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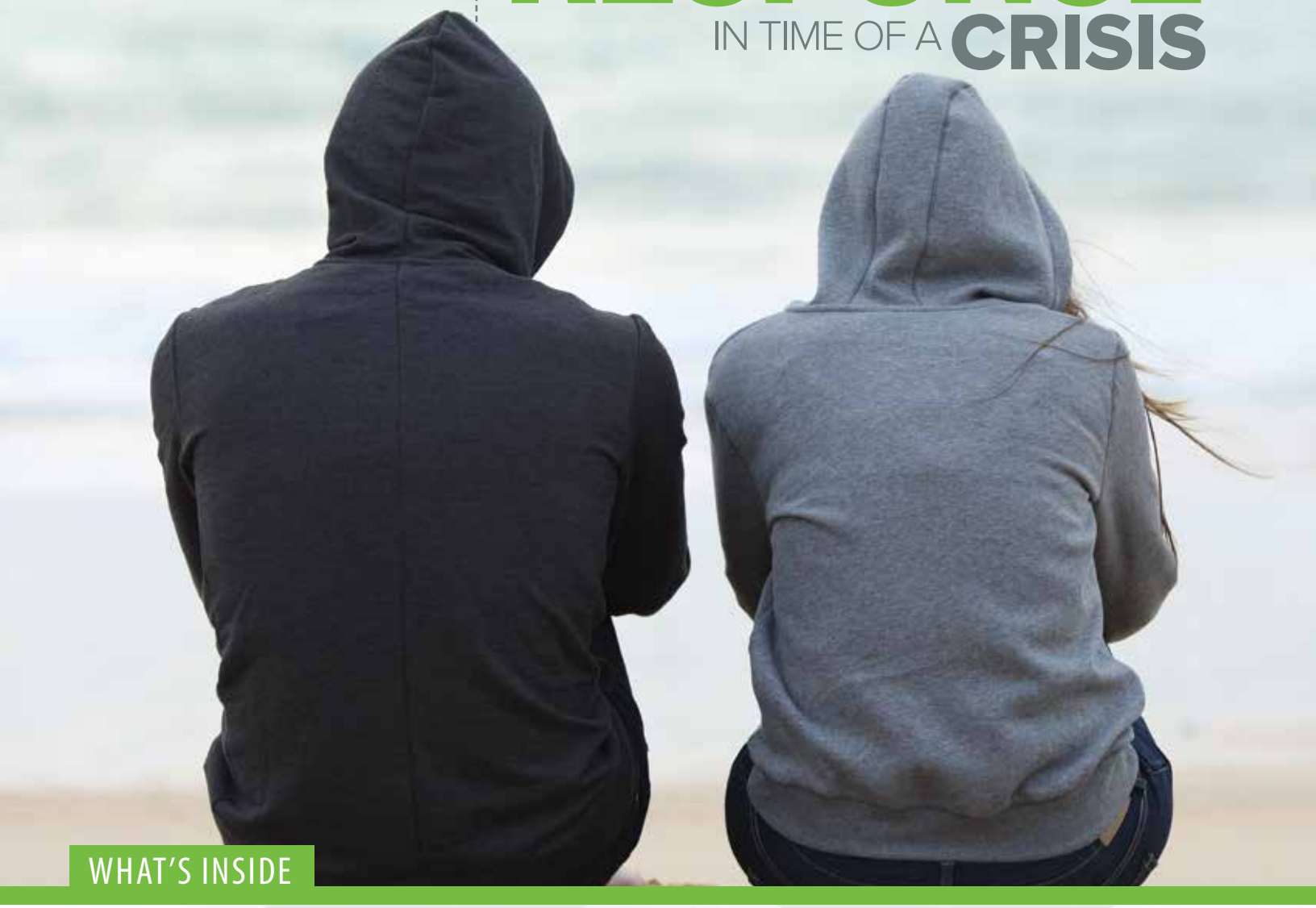
Special Section

RESPONSE
IN TIME OF A CRISIS



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PPA 2020, COVID-19, and VUCA 2.0: Making Sense of It All

MARIE C. McGRATH, PhD

This isn't the column I expected to write. This isn't the spring I expected us to have.

Three months ago, as I finished my penultimate "Presidential Perspective" column, I would have expected that this version would be bursting with news of the many PPA events that bring us physically together: a recap of a successful Spring Conference in Pittsburgh; information on a May leadership training event designed to enhance the skills and effectiveness of PPA's present and future leaders; and eager anticipation of four jam-packed days of professional development among friends this month at Convention. Instead, in the face of a pandemic that's left us trying to maintain both our health and our interpersonal ties through physical distance and layers of PPE – fearful about our personal and collective economic security, and mourning over 100,000 lost to date in the United States alone – I've found myself struggling to summarize the accomplishments of the past year, given all that still remains unfinished and uncertain.

Last week, I attended an APA webinar titled "Leadership During a Pandemic: Steadying the Course for Your Team and Organization." In that webinar, APA President Dr. Sandra Shullman made the point that, even though the context of our practice has significantly changed due to COVID-19, our goals and values have remained the same. She alluded to the work of Bill George, Harvard Business School's Henry B. Arthur Fellow of Ethics, who argues that we should respond to "volatile, uncertain, complex, and ambiguous" circumstances (a concept referred to as "VUCA" in U.S. Army War College training curricula) with "VUCA 2.0" leadership behaviors: having the ***v***ision to maintain clarity of mission in difficult times; ***u***nderstanding how one's organization fits into a changing landscape; having the ***c***ourage to implement new strategies; and demonstrating ***a***daptability in the face of ongoing change (George, 2017).

I could never have imagined when I proposed the theme "Lead by Example" for PPA's 2019-2020 year how thoroughly we'd be challenged this year, and how well our PPA members would rise to, and above, those challenges. Whether through utilizing telehealth for the first time in your own practice; sharing information about useful technologies and tools with your colleagues on the PPA listserv; presenting webinars to help your colleagues and clients cope with changing circumstances; or advocating for the adoption of laws and regulations enabling all of us to flexibly respond to COVID-related changes in psychology training and practice, PPA members and staff have individually and collectively embodied those VUCA 2.0 strategies over the past few months. Thank you all for all that you do. Dr. Dea Silbertrust, whose excellent leadership in a variety of capacities has benefited PPA for many years now, will assume the presidency of our organization in mid-June, and I can't wait to see what she has planned for us. I also can't thank PPA's incredible staff enough for their hard work and commitment to our success, both in ordinary times and in our current extraordinary circumstances. I'm so proud of our amazing team. Ann Marie, Sam, Iva, Rachael, Judy, and Erin: from the bottom of my heart, thank you.

Despite all that remains undone, our accomplishments over the past year are significant and worthy of celebration: the passage of PSYPACT, the decennial revision of PPA's bylaws to reflect our present and future organizational goals, our recognition by APA Division 31 for our commitment to Pennsylvania's early career psychologists, our decision to waive membership fees for graduate student members in order to expand their representation and involvement in PPA, and our success in maintaining financial stability in these tumultuous times, among many others. The events that I mentioned above, deferred for now due to COVID-19, will indeed happen, though at different times and in different forms. We are currently planning to deliver main 2020 Convention events, such as keynote addresses (including one by Dr. Shullman) and recognition ceremonies for our award recipients, online; stay tuned for details. Other events will happen later on, once it's safer for us to meet in person again.

I'll close this column by remembering Jean Lau Chin, Ed.D., ABPP, who passed away on May 13 from complications of COVID-19. She was a leader of multiple APA Divisions and committees; a professor at Adelphi University; a skilled practitioner, scholar, and advocate, particularly on topics related to diversity and leadership; and a generous and kind mentor who freely shared her time, knowledge, and energy to help others (myself included) develop

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A WATERSHED Moment for the Practice and Profession of PSYCHOLOGY

ANN MARIE FRAKES, MPA

We are facing a global health crisis unlike any we have faced before — one that is killing people, spreading human suffering, and upending people's lives. But this is much more than a health crisis. It is a human, economic, social, and psychological crisis. Covid-19 has provided a watershed moment for psychologists and the practice of psychology. This has truly been a time for psychologists to shine and bring much needed compassion and care to our citizens.

