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COVID-19

SPECIAL ISSUE

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SPECIAL ISSUE: COVID-19

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INTRODUCTION

to Special Issue on COVID-19

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*

During the last two months our lives have changed dramatically, and we do not know how long these changes will remain or what the future will look like. We live in an age of great fear and uncertainty.

In 2018 Bill Gates reflected the consensus of the public health community that “there will be another global pandemic. We can’t predict when... [but] there is a significant probability that a large and lethal modern-day pandemic will occur in our lifetime” (p. 2057). Such predictions were not welcomed by everyone. The World Health Organization’s warning of an international pandemic on January 30, 2020 was barely covered in the news. After all, had we not survived outbreaks of SARS, MERS, swine flu, and other viral threats with minimal harm? Now the pandemic has hit us, and we are dealing with its consequences.

The articles in this issue reflect on what the pandemic means to us as psychologists and citizens. Drs. Jeanne Slattery and Deborah Derrickson—Kossmann consider the changes that moving to telehealth in the age of COVID-19 has made to their practices as psychologists. Dr. Aviva Gaskill, interviewed by Dr. Brett Schur, describes her experience in disclosing her coronavirus status to her patients. This article was published in the April *Pennsylvania Psychologist* but is included here because of its special relevance to the theme of this issue. Drs. Randy Fingerhut and Samuel Knapp present a format to think through ethical dilemmas that may arise out of the COVID-19 pandemic. Drs. Terri Erbacher and Samuel Knapp consider the impact that COVID-19 pandemic may have on suicide rates in the United States and steps that psychologists can take to prepare for an increase in suicidal behavior among their patients. Other articles deal with considerations before resuming face to face professional services, emerging mental health needs in the COVID-19 era, the prejudice pandemic (or rise in Anti-Asian racism) in the United States, and the final article reflects on the influenza pandemic of 1918 and considers what lessons might be learned from that international tragedy.


The goal of these articles is to provide information and

perspectives that will ease the burden on psychologists dealing with the COVID-19 pandemic.

We appear to be assaulted on all fronts (professional, personal, national) at the same time. Can there be hope in a time of crisis? The tasks before us are enormous. At a time when our patients are undergoing extraordinary personal and economic stress, we are being called upon to model resilience, a commitment to our values, and compassion for those in suffering while, at the same time, dealing with the threats to ourselves, our families, and our livelihood.

No one knows these struggles more than Dr. Joshua Gordon, Director of the National Institutes of Mental Health. After discussing the many challenges faced by mental health professionals at this time, he said,

For many of us this is an opportunity to learn more about ourselves and how we can grow as people, as human beings, and as fathers and mothers and daughters and sons. This is an opportunity to prove that we can respond to an emergency like this in a way that is thoughtful, in a way that is caring, and in a way that contributes to improving the situation for all of us (cited in Collins, 2020)

Readers can earn three (3) continuing education credits for reading these articles and responding to the test questions at the end of this issue of the *Pennsylvania Psychologist*. 

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HARD TIMES are Here and MORE HARD TIMES are Coming:

Emerging Health and Mental Needs in the Aftermath of the COVID-19 Pandemic

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*

The COVID-19 pandemic is surrounded by uncertainty. Among other things, it is not known how long the pandemic will last, how many people will be infected, or how many infected persons will die. We also do not know what life will be like after the pandemic subsides. We will never completely return to normal, but we will have to deal with the grief, trauma, isolation, and physical harm done by the pandemic. Hard times are here, and more hard times are coming.

Despite these uncertainties, some health care and mental health trends can be expected from this pandemic. The predictions are informed by recent data on COVID-19 and data from other recent viral infections: the Severe Acute Respiratory Syndrome (SARS) which originated in China and spread to North America in 2003; the human swine flu (H1N1) which erupted in Hong Kong in the summer of 2009; the Middle East respiratory syndrome (MERS) which was first reported in Saudi Arabia in 2012; and the avian flu (H7N9) which emerged in the People's Republic of China in 2013.

What Health Care Sequelae Will Come from the Pandemic?

What will be the impact on the public in general, on those whose family members or friends were infected or died, on front line workers who were regularly exposed to the risk of a COVID-19 infection, and those who survived a COVID-19 infection themselves?

Mental Health Needs of the Public

We should not assume that the health care crisis will end when the rate of COVID-19 infection falls to near zero. Zhou (2020) found that the population in Sichuan province in China was severely harmed emotionally by the coronavirus epidemic. "A large number of people had emotional breakdowns, and they felt helpless, fearful,

anxious, depressed, guilty, and nervous" (p. 1). Certainly, this is understandable from a psychological perspective. Within China the psychological harm was greatest in those areas most impacted by the infection and among those who had to quit work, could not exercise, or who had chronic health care conditions (Zhang et al., 2020).

Mental health professionals in the United States are already dealing with the anxiety and terror created by the pandemic and the isolation and economic disruption caused by the shelter-in-place orders. In a recent Gallup Poll, respondents rated the quality of their lives as the lowest it has been since 2009 (Witters & Harter, 2020). Physical distancing may interrupt normal social patterns leading to loneliness and fear, especially among older adults or those vulnerable for other reasons (Yip & Chau, 2020). Whatever mental health problems the patients may have had to begin with may be exacerbated by the background of anxiety and fear that pervades society.

It is likely that suicide rates will increase even more this year or the next. Declines in physical health or increases in loneliness may push some persons to consider suicide. Also, national rates of suicide tend to increase during periods of economic recession and decline during periods of economic growth (Mann & Metts, 2017). Unemployment numbers have already started to rise, and no one knows where it will end. One in six persons who died from suicide in the United States

had recent financial problems or a job loss shortly before their deaths (Stone et al., 2018). There are also fears that domestic abuse or child abuse may increase.

Many patients will also be dealing with grief over the deaths of family members, friends, or colleagues. Some social groups that have frequent contact with each other, such as families, nursing homes, prisons or jails, or meat packing plants or other workplaces, may become hot spots of infections. Those in these social groups may feel a “tsunami of grief” (Clopton, 2020) as they see or have seen many people in their social network die or get sick. African-Americans have been disproportionately harmed by this pandemic in part because, as a group, they have poorer health and more pre-existing conditions, have less access to health care, and live in urban areas or hold front line jobs which involve more exposure to the virus (Yancy, 2020).

Mental Health Needs of Front-Line Workers

Those who work on the front lines, such as medical personnel, janitors, health care aides, and those working in essential businesses, such as grocery stores or food delivery, will likely have higher mental health needs. Even before the COVID-19 pandemic, emergency room physicians had high rates of PTSD (DeLucia et al., 2019). Now they have the additional stress of worrying if they would get infected (and many did) or that they would infect their family members as well.

Emergency room and other physicians and nurses may experience *moral injury*, or the distress that occurs when one must make a morally difficult and, in hindsight, a poor decision that violates one’s personal norms of morality. These errors may occur when health care professionals must decide which patients get priority care, quickly with little time for reflection, and a high risk of making a poor decision.

Health professionals have a weak armamentarium to deal with COVID-19. Ideally health care professionals will learn and then treat. Now they must learn as



they treat (or treat as they learn). The evidence on how to treat COVID 19 or its complications was uncertain when the pandemic started and evidence supporting (or refuting) interventions has begun to emerge gradually through anecdotes and articles that have been published after the pandemic was underway. By necessity, many of the articles in scientific journals rely on observations made without the benefit of a high-quality controlled research design. The quality of the research they are reading, as a consequence, is less reliable than what is normally published.

The demands upon the health care system have been intense. After the acute stage of infections subside, it will take several months for the existing health care workforce to recover. Although the workload will unlikely match that found in the height of the pandemic, it will unlikely return to normal as unmet medical demands, such as non-urgent surgeries that were delayed during the pandemic, need to be addressed. Also, many experts expect a second or third wave of infections after the first wave of this pandemic ends. The burden on our health care system may be especially severe if a second wave occurs at the same time as the seasonal flu.

Mental Health Needs of Survivors of COVID-19

Survivors of SARS had an increased rate of post-traumatic stress disorder (Hong et al., 2009). Factors linked to PTSD appear to be present within the experiences of many COVID-19 patients. COVID-19 patients may have serious health consequences from the infection, require hospitalization, have near death experiences and, as a result, feel anxiety, stress, and trauma even after they recover. Most COVID 19 patients have been unable to have loved ones with them in the emergency departments, ICUs, or hospitals. Reports from survivors indicate that many experienced prolonged recoveries and subclinical symptoms for weeks after “recovering” (Lowenstein, 2020). The presentation of COVID-19 accompanied by unpredictable, co-occurring shelter-in-place orders, potential for economic disruption, and disruption of one’s social field presents a context for trauma that has not presented itself for scientific study before (Horesh & Brown, 2020). The treatment of COVID-19 trauma may require innovations to ensure its effectiveness.

In addition, COVID-19 may cause longer term health problems when the acute stage

of the infection ends. There is some speculation that the influenza or similar infections have a biological pathway to psychological problems. Following the 1918 flu epidemic, some physicians identified post-viral melancholia (Spinney, 2017) or cognitive loss following the infection. Given the lack of standardized diagnostics at the time, these reports can only be considered suggestive and not definitive. Okusaga et al. (2011) found a significant link between influenza infections, mood disorders, and suicides. Of course, no causal links could be made from the correlational data.

Although COVID-19 is not the same as the influenza that caused the 1918 pandemic, the common flu, or MERS, experience should alert us to the possible neurological sequelae of infections. MERS and SARS have physical structures highly similar to COVID-19 (Petrosillo et al., 2020) and it raises the possibility that the influenza virus or perhaps the body's immune system response to it could lead to neurological damage. Arabi et al. (2015) found neurological symptoms arising in many patients following their infection with MERS. McNamara (2020) found anecdotal reports of headaches, myalgia, muscle weakness, confusion, and disorientation co-occurring with or following COVID-19 infections. Asadi-Pooya and Simani (2020) concluded that it is highly likely that some COVID-19 patients will have neurological manifestations of their infections.


What Resources Will Likely Be Available to Address Demand?

The ability of the mental health care system to address the growing mental health needs depends largely on the health of the American economy. It is too soon to predict the damage to the American economy until the pandemic has run its course. The extent of the increase in mental health needs depends on the degree to which COVID-19 permeates the population, how long it lasts, and how soon effective treatments and vaccines can be developed. The increased health care costs associated with the pandemic will likely translate into higher premiums, copays, and deductibles for beneficiaries. Because the stimulus package will increase the federal deficit so highly, we can assume that there will be pressures to reduce expenditures in Medicare, Medicaid, and other federal health care programs.

Summary

Based on preliminary reports of the COVID-19 infection and past viral epidemics, we can expect hard times ahead. There will be a large increase in mental health needs and less resources available to meet them. We may predict that

- Given the anxiety and fear generated by the pandemic and shelter-in-place orders, mental health professionals can expect an upturn in the demand for their services among the population.
- Suicides, domestic violence and child abuse may increase.

- The mental health needs of health care professionals and other front-line workers may be especially high.
- Many survivors of COVID-19 will have PTSD or subclinical PTSD symptoms, and it is possible that some may have post-viral neurological complications.
- Health care costs will increase substantially next year and the burden will be passed on to consumers and there will be pressures to cut funding to Medicare and Medicaid. 

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REFLECTIONS

on **ANXIETY** and **CHANGE**

during a Pandemic

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There is no single response to trauma, but perhaps one useful way of understanding our own and our clients' reactions is Rollo May's (1950/2015) description of normal, neurotic, and existential anxiety. Normal anxiety is transient, proportional to the situation, and helps us anticipate and resolve problems. COVID-19 swept in like a tsunami and changed life as we have known it, for both therapists and clients. One minute we were living life without awareness, and in the next we are running to a safe place as the water comes pouring in, pushing everything around us out of its path. What is normal anxiety under such conditions?

One of us (JMS) is teaching. Her students asked to meet regularly by Zoom because they wanted the structure and routine. She feels that meeting by Zoom has helped her students and herself stay on track, as it reminds all of them that there are people who care. She is asking her students how they are doing at the beginning of each class with a thumbs up/down/neutral sign. In general, they are reporting doing well. Would the ones who are attending an optional class meeting have reported doing well before? It is hard to tell. They are also reporting frustrations such as classes where there is poor communication, lost jobs, financial stressors, conflicts with siblings or children, and worries about the health of their family members.

In our private practices, we've been seeing clients at their usual times to keep things as "normal as possible." Still, therapy is *not* just the same old, same old. We

are struggling with technology glitches, getting new consents, and resolving billing issues. We are having to identify ways to get our socially anxious clients out of the house in safe ways and create healthy social interactions. One client with obsessive-compulsive disorder said, "I spent all of my therapy trying to learn how NOT to wash my hands all the time." Couples are finding it difficult to do treatment through telehealth with children present all the time at home. Some clients worry about what happens after life returns to "normal" – they feel safe now, but what will life be like then? What about the clients who want the immediacy of face-to-face therapy and have opted out of continuing psychotherapy for now – and the result of that interrupted relationship for both client and therapist?

