The Pennsylvania
Psychologist
APRIL 2021
VOLUME 81, NUMBER 4

Are You Hearing Your Patients EMOTIONAL PAIN?

Clarifying the Emotions Associated with Suicide

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A TOAST TO DR. SAM KNAPP

THURSDAY, JUNE 17, 2021
6:30 - 8:30 PM

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Reserve your spot today by making your donation to PennPsyPAC at www.papsy.org/PennPsyPAC no later than Tuesday, June 1, 2021 to ensure you receive your wine prior to June 17th.

THANK YOU FOR YOUR SUPPORT!

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VOLUME 81, NUMBER 4 APRIL 2021

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in the *Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

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ARE YOU HEARING YOUR PATIENTS EMOTIONAL PAIN?

Clarifying the Emotions Associated with Suicide

SAMUEL KNAPP, Ed.D., ABPP

Suicide is the 10th leading cause of death in the United States. About 87% of the members of the Pennsylvania Psychological Association had treated a suicidal patient in 2018. In addition, 58% of PPA members had a patient with a suicidal plan, 24% had a patient attempt suicide, and 3% had a patient die from suicide (Leitzel & Knapp, 2020).

Emotional pain is one of the hallmarks of suicidal behavior. One of the most important steps in helping suicidal patients is trying to understand how they feel.

Consider this example,
Dr. Doe interviewed a patient with current suicidal thoughts and a suicide attempt several years ago. The patient said that "I worry all the time" and "Somedays I feel like crying all day and I just can't get motivated." Despite her high position in a company and several recent promotions, she reports that she has many shortcomings on her job. When discussing her past attempt, she stated that she acted impulsively when she took many sleeping pills. Currently she says that she feels restless much of the time and has trouble getting negative thoughts out of her mind.

It is to Dr. Doe's credit that she created a safe environment where the patient felt comfortable sharing her feelings. Nondisclosure is an important clinical issue for all patients, but especially for suicidal patients who may withhold or minimize important information out of shame or embarrassment (Dunkley et al., 2017). Dr. Doe was able to elicit this information by being supportive, nonjudgmental, showing genuine concern for her patient, and striving to understand her feelings and perspectives.

Of course, Dr. Doe's evaluation of her patient requires her to ask about suicidal thoughts, past attempts, plans for suicide (if any), and the patient's personal history and life circumstances including her upbringing, social networks, physical health, acquired capacity for self-harm, and value system. Nonetheless, understanding her patient's emotions is an essential part of this thorough evaluation.

This patient described negative emotions, such as sadness, worry, and restlessness; a background of impulsive behavior; perfectionism; and difficulty in controlling negative thoughts. An effective intervention will need to reduce the saliency of these feelings and help the patient to better control them. One of the first steps in creating a good treatment plan is to understand the patient's feelings accurately.

This article will identify and clarify the feelings that often accompany suicidal behaviors with the goal of helping psychologists to better target interventions. But first we will review the nature of emotions, then the role of dysfunctional emotions and suicide, and then specific emotions associated with suicide. A Table at the end of the article lists the practical suggestions for psychologists assessing patients with suicidal ideation.

What Are Emotions?

Emotions refer to the content of feeling states. Although the exact definition of emotions is continually being debated, it can be useful to consider the two dimensions of arousal and valence. *Arousal* refers to the intensity of an emotion (high, low, or somewhere in between) while *valence* refers to the extent to which an emotion is perceived as positive (e.g., joy, love) or negative (e.g., anger, fear). Suicidal patients are likely to have emotions with high arousal and negative valence.

Dr. Doe can ask her patient to rate the arousal level of her emotions on a scale of 1

(least intense) to 10 (most intense) both now and at its highest level. Self-report remains the most direct and reliable way to measure emotion because of the wide disconnect between physiological measures, behavioral measures, and self-report. Nonetheless self-report is not without its limitations (including demand characteristics and social desirability bias; Lee et al., 2020) and can be supplemented with behavioral observations of the patients or reports from third parties.

Moods are emotional states that last longer than an emotional episode (several hours or days) and may not have an easily identifiable trigger. Temperament refers to a tendency to feel certain types of emotions. A person with an agreeable temperament would be less likely to feel anger and would be more likely to feel positive or neutral emotions.

Negative emotions can have a positive function if they motivate people to address or remedy unwanted situations or repair disrupted relationships. But emotions can have a negative function if they are out of proportion to the environmental challenge or if they prompt self-defeating behaviors. For example, self-blaming emotions can be functional if they facilitate consideration of the feelings of others or motivate a person to repair a strained relationship. But self-blaming emotions can be dysfunctional if they lead only to withdrawal or passive suffering.

Emotional Schemas

Patients enter treatment with an *emotional schema* which is "a set of beliefs and strategies that one has about emotions" (Leahy, 2016, p. 83). For example, a patient may find some emotions, such as anger to be unacceptable and to minimize or deny feelings of anger. Conversely, others may value anger and freely express it, even if it is out of proportion to the initial trigger.

Cultural norms may influence emotional schemas. Patients from individualistic European-influenced cultures, for example, commonly believe that people should strive to experience positive emotions and may pathologize sadness or distress (Brock, 2013). In contrast, patients from collectivist cultures such as those that are Spanish or Asian-influenced, commonly de-emphasize the experience of personal happiness and focus more on the well-being of the group. Mexican Americans may emphasize the importance of *simpatico*, or an atmosphere of polite positivity toward others (Sendt et al., 2020). Asian or Spanish-influenced patients may be more likely to accept negative feelings as normative.