You, our PPA members, adapted and changed the ways in which you provide therapy in record time. You were there for your clients and patients when they needed you most. Many of you quickly learned how to use technology that you had no or very little experience. You not only became comfortable using Zoom, Doxy.me, or another online platform, you helped your clients to feel safe and secure using the technology too. Thank you for being a source of strength and stability for your patients!

Several of our members, who were more comfortable with the technology and had more experience in providing services over the phone and online, stepped up to teach and lead others. Thank you so much for helping your colleagues adjust to this new normal and become proficient utilizing a new technology in a matter of days, hours, or even moments. Some of you with more experience providing virtual services shared and coached others in how to make a virtual therapy session more like an in-person session. Others shared ideas on ways to encourage your clients to be more communicative and involved during online sessions. Thank you for mentoring your colleagues.

> ***"In times of adversity and change, we really discover who we are and what we're made of."*** *—Howard Schultz, Chair, Starbucks*

PPA is here to support and assist our members in this time of change and uncertainty. Here are just a few improvements we have made to better serve our members now and into the future:

1. Access to free resources and literature. We are working hard to put all COVID-19 and tele-psychology related resources on our website in one place to give you and all psychologists easy access. If you have not yet reviewed these materials OR you have a question about a COVID-19 related topic, please click this link: **https://www.papsy.org/page/COVID19**. The answer to your question just might be there!

   Please check out our special May issue of the Pennsylvania Psychologist on COVID-19 which also can be used for CE credit. **https://cdn.ymaws.com/www.papsy.org/resource/resmgr/pdf/2020may_pa_psychologist_onli.pdf**

   In addition, we are now offering more webinars than we ever have. Any programs related to COVID-19 or tele-psychology specifically will always be available FREE if you do not require CE. This way, we can share important educational content more broadly.

2. With the support of the Board of Directors, there will be NO DUES INCREASE FOR FY 2020-2021. We will be offering a new flexible monthly payment option, that includes a minimal service fee for the convenience. This will be offered beginning July 1, 2020.

3. To encourage sustained student involvement in PPA, effective July 1, 2020, all psychology graduate students will receive FREE PPA membership from the time they enroll in their program until

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SENATE BILL 67 (PSYPACT)

Legislation Signed Into Law

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

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

Although many states have modified or eased their out of state practice restriction due to the COVID-19 pandemic, these may be temporary measures and a more unified and permanent solution is needed to address out of jurisdiction practice issues.

The Road to Passage of Act 19 of 2020

Although PSYPACT passed both the Senate and the House unanimously, it took a lot of hard work to get it to become law. Our governmental affairs representatives, The McNees Winter Group and I met with every single member of the professional licensure committees in both the House and the Senate to introduce the bill to them, address any questions that members may have had regarding the bill, and to get a vote count before the bill was to be voted out of committee. In addition, we attended meetings with the Governor's office and numerous meetings with leadership in the House to make sure that there was no opposition from them regarding this bill. We had to address false radio claims that the bill would encourage conversion therapy. We also had to address numerous questions from legislative staffers before the final approval of the bill. Lastly, the day the bill was supposed to be voted on was the day that COVID-19 shut everything down in Pennsylvania. We needed to keep pressure on the leadership in the House to bring this up for a vote.

Overview of Act 19 of 2020

PSYPACT authorizes both telepsychology through the *E. Passport* and temporary in-person, face-to-face practice of psychology across state lines in PSYPACT states through the Interjurisdictional Practice Certificate (IPC). The temporary in-person through the IPC is limited to 30 days and would be used in such situations as when a psychologist was called to testify in a court hearing in another state or if they would have to conduct a child custody evaluation and one parent lived in Pennsylvania and the other in another state. Currently, varying state requirements for providing these services have become increasingly complicated and this would streamline the process in that it would effectuate consistency for states that belong to the Compact.

Benefits of Act 19 of 2020

There are numerous benefits to PSYPACT as it increases patient access to care, facilitates continuity of care when a patient relocates, travels, is in the army or goes away to college, and it offers a higher degree of consumer protection across state lines. PSYPACT will permit psychologists to provide services to populations currently underserved or geographically isolated locations.

Here are some concrete examples of how this will help Pennsylvanians. Going to college is often a very stressful event and oftentimes produces anxiety in students. By allowing telepsychology these students can stay connected to their psychologist and make to the transition to college easier. Also, people who are in the military often will find themselves relocated to another state. This will allow families to stay connected to their psychologist during this time of transition.

How Many States Have Passed PSYPACT Legislation

Currently 14 states have passed PSYPACT legislation: Arizona, Colorado, Delaware, Georgia, Illinois, Missouri, Nebraska, New Hampshire, Nevada, Oklahoma, Texas, Utah, Pennsylvania (effective on July 8, 2020) and Virginia (effective on January 1, 2021). The following states still have legislation pending: Alabama, District of Columbia, Hawaii, Iowa, Kentucky, Michigan, Minnesota, North Carolina, Ohio, Rhode Island, Tennessee, Washington and West Virginia.

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Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF MAY 20, 2020

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

Working in INTEGRATED CARE SETTINGS in Times of Public Concern

RICHARD KUTZ, PsyD
JULIE RADICO PsyD, ABPP

Behavioral health providers in integrated care work side-by-side with other health care providers (HCP) in times of crisis. We see in real time how increased pressures and uncertainty from COVID-19 impact patients, HCP, and support staff. There has been an overwhelming amount of information shared about COVID-19, with varying degrees of accuracy. It is important that individuals remain informed during such times, however these tidal waves of information may trigger patient and HCP anxiety.

Health anxiety can be described on a continuum ranging from an absence of health concerns to pathological health anxiety (Ferguson, 2009). It is often recommended that those with high levels of health anxiety (i.e. Illness Anxiety Disorder) attend regular check-ins with their HCP, to receive reassurance, and reduce avoidance behaviors. However, this poses a significant challenge for patients and HCP during times of a pandemic when in-person appointments are limited and providers are stretched beyond their patient care capacity.

Moreover, HCP engaged in direct diagnosis, treatment, and care of patients during pandemics, like SARS/COVID-19, have a higher risk of negative mental health outcomes, including symptoms of depression, anxiety, insomnia, and distress (Lai et al., 2020; Lee et al., 2007).* These providers fear infection of those around them, may be reluctant to work, and also contemplate resignation (Lee et al., 2007; Bai et al, 2004). Psychologists can provide much needed support during these times.

Helping colleagues manage anxious patients

HCP, especially those in primary care, are tasked with being on the frontlines of initial screening, identifying who is appropriate for further testing, and providing reassurance for those who suspect they have COVID-19. Information of the specific symptoms and how the virus spreads continues to evolve making it difficult for providers to be sure they are provided accurate information. For example, the length of time to receive results of COVID-19 testing has varied from 2-10 days. Nevertheless, practices which offer integrated care services are well poised to help providers treat anxious patients

during times of increased health risk. One such strategy is providing co-visits (e.g. warm/hot-handoffs) in which patients can see both providers in one visit. During a co-visit, the psychologist provides behavioral interventions (e.g. psychoeducation on mindfulness, fight or flight, deep breathing) while allowing the physician to focus on the physical-health related content.

Additionally, screening calls to anxious patients allows for acute anxiety management skills to be delivered and in-person style clinical resources to be preserved while using distance modalities, enabling patients to maintain quarantine conditions. From home, patients can describe their anxieties in a natural setting and psychologists can use the everyday surroundings to engage "promotion focused coping strategies," such as engaging in adaptive

contact with others and emphasizing areas the patient can exercise control (Zhang, Zhang, Ng, & Lam, 2019). In moments of distress, people are prone to engage in "prevention focused coping strategies" like complaining and ignoring issues, but these behaviors are linked to worse physical and psychological well-being (Zhang, Zhang, Ng, & Lam, 2019). Psychologists are practiced at helping patients reframe and redirect attention to promotion focused strategies, helping them adapt the strategies into everyday behaviors.