We are monitoring our clients for neurotic anxiety, anxiety that is paralyzing them and preventing them from responding to stressors in adaptive ways. Is my socially-anxious client now becoming agoraphobic? Is my client struggling again with



handwashing? How paranoid is my client now? How healthy are their relationships and parenting? Where are their levels of anxiety and depression? How will the loss of a job or other financial pressures that are out of everyone's control affect their ability to engage in needed treatment? Will our clients have the resources and motivation to use online substance abuse groups to maintain sobriety?

Without the usual distractions of a typical week, some clients are now saying, "I don't have a lot to talk about, I'm not doing anything." That unexpected quiet may bring up familiar but ignored feelings: loneliness, isolation, and earlier trauma triggers. Everyone may have trouble focusing and have "the attention span of a toddler," as well as better or worse coping mechanisms – too much food, an extra cocktail, and binge TV. It may raise anxiety about being alone and what that means in the face of something life-threatening. An elderly relative's friend broke her leg in early March while visiting New York City – which meant that she was placed in a nursing home in a strange and disrupted city without family or friends. Many clients are experiencing death anxiety and examining their relationships and histories in light of what they would regret if they remained with the status quo and what they might do differently. One woman wondered, "If my aging mother dies now while I have a rupture with her, am I a horrible person?" Others believe they should be "productive" when they are home; maybe compassion and self-care is what is needed instead. Denial is another


coping strategy. During the first week of quarantine, one client said that this was similar to summertime when he doesn't work at school, so it didn't seem so bad. Two weeks later, he sent an email asking for an emergency session after a friend's parent died from the virus. "I'm terrified of not being able to breathe, what if I get sick and can't?" he wrote. Everyone's coping mechanisms are thinly stretched.

Changes brought about by social distancing can stress our interpersonal relationships and our psychological and physical health (Cohen et al., 2015). Some of our clients – and us – have increased our social media diet during this period and reduced the amount that we are talking to friends and other supports in situations where we can actually see them, with the associated problems (Padilla-Walker et al., 2019).

We therapists are also experiencing these problems. Our supervisors, colleagues, clients, and students are asking us what we will do if we get ill. We are considering our wills for our practice and wondering whether we should tell clients about our own health status. Some of our practices focus on testing and other kinds of services, are unable to work right now, and struggle with fears about financial survival. This is a new normal. As we adjust to these changes, as we come face to face with our own mortality, how will this impact our work with our clients and supervisees?

Many clients with trauma histories or medical trauma have told us that now other people will better understand

what it means to be hit with something threatening and unpredictable and learn to cope with it. This kind of resilience is an outcome to try and work towards, for both ourselves and for our clients (Park et al., 2017). We need to talk about the grief without judging it, both the big losses and the smaller ones that everyone is experiencing right now: increased feelings of isolation, losses of social support, income, meaningful work and connections, and a sense of control. Seeing our support system in whatever ways possible (e.g., Facetime and Zoom) is especially important right now.

Our own feelings of powerlessness during COVID-19 will likely affect our clinical work over at least the coming months. Can we sit with the uncertainty that our clients are also feeling? Can we remain creative and thoughtful in our work during this period? Can we survive this and use our resilience to continue to help others effectively? 

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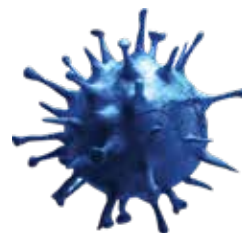


SHOULD I DISCLOSE MY COVID-19 STATUS?

The Experience of One Psychologist

AVIVA GASKILL, PH.D.

BRETT SCHUR, PH.D.



This article was published in the April *Pennsylvania Psychologist* but is included here because of its special relevance to the theme of this issue.

Aviva Gaskill, Ph.D. is a psychologist in private practice in Wynnewood, PA. She is a member of PPA and is active on the PPA Membership Committee. She has also presented at past PPA Conventions. Dr. Gaskill is interviewed by Brett Schur, Ph.D.

Dr. Gaskill attended the American Group Psychotherapy Association Meeting in New York City March 2-7, 2020, just as the COVID-19 outbreak was hitting the city. She became symptomatic after returning from New York. In this article, Dr. Gaskill talks about the decisions she made around issues of patient care and disclosure as she became aware that she had become infected.

Brett: Thank you for talking with us today about your experiences around COVID-19, patient care, and disclosure. You told me that you first noticed cold-like symptoms while you were still in New York. What were your symptoms at that time?

Aviva: On March 7th, I began to feel a bit run down. I had also attended a very busy conference beginning on March 2nd along with seeing friends and family in New York City that week.

Brett: After you returned from New York, you had some patient appointments scheduled. What did that first few days look like for you?

Aviva: I spent Sunday, March 8th with my family and on Mondays, I typically work from home managing paperwork for my business and issues in my household. Seeing that I began

to have some cold symptoms that day, I contacted my patients that I was scheduled to see the next day (Tuesday) and asked if anyone would prefer to be seen via telehealth as APA was beginning to encourage us to hold online sessions. I also offered in-office sessions to those patients who preferred it. I already used telehealth regularly within my practice for a couple of patients prior to the COVID outbreak. One patient requested the telehealth session on that last day I spent in my office, a few patients cancelled their appointments with me, and three patients requested to be seen face-to-face in my office. I honored these requests. On Tuesday, I began coughing a bit while I was in my office. I called the doctor on Wednesday and asked whether I should be seen. I was told to go to the emergency room only if I had a fever, which I never developed and otherwise to continue to monitor my symptoms, which I did.

Brett: When did you stop seeing patients?

Aviva: The very next day (Wednesday), after a conversation with my spouse, I realized it would be best for me to cancel in-person sessions with clients to rest and recuperate, but continued to assume my symptoms did not indicate COVID-19. I have asthma and allergies so it's not unusual for me to catch colds at this time of year. I saw no patients that Wednesday and saw a few patients online on Thursday while continuing to rest for much of the day. I did not return to the office to see patients in-person.

Brett: What did you tell your patients at that time?

Aviva: I told my patients I believed that I had a cold in combination with my allergies.

Brett: Did you know that you had COVID-19 yet?

Aviva: I was not diagnosed with COVID-19 until Wednesday, March 25, almost 20 days after the onset of my initial symptoms.

Brett: Are you open to telling us about the course of your illness?

Aviva: Sure. I began feeling “run down” on March 7th, noticed myself coughing a bit on March 10th as I was in my office seeing patients. When I got home from work that night, I noticed that my eyes were pretty red. Over the course of the next couple of days, my throat became very sore, I got very thirsty, drinking tons of water and I wondered if I had strep throat. I had chills on and off for a few days but never developed a fever. I began to feel more energetic for about three days about a week after the onset of my symptoms. But then suddenly, began to feel chills again one night and extremely exhausted for the next 4-5 days. I was sleeping 14-15 hours per night and during the day, found myself barely able to get off the couch. The fatigue, though less than initially, lasted days and days. I also completely lost my sense of smell and taste for about a week during the time of the most severe fatigue. Only on about the last day of my having lost my sense of smell/taste did it become widely disseminated information here in the U.S. that loss of taste/sense of smell was a common COVID-19 symptom. As an asthmatic, I was continuing to cough productively and found it difficult to take deep breaths. I have inhalers and allergy medication, including a nebulizer, at home and used those. I woke up in the night coughing and spoke with my doctor who believed that I developed bronchitis secondary to the COVID-19. I have since been prescribed a course of antibiotics. I also developed laryngitis and was barely able to speak for a few days.

Brett: Were there patients in your practice who were potentially exposed to COVID-19 in your office?

Aviva: Yes. The three patients I saw in my office prior to self-quarantining were likely exposed to my illness, though I was unaware of this at the time as there was less information available regarding COVID-19 symptoms. With that said, I have moved through and with a lot of feelings of shame and guilt about these possible exposures.

Brett: You told me that you had a prior experience of disclosing personal news to patients. Can you tell us about that experience?

Aviva: Sure. I have given birth to two children during my time working as a psychologist. I have had the experience of disclosing both pregnancies to patients. In some ways that has been helpful, yet it's also felt very different. I've noticed some similar and some quite distinct feelings emerging from disclosing my COVID-19 diagnosis to my clients.

Brett: How did that prior experience influence the choices you made about disclosing your COVID-19 status?

Aviva: With my pregnancies, I remember taking time to consider my own feelings and even some real discomfort. In disclosing my COVID-19 diagnosis to patients, I did not have as much time to consider how I would disclose due to the nature of the illness and its ability to spread widely and rapidly. I needed to act quickly but I still had a few opportunities to reflect on this disclosure. I am ever grateful to my colleagues with whom I have weekly peer consultation. They sat with me and helped me process and consider these discussions.

Brett: At what point did you tell patients who had potentially been exposed in your office about your diagnosis?

Aviva: It took a full week and a day to receive a confirmed diagnosis of COVID-19 from my healthcare network. I informed two patients during telehealth sessions that I was being tested and possibly had unknowingly exposed them. I did not inform the third patient whom I may have exposed until a few days after I received my confirmed COVID-19 diagnosis. At that point, having laryngitis, I was unable to speak over the phone and I do not have an email address for this patient as her preferred form of communication is phone. This is also information better shared in a conversation, I believe.

I also rent an office suite along with two colleagues over the age of 65 and felt it necessary to disclose my illness to them.

Brett: What did you tell them?

Aviva: First, I should mention that I am a health psychologist and a Medicare provider. I see many adults over the age of 65 and many individuals who are chronically ill. I had a strong sense of duty to disclose my illness status to them.

In one of my sessions, the fact that I had had a cough came up early in the session and I informed my patient that I had been tested for COVID-19. I informed another patient that I had been tested closer to the end of the session with enough time to discuss and process his concerns. I disclosed my diagnosis to the third patient over the phone after I had been diagnosed. I informed her after she asked how I was doing, as I hadn't seen/spoken to her for a couple of weeks due to a scheduled vacation she'd had. I think that was my most challenging discussion and to be frank, I was a bit anxious disclosing this news to her.

Brett: How did these patients react to your news?

Aviva: I have worked with each of these three patients for over a year, so these are long-term clinical relationships. The two patients to whom I disclosed before my diagnosis were both

very understanding. They reminded me that it wasn't my fault and were mostly just concerned for me. It was actually a nice moment to share with them.

When I disclosed my illness to the third patient over the phone, I could hear anxiety coming into her voice. She also asked for my advice on handling the situation. I informed her that she should contact her physician right away and inform them she'd had contact with someone who had tested positive. She also asked if I thought she should inform family members with whom she'd had contact with after her contact with me. I told her that that was her decision and it was probably a good idea, but to find out her physician's opinion before deciding. She expressed concerns about "getting blamed" or being viewed as "bad" for potentially exposing others. She seemed like she needed to get off the phone to process this information and I told her I would check in with her in the next few days. I spoke with her again the following day and while she was still processing, she seemed more at ease with the news, even joking a little and remarked that it felt good to laugh together. In that second phone call, she asked me a little about the course of my illness and we discussed some positive coping mechanisms she might employ. While frightening, again, it felt like an important shared moment in the therapeutic relationship. I'll most certainly continue to process this with her.

Brett: What did you feel before you made the disclosures?

Aviva: Antsy, scared, guilty, ashamed, uncomfortable, and a little like a kid who says, "I don't wanna do it." But I've also begun to feel brave and a bit like I can be strong, a container for my patients' anxiety, grief, and helplessness during the difficult time because I've come out on the other end.

Brett: What did you feel after you made the disclosures?

Aviva: Afterwards, I certainly felt somewhat relieved to have disclosed and helped them unpack their feelings. But I continue to have some sense of guilt and concern for my patients.

Brett: Did you disclose your COVID-19 status to any other patients?

Aviva: I actually did end up disclosing to three other telehealth patients. I told two patients because they asked me about coughing, and I don't like to lie to my patients. I informed an additional patient because it seemed clinically relevant given some of her concerns that she was expressing during the pandemic.

Brett: What did you tell them?

Aviva: I informed that I had tested positive and that I was doing significantly better.

Brett: How did they react?

Aviva: One of them seemed very unsurprised and showed minimal reaction. The other two seemed quite surprised and caring.

Brett: Have you returned to work? How have your patients reacted to your absence?

Aviva: I have been seeing patients online via telehealth exclusively and have not returned to my office. Patients reacted well to my absence, which was minimal in time. There was so much information and confusion between work, my children's school and from the local, state and federal governments within the second and third week of March that I think they didn't seem to notice my absence too much. Though I believe they've all been quite relieved to discuss the concerns that they've been coping with, whether they have been COVID related or not.

Brett: Is there anything you wish you had done differently?

