The Pennsylvania
Psychologist
SEPTEMBER 2021
VOLUME 81, NUMBER 8

EDUCATING CLIENTS

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ALSO INSIDE

DIVERSITY, EQUITY, AND INCLUSION

BRAD NORFORD, PhD

In the late 1980's my younger brother, Doug Norford, showed me an unpublished study he conducted while working on his degree in Social Work. To gather an impression of how Black Americans were portrayed in our country, he obtained 24 random issues of the three mainstream news magazines from that year: *Newsweek, Time Magazine,* and *US News & World Report,* and collected every image of Black Americans from those issues, excluding athletes and entertainers. That left 70 images which he then cut out individually and glued to a notebook page for each issue.

When I first saw the project, Doug asked me to quickly page through to get a gestalt for the overall collection. It was jarring to see roughly 50% of those photos creating a montage of negative stereotypes of violence, guns, poverty, homelessness, AIDS, and people being arrested. Sadly, less than 20% were images of Black citizens in favorable professional, family, and social roles. Doug appended a copy of Ebony's 100 most influential Black men in 1987 to clarify that the absence of positive images in the three news magazines was not due to a shortage of positive images/stories of Black people at the time. He also included a copy of Time Magazine's "American Best" issue which contained a mere two photos of Black citizens in the entire issue not connected to sports or entertainment—a group photo that includes two Black cooks and a photo of the President of Zambia.

The ways in which people from historically marginalized groups are represented in the media, as well as who we do or don't see in leadership positions in all sectors of society leads to damaging stereotypes that are difficult for anyone to shed. Examine yourself, regardless of your race, for a moment. What images first come to mind when you think of people in each of the following marginalized/misrepresented groups?

Native American?
Asian American?
Black American?
Latinx American?
Arab American?
LGBT American?

It is likely that the more personally connected we are to any of these groups, the more likely we are to have favorable thoughts come to mind that transcend unconscious bias.

In reflecting on Doug's 30-year-old study now, I cannot help but think that greater "Diversity, Equity, and Inclusion" (DEI) practices would have led to more diverse voices on the editorial boards of these publications, and which may have resulted in a deeper consideration of the content. It has been encouraging to me in recent years to see members of historically marginalized communities appearing or starring in many more broad reaching commercials, network and cable programs, anchoring news programs, and receiving recognition for accomplishments in the overall population sector and not just in designated minority categories. This is critically important to combating long held stereotypes.

Greater attention to DEI initiatives is a focus countrywide as companies, boards, award shows, sports teams, news media, government agencies, etc., work to play catch-up with what People of Color have for so long been advocating. When it comes to understanding the lived experiences of others, we don't know what we don't know. Inclusive leadership helps to mitigate that. We all benefit from opening our minds to the firsthand experiences and ideas of as many vantage points as possible. Our collective decisions, policies, and laws are more likely to reflect the needs of the broader community and to lead to greater equity.

Why am I writing about this? It's because the majority of us reading this issue of the PA Psychologist are privileged. It is important that White psychologists reflect on our privilege and that we work consciously in these times to ensure that PPA, as an organization, is actively engaged in this process (it is) and that we as individuals are utilizing our influence in the larger community.

I recognize that DEI has likely become

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WELCOME OUR NEW DIRECTOR OF PROFESSIONAL AFFAIRS AND GET ACQUAINTED WITH OUR ENTIRE STAFF TEAM

ANN MARIE FRAKES, MPA

Hello PPA Members! We have had a VERY busy summer at the PPA office. One very important and involved project was hiring our new Director of Professional Affairs.

We are happy to again announce that **Molly Cowan, Psy.D.** has been selected as PPA's new Director of Professional Affairs. For those of you who do not know Dr. Cowan, we would like to share a little background information. Dr. Cowan was born and raised in the Harrisburg area. She received her undergraduate degree in psychology from Millersville University and completed her Psy.D. in Clinical Psychology at the Indiana University of Pennsylvania (IUP).

Dr. Cowan originally joined PPA as a graduate student and has served in various roles within the organization, including secretary of the Board of Directors, chair of the Program and Education Board, chair of the Ethics Committee, co-chair of the Convention Committee, member of the President's Task Force on Interpersonal Violence, and a member of the PennPsyPAC Board.

Professionally, Dr. Cowan has worked in a range of clinical settings, including college counseling, community mental health, and private practice. Most recently, she worked at a large group practice in Harrisburg where she specialized in LGBTQ+ issues and sport psychology. In addition, Dr. Cowan has been personally mentored throughout her career by PPA's own Dr. Sam Knapp and is honored to be succeeding him in the role of Director of Professional Affairs.

In her role as DPA, Dr. Cowan will consult daily with PPA members on issues related to mandated reporting, confidentiality, insurance

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

issues, and licensing questions, just to name a few. She will present continuing education seminars, regularly contribute articles to ***The Pennsylvania Psychologist*** and serve as staff liaison for several PPA committees.

Dr. Cowan is married and has two children—an 11-year-old daughter and an 8-year-old son. In her free time, she enjoys reading, yoga, hiking, and spontaneous dance parties with her children. Dr. Cowan is a passionate supporter of all Philadelphia sports teams, especially the Phillies.

Please join us in welcoming Dr. Cowan to the PPA staff team. We wish her a long and prosperous career.

The best ways to reach Dr. Cowan are at molly@papsy.org and her direct line at the PPA office 717.510.6350.

Our entire staff team is available to help our members with a variety of professional needs. Please reach out to each of us directly, depending on your question or need.

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PPA Survey Reveals

STRESSFUL YEAR FOR PSYCHOLOGISTS, TELEHEALTH HERE TO STAY, and Other Findings

MOLLY COWAN, PsyD, *Director of Professional Affairs*
JEFF LEITZEL, PhD, *Bloomsburg, Pennsylvania*
ANN MARIE FRAKES, MPA, *Executive Director*
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Almost every year since 1996, PPA has conducted an annual survey of its members in order to determine its priorities in legislation, preferences for association services, preferences in continuing education, and other professional issues. For the last 10 years the surveys have relied heavily on the volunteer work of Dr. Jeff Leitzel of Bloomsburg University. In this year, 91% of respondents identified themselves as licensed psychologists. 807 PPA members responded, which is more than twice the survey numbers in some recent years.

The Year 2020 Was Difficult for Psychologists

Overall PPA members reported a slight increase in income in 2020 compared to 2019. It is widely believed that caseloads dropped during the early months of the pandemic and then reached unparalleled heights later in 2020 (and into 2021). Nonetheless, 45% of respondents said that the quality of their work declined in 2020; only 16 % said that it improved. This data is consistent with reports on satisfaction in one's career as a psychologist which decreased in 2020 (see Table 1). PPA has been tracking this data for 23 years and the results have been stable over the years. Nonetheless, the number of psychologists with low or very low career satisfaction has not been this high since the late 1990s when intrusive managed care practices were highly prevalent.

