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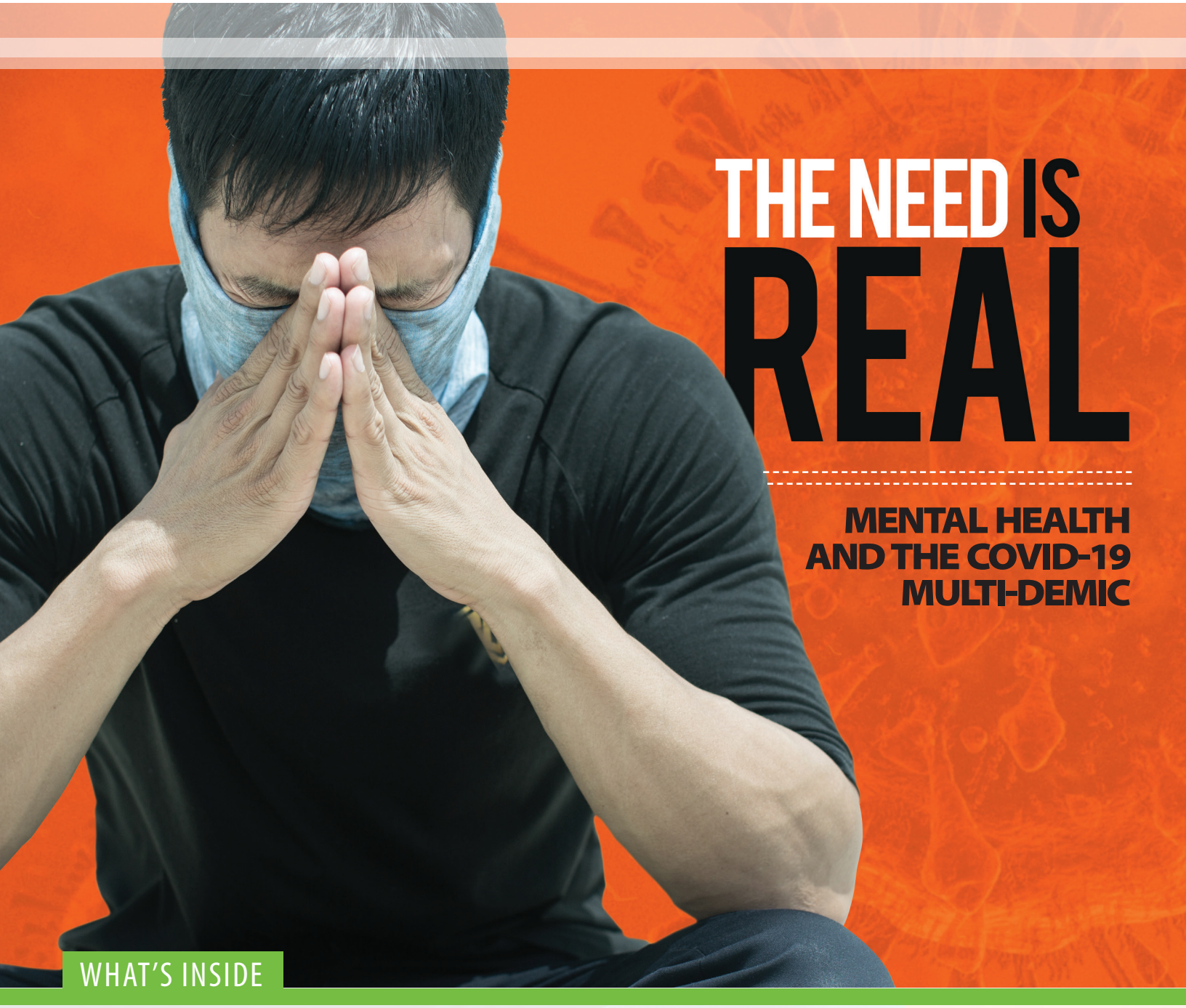

THE NEED IS REAL

MENTAL HEALTH AND THE COVID-19 MULTI-DEMIC

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CMS ISSUES REGULATIONS ON MEDICARE AND CONGRESS RESPONDS

Reimbursement for Most Psychotherapy Codes Stable, Testing Codes Cut

SAMUEL KNAPP, EdD, ABPP *Director of Professional Affairs*

On December 7, 2020 the Centers for Medicare and Medicaid Services (CMS) issued its long-awaited rules for Medicare beneficiaries. The new rules would cut reimbursements for most medical services, including those of many physicians, and sharply cut reimbursement for non-physician providers, including psychologists. Nonetheless by the end of the month Congress had responded to pressure from numerous health care groups, including psychologists, and mitigated some of the negative impact of these changes.

Although the CMS regulations would have sharply reduced payments for most of the procedure codes used by psychologists, Congress acted to boost reimbursements for psychologists and other health care professionals. The net effect on psychologists will be increases in some procedure codes and decreases in others. Because the exact rates established by CMS must be adjusted according to a geographic modifier, we cannot give the actual rates for psychologists in Pennsylvania at this time.

Nonetheless, psychologists will see a large increase in reimbursement for 90791, and smaller increases for 90832, 90834, and 90837. Psychologists will also see decreases in reimbursement for family therapy, testing, and health and behavior codes. Although CMS only directly regulates psychologists under Medicare, many commercial insurers base their rates on a percentage of what Medicare reimburses. The efforts by psychologists to stop the sharp reimbursement cuts originally proposed by CMS have prevented what would have been a 10-11% decline in reimbursements to psychologists across the board.

Congress also acted to allow psychologists to bill for psychotherapy codes through telehealth after the pandemic ends. Previously psychologists were able to bill for telehealth only through an emergency exception permitted by CMS. Also, as psychologists working with Medicare know, Medicare has waived the enforcement of HIPAA compliant platforms and permitted audio-only services when it is the only way available to provide services to Medicare beneficiaries. These audio-only services will be available until the end of the calendar year in which the pandemic ends, which will be at least the end of 2021. Other than the narrow exception for audio-only services when the needs of patients require it and insurers permit it, psychologists should be using HIPAA-compliant platforms to deliver telehealth.

Pennsylvania was a leader in the federal advocacy efforts. Data from APA's tracking system showed that Pennsylvania psychologists were tied at first place with Minnesota in terms of per capita responses to CMS's proposed regulations and first among states in terms of advocating for federal legislation to mitigate these proposed draconian cuts. APA is continuing to work with Congress and CMS to address other outstanding issues concerning Medicare.

MENTAL HEALTH AND THE COVID-19 MULTI-DEMIC:

Psychologists in Pennsylvania Report a Sharp Increase in Mental Health Needs

SAMUEL KNAPP, EdD, ABPP[1] *Director of Professional Affairs*

The COVID-19 pandemic has caused fear, anger, and uncertainty. Among other things, it is not known how long the pandemic will last, how many people will be infected, or how many infected persons will die. Although a vaccine has already started to be administered, it will take several months for a critical mass of the population to become vaccinated and for the pandemic to subside. Even then, the health consequences of the pandemic are likely to last for months or years after the pandemic has ended.