Aviva: I wish I had not gone into the office to see those three patients, but I genuinely did not know I was positive with COVID at that time. That's my deepest regret.


Brett: What lessons would you offer to other clinicians from your experience?

Aviva: I would encourage other clinicians to be mindful in considering self-disclosure about relevant issues. Sometimes, it's not helpful and even harming to self-disclose about some issues. But sometimes self-disclosure can be a real gift in terms of the work we do and can allow for increased depth and connection in the therapeutic relationship.

Brett: Is there anything you would like to say about the experience of doing this interview?

Aviva: I'm grateful for the opportunity but am still somewhat conflicted about disclosing this information so publicly. All of my colleagues and I hope most people would be supportive of my disclosure, but I fear that some colleagues may misconstrue what I did. If I can help one person by disclosing, even in a tiny way, then it's worth it.

I also want to wish everyone health and safety during this time. This truly is an opportunity for us to step in and aid the public in various ways by using our expertise. I hope we can step forward together and take that role.

Brett: Thank you, Dr. Gaskill for your willingness to talk frankly about these experiences. In all likelihood, a number of your colleagues will have similar experiences. We hope that they can learn from your experience and incorporate these lessons into their own decision-making. 

Psychologists on the Frontline of COVID-19 SUICIDE RISK

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Suicide rates have been increasing each year since 2000, after long-term trends of decline. The Centers for Disease Control reported 48,344 suicides in 2018 with approximately 1.2 million attempts annually (Drapeau & McIntosh, 2020). Someone dies every 10 minutes by suicide, and this is before introducing additional risk factors created by the COVID-19 pandemic. The effects of COVID-19 on physical, financial, and emotional health are vast.

Effects of COVID-19

The latest Kaiser Family Foundation Health Tracking poll found that 72% of Americans say their lives have been disrupted “a lot” or “some” by the COVID-19 outbreak (Kirzinger et al., 2020). Just as no group is immune to suicide, none are immune to the disruption by coronavirus with at least seven in ten men (70%), women (74%), Black adults (70%), White adults (78%), parents (73%), and non-parents (72%) saying their lives have been disrupted.

Americans are worried about the long-term impact of COVID-19 on their financial security (59%), with fear of losing their job (52%) or losing income due to workplace closure or reduced hours (45%), with 39% having already lost their job or income. Many Americans fear a family member getting sick (53%) and 57% are worried they will put themselves at risk of exposure to COVID-19 because they can’t afford to stay home and miss work. Yet with schools closed, many parents are forced to stay home to care for and educate children.

Business owners must consider the risks to employee health to remain open yet the financial strain if they don’t. Small businesses fear they may never reopen.

Further, 45% of adults reported that stress due to COVID-19 is harming their mental health. This is up from 32% in early March, suggesting that as this pandemic continues, mental health may continue to deteriorate. About one in five (19%) say that it is has had a “major impact” on their mental health, including about one-fourth of women (24%), Hispanic adults (24%), and Black adults (24%).

Mental Health and Suicide Risk

Will the rates of suicide change as a result of the COVID-19 pandemic? On the one hand, there may be room for optimism. Reger et al. (2020) reported that suicide rates have actually declined in the period after past national disasters, such as the September 11, 2001 terrorist attacks. By undergoing a shared national experience, individuals may strengthen social connectedness as they support one another through it, with current technology advancements, such as video calls, facilitating connection. Finally, the COVID-19 pandemic may alter individual views on how valuable and precious life is, thereby making suicide less likely.

On the other hand, contrasting information suggests that suicide rates may increase as a result of the pandemic. According to the interpersonal theory of suicide, suicide occurs when there is both a desire to die (commonly represented by *thwarted belongingness* and

perceived burdensomeness) and access to the means to die. Thwarted belongingness refers to a sense that “I am alone” and perceived burdensomeness refers to a sense that “Others would be better off without me.” Physical illness, unemployment, family conflict, and mental distress are significant risk factors, along with homelessness and child abuse, which might be exacerbated during this national COVID-19 pandemic. Finally, these experts state “social isolation is arguably the strongest and most reliable predictor of suicidal ideation, attempts, and lethal suicidal behavior” (Van Orden, et al., 2010, p. 579).

Further, March was the second busiest month for gun sales ever (Collins & Yaffe-Bellany, 2020). This is especially concerning considering that more than 50% of suicide deaths are by firearms and research suggests that reducing access to lethal means, such as firearms, is needed to save the lives of those considering suicide (Drapeau & McIntosh, 2020).

Suicide rates increase *during* economic recessions marked by high unemployment rates and financial strain (Stone et al., 2017). Difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress, may increase an individual’s risk for suicide. Additionally, Oyesanya et al. (2015) found an overall increase in suicide rates *following* economic recessions, suggesting long-term concern with suicide risk for individuals.

Aside from economic impact and illness, the COVID-19 pandemic can bring anxiety, sadness, grief, fear of getting ill, potential loss of loved ones, and the inability to



visit friends and family who are sick. Every individual may face these stressors and challenges differently. For some, this is a time of growth, while others may experience new or exacerbated mental health symptoms. Due to stay-at-home orders and physical distancing, many cannot readily access their support systems and may begin to feel isolated or like a burden to others.

Periods of quarantine have both short and long-term effects on mental health (Brooks et al., 2020). Mental distress, including anger, emotional exhaustion or disturbance, depression, stress, detachment,

anxiety, insomnia, poor concentration and indecisiveness, post-traumatic stress, deteriorating work performance, and reluctance to work or considering resigning, have increased during periods of quarantine. Low mood and irritability were particularly prevalent. Having a history of psychiatric illness was associated with anxiety and anger 4–6 months after release from quarantine. Even three years later, hospital employees reported depressive and post-traumatic stress symptoms and healthcare workers reported alcohol abuse or dependency along with significant avoidance behaviors, such as minimizing

direct patient contact and absenteeism.

As noted by Dutheil et al. (2019), physicians are an at-risk profession for suicide, with female physicians being at particular risk. While physicians have a high prevalence of suicide, suicide attempts, and suicidal ideation, there is less research regarding other health-care workers, although suicide rates for nurses (both male and female) are higher than the population in general (Davidson et al., 2019). The risk to nurses may be higher because of the stress and psychological trauma that they experience (Alderson et al., 2015), with at least two Italian nurses having died by suicide after testing positive for COVID-19 and fearing that they may be spreading the virus to others (Reich, 2020).

Barriers to readily accessible mental health care due to social distancing and overcrowded emergency rooms may also increase suicide risk and minimize access

to services for suicide attempt survivors. It is likely that mental health resources will be overtaxed in the months to come.

What Can Psychologists Do?

Psychologists will be on the front line of addressing the increased risk for suicide. Psychologists will be better prepared to address the forthcoming mental health needs of their patients by ensuring that they have adequate training, developing helpful strategies for patients with suicidal thoughts, and practicing self-care.

Ensure Adequate Training

Many psychologists have already moved to virtual practice and are learning the ins and outs of teletherapy as trial by fire. Many trainings are available for free or at reduced rates. To build confidence and ensure ethical practice, psychologists without expertise in teletherapy might consider further training, such as those offered by the American Psychological Association or the Pennsylvania Psychological Association.

Trainings also exist on building effective therapeutic relationships virtually. Considerations include therapist pace, tone, and nonverbal behavior and how to demonstrate compassion, show empathy, and ensure genuineness over a computer screen. For tips on building rapport via telehealth, visit https://www.researchgate.net/publication/340066049_COVID-19_Tips_Building_Rapport_with_Youth_via_Telehealth. PPA is also offering webinars on relationship building and other issues related to telehealth.

Psychologists should know the warning signs of suicide. For a refresher, visit <https://afsp.org/risk-factors-and-warning-signs> or for youth suicide warning signs, visit <https://www.youthsuicidewarningsigns.org/>.

This might also be a good time for psychologists to update their suicide risk assessment training as there are many offered online. Visit SPRC (<https://www.sprc.org/training/virtualearninglabs>) or AAS (<https://suicidology.org/training-accreditation/>) for training opportunities or

check the PPA website for home studies and continuing education alerts for webinars on suicide prevention.

Strategies with Clients Expressing Suicidal Thoughts and Behavior

When taking a new client, psychologists should ensure they have their client's contact information and address, along with an emergency contact. The suicide risk assessment should include questions about the impact of this pandemic on their emotional state. Psychologists should ensure that they ask about suicide means, especially guns, and how these can be removed. Psychologists can ask the client who resides with them and who is in their support system. Clients should be screened and monitored for suicide risk at each session until the risk of suicide has passed (FREE forms for youth are available at erbacherconsulting.com).

Psychologists should ensure that they complete safety plans with clients. Psychologists can assist clients in determining how they can distract themselves or how to reach out to others by phone or virtually, and remind clients that this is a time of physical distancing, not social isolation. Clients can learn to create a menu of enjoyable self-care activities, such as exercising, organizing, gardening, or watching Tiger King. There are also apps available so psychologists can either scan the completed safety plan to clients or assist them in uploading the information into one of the free apps, such as Safety Plan or My3. For further training on developing safety plans, visit <http://suicidesafetyplan.com> or <https://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians>.

Means restriction is an important part of safety planning. More information on the Suicide Prevention Resource Center's Counseling on Access to Lethal Means program is available at <https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>.

Psychologists can consider reaching out

several times per week via text messages or other forms of communication between sessions. Available apps can disguise phone numbers (such as Hush, Burner, or Line2). Text-based therapy, such as Talkspace appears to improve both the psychological well-being of clients and the strength of the client-therapist relationship. Visit www.talkspace.com for more information.


Similarly, brief intervention and contact, which includes post-discharge telephone contacts; emergency or crisis cards; and postcard or letter contacts, may have success with survivors of suicide attempts or clients with suicidal ideation, particularly as this intervention not require physical contact (see Fleischmann 2008 for more information). In another study by Motto and Bostrom (2001), clients who refused mental health care were contacted by letter four times a year for five years. Findings indicated that patients receiving this contact had lower suicide rates in all five years of the study as compared to a control group, with a significantly lower rate noted for the first two years.

Psychologists can help connect clients with family and loved ones, normalize their feelings and reactions, and ensure that clients know the National Suicide Prevention Lifeline number (1-800-273-TALK), the National Crisis Textline (Text HELP to 741-741), and the PA Center for Community Resources Support and Referral Helpline (1-855-284-2494). Psychologists can encourage clients to put these numbers in their phone. Psychologists should familiarize themselves with community resources (hospitals, crisis centers) that have availability during this pandemic, to be ready to make referrals when needed.

Self-Care

Finally, self-care is essential. Psychologists have an ethical responsibility to ensure that they take care of themselves. This may not mean a trip to the spa, but what psychologists do every single day to stay emotionally well. Effective psychologists take care of their mind and body, take

breaks from social media and news stories about the pandemic, and stick to reliable sources such as the Centers for Disease Control and the World Health Organization. It can be important to connect with loved ones and set clear boundaries with clients and colleagues. Exercise, garden, enjoy time in nature, paint, or draw; do whatever is soul soothing as it is possible that the busiest time is yet to come. Once the pandemic is under control, psychological and emotional pain may surface. Healthcare workers, in particular, may need significant support, clients may be in need of grief counseling, and patients may be suffering traumatic stress symptoms.

So, our advice to psychologists is to stay healthy, breath, and relax as much as possible. Remember that psychologists are in the middle of this national crisis too, so self-care must be considered important. 

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RACISM in the COVID-19 Pandemic

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*

Epidemics and pandemics tend to fuel racial and ethnic prejudices. In the 1980s, AIDS was sometimes referred to as GRID (“gay related infectious disease”) or the “gay disease,” fueling homophobia. During the Ebola epidemic, survey respondents who felt the most vulnerable to the Ebola epidemic were more likely to endorse negative attitudes toward West Africans, severe travel restrictions, and ethnocentric attitudes (Kim et al., 2016).



During the Middle Ages, the bubonic plague was blamed on the Jews. When it resurfaced in San Francisco around 1900, it was blamed on the Chinese. The 1832 cholera epidemic in New York City was blamed on Irish immigrants. During World War One, the *Spanish flu*¹ was blamed on Italian immigrants, German spies, Native-Americans or African Americans, even though the best evidence suggests that the pandemic originated among White farmers in rural Haskell County Kansas. Now during the COVID-19 pandemic, hate speech, discrimination, and hate crimes against Asian Americans has increased. Kandil (2020) reported over 650 racist acts toward Asian Americans in one week alone in March. For example, CNN host Lisa Ling received a message reading “You should apologize Lisa for your kind giving us this virus,” even though Ms. Ling has been a constant critic of how China has misrepresented the pandemic (C. Chen, 2020).

Prejudice During the COVID Pandemic

Asian Americans have been called a *model minority* in part because, as a group, their economic well-being and metrics on health, longevity, and well-being equal or excel that of White Americans. Nonetheless, they have experienced a long history of discrimination and prejudice within the United States.

