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SOCIAL DETERMINANTS OF HEALTH

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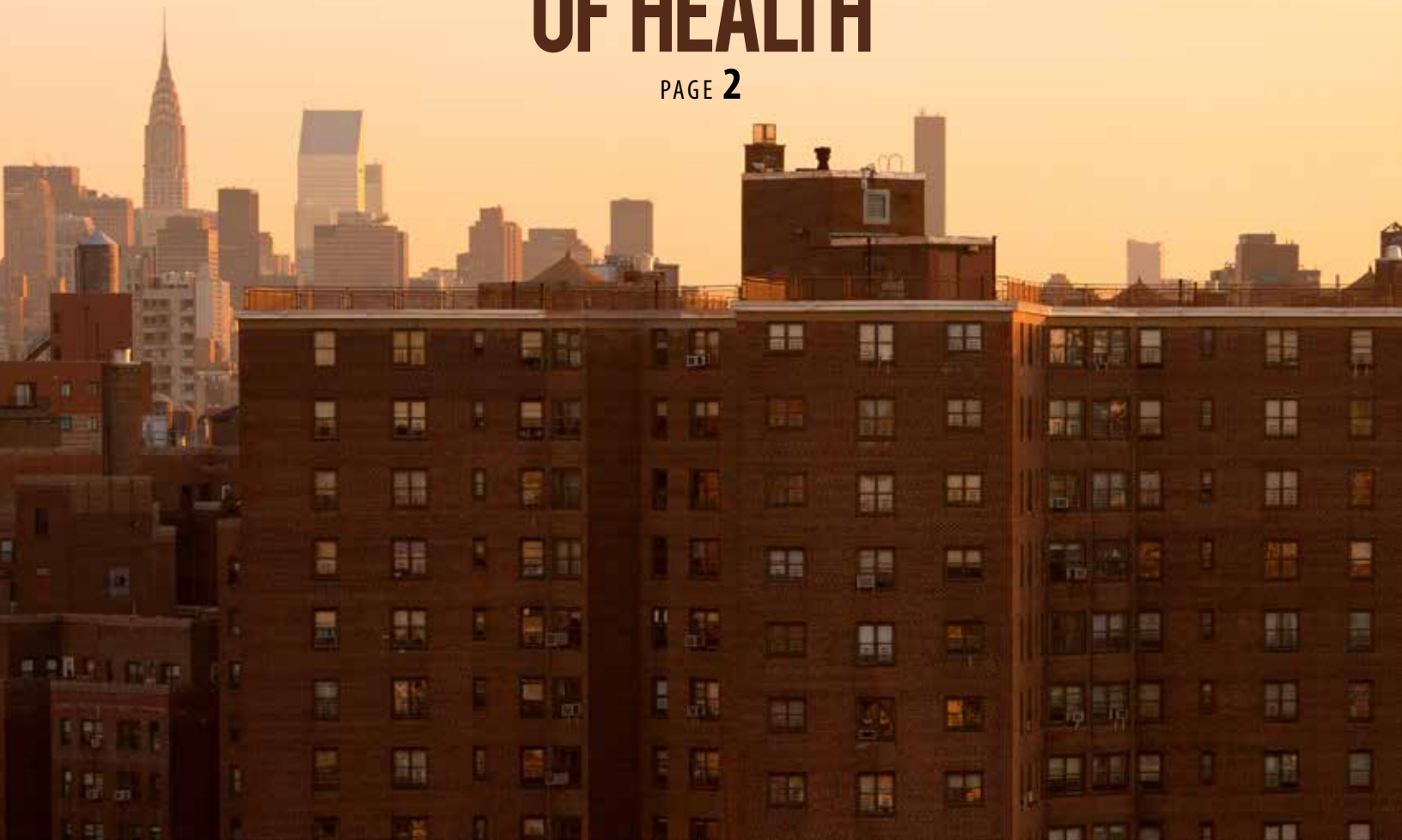

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ALSO INSIDE

SOCIAL DETERMINANTS OF HEALTH

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This is a reprint of a current home study offered by PPA.

Health equity occurs when every person can "attain his or her full health potential" and no one is disadvantaged "because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention, n.d., p. 1). These inequities result in marked differences in life expectancy, rates of disease, and quality of life. Health inequities occur because of the lack of access to health care and also because of an inequal burden caused by the *social determinants of health*. Social determinants of health are the social conditions (the conditions under which a person lives, work, and ages, including one's social environment, education, or income level) that are more removed (downstream) from the actual illness, but nonetheless substantially impact the likelihood of becoming sick and the consequences of that sickness. Persons who have historically faced discrimination such as people with disabilities, members of racial or ethnic minorities, or LGBTQIA people have been especially influenced by these social determinants of health.

Expressed another way, an antibiotic may effectively treat an infection, but it cannot treat the malnutrition that caused a person's immune system to become susceptible to such infections. Nor can an antibiotic fix a leaky roof or broken furnace or compensate for a dangerous neighborhood that stresses the immune system. A physician could prescribe higher and higher doses of an anti-asthma medication for a child, but it would be far better for the child to live in an environment that did not have intensive air pollution.

Galea et al. (2011) found that low education, racial segregation, loneliness, poverty, and income inequality contributed to as many deaths as physical or lifestyle factors, although they acknowledged methodological issues in reaching their approximation and that the relevant factors may interact in complex ways. One would not say that these social determinants necessarily caused poor health. Rather they are one of several factors, including genetic endowment or lifestyle factors, that may create either the opportunities for good health or the risks of poor health (Kinner & Borschmann, 2020).

The impact of these social determinants of health were especially obvious during the height of the COVID-19 pandemic. The COVID-19 pandemic appears to have increased the risk of *deaths of despair* which are deaths from drug overdoses, suicides, cirrhosis, and other chronic liver diseases, and which are often linked to depression and demoralization (Case & Deaton, 2015). An increase in the number of deaths of despair, the failure to address long term social determinants of health, and the failure to promote healthy lifestyles adequately have resulted in a recent decline in the life expectancy among Americans.

