The Pennsylvania
Psychologist
JUNE 2021
VOLUME 81, NUMBER 6

BIGOTRY AS A DIAGNOSIS

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If you are interested in submitting an article to be published in *The Pennsylvania Psychologist* please contact Publications Chairperson, Jade Logan, PhD, ABPP at *publications@papsy.org*.

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A NEW DAY

DEA SILBERTRUST, PhD, JD

"Birds flying high, you know how I feel/ Sun in the sky, you know how I feel/ Breeze driftin' on by, you know how I feel// It's a new dawn/ It's a new day/ It's a new life for me/ And I'm feeling good"

"Feeling Good" by Leslie Bricusse and Anthony Newley

It does feel good: walking outside with a vaccinated friend and being able to hug when we say good-bye; making plans to visit family in other states; and starting to schedule in-person therapy sessions. But it's not exactly a return to normal, whatever that was back in February 2020. There are lingering concerns for many regarding health, both mental and physical, finances, children under 12, political divides, the environment, and continuing social injustices.

Still, it does feel good to connect with those we've only seen virtually or outside at a distance. Playing with a grandchild, sharing a meal with friends, and renewing physical contact helps to heal the pain wrought by the pandemic. But psychologists continue to face unprecedented numbers of calls for help and struggle to figure out how to safely and effectively meet these needs. As always, PPA is here to help.

As I write this, more than 300 of you have already registered to take part in our first fully-virtual Convention. We will provide 20 hours of CE, including a number of speakers outside of PPA, on topics such as medical marijuana, clinical suicidology, legal and ethical issues, telepsychology, anxiety and stress management, and suicide assessment. Dr. Sam Knapp will give his last PPA address as he sums up the state of psychology, and Dr. Jade Logan, will discuss current diversity and inclusion initiatives.

In addition, both the outgoing and incoming PPA Presidents will review the past year and give a preview of the next. Awards will be given, and both PPF and the PAC will host virtual fundraisers. Each day there will be time to informally connect with colleagues around the state during morning coffee (and tea) time and afternoon snack breaks. Kudos to PPA staff, especially Judy Huntley and Erin Brady, for coming up with creative ways for members to connect and feel good while getting credits needed to renew their licenses in November.

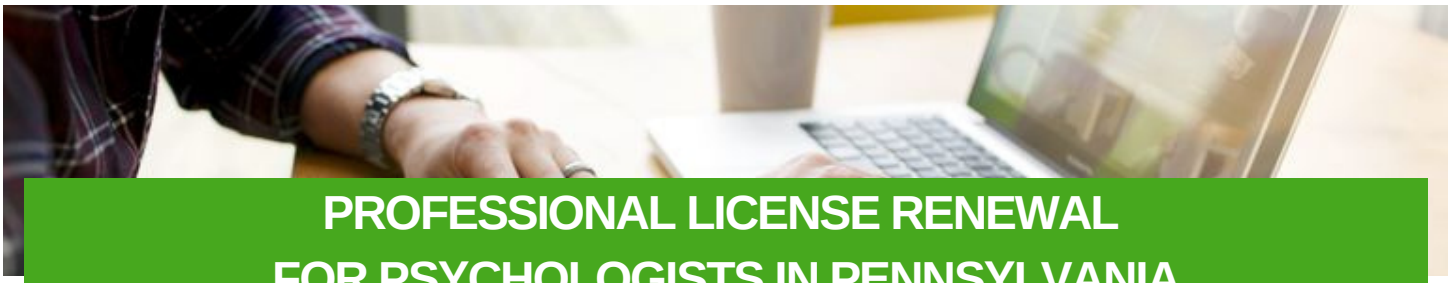
July and August are typically quieter months at the PPA office in Harrisburg, but this year there will be a lot of activity. The search is on for a new Director of Professional Affairs who will be selected and introduced to the membership before the summer ends. In addition, plans are being made for two fall CE conferences, a Max and a Mini, where you can get any of the CEs you still need before licensure renewal. We are looking into ways to make these hybrid events work both for those who join us in person, and those who connect virtually. We imagine many future conferences will follow this template.

PPA is also developing other events and programs for psychologists at all stages of their career: undergraduates, graduate students, ECPs, and seasoned psychologists (the best term for this group sparked much chatter on the listserv). Please let me (dcsilbertrust@comcast.net) or another Board member know if you have an idea for a program or Special Interest Group (SIG).

The Board of Directors and other volunteer leaders will continue efforts to make PPA a genuinely inclusive and socially conscious organization. As always, we welcome your input and involvement. Not sure who to contact? Check the committee list on the website under the About PPA tab. Call or email a board member (listed under the Governance section of the same tab). Still not sure? Send an email to Erin Brady, our Manager of Member Communications, at erin@papsy.org.

As my presidential year comes to a close, I want to thank the staff and all the volunteers who keep this organization going strong. In particular, thanks to Ann Marie Frakes, whose boundless energy and innovative ideas kept PPA in step with the myriad challenges of the past 12 months. Her leadership brings out the best in everyone who gives their time and energy to this organization.

I am so grateful I had the opportunity to serve as President despite missing the chance to see most of you in-person. Now I turn over the reins to Dr. Brad Norford who will conduct his presidency with the same thoughtfulness and determination he brings to all his endeavors. I wish him, and all of you, the very best as we reemerge into this new day.



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

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



MAAS COURT EXPANDS READILY IDENTIFIABLE PARTY TO INCLUDE GROUPS OF PEOPLE

DANIELA REY, M.A.
RACHAEL BATURIN, MPH, JD
SAMUEL J. KNAPP, Ed.D. ABBP

It is mental health professionals' responsibility to maintain confidentiality to their patient. One exception to confidentiality is when a patient conveys a threat of imminent and substantial harm to an identifiable third party or parties. The current standard for the duty to warn in Pennsylvania is *Emerich v. Philadelphia Center for Human Development, Inc.*, 720 A.2d 1032 (Pa. 1998). Under *Emerich,* mental health professionals have a duty to warn when the patient communicates specific and immediate threats of serious bodily injury against a specifically identified or readily identifiable third party. As such, the Court, in *Emerich,* held that under limited circumstances mental health professions owe a duty to warn a third party of harm against that third party. Thus, when mental health professionals determine that their patient presents a threat of violence to another, they incur an obligation to use reasonable care to protect the intended victim against such danger.[1]

Under what circumstances does a mental health professional have to warn a third-party? In *Emerich,* the Pennsylvania Supreme Court held that for the duty to warn to exist there must be both a "specific and immediate threats of serious bodily injury" and this threat must be made against "a specifically identified or readily identifiable third party." If there is no specific and immediate threat of serious bodily injury that has been communicated to the treating mental health professional or there is no threat made against someone who is readily identifiable, the mental health professional does not have a duty to warn. A victim must receive the warning directly from the mental health professional. If mental health professionals determine that it is necessary to warn a third party, it is important that the mental health professional take a logical approach and document the reasons why they thought they needed to warn the victim.

One question that has arisen is what if the identified or readily identifiable third party is a group of people? Does the mental health professional still have a duty to warn? In a recent Pennsylvania Supreme Court decision, *Maas v. UPMC Presbyterian Shadyside,* the Pennsylvania Supreme Court expanded who qualifies as a readily identifiable third party by holding that there is a duty to warn a small, distinct, and identifiable group of people.

Background of the Maas Case

Terrance Andrews murdered Lisa Maas, his neighbor, after providing warnings directly and indirectly to his doctors and therapists repeatedly in 2008. On multiple occasions, Andrews stated to his doctors and therapists that he wanted to kill his next-door neighbor (the neighbor that had been knocking on his door at night) and he continuously expressed his discomfort regarding his living arrangements and

1. According to *Emerich,* "a duty to warn is subsumed in this broader concept of a duty to protect" (footnote 5). Quoting *Tarasoff,* the *Emerich* Court stated that "the discharge of this duty may require the therapist to take one or more o various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances" (Tarasoff. 17 Cal 3rd at 431, 131 Cal. Rptr. at 20, 551 P 2d at 340). The *Emerich* Court did not deny or reject a duty to protect in Pennsylvania, thus allowing the option of diffusing the danger through other means. The Emerich Court only stated it was limiting its decision to the facts immediately before it in the case.

requested returning to his previous support living on numerous occasions. For a period of five months, he experienced multiple verbal and physical altercations with his neighbors, specifically with those residing on his same floor (20 individuals). Andrews stated that following various threats to his neighbors, including stating that he had a plan to stab and kill his neighbors with a scissor, appellants did not engage in any form of warning to Mr. Andrews' neighbors. In fact, Andrews was assured arrangements would be made for him to return to his prior living arrangements, yet measures were never taken. Andrews exclaims his suicidal as well as homicidal thoughts to a case manager at Western Psychiatric Institute and Clinic and is sent home with medication. Consequently, he follows through with his threat and murders Maas four days later. Thus, he stated to the officers, while being arrested, "I told a psychiatrist to put me in Western Psych…I told them the medication was not working…I told people I was going to kill someone." As a result of the failure to recognize the severity of his threats and mental stability, he was sentenced to life in prison. The appellants argued that they had no duty to warn anyone about their patient's threats because he never expressly identified a specific victim.

Pennsylvania Supreme Court's Holding

After reviewing the facts of the case, the Pennsylvania Supreme Court upheld the Superior Court's opinion that neighbors of a patient are such identifiable third parties when a patient makes threats to kill his neighbor but never specifically identifies which of his neighbors. The Court reviewed the duty under *Emerich* and a California case *Thompson v. County of Alameda,* 27 Cal. 3d 741, 167 Cal. Rptr. 70, 614 P.2d 728 (1980), where the California Supreme Court held that there was no duty to warn a "large amorphous public group" in a particular neighborhood. The Pennsylvania Supreme Court concluded that "unlike the threat to all of the 'young children in the neighborhood' in *Thompson*, which the Court agreed was a large and amorphous public group, the threat herein was directed at a member of a small, distinct, and identifiable group." *Maas,* 192 A.3d at 1148. The PA Superior Court further noted that the victim in *Tarasoff* was not identified by name. As such, the PA Superior Court reasoned that the duty to warn exists where the target is identifiable, not just identified by name, and that mental health professionals must use reasonable efforts to identify the victim. The PA Superior Court further reasoned "the duty to warn recognized in *Emerich* may extend to individuals who are readily identifiable because they are members of a group." Id. at 1147-48 Support for this notion came from the Code of Ethics of Pennsylvania's State Board of Psychology, section 41.61. which states that "psychologists should take reasonable measures to prevent harm when a client has expressed a serious threat or intent to kill or seriously injure an identified or readily identifiable person or group of people and when the psychologist determines that the client is likely to carry out the threat or intent. *Maas,* 192 A.3d at 1146, quoting 49 Pa. Code § 41.61. The PA Supreme Court agreed with the Superior Court that the identities of Andrew's fourth-floor neighbors in Hampshire Hall could be easily identified and the group was small enough that advising them about his threats would not "produce a cacophony of warnings" by their volume unlike the prospect of warning an entire 'amorphous' neighborhood like in *Thompson.*

> ***Under* Emerich, *mental health professionals have a duty to warn when the patient communicates specific and immediate threats of serious bodily injury against a specifically identified or readily identifiable third party.***

Conclusion

In *Maas*, the Pennsylvania Supreme Court upheld the Pennsylvania Superior Court's decision that there was a duty to warn the residents of the fourth floor about the threats. This group was certainly "readily identifiable," especially when we take Andrews' history and communication into consideration. Nonetheless, the mental health providers and the doctors failed to warn the victim. The holding of the Maas case broadens and explains the definition of a readily identifiable third party, by extending it to include a small, distinct, and identifiable group and provides more clarification of the current duty to warn standard in Pennsylvania.

As a practical matter, the case does little to change the obligations of psychologists. When faced with imminent danger to an identifiable third party, psychologists should take some action to protect the intended victim, including the option of warning that victim. Few psychologists, we believe, would feel moral qualms about acting to protect a readily identifiable class of victims from immediate or substantial harm. Much of the controversy in this Maas case dealt with whether, in this case, the facts were sufficient to trigger a reasonable to believe that the neighbors were targets of imminent violence. Nonetheless, the general rule of protecting a readily identifiable class of victims appears reasonable, in our opinion.

REFERENCES

Code of Ethics of the State Board of Psychology, 49 Pa. Code § 41.61

Emerich v. Philadelphia Center for Human Development., Inc., 720 A.2d 1032 (Pa. 1998).

Knapp, S., Baturin, R., & Tepper, A. (2019). *Pennsylvania Law and Psychology.* (7th ed.). Harrisburg, PA: Pennsylvania Psychological Association.

Maas v. UPMC Presbyterian Shadyside, 234 A. 3d 427 (Pa. 2020)

Maas v. UPMC Presbyterian Shadyside, 192 A.3d 1139 (Pa. Super. 2018).

Tarasoff v. Regents of the University of California et al., 17 Cal. 3d 435, 131 Cal. Rptr. 14, 551 P. 2d, 334.