Helping colleagues

Continued exposure to COVID-19 and growing morbidity increases the HCP risk to secondary traumatic stress with effects similar to PTSD. Identified protective factors include dispositional mindfulness, emotional awareness, and social support (Sprang, Ford, Kerig, & Bride, 2018). There are models such as Balint Groups where these practices are institutionalized into the workflow and culture; however, it can also be effective to generally engage colleagues in mindful discussion or supportive conversation. We can also encourage colleagues to engage in positive coping in response to their perceived lack of control, including doing so actively (e.g. focusing on changing oneself and/or the environment) or positively yielding control (e.g. accepting things as they are, letting go of active/negative control efforts) (Shapiro, Astin, Shapiro, Robitshek, & Shapiro, 2011). Unhelpful ways to exert control can include attempts to over-control, being too dogmatic, and/or yielding quickly by being too timid or indecisive. These positive coping responses detailed by Shapiro et al. (2011) exemplify the promotion focused strategies found to be efficacious by Zhang et al. (2019). They specify areas where control can be productive and efficacious, and also lead to better job performance and attitudes. The associated accomplishment of core tasks and better job attitudes contributes to the adaptive work engagement found to be protective against burnout symptoms.

Continued exposure to COVID-19 and growing morbidity increases the HCP risk to secondry traumatic stress with effects similar to PTSD.

Burnout has been a highlighted concern among HCP and is characterized by emotional exhaustion, cynicism/depersonalization, and lack of professional efficacy. Factors that contribute to burnout symptoms include high levels of work stress combined with lower levels of work autonomy, an imbalance between work and home life, and weak professional boundaries. Crisis situations where workloads overflow and medical professionals are engaged in extra shifts are ripe to promote burnout symptoms (Babineau, Thomas, & Wu, 2019). This is a time when our colleagues need encouragement to take breaks, engage in self-care, and make time for themselves. The instinct to de-prioritize self-care can lead to counterproductive and self-destructive outcomes.

Our own self-care

Boundaries are an important professional construct that help maintain safety for health professionals and patients alike. Office settings and waiting rooms provide a known structure to help maintain professional boundaries yet, currently, many are working from home, utilizing personal cell accessibility, and engaging in professional activities after hours. As these boundaries are blurred during moments of crisis, consultation with other psychologists becomes more important.

Throughout the COVID-19 pandemic, APA, PPA, National Register, APAHC and other professional organizations have been offering a range of webinars, teleconferences, and other opportunities for psychologists to come together and engage in self-care practices. PPA's COVID-19 website resource section includes a specific subsection dedicated to stress relief. Whether during times of crisis or throughout our standard practice it is of critical importance that psychologists identify **and engage in** self-care, this can be as simple as drinking enough water throughout the day to such complex needs as seeking our own medical/psychological care.

*Of note these studies focused on health care workers in China, which may limit generalizability based on cultural and diversity differences.

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VIRAL TEACHING:
Pandemic Psychology and Madness via Media, Some Tips*

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Temple University

Winston Churchill: "If you're going through hell, keep going."

As the professor and graduate teaching assistants (TAs) for a large undergraduate course on the Meaning of Madness, the COVID-19 pandemic has brought widespread changes and uncertainty to teaching and instruction. The experience has also provided valuable lessons for adapting a course and transitioning to virtual teaching. This course's focus on society's conceptualizations of madness versus normalcy was notably relevant to the current pandemic and provided ample opportunities to reinvent course content to incorporate concerns that are most pertinent. The recommendations outlined below aim to provide some tips on the transition to online learning through the lens of teaching a course on madness, and to provide reflections on the psychology of 'pandemic pedagogy.'

Course Format. One major consideration when offering a course online is how it should be formatted. Synchronous courses, where students attend a live class offered over an online platform, such as Zoom, offer students and instructors the opportunity to interact in real time, more closely simulating in-person interactions. On the other hand, asynchronous courses, utilizing recordings of lectures and virtual assignments, such as discussion boards, in place of live virtual interactions, provide more flexibility to students who may have technological issues or difficulty arranging schedules when working from their homes. In our course, a combination of synchronous and asynchronous classes was optimal as this format provided flexibility without losing the human element of live interactions.

Accessibility. To ensure that all students have access to the course, it is important to reach out to students to specify the technological requirements of the course (e.g., microphone, webcam) and to have resources prepared for students who may not have access to this technology. Even with the assistance of university resources, there are other barriers, such as Internet connectivity and computer literacy, which require flexibility on the part of the instructors.

Restructuring the Curriculum. The curriculum originally designed for in-person teaching also needed to be restructured to meet the needs of students learning on an online format. Planned activities were adapted, such as an originally planned in-person debate reformatted into a lively discussion board activity. It also became difficult to ensure participation from all students, so, for example, having students prepare at least one point to contribute ahead of class aided in facilitating discussions and helped increase student interactions.

The Digital Socrates. The amount of time to prepare and

especially to deliver an engaging lecture was greatly increased in pandemic pedagogy. No longer could one literally walk into a lecture hall and deliver an often seemingly informal, conversational presentation with gestures and movement through the room, an engaging thespian teaching style if you will, with ongoing Q&A, with perhaps some PowerPoint or video as adjunctive, and with Socratic dialogue/interaction, sociability, and free-flowing open all-in discussion as a desired hallmark.

Course Content. From trauma to the pandemic's effect on immigrant communities, integrating discussions on COVID-19 into the course content allowed for fruitful contemplation about the lasting impact of the pandemic and gave students the ability to engage with the course material in a way that was current and relevant. The course content was also tailored specifically to the needs of students, such as a recorded lecture on mindfulness practices when managing stress and anxiety.

Combining Compassion and Rigor. Maintaining a balance between academic rigor and displaying compassion to students during this difficult transition meant making sure that deadlines and assignments matched students' unique needs, while at the same time ensuring that students were successfully engaging with the course content. Overall, prioritizing student well-being first, while also maintaining and meeting the essential learning objectives of the course, provided us with a meaningful experience as we ventured into the world of online teaching.

Discussion Groups as Classroom Communities. Concerned that the abrupt shift to online learning could alienate students, the TAs worked at curating safe spaces and projecting a calm normalcy in their discussion groups. TAs choreographed interactions like group projects to recapture the camaraderie that had eroded after classes could no longer convene in person. When TAs observed discomfort during synchronous discussions--cognizant that many students now living with their families had lost privacy--they recalibrated their approaches. Eventually, previously reserved students began to communicate their vulnerabilities in asynchronous forums.

Leveraging Technology. Having the tools of the digital age available to us during this time has also allowed us to consider how technology can be leveraged to best benefit our students. For example, the ability to record lessons provides the opportunity for students who miss a class session to still access the information. Another feature to highlight in Zoom specifically is breakout rooms. These provide an opportunity for students to engage with one another and help add human connection back into lessons.

Keep in Mind, It Could Have Been Worse. The motivation of the instructors and students is a key element in achieving success in a sudden unexpected tectonic shift in the bedrock behaviors of traditional teaching. Staying motivated on both sides of the screen while scrambling to quickly adjust to this pandemic pedagogy is not easy, particularly against the backdrop of extreme societal and cultural fears and uncertainties and the sudden ascendancy of existential anxieties, and it was hard for some students to stay focused on demanding studies in the middle of such lethal uncertainties, as relentlessly reported in all media. BUT it could have been worse, we feel, in any comparable pandemic before the digital age and our comprehensive technologies to digitize and readily transmit all forms of knowledge. Also, all the tools of the digital age allow us to 'safely' socialize, study, and shop in constrained quarters providing the conditions for focus and academic success as we have found in this short exploration of pandemic pedagogy.

As our semester comes to a close, we hope the lessons we learned can be utilized by others when making considerations for future online courses.

We wish the best for the 95 students in our class; they will have many memories academic and beyond of this amazing period, as will we!