1. The author thanks Drs. Julie Radico, Sean Healey, Kyle Holsinger, and Richard Kutz for reviewing an earlier version of this home study.

Although the COVID-19 pandemic did not alter these long-term trends, it added more urgency and another layer to the discussion.

On the surface, COVID-19 and other infectious diseases may appear unrelated to lifestyle factors or social determinants of health but a closer examination suggests otherwise. Black Americans had rates of COVID-19 infections that were almost two times those of White Americans. The increased infection rates were likely due to many factors including a greater likelihood of being a frontline worker (such as a grocery clerk or a delivery worker), lack of access to adequate health care, a higher rate of pre-existing medical complications, and a greater likelihood of living in densely populated areas where diseases spread more easily. The deaths from COVID-19 were superimposed upon long-standing health care trends within the United States that linked social conditions to health outcomes. Although these social conditions contributed to an increase in mortality before the COVID-19 pandemic, the pandemic magnified their influence.

The long-term impact of COVID-19 remains to be seen. The development of accurate tests, effective treatments, and vaccinations have greatly diminished its impact on health and longevity. Nonetheless, is too early to declare the end of the era of deadly infections. Public health experts had been warning of a COVID-19-like pandemic stating that it was not a matter of "if" but a matter of "when" it would happen. COVID-19 was only the most recent of several coronaviruses that have entered human populations in the last 20 years (the others include SARS, H1N1, and MERS). The human population is still vulnerable to future highly contagious coronaviruses, such as SARS, H1N1, MERS, and Covid-19and non-coronavirus infections such as Zika, Ebola, and HIV as well. In addition, antibiotics are losing their effectiveness against many infectious diseases. In 2018 almost 700,000 persons worldwide died from antibiotic resistant bacterial infections (Kramer, 2020).

For decades, infectious diseases were diminishing as a major cause of illness and mortality within the United States and lifestyle factors and social determinants of health had emerged as contributing more to health and longevity. On the surface, the COVID-19 pandemic deviated from this century-long pattern. However, it may not be wise to distinguish too sharply between infectious diseases, social determinants of health, and lifestyle because COVID-19 stands at the intersection of the three. Although it is an infectious disease, lifestyle changes can reduce the risk of infection and social factors influence the risks and outcomes of infections.

Psychologists will better be able to promote health equity if they understand how social determinants of health, lifestyle factors, the increase in deaths of despair, and COVID-19 interact and impact the health of Americans and the quality of psychological services. This home study will cover those issues and make recommendations for psychologists who wish to promote health equity.

The Downward Trend in Life Expectancy within the United States

Preliminary data suggests that the COVID-19 pandemic reduced the life expectancy within the United States by one year which is now at its lowest level since 2006 (Mishra & Chandler, 2021). Even before the COVID-19 pandemic, life expectancy within the United States had been decreasing in recent years. Many factors determine life expectancy including genetics, access to health care, access to quality housing, freedom from violence, freedom from food insecurity, and healthy lifestyles including exercise, abstinence from tobacco, the moderate use of alcohol, and so on.

Data from the Organization for Economic Cooperation and Development (OCED, 2020) reported that Americans had a life expectancy of 78.7 years. Japan had the highest average life expectancy (84.2),

On the surface, COVID-19 and other infectious diseases may appear unrelated to lifestyle factors or social determinants of health, but a closer examination suggests otherwise.

followed by South Korea, Switzerland, Norway, Sweden, Spain, Iceland, Israel, and Denmark, although the rankings for these countries often vary slightly from year to year. Among the 46 countries of the OCED, the United States ranked 27th, slightly ahead of Mexico (75 years) and Estonia (78.4 years) in life expectancy. The life expectancy decreases substantially in less developed countries. It is 60 in Yemen, 55 in Burma, and 44 in Ethiopia.

Since 1980 the average life expectancy within the United States has been growing at a slower rate than in other OCED countries.[2] By 1998, the average life expectancy within the United States was lower than the average life expectancy of other OCED countries. The increased mortality within the United States occurred across the lifespan and for all the major sources of mortality, except for cancer, where the United States has a higher survival rate. Although the United States has certain demographic groups or regions with especially high mortality rates, even upper income Americans have life expectancies far below those of other OCED countries (Woolf et al., 2013). Although life expectancy varies considerably within the United States according to income level and geography, the geographic differences may be largely an artifact of income.

Starting in 2014, the average life expectancy in the United States began to decline, even though the United States spends far more on its health care than any other country (Tikkanen & Abrams, 2020).[3] The lack of investment in social safety nets may account for much of the differences in longevity between the United States

2. The countries within the OCED include most European countries and Canada, Mexico, Chile, Japan, Korea, Australia, New Zealand, Israel, and Turkey.
3. The US spends 17% of its GDP on health care. Switzerland is second highest with 12.2% of its GDP. OCED countries spend an average of one half their GDP on health care as the United States (OCED, 2020).

and other OCED countries. For every $1 that European countries spend on health care, they spend $2 on social welfare programs. For every $1 that Americans spend on health care, they spend 55 cents on social welfare programs. The United States spends far less on child-care, unemployment benefits, and job training than other wealthy countries. For example, unemployment benefits in the United States were one quarter the unemployment benefits of other OCED countries. Even within the United States, those states that spend more on unemployment benefits tend to have higher life expectancies than states that spend less on unemployment (Tikkannen & Schneider, 2021).

The downward trend in life expectancy represents a reversal of the pattern of increased longevity within the United States which accelerated around 1900. Around 1900 the average life expectancy was 46 in the United States, although that number was depressed because of high infant mortality. If individuals survived childhood, they often lived into their 60s or even longer. Within the United States the life-expectancy increased to 63 in 1940, to 74 in 1980, and peaked at 78.9 in 2014 (Xu et al., 2020).