The COVID-19 pandemic is part of a multi-demic, or a pandemic accompanied by associated problems such as an infodemic (the proliferation of false information about the pandemic), widespread unemployment and business closures, and social disharmony. Many workers have lost their jobs. The demand for services from food banks is increasing. Americans are afraid of becoming sick, a phenomenon called *coronaphobia* (Dubey et al., 2020). Other Americans have been sick or have lost loved ones to COVID-19. Front line workers are exposing themselves to risk just to keep their jobs or to fulfill needed social functions. Disruptions in schooling have hurt the social and cognitive development of children and have burdened families. The multi-demic also magnifies the consequences of racism, income inequality, and partisanship in our society. Hostility toward Americans of Asian descent has increased. Conspiracy theories about the origin or nature of COVID-19 have heightened social distrust. As Dr. Deborah Derrickson Kossmann, from Langhorne and Havertown commented, "We are in a dark and intolerant period that started before COVID."

According to many psychologists in Pennsylvania, the mental health needs of the public have increased greatly because of the multi-demic. Empirical evidence supports this impression. This article reviews the mental health impact on the public in general, on those whose family members or friends were infected with or died from COVID-19, on front line workers who were regularly exposed to the risk of a COVID-19 infection, and those who survived a COVID-19 infection themselves. This article is informed by research on COVID-19 and relies, where appropriate, on data from SARS; the human swine flu (H1N1), MERS, and the avian flu (H7N9).

Mental Health Needs of the Public

The mental health of Americans has declined during the multi-demic. Dr. Molly Cowan, from Mechanicsburg wrote that she is "flooded with new people trying to get an appointment," and that current patients often "aren't functioning as well as they typically do." Her observation is consistent with the results from a recent survey of members of the American Psychological Association (2020) who reported a substantial increase in patients with especially high increases in the amount of self-reported anxiety and depression. Dr. John Gavazzi from Camp Hill reported that many patients have subclinical features of derealization or depersonalization. This should not be surprising because derealization symptoms are one of

1. The author thanks numerous psychologists who shared their experiences and especially Drs. Rachel Ginzberg and Deborah Derrickson Kossmann who reviewed a previous draft of this article.

the sequalae of trauma. One patient commented, "Thank God it is Blursday!" referring to the way that COVID-19 reduces the diversity of day-to-day activities. Other psychologists have similarly reported an increase in the demand for their services. Dr. Rachel Ginzberg from Philadelphia commented that "The fact that many telehealth sessions are focused on the pandemic is less surprising than the occasional sessions that seems unaffected." Dr. Derrickson Kossmann also noted that "There is fatigue from feeling fear about getting sick and being exposed, depression, and also anger that others don't seem to care they are at risk."

The decline in the population's mental health is following a similar trend as occurred in Sichuan province in China which was severely distressed by the coronavirus epidemic. "A large number of people had emotional breakdowns, and they felt helpless, fearful, anxious, depressed, guilty, and nervous" (Zhou, 2020, p. 1). In Canada, the number of respondents who reported that their anxiety was extremely high quadrupled and the number of respondents who reported high rates of depression doubled (Dozois & Mental Health Research Council, 2020).

In a recent Gallup poll, Americans rated the quality of their lives as the lowest it has been since 2009 (Witters & Harter, 2020). Whatever mental health problems the patients may have had to begin with, the background of fear and anxiety that pervades society has exacerbated their symptoms (Vindegaard & Benros, 2020). Compared to the same period in 2019, Americans have seen an increase in self-reported symptoms of anxiety, depression, and traumatic stress, and the use of substances to help control their emotions (Czeisler et al., 2020). Those who reported lower levels of distress were more likely to keep in close contact with families and significant others, engage in outdoor or physical activities, or rely on spiritual resources to cope (Blanc et al., 2021). The lack of a strong safety net, such as reliable or generous unemployment benefits, is linked to poor mental health (Wanberg et al., 2020).

Worldwide, the mental health impact of the pandemic is highest among women, those who reported poor health, and those who had relatives who were infected with COVID-19 (Vindegaard & Benros, 2020). Within China the psychological harm was greatest in those areas most impacted by the infection and among those who had to quit work, could not exercise, or who had chronic health conditions (Zhang et al., 2020). Within the United States, self-reported stress was highest for those who were young, female, or caregivers (Park et al., 2020). Young adults in the United States were more likely to experience stress if they reported high levels of loneliness, COVID-19 specific worry, or lacked resilience (Liu et al., 2020). Early data shows that the rate of deaths from overdoses has increased sharply over the same time last year (Centers for Disease Control and Prevention, 2020b) and it is expected that suicides will similarly increase. Dr. David Zehrung of Greencastle noted an increase in public incivility, such as mask wearers arguing with non-mask wearers. Families and friends are missing out on attending weddings, going to funerals, celebrating birthdays, celebrating holidays together, and other socially meaningful rituals.

Furthermore, if patterns from previous pandemics hold true, then the increase in mental health symptoms in the population will continue after the pandemic subsides. The fear does not rise in proportion to the objective nature of the infectious threat, nor will it decline proportionally when the objective threat subsides. Cooper and Williams wrote, "The effects of 2020 will be felt for years to come" (2020, p. 1491).

Stress reducing activities, such as going to gyms or visiting close friends, are less available because of the pandemic. Productive means of coping were distracting oneself and seeking emotional support from others. Unproductive coping methods include substance use and adopting an attitude of giving up (Park et al., 2020).

Young children often feel distressed because their daily routines and normal supports have been disrupted (Gruber, 2021). Dr. Brett Schur, in independent practice in Haverford, reported that many families are stressed by the added responsibilities of in-home schooling, and shelter-in-place rules. Coparenting families often disagree over safety protocols. Dr. Zehrung commented that he is hearing reports of increased problem behaviors among developmentally disabled individuals living at home.

The pandemic is increasing rates of distress for adolescents. Many are missing out on important activities or developmental milestones such as participant in sports or attending their senior proms. Preliminary data from China showed that the rate of depression among adolescents increased, especially for girls and for those who did not have adults at home during workdays (Chen et al., 2020). Many American youths have found the multi-demic distressing, especially as it often ended in-person schooling. Dr. Bruce Mapes, a consultant with juvenile court in Chester County, reported that adolescents are suffering from the physical distancing that accompanies this pandemic. He wrote, "Peer relationships are a very important part of adolescent development but, because of COVID-19, there are few opportunities to interact in person with peers and to engage in community activities." Dr. Joanne Coyle, with Main Street Counseling in Jeffersonville, concurs. Even teen clients "that don't even like school want to go back." Staying at home often increases conflicts with family members.

Although older adults in the United States are experiencing high levels of distress, as a group they are feeling less distress than Americans from other age groups (Vahia, Jeste & Reynolds, 2020). Physical distancing may interrupt normal social patterns leading to loneliness and fear, especially among some older adults or those vulnerable for other reasons (Yip & Chau, 2020). Suicides, suicide attempts, and suicidal ideation increased among older adults following the SARS and Ebola pandemics, most likely caused by a combination of social isolation, fear of the illness, and a concern about being a burden to others (Zortea et al., 2020). Many have had to miss or delay routine medical appointments out of fear of

contracting the virus. Older adults with difficulties performing activities of daily living appeared to be especially harmed by physical distancing (Kotwal et al., 2020). According to Dr. Coyle, older adults often miss visiting relatives or going to restaurants or just shopping. Many older adults are physically dependent on others and terrified about the prospect of others bringing the illness into their homes. Dr. Allison Bashe of New Directions Counseling in Wexford reported that some older adults with serious health conditions worry that they may not see their loved ones before they die. Dr. Don McAleer of Northshore Psychological in Erie commented that older adults in nursing homes can be especially distressed and lonely and may withdraw socially because they need to keep physically distant from family and friends.