*This is an abbreviated and revised version of an article to appear in the 2020 Spring/Summer issue of The Amplifier Magazine of the APA Society for Media Psychology and Technology (div46amplifier.com).

A WATERSHED MOMENT FOR THE PRACTICE AND PROFESSION OF PSYCHOLOGY

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graduation. This was approved by the Board of Directors in March.

4. Sustaining members of PPA will have the opportunity to give/offer a FREE one-year introductory membership to a psychologist who has never been a member of PPA before, focusing on the recruitment of early career psychologists. This membership program was the idea of former PPA President, Dr. David Rogers. Thank you, Dr. Rogers! We will share the details about this exciting program with all members in July. We are looking forward to the opportunity to recruit more new members and additional sustaining members

Thank you for providing a calming presence and your never-ending support to your clients, friends, family and colleagues. Remember, if you have a great idea, an urgent need, or just want to talk about PPA or Penn State, please text or call me on my cell phone, 717.614.5095.

And as always, thank you for all you do for PPA.

NOTES FROM THE FIELD:
A Disaster Responder's View of the Effects of Disasters on Communities of Color

SHARI KIM, PhD

It was my first deployment with the Red Cross. I was sent to a community in East Texas that had been ravaged by flooding. Entire towns had been immersed under five feet of water, and I did not know what to expect.

I was sent to a local high school in a hard-hit community. Inside the high school, we had a shelter and a MARC (Multi-Agency Resource Center). The MARC is a place for victims to access multiple services at one time, including FEMA, Red Cross, Americorps volunteers who will help clean out homes, and people from local agencies that will help recover important documents. We had one African-American family in our shelter.

The community where the high school was located was a close-knit, White community. No one from that community needed shelter, because friends and family in the community took in those who were displaced. The neighboring African-American community was full of people already struggling before the disaster, and the climate was quite different. The family in our shelter had traveled from that community to this town, because they felt safer in the shelter there.

While staying in the shelter, the husband and wife continued to go to work as often as possible. She was also the caretaker for her brother, who suffered from schizophrenia and an intellectual disability. Under normal circumstances, a local agency sent people to care for him during the day while she worked. The agency refused to send staff to the shelter, so she brought him to work and sat him at a table where she could see him. Her employer told her she could not bring him and subsequently fired her for not being able to work.

At the MARC and shelter in their community, there had been fights that eventually led to the need for a police presence. The atmosphere was tense for most of the Red Cross workers with whom I spoke, but my roommate (who was stationed there) saw only people who were frustrated before the disaster happened and fearful about their needs not being met. When I eventually was moved to that site, I saw the same thing. Adding the stress of a disaster onto a community that has already been beaten down

can bring out fear responses in anyone. When I treated people with kindness and compassion, they treated me the same way.

The difference in point of view among Red Cross workers brings out an ugly thing that we as psychologists do not like to admit about ourselves: that we have cultural blindspots and may even have racist tendencies that we bury. Failing to look at these blindspots is dangerous for everyone. We also must remember that, the more barriers we place in the way of people getting their basic needs met (such as the wife being fired from her job after being the victim of a flood), the more distrustful they become toward anyone claiming to provide assistance. In the case of this family, they chose to be grateful for the assistance they were receiving and spoke to us often of their gratitude for a safe place to sleep and food. Not everyone is as resilient as this family, however.

Fast forward to another deployment, where families had been displaced from an explosion that destroyed two apartment buildings in Maryland. The residents of those buildings were primarily Spanish-speaking, and many were either undocumented or living with undocumented family members. While we had interpreters on site, many of the residents of the shelter did not want to speak with us. Other residents were afraid to come to the shelter at all, as they feared they would be caught and deported. While I was made aware that many of the residents were suffering from Acute Stress Disorder symptoms, I was unable to find a way to make them comfortable speaking with me.

Family members began visiting the shelter to see loved ones. A few times, a family member would speak to me, knowing that my role was Disaster Mental Health. They would then talk to their relatives and assure them that it was safe to speak with me. Only then would people start talking to me, but they were still mistrustful. It is not common practice in the Red Cross for Disaster Mental Health responders to identify as Mental Health; the feeling is that the stigma around mental illness will make people hesitant to talk to us. In this case, however, people only felt comfortable and safe speaking to me after understanding that I was a psychologist.

The difference in point of view amont Red Cross workers brings out an ugly thing that we as psychologists do not like to admit about ourselves: that we have cultural blindspots and may even have racist tendencies that we bury.

A woman told me of being in bed asleep, when her bed fell two stories through the floor. She woke up under rubble and began screaming for her husband. He did not respond, because he was still unconscious. She found him and pulled him out. He was on fire, and she put him out. Perhaps she was forced to assist him alone, because emergency vehicles did not get there quickly. Having grown up near this community, I was well aware of the common practice of emergency services avoiding calls from certain areas, often taking hours to arrive. Further, victims might attempt to avoid responders for fear of deportation.

While many people think that undocumented immigrants come to this country to receive benefits, that thought is quite untrue (they are actually unable to receive government benefits). The fear in that shelter of even talking to the Red Cross highlights the overall fear among undocumented immigrants that ANY outside agency may be able to deport them or have them deported. This fear makes it incredibly difficult to provide any services, especially in disasters. The Red Cross is a neutral organization, assisting any victim of disaster without question. Despite that neutrality, however, even we are feared.

I want to close by noting that I am a White woman and speaking from a place of privilege. While I do my best to identify and acknowledge that privilege, I also have blind spots. This article is written from a privileged perspective and may include information that reflects my own blind spots. I encourage anyone who sees them to point them out to me. We will never be able to see all of our blind spots, but we can all work a little harder every day to find them and correct them.

CLASSIFIEDS

We All Need More SELF CARE During A Public Health Crisis

JEFFREY L. STERNLIEB, PhD

What does self-care have to do with psychologists who are teaching or doing therapy now that we are not face-to-face? Uncertainty, to one degree or another, is an ever-present force in our lives, and this is as true for mental health professionals as it is for our students and our patients! Although the sources of anxiety may change over time, the defenses against anxiety often do not. Two of the major contributors to anxiety are uncertainty and change. A public health crisis creates an increased level of uncertainty and causes changes that add risk to the most important aspects of our lives — threats to our work AND threats to our and our family members' health. These changes may cause an increased awareness of some assumptions, routines and expectations that no longer function as effectively as in the past. What is indisputable is that a public health crisis such as the COVID-19 pandemic has changed all the rules of the road and added to the emotional burdens we carry. If we fail to pay attention to the impact on us personally, we may risk our health and may risk compromising our effectiveness professionally.

Our professional organization (PPA) has been exceedingly helpful in our efforts to navigate the changing conditions of our work — technological, procedural, legal, coordination with insurance, etc. We, on the other hand, are each responsible for our own roadmap to navigate the emotional impact that we personally experience. We know that, in general, our emotions can compromise logic. We must first accept the uncomfortable reality that we are all somewhat more vulnerable, in differing ways and for differing reasons. A next step is to take the advice we often give to our patients — acknowledge and name the nature of this vulnerability in order to manage it. Accepting our vulnerability can feel humbling and unsettling. In this frame of mind, using the roadmap analogy, it is helpful to reduce our speed or pace, pay close attention to the signs we experience along the way, keep your fuel tank at least half full, periodically check on our progress, do frequent self-maintenance, and especially increase the frequency of personal inspections. This is done most effectively with one or several trusted colleagues. Further, a reliance on what helps us stay grounded and a regular practice of mindfulness are core stabilizers.

What does all of this look like on the ground? Build in extra time — time to take our and others' emotional temperature. Open the therapy session or class or faculty meeting with a check in: "How is everyone doing?" Give, but don't require everyone a chance to talk about how their life, work or relationships have been impacted by Covid-19. Include a request for no cross talk and speaking in our own space. This helps everyone be more present by naming out loud (and therefore letting go of) the things on our mind and our preoccupations. Therapists working in group practices have a unique opportunity to meet together, possibly once a week. In addition, build in time to process our class or therapy session. Find a way to recognize and acknowledge our own vulnerabilities and emotions — decide how much to share, or not — and with whom. If we don't, our vulnerabilities will leak out at times we may regret. Finally, pay attention to and schedule in time to eat, sleep and exercise. We cannot count on any of this without building it into our new normal foundation. The better we attend to our own needs, the better we serve our students, clients and colleagues.