Thompson v. County of Alameda, 27 Cal. 3d 741, 167 Cal. Rptr. 70, 614 P.2d 728 (1980)

the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

AS OF MAY 21, 2021

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 102	Amends the Public School Code, in intermediate units, repealing provisions relating to psychological service; in professional employees, for school social workers; and, in school health services, for counselors, psychologists, and nurses.	Rep. Daniel Miller (D)	Support		Referred to House Education Committee 1/11/21	
HB 131	Amends Title 63 (Professions & Occupations), in powers and duties, further providing for hearing examiners.	Rep. Greg Rothman (R)	Support		Referred to House Consumer Protection and Professional Licensure Committee 1/12/21	
HB 171	Act limiting restrictive covenants in health care practitioner employment agreements.	Rep. Anthony DeLuca (D)	Support		Referred to House Health Committee 1/14/21	
HB 325	An Act amending Title 63 (Professions and Occupations (State Licensed)) of the Pennsylvania Consolidated Statutes, in powers and duties, further providing for civil penalties. Allowing for boards to give advisory opinions.	Rep. Keith Greiner (R)	Support		Referred to House Consumer Protection and Professional Licensure 3/25/2021	
HB 681	An Act prohibiting enforcement of covenants not to compete in health care practitioner employment agreements.	Rep. Torren Ecker (R)	Support		Laid on the table, 4/7/2021 [House]	
HB 729	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Brian Sims (D)	Support		Referred to Health 3/3/2021	
HB 972	Act providing for sport activities in public institutions of higher education and public school entities to be expressly designated male, female or coed; and creating causes of action for harms suffered by designation.	Rep. Barbara Gleim (R)	Oppose		Referred to House Education Committee 4/5/2021	
HB 1075	An Act amending Title 64 (Public Authorities and Quasi-Public Corporations), establishing the Pennsylvania Broadband Development Authority to provide broadband Internet access to unserved and underserved residents; and providing for powers and duties of the authority, for financial assistance and for grants.	Rep. Pam Snyder (D)	Support		Referred to House Consumer Affairs 4/1/21	
HB 1420	An Act amending the Human Services Code, in general powers and duties of the Department of Public Welfare, providing for COVID-19 mental health public awareness campaign.	Rep. Wendi Thomas (R)	Support		Referred to House Human Services Committee 5/14/21	
Cosponsor Memo	An Act addressing the shortage of Mental Health Services in Underserved Areas	Rep. Michael H. Schlossberg and Rep. Rosemary M. Brown, Rep. Jeanne McNeill, Rep. Jason Ortitay, Rep. Pam Snyder, Rep. Wendi Thomas	Support			
SB 40	An act providing for behavioral health services and physical health services integration in public assistance	Senator Kristin Philips-Hill	Oppose		Referred to Senate Health and Human Service 1/20/21	
SB 78	An Act amending Titles 23 (Domestic Relations) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, in child custody, further providing for definitions, for award of custody, for factors to consider when awarding custody, for consideration of criminal conviction, for guardian ad litem for child, for counsel for child and for award of counsel fees, costs and expenses; and, in Administrative Office of Pennsylvania Courts, providing for child abuse and domestic abuse education and training program for judges and court personnel.	Senator Lisa Baker (R)	Oppose		Removed from table, 5/10/21 [Senate]	
SB 705	An Act relating to telemedicine; authorizing the regulation of telemedicine by professional licensing boards; and providing for insurance coverage of telemedicine.	Senator Elder Vogel (R)	Support		Referred to Senate Banking and Insurance 5/21/21	

CONCEPTUALIZING BIGOTRY AS FAILURES IN MENTALIZATION:

A Potential Road Map for Impactful Therapeutic Responsiveness

KEREN SOFER, Psy.D., *drkerensofer@gmail.com*

Conceptualizing bigotry as a failure in mentalization provides a powerful framework to guide our interventions when client communications are loaded with prejudicial, racist or exclusionary views.

Simply put, mentalization is the capacity to hold others and ourselves in mind, infer the motivations and beliefs of others, and understand our own motivations (Allen et al., 2008). Mentalization guides our moment-to-moment interpersonal and intrapersonal behaviors which then become the building blocks of our relationships (Allen et al., 2003). Though the roots of mentalization are found in psychoanalytic and attachment theories, in recent decades researchers have further developed the concept to encompass findings from developmental and cognitive science, and neuropsychology (Choi-Kain & Gunderson, 2008).

Mentalization has been gaining traction as an organizing principle to understand what changes when clients change in psychotherapy. The efficacy of many different psychotherapeutic approaches could come down to ways they help clients become better mentalizers, thus equipping them with more effective strategies to navigate our complex interpersonal world and consequently improve overall functioning (Allen et al., 2008).

Failures in Mentalization

As Allen et al. (2003) write, "A person's behavior is based on mental states that are always in dynamic flux, which makes understanding other persons (and ourselves) the most complex problem solving of which we are capable" (p. 2). As such, errors are inevitable. For example, when we are hungry, tired, angry, isolated, or fearful, it is difficult to hold others in mind or even hold self-awareness of our own mental states. We may misinterpret our partner's facial expression as seeming annoyed with us and then react to them with anger, only to learn they were thinking

about the parking ticket they just received. This failure in mentalizing our partner's mental state can lead to a response that is both cognitively and affectively misattuned. Ultimately, if these failures become patterned over time, deep distrust can ensue, leading to relationship ruptures.

Mentalization and Bigotry

Bigotry, defined by Merriam Webster as "obstinate or intolerant devotion to one's own opinions and prejudices" is the opposite of holding the other in mind. Bigotry requires disengagement from perspective-taking and empathy, which distances the offender from the other person or group. For the victim or witness to bigotry, the capacity to mentalize the offender declines as they put their defenses up to protect themselves.

Considering the stress that the pandemic has exerted on society, it is no wonder that failures in mentalizing present in more blatant ways now than perhaps ever before. Allen et al. (2008) address how societal-level failures in mentalization have led to community violence, genocide and other destructive global conflicts, which are all built upon the foundation of bigotry. They propose that the propensity for violence increases as the mode allows for the actor to disengage in mentalizing. For example, pressing the button to launch a missile at your enemies is easier to do from a mentalization standpoint than having to be close enough to someone to injure them. In the latter, you do not have to look your enemy in the eye and see them as a human.

Vaughans and Harris (2016), who describe the dangers of the police's inability to mentalize Black and Hispanic boys, expand upon this idea. They write that the police do not hold awareness that the boys are children in need of support and guidance, and instead view them as subhuman criminals. This serves to justify the initiation of confrontational and sometimes violent interactions. Vaughans and Harris suggest that a key to improving community-police relations must involve increasing the police's capacity for mentalizing the communities they work in.

Addressing Bigotry by Enhancing Mentalization

If we accept the premise that mentalization failures are a key to enactments of bigotry, then a natural antidote is to help our clients engage and improve their mentalization capacities. Allen et al. (2008) detail a number of ways to do this:

Stay curious and non-judgmental: By asking questions and showing interest in the client's mind, one is helping them think through more critically what they have said. It gives the client permission to reflect and possibly realize the fallacy in their thinking on their own. Being judgmental or trying to educate them will likely lead the client to double down or try to 'prove' themselves in order to save face. Some questions to consider include: Did the client fail to mentalize due to feeling threatened or vulnerable in some way? Was the bigoted or racist comment clearly targeted at you and therefore limiting your capacity to mentalize?

Work to turn the emotional heat down or up: Too much emotional heat makes it hard to engage in mentalizing, so staying calm (and curious) will signal safety to the client and help them become calmer. Too little emotional engagement is also problematic when it comes to mentalizing because it fails to signal importance and attendance to the issue at hand. In the case of low emotional heat, you can attempt to engage the client's curiosity by slowing them down and repeating what they said. This is a strategy that, using a term from the mentalization literature, "marks" the communication as being significant in some way, and worthy of further examination.

Recognition of your own capacity to mentalize: If you as the therapist are feeling flooded, angry or at a loss for how to respond, it is a signal your capacity to mentalize is likely compromised. When we are the target of bigotry our mentalizing capacity diminishes because we feel hurt or threatened and, from a neuropsychological standpoint, we cannot engage the parts of our brain necessary to effectively mentalize the offender (Allen et al., 2003). As such, you may not want to respond in the moment. Waiting provides an opportunity for you to reflect, consult with colleagues, and plan a response that has the best chance of engaging your client's capacity for mentalizing while staying present and able to mentalize them accurately.

Tend to your relationship with the client: An effective way to enhance a client's mentalization capacity is by increasing their sense of relational safety. This requires that you are aware of the level of trust and depth of rapport that already exists and draw on that to engage their curiosity and openness to disagreement or pushback when they share bigoted beliefs. For example, a client with whom you have high trust may tolerate questions about the source of their beliefs or even an expression of surprise from you. A client with whom you are just getting to know may not tolerate such engagement. In that situation you can name the newness of the relationship and be explicit about your curiosity but also acknowledge that it may feel uncomfortable for them. This is a way to build more trust since you are attempting to hold them in mind and signal to them that you are doing so. This may increase the possibility that they will respond with less defensiveness.

In sum, though taking in a client's bigoted view is upsetting and anxiety-provoking, considering these communications as failures in mentalization can free us up to focus on what is happening in terms of interpersonal process and give us a guide for effective responsiveness. Content of such prejudicial communications does of course matter, but if we are unable to help our clients think about their own thinking, we will ultimately fail to motivate change.

REFERENCES

Allen, J.G., Bleiberg, E. & Haslam-Hopwood, G. (2003). Mentalizing as a compass for treatment. *Bulletin of the Menninger Clinic , 67, 91-112.*

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice.* Arlington, VA: American Psychiatric Publishing, Inc.

Choi-Kain, L. W., & Gunderson, J. G. (2008). Mentalization: Ontogeny, assessment, and application in the treatment of borderline personality disorder. *American Journal of Psychiatry, 165*(9), 1127-1135.

Vaughans, K. C., & Harris, L. (2016). The police, Black and Hispanic boys: A dangerous inability to mentalize. *Journal of Infant, Child, and Adolescent Psychotherapy, 15*(3), 171-178.

THE DARK TRIAD + COGNITIVE PATTERNS = BIGOTRY, A DSM PERSONALITY DIAGNOSIS?

EDWARD ZUCKERMAN, PhD, *edzucker@mac.com*

What personality traits run through today's massacres, the seditious attack on the capital, white supremacist rallies, online bullying, and all the other manifestations of extreme racism, sexism, ageism etc.? One heuristic answer could be in the Dark Triad of subclinical but impactful collection of personality traits. This Triad may underlie the cognitive, personality and behavioral elements seen in the active practice of bigotry.

The Dark[1] Triad

The Dark Triad is the three traits of Machiavellians, narcissism, and psychopathy. Machiavellianism is characterized by manipulation and exploitation, deceit, and emotional callousness, narcissism by entitled self-importance, grandiosity and egotism, and psychopathy by lack of empathy, remorselessness, cynicism, and impulsiveness.

First described almost twenty years ago by Paulhus & William (2002), as "offensive but not yet pathological personalities" were found to be moderately inter-correlated but distinct even in their normal sample. "Subclinical psychopaths were distinguished by low neuroticism; Machiavellians and psychopaths were low in conscientiousness; narcissism showed small positive associations with cognitive ability." Much research since then has established the validity of these constructs.

We would expect callous people to be more likely to be aggressive and in research on the Triad the aggression factor was indeed correlated to callousness and manipulation (Jones & Neria, 2015). "However, the individual Dark Triad traits uniquely predicted different facets of aggression. Psychopathy positively predicted physical aggression, narcissism negatively predicted hostility, and Machiavellianism positively predicted hostility." The authors concluded that "Taken together, the findings shed light on the unique elements of the Dark Triad and their ability to predict unique forms of dispositional aggression."

"Aggression involves using force to dominate a situation, whereas violence uses force to do intentional harm.

1. I am uncomfortable with the racist connotations correlating "dark" with evil, abusive, and secret behaviors and emotions but it is now a term of art in this research. Its historical employment does not justify its continued use but I have no alternative to offer. However, change is possible; "extortion" has replaced "blackmail" and "Romanie" has replaced "gypsy."

Previous research suggests the Dark Triad underlies much anti-social behaviour, and is associated with aggression" (Pailing, Boon, & Egan, 2014). Factor analysis found that Machiavellianism, psychopathy and violence load on a single factor but narcissism was a distinct construct unrelated to the antisocial tendencies. More analyses supported "the centrality of low agreeableness as a driving force behind the Dark Triad and the constructs it predicts."

The common element of all three of these socially aversive personality patterns appears to be the deficit of empathy. Wai and Tiliopoulos (2012) examined this deficit with two interesting findings. First, the psychopathy component is the best predicator of empathy deficits and, second, deficits are almost all seen in the affective component of empathy, not the cognitive one. Affective empathy is the ability to generate one's own emotional states from observing the emotional states of others. Cognitive empathy is the ability to recognize others' emotional states but without having related feeling oneself. It can be valuable in counseling others but also used as a basis for manipulating others.

Crysel, Crosier, & Webster (2013) found that the Dark Triad pattern is positively related to impulsivity and sensation-seeking as exemplified in both betting in playing blackjack and in steeper temporal discounting (preferring a more immediate but smaller gain over a larger but delayed payoff).

The Triad has also been studied in relation to online behaviors. Goodboy and Martin (2015) found all three correlated with students reports of cyberbullying (both in texts and use of visual materials) and trolling and that psychopathy was the most powerful predictor of such behaviors. More recently Petit and Carcioppolo (2020) reported that the Dark Triad traits were related to negative online behaviors like hostile political discussions ("flame wars") or harassment and threats, in complex ways. Compulsive internet behavior correlates with psychopathy and Machiavellianism while narcissists, as might be expected, update their social media pictures and statues more frequently than others do.

Ideology, cognitive processes, and personality

Who joined the mob in the January 6 attack on the Capitol? They were no all or even predominantly young white working class males (Pape & Ruby, 2021). The demographic factors do not account for their membership and coordinated actions. What else might? Might they share underlying patterns of thought and feeling, of information processing and decision making?

Supporting this idea is a highly heuristic recent study Zmigrod, et al. (2021). They investigated, with a large number of tasks and surveys and using sophisticated data analyses, the complex relationships between a person's ideological attitudes and worldviews and their cognitive information gathering and processing (such as resistance or receptivity to evidence) and decision-making processes.

Indeed, they found many connections between thinking processes and ideology. For example, dogmatism (having a fixed worldview, resistant to contrary evidence) was associated with slower evidence accumulation and also impulsive tendencies. A key finding is that dogmatism was found in those with extreme attitudes on both the far right and far left of the political spectrum. They also found impulsivity, sensation-seeking and risk taking personality traits predict the endorsement of violence in support of a person's ideological group.

A takeaway conclusion is their finding that "cognitive and personality assessments consistently outperformed demographic predictors in accounting for individual differences in ideological preferences by 4 to 15-fold."

A New DSM Diagnosis?

Based on this sample of the extensive research, bigotry may deserve diagnostic recognition as a pathological personality disorder. Bigots meet all four of the defining features of personality disorders: 1) Distorted thinking patterns and delusional ideas (even if supported by some social groups), 2) Problematic emotional responses such as rage and hatred, 3) Over- or under-regulated impulse control, and 4) Interpersonal difficulties outside of relations with similar bigots.

Bigotry is entirely consistent with the current model of DSM diagnoses. As with most DSM personality diagnoses, it overlaps others. Bigotry seems to incorporate some traits of the paranoid, antisocial and the narcissistic personality types.

While personality disorders are widely believed to be difficult to treat that does not prevent our efforts to understand their dynamics and manifestations. However, caution is needed because such a diagnostic category may provide a "medical" excuse for spewing hate and for committing murderous acts.

Conclusion

Many have been looking in the wrong places when trying to understand the mob behaviors of the extreme right we see almost daily: age, race, class, and social variable have less power to further our understanding than do psychological traits.