Deaths from opioid overdoses are increasing (Brooks, 2020). It is widely believed that the number of completed suicides in 2020 will increase for several reasons. First, the number of Americans reporting suicidal thoughts increased in 2020 compared to the same time last year (Czeisler et al., 2020). As documented above, the overall mental health of Americans has declined sharply in the last year. Declines in physical health or increases in loneliness may push some persons to consider suicide (Reger et al., 2020). Also, firearm sales have increased since the pandemic started, making the most lethal means of suicide more available to those thinking of suicide (Mannix et al., 2020). In addition, coincidentally, 2020 also saw an increase in natural disasters such as widespread wildfires and hurricanes. Suicide rates have been known to increase after these disasters, although there may be a two-year delay in the increase (Horney et al., 2020). Finally, national rates of suicide tend to increase during periods of economic recession and decline during periods of economic growth (Mann & Metts, 2017). Unemployment numbers have risen, many small businesses have closed, and it is not known when these jobs will return. One in six persons who died from suicide in the United States had recent financial problems or job losses shortly before their deaths (Stone et al., 2018).

Two different numbers can be used to measure the lethality of this pandemic. One may measure the lethality of the pandemic according to the number of persons who died from COVID-19, or one could also measure it according to the number of excess *deaths* (the difference between the actual number of deaths and the number of expected deaths). Excess deaths are likely caused by patients not having access to healthcare when local hospitals are overwhelmed with COVID-19 or by patients avoiding healthcare because of the fear of contracting COVID-19. As of July 2020, 67% of the excess deaths were due to COVID-19 and 33% of the excess deaths were due to other causes such as diabetes, heart disease, or Alzheimer's Disease (Woolf et al., 2020). The percentage of excess deaths in the United States is significantly higher than the percentage of excess deaths in European countries (Bilinsky & Emanuel, 2020). While it is appropriate to be concerned about the grief and disruption caused by deaths from COVID-19, we should also be aware that deaths in general are increasing above pre-pandemic levels.

The multi-demic does not impact all groups equally. Some social groups that have frequent contact with each other, such as families, nursing homes, prisons or jails, or meat packing plants or other workplaces, may be exposed to hot spots for infections. Highly impacted social groups may feel a *tsunami of grief* (Clopton, 2020) as they have seen many people in their social network get sick or die. One can extrapolate the amount of mental suffering when considering that 10% of those losing a loved one will develop a prolonged grief reaction (Simon et al., 2020).

Blacks have been disproportionately harmed by this pandemic for multiple reasons. Yancy (2020) claimed that, as a group, Black Americans have poorer health and more pre-existing conditions, have less access to health care, live in congested urban areas, or hold front line jobs that involve more exposure to the virus. In addition, COVID-19 infection rates are higher in rural counties that were disproportionately Black (Millet et al., 2020). Patel et al. (2020) commented that those who lack health insurance may not seek out treatment until the infection is advanced. Also, COVID-19 strikes those with pre-existing respiratory problems especially hard and it has been suggested that those with exposure to major risk factors for respiratory diseases, such as air pollution or hazardous occupations, may be at a greater risk to develop a severe reaction to a COVID-19 infection (COVID-19 Casts Light, 2020).

Also, Black and Latinx workers were more likely to lose their jobs or have cuts in their hours and reduced work-related incomes (Purtie, 2020). They are less likely to have access to smartphones or other technology that can reduce a sense of social isolation. It stands to reason that they would also be disproportionately impacted by the psychological consequences of the multi-demic as well. Native American communities have had especially high rates of COVID-19 infections and deaths. The pandemic has magnified the consequences of healthcare inequalities.

Mental Health Needs of Health Care and Front-Line Workers

Front line workers, such as medical personnel, hospital custodians, health care aides, and those working in essential businesses, such as grocery stores or food delivery, have reported high rates of mental health symptoms (Vindegaard & Benros, 2020). An increase in mental health symptoms among healthcare workers is consistent with what has been found in previous infectious disease epidemics (Schreffler et al., 2020; Ruiz & Gibson, 2020). Even before the COVID-19 pandemic, emergency room physicians had high rates of PTSD (DeLucia et al., 2019). Medical errors and other indices of substandard medical treatment increase when health care workers are stressed or feeling emotional exhaustion (Shreffler et al., 2020).

Dr. Coyle reported that their workloads are often very demanding (sometimes health care workers must get their zoom psychotherapy sessions in over lunch). She also noted that they worry about their own health and whether they would infect their family members when they go home. Some

healthcare professionals have moved out of their homes – or had their family members stay with relatives—so that they would not risk infecting them (Mock & Schwartz, 2020).

Some hospitals are overwhelmed. Many healthcare workers do not have the resources to treat all the patients who need help, nor do they always have sufficient personal protection equipment. In addition to the high volume of patients, they also have especially difficult tasks to perform. For example, they have had to facilitate final phone calls between loved ones and their family members. They have watched refrigerated trucks pull up next to their hospitals to manage the large number of dead persons. Their sacrifices are made easier when members of the public express their support and appreciation. Their sacrifices are made harder to bear when public officials minimize the impact of the pandemic or mock those who adopt public safety precautions such as wearing masks.

As of December 16, 2020, the Centers for Disease Control and Prevention (2020a) reported 298,000 cases of infection among health care workers and 928 deaths due to COVID-19. One third of the deaths occurred among nurses and infection rates were especially high among Black nurses (Kambhampanti et al., 2020). Within the United Kingdom, health care workers were seven times more likely to become infected with COVID-19 than the population in general (Mutambudzi et al., 2020). The number of deaths of behavioral health professionals, such as psychologists is low (Kambhampati et al., 2020). Nonetheless, many PPA members are senior clinicians and have higher risks because of their age and comorbid health conditions.

Emergency room and other physicians and nurses may experience *moral injury,* or the distress that occurs when one must make a difficult and, in hindsight, a poor decision that violates one's personal norms of morality. These errors may occur, for example, when healthcare professionals must decide quickly which patients get priority care. Because there is little time to reflect, there is a higher risk of making poor decisions.

Health professionals have had a weak armamentarium to deal with COVID-19, although the quality of treatments is gradually improving. Ideally health care professionals will learn and then treat. Now they are learning as they treat (or treating as they learn). The evidence on how to treat COVID-19 or its complications was uncertain when the pandemic started and evidence supporting (or refuting) interventions has begun to emerge gradually through anecdotes and recently published articles. By necessity, many of the recent articles about COVID-19 in scientific journals relied on observations made without the benefit of a high-quality controlled research design. The quality of the research they are reading is less reliable than what is normally published. Fortunately, newer treatments are reducing mortality rates and illness severity.

Even after the acute stage of infections subsides, it will take several months or longer for the existing healthcare workforce to recover and return to pre-pandemic levels of distress (Mock, 2020). Although the workload will unlikely match that found in the height of the pandemic, it will not return to normal as unmet medical demands, such as non-urgent surgeries that were delayed during the pandemic, need to be addressed.

Many of the emotional traumas experienced by healthcare or other frontline workers were suppressed or denied because of the urgency of the needs that they were addressing. One physician wrote, "I honestly have no idea how I feel. I don't have time to digest any of this. I go to work and then I go to sleep" (Mock & Schwartz, 2020, p. 38). When the immediate medical needs subside, we can expect to have the mental health problems seep through or explode for these workers. Similarly, Dr. Derrickson Kossmann found that many teachers resent the extra demands being placed upon them, and fear for the safety of themselves and their families.