Anti-Asian sentiments within the United States has risen since emergence of the COVID-19 pandemic. Former presidential candidate Andrew Yang (2020) wrote that Asian Americans can best address this prejudice by being more public about their very real contributions as health care workers, researchers, or citizens addressing the pandemic. Other Asian Americans pushed back, arguing that Asian Americans do not need to prove their Americanism any more than any other ethnic group (S. Chen, 2020).

Xenophobia is not restricted to the United States. In the People’s Republic of China, African and White residents reported being subjected to verbal assaults or seeing signs in businesses cautioning foreigners that they will not be served. One widely published cartoon pictured a non-Asian man in a garbage can ready for disposal. The official position of the Chinese government is to condemn such actions (Waden & Yang, 2020).

Responding to Prejudice

Aside from the inherent injustice of this prejudice it is self-defeating as it diverts attention away from the real issues of social distancing and ensuring adequate health care for the public. How can we address these prejudices?

1 Most likely it was called the Spanish flu because the Spain was neutral during World War One and did not censor its press like the United States and other combatants. Thus, the accurate news reports of the epidemic first came from Spanish newspapers.

According to psychologist David Steno (quoted in Timsit, 2020), uncertainty and fears make people more susceptible to false claims (fake news) and hostile attitudes, causing some researchers to refer to an *infodemic* and urging citizens to practice *information hygiene* (Vlessides, 2020). The first step to address prejudice might be to educate the public on the nature of the disease, how it is spread, and how people can reduce its spread (Jilani, 2020). Once fear levels are reduced, many people can become more receptive to fair-minded discussions. The American Psychological Association has developed a fact sheet for journalists and policy makers on how to speak or report on COVID-19 without stigmatizing groups (<https://www.apa.org/news/press/statements/combating-COVID-19-bias.pdf>).

Wong (2020) urged Asian Americans to practice self-care, place hateful comments in the larger picture of prejudice and xenophobia, address comments when it is safe to do so (but do not put your safety at risk), and seek out emotional support and validation. Individual psychologists are well positioned to provide the later. But we all have an obligation to speak out against prejudice no matter the source or the recipient. 📌

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THE INFLUENZA PANDEMIC OF 1918:

What Public Health Lessons Were Learned?

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The influenza pandemic of 1918 was the deadliest in history to date. An estimated 50 million people died across the world (Spinney, 2017). The bubonic plague in Europe in the 1300s killed a higher percentage of the population, but the pandemic of 1918 killed more people. Within the United States an estimated 675,000 persons died out of a population of 104 million (Barry, 2005). Now that we are in another great pandemic, it may be helpful to reflect on the 1918 pandemic and discern if any lessons could apply to us today.

Background on the 1918 Influenza Pandemic

The influenza epidemic was actually at least three epidemics; one in early 1918 which was contagious, but seldom deadly. The second epidemic came later in 1918 and was equally contagious, but far more deadly. It is believed that the second epidemic was the same or a highly similar form of the first virus because few people

who were infected in the first epidemic in early 1918 caught the influenza in the second epidemic later that year (Kolata, 1999). The third epidemic resulted in regional outbreaks that continued into 1922. Unlike other flus, those who were 20 to 40 years old were especially likely to die from this one.

Although no one can know for certain, the best evidence suggests that the virus

originated in rural Haskell County Kansas in February 1918 (Barry, 2005). Recruits from Haskell County spread it to nearby Fort Funston, a recently built military base that trained recruits to fight in World War One. As the soldiers were sent out to different camps and eventually to Europe to fight in the War, the virus traveled with them. The first outbreak in Europe occurred in April 1918 in Brest, France, shortly after the arrival

of American soldiers from Fort Funston. The influenza spread through the troops of the Allied and Central Powers. German general Ludendorff blamed the failure of his 1918 offensive against Paris on the fact that the flu had decimated his troops. He was only partially correct, however, because the flu had equally depleted French, British, and American troops.

Although no one can know for certain, the best evidence suggests that the virus originated in rural Haskell County, Kansas in February 1918.

The second and more deadly wave of the infection started in the fall of 1918. In September 1918, Navy sailors in Boston reported wide-spread sickness whereupon it spread to nearby Fort Devens, Massachusetts and then to the civilian population in Boston. The renowned physician William Henry Welch was sent to Fort Devens to investigate the large increase in influenza deaths. When Welch arrived, the Fort Devens hospital, built for 2,000 patients, was holding 8,000. Welch found that 70 of the 200 nurses were sick and more were falling ill every hour. Conditions were so bad that the hospital simply stopped receiving new patients. It had no staff available to help them (Barry, 2005). Similar scenarios subsequently occurred in many army and navy bases across the United States. The Surgeon General of the Army William Gorgas urged a moratorium on troop movement to stop the spread of the infection. His recommendations were ignored.

Sailors at the Philadelphia shipyard reported the flu on September 11, 1918, but then it moved into the civilian population. By early October, 11,000 Philadelphians had become sick and the hospital system was overwhelmed. Funeral homes were taxed (Anderson & Gordon, 2020). Often the dead had to stay at their homes for days before they could be collected. Family members were often required to dig the graves of

their loved ones because of the shortage of grave diggers. Orphanages were filled and child welfare services were forced to place new orphans with any adult, with minimal vetting, who would be willing to assume responsibility for them (Barry, 2005).

The epidemic went from city to city killing hundreds of thousands of Americans. Many nurses and physicians died. The American Red Cross moved nurses around the country as the infection spread to different areas which only delayed, but could not prevent, the collapse of many local hospital systems. Nurses were in the greatest demand because ensuring basic sanitary conditions and comfort to the sick appeared to help them, while the remedies administered by physicians showed little benefit (Crosby, 2003). Weeks after the epidemic hit a city, it disappeared as quickly as it came. Although the epidemic reached its apex in the fall of 1918, smaller sporadic influenza epidemics appeared in various regions of the United States until 1922.

During the epidemic, the ordinary

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activities of daily life became stalled. Businesses had to downsize or shut down because so many of their employees were sick. The ranks of fire fighters, police, and garbage collectors were depleted. The Bell telephone company had so many sick operators that it limited its services to emergency calls only (Crosby, 2003). Draft calls in the fall of 1918 were canceled because military training camps were disease-infested with overflowing hospitals. By the end of the war, about 40% of soldiers and 36% of sailors had gotten the influenza.

President Woodrow Wilson became infected while at the Paris Peace conference and, during this time, made unwise diplomatic concessions (Barry, 2005).

Some diseases are highly contagious, but relatively harmless. Other diseases are not very contagious, but very harmful. The 1918 influenza was both highly contagious and very harmful (Barry, 2005). It is true that 90% of those infected “only” had a bad case of the flu and recovered nicely (Spinney, 2017). But 10% of those infected suffered greatly and many died.

What Public Health Lessons Were Learned?

What lessons learned from this epidemic could be relevant to our current pandemic? Did the United States have a national policy that tampered down the impact of the infection? Did social distancing work? Was the public well informed of the influenza and health care risks? Did the medical community respond with an evidence-informed approach to the disease? Did the epidemic cause or exacerbate ethnic tensions? Were there unanticipated health care consequences of the epidemic?

Did the United States Have a National Policy?

The United States government under President Woodrow Wilson had a very clear and uniform policy toward the epidemic which was to deny its existence or begrudgingly to minimize its impact. There was no partisan divide: Republicans and Democrats equally ignored the epidemic until it had already ravaged the cities. The federal government did nothing to assist state or local governments, censored early newspaper reports of the epidemic, and even ignored public health warnings on the effect of the epidemic on the military until after the epidemic was well embedded in the population. Governors and mayors of cities devastated by the epidemic petitioned Washington for assistance, but none was forthcoming. President Wilson was preoccupied with prosecuting the war against Germany and no other concerns would distract him.

Even if it had intervened, the federal government lacked a public health infrastructure to assist the states. Many states had some recent experience dealing with local outbreaks of polio, measles, or other infectious diseases, but still these departments were small and understaffed (Crosby, 2003).

Did Social Distancing Slow the Infection?¹

Social distancing saved lives. For example, a strict quarantine was placed on the Samoan islands controlled by the United States. No American Samoans died from the influenza. No quarantine was placed on the Samoan islands controlled by New Zealand. About 25% of the population of New Zealand Samoa died (Spinney, 2017). Many other cases could be found where quarantines, isolation of social distancing spared communities from the worst of the epidemic.

Nonetheless, within the continental United States, public health measures were implemented inconsistently. Enforcing quarantines and social distancing noticeably impacted death rates. In San Francisco, for example, the epidemic struck in October 1918 and receded after the city banned public gatherings and required citizens to wear masks in public. The epidemic receded and then returned in January 1919 shortly after the social restrictions had been lifted (Crosby, 2003).

In Philadelphia, the director of public health initially refused to take the warnings about influenza seriously and refused to cancel a large September Liberty Bond parade in Philadelphia watched by an estimated 200,000 spectators. A few days after the parade, the number of influenza cases in Philadelphia skyrocketed. Within three days

every bed in the 31 hospitals in Philadelphia was filled. New York City refused to cancel its Columbus Day parade featuring President Woodrow Wilson. That city also quickly became overwhelmed with the influenza. It is hard to discern the impact of these large gatherings on the pandemic, because the infections were already starting to spread in the population. Nonetheless it represented a lack of awareness of the how the disease spread. Some Philadelphians opposed the social restrictions imposed by the city which still allowed smaller Liberty Bonds parades to occur during the height of the epidemic (Crosby, 2003).

Even the military ignored the warning of experts. Army Surgeon General William C. Gorgas had a background in fighting disease. His public health efforts curtailed the spread of Yellow fever among American soldiers during the Spanish-American War, and he later controlled the disease enough to allow Americans to complete the Panama Canal. At the start of World War One his goal was to enforce strict sanitary conditions because he knew that, in war, far more soldiers will die from disease than from combat.² But his warnings to the military about the need to stop troop movement during the epidemic was ignored until it was too late to stop the spread of the influenza. While the Army was minimizing the role of influenza, it was vigorously enforcing its anti-venereal disease campaign, warning that “a French prostitute is as deadly as a German bullet.”

Was the Public Well Informed?

One of the principles of public health is the need to be honest with the population about the nature of the health crises that they are experiencing. One should not

“manage” or “spin” the truth but tell the truth and communicate risks to the public honestly (Barry, 2005). That did not occur in 1918. Initially, the public was given little or no information about the epidemic on the assumption that the news would dampen their war-time morale. The censorship was strictly enforced. Other war powers had similar restrictions. Spain, a neutral country during World War One, on the other hand, did not censor its news and its newspapers reported on the epidemic, probably resulting in the influenza being called the Spanish flu.³

During most of the war newspapers published almost nothing about the epidemic, and when they did comment it was only to quote a public figure claiming that the epidemic is well under control. These denials and silences contradicted the experiences of average citizens who saw relatives and friends get sick and die, saw streets vacant of automobiles or horses, and saw the outside of the public morgues stacked with bodies waiting to be buried. Only after the epidemic was already underway did public authorities develop public health posters or allow newspapers to report on the epidemic accurately.

Did Physicians Adopt an Evidence-Informed Approach to Address the Disease?

In 1918 the scientific infrastructure for medical research in the United States was in its infancy. The United States had only a few dozen serious medical researchers at that time (Barry, 2005). The medical profession was just starting to use techniques based upon science or to use the scientific method in medical decision making. The Flexner report, which required scientific training in the education of physicians, had only been published 8 years earlier and still

- 1 Historian Alfred Crosby (2003) argued that “the case and death rate of communities which had “strict” closing orders were no better than and often worse than elsewhere.” However, we must read these comments carefully. The “strict” enforcement often started well after the infection was widespread in the population and even then, large parades and social gatherings for patriotic purposes were allowed or encouraged as described in the text. Also, the experience of the Samoan islands dramatically illustrates the value of social distancing.
- 2 Altogether one out of 67 American soldiers died from influenza. Gorgas’ goal was to have the first war in which more soldiers died in combat than disease. Gorgas might have reached his goal if not for the influenza pandemic. For every combat death there were 1.02 deaths from diseases (Crosby, 2003).
- 3 The Spanish called it the “Naples soldier” because they blamed the epidemic on the Italians. The Brazilians called it the German flu, the Senegalese called it the Brazilian flu, and so on. Every country seemed to blame it on someone else (Spinney, 2017).

many physicians largely relied on folk wisdom, personal experience, or on unconventional treatments based on bizarre theories of human anatomy and physiology. Some of the purported cures, such as taking mercury or smoking cigarettes, had seriously harmful side consequences (Spinney, 2017). Many Americans, understandably skeptical of the value of conventional medicine and aware of its general ineffectiveness, relied on folk remedies.