REFERENCES

Goodboy, A.K., & Martin, M. M. (2015). The personality profile of a cyberbully: Examining the Dark Triad. *Computers in Human Behavior. 49, 1-4.* https://doi.org/10.1016/j.chb.2015.02.052

Jones, D.N., & Neria, A. L. (2015). The Dark Triad and dispositional aggression. *Personality and Individual Differences, 86, 360-364.* https://doi.org/10.1016/j.paid.2015.06.021G

Pailing, A., Boon, J., &, & Egan, V. (2014). Personality, the Dark Triad and violence. *Personality and Individual Differences. 67, 81-86.* https://doi.org/10.1016/j.paid.2013.11.018

Paulhus, D., & William, K. (2002). The Dark Triad of personality: Narcissism, machiavellianism, and psychopathy. *Journal of Research in Personality, 36(6), 556-563. DOI:* 10.1016/S0092-6566(02)00505-6. Available at: https://www.researchgate.net/publication/222828329_The_Dark_Triad_of_Personality_Narcissism_Machiavellianism_and_Psychopathy

Petit, J., & Nick Carcioppolo, N. (2020) Associations between the Dark Triad and online communication behavior: A brief report of preliminary findings. *Communication Research Reports. 37:5, 286-297, DOI:* 10.1080/08824096.2020.1862784

Pape, R.A., & Ruby, K. (2021). The Capitol Rioters Aren't Like Other Extremists. The Atlantic, February 2, 2021. Accessed at: https://www.theatlantic.com/ideas/archive/2021/02/the-capitol-rioters-arent-like-other-extremists/617895/\

Wai, M., & Tiliopoulos, N. (2012). The affective and cognitive empathic nature of the dark triad of personality. *Personality and Individual Differences, 52:7, 794-799.* https://www.dlls.univr.it/documenti/Seminario/documenti/documenti742400.pdf

Zmigrod L., Eisenberg, I.W., Bissett, P. G., Robbins, T. W., & Poldrack, R. A. (2021) The cognitive and perceptual correlates of ideological attitudes: a data-driven approach. *Philosophical Transactions B, Royal Society. B 376: 20200424.* https://doi.org/10.1098/rstb.2020.0424

BIGOTRY HURTS, BUT IT IS NOT A DISTINCT MENTAL ILLNESS SYNDROME

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While bigotry poses harmful consequences for both the perpetrator and the general public, we oppose designating it as a mental illness. This discussion will define mental illness and bigotry and then outline reasons why bigotry should not be classified as a mental illness fitting within a diagnostic.

Pies (2015, 2007) provided specific elements to consider whether bigotry is a mental illness as well as if any syndrome is a disease. In Pies' view, there must be more than suffering and incapacity for a syndrome to be considered a disorder. In particular, suffering must be a relatively direct consequence of pathological processes (Pies, 2007). There should also be tangible features such as identifiable genetic transmission, disease course, prognosis, and response to treatment for a syndrome to be classified as a disease. Rosenberg-Javors (2007) argued that bigotry and prejudice involve "ethics, morality, and civil discourse" and do not fall within diagnosable categories. Prejudice and bigotry are sociocultural issues that result in systemic, far-reaching consequences when entrenched within powerful institutions such as schools and government (Peebles, 2020). Prejudice is a form of conditioning and thus can be changed (Peebles, 2020).

However, prejudice cannot be treated the same way as mental health. Bigotry manifests itself in societies that perpetuate and benefit from systemic oppression of minority groups. During the 19th Century, Samuel Cartwright coined the label "drapetomania," which described enslaved peoples' desire to escape their owners as a mental disorder (Bynum, 2000). While the majority in power considered this behavior to be unusual, modern psychologists would agree that it does not qualify as a mental illness. Society has previously categorized other marginalized experiences as pathology (e.g., "hysteria" and homosexuality) as well. Since bigotry originates and benefits a certain societal interest, it would not fall within the previous pattern of pathologizing marginalized individuals to keep them oppressed. Biases against groups based on race, gender, sexuality, ability, and religion are learned by living in biased systems, perpetuated by its individuals with their own prejudices. The etiology of bigotry may not seem healthy, but etiological factors for bigotry are not the same as the foundations of mental illness. In addition to cultural isolation and other contextual factors, learning processes are uniquely essential to the development

1. The order of the first two authors is random.

of bigotry in contrast to the broader range of factors that contribute to mental illness. For these reasons alone, bigotry should not be identified as a mental disorder. Beyond the cultural context for bigotry, we turn to consideration of how it emerges in the context of a variety of already identified mental health syndromes.

Bigoted individuals may have underlying clinical or subclinical factors contributing to destructive expression of their hatred for a marginalized group. While bigotry is frequently a part of many existing syndromes, specific expressions of prejudice which are associated with differences between ordinary and pathological bias, do not clarify whether or not bigotry is a disorder (Pies 2007). Outward expression of prejudice appears to live within a personal context, in that its expression is a result of other qualities of dysfunction. One may attribute toxic bigotry to poor coping mechanisms; characteristics such as paranoia, trauma, impulsivity, or narcissistic tendencies may influence harmful bigoted behaviors. Lack of accessibility to higher education (Pew Research Center, 2016) and close experiences of diverse people and contexts may also play a role in these concerns. One's vulnerability to consuming misinformation and resisting new ideas are also factors to consider.

All people have biases, but it may be more important to focus on an individual's capacity for regulating and addressing these thoughts than the iniquitous thoughts themselves. Additional factors that are broadly associated with prejudice are distinct personality traits, social identifications, threat perceptions, and behavioral manifestations (Bergh & Brandt, 2021). Threat perception is particularly salient, as there are individuals who are concerned that "more rights, power, or resources" belonging to other groups is a threat to the majority or themselves (Bergh & Brandt, 2021). To Bergh and Brandt's (2021) knowledge, there are no studies about the relationship between broad prejudice factors and directly observed behaviors. While mental illnesses affect multiple aspects of life, prejudice and bigotry appear to manifest in a more personal context.

We must consider the inadvertent but real consequences to disadvantaged groups in a decision to pathologize bigotry. Mental illness remains stigmatized in minority communities (Knifton, 2012; Knifton et al., 2010; Memon et al., 2016). Including bigotry in the nosology of mental illness may further the stereotype of mentally ill individuals being perceived as dangerous, shameful, and socially unacceptable (Knifton et al., 2010). A formal diagnostic code for bigotry may also engrain the belief that psychological disorders are incurable, which may further perpetuate resistance to engaging in progressive conversations and openness to learning about diverse peoples.

Should intolerance become pathologized, there will be increased difficulty in reducing false narratives about mental health within groups that are in great need of services yet resist engaging in them. Disadvantaged groups may further consider mental health to be delegitimized with this shift in disorder conceptualization, as they will not want to be associated with the prejudiced individuals that vehemently set out to harm them. As psychologists consider the decision of bigotry's classification, they must also remember their dedication to the American Psychological Association's Principle of advocating for marginalized groups (American Psychological Association, 2017). A meta-synthesis conducted by Choudhry, Mani, Ming, and Khan (2016) reported that the stigma of "madness" was the most prevalent barrier to marginalized populations seeking assistance for mental health concerns. Minority groups have also reported experiencing discrimination while attempting to seek out psychiatric assistance (Choudhry et al., 2016). Other factors that are considered barriers to accessing services include medical cultural competence, fear of medical professionals, and inability to accommodate cultural or linguistic needs (Memon et al., 2016). Part of advocating against these barriers would be ensuring that another unnecessary barrier, like bigotry's classification as a mental illness, is not added.

Thus, it is argued that bigotry should not be made a mental illness, since bigotry can emerge in the context of many human conditions and even existing diagnostic categories. In addition, categorizing bigotry as a mental illness promotes the risk of harm to the disadvantaged groups that the pathologizing of bigotry would purport to protect.

REFERENCES

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code/

Bergh, R., & Brandt, M. J. (2021). Mapping Principal Dimensions of Prejudice in the United States. *Journal of Personality and Social Psychology.* Advance online publication. http://dx.doi.org/10.1037/pspi0000360

Bynum, B. (2000), "Discarded Diagnosis." *The Lancet, 356*(4): 1615. doi:10.1016/S0140-6736(05)74468-8.

Choudhry, F. R., Mani, V., Ming, L.C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment, 2016*(12), 2807 –2818. https://doi.org/10.2147/NDT.S111543

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review, 21*(3). 287-298.

Knifton, L., Gervais, M., Newbigging, K., Mirza, N., Quinn, N., Wilson, N., & Hunkins-Hutchison, E. (2010). *Social Psychiatry and Psychiatric Epidemiology, 45*(4). 497-504.

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scalon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open, 6(11)*,. 1-9.

Peebles, G. (2020). Racism: Are we all prejudiced? *Dissident Voice [BLOG],* Dissident Voice [BLOG], 2020-06-29.

Pew Research Center (2016, April 26). *A wider ideological gap between more and less educated adults.* Pew Research Center. https://www.pewresearch.org/politics/2016/04/26/a-wider-ideological-gap-between-more-and-less-educated-adults/

Pies, R. (2007). Is bigotry a mental illness? *The Psychiatric Times, 24* (6), 9.

Pies, R. (2015, March 2). What is "disease"? Implications of chronic fatigue syndrome. *The Psychiatric Times, 32* (3), 1.

Rosenberg-Javors, Irene. (2007). Bigotry: Cause for therapy? *Annals of the American Psychotherapy Association, 10*(3), 34.

ETHICAL CONSIDERATIONS FOR TELEPSYCHOLOGY PRACTICE WITH LGBTQ+ PATIENTS IN THE ERA OF COVID-19

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The deleterious impact of COVID-19 on mental health has been well-documented (Amsalem et al., 2020). New evidence suggests that the LGBTQ+ community is particularly at-risk for adverse mental health outcomes due to the public health measures deployed across the United States since March 2020, including physical distancing and social isolation (Green & Price-Feeney, 2020; Salerno, Williams et al., 2020). The expansion of telepsychology services has sought to meet the growing need for mental health care services, but questions remain about how long this expansion will last. As a result of wide telepsychology implementation, unanticipated ethical considerations have emerged, and unique ethical issues have been identified for psychologists practicing telepsychology with LGBTQ+ patients. Thus, it is timely and essential to augment the existing ethical guidelines for the practice of telepsychology to meet the mental health needs of the LGBTQ+ community.

Competence of the Psychologist

Competence refers to a psychologist's ability to use diverse intellectual, social, and emotional skills to the benefit of patients and patient populations (Knapp et al., 2017). A competent psychologist working with LGBTQ+ populations during COVID-19 should be aware of several risk factors and mental health concerns including the increased risk of suicidality, trauma, anxiety, and depression among LGBTQ+ youth (Green & Price-Feeney, 2020). LGBTQ+ youth may live in hostile or abusive environments where they may experience discrimination or violence on the basis of sexual or gender identity (Salerno, Williams et al., 2020). Further, for fear of this discrimination or violence, other LGBTQ+ youth may have to hide their identity and present as inauthentic versions of themselves for safety (Salerno, Williams et al., 2020). A competent psychologist should be aware of these concerns particularly if they had previously treated their patient in an environment that provided safety. For example, easier access to telepsychology providers through interstate compacts and increased reimbursement rates through insurance providers may help to preserve and enhance safety for LGBTQ+ college students returning to dangerous homes as campuses shifted to remote instruction. However, psychologists should be aware that policy changes may limit their ability to provide ongoing care as the COVID-19 pandemic progresses. Therefore, psychologists should develop contingency plans with their patients to find affirmative

psychotherapeutic care in the patient's home state or region if necessary (Salerno, Williams et al., 2020).

Informed Consent

Telepsychology informed consent should include an overview with patients of the telecommunication technologies that will be used and information pertaining to the potential risks unique to telecommunication technologies like data breaches (American Psychological Association (APA), 2013). For older LGBTQ+ teens not yet able to legally provide informed consent (e.g., 16 to 17-year-olds) seeking new online psychological services, the issue of parental consent can be particularly complex. In meeting with new patients, psychologists should be aware of potential informed consent-related issues for sexual minority minors and be aware of any alternatives for gaining informed consent for treatment.

For many cases, a psychologist may not be aware that a patient identifies as LGBTQ+ until later in the course of treatment, at which time informed consent would have already been completed with the parents or legal guardians in addition to the minors providing assent. However, some psychologists who specialize in LGBTQ+ psychotherapy may already be aware of the particular reasons an adolescent is seeking treatment and may be aware that the adolescent faces a dangerous situation at home if their sexual orientation is disclosed during the informed consent process to their parents or legal guardians. The option of waiving parental consent in these cases should be assessed and was outlined by the APA Council of Representatives in 2018 for research settings (APA, 2019). Further, waivers of parental consent have been documented for stigmatized and sensitive health issues, including HIV prevention research (Bauman et al., 2020). Indeed, many states allow these exceptions for at-risk youth, and the extant literature suggests that adolescents as young as 14 may be capable of making informed consent decisions on their own (APA, 2019). Many psychologists may not be aware of these regulations and may be inexperienced in obtaining adolescent consent via telepsychology. These psychologists should know that special protections must be created, including assurances of privacy and confidentiality, careful screening of the adolescent for the capacity to consent, and prudent identification of adolescents who may be at a particularly elevated risk by participating in treatment (Bauman et al., 2020).

Confidentiality

Good confidentiality practices in telepsychology include protections of the telecommunication technologies and adequate protection of the patient in the remote environment. For example, psychologists should ensure robust data security by using HIPAA-compliant technologies that restrict access to patient sessions and any electronic data such as survey measures and clinical or financial documentation. In the patient's remote environment, psychologists should reduce additional threats to privacy like family or house members overhearing treatment sessions.

Additional and more robust confidentiality safeguards should be considered when working with LGBTQ+ populations of any age. First, accidental disclosure of sexual orientation can endanger patients physically, socially, and emotionally. Second, psychologists should address confidentiality concerns with their patients in order to create safe therapeutic spaces. Patients should be made aware that HIPAA-compliant technology is being used to protect their sessions. Psychologists should also initiate telepsychology sessions by reminding patients to make sure their home environment is confidential and private. Third, psychologists can agree to a particular safe word or signal that patients can use if their privacy is threatened. Preserving confidentiality is an ongoing commitment for the psychologist and should be prioritized and reassessed continuously during treatment with LGBTQ+ patients, just like with all other clients.

Conclusion

The COVID-19 pandemic has had an enormous impact on the mental health of LGBTQ+ communities around the United States (Salerno et al., 2020). As psychologists have transitioned to delivering mental health services via telehealth and may work with LGBTBQ+ patients navigating this tumultuous COVID-19 era, several ethical considerations should be readily built into the psychologist's workflow. Competent psychologists should understand the unique challenges facing LGBTQ+ patients who may be displaced from safe environments and may now be tasked with engaging in mental health services in homes with unaccepting family members and privacy limitations. By paying careful attention to these ethical issues, psychologists will be able to ensure that established LGBTQ+ patients experience limited disruptions to their mental health care and new patients have access to confidential, safe, and effective mental health care during COVID-19 and beyond.