The Historic Role of Infectious Diseases within the United States

The increase in life expectancy that occurred within the United States throughout the 20th century was due primarily to major improvements in the prevention of disease and the direct delivery of health care. In 1999, the Centers for Disease Control (CDC), identified the 10 great public health advances of the 20th century: vaccinations, motor vehicle safety, safer workplaces, control of infectious diseases, declines in deaths from coronary heart disease and stroke, safer and healthier foods and drinking water, healthier mothers and babies, family planning, fluoridation of drinking water, and recognition of tobacco as a health hazard (CDC, 1999).

The control of infectious diseases was perhaps the most salient public health advance of the modern era. For example, cholera was once a major killer. In the early 19th century, physicians did not understand the relationship between cholera and drinking water. Instead, they believed that cholera was caused by "bad air," probably reflecting the smell of garbage or sewage associated with infected water. Water systems in the early 19th century sometimes allowed sewage and drinking water to mix, resulting in plagues of cholera. It was not until 1858 that the pioneering epidemiologist John Snow proved that cholera was a water born disease. At the turn of the last century (around 1900) infectious diseases (TB, influenza, measles, smallpox, etc.) were serious health concerns of Americans and especially dangerous for babies and small children.

The rise of vaccinations and other public health measures greatly reduced the risk of death from infectious diseases. Public health efforts then shifted toward increasing life expectancy by advocating for measures to address the social determinants of health and through changes in lifestyle. The social determinants included addressing the conditions that have led to the recent increase in deaths of despair. And the lifestyle changes include improved diet, increased exercise, reductions in smoking and the consumption of alcohol and other drugs, and better adherence to disease prevention behaviors.

Deaths of Despair Were Already Precipitating Declines in Life Expectancy

Even before the COVID-19 pandemic, the life expectancy within the United States was decreasing, primarily due to an increase in *deaths of despair* among White male adults aged 25 to 64. Evans et al. (2020) estimated that the United States had 150,000 deaths of despair in 2018, although Kramer (2020) claimed that deaths of despair are underreported by at least 28%.

The pernicious increases in deaths of despair started in the 1990s. During much of the 1990s and early 2000s, decreases in deaths from cancer, heart attacks, motor vehicle accidents, and AIDS more than compensated for the increase in deaths from other causes (Woolf & Schoomaker, 2019). However, by 2014, the increases in the deaths of despair overtook the decreases in other causes of mortality.

The decrease in life expectancy has been concentrated in certain areas of the United States such as northern New England (Maine, Vermont and Northern New Hampshire), the Ohio Valley (Ohio, Indiana, Kentucky), the Ozarks, central Appalachia (West Virginia, Southwestern Pennsylvania, and southeastern Virginia), and northern California. The life expectancy in Pennsylvania has essentially remained stable since 2014. It decreased in the more economically distressed rural parts of the state and increased in the more prosperous central and eastern parts of the state (Knapp et al., 2019). It remains to be seen how much COVID-19 and the accompanying recession will alter this pattern.

Counties with more older adults and Native Americans tended to have decreases in life expectancy (Woolf & Schoomaker, 2019). Also, the 20% of the counties in the United States that have experienced economic insecurity ("the likelihood of a downward trajectory of income, material resources, and socioeconomic status," Knapp et al., 2019, p. 1) had higher rates of deaths of despair. Decreases in life expectancy were highest among adults of working age who are most likely to be impacted by economic downturns or who have been impacted by the opioid crisis. Nonetheless, deaths of despair are also increasing in more affluent counties as well, albeit at a smaller rate. Although mortality is increasing greatly for adults with a high school diploma or less, it is increasing slightly for adults in the higher education brackets as well (Siddiqi et al., 2019). Economic insecurity may increase chronic stress, pessimism, and indirectly encourage unhealthy ways to cope with stress such as by smoking tobacco, using alcohol to excess, or misusing legal or illegal drugs (Woolf, 2019). Given these dynamics, one could expect a sharp increase in deaths of despair in 2020 and beyond.

Although deaths of despair have increased across racial and ethnic groups, the increase

is higher among Whites. Nonetheless, all-cause mortality is still higher among Black and Native Americans. For many years, the gap in health disparities between White and non-White Americans was narrowing. That trend has reversed in the last decade, especially for young children of color. Although public health efforts need to address the increase in deaths among middle aged Whites, these efforts should not detract from efforts to address the continuing disparity in all-cause mortality across racial groups (Gennuso et al., 2019).

Socio-Economic Determinants of Health

The link of deaths of despair to socioeconomic status (such as lack of a high school education or meaningful job skills) is an example of a social determinant of health.

Considerations of the social determinants of health, such as socioeconomic status (SES) and culture, can help psychologists to better appreciate the circumstances that lead patients to adopt less than optimal coping strategies, the circumstances that reinforce those strategies or predispose them to more illness, and the barriers that keep patients from adopting healthier lifestyles.

SES influences health. "Poorer, less-educated individuals in the US live considerably shorter lives" (Gostin & Hodge, 2020, p. 1037). Unfortunately, since the 1970s, the financial gap between rich and poor Americans has increased substantially and millennials (those born between 1981 and 1997) have only a 50% chance of reaching the same income level as their parents (Daniel, Bornstein, & Kane, 2018).

The link between lower SES and health is called the SES *gradient* (Adler, 2009). It was documented empirically and famously in the "Whitehall Study" which found that mortality rates gradually increased as the employment level of English civil servants decreased (Marmot et al., 1984). Similar findings have been identified in the United States. The death rate for Americans varies across income level with those with the highest income living the longest and each income level living longer than the income level below it.

The *social selection hypothesis* holds that those who have better health, vigor, or mental strength will rise in the social hierarchy. For example, it could be argued that a person with disabilities lacks the personal qualities to rise in the social hierarchy. But the social selection hypothesis has weaknesses, however, in that health, vigor, and mental strength are often socially determined themselves. In the example above, dealing with the person with disabilities, the social selection argument fails to consider that lower SES increases the likelihood that one may develop a disability. Also, the social selection hypothesis fails to account for the impact of ableism ("discrimination in favor of the nondisabled," Friedman, 2019, p. 13), racism, or other prejudices. In a society free from such prejudices, much of the discrepancy in performance would be eliminated.