Table 1: Satisfaction Ratings of PPA Members over the Years
Satisfaction with Psychology as a Career

	1998	2000	2005	2008	2010	2013	2016	2018	2021
Low/Very Low	7%	7%	5%	3%	3%	6%	4%	4%	7%
Unsure	10%	8%	9%	8%	5%	10%	9%	7%	12%
High/Very High	83%	84%	87%	89%	93%	84%	87%	88%	80%

Level of Current Optimism for Psychology

	1998	2000	2005	2008	2010	2013	2016	2018	2021
Low/Very Low	17%	12%	8%	10%	7%	14%	10%	11%	6%
Unsure	26%	25%	22%	24%	21%	34%	27%	23%	23%
High/Very High	57%	63%	70%	66%	72%	51%	63%	65%	70%

Satisfaction with Psychology Income

	1998	2000	2005	2008	2010	2013	2016	2018	2021
Low/Very Low	33%	38%	32%	24%	24%	40%	26%	30%	22%
Unsure	18%	16%	15%	31%	17%	18%	21%	20%	21%
High/Very High	46%	44%	51%	45%	57%	41%	53%	51%	56%

Telehealth Is Here to Stay

During the height of the pandemic most psychologists saw patients through telehealth and only a minority of psychologists saw most of their patients in person. After the pandemic ends 40% of psychologists said that they would see patients primarily face to face, 42% said that they would continue to see patients through telehealth, and the rest anticipated a mix.

Continuing Education Needs

Other questions on the survey dealt with continuing education. Although PPA had held occasional webinars before the pandemic, webinars became the primary mode by which CE programs were offered in 2021. These programs were well received and 41% of respondents had interactive webinars as their preferred mode of receiving continuing education, compared to 28% who preferred face to face sessions.

For the sixth time in the last 25 years PPA included questions on preferred continuing education topics. The 2020 results are listed below. The percentages refer to the percentages of psychologists who were interested in receiving the CE program from PPA.

Table 2: CE Preferences of PPA Members

Ethics	51%
Suicide	28%
Diversity	28%
Psychotherapy	26%
Health Psych	24%
Diagnosis or Psychopath	23%
Psychotropics	23%
Child abuse	22%
Neuropsychology	16%
Child/Adolescent assessment	16%
Assessment	15%
Family/Marital psychology	14%
Other	9%

Impact of CE Mandates

Over the last several years, the Pennsylvania state legislature has imposed mandates on psychologists in child abuse (2 hours every renewal period) and suicide (1 hour every renewal period). However, it is not known whether these mandates improve the quality of services provided by psychologists. During the four times this question has been asked, the number of respondents who said it helped or helped a great deal varied from 27 to 33% and the number who said it helped very little or did not help also varied from 27 to 33%. The goal of the mandate is to increase awareness of child abuse and compliance with the Child Protective Services Law. The data suggests that a significant minority of psychologists found the mandated continuing education to be helpful. Nonetheless, an equal number of psychologists did not find it helpful.

Table 3: Perceived Benefits of Mandated Child Abuse Training

	2017 Survey	2018 Survey	2019 Survey	2021 Survey
1 (did not help)	15	12	14	12
2	18	15	16	15
3	40	33	39	36
4	18	19	19	21
5 (helped greatly)	9	9	12	12
No response		12		

The other statutorily imposed CE mandate for psychologists deals with suicidal patients. In the 2020 survey, 87% of PPA members had patients with thoughts of suicide in the last year, 49% had patients with suicidal plans, 19% had patients who attempted suicide while in treatment, and 6% had at least one patient die from suicide while in treatment. These findings have been highly consistent over the last 5 years.

One would hope that the mandate for suicidal prevention would lead to more comfort for psychologists when working with suicidal patients or a greater sense of proficiency. However, the data does not support that interpretation. As Table 4 shows, the level of distress when treating suicidal patients has not changed over the last 4 years, and Table 5 shows that the perceived competence of psychologists has changed little. Perhaps the self-reported levels of provider distress or perceived competence will increase over time, or perhaps the mandate is not fulfilling its goal of improving the quality of services.

Table 4: Level of Distress When Working with Suicidal Patients

Level of distress?	2017 Survey	2018 Survey	2019 Survey	2021 Survey
1 (least distress)	4	3	4	4
2	20	15	18	17
3	48	53	51	45
4	20	19	21	23
5 (most distress)	8	8	7	9
No response		11		

Table 5: Level of Self-Rated Proficiency When Working with Suicidal Patients

Level of proficiency?	2017 Survey	2018 Survey	2019 Survey	2021 Survey
1 (least proficient)	3	1	LT 1	2
2	7	5	6	5
3	43	37	34	36
4	35	32	42	41
5 (most proficient)	13	14	17	14
No response		10		

Member Demographics

Most PPA members work in independent outpatient practices. About 61% have that as their primary job and another 12% work part-time in a private practice.

Related to the age of the membership, questions were asked about services for older or seasoned psychologists. This was especially important for the PPA membership, which tends to be on the older side. The median age for PPA members is 63 and the modal age is 70. About 48% of PPA members have been licensed for at least 25 years, with about 30% of PPA members licensed for 30 or more years. Not surprising, many psychologists expressed an interest in services for seasoned psychologists. PPA held continuing education programs for seasoned psychologists last year, and more are being planned for this year. Additionally, because current membership is on the older side, in recent years PPA leadership has tried to recruit more students and younger psychologists and to have more programming related to the needs of early career psychologists in order to remain a robust membership in the years to come.

Also, 90% of PPA members identify themselves as white and 60% as female with younger members more likely to be female. About 7% of respondents self-identified themselves as having a disability. The ethnic make-up of psychology has been changing in recent years with 25% of graduate students being persons of color. Another major effort of PPA is to become a more inclusive organization that has a membership that better reflects the diversity of our society.

Diversity, Equity, and Inclusion continued from page 2

a tiresome catch phrase for people from historically marginalized communities to suddenly hear coming out of the mouths of so many White people this year. There is a warranted fear that attention to DEI will be a fad and lose momentum with various entities. BIPOC leaders assert that the concerted efforts of people from marginalized groups to increase DEI is unlikely to be sustained and meaningful without people of privilege continuing to partner in these efforts and while accepting the importance of sharing their power and resources.

As White psychologists, leaders, and people of privilege:

1. We can continue to educate ourselves on systemic racism, healthcare inequities, and justice issues that so disproportionately impact People of Color and the LGBTQ+ community.
2. We can be good listeners to people of underrepresented communities when they have the courage to offer ideas and feedback.
3. We also can be good listeners to those who are fearful of the prospects of change before them, who feel broader representation is undermining their personal and economic needs, or who have a belief that they are victims of "reverse discrimination". We can look to dialog and perhaps to expand perspective.
4. We can promote diversity in membership and leadership in all organizations and businesses in which we are involved. Diverse voices lead to broader ideas and greater representation.
5. We can be brave and say something when racism and harmful stereotypes present.

I wish you all a safe and enjoyable transition from summer to fall, as well as a fruitful and enriching professional year.

the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF AUGUST 6, 2021

Bill Number	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House
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
HB 1690	An Act addressing the shortage of Mental Health Services in Underserved Areas	Rep. Michael H. Schlossberg	Support		Referred to Health 6/24/21
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	

PAINLESS WAYS TO KEEP UP WITH RESEARCH

PAULINE WALLIN, PhD, *drwallin@drwallin.com*

Keeping up with mental health research doesn't end when we leave grad school. It is our professional and ethical duty to stay abreast of new developments related to our scope of practice.

That doesn't mean you need to read journals from cover to cover, but you should at least read summaries of research and a few original articles that pertain to the type of work you do.

Besides keeping you informed, there are other advantages to staying current. You may come across something that could benefit one or more of your clients — for example, this recent article:

McCormick, B. P., Brusilovskiy, E., Snethen, G., Klein, L., Townley, G., & Salzer, M. S. (2021). **Getting out of the house: The relationship of venturing into the community and neurocognition among adults with serious mental illness.** *Psychiatric Rehabilitation Journal.* Advance online publication. https://doi.org/10.1037/prj0000483

Abstract excerpt:

This study identified a subset of adults with serious mental illnesses who left their homes infrequently and who demonstrate significantly poorer cognitive function than those who left their homes more frequently. Spending extensive amounts of time in an unchanging environment may be a contributing factor to poor cognitive function, and a potential area for intervention.

