. Inman et al. (2019) analyzed 35 empirical studies from 25 peer-reviewed journals and one book chapter published on telesupervision between the years 1990 and 2016 (content was not found prior to 1990); their review indicated trainees typically perceived telesupervision as equally effective as in-person supervision, particularly when live and using audiovisual programs. Similarly, Martin et al. (2018) analyzed 11 papers, identifying eight themes that contribute to effective and high-quality telesupervision. Themes identified included trainee characteristics, supervisor characteristics, supervision characteristics, supervisory relationship, communication strategies, prior face-to-face contact, environmental factors, and technological considerations. The first five of these themes are cited by numerous authors as critical to effective face to face supervision (e.g., Falender & Shafranske, 2004; Norcross & Popple, 2017), while the final three are more specific to telesupervision. More recent studies examining trainees' perspectives (Jordan & Shearer, 2019; Tarlow et al., 2020) indicate that trainees find telesupervision comparable to in-person supervision, and that a supervisory alliance is possible in this modality.

Ongoing Considerations

Students seem to perceive telesupervision as favorable – or almost as favorable – as in-person supervision. Yet, there are unanswered questions. Diversity considerations are unfortunately under-addressed in the current literature and

research on telesupervision (Jordan & Shearer, 2019; Falender et al., 2014); therefore, future research should address cultural considerations in telesupervision. Supervisors can consider past literature on cultural considerations in supervision and make applications to their telesupervision practice. Trainees' comfort levels in receiving telesupervision may also be important (Jordan & Shearer, 2019), so supervisors may wish to regularly engage in a discussion of trainees' feelings toward our supervision provision. Are they feeling that their needs are met? Are we doing our best to approximate what they would receive if supervision was in person? Finally, we are limited in our understanding of how telesupervision may promote competence development and if telesupervision affects how we might evaluate competencies.

In spite of these ongoing considerations, and the need for more research on telesupervision, past research has been promising; time will tell if our transition to telesupervision results in an increase in use post-COVID-19.

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CLASSIFIED

JEROME H. RESNICK Ph.D.

(MARCH 13, 1936 – JANUARY 14, 2020)

Dr. Jerry Resnick devoted his career to the academic and clinical practice of psychology. He was born in New York City on March 13, 1936 and died in Elkins Park, Pennsylvania on January 14, 2020. Jerry attended the City College of New York for his undergraduate studies. He earned a master's degree at the University of Missouri and was awarded a doctorate in Clinical Psychology from Syracuse University. He is survived by his wife, Debra (also a psychologist), his three sons Daniel, Justin, and Jonathan and five grandchildren.

Jerry's service to the profession has been distinguished in its consistency and breath and will continue to have an enduring impact. Jerry was the Director of the Psychological services Clinic at Temple University, where he had earlier served as Director of Graduate Studies in Psychology of the Graduate Board in Psychology. For approximately two decades he was responsible for the training in assessment and diagnostics of the graduate program. He retired from Temple University as Professor Emeritus in 2001.

Within the American Psychological Association (APA), Jerry served on the Clinical Division's Board of Directors for 16 years and was President of Division 12 in 1991. He was Editor of The Clinical Psychologist for 6 years and served on APA's Council of Representatives for four terms. He chaired APA's Committee on Structure and Function of Council, served on the Finance Committee and was on APA's Board of Professional Affairs. Jerry was awarded fellow status in four APA divisions.

Jerry received APA's The Florence Halpern Award, which is presenting for Distinguished Professional Contributions to Clinical Psychology on August 21, 1999. His citation recognizes his outstanding professional contributions to clinical psychology, not only as Editor of *The Clinical Psychologist*, but also as Consulting Editor for *Clinical Psychology: Science and Practice* and the *Journal of Consulting and Clinical Psychology.* His citation also notes his service on the Division Board of Directors for 20 years, the Clinical Psychology Centennial Task Force and chairmanship of the Division 12 Task Force on the Definition and Description of Clinical Psychology, which had primary responsibility for redefining the goals of the Division and stimulated its evolution into the Society of Clinical Psychology.

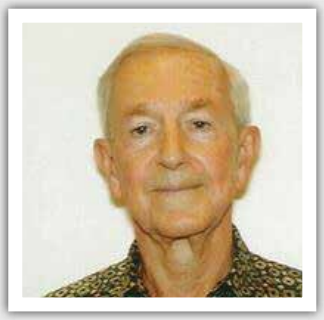
With respect to his contributions to the Pennsylvania Psychological Association (PPA) Jerry served as President from 1973 – 1974. He played a critical role in shaping the governance structure of PPA. He chaired the 1976 -77 Bylaws Revision Committee, which gave PPA its streamlined 3-tiered governance structure. He was Secretary of PPA from 1982 – 86 and Communications Board Chair in 1988 – 89.