In contrast, the *social causation hypothesis* holds that diminished social standing causes poorer health outcomes. Several strands of evidence support this theory. For example, Morozink et al. (2010) found that those with lower education levels (a crude marker of SES) had higher levels of interluekin-6, a marker of inflammation and a predictor of poor health. Perhaps, the lower SES means fewer material resources and less access to health care (persons with higher SES are more likely to have good health insurance or the resources to pay for necessary screenings and treatments). Perhaps the stress of fewer resources itself directly harms health. In addition, *early life adversity* (such as neglect of a child, exposure to violence or traumas, food insecurity, etc.) may be linked to poor health later in life by impairing the ability of the immune system to fight off infections later in life (Elwenspoek et al., 2017).

Also, unhealthy behaviors such as the use of alcohol, cigarettes, lack of exercise, or poor diets are more common among persons with lower SES, accounting for some of the disparity in the life expectancy and overall health between socioeconomic groups (Stringhini et al., 2010). But one should not assume that lifestyle factors are entirely the result of "personal responsibility." Perhaps the high stress of living in poverty increases the prevalence of unhealthy behaviors (Adler, 2009). Also, the circumstances of poverty itself may influence lifestyle behaviors. For example, those who live in an unsafe neighborhood would be less likely to go outside for walks or other physical recreation. Also fruits and vegetables are more expensive than low-cost processed foods, so that persons with lower incomes end up paying a substantially higher percentage of their income for fruits and vegetables than persons with higher incomes. More importantly, patients may be caught in a poverty trap which is a "self-reinforcing system of poverty where preexisting economic conditions determine future economic conditions" (Miller & Brooks, 2021, p. 342). Debt, lack of income, harsher living conditions, and lack of education may force a family into poverty and their children may lack the resources or opportunities to raise themselves out of it.

Education levels predict better health outcomes, although education level is a gross metric, and it is not clear which elements of education cause better health outcomes. Perhaps it is simply the fact that persons with more education can get better jobs and higher incomes, and therefore have better access to health care or are more likely to live in safer communities. Those with higher incomes are less likely to have hazardous jobs, less likely to live in inadequate housing, and more likely to have easy access to healthy foods. Or, perhaps the higher education simply increases their knowledge of healthy behaviors or increases their social capital by putting them in touch with those who are better able to facilitate their careers or perhaps they are more likely to have a social network that endorses healthy lifestyles.

Likely many factors combine and interact to explain the SES gradient. Furthermore, within the United States, racial and ethnic factors influence the SES gradient.

Racism has a negative effect on both mental and physical health independent of birthplace or education (Paradies et al., 2015). Many Black Americans receive unequal health care treatment even if

they have the same health care access as White Americans. In part this may be due to implicit biases which affect health care professionals at about the same rate as the population in general (FitzGerald & Hurst, 2019). In addition, Black Americans are less likely to trust their health care professionals, a cultural legacy of an era when Black Americans were intentionally given second rate care or used as testing subjects for treatments before they were used with White patients. Furthermore, the experience of racism, even in subtle forms, creates a physical strain on the recipients of racism that can, over time, degrade the quality of their lives.

Furthermore, according to the *Hispanic paradox,* Latinx in the United States have lower mortality and better health than their non-Hispanic counterparts even though their average incomes and education levels are lower. A common explanation is that healthier persons would be more willing to make the difficult transition from Latin-American countries to the United States while their less healthy counterparts would be less able to attempt the transition. It is also possible that the strong social relationships *(familismo)* within the Latinx community help to buffer the ill effects of diminished SES, or that lower income persons learn to survive and thrive in their circumstances by adopting a *shift and persist* orientation (shifting means accepting uncontrollable circumstances and persisting means taking advantage of opportunities when they arise). Perhaps all these factors contribute something to the Hispanic paradox. However, another line of research shows that all immigrant groups, whether White, Hispanic, or Black, have better health for the first generation of immigrants and the quality of health declines the longer the family has lived in the United States.

In summary, the relationship between SES and health is complex. Efforts to improve the health among those living in the lower rungs of the SES ladder will likely require a multifaceted approach addressing educational opportunities, racial disparities, health-related behaviors, and access to health care.

Lifestyle Factors Influencing Life Expectancy

In addition, life expectancy is influenced by lifestyle behaviors such as smoking, failing to exercise sufficiently, not eating enough fruits or vegetables, having a body mass index outside of healthy ranges, abusing alcohol or other drugs, being over exposed to ultraviolet sun rays, or failing to get preventive care (including preventive dental care). For example, skin cancer is a rapidly growing form of cancer in the United States, which is linked to over exposure to ultraviolet rays from sunbathing or using tanning salons, and the failure to use sunscreen. Tobacco is still the most preventable cause of lung cancer in the United States. Also, excess weight is associated with an increased risk of hypertension, heart attacks, diabetes, and cancer. Death from cirrhosis of the liver is linked to drinking in excess, and so on.

Lifestyle factors have often been considered a matter of individual choice and personal responsibility (Hook & Markus, 2020). However, individual choice and personal responsibility should not be overemphasized. No one I know chose to have tobacco companies misrepresent the health effects of tobacco to them or agreed to have their children exposed to positive advertising about tobacco products.

Moreover, healthy lifestyles are not distributed equally across the population but vary according to SES and education levels. As described above in the section on the SES gradient, part of the healthier lifestyles may be due to higher levels of education (Li et al., 2018). For example, American men who had less than 8 years of education died from lung cancer at a rate 10 times higher than those who had graduate education.