Black Americans may report more emotional inhibition, lower levels of emotional expression, and greater emotional defensiveness than European-Americans (Carter & Walker, 2014). Perhaps this reflects a heritage of living in a racist society that punished or discouraged authentic expressions of emotions.

Emotional schemas can have clinical implications. Judgmental attitudes toward one's thoughts and feelings are associated with an increase in anxiety and depression. "The more you judge, the worse you feel" (Barcaccia et al., 2019, p. 33). Aversive negative emotions can lead to avoidance-based strategies such as *suppression*, which reduces the negative emotion in the short-run but causes it to continue or to be amplified in the long-run, at least in patients from more individualistic cultures. Eventually Dr. Doe will want to evaluate her patient's emotional schema. If her patient feels shame over having negative emotions, then Dr. Doe will have to address this in treatment.

Another dimension of emotional schemas is the extent to which people believe that emotions are malleable or fixed and inevitable. Those who believe in the malleability of emotions are better able to control their emotions, are more likely to try emotional regulation strategies, and to try them earlier in the emotional arousal experience (Kneeland & Dovidio, 2020).

The Role of Negative Emotions in Suicide

The intense negative emotions expressed by Dr. Doe's patient should be no surprise. Suicide attempts are accompanied by negative emotions. One of the advances in suicide research in the last decade has been the identification of psychological states that precede or accompany suicide attempts.

According to cognitive behavior therapy, suicidal patients will have a set of emotional, cognitive, and behavioral reactions or a *suicidal mode* that make suicide seem like the only option to end their emotional pain. The assumption is that the suicidal mode that preceded a past attempt will resemble the suicidal mode in future attempts (Bryan & Rudd, 2018).

Although every patient is unique and the exact nature of the suicidal mode will vary from patient to patient, researchers have clarified some of the psychological events that commonly occur in suicidal modes. According to the research based on the interpersonal theory of suicide, the suicidal mode could be described as an *acute suicidal affective disturbance* (ASAD; Rogers et al., 2017a). The ASAD is an intense state of dysphoria when suicidal risks could increase quickly. The ASAD includes feelings of being a burden on others (perceived burdensomeness), feeling rejected from others (thwarted belongingness), social withdrawal, a background of insomnia and nightmares, and agitation, irritability, hopelessness, or self-disgust. Of course, patients can have other symptoms of distress in addition to those listed above. Patients may develop emotional distress and suicidal thoughts rapidly and within hours or even minutes.

Galynker (2018) has conducted a parallel research program and has identified a highly similar set of emotions and thoughts that accompany suicide attempts. The major differences between the research of Galynker and Rogers et al. is that Galynker also focuses on the cognitive processes that accompany suicidal thoughts, such as the role of rumination and unsuccessful attempts to suppress the rumination (Joiner et al., 2018). He also emphasizes the role of *entrapment* ("urgency to escape or avoid a perceived inescapable and unavoidable life situation," Joiner et al. 2018, p. 276) in precipitating suicide attempts.

Both research teams recognize the need for further research to clarify and perhaps reconcile their different approaches, and both recognize that patients may have unique presentations not captured by these syndromes. Also, both teams recognize the great importance of looking at the emotions that suicidal patients feel.

Emotions Commonly Associated with Suicide

No one emotion or set of emotions is unique to suicide. Below we review the common emotions identified by Rogers and Galynker as part of the suicidal mode: anxiety, agitation, self-hate, shame and guilt, and anger and then on the processes linked to emotions such as impulsiveness, rumination and brooding, and perfectionism. Although we are presenting these emotions separately, they can co-occur (called *emotional covariation*), interact with each other in complex ways, and have idiosyncratic presentations.

Anxiety

Anxiety is correlated with suicidal behavior. On the surface, it makes sense because anxiety often results in avoidant behavior that may lead to social isolation. However, Bentley et al. (2016) found that trait anxiety was a weak predictor of suicidal behavior. That analysis looked at the full range of anxiety symptoms. Greater benefit may come from looking at subsets or components of anxiety, such as social anxiety or anxiety sensitivity.

Social anxiety is related to suicide as well as perceived burdensomeness and thwarted belongingness (Buckner et al., 2017). This makes conceptual sense as social anxiety may cause individuals to withdraw from or avoid social relationships.

Anxiety sensitivity is the fear of negative consequences from anxiety related sensations (Stanley et al., 2018). Patients may fear that they are having a serious physical illness, that they may act in a way to embarrass themselves, or that the anxiety is evidence that they are "going crazy." Patients may fear that they are having a heart attack, perceive that their anxiety is obvious to others who will see their physical reactions such as sweating, and judge them harshly, or that they are going insane. This anxiety sensitivity may aggravate whatever primary symptoms of distress that the patients feel. Anxiety sensitivity can be considered a secondary disturbance because it represents a negative emotional reaction to a negative emotion. If her patient had expressed concerns about anxiety, Dr. Doe could ask about anxiety sensitivity and look for themes of negative physical, social, or cognitive consequences from the anxiety.

One aspect of anxiety is *emotionality* which includes subjective feelings and often physiological reactions such as a raised heart rate, sweating, wet palms, nervous stomach, or other somatic representations. *Worry*, the cognitive component of anxiety, is the "apprehensive expectation of possible negative outcomes in future events" (Barcaccia et al., 2019, p. 34). It can involve negative comparisons of one's performance with others and preoccupations with one's performance. Worry is a repetitive form of thinking that focuses on concern about the future. Worry differs from *rumination* that focuses on past events or mistakes. One worries about the future, but one ruminates about the past. Both worry and rumination may sometimes appear uncontrollable to patients.