COVID-19: Its Impact on Special Education and Mental Health Services in the Schools

HELENA TULEYA-PAYNE, DEd, *Millersville University*

The closing of school buildings due to the COVID-19 pandemic has caused major disruption in educational delivery, K-12 and post -secondary education. The expectation that learning continues has been strained by unequal access to distance learning systems, availability and skill of caregivers to support instruction and new roles that students find themselves in such as caregiver for younger children. School psychology programs are also challenged in ensuring appropriate field- based training for their candidates.

As a university professor, the learning curve for delivering and evaluating student work through distance learning has been steep. Two of the four courses I teach this semester are graduate courses for school psychology candidates where much of the content requires direct contact with students in educational settings. Based on my vantage point of supervising school psychologist candidates in the field, this article addresses the challenges and evolving solutions for meeting children and their families' needs. The important role of state associations for informing policy makers is also emphasized.

Evaluations

School psychologists are active in educational decision making whether that means working with students through the multi-tier systems of support (MTSS) process or working with teams to determine students who have a disability and are in need of specialized instruction. These decisions involve multiple sources and multiple methods. Some of the requisite activities may be continued through remote means, such as interviewing teachers and caregivers and depending on the school, access to digital records. Other data, such as derived from classroom observations (required for the diagnosis of Specific Learning Disability) are not available through distance methods.

School psychologists are active in educational decision making whether that means working with students through the multi-tier systems of support (MTSS) process or working with teams to determine students who have a disability and are in need of specialized instruction.

Concerned about pressures that some districts were placing on school psychologists to perform evaluations remotely, Dr. David Lillenstein, President of the Association of the School Psychologists of Pennsylvania and member of the School Psychology Board wrote a letter to the Pennsylvania Department of Education (PDE) outlining the ethical concerns of conducting assessments remotely. Shortly thereafter, PDE released a policy statement reiterating the points Dr. Lillenstein made concerning evaluations. Specifically, the policy statement form the Bureaus of Special Education and Early intervention stated:

May standardized tests such as IQ tests or formal achievement tests be administered virtually?

No. Standardized tests such as IQ tests, or formal achievement tests are not designed to be administered virtually. The administration of such tests must be given through the means in which they were developed and standardized to be considered valid and reliable. Deviations from standardization must be reported and, at times, can invalidate test results which could potentially impact eligibility determinations. Therefore, evaluations that require in-person testing or observations should be postponed until school reopens.

Preparation of School Psychology Interns

A collaboration of state associations and trainers from across Pennsylvania's school psychology program resulted in a letter to PDE requesting adjustments to the hours requirement and field placement expectations for internships. The commonwealth regulations require 1,000 field hours for interns but all Pennsylvania training programs abide by the higher standard of 1,200 hours, the National Association of School Psychologists (NASP) standard. The group worked off a recommendation from NASP that alternative activities determined by the training institutions be allowed to substitute for a portion of the hours mandated by PDE. On May 1st, PDE sent out an email (to be followed up with a statement on their website) concerning alterations in the completion of the internship or practicum experience. Again, the recommendations from trainers and state associations were included. For example, PDE recommended that hours should remain consistent but that alternative activities as "designed by individual preparation programs" be implemented to ensure that candidates attain the competencies dictated by the field experience.

Mental Health Support

One educational service that has continued in some districts is the provision of mental health services through Zoom meetings with students. Dr. Lillenstein, a school psychologist for Derry Township School District, reports performing individual Zoom check-ins for students who need emotional support. One of the revelations from this process has been increased interaction with parents. Dr. Lillenstein said that when he returns to more traditional service delivery in the coming year, he will continue the connections with parents.

Dr. Gordon Hall, a Systems School Psychologist for the Mifflin County School District, recently appeared on PCN Network (April 28) to discuss delivering social and emotional supports to children while school buildings are closed. Prior to the closures, Dr. Hall was active in coordinating the services of mental health providers in the district, i.e., school psychologists, school counselors, school social workers and school-based therapists. His role has now shifted towards assisting these providers through Zoom meetings as they meet the needs of children remotely. For example, school counselors connect with teachers and principals and school social workers continue to connect families to community services. Dr. Hall spoke of one evidenced-based community effort- Communities That Care, that provides the schools feedback about what children and families may need from the school.

Dr. Hall identified "isolation" as a major problem for students separated from peers, teachers and the routine that has provided their lives predictability. His recommendations for caregivers whether they be parents or teachers are two-fold. First, take stock of oneself and one's own reactions to the current situation, practice self-care, create structure in one's life and model behaviors for those in one's care. Secondly, provide as much predictability as possible. Develop schedules, to-do lists (providing choice for order of completion) and something to look forward to. Take advantage of sunny days for outside activities.

Creativity sometimes grows out of disruption. Kevin Griffin, Millersville University School Psychology intern at Lancaster Lebanon IU#13, has been creating videos as part of Nearpod lessons, slide shows that allow children the opportunity to draw on the screen. He is now developing the videos featuring lessons that other school psychologists can use as an adjunct to remotely delivered social skills curriculum.

The challenges are many but school psychologists and other educators have shown innovation and commitment to providing ethical and meaningful educational service delivery. As is often the case in state-wide policy making, the voices of state associations continue to make an impact.

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Pennsylvania Joint State Government Commission Report on the Advisory Committee on LATER SCHOOL START TIMES at Secondary Schools

GAIL R. KARAFIN, EdD, *Pennsylvania Psychological Association*
and
DAVID LILLENSTEIN, EdD, NCSP, *Association of School Psychologists of Pennsylvania Advisory Committee Members*

The road to advocacy is not a straight line, but instead a zig-zag journey. However, finally we have success. Beginning in May 2016, Rep. Tim Briggs sponsored PA House Bill 2105. After several revisions and sponsors, in October 2018, the PA Senate Resolution 417, introduced by Sen. Andy Dinniman, was passed. It requested the Joint State Government Commission "establish an advisory committee to conduct a comprehensive study of issues, benefits, and options related to instituting a later start time to the school day at secondary schools in the Commonwealth." Our PPA Lobbyists were instrumental in assuring that PPA was represented on that Advisory Committee and that the Commission issued their report no later than 12 months from the adoption of the resolution.

The Joint State Government Commission is a primary and nonpartisan research and policy development agency for the General Assembly of Pennsylvania. It is a 14-member Executive Committee comprised of both the House of Representatives and the Senate who provide oversight for the Commission. The Commission was led by Glenn J. Pasewicz, executive director, with lead project manager, Yvonne Llewellyn Hursh, Counsel. Additionally, Lydia Hack, staff attorney; Yelena Khanzhina, public policy analyst; and Maureen Hartwell, public policy intern, comprised the Project Management team.

The Commission appointed 27 members, three of whom were school psychologists, to the Advisory Committee. In addition to the Pennsylvania Department of Education, multiple organizations were represented including the Pennsylvania Association for Rural and Small Schools, Pennsylvania School Bus Association, the Pennsylvania School Counselors Association, Pennsylvania State Education Association, Pennsylvania Chapter of the American Academy of Pediatrics, Pennsylvania State Athletic Directors Association, Pennsylvania Interscholastic Athletic Association, Pennsylvania School Boards Association, Pennsylvania Psychological Association, Association of School Psychologists of Pennsylvania, Delaware County Advocacy and Resource Organization, Pennsylvania Association of Independent Schools, RAND Corporation, Pennsylvania Association of School Business Officials, and a Pennsylvania Intermediate Unit. Additionally, the Advisory Committee drew on the multi-disciplined experience and knowledge of its members which included students, parents, educators, school nurses, psychologists, pediatricians, sleep researchers, and school transportation directors. It included superintendents and principals who have converted to a later start time in their districts and who offered their experiences and solutions to the challenges they encountered. The Committee held six face-to-face meetings in Harrisburg and two phone conferences. This article summarizes the major aspects of this report.