You may also get ideas for a community presentation or fact sheet. For example, this recent article addresses parental burnout, which many parents in western countries have experienced, even before the pandemic:

Roskam, I., Aguiar, J., Akgun, E. *et al.* **Parental Burnout Around the Globe: a 42-Country Study.** *Affec Sci* **2,** 58–79 (2021). https://doi.org/10.1007/s42761-020-00028-4

Abstract excerpt:

Analyses of cultural values revealed that individualistic cultures, in particular, displayed a noticeably higher prevalence and mean level of parental burnout. Indeed, individualism plays a larger role in parental burnout than either economic inequalities across countries, or any other individual and family characteristic examined so far, including the number and age of children and the number of hours spent with them. These results suggest that cultural values in Western countries may put parents under heightened levels of stress.

More ways (besides journal articles) to keep up with research:

1. Google alerts — Set up keywords (e.g., *autism research*) at google.com/alerts. You can specify how often you want to receive an alert (as it happens, once a day, etc.) and the sources of the content. If you've set *autism research* to be delivered as it happens from news sources, you will get emails with links to news items on this topic, soon after they appear online.

2. Google Scholar alerts — Similar to Google alerts, but focused on academic sources, via scholar.google.com.

3. Alerts from mental health associations and organizations — APA, Medscape and other organizations regularly announce new research, and you can sign up to receive emails. Some, but not all, require that you be a member.

4. Academic press releases — Eurekalert and Futurity publish university press releases on various topics, including social science and culture. Each press release summarizes a research study and provides the name of the contact person for more information.

5. Social Media — On Twitter, follow journalists who write about mental health. They will often quote researchers whom you can contact directly. Also follow Twitter feeds from @APAjournals, @APAscience and other mental health organizations.

6. Podcasts — Listen on the go. NPR has some interesting podcasts, including «Hidden Brain» and «Invisibilia."The British Psychological Society has put together a list of their favorite podcasts.

Caveat: Some research is better than others

Before you quote research, search the Internet for critiques, which may reveal flaws in the methodology or interpretations.

Also, no single research study is completely definitive. Beware of studies that claim to be "ground breaking," especially if you have not heard about them from other sources. The Science-Based Medicine blog does a nice job of challenging some of the sensational claims in medicine and mental health.

TACKLING MISINFORMATION:
A Tale of Collaboration

MARY ANN McCABE, PhD, ABPP, *mamccabe@cox.net*

One of the few positive impacts of the pandemic has been a heightened interest in science-based information by a range of media and social media outlets. Psychologists have the opportunity to share our science like never before, and we can play a part in combating misinformation.

Parents, caregivers, educators and health professionals are regular consumers of information about child development, parenting, and psychological well being. There is evidence that the Internet is an important source of this information. For example, in a survey with a nationally representative sample of 2,200 parents (children 0-5 years), ZERO TO THREE (2016) found that 71% of parents referred to parenting blogs to answer parenting questions, and 82% used Google searches or visited parenting websites. Slightly over half of parents (54%) reported wanting information from a website or blog from child development experts. However, parents were often unsure of what information to trust.

Questions about infants, children and youth arise in daily living (e.g., children's sleep problems) and developmental transitions (e.g., parenting teens), from seasonal events (e.g., the start of school), from concerns about children or parents' wellbeing (e.g., behavioral problems) and from national/global events (e.g., the pandemic). Yet there is no single trusted website for parents or professionals to obtain reliable and valid behavioral science across these areas. The Society for Clinical Child and Adolescent Psychology, American Psychological Association (APA) Division 53, has found that a web presence enhances the reach of evidence-based practice to the public in ways that scientific journals cannot (www.effectivechildtherapy.com).

With all of this in mind, the leaders of 7 APA divisions with a child and family concentration (Divisions 7, 15, 16, 37, 43, 53, 54) formed the Collaborative for Science-Based Information on Children, Youth and Families (CSICYF) and developed a scientifically-based, centralized web resource for parents, educators and health professionals. A grant was awarded for this project from the Committee on Division/APA Relations (CODAPAR), and we launched www.infoaboutkids.org in March, 2016. Since then, the site has received financial support from the sponsoring divisions and the Children, Youth and Families Office of APA while remaining fully independent of any organization.

The project's founders formed its Advisory Board, and we invited early career psychologists and graduate students to join our project. We reviewed definitions, criteria, and best practices for determining *"scientifically sound* information on healthy child development and risks and challenges to healthy development, and/or *evidence-based* approaches to promote healthy development among those children and families who are at risk for, or have, identified conditions." Subsequently, each resource that appears has been vetted by two psychologists according to highly specific criteria. (See the website's "About Us" page.) We categorized resources according to "body," "mind," "emotions," and "relationships" — with some resources crossing categories; we also created an overarching group of "general resources." We differentiated resources that are intended for parents/caregivers, educators and health professionals, again with some overlap. Initial resources were recommended by experts, and the website allowed visitors to recommend additional sites for review. A mechanism was also built into the site for gathering basic feedback from visitors. We followed standards both for accessibility by persons with disabilities and language translation.

Since its launch, we have posted monthly blogs for parents/caregivers on topics of interest. Written by expert psychologists, the blogs present scholarly information in lay language and provide publicly available resources. To the greatest extent possible, we aim for a sixth-grade reading level in order to reach the widest possible audience. Over the last year, we have focused many of these blogs on the unique challenges and stressors of the pandemic (e.g., online learning, stress management, parents' self-

care). websites that are updated frequently appear earlier in Internet searches, these monthly postings aid our overall reach.

Following the initial launch, we shared the site with colleagues across APA and with intermediary groups (e.g., the National Parenting Education Network, YMCA/YWCA, military family organizations). We also conducted outreach to like-minded organizations that strive to share evidence-based information and invited them to link to our resources and become "Allied Sites"; their logos are featured on our website. Subsequent dissemination/marketing of the site focused on expanding reach to under-resourced communities (e.g., through libraries and faith-based and community organizations) and establishing a social media presence. Visitors to the website are asked to provide simple demographic data, and the website itself captures from what country and through what channels the visitor reaches our site. Analytics on visits to the site are captured monthly. Importantly, in 2017, we earned the HONcode certification for trustworthy health information on the internet (https://www.hon.ch/HONcode/).

How are we doing five years later?

We have seen a steady rise in visits to the website, with 950, 1,545, 2,704, 3389, and 4,995 for the month of March each year since launch, respectively. Across time, a majority of visitors have been female (generally > 70%). Visitors have spanned the full adult age spectrum, with most falling between 18 and 34 years of age. We have often seen a dip in visits during the summer months and a rise in the fall. Looking at our current data, just over half of our visitors are directed to our website from a search engine and just less than half are going directly to our website; a small portion of visitors are finding us via social media or other websites. In terms of social media platforms, Facebook sends the most referrals to our website. The majority of recent visitors (64%) are from the United States, yet we now have a presence in 254 countries. We continue to strive to improve our social media presence.

I have had the privilege of leading this initiative, serving as Chair of CSICYF, and overseeing the web resource center through the present time. Sharing psychological science with the public and advancing evidence-based practice has been a long-standing passion of mine.