Agitation

Agitation refers to "a state of cognitive and motor hyperactivity characterized by excessive or inappropriate motor or verbal activity with marked emotional arousal" (Martinez-Raga et al., 2018, p. 1). Acute agitation involves restlessness, such as wringing one's hands or pacing, and subjective distress such as wanting to crawl out of one's skins, feeling so stirred up that one wants to scream, or feeling emotional turmoil in one's gut1. Although anxiety and agitation are similar in that they involve heightened emotional arousal, "Anxiety is characterized by future-oriented cognitions that prepare an individual for an anticipated event, agitation is more focused on immediate experience of physical and psychological unrest" (Ribeiro et al., 2015, p. 26). Heightened states of agitation sometimes precede suicidal behavior.

Negative Self-Regard (Self-Hate or Self-Disgust)

Suicidal patients often hate themselves or feel disgusted by their own looks, behaviors, thoughts, and feelings. Although researchers may define self-hate differently, generally it refers to "enduring and destructive self-evaluation, characterized by attributions of undesirable and defective qualities, and failure to meet perceived standards and values leading to feelings of inadequacy, incompetence, and worthlessness" (Turnell et al., 2019, p. 780). Some statements that may indicate self-hate include "I am a failure," "I feel disgust when I think about myself," or "I am ashamed of myself" (Turnell et al., p. 782).

Shame and Guilt

Shame and guilt are similar in that they occur when a patient breaks a social norm. However, they differ in that the objectionable behavior in shame reflects "a defective, objectionable self" (Tangney et al., 1996, p. 1257). The objectionable behavior in guilt generates remorse or "a desire to behave differently regarding the transgressed social norm, or a need to make up for a fault by confessing, taking reparative action. . ., or employing other methods for releasing guilty feelings" (Bastian et al., 2016, p. 456). Guilt focuses on what was done, activates empathy toward others and efforts to repair relationships. Expressed another way, shame deals with internal attributions while guilt deals with behavioral attributions. Shame is focused on the "I am" while guilt is focused on the "I did." With shame any empathy or concern about others is overwhelmed by feelings of worthlessness, inferiority, and social withdrawal.

Anger

Anger is part of a family of hostile emotions that include irritability or resentment. It may be accompanied by behavioral and physiological changes such as a furrowed brow or an increase in blood pressure. Anger involves a triggering event, an interpretation of the event, and a consideration of one's resources to resolve the perceived wrong. (Deffenbacher, 2011, p. 212). Poor quality sleep is associated with an increase in anger and irritability (Krizan & Hisler, 2019).

Anger may especially be a factor in some diagnoses such as antisocial personality disorder, PTSD, or intermittent explosive disorder, borderline personality disorder, or conduct disorders. It can sometimes be adaptive if it protects an individual from physical harm or motivates an individual to rectify an injustice. It can be maladaptive if it is out of proportion to the external stimuli, weakens social support systems, or alienates others.

Good interviewing of patients about anger requires precision because patients may not distinguish between the different emotional states under the anger umbrella. When assessing for anger, psychologists can also look to parse out resentment which is characterized by the perception of having suffered an unresolved wrong and sometimes the desire for retaliation against the offender (Miceli & Castelfranchi, 2019). Anger and aggression overlap but are distinct. Anger may sometimes lead to aggression which refers to actions intended to harm an individual. Some aggression occurs out of anger, although this is not always the case. Aggression is found in several diagnostic disorders such as intermittent explosive disorder.

Researchers do not agree on how to define irritability, although one definition

1 This description paraphrases the three items from the Brief Agitation Measure retrieved from https://psy.fsu.edu/~joinerlab/measures/BAM-SR.pdf

is that it is "an emotional process that is characterized by a proneness to experience negative affective states, such as anger, annoyance, or frustration, which may or may not be outwardly expressed. Irritability often includes a feeling that one's emotional responses are unjustified or disproportionate to the immediate source, but difficult to control" (Toohey & DiGiuseppe, 2017, p. 97). Consequently, it is sometimes referred to as a mood, as opposed to an emotion itself. Some items that measure irritability are "I have been feeling ready to explode," "I have been rather sensitive," "It took very little for things to bother me," or "He/she is easily frustrated" (Toohey & DiGiuseppe, 2017, p. 99).

Anger and aggression are linked to suicide. In fact, earlier theories of suicide considered suicide to be anger toward inward. The relationship of irritability to suicide is less well understood, perhaps reflecting difficulties in defining irritability (Orr et al., 2018).

Processes Related to Emotions

The emotion-related cognitive processes especially relevant to suicide include impulsivity and perfectionism, and repetitive negative thinking styles such as rumination and brooding.

Impulsivity

Impulsivity refers to "actions that are unduly hasty, risky, and ultimately damaging to the individual" (Chamberlain et al., 2017, p. 11). Impulsivity may not be a unitary event but may include different dimensions including *negative urgency* ("the tendency to act rashly in an effort to reduce the intensity of negative affect," Anestis et al., 2014, p. 376) or *deficits in planning* ("the tendency to act quickly without planning," Anestis et al., 2014, p. 376). Even the lack of planning can be further subdivided into *cognitive impulsivity* or "the tendency to prefer small immediate rewards over larger delayed ones," and *behavioral impulsivity* or "difficulty preventing the initiation of a behavior or stopping a behavior that has already been initiated" (Liu et al., 2017, p. 441). Impulsivity can be a feature of borderline personality disorder, attention deficit hyperactivity disorder, gambling, or other disorders, although it can appear in other disorders as well.