A comprehensive 92-page report was prepared, "Sleep Deprivation in Adolescents: The Case for Delaying Secondary School Start Times" was published October 17, 2019. It was organized into several important sections:

- Insufficient Sleep and Adolescent Health, Well-Being, and Academic Performance
- Policy Statements by National Educational, Medical, and Psychological Organizations
- The Current Status of Secondary School Start Times in Pennsylvania
- Common Perceived Challenges and Potential Solutions
- Experiences in Other States

Portions of this report are summarized below:

Insufficient Sleep and Adolescent Health, Well-Being, and Academic Performance

There is robust and irrefutable evidence that chronic short sleep in adolescents has negative consequences for their behavioral health (e.g., risky behaviors, substance abuse), physical well-being (e.g., immune system function, obesity, diabetes, metabolic dysfunctions), mental health (e.g., depression, anxiety, suicidal ideation), safety (e.g., car accidents, athletic injuries), and cognitive and academic performance (e.g., grades, test scores, absence rates, tardy rates, discipline incidents, graduation rates). Also there is a growing body of evidence that delaying secondary school start times reduces the achievement gap between upper and lower socioeconomic students.

Teenagers have a delayed circadian rhythm which delays melatonin secretion that triggers the start of sleep, and therefore, amount of sleep opportunity is reduced when teens have to make their buses at 6:30 to 7:00 a.m. Excessively early school start times deprive adolescents of quality sleep, are not in sync with teen biological needs, and contribute to a chronic sleep loss. This has deleterious effects.

Policy Statements by National Educational, Medical, and Psychological Organizations

In 2014, the American Academy of Pediatrics (AAP) issued a statement that secondary school start times should not start before 8:30 a.m. to ensure that adolescents have the opportunity for sufficient, age-appropriate sleep, between 8.5 and 9.5 hours each night. In 2015, the Centers for Disease Control and Prevention (CDC) issued a report stating that insufficient sleep in adolescents had been associated with risky behaviors, poor health outcomes, and poor academic performance. They further stated that given the negative outcomes, the prevalence of insufficient sleep among high school students is a public health concern. Delaying school start times has the potential for the greatest positive population impact. In 2016, the American Medical Association issued a statement encouraging school districts to establish later secondary school start times.

There is a long list of national medical and psychological organizations that have issued position statements endorsing later high school start times: American Academy of Pediatrics, American Psychological Association, National Association of School Nurses, Society of Pediatric Nurses, American Academy of Sleep Medicine, The Society of Behavioral Medicine, American Sleep Association, The National Parent Teacher Association, and the National Education Association.

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The Current Status of Secondary School Start Times in Pennsylvania

The Commission, in collaboration with the Pennsylvania Department of Education, conducted surveys of the 500 Pennsylvania public school districts, in addition to Charter Schools, Career and Technical Centers, and nonpublic schools. The information received in their investigation generated tables of data and is too long to summarize in this article, but it was reported that as of 2019:

- 15.7% of school districts had 7:00 a.m. to 7:29 a.m. secondary school start times
- 62.5% of school districts had 7:30 a.m. to 7:59 a.m. secondary school start times
- 20.1% of school districts had 8:00 a.m. to 8:30 a.m. secondary school start times
- 1.6% of school districts had 8:30 a.m. or later secondary school start times.

Additional attention was given to 26 school districts who had delayed their school start time. Also reports were made of districts who were formally studying later school start times, or who were engaged in informal discussions on the topic. The Commission also reported on schools who decided against later school start times or who moved their start times to an earlier start. The school districts of Pittsburgh and Philadelphia were reviewed separately in this report.

Common Perceived Challenges and Potential Solutions

The most unique section in this report was that it did not stop with the review of the science and the current status of school start times. This report included a section addressing the common perceived challenges to changing school schedules with their potential solutions. The challenges and suggested strategies for resolution were made on the following issues: the instructional school day requirements, general transportation concerns, bus driver shortages, transportation mandates to transport to schools outside the district, athletics and other extra-curricular activities, elementary school students and families impact, teachers and staff impact, and community response.

Experiences in Other States

The final section cited experiences and studies conducted in other states including Minnesota, Washington, New York, and Colorado. In addition, legislative proposals and actions in Connecticut, Hawaii, Maine,

Maryland, New Jersey, South Carolina, and Texas were summarized.

California passed a Senate Bill No. 328 on October 13, 2019. That Bill requires "the school day for middle schools and high schools, including those operated as charter schools, to begin no earlier than 8:00 a.m. and 8:30 a.m., respectively by July 1 2022…"

Nationally, Rep. Zoe Lofgren reintroduced the ZZZ's to A's Act in March 2019. This Act directs the U.S. Secretary of Education to conduct a national study of the relationship between school start times and adolescent health, well-being and performance. This bill currently sits in the House Committee on Education and Labor.

Conclusions

The Advisory Committee recognized that there is an epidemic of chronic sleep loss and daytime sleepiness in U.S. adolescents; "It is a public health crisis of epidemic proportions." The benefits of later school start times for secondary schools are supported by robust research. The benefits of establishing later school start times have the greatest potential to positively impact the greatest number of students. The Commission recognized that there is a wide range of demographics between schools in Pennsylvania, and there is no one approach that fits all.

The Committee also recognized that there are other factors that contribute to the problem of sleep deprivation in our students, such as social activities, electronic entertainment/communications, homework, extra-curricular activities, etc. Therefore, they recommended it is important to educate students and parents about the importance of healthy sleep hygiene, and that sleep hygiene be included in the school health curriculum.

Based on medical evidence and scientific data, the Commission concluded that the best practice start time for secondary schools is 8:30 a.m. or later. They also recommended no early practices, rehearsals, or activity periods be scheduled before the official start time.

"The Advisory Committee's most salient recommendation is that Pennsylvania's school districts should consider studying the advisability of changing their secondary school start times to improve the health and welfare of their students."

A copy of the report can be found at http://jsg.legis.state.pa.us/publications.cfm

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PPA 2020, COVID-19, AND VUCA 2.0: MAKING SENSE OF IT ALL

Continued from page 2

their own leadership skills. She ran for APA's presidency last year on a platform that she described as a "call to action for psychologists to join [her] as leaders to empower, to advocate, and make a difference," goals similar to those underlying my own desire to serve as a leader within PPA. As my presidential year comes to a close, I remain committed to the continued pursuit of those goals and look forward to continuing to work alongside all of you – and now, in honor of Jean – to achieve them..

THERE ARE TWO WAYS TO

PRACTICE UNDER PSYPACT

As a psychologist licensed in a PSYPACT state, you will soon be eligible to apply to practice telepsychology and/or conduct temporary in-person, face-to-face practice in PSYPACT states.

HERE IS WHAT YOU NEED TO KNOW:

TO PRACTICE

TELEPSYCHOLOGY

PSYPACT Commission Requirements

- In order to practice telepsychology under the authority of PSYPACT, the PSYPACT Commission requires that a psychologist obtain an Authority to Practice Interjurisdictional Telepsychology (APIT).

Authority to Practice Telepsychology Requirements

- Possess an active ASPPB E.Passport (see requirements below)
- Hold a full, unrestricted license to practice psychology in a PSYPACT state
- Provide attestations

ASPPB E.Passport Requirements

- Have a current, active psychology license based on a doctoral degree in at least one PSYPACT state
- No disciplinary action listed on any psychology license
- Have a doctoral degree in psychology from a program that was accredited by APA/CPA or designated as a psychology program by the ASPPB/ National Register Joint Designation Committee at time of conferral; or deemed to be equivalent by a recognized foreign credential evaluation service
- Official transcripts must be sent to ASPPB from institution granting degree
- Successful completion of the Examination for Professional Practice (EPPP) with a score that meets or exceeds the established ASPPB recommended passing score at the time of application
- Annual renewal with three (3) hours of continuing education relevant to the use of technology in psychology

Fees

- APIT Fee: $40 (one time fee)
- ASPPB E.Passport Application Fee: $400 (one time fee)
- ASPPB E.Passport Renewal Fee: $100 (annual fee)

Time Limit

- Unlimited

Scope of Practice

- Subject to the Receiving State's scope of practice

Initiation and Provision of Psychological Services

- When treating a client/patient in a Receiving State, a psychologist must initiate a client/patient contact while physically located in a psychologist's Home State via telecommunications technologies.