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ZeroToThree. (2016). *Tuning In: National Parent Survey.* https://www.zerotothree.org/resources/1424-national-parent-survey-overview-and-key-insights#chapter-920

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EDUCATING CLIENTS ABOUT DECENTERING FROM RESPONSIBILITY FOR THEIR OPPRESSION

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A central feature of what practicing psychologists do is to facilitate clients' decentering, looking at the big picture when stress and trauma occur by promoting "the capacity to shift… from within [their] subjective experience onto that experience" (Bernstein et al., 2015, p. 599). Decentering involves taking a step back from being immersed in one's feelings surrounding an event to consider the event from a new self-distanced perspective; examples of common therapeutic strategies that enable clients to decenter include cognitive restructuring, therapeutic letter writing, constructing a trauma narrative, and viewing one's circumstances from the perspective of a third party such as a parent, partner, or outside observer. An individual is more likely to rebound from a stressful experience if they can successfully self-distance from their negative affect to consider the multiple factors beyond themself that contributed to the experience, to reflect on the broader context within which their stressful experience unfolded, and to make meaning out of the experience (Kaplow et al., 2018; Kross et al., 2012). Decentering is particularly important for clients from marginalized groups who, based on society's perception of their status, experience multiple forms of oppression, including exclusion, subjugation, and abuse, at the hands of those in positions of privilege. Discrimination based on cultural identity is commonplace for women, LGBTQ, Asian, Black, Latinx, and Native American individuals (Benson et al., 2019) and, when therapists miss opportunities to address cultural identity, clients report worse treatment outcomes even if they do not endorse oppression as a central presenting problem (Owen et al., 2016).

Although discrimination is rarely explicitly mentioned as an initial presenting concern (Pérez-Rojas et al., 2017), all too often, our clients report feeling that they have a target on their back because of the color of their skin, are belittled because they are a woman, ostracized because of their sexuality, or overlooked because they are a person with a disability. As psychologists, it is our job to enable clients to recognize that the cause of their struggle is not something that resides within them, not some internal feature or personal limitation, but instead their experience of oppression arises from the failures or deficiencies of the individuals engaged in the oppressive acts. In short, the responsibility for the oppression does not lie with the target of the oppression; the responsibility lies with the *agent(s) of the oppression. This is the central goal of educating clients about decentering from responsibility from their own oppression — psychologists must acknowledge the wounds that clients suffer, while simultaneously helping clients to see beyond those wounds and center the responsibility for their suffering on the true agents of oppression, rather than internalizing blame.*

Psychologists have two primary roles when educating clients about decentering from responsibility for oppression: the role of linguist and teacher. The first role is akin to a linguist because it involves attending to and adjusting our language so that how and what we communicate is consistent with decentering. When addressing clients, we must use the active voice to name the agents who are responsible for abuse or discrimination rather than the passive voice which obscures the agents responsible for the oppression (Johnson, 2020). For instance, a psychologist who shifts their language from, "It appears that you were a target because of who *you*

are…" to "It appears that who they are drove them to target you…" is centering responsibility on the perpetrators and not on the target. Similarly, statements such as "you were passed over/assaulted/invalidated because you are [marginalized identity]" should be replaced with "because [agent of oppression] believed that it was acceptable to exploit/attack/belittle you or failed to see your worth/individuality, you were passed over/assaulted/invalidated." This type of linguistic shift is important when conducting initial clinical interviews (e.g., shift from "Have you ever been discriminated against because of your identity?" to "Have other people or groups ever discriminated against you because of how they view you?") and when extending the conversation about identity later in treatment. The linguistic shift may seem minor but, given that passive voice is associated with victim blaming (Bohner, 2001; Henley et al., 1995), using the active voice to emphasize decentering may be especially significant for clients mired in self-blame, shame, or guilt associated with their experience of oppression. The second role that psychologists should keep in mind when encouraging clients to decenter from responsibility for their oppression is the role of teacher. Psychologists should engage in psychoeducation to help clients understand the links between messages ingrained in them over time from various levels of the ecological system and how those messages impact their sense of self (e.g., a client who's learned over time to think of themselves as a "target" or as a "burden"), thus helping clients to externalize blame by recognizing the broader context that contributed to the discrimination, reducing internalized oppression, and making meaning out of their circumstances.

There are several practical approaches and cautionary steps to consider when helping clients to decenter from responsibility for their oppression. The Healing Ethno and Racial Trauma (HEART) framework (Chavez-Dueñas et al., 2019) has been applied in clinical work with Latinx immigrants and includes many components relevant for clients from various cultural backgrounds whose clinical concerns are linked to broader systems of oppression and experiences of being marginalized (e.g., members of the LGBTQ community, persons with a disability). For instance, in Phase I of the HEART framework, psychologists "normalize, address, and challenge self-blaming statements;" in Phase III, psychologists "create opportunities to dialogue about the impact of external and systemic factors on the client's current symptoms [and] help clients contextualize the challenges…they face;" and, ultimately, in Phase IV, psychologists focus on "exploring causes [clients] are passionate about and where they would like to create change [and] finding activities and roles that engage in social action" (pp. 58-59). Psychologists should use these approaches while encouraging self-compassion in their clients and avoiding presenting themselves as the expert on their client's identity. Finally, psychologists must attend to their own cultural comfort and utilize self-reflection, supervision, and consultation to gain greater comfort with intentional cultural dialogue and the affective reactions that will inevitably arise.

Just as prejudice is learned (Allport, 1979), internalized oppression is also learned. Part of that learning process is driven by the language and messages that clients hear around them and about them. Therefore, as psychologists, we must seriously consider our role in educating clients about decentering from the responsibility for their own oppression.

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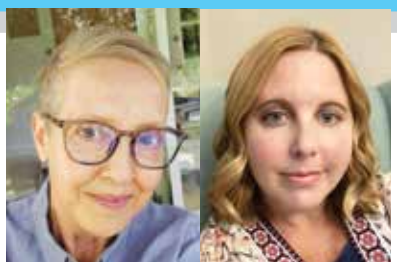

POST-ACUTE SEQUELAE OF COVID-19: Considerations for Psychologists

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The post-acute sequelae and long-term complications of COVID-19 infection remain to be discovered over the coming months and years, with significant global public health implications if such sequelae are associated with even a small fraction of cases (Troyer at al., 2020). Viral pandemics of the past have revealed evidence of symptoms such as encephalopathy or altered mental status, psychosis, mania, delirium, insomnia, narcolepsy, seizures, encephalitis, anxiety, depression, suicidality, neuromuscular dysfunction, and demyelinating processes; these symptoms may follow infection by weeks, months, or longer (Troyer et al., 2020). An understanding of the research around COVID-19 and its sequelae is essential for psychologists, who will likely provide psychological services for survivors of COVID-19.