Researchers do not agree on how to define an impulsive suicide attempt, although it commonly refers to either an attempt with a short interval between the thought and the action, or to an attempt with little planning or preparation (Rimkeviciene et al., 2015). When suicide attempts are impulsive, they are more likely to be carried out with the means at hand and they tend to involve less lethal means

Table One: Summary of Considerations When Evaluating Patient Emotions

Do you create a nonjudgmental atmosphere characterized by genuine caring for your patients and a desire to understand their perspectives?
Did you check for the intensity of their emotions? You can ask patients to rate the intensity of their emotions at the worst point on a scale of 1 to 10.
What is the patient's schema about emotions? How does the patient feel about having intense negative emotions?
How does the patient's cultural background influence how they express or think about emotions?
Does the patient believe that emotions are fixed or malleable?
Do you look for anxiety sensitivity?
Do you distinguish between anxiety and agitation?
Do you distinguish between shame and guilt?
Are you alert for feelings of self-hatred or self-disgust?
Do you distinguish between the different emotions in the anger spectrum?
If the patient acts impulsively, do you try to understand the sources of the impulsivity?
Are you alert for potential problematic thinking styles such as worry, rumination or brooding? Does the patient have suicide specific ruminations? Does the patient engage in absolutistic black and white thinking?
Has the patient ever experienced an emotional cascade?
Does the patient display perfectionism? If so, is it self-oriented, social perceived, or other oriented perfectionism? Is it adaptive or maladaptive?

of death. Anestis et al. (2014) argued that all attempts involve some planning, even if it was done hastily or that the planning for the attempt was not reported.

Dr. Doe's patient reported that she had an "impulsive" suicide attempt in the past. It may be helpful for Dr. Doe to learn if this attempt was prompted by negative urgency, a general tendency to act with lack of planning, or difficulty in stopping a behavior that she had already started.

Rumination

While it may be profitable for patients to self-reflect (take a problem-solving approach to themselves), self-reflection differs from repetitive negative thinking. One such form of repetitive negative thinking is rumination which refers to "repetitive thoughts focused on one's own distress" (Galynker, 2018, p. 165). *Brooding* is a form of rumination that dwells "on the consequences of a depressed mood" (Law & Tucker, 2018, p. 68).

It may be useful to look at the cognitive processes behind the ruminations which often reflect rigid and absolutistic thinking that does not allow for shades of grey, or the consideration of other options. Some of the relevant cognitive processes include overgeneralization, catastrophizing, dichotomous thinking, the inability to up-regulate (increase) positive emotions, or the inability to down regulate (decrease negative) emotions. Rogers et al. (2017b) found a positive association between agitation, nightmares, brooding, and past suicide attempts suggesting that they may often form a cluster of emotions, thoughts, and behaviors. Horwitz et al. (2019) also found that brooding was associated with a history of one or more suicide attempts.

Worry and rumination are similar but worry tends to be more future oriented while rumination appears to be more past oriented. Worry becomes problematic when it is out of proportion to the problem, persistent, apparently uncontrollable, or causing high distress. Dr. Doe's patient reported that she "worried a lot," but sometimes patients use these terms imprecisely and Dr. Doe will need to determine if the patient is worrying or ruminating.

Suicide specific ruminations reflect "a repetitive mental fixation on one's suicidal thoughts, emotions, and plans" (Rogers & Joiner, 2018, p. 76). Rumination is a risk factor for suicide in part because it shows an attentional bias toward negative emotional states. Negative information gets selected more easily and less negative information gets crowded out.

The rumination cycle can result in an *emotional cascade* (Selby, 2008) and take on an appearance of uncontrollability. Galynker (2018) also introduced the term *ruminative flooding* which he identified as being perceived as uncontrollable, but which also may be accompanied by somatic symptoms such as headaches. Rumination accompanied by catastrophizing and failed attempts to control emotions create a dysfunctional feedback loop that amplifies the negative emotions, often leading to a suicide attempt. The suicide specific ruminations may occur along all points of the continuum of a suicide attempt from the first ideation to the final moments before an attempt. If not stopped, the suicide specific ruminations may lead to a sense of entrapment. Suicide specific ruminations can predict the presence of a lifetime suicide attempt better than many other variables commonly associated with a suicide risk. Understanding the emotional cascade is necessary to develop the best suicide management strategies.

Perfectionism

Perfectionism is the "combination of excessively high personal standards and overly critical self-evaluation" (Curran & Hill, 2019, p. 410). Perfectionism is multidimensional and transdiagnostic, although it is more likely to occur in eating disorders, compulsive personality disorders, depression, and anxiety. It is positively correlated with suicidal ideation (see review by Zeifman et al., 2020). Dr. Doe's patient, who reports that she has many shortcomings at work despite numerous promotions, may be suffering from perfectionism. It is important to explore that aspect of the patient's life more closely.

Researchers disagree on the dimensions of perfectionism, although it is commonly interpreted to involve three processes. In *self-oriented perfectionism*, individuals place unrealistic demands on themselves and are overly critical of their failures. In *socially prescribed perfectionism*, individuals feel that others are placing unrealistic demands on them and they are critical of their failures to meet those expectations. Some individuals show a combination of self -oriented and socially prescribed perfectionism. In *other oriented perfectionism*, individuals expect others to be perfect and hold them in disdain if they do not meet those expectations. Other oriented perfectionism is distinct because it disrupts personal relationships more than the other two forms of perfectionism.