Very likely tens of millions in the United States . . . tried every kind of folk medicine or fraudulent remedy available or imaginable. Camphor balls and garlic hung around people's necks. Others gargled with disinfectants, let frigid air sweep through their homes, or sealed windows shut and overheated rooms. (Barry, 2005, p. 419)

Eventually an editorial in the *Journal of The American Medical Association* admitted that: "Unfortunately we as yet have no specific serum or other specific means for the cure of influenza, and no specific vaccine for its prevention. Such is the fact, all claims and propagandists in the newspapers and elsewhere to the contrary notwithstanding" (cited in Barry, 2005, p. 422).

Were Efforts Taken to Reduce Prejudices?

Americans at the time were highly prejudiced, especially against recent immigrants to the United States. World War One fueled ethnic hatred which was especially directed at Germans and German Americans or Russians and Russian Americans. The epidemic of 1918 exacerbated this national feeling. One conspiracy theory was that influenza was a form of German chemical warfare. Allegedly the virus was placed in aspirins because the German based Bayer pharmaceutical company owned the original patent. The United States Public Health Service had to conduct tests to assure the public that aspirin did not cause influenza (Crosby, 2003).

Another theory in the United States was that influenza spread because of the unsanitary living conditions of Italian Americans or Native Americans who were

especially hard hit by the influenza. Many Italian Americans were recent immigrants who tended to live in crowded cities, and, at the time, many recent immigrants were young men and women in the age group most seriously impacted by the disease. Also, Native Americans and Eskimos were especially vulnerable to the epidemic, perhaps because of malnutrition or lack of adequate medical attention (Spinney, 2017). In 1918 public officials did little or nothing to dispel these accusations. Ironically, African Americans were less affected by the influenza, perhaps reflecting the "protective" influence of the very strict segregationist policies pervasive in the United States at the time. Nonetheless, this did not stop some demagogues from blaming them for the epidemic (McDonald, 2020).

Even though the flu likely started in the United States, Americans called it the *Spanish Influenza*. Such person or people related descriptions of diseases were common. Many of us remember that AIDS was first called GRID (gay related infectious disease). Such nomenclature only feeds or reflects prejudices. Now, to reduce ethnic blame for diseases the guidelines of the World Health Organization do not permit the names of diseases to refer to places, people, or animals, but instead should include general descriptions that could include the symptoms or disease causing agent (Spinney, 2017)

Did the Influenza Cause Unforeseen Public Health Consequences?

The number of non-influenza deaths from chronic disorders such as cardiovascular diseases or diabetes temporarily increased shortly after the epidemic subsided. It is not clear if the increase occurred because the victims had lost needed nursing care from family members who were sick, had a subclinical infection from the influenza, or if the stress surrounding the epidemic influenced their health.

After 1920 the nation went into a collective amnesia about the epidemic and the psychological consequences to the survivors were hardly ever discussed, even though many families were devastated by

their losses. Nonetheless, after the epidemic ended there were many reports of persons who suffered from post-viral melancholia (Spinney, 2017) and suggestions that some survivors of the influenza experienced cognitive loss after recovering.

Summary

What conclusions can we draw from the 1918 pandemic?

- Local and state governments did not have resources to adequately handle the pandemic. It is likely that a coordinated effort involving the federal government could have better contained the spread of the disease or local responses to it.
- Withholding information from the public increased fear, reduced commitments to public safety measures and cost lives.
- Social distancing, when properly enforced, saved lives.
- Given the lack of a cure or a vaccination, unscientific, useless, and sometimes harmful "cures" proliferated.
- The pandemics made it ripe for rumors to spread about conspiratorial causes of the disease, and racist theories of its origin.
- Evidence suggests that there were long-term secondary health effects for some survivors of the influenza.

Our ability to manage or recover from the current pandemic will depend largely on our ability to understand what happened in 1918 and to try to avert those mistakes. 📖

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ARE WE **THERE** YET?

Considerations Before Resuming Face to Face Services

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Many Americans are asking when the social distancing restrictions will end or be lifted. Despite the wide-spread desire to resume normal life, psychologists need to be thoughtful when deciding if or when to resume face to face services.

The decision on whether to start accepting patients or clients for face to face professional contacts requires psychologists to consider the impact on their businesses as well as the impact on their health and the health of others. Psychologists who fall into a high-risk category (are older or who have serious medical conditions) or have vulnerable family members may wish to adopt a high threshold for resuming face to face services. Nothing requires psychologists to see patients for face to face services. Psychologists who do not offer face to face treatment can decline to treat patients who only want to be seen in face to face psychotherapy. No one

should feel compelled to return to face to face services at the risk of their personal safety. Conversely, in Pennsylvania, as of now, psychological services are considered an essential business, and no law blanketly prohibits psychologists from seeing patients for face to face services either, although such decisions require thoughtful consideration.

Psychologists who are considering resuming or increasing face to face services will need to consider practical issues concerning personal and patient safety. Some psychologists work in small offices where they have more control over physical conditions because



there is, for example, only one entrance to the office or a bathroom unique to their office. Other psychologists work in offices that pose a greater risk to themselves and their patients. For example, some psychologists may have offices in large buildings where their patients need to use a heavily trafficked common entrance, have to ride a commonly used elevator for several floors, or use a public bathroom that may not be sufficiently cleaned. Also, some psychologists work in counties where the rate of infection is low, while others work in counties where the rate of infection is quite high.

Some psychologists will transition back to face to face services over time. To reduce traveling from office to home, psychologists may designate some days as office days and other days as telehealth days. However, if insurance companies continue to reimburse for telehealth services and patients find it convenient, it is likely that many psychologists will continue to deliver all or a substantial portion of their services through telehealth at least in the foreseeable future.

When deciding whether to see a patient for face to face services, psychologists need to consider if they can benefit equally from telehealth services. It is possible that a subset of patients may not benefit sufficiently from telehealth that argues in favor of them being seen in face to face psychotherapy. If this is the case, psychologists should document why they are recommending face to face services.

Here are some considerations for psychologists who are anticipating a transition to face to face services. They are informed by comments shared by many psychologists and by OSHA (2020) and CDC (2020) recommendations, although these are only generic recommendations and I have attempted to extrapolate them for the offices of psychologists. *The recommendations below may be changed or updated as more psychologists have experience with these safety practices and as more information comes to light concerning the transmission of COVID-19.*

In listing these considerations and precautions, I am aware that they place a burden on psychologists. A substantial amount of uncompensated effort is required to notify patients of safety precautions, to document why a patient needs to be offered face to face psychotherapy, and to sanitize offices repeatedly. Nonetheless, I just don't see how services can be provided safely without these or equivalent precautions in place.



Before Patients Enter the Office

Before patients arrive for their appointments, I suggest that psychologists explain safety precautions to them and what is expected of them when they come to the office in an email or over the phone, and also to reiterate those precautions in handouts in the office and on their websites. Psychologists can tell patients not to come in if they have a fever, shortness of breath or coughing, or other symptoms of COVID-19, or have been exposed to someone who shows signs of COVID-19. Patients can be instructed to wash their hands before they come to the office. It is acceptable to have a hand-held thermometer and to decline service to those who show a temperature over 100°. Psychologists can tell patients to wear a mask to their appointments or require

patients to adhere to any other reasonable public safety requirement.

I would suggest that the announcements of psychologists emphasize that they are concerned about the personal safety of their patients and that these steps are taken to protect them, their family members, and the public in general. Psychologists can also note that it is the patients' decision to take advantage of the offer of a face to face visit if they so choose, that there is always

some risk of infection involved, and that they are more than welcome to opt for a telehealth session. Prudent psychologists will document that they discussed the risks of face to face appointments with their patients. APA has developed a special informed consent document for the return to face to face treatment which can be found on the PPA website. Like all informed consent agreements, it should form the basis of a conversation between the psychologist and the patient. In addition, psychologists can ask patients to sign a release of information form to "public health authorities" which would allow them to release some patient information if contacted for purposes of contact tracing.

Safety Precautions in the Office

Psychologists can ask patients not to come into the office until their appointment

time—thus reducing the use of the waiting room or, if possible, ask patients to stay in their cars until the psychologist can text or call them that it is okay for them to come directly into the office. In the waiting room psychologists can place chairs apart or put a “DO NOT SIT HERE” sign on every other seat.

Although psychologists can require patients to wear a mask when they come to the office, it is also advisable to have extra masks around in case they have forgotten. It is prudent to place hand sanitizers in the office and to have trash receptacles easily available. Psychologists can place notices or handouts in their offices encouraging people to wash their hands, avoid touching their faces, use social distancing, and take other public health precautions.

If possible, psychologists should ventilate the office or try to ensure a flow of outside air. Bathrooms need to be cleaned frequently. Psychologists should schedule enough time between appointments to disinfect the waiting room or the office including doorknobs and other commonly touched surfaces. Here is the link to the CDC’s approved list of disinfectants <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2> <<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>>

Psychologists can instruct their office staff to wear masks when interacting with the public and to use social distancing as well. Office staff and other employees should not come to work if they or members of their family are sick or show symptoms of COVID-19. It is prudent to show flexibility in granting sick or family leave. Staff who can work from home should be allowed or required to do so. Staff should try to minimize physical contact when patients are paying for services. If patients need to touch a credit card machine, ensure that it is sanitized after they touch it. Sanitize all surfaces commonly touched including keyboards.

Bhargava (2020) claimed that coronavirus can live on paper from a few minutes to up to 5 days. The conservative interpretation is that psychologists should set aside mail or papers touched by patients for 5 days or at least ensure that they wash their hands immediately after touching paper handled by others. Do not reuse pens or pencils touched by patients without sanitizing them.

Psychologists can instruct their office staff to wear masks when interacting with the public and to use social distancing as well. Office staff and other employees should not come to work if they or members of their family are sick or show symptoms of COVID-19.

Special Precautions with Psychological Testing

Those who conduct psychological testing can consider other precautions. One psychologist uses a plexiglass shield on the desk between her and her patients. She keeps stimulus books on her side of the barrier when possible. Since testing ordinarily requires psychologists to be closer than 6 feet away from their client, both the psychologist and clients should wear masks. Clients can be asked to wear gloves when handling materials that require physical manipulation. Use only one pair of gloves per patient. Another psychologist uses a clear transparency to cover the pages of the testing stimuli that patients would ordinarily touch. These can be washed after every patient encounter. Test materials touched by patients need to be cleaned thoroughly.

Psychologists can minimize direct patient contact by conducting the initial interview and feedback sessions through telehealth. As

much as possible patients can use computer-based applications to minimize the exchange of materials. Patients can complete some brief rating scales and simple self-report questionnaires on-line. As psychologists have more experience with testing with COVID-19 precautions, additional safety measures may come to light.

Summary Points

Here are three points to remember when making return to face to face decisions. Psychologists

- Should not feel compelled to jeopardize their personal safety and may decline to see patients for face to face treatment.
- Can inform their decisions by information provided by the CDC or state or local public health officials. They should be aware that recommendations may change over time depending on what is learned about COVID-19 or the practicalities of implementing safety precautions.
- Should empower patients with enough information so that they can make an informed decision about using face to face services.
- Should make decisions with the public interest in mind and, when in doubt, err on the side of caution. 📌

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COVID-19 DILEMMAS

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The widespread prevalence of COVID-19 and corresponding shelter-in-place restrictions have quickly changed the landscape of psychological services. Many psychologists have adapted their practices to address the mental health needs of their clients while adhering to social distancing guidelines. Advances in telehealth technologies provide new opportunities for psychologists to maintain continuity of care for their existing clients and broaden their reach to treat those in underserved communities. However, the current COVID-19 crisis has raised many new ethical questions for psychologists. Consider this example where we tried to imagine several ethical issues within one vignette:

You were working in an outpatient hospital setting. On the last day of seeing patients face to face before the clinic shifts to telehealth appointments due to the COVID-19 virus, your first patient Jack arrived. Jack is a 63-year-old single, white, cisgender, straight man, with no children. You had been treating Jack for the past three months for depression and chronic pain related to a work-related accident. Jack is currently on disability and lives alone. In addition to the presenting concerns, Jack exhibits narcissistic traits along with a long-standing history of mistrust of authority.

Once the session with Jack began, it was clear that he was not physically well. He coughed uncontrollably and looks fatigued. You expressed concern regarding Jack's well-being given the recent number of COVID-19 cases in the county and asked Jack if he has seen a doctor or been tested. Jack stated that he saw no need for doing either. He believes the current COVID-19 virus is "all hype" and "a left-wing conspiracy to ruin the economy and get Trump out of office." He further states that he plans on supporting local businesses as much as possible and not giving in to "group think" by obeying shelter-in-place orders that are likely to begin this week.

You discussed with Jack the clinic's decision to transfer to telehealth. Jack stated that he hates technology and considers video conferencing to be too impersonal. He told you that he would prefer to wait until the clinic re-opens than having sessions remotely. When you stated your concerns about an undetermined suspension of his clinical care given his depression history, he said, "Don't worry. I'll be fine," and abruptly left the session.