REFERENCES

American Psychological Association. (2013). *Guidelines for the practice of telepsychology.* https://www.apa.org/practice/guidelines/telepsychology

American Psychological Association. (2019). *Studying adolescents without parents' consent.* https://www.apa.org/monitor/2019/02/parents-consent

Amsalem, D., Dixon, L. B., & Neria, Y. (2020). The coronavirus disease 2019 (COVID-19) outbreak and mental health: Current risks and recommended actions. *JAMA Psychiatry.* https://10.1001/jamapsychiatry.2020.1730

Bauman, L. J., Mellins, C. A., & Klitzman, R. (2020). Whether to waive parental permission in HIV prevention research among adolescents: Ethical and legal considerations. *The Journal of Law, Medicine & Ethics, 48*(1), 188-201. https://10.1177/1073110520917010

Green, A. & Price-Feeney, M. (2020). LGBTQ youth face unique challenges amidst COVID-19. *Center for Primary Care, Harvard Medical School.* http://info.primarycare.hms.harvard.edu/blog/lgbtq-youth-challenges-covid-19

Knapp, S. J., VandeCreek, L. D., & Fingerhut, R. (2017). *The legal floor and positive ethics.* In S. J. Knapp, L. D. VandeCreek, & R. Fingerhut, *Practical ethics for psychologists: A positive approach* (p. 3–15). American Psychological Association. https://doi.org/10.1037/0000036-001

Salerno, J. P., Devadas, J., Pease, M., Nketia, B., & Fish, J. N. (2020). Sexual and gender minority stress amid the COVID-19 pandemic: Implications for LGBTQ young persons' mental health and well-being. *Public Health Reports,* 0033354920954511. https://10.1177/0033354920954511

Salerno, J. P., Williams, N. D., & Gattamorta, K. A. (2020). LGBTQ populations: Psychologically vulnerable communities in the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy,* 12, S239-S242. https://10.1037/tra0000837

COMING OUT OF COVID: Creating a Better New Normal

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With COVID -19, the world has gotten itself into a mess. By learning, we could guarantee coming out better.

We haven't had a global catastrophe like COVID-19 in some time. One could fairly ask if responses to past major disasters and pandemics might teach us how to recover from COVID-19. How have individuals, communities, even countries recovered from such disasters? Are there patterns from which to learn? Moreover, by linking such patterns to our knowledge of general and individual well-being, survival and global safety, can our response to COVID-19 ensure we re-emerge better? We believe so. Others do too.

In February, the King's Fund (2021), an English health charity whose vision seeks to identify the best possible health and care for all, published an analysis of ten world-wide calamities experienced over the past 20 years. There are, they report, specific patterns of human response and recovery to mass disasters. Upon analysis, these patterns of recovery from mass disaster are analogous to pathways of recovery observed in individuals recovering from mental and physical illness, as well as substance abuse. There may be a message here.

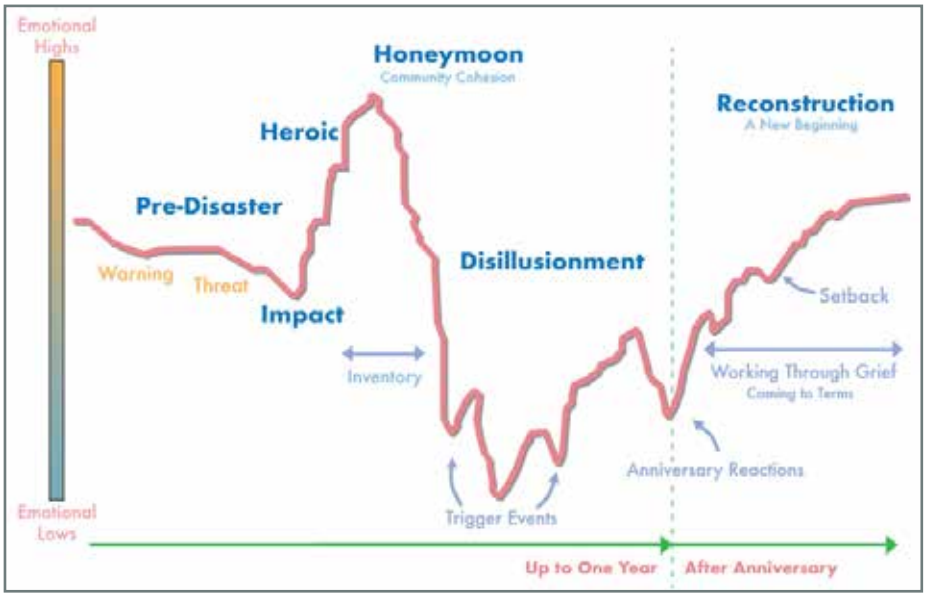
The key findings of The King's Fund report:

1. The people who have been most affected by COVID-19 are generally those who had the worst health access before the pandemic, especially people from ethnic minority groups and those living in poorer areas. COVID-19 exposes deep inequalities and disparities in healthcare that exist between different populations in the U.S and around the world.
2. COVID-19 has laid bare weaknesses in our social fabric (e.g., nursing homes, schools, jails, tech access/use, daily services) and mental health systems. This lack of preparedness led to tragic consequences for families and staff, and catastrophic numbers of deaths. With commitment, intentional planning, and strategic investment, the systems that provide social, medical, and behavioral care should be made better prepared for disasters.
3. A significant workforce shortage has created a crisis across all of health and service care. COVID-19 has taken a disproportionate toll on staff from social and ethnic minority backgrounds, who already faced higher levels of systemic discrimination, poorer work conditions, and less support than wealthier or white counterparts. Of particular concern are significant "skilled" staff shortages in hospitals, nursing homes, and prisons.

The King's Fund report adds that major disasters come with phases similar to those documented by America's Substance Abuse Mental Health Services Association (2000) below: pre-disaster, impact, heroic response, initial community response, disillusionment, setbacks and grief, and reconstruction with a new beginning:

In this phased analysis, it would seem we are in the "disillusionment" phase, where our progress is challenged daily by logistics, limited resources, and continued personal frustration and uncertainty. Negative numbers from the disaster continue to

Figure One: Phases of Disaster (SAMHSA, 2000)



grow, even as solutions appear. As citizens, we are close to hitting a "bottom," a point of prolonged weariness and surrender. We might be "being sick and tired of being sick and tired" (Hamer, 1964).

There are other shared learnings from societal disasters and personal recovery: Progress is seldom linear. Recovery doesn't just happen. Most people avoid formal help until the need is unavoidable and more costly. With COVID-19, special challenges arise: limitations in mental and physical health access and in technology access; disparities in wealth and housing; and the unique needs of youth, the aged, and those without jobs. Within these disparities are those individuals who are at greatest risk of COVID-19 and its later consequences.

Whether a disaster, mental Illness or substance use disorder, experts also tell us that recovery for all might not be possible (King's Fund, 2021; Clay, 2014; White, 2012). Worse, without guidance, attention and equal opportunity, recovery is not an opportunity for all. Additionally, the psychological damage from a major disaster is long-term, reported to take about 10-15 years for remission of related trauma and uncertainty to cease. Clear, accepted messages from leadership and science and health equity are critical to assure and expedite healing.

Learning from the Past

In 1918-19 the world experienced another flu epidemic where 50 million died, 675,000 Americans (Johnson and Muller, 2002). The authors' analyses of America's response to that pandemic identified markedly parallel situations to our 2020 health preparedness and our national unpreparedness, uncertain avian origin, inconsistencies of messages to the public and a then similarly besieged health system of limited capacity. A world at war fought the biological reality of a rapid deadly flu onset challenging socio-economic realities, e.g. a draft to end a World War. There was also an initial similar minimization of gravity and pre-emptive steps that could have prevented many early deaths. There was no vaccine. While youth suffered more, the impact of health disparity was acutely obvious, again, worldwide. The same social health measures: masks, hand washing and social distancing or "crowding control" ultimately proved effective.

So, did we learn from that epidemic? Were we more prepared, more honest in 2020?

For answers we have to search our responses and honestly appraise our actions. Did we change? Were we prepared? How can our responses to COVID-19 now better inform and prepare us for the future.

Early Lessons from COVID-19

There are many lessons that can be deduced from COVID-19. From the King's Fund report and our own analyses some insights are now clear.

First, we must have a sustained will to learn and courage to change based on what is factually presented to us by disaster. The message is clear, no will to honestly change, no better future.

Second, we must look at what didn't work and ask why? If we are to come out better than we were before COVID-19, the analysis must focus, within strong community collaborations and in the absence of blame, on systemic downfalls, preparedness, shortages, and barriers, with particular attention to population inequities and the needed leadership to address them.

Third, we must make our work, our systems, science, media, and leaders trustworthy. In order to achieve this, social, medical and behavioral systems must be better prepared in disaster science and in the prevention of risk, related harm and trauma to all populations. We'll need anticipatory practice, emergency plans, bed capacity, critical equipment inventories, and skilled personnel with knowledge of short- and long-term mental health impact in all populations. Understanding and building on the social determinants of health for individuals and groups, and for each community, will promote communal trust, engagement, and success.

Fourth, we need to prioritize and build a skilled, appreciated service and clinical workforce that is seen as a societal treasure, not a lower class or a burden. In this 21st century, supporting and expanding service and health careers should be a noble, world-wide undertaking. Remember, in service and health care, knowledgeable workers are our greatest asset.

Fifth, we need to remember what those who came to personal recovery before have taught. Recovery takes time and patience. It can be progressive one day, regressive another. It arises from reflection, hope and faith to transform the person, family and community through reconciliation and growth. It rests on integrating the past into a positive and dignified way of moving forward. Recovery has strong cultural and community support within phases of learning, exploration, acceptance, anxiety, and even failure – all within cycles of renewal offering clearer, greater purpose (Flaherty, Kurtz, White, & Larson, 2014).

Finally, to come out better, we must learn that constructive societal evolution is not about self-survival or the survival of one group over another, but – as demonstrated in both disaster responses and in personal recovery – is about a commitment to the survival of everyone, leaving no one behind. By doing this, we all will reach a better new normal – if we have the will for it.

REFERENCES

Clay, R. (2014, September). From serious mental illness to recovery. *Monitor on Psychology, 45,* Retrieved from APA/org/monitor/2014/09/recovery.

Flaherty, M. T., Kurtz, E., White, W. L., & Larson, A. (2014). An Interpretive Phenomenological Analysis of Secular, Spiritual and Religious Pathways of Long-term Addiction Recovery. *Alcoholism Treatment Quarterly, 32*(4).

Hamer, F. L., (1964). Expression of exhaustion in her speech advocating for civil and voting rights for African Americans, made at Democratic National Convention in 1964).

Johnson, P. and Mueller. (2002). Updating the accounts: global mortality of the 1918-1920 "Spanish" influenza pandemic. *Bull. Hist. Med. 76* (1): 105-115.

King's Fund. (2021). *Covid-19 recovery and resilience: What can healthcare learn from other disasters.* The King's Fund charity. London, UK. http;//www.kingsfund.org.uk

Substance Abuse and Mental Health Services Administration. (2000). *Phases of disasters. Training manual for mental health and human service workers in major disasters* (2nd ed.), HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services.

White, W.L. (2012). *Recovery/remission from substance use disorders: An Analysis of reported outcomes in 415 scientific studies, 1868-2011:* Chicago: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Developmental disAbilities, Northeast Addiction Technology Transfer Center, Pittsburgh, Pa.

READY OR NOT. . . .: Stories of Professional Transitions

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Retirement, embrace him like you did me. Teach him all that you taught me about finding who I was off the court.

My place in the community. My purpose.

Most of all, help him realize that there is no such thing as retirement, merely passing from one room into another.

A bold adventure in self-discovery where he may find a new Kobe who may surprise and delight him all over again.

Ideally psychologists would plan and implement an orderly retirement for years in advance. That does not always happen, however. Retirement was not on the horizon for either of us until the horizon came to us in the form of a serious medical challenge. Being forced to face our mortality, the horizon was closer than we ever realized. We may not have the luxury of as much time as we preferred for a full or better planned transition. On the other hand, one cannot anticipate everything about a change that involves some loss as well as some opportunity. Perhaps our fellow psychologists can benefit from real-life stories about how these decisions are made. Here are our stories:

Sam:

On February 17, 2020, the emergency room physician said to me, "You are in remarkably good health. . . except for your cancerous tumor." The next six months involved one surgery and four sessions of infusion therapy. My diagnosis coincided with the emergence of the COVID-19 pandemic and the shift in psychology practices to tele-health. I worked for almost the entire time I was in treatment (including some very long days during the early stages of the pandemic), although for three months I stopped taking phone calls and responding to member emails because I could not always predict my fatigue level from one day to the next.

Although my cancer is in remission, post treatment my fatigue and arthritic pain increased, I found it harder to manage the tasks I have, and I had higher than desired levels of emotional distress. It is not clear how much of my distress is due to the general distress that all psychologists now feel during these stressful times, or how much is it due to greater difficulty in meeting my professional obligations. This awareness occurred in part because of my personal insight, but it also occurred because of outsight, or the willingness of my wife and friends to give me feedback.

I could work longer, but I would rather leave too early than too late. It is probably a good sign that I do not regret my decision, although the change in my professional relationships with the PPA staff and other PPA members will be painful for me. But I will continue as a PPA member and the Colleague Assistance and Ethics Committees.

Jeff:

From time to time, people would ask me when I plan to retire. My basic response was that retirement seemed far enough away that I did not even think about making plans. It seems like I have always had this fantasy that, as a psychologist, I could always just work a little bit less – see fewer patients, etc. Even when my wife retired from teaching in her early 60's, it did not occur to me to consider retirement. I think the primary issue for me was that I loved my work! I felt especially appreciated as a psychologist in a medical training program that valued what I had to offer. Who would want to leave this?

At age 69, after fifteen years on the faculty of a Family Medicine residency and the same fifteen years after an emergency open heart surgery to repair an aortic aneurysm, I experienced a rupture of the repair to my aorta, and I went through a second emergency operation. This time recovery was slower, and being almost 70 years old, it felt like it was time to take stock. I felt like I had been living on bonus time since my first surgery. This time, my experience of an emergency had been complicated by a stroke a month earlier,

and I could not escape the reality of how precarious my life is!

Taking stock for me was made easier and more systematic by attending a series of four structured weekend retreats with content based on the four seasons of the year. This was designed for people going through transitions in their lives, and it was a perfect metaphor for the seasons of one's life. There were numerous exercises, journal writing prompts, small group discussions and a lot of learning about what I have accomplished and endured along with what is left for me to do. I was not only leaving one life circumstance, I was also going toward something else.

What became clear to me was that I did have some writing and teaching I wanted to and could do on a modified schedule, I had to give up the one thing that provided so much satisfaction – my full-time faculty position. Accepting this trade- off was obvious and necessary and at the same time challenging emotionally. I had developed so many relationships that I could not keep in the same way. I wanted to do it all, and I knew I could not!