Nonetheless poor diet is the leading underlying cause of death in the United States, surpassing the impact of tobacco (Belanger et al., 2020). This is not a matter of access to enough calories, but to a nutritionally balanced diet. Poor diets can result in excess weight which predisposes individuals to diabetes, heart attacks, and other diseases. Again, one should place all the responsibility for excess weight on lack of will power. In contrast to past generations, there is currently fewer opportunities for exercise (people are less likely to walk to school, shopping, or work) and incessantly advertising and exposure to cheap and unhealthy food choices.

While looking at just five low risk factors (not smoking, moderate alcohol use, healthy weight, healthy diet, and adequate exercise) in longitudinal studies, Li et al. (2018) found that women at the age of 50 who had all 5 low risk factors lived an average of 43 more years (37 years for men). However, women at the age of 50 who had none of the low risk factors lived an average of only 29 more years (26 years for men). In other words, women who had all 5 low risk factors lived an average of 14 years longer than women who had none of the low risk factors. Men who had all 5 low risk factors lived an average of 12 years longer than men who had none of the low risk factors.

In a follow-up study, Li et al. (2020) looked at the number of years that an individual was free from chronic diseases. Women at

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the age of 50 who had all 5 low risk factors lived free from diabetes, cardiovascular diseases, and cancer an average of 34 years more (31 more years for men). However, women at the age of 50 who had none of the low risk factors only lived free from diabetes, cardiovascular disease, and cancer an average of 23 more years (24 more years for men). In other words, women who had all 5 low risk factors lived free from these chronic diseases an average of 11 years longer than women who had none of the low risk factors. Men who had all 5 low risk factors lived free from these chronic diseases an average of 7 years longer than men who had none of the low risk factors.

In summary, an individual's health is influenced by their physical and social environment, and socioeconomic status, as well as the quality of health care they receive (Woolf, 2019). It is hard to separate the impact of these interactive factors. Good health care cannot address alone the upstream causes of poor health. "Health is more than health care" (Woolf, 2019, p. 1). Nonetheless, psychologists who are aware of these social determinants can promote health equity by tailoring more effective treatments.

Treatment Implications of a Health Equity Perspective

Considerations of the social determinants of health, such as SES and culture, can help psychologists and other practitioners to better appreciate the circumstances that led patients to adopt less than optimal coping strategies, the circumstances that reinforce those strategies or predispose them to more illness, and the barriers that keep patients from adopting healthier life- styles.

Although the root causes may be far upstream from the treatment room, psychologists can consider several factors when addressing patients downstream. First, they can appreciate the role of stress and the frequency of trauma in the lives of their patients (Woods-Jaeger et al., 2021). Poverty is bad for one's health and it takes a lot of energy just to secure the necessities of living. The chronic high levels of stress and traumas associated with poverty may depress children's intellectual functioning, impair their ability to regulate their emotions, and weaken their immune systems (Sleek, 2015).

Or consider a patient who is spending money on cigarettes instead of needed medications. Instead of viewing this as an example of personal weakness, it may be more productive to consider that this patient may have been exposed to greater stress in early life and is using one of the few available ways to reduce that stress, or that this patient has grown up in a culture where smoking is normative or expected. According to Dr. Richard Kutz, "We see our own cultural attitudes and assume them to be normal and fail to recognize that poverty has its own culture which may include behaviors contrary to adaptive health. Effective psychologists understand how hard it is to behave contrary to one's own culture" (personal communication, June 23, 2020).

Psychologists can consider the impact of unemployment in demoralizing patients, especially men who believe that full employment is an essential part of "manhood." Economic downturns often result in demoralization, pessimism, or internalized shame and self-stigma. At the extreme end, incarceration or homelessness can massively disrupt lives and can lead to a social death, or a condition where there is "a loss of social roles and consequently all significant components of one's identity" (Salhi & Osborne, 2021). It may be clinically indicated to address this despair, alienation, and the lack of self-efficacy to reduce a sense of entrapment (Rehder et al., 2019). Although psychologists should always be vigilant for suicidal thoughts and behaviors among their patients, this vigilance should increase during times of economic stress. Job loss may increase the loneliness, hopelessness, and sense of entrapment that are commonly found among suicidal patients.

Furthermore, if possible, psychologists can strengthen the patient's access to resources by promoting family unity and social connectedness when delivering health care. Across the SES ladder, those with strong social networks tend to have better health. This may be due to the availability of greater resources during a time of need or of the access to emotional support. At times it may be indicated to involve or strengthen the patient's relationships with important social networks such as one's family or church group.

Also, psychologists can take special efforts to be sensitive to racial issues and implicit bias in delivering health care. None of us are immune from implicit biases, but we can monitor ourselves and become closer to living out our values in our professional interactions. Implicit bias may also include class bias. Social class is often underappreciated as a variable in psychotherapy, although it does influence the patient's experiences, including the likelihood of adverse childhood experiences, levels of stress, access to resources, and expectations from others (Thompson et al., 2019). According to Oh et al. (2018), childhood adversity is related to asthma, delays in cognitive development, infections, somatic complaints, and sleep disruption as well as alterations in an individual's immune system, inflammatory responses, and acceleration of telomere erosion.

Psychologists who deliver sensitive and compassionate care are more likely to have patients who are satisfied and who would be more likely to spread the word among their friends and neighbors. If patients from a marginalized group told their friends or family that "Dr. So-And-So did a good job," or "Dr. So-And-So really helped me," then those comments would likely lead to more acceptance among potential patients from marginalized groups who would otherwise be reluctant to participate in treatment or would be more skeptical and uncooperative if they did participate.

Although this may not be practical for all psychologists, it would nonetheless be advantageous to engage in *social prescribing,* when possible (Roland, Everington, & Marshall, 2021). Social prescribing refers to the practice of referring patients to relevant resources such as a community agency that could help them with debt management, housing, or the availability of other safety net resources.