Mental Health Needs of Survivors of COVID-19

A diagnosis of COVID-19 increases the likelihood of a first-time psychiatric diagnosis within 14 to 90 days, compared with other health-related events (Taquet et al., 2020). Anxiety, insomnia, and dementia (among those older than 65) were the most likely diagnoses. Survivors of SARS had an increased rate of post-traumatic stress disorder (Hong et al., 2009). Similarly, Vindegaard and Benros (2020) found that survivors of COVID-19 often reported PTSD and depressive symptoms. COVID-19 patients may have required hospitalizations, had invasive or frightening medical experiences likely to induce PTSD symptoms, and felt anxiety, stress, and trauma even after they recovered. Also, most COVID-19 patients have had to endure these experiences alone because they have been unable to have loved ones with them in the emergency departments, ICUs, or hospitals.

Survivors of COVID-19 reported higher than normal symptoms of depression (Vindegaard & Benros, 2020). Hu et al. (2020) found that the risk for depressive symptoms was highest among those who had the longest duration of the disease, highest levels of inflammatory markers, and the worse self-reported symptoms of the disease. Furthermore Yuan et al. (2020) found that the rates of self-reported depression were highest among those who had an increased white blood cell and neutrophil counts and neutrophil-to-lymphocyte ratio.[2]

The reasons for the link between disease severity and the risk of depression are not clear. It is possible that the lingering physical symptoms of the illness may precipitate depression. After all, reports from survivors indicate that many experienced prolonged recoveries and subclinical symptoms for weeks after "recovering" (Lowenstein, 2020). Nine out of ten COVID-19 patients reported lingering symptoms such as fatigue or difficulty concentrating (Cha, 2020). As found with SARS, neuromuscular complications, such as Guillain-Barré syndrome or other myalgias have been found following COVID-19. Or perhaps some of the increased symptoms of depression may be caused by the co-occurring requirement to self-isolate, the disruption of one's social field, the loss of work (Horesh & Brown, 2020), or some

2. Neutrophils are a form of white blood cells. The neutrophil-to-lymphocyte ratio is a common marker of subclinical infections.

combination of the above.

Furthermore, COVID-19 may cause longer term neurological or mental health problems after the acute stage of the infection has ended. Some speculate that the influenza or similar infections have a biological pathway to psychological problems. Okusaga et al. (2011) found a significant link between influenza infections, mood disorders, and suicides. Following the 1918 flu epidemic, some physicians identified post-viral melancholia or cognitive loss (Spinney, 2017). Given the lack of standardized diagnostics at the time, these reports can only be considered suggestive and not definitive.

It appears that COVID-19 may harm central nervous system functioning in many patients. The exact number of patients is not known because many of these harms may be long-term and not obvious during the acute phase of the illness. McNamara (2020) found anecdotal reports of headaches, myalgia, muscle weakness, confusion ("brain fog"), and disorientation cooccurring with or following COVID-19 infections. Rogers et al. (2020) reported causes of delirium, agitation, altered consciousness, and dysexecutive syndrome[3] among many patients hospitalized with COVID-19. COVID-19 leads to an increased risk of strokes (Josephson & Kamel, 2020). The risk of neurological disorders appears to increase with the severity of the infection. Also, comorbidities such as hypertension and diabetes may increase the risk of neurological problems (Hein, 2020). Currently, the data is insufficient to determine the frequency and nature of these neurological problems.

DeFelice et al. (2020) suggested that the actual neurological impact of COVID-19 may not be determined for many years. They suggested that the COVID-19 infection may worsen existing neurological problems or prompt the start of a degenerative neurological disease that would not be obvious for many years in the future.

Asadi-Pooya and Simani (2020) believe that such connections should be expected because of past research linking CNS involvement with past influenza pandemics. Although COVID-19 is not the same as the influenza that caused the 1918 pandemic, the common flu, SARS, or MERS, experience should alert us to the possible neurological sequalae of infections. MERS and SARS have physical structures like COVID-19 (Petrosillo et al., 2020), and it raises the possibility that the virus or perhaps the body's immune system response to it could lead to neurological damage. Also, Arabi et al. (2015) found neurological symptoms among many patients following their infection with MERS. Nonetheless, it is possible that some of the neurological complications may not come from the virus itself but from hypoxia, sepsis, or multi-organ failure (Kwong et al., 2020).

Summary

Based on preliminary reports of the COVID-19 infection and past viral epidemics, we can expect hard times ahead. Mental health needs will continue to increase, and fewer resources will be available to meet them. We are currently seeing that

- Given the anxiety and fear generated by the pandemic, shelter-in-place orders, job losses, and other social tensions, psychologists are seeing an increase in emotional distress. Deaths from opioid overdoses are increasing as well.
- Groups especially impacted by the multi-demic include youths who cannot attend school, older adults who have difficulties with activities of daily living, and those with pre-existing psychological problems.
- About one-third of the excess deaths since the pandemic started are for medical reasons not directly linked to COVID-19. As hospital systems become overwhelmed, this percentage may increase.
- Evidence suggests that the mental health of Americans will not decline to pre-pandemic levels after the pandemic ends.
- The mental health needs of healthcare professionals and other front-line workers are especially high.
- Because of long-term social and health care inequalities, certain groups, such as Black, Latinx, or indigenous Americans have a higher risk of becoming infected from or dying from COVID-19.
- Some survivors of acute COVID-19 infections have long-term physical symptoms. Many survivors of COVID have PTSD or subclinical PTSD symptoms, or depression or anxiety, and some have or will have post-viral neurological complications.

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SUICIDE and MEDICATIONS

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Almost 60% of patients in psychotherapy are also on some psychotropic medication (Clay, 2011). Of course, psychologists should refer their suicidal patients for medications when they believe that the patients would benefit from them. But medications are seldom optimal as a stand-alone treatment for patients with suicidal risks, although they often can be part of an overall helpful treatment plan. As psychiatrist Ronald Maris expressed it, "Treating depression and other mood disorders involves far more than just titrating neurotransmitters" (Maris et al., 2019, p. 202). It is commonly believed that the optimal treatment for suicidal patients involves a combination of psychotherapy and medications, although no empirical studies support this assumption (Bryan & Rudd, 2018).

Whenever psychologists see new patients, they should learn what medications their patients are taking. In addition, psychologists should ask their patients if they know why they are taking the medication, if they understand the instructions for taking the medication, and their perceptions of the benefit of the medication.

Medications vary on their short-term effectiveness in reducing suicidal risk. Evidence suggests that clozapine (Clozaril) can reduce the short-term risk of suicide for persons with psychotic disorders such as schizophrenia. Also, it is widely believed that lithium may reduce the risk of suicide for patients with bipolar disorders (Maris, 2019), although psychiatrists may be more reluctant to prescribe lithium to highly suicidal patients because an overdose of lithium can be fatal (Bryan & Rudd, 2018).

Medications have not proven effective in reducing suicidal risks in the short-term for other disorders. For example, patients may need to take anti-depressants for 4 to 8 weeks before they experience any benefit and even then, the medications may need to be changed or modified. Furthermore, anti-depressants only produce clinically meaningful results in 60 to 70% of all depressed patients (Maris, 2019). The risk of suicide is high during the first month that patients start anti-depressant medications. Some fear that the administration of medication may give suicidal patients just enough energy and motivation to prompt them to attempt suicide. But it is unlikely that the medication caused such an increase in suicide risk because the risk of suicide is even higher during the month preceding the start of medication. Most likely the high suicidal risk during the first weeks of medication reflects an ongoing risk of suicide.