Jerry was described, when awarded PPA's Distinguished Service Award: "Jerry's manner of methodical reflection has become part of all of us who have worked with him; a frequent refrain is, 'What would Jerry Resnick say?' Even in his absence, he helps us make hard, rational decisions, and then to smile together."

Respectfully submitted,
Dr. Debra B. Resnick (10/18/20)

DR. RODNEY E. McLAUGHLIN

(APRIL 4, 1933 – NOVEMBER 7, 2020)



Dr. Rodney E. McLaughlin, 87, of Palmyra and formerly of Hershey and Hummelstown, passed away on November 7th at his home in Londonderry Village surrounded by his family. Rod was born on April 4, 1933 in Chambersburg PA, the son of the late Leonard and Helen McLaughlin. He was a loving and devoted husband and is survived by his wife of 64 years, Maria Teresa "Tere" and his sister, Betty Newman. He was the loving father of two sons: Michael and Steve (wife Donna).

After growing up in Fort Loudon PA, Rod attended the Pennsylvania State University earning a B.S., and in 1959 earned his M.S. in Psychology. After further graduate studies at PSU he started his professional career returning to Penn State to complete a Ed.D in School Psychology in 1976. Rod was a true Penn State fan!

In 1961, Rod began a long and rewarding career at the Milton Hershey School for 31 years. He began as Director of Student Personnel Services and retired with the title of Medical Director. Rod was grateful for the opportunity to work with the entire MHS family in a cooperative effort to fulfill Mr. and Mrs. Hershey's dream, and especially to form friendships with and play a role in the growth and development of the MHS students with whom he interacted.

Rod was an active supporter of the Pennsylvania Psychological Association where he chaired numerous committees, served a term as President, and received the Distinguished Service Award. The PA School Counselors' Association recognized him for outstanding service, and the Pennsylvania Dental Association for Outstanding Service to Children. As a Fellow in the Association of State and Provincial Psychology Boards he received an award for Distinguished Service. He was also appointed by three Pennsylvania Governors to serve on the Pennsylvania Board of Psychology where he was a Vice-Chair. The most meaningful recognition Rod ever received was being elected an Honorary Alumnus of the Milton Hershey School.

After retiring in 1992, Rod and Tere lived in Hummelstown before moving to Palmyra in 2016. He thoroughly enjoyed everything tennis, and traveling with his family.

Rod will be deeply missed by his family, friends, and all those who he positively influenced throughout his life. He will forever be remembered for being willing to help anyone in need, and for showing the love that he had for everyone.

RACISM OR ANTIRACISM?

JEANNE M. SLATTERY, PhD, LINDA K. KNAUSS, PhD, ABPP, and DEB KOSSMANN, PsyD

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the three of us, respondents to this vignette included Drs. Gina Brelsford, Claudia Haferkamp, Deb Kossmann, Jade Logan, Don McAleer, Chris Molnar, Brett Schur, Max Shmidheiser, David Zehrung, and Ed Zuckerman. Rather than immediately reading our responses, consider reviewing and carefully working through the vignette first.

Dr. Eval has been doing BHRS evaluations for a local agency for a long time. As she was looking over her records, she noticed that boys are disproportionately represented in new referrals, as are African Americans and Latinos. Further, her referral agencies request more hours on average for children from non-majority racial and ethnic groups. Her agency is in a rural and largely White part of the state, as are the schools that are the primary source of her referrals. What should she do?

What is the Problem?

The five of us agreed that Dr. Eval may be observing systemic racism, that is racism embedded in society's normal functioning and which affects policing, housing, educational decisions, employment, and more. We also wondered about the role of classism, as referrals were disproportionately from subsidized housing and trailer parks in the county in question. A large proportion of the African Americans and Latinx parents that she saw in the course of her evaluations were university college students and, thus, poor, stressed, and overextended.

The Behavioral Health Rehabilitation Services (BHRS) system tends to identify and address individual problems at the expense of more systemic issues. Even in-home family-based therapy focuses on the child and family unit rather than community or systemic issues. Should we silo individual, family, community, and cultural issues rather than considering them as an integrated whole? For example, Dr. Kossmann raised sleep disturbances, a frequent concern of parents, and wondered whether those disturbances might be better attributed to crowded living situations, noise pollution, family stressors, or family and community violence. Attributing the problem to the individual child rather than to the family living environment or larger cultural issues has very different implications for the child and treatment.