In addition, psychologists should consider offering lifestyle interventions to their patients when appropriate. Psychologists may respectfully ask their patients for permission to discuss health issues even if they were not directly linked to the patient's initial

presenting problem. Psychologists could assess their patients' willingness to change and proceed accordingly. For example, a patient who uses tobacco products may have low health literacy skills or live in a social environment where unusual theories on health are circulated and believed. Psychoeducation, motivational interviewing, or Socratic questioning may help some of these patients, if they are amenable, to reconsider their positions and adopt healthier habits. Of course, patients can always decline the invitation and psychologists would respect the decisions of their patients.

Finally, psychologists can advocate for social policies that help mitigate the stress of persons with diminished financial resources. Even modest improvements in access to resources, such as easier access to food stamps or increases in minimum wage can substantially improve the quality of the lives and health of persons at the lower ends of the SES gradient.

Within our profession, psychologists can continue to advocate for a more diverse psychology workforce and for curriculum that train psychologists in cultural competence, cultural humility, and the importance of health equity.

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Alliant International University
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**Prescriptive authority varies from state to state.*

CE QUESTIONS FOR THIS ISSUE

EARN 1 CE CREDIT FOR THIS ISSUE!

The home study selected for 1 CE credit in this issue of the Pennsylvania Psychologist is sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. During this renewal period only, the limit on the number of home study and distance learning continuing education hours has been lifted. For this renewal period, psychologists can receive all of the continuing education through home studies or distant learning programs. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.

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 **$25 for members ($50 for nonmembers) and mail to:**

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

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

Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before November 30, 2023.

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.

Social Determinants of Health

1. Social determinants of health could include
- a. Racial segregation
- b. Poverty
- c. Loneliness
- d. All the above

2. All the following are examples of deaths of despair EXCEPT
- a. Drug overdoses
- b. Suicides
- c. Accidents at work
- d. Cirrhosis of the liver

3. Black Americans are more likely to get infected with or die from COVID-19 because they

a. Have a genetic mutation that makes them more susceptible to infection
b. Are more likely to be front line workers, such as delivery person or grocery store clerks who have greater exposure to the virus
c. Are more likely to seek out medical attention for illnesses
d. All the above

4. In 2019, almost 700,000 persons world-wide died from antibiotic resistant bacterial infections.

TRUE
FALSE

5. The life expectancy in the United States is closest to which country?
- a. Japan
- b. Sweden
- c. Mexico
- d. Ethiopia

6. Since 1980, the longevity of Americans has been increasing at a rate that is _____ than the increase in longevity found in most countries of the OCED.
- a. Faster
- b. Slower
- c. The same as

7. Compared to European countries with higher life expectancies, the United States spends _____ on health care and _____ on social safety net.
- a. More; more
- b. More; less
- c. Less; more
- d. Less; less

8. Deaths of despair are more likely to occur in counties in the United States that have
- a. A high percentage of young adults
- b. A high percentage of Latinx Americans
- c. Experienced recent economic downturns
- d. All the above

9. The link between socioeconomic status and health has been called the
- a. SES gradient
- b. Hispanic paradox
- c. Shift and persist model
- d. Early adversity syndrome

10. The reason(s) given that more education is linked to better health outcomes is(are) that education

a. Increases information about the benefits of healthy behavior
b. Leads to better jobs and more disposable income to spend on health care, food, or other commodities that improve health
c. Increases social capital or puts people in contact with those who can further their careers
d. All the above

11. The gap between White and Non-White Americans was narrowing until recently, but now it is increasing.

TRUE
FALSE

12. Displaying resignation when faced with obstacles that cannot be changed, yet taking advantage of opportunities when they arise is a description of the _____ strategy.

a. Broad and build
b. Shift and persist
c. SES gradient
d. Social determinant

13. The social class of patients may influence their

a. Life expectancies
b. Expectations from others
c. Access to resources
d. All the above

14. Li et al. (2019) found that women at the age of 50 who had all 5 of the low risk factors lived for an average of _____ more years, but women at the age of 50 who had none of the low risk factors only lived for an average of _____ more years.

a. 43; 29
b. 29; 43
c. 19; 19
d. 19; 23

HOME STUDY CONTINUING EDUCATION PROGRAM:

The Pennsylvania Psychologist November 2021: Social Determinants of Health
One (1) Continuing Education Credit for Psychologists

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. a b c d	6. a b c	10. a b c d	14. a b c d
3. a b c d	7. a b c d	11. T F	
4. T F	8. a b c d	12. a b c d	

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

	(Strongly Disagree) 1	2	3	4	(Strongly Agree) 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 below) 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.	[ ]	[ ]	[ ]	[ ]	[ ]

Continued on page 12

CE QUESTIONS *Continued*

Learning Objectives	**Strongly Disagree**				**Strongly Agree**
1. As a result of this continuing education program, I was better able to:					
Describe how the health of Americans is influenced by social factors.	1	2	3	4	5
LIst ideas as to how psychologists can adjust their practices to promote health equity.	1	2	3	4	5
	Not Useful				**Extremely Useful**
2. How useful was the content of this CE program for your practice or other professional development?	1	2	3	4	5
	Very Little				**A Great Deal**
3. How much did you learn from this CE program?	1	2	3	4	5

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

_____

Suggestions for future home study/workshop topics: _____

Please print clearly.

Name _____

Address _____

City _____ State_____ Zip _____ Phone ( ) _____

Email _____

Signature _____ Date _____

A check or money order for $25 for PPA members ($50 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

Now available online, too! Purchase the quiz by visiting our online store at papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

CLASSIFIED

PSYCHOLOGISTS: Montgomery, Bucks, Lehigh, Berks Counties. Contact us regarding opportunities to provide services in nursing homes, long term care and short-term rehab centers. We offer training and ongoing support as you deliver a unique and valuable service to residents and a perspective to the interdisciplinary team. www.GoldenwoodServices.com.

TIPS TO RENEW YOUR PSYCHOLOGY LICENSE FROM YOUR FRIENDS AT PPA

Renewal notices from the State Board of Psychology have been sent out to licensees via EMAIL for 2021. The email will come from **RA-STPALSNOTIFY@pa.gov** and the subject line is "Attention: Commonwealth of PA State Board of Psychology Update". This email includes the link to renew your license, your user ID, and your personal Registration Code. The text of the notice is included below:

Dear Licensee,

Your renewal is available and can be processed at *www.pals.pa.gov*. Please follow the instructions below to renew your license.