After Jack left, you received a call from your supervisor. The hospital is working with the county's Office of Public Health (OPH) to track patients who may have been exposed to COVID-19. The supervisor asked you to give her a list of her patients who have exhibited COVID-19 symptoms and their contact information so that OPH can follow up with them for testing.

How should you have handled the situation? Should you have even seen the patient after he presented with an apparent respiratory illness? Should you have agreed to see him face to face instead of over telehealth given the severity of his mental illness? Did you have an obligation to address his dismissal of social distancing guidelines? Should you cooperate with your supervisor and give the names of patients who were likely exposed COVID-19?

Should You Have Even Seen Jack?

Jack has put you in a difficult position. While he hasn't been tested, Jack's symptoms are consistent with COVID-19. Now, you must decide how to balance your obligations to treat Jack, with your obligations to keeping your other patients safe from harm. Furthermore, you may be putting your own health at risk by having contact with someone who is symptomatic.

You may utilize a principle-based decision-making approach to decide upon the best course of action. One might view your

decision as a conflict between the principles of beneficence (i.e., doing what is best for your patient) versus general beneficence (i.e., promoting public well-being or protecting the public from harm; Knapp & VandeCreek, 2004). According to Beauchamp and Childress (2019), when faced with a conflict between principles, one should examine the situation to determine which principle is most salient. An intervention should then be developed that is in line with the most important principle, has a reasonable chance of success, and minimizes harm to the subordinate principle.

Many clinics will now instruct patients to stay home if they have a fever or signs of any respiratory infection. Apparently, the clinic where you worked had not yet issued that instruction. Nonetheless, you have an obligation to yourself and to your other patients to protect them from possible infection. Therefore, we might suggest that general beneficence is most salient. You can maintain your clinical obligations to your patient (i.e., beneficence) by conducting a brief screening of Jack for life-endangering qualities and then terminating the session. If it turned out later that Jack did get confirmation that he was infected with the coronavirus, you would then have an obligation to inform the other patients who were in the waiting room or other staff who had contact with Jack that they may have been exposed to the coronavirus. The CDC guidelines only recommend contacting others if the index patient had a laboratory confirmed case of coronavirus, which Jack did not have at the time of the appointment (CDC, 2020).

Should You See Jack in Face-to-Face Psychotherapy?

Assuming that Jack will be symptom free for future meetings, should you have agreed to see Jack face-to-face instead of over telehealth as you are doing with other patients? Such a decision needs to consider the health consequences of doing so as well as the mental health needs of the patient.

The APA Ethics Code provides no direct

guidance here. Although the APA Code of Ethics Standard 10.10b (2017) says that psychologists may terminate therapy if they feel endangered by their patients, the degree of immediate harm from an infection is more remote than an assault from a patient as anticipated in the APA standard. Even then, the standard only states that psychologists *may*, not *must*, terminate. Here again you need to rely on an ethical decision-making format to make your decision.

From a principle-based perspective, you must determine how to best meet your obligations as Jack's psychologist (i.e., fidelity, beneficence) while also considering your own health and well-being and the health and well-being of others with whom you may have contact. Some issues to consider are whether Jack has the technological skills to use telehealth services. Would it be possible to conduct one or two sessions by phone to gradually migrate him into video telehealth platform? Are there life-endangering qualities that could only be adequately assessed or addressed through a face to face meeting? Does the refusal to use telehealth reflect a narcissistic demand that Jack be treated differently from others? We are not going to take a position on this topic but will only say that it could be a complex decision that requires balancing many factors.

Do You Have an Obligation to Address Social Distancing Issues?

Social distancing saves lives and Jack may be putting himself or members of the public at risk by failing to follow social distancing guidelines. Based on the principle of general beneficence, we believe that psychologists have an obligation to advocate for social distancing when possible. In this case, however, it is not clear that Jack would be responsive to efforts to change his attitudes or behavior about social distancing. If you pushed the issue too strongly, then he may drop out of treatment. Once again, you must decide whether beneficence and nonmaleficence for your patient or general beneficence is most salient. Consequently, you will need

to determine if it is worthwhile raising the issue of social distancing and, if so, how to do it so that it has a reasonable chance of being successful without jeopardizing their therapeutic relationship. Often motivational interviewing techniques are helpful in these situations (Knapp, Gottlieb, & Handelsman, 2020). You can discuss with Jack the risks and benefits of adhering and not adhering to social distancing rules and raise his awareness of the emerging health information on coronavirus that is available from reliable sources (e.g. CDC).

Should You Reveal the Names of Patients Exposed to Coronavirus?

Within this element of the dilemma, you must balance your obligations to your employer (i.e., fidelity), the public (i.e., general beneficence), and Jack's right to confidentiality (i.e., respect for autonomy). The HIPAA Privacy Rule permits health care professionals to reveal such information to public health authorities. However, the HIPAA Privacy Rule needs to be read in conjunction with state laws and, according to the preemption analysis embedded in the Privacy Rule, the law that is most protective of patient privacy prevails. Since Pennsylvania laws for psychologists permit no exception to confidentiality for infectious diseases, you must decline the request of the supervisor to reveal names of patients who might have been infected (Knapp, 2020). This is similar to how Pennsylvania handles HIV infections where psychologists may not reveal the serostatus of patients without their consent or a court order. Of course, if you received a request from a public health official about a patient or patients, then it would be responsible for you or someone from the hospital to call the patients and ask for an authorization allowing them to share names with public health officials. Perhaps it would also be possible to provide information on possible patient exposures without revealing information that would identify specific patients. It should also be noted that there is no confidentiality for staff persons and their names can be revealed to public health officials. Proactively you can ask

future patients to sign an authorization that would permit you to disclose information for contact tracing by public health authorities. 

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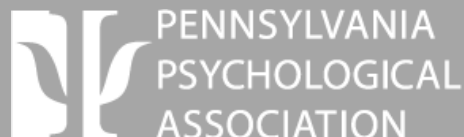
How PPA is working through COVID-19

a podcast

• INTERVIEW WITH PPA STAFF INCLUDING ANN MARIE FRAKES, JUDY HUNTLEY, SAM KNAPP AND RACHAEL BATURIN •



SEARCH PSYCHOLOGY RADIOCAST WHERE YOU LISTEN TO PODCASTS (ITUNES, SOUNDCLOUD, STITCHER, ETC)



When an Out-of-State Client **NEEDS MY HELP** and I Do Not Know if I am Legally Able to Provide It

RANDY FINGERHUT, PH.D., *La Salle University*

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*



The current COVID-19 pandemic has created a seismic shift in methods used to conduct psychotherapy. Prior to the coronavirus, few providers conducted telehealth extensively. Now, almost all psychologists are using videoconferencing to conduct their therapy sessions.

While APA has guidelines for providing telehealth (APA, 2011) and other resources available for practitioners, many psychologists find themselves in uncharted waters. We are all trying to figure out how to conduct telehealth in a way that is ethical and flexible to meet our clients' needs during a difficult time. Nonetheless, many therapists are struggling to accommodate to a new telehealth platform and are encountering unique ethical dilemmas. One issue currently faced by telehealth providers is whether they can practice across state lines. A common assumption is that psychologists are bound by the state regulations of where the client is currently physically located. Some states have put that in their licensing laws. Nonetheless the regulatory picture is more complicated because several court cases have limited the state's ability to take action against an out-of-state psychologist (Siegel & Harris, 2019). So, the conservative—but not uniformly accepted—interpretation is that the practice of psychology occurs where the client is located. This can be an obstacle in situations when a client is physically in a state that does not have flexible out-of-state practice provisions. Consider the following scenario:

Last fall, Jorge, a 20-year-old single, straight, cisgender, Latino, male, presented to your private practice seeking CBT for depression. Jorge is from upstate New York but attends a nearby college in Pennsylvania. Jorge's presenting problems

included moderate depression, sub-clinical social anxiety, and an over-reliance on avoidance as a means of coping. At intake, he reported fleeting passive suicidal thoughts occurring once per week, with no intent. He denied a history of suicide attempts, non-suicidal self-injury, homicidal ideation, or psychiatric hospitalizations. Jorge reported previous psychotherapy at his university counseling center but stated that his therapist provided no guidance or structure and he did not find the experience to be helpful.

Over the course of the fall and winter, you conducted weekly CBT sessions with Jorge. Jorge found the sessions very helpful, learning valuable coping skills that significantly reduce his depression and anxiety. Furthermore, you and Jorge developed a strong working alliance and he stated that he feels a trust in you that he has never had with anyone outside of his family.

When the COVID-19 pandemic hits Pennsylvania, Jorge's university moved their courses online and sent their students home. Before he moved back to his family in New York, you and Jorge agreed to have one final face to face session. During the final session, you assessed his depression and he scored in the mild range on the BDI. You and Jorge discussed his treatment options. Jorge wanted to receive additional treatment to further enhance his cognitive-behavioral skills

and help him cope with the stress associated with the coronavirus and re-adjust to life back home. While his university's counseling center offers telepsychology sessions, he does not wish to pursue this treatment option. You agreed that Jorge would benefit from further treatment and symptom monitoring. You gave Jorge a list of three psychologists near his home who are certified providers of CBT. You and Jorge agreed to check in by phone in two weeks to ensure that he was connected with a new therapist.

During your follow up call, you find that Jorge has not found a new therapist. The first therapist was not in network with Jorge's insurance and did not offer a sliding scale fee. The second therapist was not taking new clients for telehealth. He left a message with the third therapist, but she did not call him back. To make matters worse, Jorge's depression has intensified. His parents have both lost their jobs and Jorge fears that he will not be able to afford his college tuition. Jorge reports hopeless thoughts about his current situation, but he denies suicidal ideation. Jorge asks you whether you and he could resume weekly CBT sessions over the phone.

In this situation, you and Jorge are fortunate in that New York has the option of a temporary license for out of state licensed psychologists. Psychologists who are licensed in other states may apply to the New York State Board of Psychology to practice for 10 consecutive days within a 90-day period or 15 days aggregate within a 90-day period (Education Law, n.d.)

However, the situation might have been different if Jorge was living in another state that did not permit limited out of state practice. During the coronavirus epidemic, many states have loosened their restrictions on out-of-state practice (for an update on changes, psychologists can check the ASPPB website, www.asppb.net or see

the direct link in the references). Because of these out of state provisions and some psychologists may find themselves in a situation where a patient in another state needs their assistance, but the psychologist has no unequivocal legal way to provide those services. PSYPACT legislation, recently signed into law in Pennsylvania will address this issue, although it may be several months before it gets implemented. Also, presently only 12 states have adopted PSYPACT and it may be several years before most or all states do so.

In the time being, many psychologists will be in a situation where the conventional assumptions about out-of-state practice appear to conflict with the needs of their patients. The APA Ethics Code (2017) provides little guidance here. Standard 1.02 states that

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

The interpretive picture is more complicated because, as noted above, states vary on whether their laws explicitly prohibit out of state telepsychology practice and not all legal experts agree with the conservative interpretation on out of state practice.

A principle-based decision-making approach may help psychologists determine how to proceed. Generally speaking, psychologists and other health care professionals follow several ethical principles in their practices such as beneficence (working to help patients), respecting patient autonomy, nonmaleficence (avoiding harm to patients) and fidelity (being faithful to promises




one makes to a patient). Sometimes these principles collide, however. When they do, Beauchamp and Childress (2019) recommend that the health care professional looks at the situation and determines which principle is most salient. The action taken should be in line with the most important principle, be likely to succeed, and minimizes harm to the offended moral principles.

One can use the same Beauchamp and Childress methodology when laws conflict with moral principles as when moral principles conflict with each other. That is, one can decide whether following moral principles or obeying the law is more important, whether the intervention has a chance of success, and if an effort is made to minimize harm to the offended principle (or law). If Jorge was in a state that did not have flexible out of jurisdictional practice laws, then a conflict could occur between following the conservative interpretation of the out-of-state law and beneficence (acting to help Jorge), respecting patient autonomy (Jorge wants telehealth services), and nonmaleficence (Jorge may become harmed without treatment).

To find a solution that best balances these competing concerns, we argue that in this case the psychologist should

make beneficence/nonmaleficence the highest concern. Therefore, we recommend establishing a telehealth session with Jorge to ensure his safety while at the same time pursuing a temporary practice permit in New York. During that time, we would better assess Jorge's mood, determine if limited telehealth services would be sufficient for his immediate needs, and possibly help Jorge transition to a new psychotherapist. Jorge's clinical history is enough, in our opinion, to justify an inquiry into his safety. We would recommend documenting our decision and why it was in the patient's best interest. Given the good relationship between Jorge and the psychologist and the way that Jorge has responded well to treatment in the past, one would think that the crisis call would be helpful to Jorge. Also, an attempt would be made to minimize harm to the offended law, by immediately seeking a temporary practice permit in New York.