Others distinguish between *adaptive* and *maladaptive perfectionism*. Initial research held that adaptive perfectionism appeared to be a form of enhanced conscientiousness and was related to life satisfaction, high striving, and positive emotions, while maladaptive perfectionism involved an overly critical attitude toward one's performance and continual dissatisfaction because of a failure to reach an unrealistic goal. Maladaptive perfectionism was also related to stress, low self-esteem, depression, and a perception of helplessness. Recent research has cast doubt on this distinction because some studies have found high rates of poor coping ability and negative emotions among those who scored high on adaptive perfectionism (Lenton-Brym & Anthony, 2020) and interventions that successfully addressed maladaptive perfectionism usually found decreases in adaptive perfectionism as well (Suh et al., 2019).

Summary

This article reviewed the different forms of emotions that commonly occur among suicidal patients. Psychotherapists will be able to write better treatment plans if they look for self-hate or anxiety sensitivity among patients with anxiety, and if they distinguish between anxiety and agitation, guilt and shame, brooding and rumination, the different forms of anger and impulsiveness, or between the different types of perfectionism.

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CLASSIFIED

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION SEEKS DIRECTOR OF PROFESSIONAL AFFAIRS

Opportunity

The Pennsylvania Psychological Association (PPA), a 501C (6) membership organization, is conducting a nationwide search for its next Director of Professional Affairs (DPA). For 34 years, this position has been filled by Dr. Sam Knapp, a dedicated and indefatigable advocate of the profession of psychology. While this is a salaried full-time position, the schedule is negotiable for the well-qualified candidate. Also, while based at PPA headquarters in Harrisburg, PA, the position might also lend itself to a hybrid arrangement of remote work blended with on-site work in Harrisburg.

Founded in 1933, PPA is the third largest state association affiliated with the American Psychological Association. PPA has evolved from a small meeting of psychologists to a thriving professional association with more than 3,000 members, comprising psychologists and students from across Pennsylvania. PPA serves psychologists in independent practice, schools, business organizations, hospitals, private and government agencies, and academia. PPA also prepares psychologists of the future by offering membership and programing for doctoral and undergraduate students of psychology. Policy and activities of the association, determined by a Board of Directors, are carried out by several hundred volunteers and a professional staff of six. PPA has annual revenues of almost $1 million.

Position Summary

The Director of Professional Affairs (DPA) is the lead psychologist of the association and the primary consultant for members in matters regarding professional practice and the application of Pennsylvania law to the practice of psychology. The DPA reports directly to the executive director and serves as the key liaison between PPA and other associations including APA, government agencies, health care entities, insurance providers, and oversight agencies in policy related to the practice of psychology in the state of Pennsylvania. The DPA serves an integral role in PPA, interacting with leadership, the board of directors, the executive director, committees and volunteers, members, and staff, including the contract lobbyist. The DPA writes articles and creates CE presentations regularly.

Position Requirements

- Doctorate in psychology (PhD, PsyD, or EdD) essential. Additional JD would be a plus.
- Significant expertise regarding the scope of practice of psychology, the business of the practice of psychology, regulations related to professional practice, and legislative process in Pennsylvania, including expertise in one or more of the following topics and proficiency in the others: insurance reimbursement, ethics, suicide, and/or child abuse.
- Willingness to learn PPA's structure, practices, and processes.
- Willingness to learn APA's structure, practices, and processes.
- Knowledge of and experience with technology and social media platforms used to communicate with PPA members and others.
- Excellent writing and presentation skills, including the ability to write articles for The Pennsylvania Psychologist and other association publications, and to present continuing education programs for members as needed.
- The ability to staff committees and work interpersonally with a wide variety of individuals, and to provide consultation to PPA members on ethical, legal, and practice issues in a patient and professional manner

Professional Qualifications

- Twelve or more years of post-doctoral experience as a licensed psychologist in a clinical and/or academic setting.
- Experience interacting with government agencies, elected officials, and insurance companies preferred.
- An understanding of the mental health community in PA and how state and federal legislation impact the practice of psychology and the quality of mental health care.
- Experience working with boards and committees to build consensus and achieve organizational goals.
- Experience developing partnerships and fostering collaboration across organizations.
- A visionary leader who lives to advance the practice of psychology in Pennsylvania and beyond.
- Ability to define problems, collect data, gather facts, and develop valid conclusions.
- Evidence of sound judgment in developing, implementing, and evaluating plans, procedures, and policies.
- Effectiveness as team player who motivates others to work to the highest level of their abilities and education.

Compensation

A competitive compensation package will be offered to an outstanding candidate.

For more information regarding the position, please contact:

Ann Marie Frakes
PPA Executive Director
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
annmarie@papsy.org
717.614.5095 cell

To Apply

To apply, please send a cover letter and a current curriculum vitae in a PDF format to ppadpa@papsy.org. The cover letter should specify experience and training relevant to this position as well as the proposed model for meeting this position's requirements as a full- or part-time employee or contract worker, an important factor in considering candidacy. Application materials are due no later than Friday, April 16, 2021 at 5:00 PM EDT.

PPA is an equal opportunity/affirmative action employer committed to inclusion and cultural diversity in the workplace. Employment selection and related decisions are made without regard to sex, race, color, age, disability, religion, national origin, sexual preference, genetic information, or any other protected class.

This job posting is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities that are required of the employee. They may be subject to change at any time. This position is at-will by Pennsylvania law; it can be terminated at any time by the employer or employee for no specific reason.

MASKS AT WORK

RACHEL GINSBERG, Psy.D.

Many therapists are asking, "When is it appropriate to return to in-person treatment?" For those of us who are considering the transition while COVID-19 remains a public health risk, the issue of masking has become a pivotal factor. As I considered the prospect of conducting therapy in masks, I found that the issue poses both practical and symbolic challenges.