Instructions to renew your license - PS000000

- Renew your license at www.pals.pa.gov.
- Login using the User ID below.
- Your User ID: xxxxxxx
  - Please note: For security reasons, we cannot send your password in this email. If you do not remember your password, visit www.pals.pa.gov/recover to recover your password.
  - Your Registration Code is: xxxxxxxx
- To renew your license, click the "Renew" box in the toolbar located at the top of your screen. Read the pop-up message for additional information about the license(s) available for renewal and click "Renew" to proceed to the renewal application.

You will receive confirmation via email when your license has been renewed. If you have already attempted to renew your license but there is a renewal hold on the record, you will need to address the renewal hold as directed in the emailed discrepancy notice before your license can be renewed.
We recommend your prompt attention to this matter to ensure that your license does not expire on November 30, 2021.

IMPORTANT:
Please note that there is no longer a grace period for renewals. This means you CANNOT renew your license after November 30, 2021. After the expiration date, you must submit a reactivation application and meet all requirements before your license will be returned to active status.

Additional Information:

Have you been issued a temporary COVID related license to practice in another state? Then answer YES to "With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a health-related profession in any state or jurisdiction?" and list each state in which you have temporary authorization to practice.

Do you have an NPI number? If you have an NPI (National Provider Identifier), add it in the Professional Details section. This number can be found through your biller/online billing account or CAQH. If you do NOT have an NPI number, you do not need to provide one.

Does it say you need Act 31 Child Abuse Reporting credits before renewing?

- If you believe you already completed them and they do not show on your account, contact the company who provided the training (PPA only has record for people who completed the training through us).
- If you have not completed them yet, PPA offers a Home Study course (*www.papsy.org/store*)

Is your web page running slowly? Please note that the web pages may be slow to load - please be patient and allow yourself at least 30 minutes to complete the license renewal process.

Additional questions should be directed to the State Board of Psychology:
(717) 783-7155 or ST-PSYCHOLOGY@pa.gov

The PA State Board of Psychology is a government entity responsible for licensing and disciplining psychologists in the Commonwealth. PPA is a membership organization that is separate and apart from the State Board of Psychology.
This resource is a member-benefit of your membership with PPA

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Other things to know about the PALS system and licensure renewal

Once you have submitted your renewal:

- There will be a new entry in the "Activities" section of PALS that shows “Renewal Application Psychology” with “Submitted” as the status
- Under the “Correspondence” section, you will see a Payment Receipt with the date your submission was received
- You will receive an email from **ST-PALSNOTIFY@pa.gov** confirming your submission.
    - There can be a delay of several hours between submission and the receipt of the email, but the PALS sections should update immediately. **Note: the expiration date of your license will still say 11/30/2021 during this step in the process.**

Once your renewal application has been approved:

- You will receive another email from ST-PALSNOTIFY@pa.gov with the subject line “Attention: Renewal Update” confirming that your license has been renewed.
    - At that time, you can log into your PALS account, and the expiration date for your license in the “Professional License Details” section should be updated to 11/30/2023.
- The entry in the "Activities" Section will update the “Renewal Application Psychology” status to “Completed.”
- Under the “Correspondence” section, you may see that your License Certificate was Printed, although there may be some delays between official renewal and the printing/mailing of the paper license.

Once you receive the email that your renewal was approved, and the expiration date has been updated in PALS, you are officially renewed, even if you have not received the paper copy yet.

The deadline for license renewal in Pennsylvania is **Tuesday, November 30, 2021.** Please begin the renewal process as soon as possible if you think you will need assistance with renewal. The time between submission and approval can take a few business days, so we recommend submitting your renewal by Tuesday, November 23.

PPA and the State Board of Psychology will be closed on the following dates - renew early to avoid any issues!

Thursday, November 25: Thanksgiving
Friday, November 26: Day after Thanksgiving
Saturday, November 27 & Sunday, November 28: Weekend

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

CONTINUING EDUCATION INFORMATION for Licensed Psychologists in Pennsylvania

Information adapted from
https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Pages/General-Board-Information.aspx

Certificates of Attendance/Completion

Please be sure to review your certificates of attendance/completion. Certificates of attendance/completion must contain the following:

- ❒ your name
- ❒ date of the course/program
- ❒ number of continuing education hours earned
- ❒ a statement that the course/program was offered by an approved sponsor (see listing below)

Approved Sponsors

Section 41.59(d)(3) of the Board's regulations provides the following list of sponsors approved by the Board:

(i) Accredited colleges or universities as long as the course/program corresponds to the scope of practice of psychology and generates semester/quarter hour credit.

(ii) The American Psychological Association (APA) and APA-approved sponsors.

(iii) Sponsors approved by the American Medical Association (AMA) that offer programs that relate to the practice of psychology.

(iv) Providers approved by the Pennsylvania State Board of Psychology. (Click here to view a listing of these providers)

Ethics Continuing Education

Completion of at least 3 hours of continuing education in ethics is required. If the word "ethics" or a derivative of the word "ethics" is contained in the title of a course/program taken through an approved sponsor, the continuing education earned can be used towards satisfying the ethics continuing education requirement. If the course/program pertains to ethics and the title of the course/program does not contain the word "ethics" or a derivative of the word "ethics", the provider of the course/program must indicate on the certification of attendance/completion the number of hours of ethics earned. If the

certificate does not designate a specific number of ethics hours, no ethics credit will be awarded.

Suicide Prevention Continuing Education

Completion of at least 1 hour of continuing education in suicide prevention is required. If the word "suicide" or a derivative of the word "suicide" is contained in the title of a suicide prevention course/program taken through an approved sponsor, the continuing education earned can be used towards satisfying the suicide prevention continuing education requirement. If the course/program pertains to suicide prevention and the title of the course/program does not contain the word "suicide", the provider of the course/program must indicate on the certification of attendance/completion the number of hours of suicide prevention continuing education earned.