Of course, such distant treatment relationships are not without their problems, especially if life-endangering qualities are present. If Jorge were to deteriorate badly and need a referral to a psychiatrist or a psychiatric hospitalization, we would have an obligation to help Jorge find the psychiatrist or facilitate a hospitalization even though we might not be familiar with local resources. We might have to inform ourselves of relevant New York laws on confidentiality and psychiatric hospitalizations.

And of course, one could modify the vignette slightly to make Jorge more resilient and less in need of treatment or could change his physical location to make the relevant laws different. One could create a scenario in which an outreach call to provide telehealth services would not be justified. Nonetheless psychologists can use the same methodology of balancing moral concerns with the law. 

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May is Mental Health Awareness Month, and PPA is Recognizing this by Offering the Following Webinars

15

Friday, May 15 from 12:00 pm - 1:00 pm

Ethical Issues with COVID-19

Samuel J. Knapp, EdD, ABPP and Randy Fingerhut, PhD

18

Monday, May 18 from 11:00 am - 1:00 pm

Pennsylvania Child Abuse Recognition and Reporting (Act 31)

Rachael Baturin, MPH, JD

28

Thursday, May 28 from 12:00 pm - 1:00 pm

Mental Health Access in Pennsylvania: Examining Capacity for a Global Health Crisis Response

Dan Warner, PhD and Kirby Wycoff, PhD

2019 PPA SURVEY HIGHLIGHTED LONG-TERM CHALLENGES

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*

JEFFREY D. LEITZEL, PH.D., *Bloomsburg University*

ANN MARIE FRAKES, MPA, *Executive Director*

Since 1996, PPA has conducted an annual survey of its members on topics related to their professional experiences, professional challenges that they face, and ways that PPA can better meet their concerns. The PPA Board of Directors use the information to help them set priorities and allocate resources for PPA. This article reviews data from the 2019 PPA Annual Survey and integrates it with data from other recent surveys to give a picture of psychology at that time in Pennsylvania, some challenges facing professional psychologists, and the steps PPA is taking to address those challenges. PPA will be following up with a survey later this year that will address emerging issues related to the COVID-19 pandemic.

This survey asked about legislative issues and especially problems in accessing psychopharmacological services for patients; member

challenges; perception of the value of various PPA services; and demographic questions about the membership.

Legislative Priorities

Every other year, the survey asks members for their legislative priorities (see Table One). "Bread and butter" issues concerning parity or reimbursements continue to be major issues as has been consistent with surveys in past years. However, the 2019 survey showed an increased interest in the reduction of jurisdictional practice limitations (being able to practice in other states, such as through telepsychology services). PPA's work on PSYPACT legislation is meant to address this concern. PSYPACT was just signed into law by Governor Wolf on May 8th, although it may take several months before it gets implemented.

TABLE ONE: **Legislative Priorities**

	Top priority	Top two priorities
Greater parity in reimbursements for psychology	42%	68%
Reduction of jurisdictional practice limitations	25	39
Increase Medicaid and Medicare reimbursements	18	49
Reimbursement for Telehealth Services	5	20
Protecting Roles of School Psychologists	4	9
Rx P for Psychologists	4	8
Other	2	3

Psychopharmacology

Only a small number of PPA members rated seeking prescriptive authority for psychologists as their highest legislative priority, although past surveys show that a large majority of psychologists support the concept of prescriptive authority for psychologists. The survey also showed a very acute need for more professionals available to prescribe psychotropic medications. Table Two, which asked “What is the percentage of your patients who are on psychotropic medications?” presents the data below. This is consistent with other sources that show about half of patients in psychotherapy also take some form of psychotropic medications.

TABLE TWO: Number of Patients on Psychotropic Medications

Percentage of Patients On Psychotropic Medications	Percentage of Psychologists
0%-20%	6%
20%-40%	28%
40%-60%	31%
60%-80%	21%
80%-100%	11%

Table Three presents data on psychologists and whom they referred patients to for medications, including the last patient they referred for medication and whom they most frequently refer patients to for medication. When seeking someone to prescribe medication, psychologists most often referred patients to a psychiatrist (54%) or a family physician (34%).

TABLE THREE: Referrals for Medications

	Last referred to a:	Most frequently refer to a
Psychiatrist	57%	54%
Family Practitioner	27	34
Other Physician	1	1
Nurse	9	6
Physicians' Assistant	2	2
Other	2	1

Table Four shows that the wait times for psychiatrists is usually 3 or more weeks.

TABLE FOUR: Wait time for psychiatrists is

Less than one week	6%
1 to 2 weeks	21%
3 to 4 weeks	29%
4 or more weeks	41%

Although only a small percentage of psychologists reported that prescriptive authority was their highest priority, Table Five showed that a significant number of psychologists would likely take a class or enroll in a Master of Science program in clinical psychopharmacology leading to prescriptive authority, if it had distance learning or weekend options.

TABLE FIVE: Interest in a Master of Science in Clinical Psychopharmacology Program

15% would be very likely to take courses	9% would be very likely to enroll in a program
12% would be likely to take courses	5% would be likely to enroll in a program
24% maybe would take courses	14% maybe would enroll in a program
9% would be unlikely to take courses	16% would be unlikely to enroll in a program
38% would definitely not take courses	54% would definitely not enroll in a program

Member Challenges

The survey also asked respondents to identify the professional challenges that they face, the PPA services that benefit them the most, and their priorities for the PPA Board of Directors. The data from the 2019 PPA survey was reviewed in conjunction with data from other surveys in recent years. Table Six reports on responses to the question "Please identify the top five professional challenges you face (ranked 1 to 5)." Table Seven reports responses to the question "Which needs are most relevant for you at this stage of your career?" Table Eight reports on responses to the question "Which of PPA's services are most important for you? (rate on scale of 1 to 5)." Table Nine reports on member rankings of the priorities of PPA on a five-point scale.

TABLE SIX: Professional Challenges- 2019 Survey

	Ranked 1	Ranked 1 or 2
Low reimbursement from insurance companies	34%	56%
Keeping abreast of changes in the field	16%	30%
Continuing education, good and affordable	14%	28%
Dealing with managed care restrictions	13%	33%
Competition from other health care providers	6%	13%
Getting help in developing telehealth services	5%	12%
Getting help in developing integrated care services	3%	8%
Malpractice fears	4%	8%

TABLE SEVEN: Professional Development Needs- 2019 Survey

	Most Relevant	2 Most Relevant	3 most Relevant
Setting up a practice	12	12	12
Transitioning a practice	32	36	36
Closing a practice	17	26	27
Training in assessment	17	29	30
Training in psychotherapy	11	41	49
Training in psychotherapy supervision	3	18	31
Presenting Strategies and techniques	3	15	33
Leadership strategies	2	9	23
Writing/Publication/Research	0	1	15

Tables 6 and 7 describe the professional challenges and continuing education needs of psychologists. Practice issues continue to dominate for psychologists including concerns about reimbursement rates. Also, keeping abreast of changes in the field and continuing education were rated as high priorities. Many of the professional development challenges dealt with practice management issues as well as the content of professional psychology itself.

Because of restrictions placed on psychologists and other health care professionals, psychologists cannot organize to advocate for higher reimbursement from insurance companies. Nonetheless, the work on reimbursement in Medicare is extremely important because many commercial insurers link their rates to Medicare reimbursements. Recent efforts by APA have resulted in modest increases in reimbursement for Medicare, reversing years of decline.

TABLE EIGHT: PPA Benefits- 2019 Survey

	Highest (ranked 1)	High (ranked 1 or 2)
Continuing education	38%	58%
Consultation with Rachael or Sam	27%	53%
Government advocacy	13%	27%
List serv	10%	18%
Legal consultation plan	4%	14%
PA Psychologist	2%	15%

TABLE NINE: Top Priorities PPA- 2018 Survey

	Very highly valued	Valued or very highly valued
Government Advocacy	40%	60%
Continuing Education	28%	59%
<i>PA Psychologist</i>	14%	36%
List Serv	11%	18%
Public Education	2%	16%

The wording of the questions in Tables 8 and 9 are somewhat different. Table Eight asks about benefits to individual members and Table Nine asks members of their perception of priorities for PPA. The categories overlap somewhat, but together they reflect the priorities of PPA members.

Members highly valued the continuing education and legal/ethical consultation from the PPA staff. Government advocacy was considered highly important, as were the list-serv and *The Pennsylvania Psychologist*. The PPA budget and staff allocations reflect these priorities. Rachael Baturin, J.D., has the primary responsibility for coordinating the governmental affairs program with our contract lobbyists. Samuel Knapp and Ann Marie provide support for Rachael as needed.

Rachael Baturin and Samuel Knapp commit a substantial portion of their time offering consultations to members on ethical and practice issues. PPA also offers an option of a legal consultation plan with attorney/psychologist Allan Tepper.

Continuing education has increased in importance throughout the years. This may be due, in part, to new mandates imposed by the state concerning suicide prevention and child abuse training. Also, the knowledge base for psychologists is exploding rapidly with the half-life of a psychologist's knowledge base now at an average of 9 years.

Judy Huntley with support from Erin Brady coordinate the continuing education program for PPA, although all staff contribute to the CE programs in some way. Ms. Huntley coordinates the convention, fall and spring conferences, and other CE events. In response to this growing concern PPA has been increasing its continuing education options in recent years, including increasing the number of webinars and home study programs available. Last

year PPA offered approximately 60 different home studies. For the 2021 renewal cycle, all home studies will be reviewed for relevance and updated or retired as needed. Efforts are also underway to solicit home studies in more areas of psychology.

Effectiveness of Suicide Prevention and Child Abuse Protection CE Mandates—2017-2019 Surveys

In the last five years the Pennsylvania General Assembly has placed continuing education mandates on psychologists for child abuse reporting and suicide prevention. Questions on the PPA survey for the last several years asked about psychologists' experiences working with suicidal patients, changes in their perceived effectiveness or comfort in working with suicidal patients considering the mandate for continuing education in suicide, and perceived benefit of mandatory training in child abuse. We will continue to ask these questions on surveys to determine the long-term benefits, if any, of these mandates that occur.

Demographics of Members

PPA's membership is older. About 33% have been licensed for more than 30 years and 50% for more than 25 years. The median age of the respondents was 63 years old.¹ The modes were 67 and 68 years old. The percentage of our membership that is retired is now 5%, up from 3% in 2010. The average age of PPA members was 53 in 1996. Help in closing a practice was identified as an important continuing education need by respondents. Although the membership has always skewed on the high side in terms of age, the lopsidedness is even more pronounced than what was found in the 2010 and 2016 survey (See table on page 40).

¹ Samuel Knapp recalls, but cannot find data for this recollection, that the median age of PPA members was about 55 in the 1990s.

HOW LONG LICENSED: **Surveys 2010, 2015, 2019**

	2010	2016	2019
LT 10	17%	20%	14%
10 to 15	11%	9%	8%
16 to 20	16%	9%	9%
20 to 25	14%	16%	15%
26 to 30	19%	17%	19%
30 or more	24%	28%	34%

About 91% of PPA members identified themselves as White non-Hispanic, compared to 86% who were White non-Hispanic in the American Psychological Association. The lower percentage reported in this survey reflects the lower percentage of diverse ethnicities within Pennsylvania and the age of the membership which is skewed toward older white persons. According to APA data, about 25% of graduate students in psychology are persons of color.

The aging members has implications for psychology and PPA in general. The trend is that younger psychologists tend not to join associations, including professional associations at the same rate as past generations. But if this trend continues unabated, the financial strength of PPA will become eroded and our ability to advance legislation to promote public access to psychological services will be undercut. PPA is pursuing several initiatives to address this growing concern.

Steps to Address Generational Gap

In order to continually attract new and younger members to PPA, we first need to do a better job building relationships with our student members, so they continue as PPA members after graduation. Free PPA membership for graduate students in psychology will be available beginning July 1, 2020. Graduate students will be eligible for free membership from the time they enroll in a graduate program in psychology until they graduate. We believe that this will help to build our pipeline of future members.

Next, we need to make membership affordable our millennial psychologists. Starting July 1, 2020, all members will have the option

to pay their dues monthly if desired, with an automatic withdrawal from a debit or credit card. Several early career psychologists have told us that this way of paying their PPA dues is more budget friendly and more convenient.

And finally, we need to offer new and different benefits that are meaningful to younger professionals. Here are some of the new member benefits that we are considering developing or have developed:

- Mentoring program for members at all levels.
- Health and disability insurance
- 401K and Solo K retirement programs
- More webinars and podcasts for CE
- Interest Groups
- Consultation Groups
- Patient referral service for members (possibly in conjunction with APA)

Conclusion

The COVID-19 pandemic has placed many demands upon professional psychologists and PPA will be adjusting its services to meet those demands. However, this 2019 survey also highlighted some long-term issues, especially concerning the demographics of the PPA membership that also need to be addressed. Activities designed to strengthen PPA will help us better respond to the needs of psychologists emerging from the COVID-19 pandemic. **NP**

CE QUESTIONS FOR THIS ISSUE

The articles selected for 3 CE credits in this issue of *The Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of \$60 for members (\$120 for nonmembers) and mail to:

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

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

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you.