Consequently, psychologists should use other suicide management strategies while the suicidal risk remains high even if patients have started on medication. This

1. The author thanks Richard Kutz, Psy.D. and Tony Ragusea, Psy.D. for their reviews of an earlier version of this article.

means monitoring the patient, developing a crisis plan, restricting access to the means of suicide, and motivating patients to invest in and participate fully in treatment. Antidepressants alone are seldom sufficient to reduce suicidal risk even after the medications start to have a therapeutic effect. "There is no anti-suicide pill" (Maris, 2019, p. 397). Taking a pill does not remove a gun from the house, nor does it repair a broken relationship (Knapp, 2020).

Provider Communications

When patients are involved in hybrid services (receiving psychotherapy from one independent provider and medication from another independent provider), efforts should be made to coordinate services through phone calls and consultation on important issues. Psychologists can inform the prescriber of how the patient is progressing in treatment, their perceptions of suicide risk, any relevant information about medications, including medication compliance, and how they can work together to help the patient. Prescribers can inform psychologists about their perceptions of patient progress and suicide risk.

Often patients develop closer relationships with their psychologists than with their prescribers and are more willing to disclose their problems with medications or their perceptions of the benefits of medications to their psychologist. Nondisclosure (failure of patients to disclose all relevant information) is an important issue in health care in general and it can have especially pernicious consequences when treating suicidal patients. Psychologists can facilitate disclosure by being open, accepting, and nonjudgmental with patients.

Psychologists (and prescribers) can jointly monitor patients for side effects from the medication which can range from minor and only irritating, to being severe enough that patients will discontinue the medication. Such patients may need an adjustment in their medication, a change in their medication, or supplemental medications to help control the side effects.

A continual concern is whether patients would use the medication to overdose. Therefore, prescribers should limit the amount of medications given to patients especially when the risk of suicide is high. As part of their evaluation of suicide risk, psychologists should ask patients about past suicide attempts (including what means they used to attempt suicide), their current suicide plans, and any preparations for suicide (including what means they would use to attempt suicide). Psychologists should also remember that patients may sometimes have more than one plan for suicide and they should ask their patients about secondary or tertiary suicide plans (Knapp, 2020).

Adherence Issues

In addition, psychologists can gather information that would help them to proactively address obstacles to compliance with medication. One of the major reasons for medication failure is that patients do not take the medications as prescribed. For example, 50% of patients prescribed lithium for manic-depressive disorders do not adhere to their treatment (Maris, 2019) which is consistent with medication nonadherence for hypertension (Bosworth et al., 2017). Nonadherence could occur for many reasons including the possibility that patients did not understand why the medication was prescribed, did not believe that it would be effective, lacked vigilance, or did not understand the instructions (Marcum, Sevick, & Handler, 2013). At times psychologists need to consider whether cultural factors, such as a mistrust of White mental health professionals, may influence adherence.

As much as possible, instructions for medication should be made simple. Although psychologists will not be prescribing the medications, ideally, they will be communicating with the prescriber and will be able to check their patient's understanding of the medication instructions.

Some patients encounter practical obstacles, such as lack of money to pay for the medications. One patient took one-half the dosage of medication to stretch it out because she could not afford to pay for all the medication prescribed. She did not understand the importance of keeping a certain threshold of the drug in her system to derive therapeutic benefits. Often arrangements can be made for patients who cannot afford their medications.

Here are some questions that psychologists can ask their patients about the medication including their attitudes and beliefs about the medication, and specific intentions related to medications. These questions reflect the perspective of "patient-centered care" which focuses on maximizing patient choice and in implementing a treatment that is most congruent with the values of the patient (Bosworth et al., 2017).

How do you feel about taking this medication? Do you know why the medication was prescribed? Do you believe it will help you? How do you think it will help you?

Do you know how to take the medication? What instructions did your doctor or advance practice nurse, or physician's assistant give you about taking this medication? Who will you call if you have questions about the medication?

What is your plan for when and how you will take the medication? Where will you store it?

How will you remember to take each dose?

Do you have a pharmacy that you regularly go to? Does insurance pay for the medication?

Can you afford it?

What as the last medication that you took? Did you take it as prescribed? If not, why did you not take it as prescribed? Did you tell your physician that you were not taking it as prescribed? If not, why?

How would you rate, on a scale of 1 to 5, the likelihood that you will take this medication as prescribed?

The answers to these questions will help psychologists to understand their patients better and to address obstacles with adherence to medications ahead of time.

Anti-Depressants and Black Box Warnings

In 2004, the Federal Drug Administration told manufacturers of anti-depressant medications to include a black box warning noting an increased risk of suicidal thoughts and behaviors for children and adolescents who started on antidepressants. In 2007 the warning was expanded to include persons up to the age of 24. In 2009 it was updated again to include medications commonly called "mood stabilizers."

The black box warning was based on a small, but statistically significant, increase in suicidal thoughts among adolescents found in industry sponsored research on anti-depressants (although there were no suicides in the reported trials). Despite methodological issues in subsequent studies, Pozzi et al. (2016) concluded that "a small increase in suicidal risk may be attributed to antidepressant therapy, at least concerning pediatric, adolescent, and young adult patients, affected by major depression in the early phases of treatment" (p. 49). According to one study, 11% of adolescents taking anti-depressant medications developed suicidal thoughts while 3% of the adolescents without medication had suicidal thoughts (Högberg et al., 2015). The net result of the black box warning was a significant decrease in the use of anti-depressants, no increase in face to face psychotherapy, but an increase in the use of benzodiazepines and anti-psychotics, especially for young women (Fornaro, et al., 2020).

Given this change in prescribing patterns, a question arises as to whether professionals overreacted to the black box warnings and overestimated the potential risk of prescribing antidepressants. Several authorities believe that the black box warnings may do more harm than good, in that the benefits of taking anti-depressants are far greater than the harm of increasing suicidal behavior in a small number of patients (e.g., Bryan & Rudd, 2018; Fornaro, et al., 2020, Maris, 2019).

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SELF-CARE in the AGE OF COVID-19

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The stresses of 2020 on all healthcare professionals are numerous, impactful on all of us as humans and at least as significant on our work as psychologists. We coined the term *Multi-Demic* to describe the multiple and cumulative effects of a health pandemic, the resultant economic recession, racial tensions, and political upheaval. These are stressors added to the typical range of stress inducing events in our lives. The pervasive impact on the public has increased anxiety and depression, further adding to the demand on the profession for psychological services. Our ethical standards for self-care suggest that these stresses and their resultant impact on each one of us be addressed specifically and directly.

We designed a 90-minute virtual continuing education program that included opportunities for participants to identify and name their stressors and the emotional impact, the values they wish to uphold, barriers to maintaining the professions high standards, and finally strategies that they found were helpful. We invited participants to share their answers to these questions with us through the Chat and Q & A functions of Zoom. They had the option to share them with only presenters, maintaining a small degree of privacy. We also encouraged everyone to write down their answers privately, even if they did not want to share their responses. As presenters, we summarized and highlighted the primary themes reflected in the experiences shared by participants. For example, we named the range and the significance of the losses many people had shared.

Our planning of the details for this program began several weeks in advance with one of us (SK) beginning with a list

of topics that we might want to consider and incorporate. It took two days for the other (JLS) to respond, and most of that response included details of the emotional roller coaster he had been experiencing since receiving that list. After SK's response in kind, we decided to read and/or describe each of our emotional starting points in the planning process as an example of what we hoped to encourage from participants. We thought sharing our experiences would provide not only an example, but also permission and validation of these realities that we are all experiencing.