TO CONDUCT

TEMPORARY PRACTICE

PSYPACT Commission Requirements

- In order to conduct temporary practice under the authority of PSYPACT, the PSYPACT Commission requires that a psychologist obtain a Temporary Authorization to Practice (TAP).

Temporary Authorization to Practice Requirements

- Possess an active ASPPB Interjurisdictional Practice Certificate (IPC) (see requirements below)
- Hold a full, unrestricted license to practice psychology in a PSYPACT state
- Provide attestations

ASPPB IPC Requirements

- Have a current, active psychology license based on a doctoral degree in at least one PSYPACT state
- No disciplinary action listed on any psychology license
- Have a doctoral degree in psychology from a program that was accredited by APA/CPA or designated as a psychology program by the ASPPB/ National Register Joint Designation Committee at time of conferral; or deemed to be equivalent by a recognized foreign credential evaluation service.
- Official transcripts must be sent to ASPPB from institution granting degree
- Annual renewal

Fees

- TAP Fee: $40 (one time fee)
- ASPPB IPC Application Fee: $200 (one time fee)
- ASPPB IPC Renewal Fee: $50 (annual fee)

Time Limit

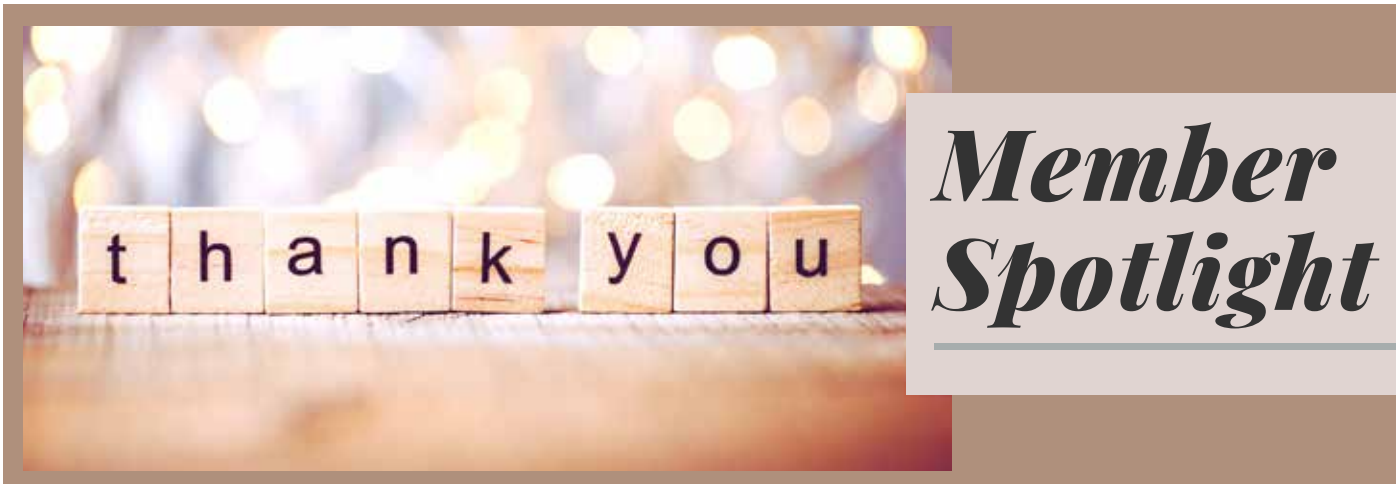
- 30 days per calendar year per PSYPACT state

Scope of Practice

- Subject to the Distant State's scope of practice

Authority and Law

- A psychologist practicing into a Distant State under the TAP will be subject to the Distant State's authority and law.



Member Spotlight

PPA would like to recognize the following members for their service to the public and the field of psychology.

Drs. Brittany Hayden and **Sallie Richards**, of Sarah A. Reed Children's Center, have been hosting a video series (Sarah Reed's Psych Snippets) featuring guest appearances by doctoral interns as the Children's Center. Dr. Brittany Hayden is a member of PPA's current Emerging Leaders Cohort. Access all of their episodes here: **https://www.sarahreed.org/sarah-reeds-psych-snippets/**

Dr. Shirley Woika, a professor at Penn State and a PPA member, has combined her sewing skills and child psychology knowledge to come up with a creative and fun solution: masks that turn kids into their favorite animal. Read all about this amazing initiative here: **https://www.collegian.psu.edu/news/campus/article_0bf6d2a8-9af1-11ea-bccc-4379417f9f86.html?utm_medium=social&utm_source=email&utm_campaign=user-share**

SENATE BILL 67 (PSYPACT) LEGISLATION SIGNED INTO LAW

Continued from page 4

Effective Date of Act 19 of 2020

This Act goes into effect sixty days from being signed into law. On July 1st, PSYPACT will be opening up registration for the E. Passport and the Intrajurisdictional Practice Certificate. For more information on how to register, psychologists can go to the website at https://psypact.org/.

Special Thanks

PPA would like to thank both APA and ASPPB for approving the grants that PPA submitted to them and for providing grant money to assist in our legislative efforts regarding this bill. In addition, we would like to thank ASPPB for allowing us to use its advocacy tool to send out messages to legislators.

PPA would also like to thank Dr. Alex Siegel and Dr. Jennifer Collins for their advocacy work on this bill. Dr. Alex Siegel was very instrumental in providing key information to legislators and their staff at the meetings he attended in Harrisburg and for the consultation that he provided to PPA staff regarding specific issues in the bill. Dr. Jennifer Collins attended key meetings and made key calls to Rep. Cutler to assist in propelling this bill forward.

Lastly, we would like to thank all the PPA members that took the time to advocate for your profession by sending email messages to their legislators throughout this process. We were able to email hundreds of emails to legislators. The membership's emails and calls to the legislators really made a difference and showed the legislators that this was an important piece of legislation that would help Pennsylvanians access mental health services.

REMAINING ETHICAL
DURING A PANDEMIC

JEANNE M. SLATTERY, PhD, LINDA K. KNAUSS, PhD, ABPP, and MELISSA HUNT, PhD

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the three of us, respondents to this vignette included Drs. Jade Logan, Jeff Pincus, Brett Schur, and David Zehrung. One of us asked,

> *I wonder if we might want to devote at least part of today's meeting to a discussion of the ethical trade-offs of continuing clinical practice and training versus shutting everything down during the COVID-19 crisis in order to protect vulnerable individuals and public health. That's the topic so many in our field are struggling with right now. How do we move forward over the next several weeks or months?*

There are probably many issues that you have been considering in the last several months. Stop and identify your own thinking before going further.

What is the Problem?

We met to talk about these issues on March 13, 2020, at a point when there was an order from Gov. Wolf for everyone in Montgomery County to stay at home, except for essential services. Counties in western Pennsylvania did not have any cases of COVID-19 for an additional two weeks. In mid-March, it was unclear what "essential services" were. Does this include psychotherapy? Supervision? Assessment?

Sam Knapp very quickly opined on the listserv that psychological services are an essential service. Shortly after our discussion, Valerie Vicari, the acting deputy of the Pennsylvania Department of Health and Human Services, released a statement, "both mental health and substance use services are considered essential and life sustaining services." Because these services are "critical to the health and wellness of our communities,… providers are expected to continue offering those services during the COVID-19 crisis period" (Vicari, March 20, 2020).