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.

The Influenza Pandemic of 1918

1. Which is TRUE about the flu epidemic of 1918?

- a. About 675,000 Americans died
- b. About 50 million people died across the world
- c. It was likely the deadliest infection in world history
- d. All the above

2. The best evidence suggests that the influenza of 1918 was spread mostly by

- a. Chinese migrant workers in the United States
- b. American soldiers sent to Europe during World War One
- c. Italians especially Neapolitans, visiting Spain
- d. Brazilians

3. Historians reported that the number of influenza cases rose very quickly in Philadelphia

- a. Following a Liberty Bonds parade in September watched by 200,000 persons
- b. After the Philadelphia Athletics won the World Series over the Cincinnati Reds
- c. Following the signing of the Armistice on November 11, 1918
- d. After the Paris Peace Accord was signed in 1919

4. Which statement BEST represents conditions in the United States in 1918?

- a. Newspapers freely and responsibly informed the public of the epidemic
- b. In the early stages of the pandemic the government censored newspaper reports of influenza because they thought it might undermine morale needed to prosecute the war against Germany
- c. The American military responded quickly to impose social distancing within its troops
- d. President Wilson and the federal government responded quickly to assist governors and mayors requesting help

5. During the flu epidemic of 1918,

- a. Physicians largely applied scientifically informed and effective treatments
- b. The United States had vigorous and well-developed medical research programs
- c. Many Americans relied upon folk remedies because of the ineffectiveness of conventional medical treatments
- d. All the above

6. Currently the World Health Organization does NOT permit diseases to be named after places, persons or animals.

TRUE FALSE

7. Following the 1918 influenza epidemic,

- a. The number of deaths from non-influenza related causes, temporarily increased after the epidemic subsided.
- b. There were reports of an increase in post-viral melancholia (depression)
- c. Anecdotal evidence suggests that some patients who recovered from the influenza experienced loss of cognitive functioning
- d. All the above

CE QUESTIONS FOR THIS ISSUE

8. Which public health lessons could one infer from this review of the 1918 pandemic?

- a. Social distancing, when properly enforced, saves lives
- b. Public health officials should be candid with the public about the nature of the pandemic
- c. Public health measures are more likely to be effective if the federal, state, and local governments coordinate their activities.
- d. All the above

Racism in the COVID-19 Pandemic

9. Many Americans blamed the Spanish flu on Chinese, Italian Americans, or African Americans, even though it most likely originated in

- a. Germany
- b. Spain
- c. Predominately White rural Haskell County in Kansas
- d. Russia

10. According to Jilani (2020), one of the first steps in addressing prejudice is to correct misinformation and thereby reduce fears.

TRUE FALSE

Hard Times are Here and More Hard Times are Coming

11. The rate of death from COVID-19 is high among African Americans because they are

- a. More likely to have pre-existing medical conditions
- b. More likely to have jobs or live in areas where exposure to COVID-19 is higher
- c. Less likely to have access to good health care
- d. All the above

12. According to Hong (2009), many survivors of SARS developed

- a. Schizophrenia
- b. PTSD
- c. Dissociative identity disorder
- d. All the above

13. The word to describe the psychological consequences when an individual makes a morally difficult decision that contradicts their deeply held value system is

- a. Moral injury
- b. Post-traumatic distress disorder
- c. Ethical dilemmas
- d. Ontological injury

14. According to Spinney (2017) anecdotal evidence suggests that many survivors of the 1918 flu epidemic developed

- a. Immunities that helped them live extraordinarily long lives
- b. A rate of cancer far higher than what we expected in a normal population
- c. Melancholia
- d. All the above

15. According to Petrosillo et al., COVID-19 is highly similar structurally to MERS and SARS

TRUE FALSE

16. According to Asadi-Pooya and Simina, it is highly likely that some survivors of COVID-19 may incur neurological damage

TRUE FALSE

Considerations for Resuming Face to Face Psychotherapy?

17. The author believes that psychologists can refuse to treat patients face to face if doing so would compromise their health.

TRUE FALSE

18. Psychologists who are administering psychological testing can minimize risk of contagion by

- a. Thoroughly cleaning testing materials touched by patients
- b. Wearing a mask and having patients wear a mask
- c. Conducting all or portions of the interview or feedback sessions by telehealth
- d. All the above

Psychologists on the Frontline of COVID-19 Suicide Risk

19. According to the interpersonal theory of suicide, a completed suicide involves both

- a. The desire to die and the means to die
- b. The desire to die and the desire to live
- c. Anger expressed inward and anger expressed outward
- d. Unemployment loss and troubled relationships

20. A person who experiences perceived burdensomeness might be most likely to say

- a. Others would be better off without me
- b. My social group burdens me
- c. I perceive that others are a burden to me
- d. The burdens I carry are perceptual

21. Suicide rates tend to increase during periods of economic recessions

TRUE FALSE

22. Psychologists can reduce the risk of suicide by

- a. Considering means restriction
- b. Having brief contacts with suicidal clients between sessions
- c. Ensuring that clients have emergency numbers to call or text
- d. All the above

Reflections on Anxiety and Change During a Pandemic

23. Normal anxiety is

- a. proportional to the situation
- b. generally brief in duration
- c. helps us anticipate and resolve problems
- d. All the above

24. Neurotic anxiety

- a. is characterized by gastric rather than cardiovascular symptoms
- b. is generally brief and relatively mild.
- c. prevents adaptive responses
- d. All the above

COVID-19 Dilemmas

Please match the overarching ethical principle with its definition

- | | |
|-------------------------------------|---|
| 25. ____ Beneficence | a. obligation to protect the public |
| 26. ____ Nonmaleficence | b. Avoiding harm to patients |
| 27. ____ General Beneficence | c. Promoting the well-being of patients |

28. According to Standard 10.10b of the APA Ethics Code, psychologists

- a. Must see patients even if they present a danger to the psychologist
- b. Must terminate with patients if they present a danger to the psychologist
- c. May terminate with patients if they present a danger to the psychologist

29. A psychologist who spoke to a patient about the importance of social distancing would be acting upon the ethical principle of

- a. Confidentiality
- b. General beneficence
- c. Privacy
- d. Kohlberg's level of morality stage 1

30. According to the preemption rule of the HIPAA Privacy rule, the state or federal law that is more protective of patient privacy, from the standpoint of the standpoint of the patient, is the law that prevails in the event that state and federal laws conflict with each other.

TRUE FALSE

When an Out of State Client Needs My Help

31. The conservative interpretation of out of jurisdiction practice is that psychologists should be licensed or otherwise authorized to practice psychology in the state where the patient is physically located.

TRUE FALSE

32. According to Standard 1.02 of the APA Ethics Code, when the laws conflict with the APA Ethics Code, psychologists should

- a. Make known their commitment to the Ethics Code
- b. Try to resolve the conflict with maximum adherence to the Ethics Code
- c. Never use the standard to justify or defend violations of human rights
- d. All the above

33. According to principle-based ethics, when two or more ethical principles appear to collide the psychologists should consider whether

- a. One ethical principle has a higher priority or importance than the others
- b. The proposed intervention has a likelihood of success
- c. An effort has been made to minimize harm to the offended ethical principle
- d. All the above

Should I Disclose My COVID-19 Status?

34. Dr. Gaskill had to disclose her COVID-19 status for ethical reasons. What were those ethical reasons? She

- a. Wanted to support her patients in maintaining their own physical safety as well as the safety of those around them
- b. Wanted her patients/clients to feel sorry for her
- c. Was coping with her own issues about contamination
- d. Wanted to see their reaction

CE QUESTIONS FOR THIS ISSUE

Answer Sheet to Home Study on Readings on COVID-19 May 2020

Name: _____

- | | | | | | | | | | |
|-----|------|-------|---|---|-----|------|-------|---|---|
| 1. | A | B | C | D | 18. | A | B | C | D |
| 2. | A | B | C | D | 19. | A | B | C | D |
| 3. | A | B | C | D | 20. | A | B | C | D |
| 4. | A | B | C | D | 21. | TRUE | FALSE | | |
| 5. | A | B | C | D | 22. | A | B | C | D |
| 6. | TRUE | FALSE | | | 23. | A | B | C | D |
| 7. | A | B | C | D | 24. | A | B | C | D |
| 8. | A | B | C | D | 25. | A | B | C | |
| 9. | A | B | C | D | 26. | A | B | C | |
| 10. | TRUE | FALSE | | | 27. | A | B | C | |
| 11. | A | B | C | D | 28. | A | B | C | |
| 12. | A | B | C | D | 29. | A | B | C | D |
| 13. | A | B | C | D | 30. | TRUE | FALSE | | |
| 14. | A | B | C | D | 31. | TRUE | FALSE | | |
| 15. | TRUE | FALSE | | | 32. | A | B | C | D |
| 16. | TRUE | FALSE | | | 33. | A | B | C | D |
| 17. | TRUE | FALSE | | | 34. | A | B | C | D |

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Continuing Education Participant Satisfaction/Evaluation Form

PLEASE PRINT.

Name: _____ Degree: _____

Address: _____

City/State/Zip _____

HOME STUDY CONTINUING EDUCATION PROGRAM:

Readings on COVID-19 May 2020
Three Continuing Education Credits for Psychologists
(1 hour of which is for ethics)

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

PLEASE COMPLETE AND RETURN WITH THE COURSE ANSWER SHEET.

Using the scale below, check the appropriate number after each statement to indicate the degree to which you agree or disagree with the statement.

	1 (Strongly DISAGREE)	2	3	4	5 (Strongly AGREE)
	1	2	3	4	5
1. The home study description was accurate.	[]	[]	[]	[]	[]
2. I acquired new knowledge and/or skills.	[]	[]	[]	[]	[]
3. The teaching format/length was suitable to the content.	[]	[]	[]	[]	[]
4. The objectives (listed on back) of the course were met.	[]	[]	[]	[]	[]
5. The concepts were well explained.	[]	[]	[]	[]	[]
6. This home study met or exceeded my expectations.	[]	[]	[]	[]	[]
7. I would recommend this home study to others.	[]	[]	[]	[]	[]

	Not Useful		Extremely Useful
	1	2	3
How useful was the content of this CE program for your practice or other professional development?	1	2	3

	1 – Very Little		5 – great deal
	1	2	3
How much did you learn as a result of this CE program?	1	2	3

CE QUESTIONS FOR THIS ISSUE

LEARNING OBJECTIVES

Please rate the following statements on the scale below (check numbers 1 through 5).

	1 (Strongly DISAGREE)	2	3	4	5 (Strongly AGREE)
Based on the content of this workshop, I am able to:					
1. Describe how to respond to clinical and ethical issues That may arise as a result of the COVID-19 pandemic	1 []	2 []	3 []	4 []	5 []
2. Identify emerging mental health needs arising out of the COVID-19 pandemic; and	[]	[]	[]	[]	[]
3. List the lessons from the 1918 influenza pandemic that may be relevant today	[]	[]	[]	[]	[]
4. Describe the safety precautions needed to resume face to face psychotherapy	[]	[]	[]	[]	[]

Comments and recommendations for change in this home study program: _____

Suggestions for future home study/workshop topics: _____

I certify that I personally completed this Continuing Education home study offering.

Signature

Date



2020 PPA CONTINUING EDUCATION

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2020, we are expanding the options. We hope you'll join us for one or more of these programs!

Calendar

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

MAY 15, 2020

Ethical Issues with COVID-19

Webinar

12:00 – 1:00 pm

MAY 18, 2020

Pennsylvania Child Abuse Recognition and Reporting (Act 31)

Webinar

11:00 am – 1:00 pm

MAY 28, 2020

Mental Health Access in Pennsylvania: Examining Capacity for a Global Health Crisis Response

Webinar

12:00 – 1:00 pm

OCTOBER 16, 2020

Fall Continuing Education Conference

Normandy Farms

Blue Bell, PA

NOVEMBER 6, 2020

Fall Continuing Education Conference

Hotel Monaco

Pittsburgh, PA

Still have questions about telpsyhology?
Check out PPA's available webinars:

Introduction to Telpsyhology: Part 1

Introduction to Telpsyhology: Part 2

Introduction to Telpsyhology: Part 3

Telpsyhology Q&A

Home Study CE Courses

Act 74 CE Programs

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

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

Essential Competencies When Working with Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Telpsyhology Q&A (Webinar)—1 CE

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

*Introduction to Ethical Decision Making**—3 CEs

*Ethics and Self-Reflection**—3 CEs

*The New Confidentiality 2018**—3 CEs

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

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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



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

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