Post-Acute COVID-19 Symptoms and Clinical Course

Emerging research suggests many COVID-19 survivors may experience prolonged heterogeneous post-acute infection sequelae that often involve multiple organ systems and impact functioning and quality of life, even among outpatient cases with mild disease (Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Chopra et al., 2020; Halpin et al., 2020; Havervall et al., 2021; Huang et al., 2021; Logue et al., 2021; Maxwell, 2020; Mizrahi et al., 2020; Sudre et al., 2021; Taquet et al., 2021; Taquet et al., 2020; Tenforde et al., 2020). A Swedish study of low-risk individuals with mild disease assessed at 8 months demonstrated that a considerable proportion experienced a diversity of long-term symptoms, with 11% having at least one moderate to severe symptom lasting for at least 8 months (Havervall et al., 2021). While no case definition has yet been agreed upon to encompass persistent features of post-acute COVID-19, some study authors have proposed a preliminary definition as a constellation of symptoms that develop during or following COVID-19 infection and continue beyond 28 days (Sudre et al., 2021). In a review of current literature on post-acute COVID-19, Nalbandian et al. (2021) define post-acute COVID-19 syndrome as persistent symptoms and/or delayed or long-term complications beyond 4 weeks from onset of SARS-CoV-2 infection. The authors further subdivide ongoing symptomology into 2 categories: subacute or ongoing COVID-19 present from 4-12 weeks beyond onset of acute phase COVID-19; and chronic or post-COVID-19 syndrome, encompassing symptoms and abnormalities present beyond 12 weeks of acute COVID-19 onset and not attributable to other diagnoses. It is possible that ongoing symptoms may be due to one or more different but potentially overlapping syndromes, such as Post Viral Fatigue syndrome, Post Intensive Care syndrome, and Long Term COVID syndrome (Maxwell, 2020). The lack of consensus on diagnostic criteria for persistent COVID-19 symptoms and a code for clinical datasets present a major obstacle to research and access to care (Maxwell, 2020).

While late sequelae after infectious disorders are not uncommon, the severity and duration of persisting symptoms in COVID-19 appear to be greater than what

is seen with other common community-acquired infections including seasonal influenza (Al-Aly et al., 2021) and bacterial pneumonia (Halpin et al., 2020). Data from the COVID Symptom Study (2020) suggest that one in ten patients still has symptoms after three weeks, with one in 20 likely to experience symptoms lasting more than 8 weeks. Clinical course and recovery time have been revealed as highly variable, with different patterns of symptoms along time (Mizrahi et al, 2020). COVID-19 appears to occur not in a linear progression of acute disease followed by recovery or steady rehabilitation, but rather as a cyclical disease, with symptoms that fluctuate in severity and move around different body systems (Maxwell, 2020). Sudre et al. (2021) found some symptoms such as fatigue were reported continuously while other symptoms including headache were reported intermittently. The authors identified two main symptom patterns among people with lingering COVID-19 sequelae: those who reported only fatigue, headache, and upper respiratory complaints, and those who reported multi-system symptoms including fever and gastroenterological complaints. Cardiac symptoms (tachycardia, palpitations), memory or concentration issues, earache and tinnitus, and peripheral neuropathy symptoms (numbness, pins and needles) were overrepresented in individuals with symptoms lasting beyond 28 days compared to those with a short disease course, with most of these symptoms appearing for the first time 3-4 weeks post COVID-19 onset (Sudre et al., 2021). The variability in symptom presentation and lack of recognition of symptom patterns by healthcare services and the public have left patients with ongoing symptoms frequently feeling isolated and alone (Maxwell, 2020).

Limitations of the current research include lack of control groups, lack of information on patients' symptom histories prior to COVID-19, differences in SARS-CoV-2 testing policies, selection bias, recall bias, and use of subjective rating of symptoms. Few studies on persistent sequelae of COVID-19 have evaluated the association of race/ethnicity (Nalbandian et al., 2021). Future research is needed to elucidate how post-acute sequelae may differentially impact communities of color (Nalbandian et al., 2021).

Clinical Considerations for Psychologists

It is becoming increasingly clear that a subset of COVID-19 survivors may develop chronic sequelae spanning multiple organ systems (Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Halpin et al., 2020; Havervall et al., 2021; Huang et al., 2021; Logue et al., 2021; Maxwell et al., 2020; Nalbandian et al., 2021; Sudre et al., 2021; Taquet et al., 2021; Zhao et al., 2020; Zhou et al., 2020). Multidisciplinary care strategies tailored specifically to post-acute COVID-19 are proposed to reduce chronic health loss among survivors (Al-Aly et al., 2021; Halpin et al., 2020; Maxwell, 2020; Nalbandian et al., 2021).

Furthermore, studies reveal that a subset of COVID-19 survivors may develop chronic neurological issues (Bellan et al., 2021; Carfi et al., 2020; Halpin et al., 2020; Helms et al., 2020; Huang et al., 2021; Janiri et al., 2021; Janiri et al., 2020; Logue et al., 2021; Sudre et al., 2021; Taquet et al., 2021; Taquet et al., 2020; Zhao et al., 2020; Zhou et al., 2020). Brain abnormalities indicating possible disruption to functional and micro-structural brain integrity have been found in recovering COVID-19 patients at three-month follow-up (Lu et al., 2020). Much is yet unknown regarding cognitive dysfunction that may arise from the effects of hyperinflammation even in less severe and subclinical COVID-19 cases (Cothran et al., 2020). Longitudinal investigations are needed to understand the potential neurological and neuropsychiatric outcomes of COVID-19 and to develop evidence-based strategies for therapy (Troyer et al., 2020). Psychologists who work with these patients need the tools to keep actively alert for neurological symptoms, effectively communicate with other providers, and provide appropriate referrals for concerning symptoms. A summary of post-acute sequelae of COVID-19 is provided in Table 1.

Table 1
Post-Acute Sequelae of COVID-19

Potential Multifactorial Mechanism
Direct effects of viral infection: aberrant immune response, prolonged systemic inflammation, potential latent infection (Al-Aly et al., 2021; Gennaro et al., 2021; Zhou et al., 2020).
Indirect effects of viral infection: social, behavioral, and economic factors such as loneliness, reduced exercise, and job loss (Al-Aly et al., 2021; Chopra et al., 2020).

Risk Factors/Positive Predictors
• Older Age (COVID Symptom Study, 2020; Logue et al., 2021; Sudre et al., 2021; Tenforde et al., 2020)
• Multiple Chronic Conditions: Asthma (Logue et al., 2021), Hypertension or Diabetes (Sudre et al., 2021)
• Female sex (Sudre et al., 2021)
• More than 5 symptoms in the first week of illness, especially fatigue, headache, dyspnea, hoarse voice, and myalgia (Sudre et al., 2021)