What has emerged has been a much more relaxed schedule, continued involvement with PPA, continued leading Balint groups along with involvement in that organization, and opportunities to do some consulting work as well. With my more relaxed schedule, my flower and vegetable gardens have never been better! And hopefully, as the COVID-19 restrictions are relaxed, my wife and I can resume doing a little more traveling.

Having some financial security was crucial. Structured retreats gave me an opportunity to step away from my life in order to look at it, explore my current situation more clearly, and decide what I wanted to shift and how. Understanding our responsibility to what we are leaving is important; this includes scheduling for patients who need to continue therapy, or in my case, I was able to help recruit and orient my replacement before I left. And, of course, coordinating these plans with my partner with whom I will be entering a totally new phase of our lives together, would help to make this transition one that meets both of our needs.

What Take-aways Do These Stories Have for You?

When should a psychologist retire? When should we cut back on services and decide to close our practices, surrender their licenses, or otherwise transition into other areas of life? These decisions involve many factors including economic security, health issues, post-retirement options, personal obligations or even world events that cause us to reconsider ways of living and giving.

What Learnings or Awarenesses Will Be Important to Keep in Mind?

Just in case, have a professional will. Both Jeff and Sam were able to return to work and effect a transition, but some of our colleagues have become seriously disabled or died suddenly and have left the process of winding down their practices to their overwhelmed and grieving loved ones or survivors. (For samples of professional wills go to the PPA website, log in as a member, click on Resources> Practice Resources>Business and Practice> Professional Wills).

Embed yourselves in a loving community that gives you feedback on your performance (although this is important for all psychologists, not just those planning to retire).

Periodically examine your life situation, including goals, level of satisfaction, unmet needs, and your personal and professional journey and trajectory.

Acknowledge that there may be pain and sadness involved in a decision to make a life change. There will also be risk and potential reward. The hopeful comments of Kareem Abdul-Jabbar upon the retirement of his friend Kobe Bryant, despite being bitter sweet, may provide additional perspective to the reality of retirement.

BIGOTRY AS A DIAGNOSIS: Observations and Bringing Psychology into the 21st Century- An Interview with Celeste Malone, Professor of School Psychology

JULIE MERANZE LEVITT, PhD

Dr. Malone starts with the premise that we need to know ourselves when we work with others. And that we must define culture and its complexities. Those from the majority culture may be least likely to understand their circumstances because they are seldom questioned. Others may not know the words to describe their discomfort, frustration, or the despair they experience because of marginalization. Dr. Malone says further that we all have multi-faceted identifications, and intersections between them. Each is associated with societal privilege or marginalization. She draws from Dr. Pamela Hays (Hays ADDRESSING Model) that posits 10 major factors: **A**ge, **D**evelopmental and acquired **D**isabilities, **R**eligion and Spirituality, **E**thnicity/ Race, and **S**ocioeconomic status, **S**exual orientation, **I**ndigenous heritage, **N**ational origin, and **G**ender (Hays, 2016).) Hays posits that we see race and ethnicity as a zero-sum game, with one group's gain tied to another group's loss. What is needed for clients and us as therapists is to break down areas in which we experience ourselves as privileged or diminished, and see how our status is connected to broader locked-in, oppressive systems. Through exploration, we can consider the roots of our beliefs and feelings by looking at family history, relationships with others, and our unique experiences. Probing, however, requires slow exploration; it is unlikely therefore that a psychological evaluation would be a venue for this kind of work.

We need to recognize that the client is the expert for his/her/their feelings and beliefs and what he/she/they want from therapy. However, within this framework we can help with self-advocacy training skills that can be empowering. Our work requires figuratively standing beside a client, not doing the work for the client. And we should build critical consciousness to help our client recognize racist action for what it is and therefore, prevent our client from internalizing a view as victim. Envisioning steps clients can take, by the therapist asking, "How would you like me to help?" instead of assuming we can use our power to directly problem-solve is important. "I, the psychologist, could be there beside you as opposed to doing something in your behest."

What about when there is client intractability? Dr. Malone maintains that the location of the intractability in therapy is key. She believes that being stuck often relates to race, because people equate culture with race. And, she says, it is helpful to talk about other cultural dimensions that may be "more salient" to a client, by asking what part of these variables they find most personally meaningful and inspiring. Religion, or socio-economic status, may be a starting point. Bottom line, we must help clients to discard stereotyping , but instead, to value what is unique to them. In addition, we must do the same work for ourselves and know more about how our self-knowledge can help us in our relationship with the client.

And what if treatment is ending because of insurance or relocation? If we are helping a person to find voice and consciousness about self and what is possible, how do we help sustain the evolving self-generated development? Dr. Malone believes we must leave the client with tools for growth. Learning self-reflection may help as may further reading because, according to Dr. Malone, "…this (process) really is a lifelong journey, and it's helpful for therapy---talking about it in this therapeutic context, but it's also impacting how they're interacting with others and society and shaping and changing and challenging their worldview. ... You always want to leave clients with tools to help them grow, and this would be

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THE PANDEMIC'S LASTING IMPACT ON EDUCATIONAL DECISION-MAKING

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Abstract

The COVID-19 pandemic brought immediate and drastic change to how schools function, and as a result, the delivery of school psychological services. With vaccination efforts increasing, there is hope that schools will soon be able to return to more regular functioning. However, even when all students can return to consistent face-to-face instruction, the disruption to instruction over the past year will affect educational decision making such as multidisciplinary evaluations for years to come. School psychologists must proactively address these threats to the validity of high-stakes educational decisions while at the same time supporting all students who have experienced a loss of educational opportunity. Supporting schools with the implementation of evidence-based practices including a Multi-Tiered System of Supports, scientifically based reading and math instruction, class-wide intervention, locally derived data-decision rules, and an emphasis on student response to instruction will support student learning and mitigate the pandemic's impact on educational decision-making.

The Pandemic's Lasting Impact on Educational Decision-Making

The COVID-19 shutdown and resulting shift to various forms of virtual and hybrid models of instruction disrupted the learning of students and the delivery of school psychological services. Many school psychologists had to shift to a virtual service delivery model or adapted in person assessment activities to include safety measures (e.g., personal protective equipment) to meet IDEA requirements. This shift resulted in threats to the validity of our assessment results and the educational decision-making that depends on them (Association of School Psychologists of Pennsylvania, 2020). As vaccination efforts increase, there is hope that more schools will return to in-person instruction. With the promise of a return to normalcy on the horizon, the most intrusive impacts of the pandemic on the day-to-day service delivery of school psychologists may prove to be transient. However, even when we can fully return to in person instruction and assessment, the impact of the pandemic on the decisions school psychologists must make will be relevant for years to come. Assessment results cannot be interpreted without context and the quality of instruction that students have received is one such contextual variable that has been disrupted to some extent for all students in the commonwealth for nearly full a year.

Despite this, school psychologists will still be required to make high-stakes decisions about students in the form of special education eligibility determinations. Waiting until it is time to conduct a multidisciplinary evaluation (MDE) to address the factors that threaten the validity of our decisions is likely too late and will result in compromising situations for both school psychologists and the students they serve. School psychologists must proactively address these issues. The following evidence-based practices will help schools and school psychologists navigate the challenging educational decisions they will have to make and support the well-being of all students even when the most restrictive impacts of the pandemic are lifted. These include providing a continuum of student supports using a multi-tiered system of supports, providing quality universal supports including the science of reading and math combined with class-wide intervention, an emphasis on local context and local decision-making criteria, and an emphasis on considering student response to instruction and intervention when

making eligibility determinations regardless of the method used to determine eligibility.

Multi-Tiered Systems of Support

MTSS is a comprehensive support system that includes universal screening, data-based decision making, and a continuum of evidence-based practices (including universal practices) that increase with instructional and measurement intensity as student need increases (Stoiber, 2014)). MTSS relies on the efficient and equitable distribution of resources to address student needs while engaging in a continuous improvement process. A number of contextual and individual factors resulted in a differential impact on students and communities by the COVID-19 pandemic. Not all students will require the same level of support to address the educational impact of the past year so a single intervention will not adequately address all students' needs. An MTSS framework will provide the infrastructure to identify and deliver interventions matched to student needs and evaluate the outcomes of instructional efforts for all students.

Universal Practices

It is imperative that schools address issues with the delivery of core instruction. There is extant literature on the research to practice gap in delivering effective reading and math instruction (Kilpatrick, 2015; VanDerHeyden & Codding, 2020). In order to address the lost instructional opportunities of the past year and prevent the further widening of achievement gaps in vulnerable populations, schools must provide evidence-based core instruction to all students. Additionally, schools will need to augment their universal screening practices with classwide intervention. Intervention trials increase the accuracy of screening results under optimal circumstances. When large numbers of students are below a risk criterion, providing supplemental intervention becomes difficult from a resource allocation standpoint. Additionally, class-wide intervention rules out the high numbers of false positives and negatives that impact screenings under such conditions (National Association of School Psychologists, 2020a). The combination of high quality instruction combined with class-wide intervention will help schools to maximize instructional benefit with efficient resource allocation.

Local Decision Making Criteria

Many universal screening measures are interpreted using normative comparisons or empirically based criterion-referenced benchmarks (Hosp et. al, 2016). Given that these norms and benchmarks were developed under drastically different instructional conditions than the previous year, the validity of using them to classify students by risk level is questionable and in some circumstances, may identify a number of students in need of supplemental intervention that is unrealistic for a school to provide. Schools will need to interpret screening data based on local context and develop local decision-making criteria based on the needs of their students. When done in conjunction with evidence-based core instruction and a classwide intervention approach, all student needs will be addressed with a manageable number of resources for districts.

Emphasis on Student Response to Instruction

Despite the myriad of factors interfering with our decision-making processes, child find mandates continue and school psychologists must conduct MDEs for special education eligibility purposes. The disruption to consistent instructional opportunities for many students will make relying on normative comparisons of achievement insufficient to make valid high-stakes decisions. Regardless of the eligibility method employed, a serious consideration of student response to instruction and intervention will be essential to accurately refer and identify students for special education (National Association of School Psychologists, 2020b).

Conclusion

Although many of the physical restrictions associated with the pandemic may no longer impact the delivery of school psychological services in the future, the impact of the pandemic on school psychology is far from over. School psychologists will be tasked with making high stakes decisions for students who likely have not experienced optimal instructional conditions for close to a year. A proactive approach including an MTSS framework with an emphasis on high-quality core instruction, an additional gate to traditional screening approaches, and interpreting screening data within ones local context will be needed. Student response to instruction and intervention will be an essential component of educational decision-making at all levels.

REFERENCES

Hosp, M. K., Hosp, J. L. (2016). *The ABCs of CBM, second edition*. New York, NY: The Guilford Press.

Kilpatrick, D. A. (2015). *Essentials of assessing, preventing, and overcoming reading difficulties*. Hoboken, NJ: Wiley.

Lillenstein, D. E. (2020). *Position statement on virtual testing during COVID-19 closures.* Association of School Psychologists of Pennsylvania. https:// www.aspponline. org/docs/ASPP_COVID_Virtual_ testing_letter_to_PDE.pdf

National Association of School Psychologists. (2020a). *Considerations for academic assessments and interventions upon returning to school* [handout]. Retrieved from: https://www. nasponline.org/ return-to-school-academic.

National Association of School Psychologists. (2020b). *The pandemics impact on special education evaluations and SLD identification* [handout]. Retrieved from: https:// www.nasponline.org/ resources-and-publications/resources-and-podcasts/covid-19-resource-center/return-to-school/the-pandemics-impact-on-special-education-evaluations-and-sld-identification.

Stoiber, K. C. (2014). A comprehensive framework for multitiered systems of support in school psychology. In P. L. Harrison & Alex Thomas (Eds.). *Best Practices in School Psychology* (pp. 41-70). National Association of School Psychologists.

VanDerheyden, A. M. & Codding, R. S. (2020). *Belief-based versus evidenced-based math assessment and instruction. Communique,* 48(5).

ANTI-RACIST ASSESSMENT FOR SCHOOL PSYCHOLOGISTS

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This past summer, as a nation, we reached a critical boiling point after the brutal, highly publicized, unjust killings of Breonna Taylor, Ahmaud Arbery, George Floyd, and incalculable other victims of racist violence. The spotlight on the recent events hit a new critical mass, and many who had previously been dormant on these issues recognized that it is time for action and unity to work towards solutions. Looking for answers, books flew off the shelf for Ibram X. Kendi's How to be an Antiracist (Kendi, 2019) and other readings about race and racism in our country. In Kendi's (2019) book, he stated that it is not enough to be "not racist", but that we all need to embrace being an "antiracist," defined as "one who is supporting an antiracist policy through their actions or expressing an antiracist idea" (p. 13).

In June 2020, multiple professional school psychology organizations, including the National Association of School Psychologists (NASP) and Division 16 of the American Psychological Association (APA), developed the *School Psychology Unified Anti-Racism Statement and Call to Action* (Garcia-Vazquez et al., 2020), asking all school psychologists to formally commit to anti-racist action in our field. As of September 2020, more than 2,000 individuals and 200 organizations had publicly endorsed the anti-racism statement. The question is now, how do we, as school psychologists, meet the call to action? How do school psychologists act as anti-racist agents of change in our every practice of school psychology?

School Psychologists' Role in Anti-Racist Assessment

As a field, we have been trying to address moral and ethical civil rights issues for decades, but still struggle to reach our aspirational goals. Our professional ethics codes call for fairness, equity, and justice (APA, 2017; NASP, 2020). Legally, the Individuals with Disabilities in Education Act (IDEA, 2004) has been revised multiple times to emphasize that special education eligibility must not be due to culture differences and must rule out lack of appropriate instruction. Despite ethical and legal imperatives for equity, educational inequalities and disproportionality in special education persist (e.g., Codrington & Fairchild, 2012). Before we can truly become anti-racist advocates for students, awareness of how general education and special education systems fail students from marginalized groups is critical (Skiba et al., 2008). Further, as school psychologists who work in these systems, we must acknowledge our role in perpetuating these practices at each phase of the assessment process: pre/referral, assessment, eligibility, and placement (Gold & Richards, 2012).

How Will Each of Us Meet the Call to Action?

Large-scale systemic changes are overwhelming for individuals, but a major domain of our comprehensive and integrated model of school psychology includes Equity for Diverse Populations (Domain 8, NASP, 2020). It is our responsibility to "work to correct school practices that are unjustly discriminatory or that deny students or others their legal rights" (NASP, 2020, p. 44). We need to address racist and inequitable practices in our schools and can start with reflecting on and changing our own practices.