"Dr. Eval may be observing systemic racism, that is racism embedded in society's normal functioning and which affects policing, housing, educational decisions, employment, and more."

This focus on individual pathology seems rooted in the medical model. Rather than working with the family as a whole, both families and insurance companies seem more comfortable with a child focus and prescription of medications or therapy than changes in the family, community, or culture. But such a focus seems to underappreciate the impact of the macro-environment on individual development. Adverse childhood experiences (ACE) can impair the immune system, at least in the short-term and perhaps for life (Waite & Ryan, 2020). We believed that overlooking the role of ACE and systemic factors and only treating the symptoms resulting from a compromised immune system seemed shortsighted. As Dr. Knapp observed, "antibiotics can fix the illness, but not the leaking roof that led to the infection in the first place. Physicians can treat an illness caused by malnutrition, but no medicine can cure malnutrition itself."

This is not to suggest that no mental health services are needed. However, in attempting to understand a child's behavior, we may miss the impact of environmental stressors; further mental health services, in and of themselves, may be inadequate. Being therapeutic isn't just sitting in a room and asking clients what they are anxious about – or as Dr. Knapp quipped, "How does it feel to be hungry, Johnny?" Dr. Knauss

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

argued it can be just as therapeutic to help someone obtain access to warm clothing, shelter, and food. In terms of positive mental health outcomes, it may be more therapeutic to help clients access their basic needs, as we both remove causative factors of anxiety, for example, and reframe the problem as a systemic issue rather than an individual one, thus removing blame.

Aspirational Principles

Although Dr. Eval does not describe anything that explicitly violates the ethical standards, the aspirational principles seem very relevant here. Dr. Eval was concerned both about promoting good and preventing harm by not labeling a child when the problems appeared to be more a reaction to the immediate environment as opposed to a "mental illness" (Beneficence and Nonmaleficence). Further, she raised a question that many psychologists ask, to what degree should psychologists advocate for changes to the broader system (Justice)? Nadal (2017) argued that we should be required to intervene.

Racist or Antiracist?

At least two kinds of questions are raised here. To what degree could Dr. Eval be engaging in unjust or racist practices by failing to address the systemic or environmental issues that are responsible for many of the problematic behaviors? Although the referral sources may not be acting out of malice or ill will, is Dr. Eval ethically obligated to raise the extent to which they may be supporting racist practices by ignoring or minimizing environmental stressors when referrals are made?

In this "colorblind" era, racist policies and consequences may be so embedded in the fabric of the profession and culture, that individual psychologists may not recognize engaging in behaviors —even well intended behaviors-- with racist consequences. Alexander (2010), for example, described a range of decisions in policing, courts, and the criminal justice system that masked racial bias, even though they disproportionately impacted minority communities. Such systemic bias has also been identified in schools and employment situations. For example, prospective teachers more frequently perceived black children as angry relative to whites (Halberstadt et al., 2020). People endorsing elitist attitudes showed a preference for white candidates in mock employment settings, whereas those who endorsed egalitarianism evaluated black candidates more positively (Reynolds et al., 2020). Recognizing these sorts of biases, Dr. Eval might review her materials outlining how referrals for BHRS evaluations should be made – particularly with thoughtful colleagues, from whom she would be willing to accept feedback – and consider whether she was making racially- or class-biased diagnoses and recommendations.

Kendi (2020) argued that it is not enough to not be racist, but that we should strive instead to be *antiracist,* to counter racist beliefs, attitudes, policies, and behaviors so power is shared equitably across groups. Dr. Eval, however, might consider to what degree she is responsible for responding to the racism built into the referral process. She might fear that if she raised these concerns during or after a meeting with her referral sources, that she might lose future referrals, which she might ill afford; however, there are other things that she could do instead. She could talk to her students, supervisees, and colleagues about systemic bias. She could offer local trainings on implicit bias. She could gather allies to collaborate on this work and to support her in this process.

As she does so, she might ask herself what is appropriate and effective for this group with whom I'm working? For example, Dr. Slattery disclosed that 25 years ago she made a presentation on bullying to a local school where she talked about systemic issues that might play a factor in this behavior. Some teachers responded well, but others did not. What is realistic for us to do? How can we be effective? To what extent do misguided politeness and colorblind protocols prevent someone from taking action – or allow inaction? Dr. Kossmann observed that inaction or avoidance is a privilege that many People of Color do not have.