The response from participants was overwhelming, suggesting an unmet need. We realized that many more colleagues may benefit from a summary, and even in the paragraphs that follow, there is insufficient space to fully acknowledge all the experiences shared by the 60+ participants. *We suggest that you can participate privately* by writing down your own responses to the prompts, including your own narrative about your emotional roller coaster, and finally, write one or more poems in the Japanese form of Haiku — three lines of 5-7-5 syllables as a way of expressing your own emotional experience.

1. What stressors have you been experiencing?

Health concerns for self, family and friends, deaths of family members and friends, funerals missed, cancer diagnoses and treatment, cancelled surgeries, being in a high risk group due to age or pre-existing conditions, feeling isolated from friends and family, family living outside the US, multiple job related stressors — changed or increased responsibilities, lay-offs, decrease in income, job security uncertainty, wide range of concerns about dependent children — lost and missed opportunities for celebrations, risks of child care, education challenges, multiple home responsibilities simultaneously, the political climate in our country - political differences among family members, providing therapy to clients with differing political beliefs.

2. Name the emotions that you have been experiencing:

Fear, uneasiness, anxiety, worry, helpless, dismay, resignation, agitated, isolated, sad, scared, overwhelmed…just going through the motions much of the time, angry, uncertain, unsafe, not enough of good times, frustrated, loneliness, and metaphors like *Rainbow* of emotions, emotional *roller coaster,* a sense of having no *anchor,* a sea of great pain, emotional soup.

3. "What are your core values?" "At the end of this Multi-Demic, I would like my friends and family to say that I showed the virtues of . . ."

Hopefulness, optimism, patience, caring, authentic, principled, ethical, consistent, supportive, inquisitive, rationality, optimism, compassion, love, kindness, hope, connecting to others, we will get through this, gratitude, resilience, empathy, understanding, honesty, generosity, justice, listening, humility, forgiveness, strength, steadfastness.

4. What barriers limit you in achieving your goals?

Episodic hopelessness, persistent pervasive stress, physical and emotional exhaustion, strong opinions that do not involve compassion, sleep deprivation, stubbornness on my part in clinging to my view versus listening to the other, maintaining respect for those who do not socially distance or wear masks, tears falling daily.

5. What supports (social/emotional) help you in your work and your life?

Appreciation...of all the little blessings...this breath, this moment, gratitude, compassion, writing thank you notes, mindfulness … one breath at a time, listening, sharing, bearing witness, seeing better choices together, talking with colleagues regularly, finding my own safe spaces where I can be honest about my experiences.

Our Lived Experiences

We are not sure what is more alarming — the power of individual quotes or the list of individual concerns. We did not imagine we would elicit the number and nature of burdens our colleagues were experiencing, and it did not occur to us that we might want to share their quotes with all their emotions embedded. Without permission to quote, we offer a summary of the types of challenges our colleagues shared and have been carrying:

Personal health challenges among close family, friends, neighbors, acquaintances - illness, hospitalization, death, divorce, health concerns and health safety, serious diagnoses, and treatment,

Work challenges such as job insecurity, increased responsibilities, staff retrenchment, colleague firings, reduced income, crises in clients' lives, difficulty with technologies, changing insurance company regulations, clients moving out of state

Child-care dilemmas, schooling choices, school disruption for those in high school or college, struggling with children at home 24/7

Political stresses among friends, clients with very strong political beliefs, people who do not respect COVID-19 restrictions (masks, social distancing)

Multiple losses including freedom to move about, to visit family and friends, to attend a funeral of a loved one, to just get away, arranging our lives

Finally, we provided an opportunity for participants to capture the sense of their experiences in a poem through the form of a Haiku - a three-line Japanese poem with a 5-7-5 syllables per line. We include several examples below:

Hate fueled by fears
Can be diluted by
Fellowship

Dr. Sandy Kornblith

Sickness, fear, loneliness
Around us the world crumbles
Where are our values?

Dr. Samuel Knapp

Humanly perfect
Naming insecurities
Perfectly human

Dr. Jeff Sternlieb

Q&A TOPIC: Postdoctoral Master's Degree in Clinical Psychopharmacology (MSCP)

DANIEL WARNER, Ph.D.
JENNIFER COLLINS, Psy.D.

Do you have an interest in specialty training in psychopharmacology? Are you considering a Master's degree in Clinical Psychopharmacology which is the first step towards becoming a prescribing psychologist in a state that allows psychologists to prescribe? Jennifer Collins, PsyD recently completed her post doctoral Master's of Science in Clinical Psychopharmacology (MSCP) Program at Fairleigh Dickinson University (FDU) with hopes of a prescriptive authority for psychologists (RxP) bill being passed in PA in the near future. Daniel Warner, PhD is considering applying for a MSCP program and we decided to take this opportunity to share a real life Q&A that may be helpful to any other PPA members who are considering postdoctoral training in psychopharmacology.

Dan: What is your background in psychology? What kind of work do you practice, and where did you study?

Jen: I have a PsyD in Clinical Psychology from Philadelphia College of Osteopathic Medicine. I have worked for Penn Medicine Lancaster General Health in Lancaster, PA since 2009. The majority of my clinical work is in health psychology (e.g. bariatrics, pain, fertility).

Dan: How did you come to decide to pursue a masters in clinical psychopharmacology? What was your background in medical knowledge before starting the post-doc?

Jen: I started to think about a Master's in psychopharmacology after years of frustration of limited access to psychiatrists for my patients, even within my own health system. The wait times would often be 6 months or more and frequently psychiatrists would not be accepting new patients or only take certain insurances. I knew some states allowed prescriptive privileges for psychologists so I was curious about what qualifications one would need. Around the same time, my good friend and colleague, Dr. Tracy Ransom had started the Master's in Clinical Psychopharmacology program at Fairleigh Dickinson University so I asked her a bunch of questions about the program and decided to apply. I also connected with John Gavazzi, a long-time PPA advocate for RxP to see how I could help reignite momentum for RxP in PA.

Dan: Why did you choose the program you are attending? How is the quality of your training? Can you describe a "class"?

Jen: I chose FDU because it is 100% online which fits best with my life right now with full-time work and 2 young children. Some of the other programs required some onsite presence and none of the programs are particularly close to PA (New Mexico State, Alliant in CA, and Chicago School of Professional Psychology are a few of the other programs). I also had heard good things about FDU's program through Tracy and appreciated having a resource who was ahead of me in the program. Many of the professors are prescribing psychologists which was very appealing to me. Additionally, the cost of the program was quite reasonable for a Master's degree.

Dan: Do you think it matters if one starts in the Spring semester, instead of starting with a cohort in the Fall?

Jen: I do not think it matters too much because you will have all the same courses over time, just in a slightly different order. For me personally, I wanted to start in the Fall so that I went through the program in the order it was designed.

Dan: When do you study for this program? How did you fit it in? How much control do you have on when you do things in the training, for instance: How much live time with trainers is necessary? Are you basically leading your own training through videos? How has your training adjusted to Covid?

Jen: Every week there is an hour long LIVE online lecture with a professor plus 1-2

video modules and reading assignments. I dedicated 1-2 evenings a week plus a few hours on Sundays to keep up with the videos and readings. If I was able, I tried to watch shorter videos over my lunch hour at work. Absolutely nothing changed during COVID since the entire program was online already. In fact, I heard that other programs within FDU were reaching to the Director of the MSCP program for guidance on converting to online lectures when FDU campus closed.

Dan: How are the study materials in school? If you want to do extra work to study, are there extra materials or apps one can buy?