Post-Acute Sequelae

- Increased risk of death (Al-Aly et al., 2021; Bellan et al., 2021; Chopra et al., 2020)
- Neurologic, Neuropsychiatric, and Psychological Symptoms: **taste and smell changes, headache, cognitive dysfunction, memory impairment, sensorimotor symptoms, anxiety, depression, PTSD, insomnia,** dementia, psychotic disorders, parkinsonism, GBS (Abu-Rumeileh et al., 2020; Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Gennaro et al., 2021; Halpin et al., 2020; Havervall et al., 2021; Huang et al., 2021; Logue et al., 2021; Nalbandian et al., 2021; Taquet et al., 2021; Taquet et al., 2020; Zhou et al., 2020)
- Systemic Symptoms: **fatigue, post-exertional malaise and reduced physical performance,** elevated temperature/fever (Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Halpin et al., 2020; Havervall et al., 2021; Huang et al., 2021; Logue et al., 2021)
- Pulmonary Issues: **dyspnea, cough,** lung damage (Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Halpin et al., 2020; Logue et al., 2021; Nalbandian et al., 2021; Zhao et al., 2020)
- Cardiovascular Issues: **heart palpitations, tachycardia, chest pain,** myocardial injury (Al-Aly et al., 2021; Carfi et al., 2020; Nalbandian et al., 2021)
- Musculoskeletal Issues: **arthralgia, myalgia, chest tightness** (Al-Aly et al., 2021; Bellan et al., 2021; Carfi et al., 2020; Logue et al., 2021)
- Eye, Ear, Nose, and Throat Problems: **sore throat, runny nose, tinnitus,** hearing changes, ear pain, swallowing problems, voice changes, red eyes (Carfi et al., 2020; Halpin et al., 2020; Logue et al., 2021; Munro et al., 2020)
- Gastrointestinal and Nutrition Issues: **lack of appetite/poor nutrition, diarrhea**, nausea, bowel problems (Al-Aly et al., 2021; Carfi et al., 2020; Halpin et al., 2020; Nalbandian et al., 2021; Zhao et al., 2020)
- Kidney Issues: kidney disease and reduced kidney function (Al-Aly et al., 2021; Nalbandian et al., 2021; Nugent et al., 2021)
- Dermatologic issues: **hair loss, skin rash** (Al-Aly et al., 2021; Huang et al., 2021; Nalbandian et al., 2021)
- Endocrine, Sexual/Reproductive, and Genitourinary Issues: newly diagnosed diabetes, erectile dysfunction, continence problems (Al-Aly et al., 2021; Halpin et al., 2020; Nalbandian et al., 2021; Sansone et al., 2020; Sathish et al., 2020)
- Immunologic and Autoimmune Issues: Sjögren (Sicca) syndrome (Carfi et al., 2020)
- Reduced Daily Functioning and Quality of Life: **inability to resume normal activities, reduced work and social functioning** (Carfi et al., 2020; Chopra et al., 2020; Halpin et al., 2020; Huang et al., 2021; Logue et al., 2021)
- MIS-C and Long COVID in children and adolescents (Feldstein et al., 2021; Feldstein et al., 2020; Nalbandian et al., 2021)

Note: Symptoms more commonly reported across studies have been bolded..

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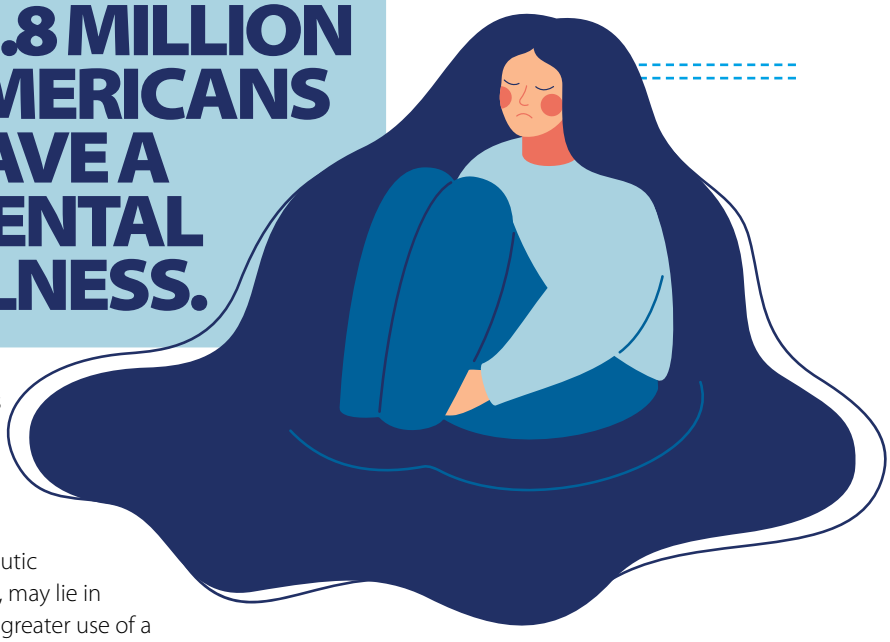
CLASSIFIED

THE TIME HAS COME FOR DO-IT-YOURSELF MENTAL HEALTH STREAM AND T.V.

JOSEPH CAUTILLI, PhD
MIKE WEINBERG, PhD

43.8 MILLION AMERICANS HAVE A MENTAL ILLNESS.



According to the National Alliance for the Mentally Ill (NAMI), 43.8 million Americans have a mental illness. Less than half the people with mental illnesses receive treatment [Substance Abuse and Mental Health Services Administration (SAMHSA), 2015], leading or contributing to a vast number of health problems. The culmination of this situation is that people with mental illness, including substance abuse, die twenty-five years earlier, on average, than those without a diagnosis of a psychological disorder (National Association of State Mental Health Program Directors Council, 2006). In addition, the number of people impacted by those with a psychological disorder expands as the impact on families is considered. Those suffering with mental illness and not receiving treatment could be considered a social justice issue in the sense of the writings of Augustine of Hippo, who some believe battled depression himself (Aleteia, 2018), and thus an issue requiring advocacy.

There is reason to suspect the problem of mental health service access is getting worse. In the face of a growing US population, mental health dollars have received substantial cuts – to the tune of five billion dollars from 2009 to 2013 (Szabo, 2014). The answer to problems of cuts in funding and reaching difficult to access populations, such as older adults and rural populations and those who do not desire to be involved in a therapeutic relationship, may lie in developing greater use of a communication technology, which has been around for close to eighty years (the television).

The US has reached the time for the mental health fields to develop effective prevention and intervention techniques that can be delivered to consumers through mass media. We are seeing more reasons to offer clinical and therapeutic services via online means especially in situations such as pandemics or epidemics requiring the public to not gather in any public place including clinicians' office waiting rooms, and in-person sessions. This is a life-saving practice. But telehealth will only get us so far. A recent study by Rand Corporation found that while some increase in telehealth usage occurred in rural areas, it did not rise to nearly the same extent as urban areas and overall usage dropped when observing losses in-in person services (Cantor et al., 2021).

This suggests that more and varied types of intervention may need to be utilized to attack the problem. One method would be a mass media approach based on the development of a television/streaming channel. It could be cost free (see Strimm http://www.strimm.com/), part of a free, public access channel and can provide both online and traditional television viewing

availability for psychosocial mental health and biobehavioral health treatments. Considerable research has been conducted to show the effectiveness of mass media approaches in health campaigns (e.g., Wakefield et al. At this time there a lack of evidence suggesting that such success cannot be transferred to mental health issues, especially if such stations use a science board of five or six psychologists with strong behavioral, skills based, and cognitive behavioral training. Such a board would support analysis of the research to determine if a particular technique or skill has sufficient evidence to warrant its being scripted on a television or streaming service. Such an approach would represent a core psychologist value: giving away psychology.

The giving away of psychology is certainly not new. For example, Miller (1969/1970) in his presidential address advocated for this position. One such approach to giving away psychology has been the self-help movement. Self-help or what might be termed — Do It Yourself — has an extensive literature base with demonstrated effectiveness. For example, Guild and Clum (1993) reviewed 40 self-help studies and found the average effect size on treatment to be .76 and on follow up to be .53. This is a large effect during treatment and moderate range post treatment. By the early 2000s, many meta-analytic studies on self-help were being conducted. For example, a moderate effect size for treating Obsessive-compulsive Disorder (Pearcy et al., 2016) was found, a large effect size of .8 for Cogntive-behavioral therapy (CBT) self-help in insomnia (Yan-YeeHoa et al., 2015), a large effect size was also found for binge-eating disorder for CBT self-help (only smaller than in person CBT) (Hibert et al., 2019). A moderate effect size was found for mindfulness and acceptance (Kavanaugh et al., 2014). A moderate effect size was found for CBT for anxiety and depression (Ferrand & Woodford, 2013). CBT is not the only treatment intervention that lends itself to self help and has received meta-analytic support. For example, French et al. (2017) found Acceptance and Commitment Therapy, a contextually based behavior analytic therapy, rendered by self help to have a small but persistent effect size on psychological flexibility, anxiety, and depression. Even psychotherapy for depression appears to have at least one meta-analysis showing it to be as effective as in person psychotherapy (Cuijpers Donker et al., 2010).