PLEASE NOTE: The 1 hour of continuing education in suicide prevention may NOT be used towards satisfying the 3 hours of continuing education in ethics.

Act 31 Child Abuse Recognition and Reporting Continuing Education

Verification of completion of 2 hours of child abuse recognition and reporting continuing education must be received electronically from an approved provider in order to renew a license. A certificate of attendance/completion cannot be accepted in lieu of the required electronic verification.

Home Study

During this renewal period only (December 1, 2019 – November 30, 2021), the limit on the number of home study and distance learning continuing education hours has been lifted. For this renewal period, psychologists can receive all of the continuing education through home studies or distant learning programs.

Acceptable Proof of Completion

- Attendance at a College or University course/program-- Continuing education is earned for completion of a college or university course/program that has a PSY Prefix and generates semester/quarter hour credit. 1 college/university credit=15 hours of continuing education. A transcript is required to prove course/program completion.

- Teaching – A psychologist may obtain up to 15 hours of continuing education either by: (1) teaching a course in psychology for a regionally accredited college or university if the course generates semester/quarter hour credit or (2) teaching a workshop for an approved sponsor. The Board will only accept courses with PSY in the prefix or "psychology" in the title of the course as a "course in psychology". Acceptable documentation, which must be maintained in the event of an audit, is:

  College/university course – A letter from the department chair identifying the course prefix, number and title; the dates, time and place of teaching; and the number of credits. A course syllabus may also be requested.

  Workshop – A letter from the approved sponsor of the workshop stating that the psychologist successfully conducted the workshop and indicating the dates and locations of the workshop.

  PLEASE NOTE: A psychologist may only be awarded credit for teaching the same course/workshop once every 4 years. Credit for workshops with multiple instructors will be determined by dividing the number of continuing education hours granted for the workshop by the number of instructors participating in the workshop.

- Professional Writing – A maximum of 10 hours of continuing education may be obtained by authoring an article published in a journal abstracted in PsycINFO or a chapter(s) in a text or trade book for psychologists. Credit is only awarded for the year in which the article/chapter was published. Acceptable documentation, which must be maintained in the event of an audit, is:

  Journal article – Copies of the page or pages of the article that show the title of the article, author(s), journal title and date of publication of the article.

  Chapter(s) in a text or trade book for psychologists – Copy of the title page of the book, the table of contents, the title page of the chapter indicating authorship and the date of publication.

  PLEASE NOTE: Book reviews and test reviews are not acceptable. Ten hours per publication, divided by the number of authors, will result in the number of contact hours granted (e.g., an article that has two authors will result in five contact hours for each author).

PENNSYLVANIA PSYCHOLOGICAL FOUNDATION

APPLY FOR A STUDENT EDUCATION AWARD TODAY!

MONETARY AWARDS AVAILABLE

APPLICATIONS ARE DUE NO LATER THAN DECEMBER 31, 2021

The Pennsylvania Psychological Foundation (PPF) has established monetary awards to be given to graduate students in psychology. The purpose of these awards is to help defray some of the many expenses incurred during graduate study that may not be covered by other stipends and scholarships.

APPLICANTS WILL BE JUDGED ACCORDING TO THE FOLLOWING CRITERIA

- Financial need
- Academic performance
- Potential for service to the field
- Community service and involvement

Students should prepare a statement (two-pages, typewritten) that addresses these criteria and should note circumstances that may have presented a challenge to pursuing their graduate education. In determining the final list of award recipients, the Awards Committee will make efforts to assure that the group reflects ethnic and cultural diversity.
Eligibility Requirements:

Applicants must be

- A full-time student in a graduate program leading to a doctoral degree in Psychology
- Enrolled at a Pennsylvania institution or be a resident of Pennsylvania

STUDENTS MUST SUBMIT THE FOLLOWING

- Personal Information cover sheet (Found at papsy.org/page/StudentAwards)
- Unofficial graduate transcript
- A typewritten statement (two-page limit) specifically addressing these four (4) areas: a) financial need, b) academic performance, c) potential for service to the field, and d) community service and involvement
- A curriculum vitae or resume
- A letter of support from their major advisor or program chair outlining applicant's potential for accomplishment and documenting their need

Please email applications to erin@papsy.org as one complete PDF document
Applications must be submitted by 11:59 PM on Friday, December 31, 2021.
Submissions received after that time will not be accepted.

Pennsylvania Psychological Foundation
LEAVING A LEGACY

The Pennsylvania
Psychologist

SAVE THE DATE

PPA2022

May 18 - 21, 2022

KALAHARI RESORT & CONVENTION CENTER

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PPA 2022
BEING IN THE ROOM WHERE IT HAPPENS

Home Study CE Courses

Act 74 CE programs

Essential Competencies when Working with Suicidal Patients—1 CE
Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE
Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE
The Essentials of Screening and Assessing for Suicide among Adults—1 CE
The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version
Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General

Ethical Issues with COVID-19 (Webinar)—1 CE*
Ethical Responses when Dealing with Prejudiced Patients (Webinar)—1 CE*
Ethics and Self-Reflection—3 CE*
Foundations of Ethical Practice: Update 2019—3 CE*
Integrating Diversity in Training, Supervision, and Practice (Podcast)—1 CE
Interdisciplinary Collaboration in Assessing Capacity in the Elderly (Webinar)—1 CE
Introduction to Working with Chronic Health Conditions—3 CE
Legal and Ethical Issues with High Conflict Families—3 CE*
Mental Health Access in Pennsylvania: Examining Capacity (Webinar)—1 CE
Record Keeping for Psychologists in Pennsylvania—3 CE*
Telepsychology Q&A (Webinar)—1 CE
Why the World is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

This program qualifies for 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.

Visit PPA's online store for a full listing of our home studies.