A primary goal of therapy is to allow the patient to figuratively unmask: to expose and disarm their defenses in order to examine the self as is. Indeed, a significant part of our work can be to help patients cope with their fears about being seen and known by another person. Thus, literally covering one's face in the name of physical safety creates an interesting conflict with the therapeutic effort.

Fundamental to the work of therapy is the creation of a "safe space." The presence of masks inherently signals that the occupied space is not, in fact, safe. A mask conveys the message, "you can hurt me." Even if we rationally recognize that two people in masks, especially if vaccinated, are unlikely to transmit the virus to each other, the construct of the "safe space" is nonetheless compromised.

Additionally, masks impede therapists' ability to recognize patients' facial expressions and their underlying emotions. I often find myself directing my conversations with patients based on their non-verbal cues, and it is likely that conducting therapy in masks will lead to missed opportunities for better understanding and further discussion. Correspondingly, patients may have trouble interpreting masked providers' reactions to their disclosures. Traditionally, therapists rely on their own facial expressions to communicate attention, empathy, and caring. Behind a mask, however, a clinician's innocuous look may be mistaken for judgment, which can have deleterious implications for the therapeutic relationship. In fact, two recent research studies from the medical field found that providers' mask-wearing negatively impacted patients' perception of empathy and trust (Kratzke et al, 2021; Wong et al, 2013). In these ways, masks act as both a physical barrier against the transmission of germs but also as an interpersonal barrier to the transmission of emotions, trust, and connection.

Aside from these relational concerns, I foresee some more mundane obstacles related to masking. If a patient is moved to tears during a session, is it safe for her to lower her mask in order to blow her nose and wipe her face? With my soft-spoken patients, I worry that I will have to interrupt to ask them to repeat themselves.

So, is the solution to continue providing therapy via videoconference until COVID-19 is no longer a threat to public health? While teletherapy allows us to avoid the mask-associated challenges detailed above, it brings its own substantial set of drawbacks. For one, there are increased distractions for both parties related to being in the home environment. Additionally, although our faces are not covered, our bodies may be hidden from the view of the camera, obscuring other essential aspects of non-verbal communication. And while the physical barrier imposed by masking is not in play, the barrier of the computer screen creates a sense of distance between patient and provider, thereby detracting from the intimacy of the session. Thus, while the field of psychotherapy was uniquely well-positioned to adapt to the virtual platform,

teletherapy is no panacea.

Whether we choose to return to the office in masks or to wait out the rest of the pandemic with teletherapy, there are certain to be ongoing challenges. I know that I am not alone in yearning for a return to in-person treatment as it used to be. In the meantime, I consider myself lucky to be able to work and help others during this difficult time.

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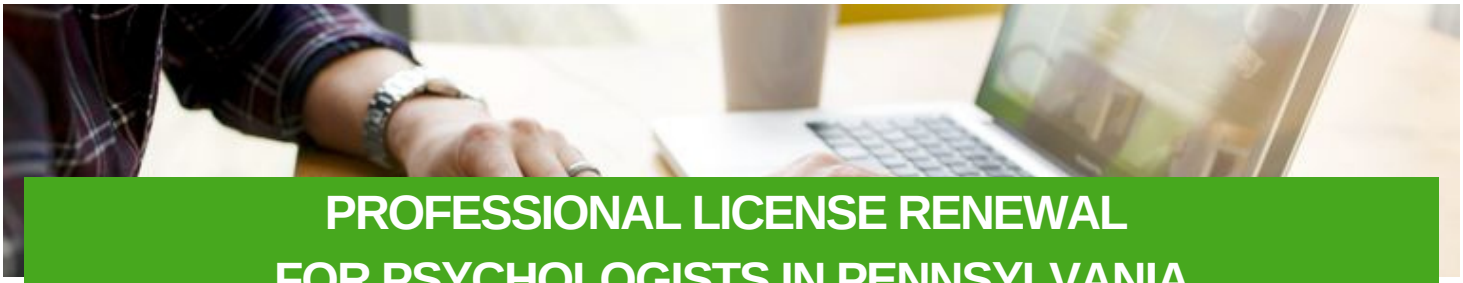

PROFESSIONAL LICENSE RENEWAL FOR PSYCHOLOGISTS IN PENNSYLVANIA

THE DEADLINE TO RENEW YOUR LICENSE IS NOVEMBER 30, 2021

Renewal notices from the *PA State Board of Psychology* **will be sent out to licensees via EMAIL about 60 days prior to the license renewal deadline for 2021.** This email will include the link to renew your license, your user ID, and your personal Registration Code. If you have changed your email address since the 2019 renewal, please contact the *State Board of Psychology* to make sure they have your most up to date email address on file.

All 2021 license renewals must be completed online. Paper renewal applications are not available.
Renewal notices are only being mailed to those licensees who do NOT have an email address on file with the State Board of Psychology

Specific licensing 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.

PENNSYLVANIA PSYCHOLOGY LICENSE RENEWAL CHECKLIST

30 credits required

- 3 credits for Ethics - The word "ethics" must be part of the title, or the certificate must state that the programs specifically meets the requirements for ethics credits
- 2 credits for Child Abuse Recognition and Reporting (Act 31)
- 1 credit for Suicide Prevention (Act 74)

During the 2021 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 meet all of the continuing education requirements through home studies and/or distance learning programs.

If you have more than 30 continuing education credits, you may carry over up to 10 credits of CE into the next renewal period. Credits for the specific requirements listed above must be completed each renewal period.