Jen: The articles and chapters are provided via Blackboard for each class and are very valuable. In addition, there is a text or two for each class that you need to buy. Many of them are great guides for prescribing that I refer to often. Many of the professors will also send valuable links, additional articles,and helpful resources along the way.

Dan: Do you feel confident acting as a peer with physicians from this training? Do you feel confident disagreeing with a psychiatrist thanks to the training you're learning in this program?

Jen: I definitely feel more knowledgeable about psychotropics than I did before this program. I can speak more confidently about medication choices to physician colleagues and patients. Since I work with many bariatric patients, I often find myself talking to them about weight gain side effects of specific medications. I am fortunate to have a great relationship with the bariatric surgeons and many primary care physicians to whom I can offer my suggestions. I have not had many opportunities to overlap with psychiatrists yet. I am hoping to build relationships with a few psychiatrists in my organization who view RxP favorably and would provide me with supervision and ongoing consultation. In my opinion, psychiatrists will remain the best choice for patients who have severe mental illness and complex medical histories, but I believe prescribing psychologists are just as competent in treating anxiety disorders, mood disorders, sleep disorders, ADHD and others for which a combined treatment approach is best.

Dan: What do the residencies look like? How did you get a psychiatrist to be willing to oversee your work? Isn't their professional pressure against them to do that? How about the institution where you work? Have you heard of anyone having a hard time getting that kind of support?

Jen: After you have obtained your MSCP you must then pass the licensure exam called the PEP (Psychopharmacology Exam for Psychologists). Once licensed, you are required to have supervision for a designated number of patients (based on wording of the state's RxP bill). The supervision typically can be provided by a psychiatrist, primary care physician or psychiatric nurse practitioner. I think psychiatry generally will be opposed to RxP, but I have heard of prescribing psychiatrists

Guide For Antidepressant Choice **

DEPRESSION-ANXIETY-INSOMNIA-PAIN

	NEUROTRANSMITTER TARGETS						
CONDITION	+ 5HT	+ NE	+ DA	Ø ACH	Ø H1	+GABA	**SOME EXAMPLES OF MEDICATIONS**
Depression *							
With Low Energy	X	X	X				**Bupropion** (NDRI) +NE+DA, **Venlafaxine** (SNRI) +5HTP+NE, **Selegiline** (MAOI) + 5HT+NE+DA
With Anxiety	X				X		**Fluoxetine, Sertraline** (SSRI) +5HTP, **Trazodone** (SARI)+5HTP Ø H1
Anxiety	X				X	X	**Citalopram** (SSRI) +5HTP, **Buspirone** (+5HTP) +5HT1A , **Hydoxyzine** Ø H1, **Diazepam** (BZ) +GABA
Insomnia							
With Depression	X				X		**Trazodone** (SARI) +5HTP Ø H1, **Mirtazapine (NASSA)** +5HTP +NE Ø H1
With Depression & Pain	X	X		X	X		**Amitriptyline**, **Imipramine** (TRI-C)+5HTP+NE+DA Ø ACH
Without Depression					X	X	**Hydoxyzine** Ø H1 **Zolpidem** + GABA
Physical Pain	X	X					**Duloxetine** +5HT+NE

+ means "increase" Ø means "blockade"

* Listed Rx may affect only one NT system (see NT list on right of Rx name)

** Reflect author's study and clinical experience - utilize additional resources to make your clinical decisions

+ 5HT	Increasing serotonin improves mood and reduces anxiety
+ NE	Increasing norepinephrine improves mood, increases energy, and inhibits pain signals
+ DA	Increasing dopamine increases attention and concentration and increases energy
Ø ACH	Blocking acetylcholine inhibits the relaxation response, salivation, sweating, digestion, memory, and causes sedation
Ø H1	Blocking histamine causes sedation
+ GABA	Increasing gaba inhibits anxiety

	Ø H1	Ø ACH	+NE	+5HT	+DA	+GABA	1/2 Life	Cost	Primary Risk
Amitriptyline - Elavil	***	***	**	***			10-26	$	QT SS ≠
Bupropion - Wellbutrin			**		**		21	$50	
Buspirone - Buspar				**			3	$15	SS
Citalopram - Celexa	*			***			35	$	SS QT
Diazepam - Valium						***	30-60	$15	≠
Duloxetine - Cymbalta			***	***			12	$250	
Fluoxetine - Prozac				***			90-108	$	SS
Hydroxyzine - Vistaril	***						20-25	$	
Imipramine - Tofranil	**	**	**	**			15-25	$10	QT SS ≠
Sertraline - Zoloft				***	*		26	$10	SS
Mirtazapine - Remeron		**					20-40	$50	≠
Trazodone - Desyrl	**			***			5-9	$10	SS ≠
Zolpidem - Ambien						*	3	$50	≠

+ 5HT	Increasing serotonin improves mood and reduces anxiety
+ NE	Increasing norepinephrine improves mood, increases energy, and inhibits pain
+ DA	Increasing dopamine increases attention and concentration and increases energy
Ø ACH	Blocking acetylcholine inhibits parasympathetic activity
Ø H1	Blocking histamine causes sedation
+ GABA	Increasing gaba inhibits anxiety

KEY: **(Enroll: Nat. Preg. Registry for AD's 844 405 6185)**

$ = Approximate Cost SS = Serotonin Syndrome

1/2 Life = Approximate +QT = QT Prolongation

≠ = Extra Caution in Pregnancy and/or lactation

* ** *** = Intensity of Reaction

(Mediations selected are illustrative of class & similar medications)

Other Considerations: *(1) Weight Gain Correlates with Ø H1 (2) Hypnotic Potential Correlates with Ø H1 or +GABA (3) Beers Criteria for Ø ACH*

in other states who have wonderful relationships with psychiatrists who they consult with regularly.

https://www.apaservices.org/practice/advocacy/authority/prescribing-psychologists

Dan: Can you tell a difference between your approach to prescribing from that of psychiatrists? Or is this really forming a uniform medical approach?

Jen: It is my goal to continue to conduct thorough biopsychosocial evaluations with multiple treatment recommendations which may or may not include starting a psychotropic medication. I think patients expect that they are prescribed a drug when they see a psychiatrist. As psychologists, we can continue to use "skills before pills," but have medications as a tool in our toolbox if and when we need it.

Dan: How do you imagine this knowledge and degree will change your clinical practice? How do you practice now (i.e. what environment? What kind of interventions and/or therapy do you do?)

Jen: Even if an RxP bill is never passed to allow me to prescribe, I think my increased knowledge in psychotropics will change the level of confidence I have talking to patients and their medical teams about whether or not medication would be beneficial for them, and to give more specific recommendations to PCPs on what medication I think a patient should be started on (or in somes cases, weaned of off). I often make recommendations to patients such as "consider talking to your primary care physician about medication to help address your anxiety/depression." With my additional Master's degree in psychopharmacology, I feel qualified to make more specific medication recommendations based on whether or not their depression is associated with low energy, anxiety, sleep disturbance, etc. One of my professors, prescribing psychologist Dr. Marlin Hoover, created a helpful chart as a guide which his physician colleagues frequently refer to. I find it very useful and it makes perfect sense to me after completing the courses in the MSCP program.

Dan: How important is the information you're learning to the work one does as a psychologist? Are you learning things drastically out of our field? Or, are these things you feel really any licensed psychologist should know?