The US has reached the time for the mental health fields to develop effective prevention and intervention techniques that can be delivered to consumers through mass media.

Indeed, there is nothing to suggest that most manualized treatments cannot be implemented in an educational format and offered in a television or streaming format. I would suggest programming could range from behavioral parent training such as PCIT for children with conduct disorder and other behavioral problems; interventions to help children acquire language skills; problem solving; social skills training for teens; and treatment of adults with anxiety and depression. Indeed, over twenty-five years has passed since the first publications on evidenced-based mental health practices (i.e., Chambless et al. 1998; Chambless et. al. 1996); all these interventions are ripe for translation to publicly-available media more accessible by the community. Pennsylvania can lead the change in this area, as much of the state is rural and even densely-populated areas have difficulty with adequate access to services.

For the consumer, there is a core focus in America on Do-It-Yourself (DIY) interventions, as this is an American value. There was a mass explosion of people subscribing to this view back in the 1950s, which has continued to grow today (Science Museum, 2020). Indeed, YouTube fosters thousands of content creators, based on people wanting to fix everything from their cars to their backs. Thus, to a core group of consumers, EBPs might be the only option they feel comfortable receiving. It allows them to feel empowered and to control their future.

All in all, it seems clear that communities that effectively implement such transition to accessible media, will undoubtedly see improved numbers in mental health, while those that do not, will stagnate and have considerable difficulty reaching core constituencies of behavioral health consumers. Psychologists should be leading the way to advocate for offering no-cost services (Miller, 1969) using behavioral technologies for a better society. In these difficult times, behavioral health issues are more likely to

increase in our society and the need for effective, online, free or low-cost interventions are at a critical level. The time has arrived to pursue these endeavors to improve the lives of the citizens of the commonwealth.

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CONJOINT BEHAVIORAL CONSULTATION (CBC) EXPANDING PARENT AND TEACHER SKILLS

RICHARD E. HALL, PhD, *Chairperson of the Pennsylvania Psychological Association: School Psychology Board*

Early in my career, I worked with students with severe emotional/behavioral disorders as a "Prescriptive Teacher-Counselor-Liaison Worker" for a residential treatment center in Pittsburgh. This was a professionally and personally formative experience as I learned how to implement research-based approaches to positive behavior change. I saw the extraordinary power of involving parents in developing and implementing the therapeutic effort. I observed that where parent involvement was limited, student-response was minimal.

With parent involvement that was respectful, open, and focused on solutions, student response to therapeutic efforts was dramatically improved, more easily generalized, and sustainable. This led me to explore consultation models which specifically included parents/caregivers in the consultation process. The one that stood out was the Conjoint Behavioral Consultation (CBC) model developed by Sheridan, Kratochwill and Elliott (1990).

In this article I will provide a review of research supporting CBC and describe the model and how to implement it in clinical practice. I will focus on the available large-scale reviews and meta-analyses, specifically those that provide support for its efficacy as a model useful in a wide range of circumstances.

Research Base

CBC's efficacy has been studied using rigorous, randomized control trial methodology (Sheridan, Bovaird, Glover, Garbacz, Witte & Kwon, 2012). Findings show that CBC resulted in significant positive student outcomes, parent outcomes and improved parent-teacher relations. Positive behavior change was noted in both home and school and were sustained over a 6-month period. Experimental studies of academic outcomes (Power, Mautone, Soffer, Clarke, Marshall, Sharman & Jawad, 2012) showed significant improvement in student

academic engagement, family involvement in education, and family-school collaboration. Studies exploring CBC implementation have shown that the model can be reliably implemented with a high degree of treatment integrity (Sheridan, Swanger-Gagne, Welch, Kwon, & Garbacz, 2009). Suffice to say the CBC model has extensive research support for its efficacy, flexibility, reliability, and integrity of implementation.

CBC Implementation

The goals and objective of the Conjoint Behavioral Consultation model are summarized in the table below.

GOALS AND OBJECTIVES OF CBC

Goals

1. Promote healthy development of children through cross-system intervention development
2. Build capacity of families and educators for data-based decision making and evidence-based intervention implementation
3. Establish and strengthen home-school partnerships

Outcome Objectives

1. Obtain comprehensive, functional progress monitoring data.
2. Establish intervention plans across home and school and program for generalization and maintenance of intervention effects
3. Improve skills, knowledge, and behavior of families and educators for immediate and ongoing problem-solving

Relational Objectives

1. Establish and strengthen relationship within and across home and schools
2. Improve communication, knowledge, and understanding across home and school to maximize opportunities to meet the needs of the family, child, and school
3. Promote perspective taking, shared ownership of educational goals, and joint responsibility for problem solution

Note. Table adapted from Sheridan, S. M., Clarke, B. L., & Ransom, K. A. (2014). The past, present, and future of conjoint behavioral consultation research. In W. Erchul, & S. Sheridan (Eds.), Handbook of research in school consultation (2nd ed., pp. 210–247). New York, NY: Routledge

These goals and objectives are achieved by working through the following four consultation stages using structured meetings, interviews and semi-structured contacts between the consultant and consultees (i.e., parents and teachers): 1) Conjoint Needs Identification, 2) Conjoint Needs Analysis, 3) Conjoint Plan Implementation and 4) Conjoint Plan Evaluation. Although not considered a specific stage, Pre-Consultation activities can be an important antecedent to the consultation process where roles for each participant and outcome expectations are clarified.

Stage 1 Conjoint Needs Identification

In this stage, parents and teachers are guided by the consultant to develop a collaborative working relationship as they determine the students' needs for behavior change across home and school. The Conjoint Needs Identification Interview is used to determine agreed-upon target behaviors which are defined in measurable terms and to identify procedures for collecting baseline data in home and school settings. An important goal of this stage is to promote a positive relationship between parents and teacher. The consultant is available to assist with data collection and to answer any questions that might arise.

Stage 2 Conjoint Needs Analysis

At this stage, the consultant guides the consultees in developing therapeutic strategies that can be effective across settings. The consultant and consultees explore environmental variables that affect the achievement of desired goals such as setting events and ecological conditions (e.g., classroom seating, delivery of instruction, environmental distractions, etc.). They collaborate to develop a research-based and solution-focused intervention plan targeting problem behaviors in home and school. The consultant facilitates collaboration by recognizing and incorporating parents' and teacher's suggestions into the plan. By reinforcing the equal participation of parents and teacher shared ownership of the plan can be achieved. This shared ownership increases commitment to the plan and the integrity of the intervention implementation.

Stage 3 Conjoint Plan Implementation

At this stage consultees are implementing the plan in home and school. The consultant is in frequent contact with parents and teacher using phone calls, email, texts, and personnel visits to provide support and encouragement. The consultant uses specific strategies to ensure the plan is implemented as intended., e.g., shared development of the plan, articulation of the plan in writing describing each step-in detail and ongoing performance feedback. Other treatment integrity strategies may include modeling plan components and consultee self-monitor their adherence to the plan.