Credits for psychologists must come from:

- An APA approved provider/course
- A provider approved by the State Board of Psychology
- An accredited college or university with semester hours, related to the practice of psychology
- AMA courses related to the practice of psychology that include an evaluation of learning objectives. It is commonly referred to Category I CE.

Visit *www.papsy.org/CE* for more information on PPA's continuing education, including Frequently Asked Questions

This resource is provided to you as a benefit of your PPA membership.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

CHECKLIST FOR RESUMING IN-PERSON SERVICES While the State of Emergency is Still in Effect: Interim Guidance

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

Authors Note: The data on COVID-19 is continually evolving and the CDC and local public health officials are continually revising their recommendations. Therefore, these recommendations should be considered as interim and subject to further change.

It is hoped that Americans can return to a state of semi-normality by this summer, although much depends on the impact of the more infectious COVID-19 variants, the speed with which the population becomes vaccinated, and the extent to which Americans comply with public safety measures. Despite the wide-spread desire to resume normal life, psychologists need to consider the impact of resuming in person services on their health and the health of others while the state of emergency is still in effect.

Until they feel safe, nothing requires psychologists to see patients for in-person services. No one should feel compelled to return to in-person services at the risk of their personal safety or the safety of others. Conversely, nothing prohibits psychologists from seeing patients for in-person services either, although such decisions require thoughtful consideration and adequate public safety measures.

Psychologists who are considering resuming or increasing in-person services while the state of emergency is in effect will need to consider practical issues concerning personal and patient safety. Psychologists need to make these decisions based on their unique circumstances. For example, some psychologists work in offices where they have control over physical conditions because there may be only one entrance to the office or a bathroom unique to their office. Other psychologists may work in offices in large buildings where their patients must use a heavily trafficked common entrance, must ride a commonly used elevator for several floors, or use a bathroom shared by many people. Also, some psychologists work in counties where the rate of infection is low, while others work in counties where the rate of infection is higher.

Below is a checklist of factors for psychologists to consider if they are moving to in person services while the state of emergency is still in effect. The selection of items on the checklist is informed by comments of many psychologists, OSHA (2020) and CDC (2020; 2021) recommendations, an article from the American Psychological Association (Galietti, 2020), and recommendations from Pennsylvania's Alliance of Health Care Professionals.

Checklist for Resuming In-Person Psychological Services During the COVID-19 State of Emergency

BEFORE THE APPOINTMENT	
✓	Is your decision to resume in person services informed by local health conditions and the recommendations of state and local public health officials?
✓	Have you spoken to your patients about the advantages and disadvantages of in-person sessions?
✓	Have you informed patients of the option of being seen by telehealth, if appropriate?
✓	Do your patients sign an informed consent agreement for in-person sessions during the pandemic? APA has a sample form which can be found at https://www.apaservices.org/practice/clinic/covid-19-informed-consent. After the state of emergency ends, this an informed consent form will no longer be needed.
✓	Are your safety precautions on your website or otherwise communicated to your patients via phone, email, letter, or text ahead of their appointments?
✓	Do you tell your patients not to come in person if they have tested positive for COVID-19 or had recently been exposed to someone with COVID-19 and have not yet spent time in isolation or received a negative COVID-19 test since the exposure?
✓	Do you tell your patients to take their temperature before leaving home and not to come to the office if their temperature is 100 degrees or higher? Did you tell your patients to stay home if they have a fever, shortness of breath, or a cough? Do your patients know that you or your staff may be taking their temperature when they enter the office?
✓	Do you tell your patients to bring a mask with them to the office?
✓	Do you tell your patients to wash their hands before they come to the office?
✓	Do you encourage patients to get a COVID-19 shot and a flu shot?
✓	Do you explain to patients that you put these precautions in place to ensure their safety as well as the safety of others?

IN THE OFFICE	
✓	Do you adjust your public health requirements to meet the specifications of your practice? For example, a psychologist who has a small office with a dedicated waiting room and one secretary may need to adopt a different set of in-office policies than a psychologist who works in a group practice with a shared waiting room and several support staff members.
✓	Are your safety protocols clearly posted in your office?
✓	Is the office seating arranged to encourage physical distancing (such as having a "Do Not Sit Here" sign between seats)?
✓	Is your office well ventilated?
✓	Do you and your patient wear a mask? Do you have an extra mask available if the patient forgets to bring one?[1]
✓	Do you keep hand sanitizers in the office or waiting room?
✓	Do you schedule appointments so that you have time to disinfect the office between appointments? Do you also regularly disinfect the waiting room, doorknobs, or other commonly touched areas? (The EPA has a list of approved disinfectants for COVID-19 at https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19). If you have control over the bathroom facilities, do you ensure that they are frequently cleaned?
✓	Do you ask your patients to stay outside until their appointment time OR do you inform patients to stay in their cars and you will text them when they can come inside?

1 The question of whether masks should be worn if both the psychologists and patient have been vaccinated is difficult to answer. Although the CDC recommends that vaccinated persons "can visits other fully vaccinated people indoors without wearing a mask" (March 8, 2020), as of March 17, 2020 they have not yet updated their mask wearing guidance for health care settings. Consequently, this recommendation should be seen as tentative, pending further clarification as it applies to vaccinated patients.

WITHIN OFFICE PROCEDURES	
✓	Do you require your employees to follow the same public health measures as you and your patients follow?
✓	Do you offer sick time to employees, require them to stay home if they are sick, or allow them to work from home when appropriate?
✓	Do you take steps to minimize staff contact when dealing with patients, such as when patients are paying bills? For example, when paying with credit cards does the staff sanitize the machine after the patient touches it?
✓	Are you especially scrupulous about sanitizing their workspaces and, for example, avoid sharing computer keyboards or phones or, if they are shared, ensure that they are sanitized?