Jen: Psychopharmacology is important for all psychologists to have some familiarity with since the majority of our patients are on psychotropics. I find it particularly necessary since I work in a medical setting and am responsible for documenting that I reviewed patients' medication lists with them. The level of detail you learn in the MSCP program is far and above just knowing names of common psychotropics. The first year is full of neuroscience, anatomy and physiology, and pharmacology. My doctoral program had coursework in biological basis of behavior and neuroscience so I had some familiarity, but this was a much deeper dive. The courses are only 7.5 weeks long, so the first year of those core courses feels rapid and intense. The second year is more practically focused with treatment of specific disorders. The professors do a good job of incorporating research on what disorders have best success with psychological intervention vs medication (e.g. insomnia, OCD, PTSD), which really solidifies the fact that psychologists have so much to offer clients/patients already and the psychopharmacology speciality adds another layer of expertise for those who want it.

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DR. LEONARD SZPARA

(NOVEMBER 30, 1943 – AUGUST 20, 2020)

Dr. Leonard L. Szpara passed away peacefully on Friday, August 21st, at the age of 76. Leonard was born and raised in Blakely, Pennsylvania. At the University of Scranton, Leonard completed a Bachelor of Science in Psychology (1965) and a Master of Science in Counselor Education (1967). He went on to complete his Doctor of Education degree in Psychoeducational Processes from Temple University in 1977. Leonard initiated his career at The Pennsylvania State University, Worthington-Scranton campus, in 1968. During his almost 30-year career at Penn State, Leonard coordinated Counseling and Advising Services, and served as Campus Psychologist, Counselor, and Advisor. He also directed the Learning Center and taught multiple psychology, education, and counseling courses. During his training and career, Leonard also taught courses on psychology at the University of Scranton, Marywood University, and Temple University. Leonard maintained an active psychologist license until his death, and was a member of the American Psychological Association (APA) and the Pennsylvania Psychological Association (PPA). After his retirement from Penn State in 1997, Leonard turned his lifelong interest in automobiles into a part-time career in automotive appraisal, repair and detailing, and resale.

Leonard served the community in numerous roles, most recently as a School Board member for the Manheim Central School District and as a School Director for the Lancaster County Career & Technology Center. In his retirement community in Mount Joy, PA, Leonard served on the Homeowner's Advisory Group for The Villas at Elm Tree, and was a member of Mary Mother of the Church Parish. In his many years in Peckville, PA, Leonard was an active member of the Sacred Heart of Jesus Parish, and served both as a Eucharistic Minister and Lector.

Leonard is survived by his wife Yvonne Mahig Szpara, his two daughters, Michelle Yvonne Szpara (Kenneth Robert DeNisco) and Moriah Louise-Teresa Szpara (Manuel Llinás), grandchildren, Sahara Ann Szpara-DeNisco, Silvio Szpara Llinás, and Amadeo Szpara Llinás, his brother Edward Sparrow (Patricia and daughter Stacey), and was preceded in death by his sister, Lorraine Malewich (daughter JoAnn Harvie).

DR. ELEANOR MURDOCH

(AUGUST 15, 1931 –NOVEMBER, 2020)

Eleanor Murdoch, Ph.D. of Lafayette Hills, PA passed way in November 2020 at the age of 89. Dr. Murdoch was a long-time member of the Pennsylvania Psychological Association.

"It is a sad moment. Well, sad is an understatement, given how amazing a human being she was. A celebration of her life will be held in the Spring, when hopefully this scourge eases up and we can gather at her graveside, or still Zoom in.

Eleanor was so many things to so many people...wise, smart, always with that glow of a smile. My sister, Kate, and I thank all of those who knew her, as she would want me to say.

Hold a special place for her -- her incredible life, all those thousands she helped as a psychologist, and those kindnesses she showed because she knew what it was like to be both poor and well off. Her generosity of Spirit, her love of family and friends, her open heart.

As the saying goes, "I may not be here, but I am not gone."

Journey on, Mom."

— Alfred Murdoch

CE QUESTIONS FOR THIS ISSUE

EARN 1 CE CREDIT FOR THIS ISSUE!

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

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 January 31, 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.

Mental Health and the COVID-19 Multi-Demic

1. **If evidence from previous pandemics holds true, then it is likely that the distress related to COVID-19 will**
   a. Rapidly decline after the pandemic subsides
   b. Return to pre-pandemic levels soon after the pandemic subsides
   c. Stay high even after the pandemic subsides
   d. Drop far below pre-pandemic level

2. **Older adults are especially likely to be harmed by physical isolation if they**
   a. Are aged 65-75
   b. Are married
   c. Have difficulties with activities of daily living
   d. All the above

3. **An unexpected increase in the rate of suicide will likely be caused by**
   a. An increased access to firearms
   b. The increase in unemployment and economic distress
   c. A decrease in social contact due to physical distancing
   d. All the above

4. **The difference between the actual number of deaths and the expected number of deaths is called**
   a. True deaths
   b. Physician-fabricated deaths
   c. Excess deaths
   d. Formal deaths

5. **The rates of deaths from COVID-19 is higher among Black Americans because they**
   a. Are more likely to have pre-existing medical conditions
   b. Are less likely to have access to health care
   c. Disproportionately work in front-line or service jobs that require direct contact with other people
   d. All the above

6. **Within the United Kingdom health care workers had rates of infection from COVID-19 that were _____ the rates found in the population in general.**
   a. Lower than
   b. About the same as
   c. 7 times higher than
   d. More than 20 times higher than

7. **Moral injury refers to**
   a. Distress that occurs when one must make a decision that violates one's norms of ethical conduct
   b. A physical injury caused by a moral transgression
   c. A sense of being morally uplifted by observing courageous behaviors of others
   d. The lack of morality found in most medical schools today

8. **According to Hu et al. (2020), survivors of COVID-19 are more likely to have depressive symptoms if they have**
   a. Worse self-reported symptoms of COVID-19
   b. Higher levels of inflammatory markers related to COVID-19
   c. Longer duration of the disease
   d. All the above

9. **According to McNamara (2020) some of the neurologicl symptoms that have been found among survivors of COVID-19 include.**
   a. Headaches and confusion
   b. Poor performance on the Stroop test and poor attention span
   c. "Brain fog" and psychogenic nausea
   d. All the above

10. The study reported by Hein claimed that the comorbidities that may increase the risk of neurological programs among COVID-19 patients are

a. Hypertension and diabetes
b. Hypertension and coronary heart disease
c. Heart disease and diabetes
d. Coronary heart disease and Alzheimer's Disease

11. Experts believe that the neurological symptoms associated with COVID-19 may be caused by all of the following EXCEPT the

a. Direct effect of the virus on the central nervous system
b. Psychological trauma of having a high number of adverse events in childhood
c. Processes precipitated by the disease such as multi-organ failure
d. Difficulty breathing (hypoxia or lack of oxygen) that sometimes occurs with COVID-19

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, January 2021

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

1.	a	b	c	d	4.	a	b	c	d	7.	a	b	c	d	10.	a	b	c	d
2.	a	b	c	d	5.	a	b	c	d	8.	a	b	c	d	11.	a	b	c	d
3.	a	b	c	d	6.	a	b	c	d	9.	a	b	c	d					

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

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

Comments or suggestions for future issues _____

_____

_____

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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.

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Calendar

SAVE THE DATES

JUNE 17 – 19, 2021
PPA2021 Create Your Own Convention
Virtual Convention

SEPTEMBER 23 – 25, 2021
PPA Fall Conference MAX
Lancaster Marriott at Penn Square
Lancaster, PA
Hybrid Event (In-Person and Virtual)

FRIDAY, OCTOBER 8, 2021
PPA Fall Conference MINI
Normandy Farm
Blue Bell, PA
Hybrid Event (In-Person and Virtual)

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