Pre-Referral/Referral

The literature suggests that disproportionality in special education has its roots in biases related to who gets referred for special education. Teachers' referral decisions are affected by student race and ethnicity (e.g., Elhoweris et al.,

2005). Use of more objective universal screening measures may decrease disproportionality (Card & Giuliano, 2016). However, even with more quantifiable perception screening measures (e.g. social-emotional screeners), research indicates that teachers may still over identify Black students, especially when the teacher is experiencing exhaustion or burnout (McClean et al., 2019).

With a biased referral process, it is imperative that instruction is high quality and interventions are evidence-based and implemented with fidelity before special education referral. Response to intervention (RTI) or multi-tiered systems of support (MTSS) is an alternative approach to the wait-to-fail discrepancy model, but there are also issues in the application of those models (e.g., Proctor & Graves, 2012; Sabnis et al., 2020). Most notably, Sabnis et al. (2020) reported that even when RTI was implemented, the focus was overly compliance-driven and student deficit focused, rather than strengthening problem-solving and instruction. RTI is a promising approach, but more work is needed in training, implementation, resource alignment, and accountability (e.g., Gravois, 2016). We must continue to advocate for an ecological approach, shifting time and services to consultative problem-solving to enhance instruction. School psychologists are encouraged to consider: What is our role in supporting schools to develop pre-referral interventions and processes? How can we advocate for referred students who have not received adequate instruction and interventions?

Assessment

Each aspect of the assessment process warrants attention and careful consideration. As a field, we must examine our overreliance on cognitive tests, which have a history of racist use connected with eugenics, are biased, and lead to disproportionate outcomes (e.g., Izumi et al., 2019; Proctor & Graves, 2012). There are many ways to think about "test bias" (e.g., Warne et al., 2014; Weiss & Saklofske, 2020), and there is little consensus about whether cognitive tests should continue to be used as tools for decision-making with diverse populations. Aston and Brown (2020) found that school psychologists continue to select tests that they feel are less culturally appropriate when testing Black students. We must question practices that are based on tradition and seek additional training to increase our comfort with new approaches.

Different approaches that rely less on standardized test data, such as culturally responsive assessment (Kea et al., 2003), have been suggested to better account for ecological factors, including cultural norms and learning styles, and to address biases that the examiner brings into the assessment process. On the other hand, despite the ban on administering cognitive tests to Black students in California, disproportionality in special education continues to be a problem (Powers et al., 2004). This lack of clarity for what truly constitutes best practice when assessing a child from a culturally or linguistically diverse background puts school psychologists who conduct high-stakes assessments in a difficult position. However, school psychologists have ethical and legal responsibilities to question existing practices, learn new approaches and strategies, and advocate for the best interests of the students and families they serve. School psychologists are encouraged to consider: What measures are appropriate for this child? How can I flexibly adapt my approach for this child's individual learning and mental health needs? How can I collaborate with this child's family and community during the assessment?

Eligibility and Placement

As we make eligibility and placement decisions, it is important to self-reflect on our own cultural background and privilege and address the unintentional bias we each bring into the data collection and interpretation process. In addition to the implicit teacher bias discussed above, there have been a few key studies indicating that we are subject to our own biases such as the confirmation bias or other flawed heuristics when making eligibility determinations (O'Reilly et al., 1989; Wilcox & Schroeder, 2015). For example, school psychologists when given report data that were fairly ambiguous between two disability categories, were more likely to make an eligibility determination that confirmed the original suspected disability of the referral (O'Reilly et al., 1989). Being on guard for our own biases may be an important first step in dismantling disproportionality.

Making eligibility decisions for students may sometimes feel like a decision about access to much needed services, that should be available to students in general education who need support but have no disability. However, special education services often do not increase student performance; in fact, the label may be harmful (Gold & Richards, 2012) and special education may widen the gap, especially when compared to evidence-based interventions delivered in general education (Burns et al., 2020, Cole et al., 2021; Lloyd et al., 1998). School psychologists should consider: Does this child require specialized instruction due to a disability, or is this child in need of evidence-based interventions in general education? What can we do to address the disproportionate numbers of children from historically marginalized groups in special education and restrictive placements?

For Further Learning and Action

Importantly, school psychologists will find themselves at different stages of awareness, understanding, and action when it comes to social justice advocacy (Shriberg et al. 2011). Many school psychologists, especially individuals from historically marginalized groups, have been incredible advocates for social justice in their professional roles. How can all of us, particularly white school psychologists like us, the authors, join in or enhance existing efforts? Here are some ideas:

- Develop a social justice action plan that includes specific actions as well as learning.

- Advocate within your district:
  - Join a committee or workgroup focused on addressing social justice issues.
  - Advocate for RTI/MTSS training and implementation in your district with a focus on instructional quality, consultation, and coaching for school staff
  - Seek resources and training from PaTTAN to build capacity. https://www.pattan.net/Multi-Tiered-System-of-Support/Response-to-Intervention-RTI/RTI-SLD-Determination
- Emphasize record reviews, observations, and interviews in your current and future assessments of children, especially during the pandemic (Hass & Leung, 2020) and learn additional measures that are more appropriate for the diverse students you serve • NASP: https://www.nasponline.org/social-justice
- APA: https://www.apa.org/topics/racism-bias-discrimination

REFERENCES

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code/

Aston, C., & Brown, D. L. (2020). Progress or Setback: Revisiting the Current State of Assessment Practices of Black Children. *Contemporary School Psychology,* 1-9.

Burns, M. K., Maki, K. E., Brann, K. L., McComas, J. J., & Helman, L. A. (2020). Comparison of reading growth among students with severe reading deficits who received intervention to typically achieving students and students receiving special education. *Journal of Learning Disabilities, 53*(6), 444-453.

Card, D., & Giuliano, L. (2016). Universal screening increases the representation of low-income and minority students in gifted education. *Proceedings of the National Academy of Sciences, 113*(48), 13678-13683. https://doi.org/10.1073/pnas.1605043113

Codrington, J., & Fairchild, H. (2012). *Special education and the mis-education of African American children: A call to action (Position Paper). The Association of Black Psychologists.* https://www.abpsi.org/pdf/specialedpositionpaper021312.pdf

Cole, S. M., Murphy, H. R., Frisby, M. B., Grossi, T. A., & Bolte, H. R., (2021). The relationship of special education placement and student academic outcomes. *The Journal of Special Education, 54*(4), 217-227.

Elhoweris H, Mutua K, Alsheikh N, Holloway P (2005) Effects of children's ethnicity on teachers' referral and recommendation decisions in gifted and talented education. *Remedial Special Education, 26*(1), 25–31.

Garcia-Vazquez, E., Reddy, L., Prerna, A., Crepeau-Hobson, F., Fenning, P., Hatt, C., Hughes, T., Jimerson, S., Malone, C., Minke, K., Radliff, K., Raines, T., Song, S., & Vaillancourt Strobach, K. (2020). School psychology unified antiracism statement and call to action. *School Psychology Review, 49*(3), 209-211. https://doi.org/10.1080/2372966X.2020.1809941

Gold, M. E., & Richards, H. (2012). To label or not to label: The special education question for African Americans. *Educational Foundations, 26,* 143=156.

Gravois, T. (2016). Aligned service delivery: Ending the era of triage education. In L.C. Burrello, W. Sailor, & J. Kleinhammer-Tramill (Eds). *Unifying Educational Systems: Leadership and Policy Perspectives* (pp. 109-134). Routledge: New York.

Hass, M. R., & Leung, B. P. (2020). When You Can't RIOT, RIO: Tele-assessment for School Psychologists. *Contemporary School Psychology,* 1-7. Advance online publication. https://doi.org/10.1007/s40688-020-00326-5

Individuals With Disabilities Education Act, 20 U.S.C. § 1400 (2004).

Izumi, J. T., Burns, M. K., & Frisby, C. L. (2019). Differences in specific learning disability identification with the Woodcock-Johnson IV. School Psychology, 34(6), 603–611. https://doi.org/10.1037/spq0000336

Kea, C. D., Campbell-Whatley, G. D., & Bratton, K. (2003). Culturally responsive assessment or African American students with learning and behavioral challenges. *Assessment for Effective Intervention, 29*(1), 27-38.

Kendi, I. X. (2019). *How to be an antiracist.* One World.

Lloyd, J. W., Forness, S. R., & Kavale, K. A., (1998). Some methods are more effective than others. *Intervention in School and Clinic, 33*(4), 195-200.

National Association of School Psychologists (2020). *Model for comprehensive and integrated school psychological services.* Author. Retrieved from https://www.nasponline.org/standards-and-certification/nasp-practice-model/about-the-nasp-practice-model

McLean, D., Eklund, K., Kilgus, S. P., & Burns, M. K. (2019). Influence of teacher burnout and self-efficacy on teacher-related variance in social-emotional and behavioral screening scores. *School Psychology, 34*(5), 503–511. https://doi.org/10.1037/spq0000304

National Association of School Psychologists (2020). *The Professional Standards of the National Association of School Psychologists.* Author. Retrieved from https://www.nasponline.org/standards-and-certification/nasp-practice-model/about-the-nasp-practice-model

O'Reilly, C., Northcraft, G. B., & Sabers, D. (1989). The confirmation bias in special education eligibility decisions. *School Psychology Review, 18 (1),* 126-135.

Powers, K. M., Hagans-Murillo, K. S., & Restori, A. F. (2004). Twenty-five years after Larry P.: The California response to overrepresentation of African Americans in special education. *The California School Psychologist, 9*(1), 145-158.

Proctor, S. L., Graves, S. L., Esch, R. C. (2012). Assessing African American students for specific learning disabilities: The promises and perils of response to intervention. *The Journal of Negro Education, 81*(3), 268-282.

Sabnis, S., Castillo, J. M., & Wolgemuth, J. R. (2020). RTI, equity, and the return to status quo: Implications for consultants. *Journal of Educational and Psychological Consultation, 30*(3), 285-318.

Shriberg, D., Wynne, M.E., Briggs, A., Bartucci, G., & Lombardo, A. (2011). School psychologists' perspectives on social justice. *School Psychology Forum: Research in Practice, 5*(2), 37-53.

Skiba, R., Simmons, A., Ritter, S., Gibb, A., Rausch, M., Cuadrado, J. & Chung, C. (2008). Achieving Equity in Special Education: History, Status, and Current Challenges. *Exceptional Children,* 74(3), 264-288.

Warne, R. T., Yoon, M., & Price, C. J. (2014). Exploring the various interpretations of "test bias". *Cultural Diversity and Ethnic Minority Psychology, 20*(4), 570-582.

Weiss, L. G., & Saklofske, D. H. (2020). Mediators of IQ test score differences across racial and ethnic groups: The case for environmental and social justice. *Personality and Individual Differences, 161,* 109962.

Wilcox, G. & Schroeder, M. (2015). What comes before report writing? Attending to clinical reasoning and thinking errors in school psychology. *Journal of Psychoeducational Assessment, 33*(7). 652-661.

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another area to help guide their learning and on-going process of self-reflection." (interview, 3/24/2021)

Dr. Malone has done pioneer work in evaluating school psychology programs, including developing the School Psychology Multicultural Competence Scale (SPMCS). I plan a second article in our September Pennsylvania Psychologist issue to consider what changes she would like to see in training of school psychologists that will increase multicultural understanding and development of practices that will expand our ability to create more equitable, comprehensive educational approaches. Implications for independent psychology practice will be discussed. Where the larger area of justice, breaking down toxic practices, fits into the training and implementation will be explored.

REFERENCES

Hays, P.A. (2016). *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy (3rd ed.).* Washington, D.C. American Psychological Association.

SUPPORTING ASIAN AMERICAN STUDENTS AND FAMILIES IN THE COVID-19 ERA: Recommendations and Resources for Educators

MARIE C. McGRATH, Ph.D.

The twelve-month period following the onset of the COVID pandemic in the United States has been marked by a significant increase in violent behavior and harassment directed toward members of the Asian American and Pacific Islander (AAPI) communities. In March 2021, the Stop Asian Hate Campaign announced that they had received reports of 3,795 such incidents occurring between March 19, 2020 to February 28, 2021; 68.1% of these incidents were described as verbal harassment, 20.5% as shunning, and 11.1% as physical assault. Children and adolescents were the target of 12.6% of the reported incidents. An earlier report by Stop AAPI Hate (2020) indicated that youth between the ages of 0 and 17 years experienced violence and harassment in proportions similar to the overall sample (81.5% bullying/verbal harassment; 24% shunning/social isolation; and 8% physical assault). Notably, youth reporters indicated that adults were present in almost half (48%) of these incidents, but rarely intervened to support youth (and often carried out the harassment themselves). Overall, youth reported that bystander intervention occurred in only 10% of the reported incidents. The authors of the Stop Asian Hate campaigns have posited that, because of the opt-in reporting methodology used, these numbers may significantly underrepresent the actual number of incidents.

While the current surge in harassment and violence directed toward AAPI individuals can be attributed to pandemic-related prejudice, it is important to note that this is not the first time that the AAPI community has experienced harassment, blame, and social exclusion in response to societal events. In written testimony to the United States House of Representatives Judiciary Committee in March 2021, the Asian American Psychological Association noted that "[b]ias towards Asian Americans is not new, and has been enacted culturally, institutionally, and interpersonally since the first Asians settled in the United States…. There has been a history of Asian Americans being viewed as a perpetual foreigner, regardless of nativity" (p. 3-4). AAPI youth who have experienced verbal harassment over the past year have reported that many of those incidents reflected these prejudices (e.g., accusations that they "brought" COVID to the United States or were otherwise responsible for the spread of a pathogen frequently referred to by harassers as the "China virus" or "Wuhan virus").

It has also been hypothesized that the "model minority" myth, which suggests that AAPI individuals possess personal characteristics that have given them

academic, socioeconomic, and health advantages relative to other minority groups in the United States, may have contributed to the stress that AAPI individuals have experienced over the past year. Lee et al. (2017) note that, in addition to stoking conflict among ethnic groups, the myth obscures significant heterogeneity in functioning among AAPI individuals, which may lead to overlooking the needs of those experiencing difficulties. In educational contexts, the myth may lead educational staff to mistakenly believe that AAPI students have personal competencies that will enable them to effectively cope with bullying and harassment, and thus that intervention by school staff to address pandemic-related harassment of students is unnecessary.

Additionally, research suggests that the mental health needs of AAPI individuals are exacerbated by their experiences with discrimination and harassment. A meta-analysis conducted by Wyatt et al. (2015) indicated that perceived discrimination, social exclusion and alienation, and acculturative stress are risk factors for depression in AAPI youth, and that lower acculturation and exposure to bullying and/or violence are associated with greater risk of suicidality in this group. They also reported that, while higher levels of both individual self-esteem and collective self-esteem (the portion of self-concept based in one's ethnic identity) seem to protect against depression in this group, collective self-esteem and ethnic identity factors do not sufficiently protect against the negative impacts of discrimination on mental health.