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Virtual PPA 2021 IS WHERE EVER YOU ARE!

Why should you attend PPA2021?

- Receive up to 20 CE credits, including ethics, Act 31, and Act 74. Nearly everything you need for your 2021 license renewal, all in one place!
- PPA will be using a new, interactive event platform, Whova, to allow attendees to interact with each other, presenters, and exhibitors.
- PPA member will have access to 20 CE credits valued at $500 for only $395 by purchasing the All-Access Pass.
- Receive a Convention Goodie Bag!
- And trust us - you do not want to miss this speaker line-up!

Registration Type	PPA Member	Non-member
All-Access Pass (Members Only)	$395.00	N/A
A la Carte	$25.00/credit	$50.00/credit
Non-CE (Members Only)	FREE	N/A

To receive your Convention Goodie Bag, you MUST register by Friday, May 14, 2021.

For more information and to register or visit *www.papsy.org/PPA2021*

PENNSYLVANIA PSYCHOLOGICAL FOUNDATION'S FIRST EVER

Virtual Silent Auction

Chaired by Dr. Nicole Polanichka
Secretary-Treasurer, PPF

Bidding will begin at Noon on Monday, June 14, 2021 and end at the conclusion of our Virtual PPF Student Awards Ceremony at 8:30 PM on Saturday, June 19, 2021.

To make PPFs fundraising auction as successful as possible, we need as many great auction items as possible! Do you have a favorite location you'd like other people to check out? Donate a stay at a local B&B or a dinner at a nearby restaurant. Maybe you have your own vacation home you'd be willing to share for a weekend getaway. Perhaps you are an artist or craftsperson (or know an artist or craftsperson) who would be willing to donate something one-of-kind. Do you have a talent or skill you are willing to share in a workshop for a lucky winner? Or perhaps you just have a great idea of a themed 'basket' and have been looking for an excuse to put it together. Even donations of cash are welcome and will be used by to purchase items for the auction.

Donated items need to make their way to the PPA offices by May 15th to allow enough time for staff to write descriptions, take photos, and load it all onto the auction site.
Visit *www.papsy.org/Foundation* to access a form to complete for donated items. This way the auction team knows exactly what was donated and by who, donors will also receive a letter documenting their donation for tax purposes. Questions? Reach out to Nicole Polanichka at polanichkan@upmc.edu or Ann Marie Frakes at annmarie@papsy.org

Thank you for your support!

Pennsylvania Psychological Foundation
LEAVING A LEGACY

CE QUESTIONS FOR THIS ISSUE

EARN 1 SUICIDE 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 April 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.

Clarifying the Emotions Associated with Suicide

1. **An emotional state that lasts for hours or days and may not have an obvious trigger.**
   a. Temperament
   b. Entrapment
   c. Emotional schema
   d. Mood

2. **A tendency to feel certain types of emotions.**
   a. Temperament
   b. Entrapment
   c. Emotional schema
   d. Mood

3. **A set of beliefs and strategies about emotions.**
   a. Temperament
   b. Entrapment
   c. Emotional schema
   d. Mood

4. **Compared to patients from East Asian influenced cultures, patients from European influenced cultures are more likely to**
   a. Believe that they should strive to experience positive emotions
   b. Focus on maintaining social harmony
   c. Smile even when they feel distress
   d. All the above

5. **Judgmental attitudes towards one's thoughts and feelings are associated with an increase in anxiety and depression.**
   TRUE
   FALSE

6. **Compared to persons who believe that emotions are fixed and inevitable, those who believe that emotions are malleable are**
   a. Better able to control their emotions
   b. More likely to try emotion regulating strategies
   c. More likely to attempt to regulate their emotions earlier in the emotional experience
   d. All the above

7. **According to Galynker, being in a perceived inescapable life situation can lead to feelings of**
   a. Temperament
   b. Entrapment
   c. Emotional schema
   d. Mood

8. **The fear of negative consequences from anxiety.**
   a. Agitation
   b. Aggression
   c. Anxiety sensitivity
   d. Negative urgency

9. **A state of cognitive and motor hyperactivity characterized by inappropriate behavior and emotional arousal.**
   a. Agitation
   b. Aggression
   c. Anxiety sensitivity
   d. Negative urgency

10. **_____ is likely to prompt an individual to repair or make amends for their past mistakes whereas _____ is likely to prompt an individual to withdraw socially.**
    a. Anger, irritability
    b. Irritability, anger
    c. Guilt, shame
    d. Shame, guilt

11. Actions intended to harm an individual.

a. Agitation
b. Aggression
c. Anxiety sensitivity
d. Negative urgency

12. The tendency to act rashly to reduce the intensity of negative affect.

a. Agitation
b. Aggression
c. Anxiety sensitivity
d. Negative urgency

13. **Worry differs from rumination in that worry**

a. Focuses on fears of the future, while rumination focuses on past mistakes.
b. Focuses on past mistakes, while rumination focuses on fears for the future.
c. Focuses on physical pain, while rumination focuses on emotional pain.
d. Focuses on emotionality, while rumination is primarily a cognitive process.

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, April 2021

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

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

Satisfaction Rating

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

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

Comments or suggestions for future issues _____

_____

_____

Please print clearly.

Name _____

Address _____

City _____ State_____ Zip _____ Phone ( ) _____

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!

The Pennsylvania
Psychologist

Calendar

JUNE 17 – 19, 2021
PPA2021
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)

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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