Dr. Kossmann reminded us of a recent article that puts these ideas in context and that challenges the dichotomous thinking that we might be tempted to engage in – doing nothing or needing to fix all problems. Wilkerson (2020) described America as an old house battered by time with original flaws built into the system. We ignore systemic racism, like a faulty electrical system at our own peril, as neither will just go away. Both will fester instead. Although we did not cause the problems, we are heirs to whatever is right or wrong with the system and must deal with these problems now.

Those of us who have lived in an old house know that these problems will not fix themselves. In fact, in both the old house and our culture:

> The awkward becomes acceptable, and the unacceptable becomes merely inconvenient. Live with it long enough, and the unthinkable becomes normal. Exposed over the generations, we learn to believe that the incomprehensible is the way that life is supposed to be. (Wilkerson, 2020, para. 9)

We do not need to do everything all at once, but we need to speak, challenge, and change ourselves and the system. Like with an old house, we may not be able to solve all problems right now, but we can commit to recognizing and addressing our roles in systemic racism.

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CE QUESTIONS FOR THIS ISSUE

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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. During this renewal period only, the limit on the number of home study and distance learning continuing education hours has been lifted. For this renewal period, psychologists can receive all of the continuing education through home studies or distant learning programs. 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.

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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.

Jaffe

1. **The definition of "rankism" is**
   a. Utilizing sarcasm to demean others
   b. Abuse of the power attached to rank
   c. The tendency to value one's own cause, such as confronting racism, over another (e.g., ending homophobia)

2. **In psychotherapeutic practice, dignity involves**
   a. Helping clients recognize when their dignity has been diminished and helping them respond effectively
   b. The comportment of the therapist in a professional manner
   c. Setting appropriate boundaries with clients when they wish to treat you as a friend

Mondair

3. **50% of African Americans are able to work from home during COVID-19.**
   TRUE
   FALSE

4. **Decreased productivity and work performance are correlated with the experience of microaggressions at work.**
   TRUE
   FALSE

Starkey

5. **What is the overall per capita rate of incarceration of Blacks vs. Whites in the U.S.?**
   a. 2 to 1
   b. 4 to 1
   c. 10 to 1
   d. None of the above

6. **The 1994 California law that mandated "three strikes and you're out"**
   a. Made incarceration mandatory for a single crime involving three different offenses
   b. Made a life sentence mandatory for any violent crime
   c. Doubled the number of individuals incarcerated over a ten-year period
   d. Mandated three crimes involving drug use carry a life sentence

Nwordu, Mirmanas, & Alaribe

7. **Black Americans have a three times higher COVID-19 case rate than White Americans.**
   TRUE
   FALSE

8. **During COVID-19, clinicians who work with ethnic and racial minorities need to be competent in**
   a. Providing culturally sensitive treatment around grief and loss
   b. Providing a warm environment
   c. Setting specific goals for treatment
   d. Using a CBT approach

Zacharcenko

9. **Computer anxiety has been found to be the most consistent predictor carrying a negative impact on attitude and intention to use technology.**
   TRUE
   FALSE

Royer

10. **When choosing whether to evaluate a client through telehealth or in person, the psychologist must only proceed if her/his test battery is identical to the battery typically used in the office.**
    TRUE
    FALSE

Hollin-Sims & Kaiser

11. Which of the following is not a PDE Pillar of Practice?

a. Data practices
b. Discipline
c. Family/Community Engagement
d. Self-Awareness

Phillips

12. What is APA's Commission on Accreditation's (CoA) stance on programs and training sites providing telesupervision?

a. Telesupervision is never appropriate
b. In-person supervision is typically required for at least 50% of supervision, though this has been relaxed due to COVID-19
c. In-person supervision is typically required for at least 75% of supervision, though this has been relaxed due to COVID-19
d. APA's Commission on Accreditation (CoA) does not have a stance on telesupervision

Slattery, Knauss, & Kossmann

13. Systematic racism

a. Is easily identified in oneself
b. Is easily identified in the culture
c. May be manifest in people or settings that don't see themselves as "racist"
d. None of the above

14. If racism is prejudice, discrimination, or antagonism directed against a person or people based on their race, what is antiracism?

a. Holding and acting on racist attitudes
b. Not being racist
c. Challenging and changing racist attitudes, structures, and processes
d. All of the above

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, December 2020

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

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