Finally, Wyatt et al. (2015) noted that social and family supports have protective effects against depression for AAPI youth, as they do for members of other ethnic groups; however, other studies (e.g., Choi et al., 2020) have suggested that AAPI youth may experience unique social and familial stressors that can reduce the degree to which they benefit from these supports. Cheah et al. (2020)'s recent study of the experiences of Chinese American families during the pandemic supports these findings. Almost half of Cheah et al.'s 773 participants (543 parents and 230 children) reported experiencing overt COVID-related racial discrimination, with higher levels of parent- and youth-perceived racism associated with poorer mental health. Taken together, these findings suggest that intervention by educators to address both overt harassment and social exclusion experienced by AAPI youth may yield mental health benefits that will outlast the pandemic.

Recommendations for Educators

In 2020, the National Association of School Psychologists disseminated a handout titled "Countering Coronavirus Stigma and Racism: Tips for Teachers and Other Educators." This document contains the following recommendations that can be implemented to support AAPI members of the school community:

- Sharing accurate and factual information on, and debunking misinformation about, COVID
- Discussing the history of prejudice and racism in the United States
- Avoiding statements that contain stereotypes about AAPI individuals or Asian countries
- Sharing materials and resources in which AAPI individuals are portrayed positively
- Affirming, socially including, and behaving compassionately toward AAPI students and staff
- Speaking up against and immediately stopping any harassment that is witnessed
- Encouraging students who experience harassment to seek help from trusted adults

Similarly, young adults surveyed by the Stop AAPI Hate Campaign (2020) proposed implementation of the following strategies in school settings to reduce harassment experienced by AAPI students:

- incorporation of "ethnic studies" curricula in high schools to expose all students to the histories of different U.S. communities, racism and its impacts on those communities, and social justice movements
- provision of anti–bullying training for teachers, staff, and administrators
- training in and implementation of restorative justice practices to address incidents of bullying and harassment
- accessible and anonymous means of reporting incidents
- support for AAPI and anti-racism student groups

Finally, in a joint position statement titled "Addressing Anti-AAPI Racism and Xenophobia" released in February 2021, the Trainers of School Psychologists and APA Division 16 (School Psychology) reiterated the recommendations contained in the above documents and offered the following additional suggestions for individuals affiliated with school psychology training programs:

- Checking in with AAPI colleagues, students, family, and friends
- Sharing resources with K-12 school and university affiliates
- Advocating for anti-racism training opportunities for colleagues and students
- Supporting advocacy organizations that work to combat anti-AAPI racism and support AAPI individuals

The authors of this joint statement also called for addressing anti-AAPI racism in conjunction with, rather than separate from, efforts to combat anti-Black racism and other forms of discrimination in order to "[convey] a powerful message of a collective working together to dismantle oppressive systems that benefit from xenophobia and racism targeting AAPI, Black and other minoritized communities" (p. 2).

Additional Resources for Educators

The following resources may also be useful for school psychologists and other educators as they work to implement the recommendations described above:

Asian American Health Initiative Resource Library

Authors: Asian American Health Initiative, Montgomery County (MD) Department of Health and Human Services

Link: https://aahiinfo.org/aahi-resources/

Description: This website contains a variety of

informational resources, including illustrated "photonovels" in Chinese, Korean, Vietnamese, Hindi, and English that discuss mental health, stressors that contribute to mental health issues, and mental health care options.

Asian Americans

Author: PBS LearningMedia

Link: https://www.pbslearningmedia.org/collection/asian-americans-pbs/

Description: This website contains over thirty lesson plans for middle and high school classrooms based on the PBS film series Asian Americans. Lesson plans include clips from the film, classroom activities, background readings, and links to supplemental materials on each topic.

Humanizing Asian Americans in the Classroom Through Children's Literature

Authors: Southern Poverty Law Center Learning for Justice Project (formerly Teaching Tolerance)

Link: https://www.learningforjustice.org/magazine/humanizing-asian-americans-in-the-classroom-through-childrens-literature

Description: This article provides a list of books suitable for elementary and middle school students that center AAPI protagonists and discuss Asian American history and culture. Some of the books explicitly address bullying or teasing that targets various aspects of AAPI students' cultural heritage.

Public Service Announcements for AAPI Families Facing COVID-19 Discrimination

Authors: APA Division 45 (Society for the Psychological Study of Culture, Ethnicity, and Race) Anti-Asian Discrimination Task Force and the Asian American Psychological Association

Link: https://division45.org/public-service-announcements-for-aapi-families-facing-covid-19-discrimination/

Description: This webpage contains videos and infographics describing how families and other concerned individuals can support Asian Americans who experience COVID-related discrimination. The resources are available in the following languages: Simplified and Traditional Chinese; Korean; Vietnamese; Tagalog; Bengali; Urdu; Hindi; and English.

Stop AAPI Hate

Authors: The Asian Pacific Policy and Planning Council (A3PCON), Chinese for Affirmative Action (CAA), and the San Francisco State University's Asian American Studies Department

Link: https://stopaapihate.org

Description: This webpage contains a portal that can be used to report hate incidents against AAPI individuals; safety tips for members of AAPI communities; and data reports. The site's resources are available in the following languages: Simplified and Traditional Chinese; Japanese; Korean; Khmer; Vietnamese; Tagalog; Hmong; Punjabi; Hindi; Thai; and English.

REFERENCES

Asian American Psychological Association. (2021, March 18). *Written testimony from the Asian American Psychological Association before the United States House of Representatives Judiciary Committee, Subcommittee on the Constitution, Civil Rights, and Civil Liberties, on discrimination and violence against Asian Americans.* https://aapaonline.org/wp-content/uploads/2021/03/AAPA-Testimony-to-House-Judiciary-on-3.18.2021.pdf

Cheah, C. S. L., Wang, C., Ren, H., Zong, X., Cho, H. S., & Xue, X. (2020). COVID-19 racism and mental health in Chinese American families. *Pediatrics,* 146. https://doi.org/10.1542/peds.2020-021816

Choi, Y., Park, M., Noh, S., Lee, J. P., & Takeuchi, D. (2020). Asian American mental health: Longitudinal trend and explanatory factors among young Filipino- and Korean Americans. *Social Science & Medicine (SSM) — Population Health, 12.* https://www.sciencedirect.com/science/article/pii/S2352827319302769

Lee, D. M., Duesbery, L., Han, P. P., Thupten, T., Her, C. S., & Pang, V. O. (2017). Academic needs and family factors in the education of southeast Asian American students: Dismantling the model minority myth. *Journal of Southeast Asian American Education and Advancement, 12(2).* https://docs.lib.purdue.edu/cgi/viewcontent.cgi?article=1154&context=jsaaea.

National Association of School Psychologists. (2020). *Countering coronavirus stigma and racism: Tips for teachers and other educators [handout].* https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/health-crisis-resources/countering-coronavirus-stigma-and-racism-tips-for-teachers-and-other-educators

Stop AAPI Hate Campaign. (2020, September 17). *They blamed me because I am Asian: Findings from youth-reported incidents of anti-AAPI hate.* https://stopaapihate.org/wp-content/uploads/2021/04/Stop-AAPI-Hate-Report-Youth-Campaign-200917.pdf

Stop AAPI Hate Campaign. (2021, March 16). *2020-2021 national report.* https://stopaapihate.org/2020-2021-national-report/

Trainers of School Psychologists and APA Division 16 (2021, February 18). *Position statement: Addressing anti-AAPI racism and xenophobia.* https://tsp.wildapricot.org/resources/Documents/Addressing%20Anti-AAPI%20Racism%20and%20Xenophobia_Final.docx

Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: A systematic literature review. *Journal of Health Care for the Poor and Underserved, 26(2), 191-237.* https://doi.org/10.1353/hpu.2015.0059



EDUCATING FUTURE PSYCHOLOGISTS:
The Impact of Bias

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GABRIEL RIVERA
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As educators, we are charged with the responsibility to mold the minds of future psychologists and educators. We also serve as gatekeepers to the profession. In this article, we summarize some of the research on diagnostic bias and implicit bias in treatment. When you read news stories about bias in other fields (e.g., policing, education), do you think about how your own biases affect your work as a psychologist and how you engage your trainees in being aware of bias in assessment and intervention? Psychologists play an essential role in educating future psychologists and other treatment providers, providing ethical and culturally humble treatment, and in advocating for change. We conclude with suggestions for this endeavor.

Diagnostic Bias

Bias can occur at the very beginning of our relationship with those we serve. Diagnostic bias in mental healthcare is well documented, and we provide just a few examples here. To begin, Chun et al. (2017) found that overlapping characteristics of antisocial and borderline personality disorders may explain bias as a possibility for the greater diagnosis of antisocial personality disorder in men and borderline personality disorder in women. Adeponle et al. (2012) found that 49% of individuals diagnosed with a psychotic disorder had their primary diagnosis changed to a nonpsychotic disorder diagnosis following a referral to a cultural consultation service. African Americans continue to be three to five times more likely than European Americans to be diagnosed with schizophrenia (Schwartz & Blankenship, 2014), and this bias is likely due to errors in the diagnostic process (Schwartz et al., 2019). Cultural mistrust resulting from oppression and discrimination faced by African American men can be misinterpreted as paranoia, even on clinical scales from non-clinical samples of African American men (Mosley et al., 2017).

Implicit Bias in Treatment

Implicit bias also affects treatment decisions (i.e., attitudes we have toward individuals that can occur without our conscious awareness). In a landmark study, Green et al. (2007) found that while physicians indicated equal preference for White and Black patients (explicit), their Implicit Association Tests (IATs) indicated that they had a White preference. The IAT measures the strength of associations between concepts (e.g., White people vs Black people) and evaluations (e.g. good, bad) or stereotypes (e.g., athletic, clumsy)" (Project Implicit, 2011). Green et al. (2007) found that as implicit bias of White preference increased, likelihood of treating thrombosis in White patients and not Black patients increased (measured by response to a scenario). More recently, FitzGerald and Hurst (2017) reviewed 42 studies, finding that healthcare professionals exhibit the same rates of implicit bias as the general population, and providing correlational evidence that bias likely influences diagnostic and treatment decisions. Moskowitz et al. (2012) found that physicians have implicit stereotypes for both disorders with genetic predispositions and disorders without a biological association

(e.g., stereotyping substance use disorders in African American men). Although much of this research has occurred in samples of physicians, psychologists wanting to prevent implicit bias adversely affecting the lives of their clients would benefit lessons learned in the medical field.

Are We Teaching This?

Lessons learned about these concepts could be taught from undergraduate level to post-doctoral training and beyond, as the importance of these concepts extend the entire life of our professional career. In discussing diagnostic biases toward People of Color, Cheng et al. (2019) emphasized the need for diversity considerations in teaching and training of psychologists. For example, they suggested incorporating readings and/or personal accounts of mental illness from the perspective of diverse individuals in psychopathology coursework (Cheng et al., 2019).

Benuto et al. (2019) examined the training experience of doctoral students in clinical psychology; in particular, they sought to know how prepared students felt in terms of multiculturalism coursework and integration of diversity throughout courses. A total of 142 psychologists completed a survey on their training experience. An overwhelming majority (85%) reported that their schooling did incorporate one diversity course. In addition, 82% reported that they had didactic experience with cultural competency as well as 76% shared they were asked to explore their own racial biases (Benuto et al., 2019). Most psychologists noted the importance of this training, but several expressed a desire for more concrete and technical training. Individuals expressed that their experience with cultural competency and multicultural education focused on knowledge about different groups, rather than developing skills for working with diverse clients. By incorporating skills-based teachings in multicultural training, students can gain knowledge on diversity, challenge their own biases and privilege, and have better tools to serve clients of diverse and intersecting identities (Benuto et al., 2019).

Are We Using this Knowledge in our Practice and Teaching?

In our lifelong aim to provide culturally humble services, we conclude with strategies to be aware of to assist in minimizing diagnostic bias and implicit bias in treatment. We encourage psychologists to take these steps and to encourage our students and trainees to do the same.

1. We need to take note of our own implicit biases, either revealed by our own pursuit of the IAT (https://implicit.harvard.edu/implicit/takeatest.html) and/or by what we know about bias in general. What does research say about our views of certain individuals? Is this impacting the way we see people? We add this suggestion with the understanding that there are concerns with reliability and validity of the IAT, however, cautious exploration and interpretation of results might provide a chance for individuals to introspect about bias.
2. In diagnostic situations, psychologists and educators would benefit from thinking about how their own biases may impact their clinical diagnosis of a client. Think about how we are socialized and notice when bias might occur and slow down to include knowledge of biases in our clinical and professional decision-making processes. Psychologists and educators could also think about the experience of taking a Stroop test when you need to slow down to read the word, or slowing to prevent any automatic error. If we are aware of a common diagnostic bias, we should slow our thinking and engage in careful differential diagnosis. With students seeking more concrete skills from diversity coursework (Benuto et al., 2019), engaging them in discussion of biases when conducting clinical assessments could develop this skill for use into their career.
3. In order to reduce bias, psychologists and educators need to focus on expanding diverse experiences in their personal and professional lives. In these moments, the authors are often reminded that "we don't know what we don't know." In order to know, we are charged with stepping outside of our comfort zones. For example, approach diversity conversations with curiosity rather than judgment, and explore our own socialization practices.
4. Another important step would be to actively engage in training, reading, and consulting to expand our knowledge. Encourage this in our students and incorporate relevant readings and discussions into all coursework.
5. In moments of stress, we often rely on our gut and in these moments our own biases are likely to impact our judgment. This brings us to the importance of self-care and monitoring exhaustion. Self-care might be a vital way to buffer against stress and engage in cultural humility.
6. When monitoring bias, it will also help to think systemically. We can monitor when biased views are reinforced by others (e.g., insurance companies, treatment teams). We can monitor in our own thinking and for situations where we identify a systemic issue that requires action to address.

REFERENCES

Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services, 63*(2), 147–153. https://doi.org/10.1176/appi.ps.201100280

Benuto, L. T., Singer, J., Newlands, R. T., & Casas, J. B. (2019). Training culturally competent psychologists: Where are we and where do we need to go? *Training and Education in Professional Psychology, 13*(1), 56–63. https://doi.org/10.1037/tep0000214

Cheng, A. W., McCloskey, K., & Matacin, M. L. (2019). Teaching personality and abnormal psychology with inclusivity. In J. A. Mena & K. Quina (Eds.), *Integrating multiculturalism and intersectionality into the psychology curriculum: Strategies for instructors.* (pp. 225–241). American Psychological Association.