Governmental recommendations about COVID-19 have typically focused on *physical* health: social distancing, handwashing, and self-quarantining. They have not focused on *mental* health. It is very likely that in the coming months, especially if stay at home or lockdown orders continue, we will see an increased number of cases of depression, anxiety, suicide, relational problems, domestic violence, child abuse, and substance abuse. In fact, in a review of the literature, Brooks et al. (2020) suggested that these symptoms might be long-lasting. They reported that stressors experienced during a quarantine include the quarantine's length, fears of infection, frustration and boredom, inadequate supplies, and inadequate information. Stressors do not disappear after the quarantine, but change form, with stressors now including finances and stigma.

Most studies reviewed by Brooks et al. (2020) reported relatively brief quarantine periods (8-21 days), briefer than currently predicted for the US response to COVID-19 (at the time of our writing, at least six weeks). Behavioral health treatment is essential, not just for the people who had been experiencing psychological distress beforehand, but also for those people who will become distressed.

Decision-making

The Pennsylvania Department of Health and Human Services decision states that mental health services are essential and should continue (Vicari, March 20, 2020), but it does not say how they should continue or even what sorts of services should continue. This decision might depend on the client's diagnosis, the client's suicidality, the nature of the services, and the availability of computers and wifi for other treatment modalities. These become decisions that individual psychologists must consider. As Dr. Hunt observed, many of us find it difficult to identify when we are responding to ambient panic versus exercising reasonable or responsible caution. Considering these factors may help us respond mindfully rather than impulsively.

In most situations, one might be making decisions by considering risks and benefits for the client and, perhaps, the family. In this case, however, several of us were concerned about our other clients who might

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become infected by a sick client; about our supervisees, who were concerned about their health and those of their families; and our own health. We were also concerned about stemming the pandemic, believing at that time that two weeks might be sufficient to do so.

Our needs and fears have rarely been so front and center in the therapy room as they have been in our response to this pandemic. As Dr. Pincus observed, when we work with a couple, it is their marital stress, but not ours. Now, however, we are sharing a single stressor. Under some circumstances, we might be willing to put ourselves in harm's way, as when Dr. Pincus was asked to transport patients out of the county following the Three Mile Island disaster and agreed to do so, although ultimately did not. Would his decision have changed depending on who else he put at risk in the process? He recommended that we work with a trusted colleague to explore our moral values during this period.

Balancing Values

At the beginning of this period of self-quarantine, some of us may have made decisions about whether to see clients face to face based on their risk factors (e.g., symptoms, exposure, and travel to affected parts of the world). We would have informed them of the risks of face to face treatment at this point and explored other options, but respected their decisions and autonomy – if they were not at high risk. However, as the pandemic continued, some of us may have shifted to considering whether safety of the community might be a more important value, especially when a reasonable alternative (teletherapy) exists. At the time of our discussion, however, insurance companies were generally not covering teletherapy. Further, when one of us initially asked her clients about using teletherapy, all indicated that they preferred being seen in person. When the first cases were reported in her home county, she moved all of her clients to teletherapy, which they grudgingly accepted (and then were pleased with). As Dr. Zehrung observed, we may incur additional risk when we choose to stay open when everyone else closes (Knapp et al., 2013).

So far, the research suggests that teletherapy is equal in effectiveness to treatment in person (Mitchell et al., 2008; Turner et al., 2014). However, such research typically focuses on clients deemed appropriate to be moved online and often recommends that a first meeting occur face-to-face. A serious concern is whether such research would apply to clients who are not given access to in-person treatment at this point.

Competency

Of course, most of us did not train in teletherapy and would, under more typical conditions, consider ourselves less than competent to offer such services. Gaining competence in this area involves quick study of the various telehealth and video conferencing platforms, their technical reliability, their level of HIPAA compliance, and the security/confidentiality of the platform (which are all separate issues), as well as attending to issues of interstate provision of services when the client is sheltering in place in a different state from the one in which the therapist is licensed. We should also develop extra telehealth informed consent procedures to make sure clients are aware of the risks (e.g., having back-up plans in case of technical failure and ensuring that the client has a private space in which to connect, without risk of being overheard by family members).

We may not have time and energy at this point to develop the level of competency that we would typically seek – but we cannot put off seeing clients until we develop such a competency. Some of us may decide that it makes sense to take a hiatus from treatment at this point, while others of us may be willing to take what we see as acceptable risks. For example, we may choose to see highly needy or suicidal clients using teletherapy, while typically we would find doing so an unacceptable risk. Problems with competency under these new conditions may be balanced by the risks of disruption of treatment or the lack of treatment.

The APA Ethics code (2017) specifically allows psychologists to provide services during an emergency, even when providers do not believe they are fully competent to offer those services. We believe that a pandemic clearly counts as an emergency. The Ethics code recommends, however, that such services be "discontinued as soon as the emergency has ended or appropriate services are available" – unless, of course, competency was obtained during the intervening period (Section 2.02, p. 5).

Take Care of Yourself, Too!

In order to do this work at this point, we need to be taking care of ourselves. We need to engage in regular self-assessment, recognize our tendencies to overlook or downplay risks, and consult as needed. We must live with ambiguity in a world where it is unclear what the right answer is or how we should be handling our clinical practice, especially as our short-term decisions might be very different than if we were to know that our current decisions would hold for the next nine months. And, we need to be engaging in regular self-care: talking to friends, engaging in yoga with online instructors, walking, and talking through issues with respected colleagues.

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

Kutz & Radico

1. Which of these is *not* a component of burnout?

a. Emotional exhaustion
b. Cynicism/depersonalization
c. Betrayal
d. Lack of professional efficacy

2. Prevention focused coping strategies like venting and complaining are helpful because they allow for catharsis and the ability to "get it all out".

TRUE
FALSE

Miodus, Joseph, Farley, Bridgelal, & Duffield

3. It is better for students to ignore the topic of COVID-19 in course content during this pandemic.

TRUE
FALSE

4. One technique that is helpful in Zoom-based teaching for creating interpersonal connection among students is the breakout room.

TRUE
FALSE

Kim

5. Why is it important for psychologists (and everyone else) to understand their own privilege?

a. So that we can better understand the point of view of others who do not share that privilege
b. So that we can take steps to avoid microaggressions
c. To provide services to those without that privilege in a culturally sensitive way
d. All the above

6. Which of the following is *not true* about undocumented immigrants?

a. They intentionally entered the country illegally
b. They are not eligible for government benefits
c. They avoid contact with outside agencies and government
d. It is difficult to provide services to the population

Sternlieb

7. When using the roadmap analogy to accept one's own vulnerability, they should

a. Reduce their speed or pace and pay full attention to the signs they experience
b. Periodically check their progress
c. Do frequent self-maintenance and personal inspections
d. All of the above

8. Certainty and stability are two major contributors of anxiety.

TRUE
FALSE

Tuleya-Payne

9. Which of the following is true about PDE's statement on evaluations and virtual assessments?

a. It is unethical to provide counseling through Zoom meetings with students
b. Following certain guidelines, administration of standardized achievement tests with the examinee can be performed
c. Evaluations that require one-to-one contact such as IQ tests should be postponed until school opens
d. In order to receive special education services, the requirements for evaluations are lifted

10. What was a major problem facing students identified by Dr. Hall?

a. Isolation
b. Poor instruction by caregivers
c. Lack of motivation of students to perform educational tasks
d. Lack of community concern about student access to education

Karafin & Lillenstein

11. What percent of Pennsylvania secondary schools currently (October 2019) start at 8:30 a.m. or later?

a. 10.2%
b. 5.5%
c. 1.6%

12. What are some of the commonly perceived challenges for school districts wanting to change their secondary school start times?

a. Transportation
b. Bus driver shortages
c. Athletic schedules
d. Elementary school considerations
e. All the above

Slattery, Knauss, & Hunt

13. As the lockdown continues, there is likely to be an increase in the number of cases of

a. Depression
b. Anxiety
c. Relational problems
d. All the above

14. One overarching moral principle that may be compromised for clients during this crisis is

a. Beneficence
b. Fidelity
c. Autonomy
d. Justice

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, June 2020

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

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

Satisfaction Rating

Overall, I found this issue of the Pennsylvania Psychologist:

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

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General

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