Chun, S., Harris, A., Carrion, M., Rojas, E., Stark, S., Lejuez, C., Lechner, W. V., & Bornovalova, M. A. (2017). A psychometric investigation of gender differences and common processes across borderline and antisocial personality disorders. *Journal of Abnormal Psychology, 126*(1), 76–88. https://doi.org10.1037/abn0000220.supp

Corneau, S., & Stergiopoulos, V. (2012) More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychology, 49*(2), 261-82. https://doi.org/10.1177/1363461512441594.

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ethics in action

NOT KNOWING:
A Source of Ethical Errors

JEANNE M. SLATTERY, PhD, LINDA K. KNAUSS, PhD, ABPP, and DON McALEER, Psy.D.

Dr. Healer is a provider in a community mental health clinic. During the COVID-19 pandemic, Dr. Healer was scheduled for a telepsychology intake appointment with a middle-aged female who self-identified as being of Middle Eastern descent. The woman, Ms. Searching, was self-referred for a neuropsychological evaluation because of "memory problems." Shortly before the scheduled appointment, a man called the facility's intake line to cancel the appointment, stating that his wife no longer needed services. No other reasons were given. The potential client was never on the phone.

Dr. Healer, unaware of the last-minute cancellation, called the intended client at the appointment time. Ms. Searching answered and began the intake conversation in a consenting manner. A few minutes into the session, her husband took the phone, saying that he had canceled the appointment and the service was no longer needed. Dr. Healer clearly heard the female voice in the background state, "but I want it." The call abruptly ended.

What are the various legal, ethical, clinical and moral issues involved? How should Dr. Healer proceed?

Is She a Client?

As we considered Dr. Healer's dilemma, it became clear that this dilemma was difficult because we did not have answers to basic questions. Would Ms. Searching be a client if she never talked directly to Dr. Healer? What are her goals? Is the cancellation an instance of a controlling or possibly abusive relationship? What are our legal and ethical obligations in this case?

> ***Rescuing our clients has the potential to make us feel good — and do good — yet such rescues may be paternalistic, suggest we believe we know better than our clients, and compromise our clients' autonomy.***

Ms. Searching may believe she is Dr. Healer's client, but they have only talked briefly during an intake. There was no formal consent, although she appears to have given informal consent for an evaluation. How much obligation do we have to follow up in an ambiguous situation like this?

Dr. Knapp believes that a person becomes a client when a reasonable person assumes oneself to be a client. If Ms. Searching asked for an appointment with the psychologist and the psychologist agreed to that appointment, then that reasonable person would assume herself to be a client. If she asked for an appointment and the psychologist declined to give it to her, then a reasonable person would assume herself to not be a client.

But a more fundamental question is what does this ambiguity about her client status change about our obligations to her? There may not be an ethical or legal obligation, but depending on our assessment of what was happening, we may recognize a moral obligation. Some of us would follow up after the cancellation and only talk with Ms. Searching, per our policy of how to respond to no shows and ambiguous cancellations such as this. Dr. Schur would attempt a contact when Ms. Searching's husband would likely not be present.

Most of us framed our decisions based on a respect for the client's autonomy – at least as it could be expressed here. Some of us felt that intervening could be intrusive without any contract encouraging more significant intervention. Others suggested

Would you like to be involved in future discussions of vignettes? Let us know by emailing jslattery176@gmail.com

that although intervening might be in the service of beneficence, it might violate autonomy and escalate the risk of possible abuse – if that was what we believed based on the nature of our phone interactions. As Dr. Kossmann argued, people have a right to make their own decisions, even when they are bad ones. Of course, we might have chosen to act differently if there was clear abuse – yelling, thrown dishes, etc. – in the background. Absent this, Dr. Kossmann suggested a deep breath rather than an ill-considered response.

Influences on Our Frame of the Problem

Some of us were more likely to intervene than others, which led us to consider why. Dr. Schur wondered whether we were engaging in a rescue fantasy, which Dr. Kossmann suggested is threaded throughout our professional culture. Rescuing our clients has the potential to make us feel good – and do good – yet such rescues may be paternalistic, suggest that we believe we know better than our clients, and compromise our clients' autonomy. Again, if this was clearly abuse, we might choose to respond differently.

We asked ourselves whether we would respond differently if this had been a male rather than a female requesting help. Would it matter if she were 17 or 80? For some of us, absent other information, this case activated our stereotypes of controlling Middle Eastern men and led to questions about how we would advocate for Ms. Searching. Although we may prioritize individual autonomy, the Searching family may value collective decisions, especially those that are beneficial for the whole family.

The Real World

As with many of our vignettes, this case was based on real events. In the real world, after consulting with her peers, Dr. Healing chose to call the Searching family to ask about the cancellation, as she remained unsure about what was going on. She talked to Mr. Searching, who apologized, but observed that similar requests had occurred many times when they were living in other parts of the country. He described Ms. Searching as somewhat hypochondriacal – and noted that previous evaluations had found no evidence of memory problems or any other sorts of problems that might be affecting her functioning. He was frustrated, but did not believe that further testing would make sense at this point in time. Dr. Healing believed and respected Mr. Searching's explanation and decision.

All of us hold stereotypes to some degree or another. Although we should identify, reflect on, and challenge these stereotypes so they maintain a weaker hold on us, it seems that what we do with those stereotypes matters as much or more than we think.

Conclusions

If Dr. Healer had seen Ms. Searching at greater length, there would have been a clearer contract for services and more defined goals for treatment. There also would have been more information to guide assessments of Ms. Searching and the situation. In its absence, some of us jumped to conclusions about the presence of domestic violence. Because the situation was ambiguous, we seemed to use gender, age and cultural stereotypes to guide our decisions. The Gestalt psychologists described this process as closure, the tendency to create a coherent image from fragmented elements (Wagermans et al., 2012). Such a process clearly reminded us of unvoiced stereotypes assessed by the Implicit Attitudes Test in the absence of conscious stereotypes (Banaji & Greenwald, 2013).

Stereotypes are a cognitive shortcut that allow us to make decisions rapidly (Macrae et al., 1994). All of us hold stereotypes to some degree or another. Although we should identify, reflect on, and challenge these stereotypes so they maintain a weaker hold on us, it seems that what we do with those stereotypes matters as much or more than what we think. When we recognize the gender, age and cultural stereotypes that are activated by this scenario, consider other options for responding to them, consult with colleagues, and choose strategies for responding that are consistent with our ethical principles (e.g., maximizing beneficence, minimizing maleficence, respecting autonomy, and fostering social justice), we can remain ethical and competent practitioners despite background stereotypes.

REFERENCES

Banaji, M. R., & Greenwald, A. G. (2013). *Blindspot: Hidden biases of good people. Delacorte.*

Macrae, C. N., Milne, A. B., & Bodenhausen, G. V. (1994). Stereotypes as energy-saving devices: A peek inside the cognitive toolbox. *Journal of Personality and Social Psychology, 66*(1), 37-47.

Wagemans, J., Elder, J. H., Kubovy, M., Palmer, S. E., Peterson, M. A., Singh, M., & von der Heydt, R. (2012). A century of Gestalt psychology in visual perception: I. Perceptual grouping and figure–ground organization. *Psychological Bulletin, 138*(6), 1172-1217.

SPOTLIGHT on the Publications Committee

JADE LOGAN, PhD, ABPP

The major purpose of the publications committee is to aid in production of the four quarterly issues of *The Pennsylvania Psychologist* (March, June, September, and December). Over the last year the committee has focused on soliciting articles from PPA at large. Each issue focuses on a theme relevant to the current times. Since June 2020, themes have included public health, political psychology, telehealth, antiracism, COVID-19, assessment & testing, bigotry as a diagnosis and educating clients. The goal of each special issue is to reflect the times and the role our members play during these times. We have been pleased with the range and variety of articles that have been submitted. Each submission period we receive up to ten articles for review with only five slots to fill. The special issue also includes a special section for school psychology, the "Academicians Corner", and "Ethics in Action".

Our current members include Jade Logan (chair), Jeanne Slattery, Edward Zuckerman, Anne Murphy, Helena Tuleya-Payne, Chris Molnar, Frank Farley, and Tracie Pasold (Communications Board Chair). We work with PPA's Erin Brady to assist in the layout and publication of each special issue. We are currently welcoming new members. If you think you might have an interest please don't hesitate to reach out to one of our members or email publications@papsy.org.

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Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research, 49*(1), 206–229. https://doi.org/10.1111/1475-6773.12095

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 1-18. https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for Black and White patients. *Journal of General Internal Medicine, 22*(9), 1231–1238.https://doi.org/10.1007/s11606-007-0258-5

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings, 24*(3–4), 187–210. https://doi.org/10.1007/s10880-017-9510-2

Moskowitz, G. B., Stone, J., & Childs, A. (2012). Implicit stereotyping and medical decisions: Unconscious stereotype activation in practitioners' thoughts about African Americans. *American Journal of Public Health, 102*(5), 996–1001. https://doi.org/10.2105/AJPH.2011.300591

Mosley, D. V., Owen, K. H., Rostosky, S. S., & Reese, R. J. (2017). Contextualizing behaviors associated with paranoia: Perspectives of Black men. *Psychology of Men & Masculinity, 18*(2), 165–175. https://doi.org/10.1037/men0000052

Ocampo, M., & Pino, F. L. (2014). An anti-racism and anti-oppression framework in mental health practice. In R. Moodley & M. Ocampo (Eds.), *Critical psychiatry and mental health: Exploring the work of Suman Fernando in clinical practice.* (pp. 145–155). Routledge.

Project Implicit. (2011). Preliminary Information. https://implicit.harvard.edu/implicit/takeatest.html

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry 4*(4), 133-140. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/

Schwartz, E. K., Docherty, N. M., Najolia, G. M., & Cohen, A. S. (2019). Exploring the racial diagnostic bias of schizophrenia using behavioral and clinical-based measures. *Journal of Abnormal Psychology, 128*(3), 263–271. https://doi.org/10.1037/abn0000409

CE QUESTIONS FOR THIS ISSUE

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

Conceptualizing Bigotry as Failures on Mentalization

1. Mentalization is

a. A brand new concept that has developed through advances in neuropsychology
b. A concept that encompasses the complexities of holding self and other in mind in order to navigate the interpersonal world
c. A trait that is inherited rather than learned or acquired
d. None of the above

2. Use of the concept of mentalization to respond to bigotry can help because:

a. It enhances the client's capacity to reflect on self and other
b. It educates the client regarding the fallacy and harm on their beliefs
c. It helps the therapist stay aware of their own capacity to respond curiously and empathically in the moment or guides them to wait until a later time when they can engage their own mentalizing of self and other more effectively
d. Both a and c

The Dark Triad + Cognitive Patterns = Bigotry, a DSM Personality Diagnosis?

3. There are distinctive and consistent cognitive patterns such as information processing and mental flexibility which underlie behaviors like extremism and bigotry across all demographics.

TRUE
FALSE

4. The Dark Triad is a subclinical collection of personality traits including all of the following except:

a. Machiavellianism
b. Sadism
c. Psychopathy
d. Narcissism

Bigotry Hurts, but it is Not a Distinct Mental Illness Syndrome

5. "Drapetomania"

a. Is a term added to the DSM-V to identify a specific sort of mood instability
b. Was a 19th Century term coined to describe the disorder of enslaved peoples' desire to escape their owners
c. Is seldom observed in western nations since 1950
d. Has been all but eliminated via civil rights reforms

6. **A major argument *against* making bigotry a mental illness is that**

a. The label of mental illness has no bearing on stigma
b. The epidemiology of bigotry does not support such a decision
c. Categorizing bigotry as a mental illness promotes harm to groups that the pathologizing of bigotry would purport to protect
d. Prejudice and bigotry are personal

Ethical Considerations for Telepsychology Practice with LGBTQ+ Patients in the Era of COVID-19

7. Guidance for waiving parental consent for sexual minority youth in research settings was established by the APA in 2019.

TRUE
FALSE

8. Which of the following safety practices should psychologists utilize for LGBTQ+ patients when using telepsychology?

a. Assurances of safety and ongoing assessment of privacy at each visit.
b. Explanation of data privacy and the potential for data breaches in informed consent
c. Careful screening for susceptibility to risk and appropriateness of telepsychology
d. All the above

Coming out of COVID: Creating a Better New Normal

9. Recovery from COVID-19 as with most major personal disasters:

a. Could take 15-20 years for psychological and economic recovery
b. Should be built upon what didn't work in all populations and communities
c. Must strengthen both service and health workforce
d. All the above

Bigotry as a Diagnosis: Observations and Bringing Psychology into the 21st Century

10. Cultural identity is complex because

a. It combines genetics, family experience and history, experience with others, own experience, country and regional views and intersections of these, all contributing to unique identities
b. There are no ways to breakdown such identity and consider parts of identities
c. All people see themselves as belonging to one significant group, without intrusion of other parts of experience
d. Racism is a dominant force that overwhelmingly controls how we see ourselves
e. None of the above

The Pandemic's Lasting Impact on Educational Decision-Making

11. How should school psychologists approach eligibility determinations and child find mandates amidst the lost instructional opportunities of the past year?

a. Work with key stakeholders to implement MTSS
b. Work to ensure students have access to scientifically-based instruction
c. Carefully consider student intervention response
d. All the above

Anti-Racist Assessment for School Psychologists

12. While RTI/MTSS is a promising alternative, what is a potential issue?

a. Lack of implementation or accountability
b. Continued focus on student deficit attributions
c. Overly focused on compliance over complex problem-solving
d. All the above

Supporting Asian American Students and Families in the COVID-19 Era

13. Which of the following factors does NOT increase the risk of depression in AAPI youth?

a. The perception that one is being discriminated against
b. Having a high level of collective self-esteem
c. Being socially excluded by peers
d. Being bullied by peers
e. All the above factors increase the risk of depression in AAPI youth

Educating Future Psychologists: The Impact of Bias

14. Which is true of healthcare professionals and implicit bias?

a. Healthcare professionals are less likely to exhibit implicit biases than the general population
b. Healthcare professionals exhibit the same rates of implicit bias as the general population
c. Bias in healthcare settings has not been researched
d. Bias in healthcare settings is likely rare

Not Knowing: A Source of Ethical Errors

15. Which of the following things did Dr. Healer do that were helpful in her work with Ms. Searching?

a. Consulting with colleagues
b. Considering other explanations for what was happening in the Searching family
c. Gathering more information
d. All the above

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, June 2021

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

1.	a	b	c	d	5.	a	b	c	d	9.	a	b	c	d	13.	a	b	c	d	e
2.	a	b	c	d	6.	a	b	c	d	10.	a	b	c	d	e	14.	a	b	c	d	
3.	T	F			7.	T	F			11.	a	b	c	d		15.	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

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Psychologist

Calendar

SEPTEMBER 24 – 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)

MAY 18 – 21, 2022
PPA2022 Convention
Kalahari Resorts and Convention Center
Pocono Manor, PA

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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