Stage 4 Conjoint Plan Evaluation

This is the final stage of the CBC process. Using the Conjoint Plan Evaluation Interview, the team examines behavioral data to

determine: (1) if the goals of consultation were achieved, (2) if the plan was effective in both settings and (3) what are the future courses of action (continue plan, end plan, fade plan and/or plan for maintenance and follow-up). The discussion at this stage focuses on how to address possible future concerns, identifies resources, supports and networks available to assist in the maintenance of goals and skills achieved and ways to communicate if problems arise and consultees require assistance.

Conclusion

Conjoint Behavioral Consultation is a model where parents and teachers guided by a trained consultant collaborate to meet a student's needs. Positive student behavior change is achieved through skills development in parents and teachers. The ultimate outcome is not only an improvement in student's skills but the capacities of parents and teachers to meet the social, behavioral, psychological, and academic needs that students present.

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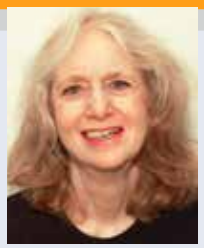

SOCIAL JUSTICE IMPERATIVE IN SCHOOL PSYCHOLOGY TRAINING AND PRACTICE: A Second Interview with Celeste Malone

JULIE MERANZE LEVITT, PhD

Celeste Malone, PhD, Associate Professor of School Psychology at Howard University and president-elect of the National Association of School Psychologists (NASP), reflected on the importance of social justice in training school psychologists in this follow-up interview. We discussed topics including equal access to services, impact of being raised in Harlem, and the charge to cherish and support cultural communities.

Social Justice

School psychologists, Dr. Malone argues, may have difficulty understanding what social justice in practice is about. Social justice includes unbiased service delivery at the individual level and throughout the delivery system, including ending how the system itself unwittingly diminishes the worth and contributions of members of non-dominant cultures. She argues that there is need for services for all children but that we must go further. We must ensure that children and families are recognized as equally worthy as recipients even while their worthiness and style of presentation may not look the same as those who are white. How we may inadvertently contribute to marginalization of people of color must be addressed with actions designed to change the tendency to disregard those who are different and our readiness to define them as less competent and unapproachable.

Dr. Malone contends that training in academic psychology programs needs to foster heightened understanding of social justice issues for minorized children, families, and communities and that we as psychologists should work to ensure that people who do not look like and behave exactly like those from the dominant white culture are treated as equals within our society. In *Demystifying Social Justice for School Psychology Practice* (Malone & Proctor, 2021), Drs. Malone and Proctor discuss the need for equal power and access to service for all cultural groups in our society, without trivializing the differences among groups. Drawing from Grapin (2016), she argues that action must be taken to reduce the trivializing and disregard of contributions and needs of minoritized populations. An example of steps to revamp school policies can be found in School Pathways to the Juvenile Justice System (Hughes, Raines, & Malone, 2020). Dr. Malone refers to a model for faculty and students that includes three levels of advocacy: client/student, school community, and public arena (Malone & Proctor, 2021). An example of revamping school policies in all three levels is found in School Pathways to the Juvenile Justice System (Hughes, Raines, & Malone, 2020). The article presents an overview of what change could look like in a school system when faculty, students, and other power holders work for change.

Dr. Malone argues that we must prevent perpetuation of silos, i.e., segregating difficult conversations from discussion by not openly addressing them. The minoritized must get into conversations, and beyond committees of organizations, into leadership groups in schools, professional organizations and community efforts.

Considering Personal Background and its Place in one's Professional Journey

We explored background factors that predisposed her to take on the daunting issues of injustice, activism, and training.

What she said took me by surprise. About social justice in schools and education she shared that, "It's not just something I've read about. Like, this is my life." Her graduate work in school psychology validated the experiences earlier in her life and gave her the language and evidence that allowed her to move forward.

Dr. Malone grew up in New York Harlem, the child of immigrants from the British Virgin Islands who chose to emigrate here. While there were differences in culture and background experience because her family background had not included slavery in the United States, her family's background did include colonialism and oppression. Mostly everyone came from a background of historical oppression. What she experienced in Harlem was a vibrant culture with other Black students in a place that celebrated the Black culture as a community. She attended parochial school in Harlem where Black history was celebrated, including appreciation of the diaspora of Black citizens that incorporated a vast, deep, rich history greater than being enslaved and oppressed in America. Harlem streets were named for Malcolm X, Adam Clayton Powell, Martin Luther King, and Marcus Garvey; Black holidays were celebrated with enthusiasm. In essence, she was immersed in Black culture. The irony of her location in the city, however, did not escape her: the area where Columbia University is housed was called Morningside Heights, isolating the university from its residence in Harlem. She believes she was inoculated from microaggressions from white faculty and students in her high school to some extent by being raised in a community that saw the Black experience as greater than a comparison to those from white privilege.

Cherishing one's Own Culture

We discussed what she sees as important emerging from that culture. Dr. Malone thinks we need to cherish and support cultural communities that are different. For example, Harlem was diminished by having no movie theaters until the 1990s when Magic Johnson financed its first movie theater. Historically Black colleges and universities (HBCU) would benefit from funding. Rather than removing children from their communities to expose them to elite white culture, we should be enhancing their brick-and-mortar infrastructure (e.g., HBCUs) and opportunities to learn and question in their own environment. Dr. Malone further believes that we need a better understanding of mentoring and how to become more expert in working with children from different cultures with whom we can dialogue. Mentors from one's own group become important.

Research Investigation and Place of What Background We Bring to Teaching and Mentoring

Within academic settings, she is saddened that areas of inquiry about one's own culture can be disregarded as a scholarly area of inquiry. All of us, she maintains, are grounded in our own cultural experience and norms and these experiences are a valid area of study, not niche areas of no consequence. Reexamining of our reality and how we work with realities of others must be studied. She is focused on the experience of being Black in America and sensitizing Black individuals to find ways in which they can enter and change existing structures. She encourages joining and participating in committee work of professional organizations, but cautions that the minoritized need help in navigating in systems that that have not been transparent. This is where faculty of color is necessary and support from white faculty, essential. Dr. Malone maintains each cultural group needs to work with its own to build understanding and capacity. Her concentration is on those who are Black, mine, as a white psychologist, must be to sensitize those who are white and learn better how to work with them. I shared an experience of working with a white neighbor in Maine who welcomed a chance to explain his origins and why his belief system in politics differed so from mine. Our relationship and understanding deepened. Dr. Malone responded that this cannot be her concern. I need to work with white populations—her focus must be engaging with Black individuals.

Where Do We Go from Here?

In working harmoniously between cultures, we need to keep in mind that this is a long game. This kind of mentoring must be incorporated into educational programs. We also need more Black faculty in school psychology, faculty willing to work with students about what is needed and how to make changes. She also believes that Black faculty and others of color will need support in finding ways to change systems without reacting as though others are personally attacking them. Being ready to call out defensiveness and redirect it is important. The real work is changing the culture and all of us are needed to work with our own groups. Only by actively seeking to breakdown systems that oppress our children and families will change occur. Psychologists and educators are needed to uncover areas of systemic oppression and to insist on equity for all children, families, and academics/teachers who work with them. Dr. Brad Norford, in his acceptance speech as PPA President, *Being in the Room Where it Happens,* (6/18/2021), spoke about why we as psychologists must concentrate on inclusion of all cultures and end racism as a new reality. PPA must be a leader in this effort and it is imperative that people of color be at the table.

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SCHOOL BEHAVIORAL HEALTH ASSESSORS

Opportunities for School Psychologists

HELENA TULEYA-PAYNE, DEd

As a school psychologist and former university trainer, I know the importance of keeping up to date with legislative acts and Pennsylvania Department of Education regulations that impact my roles and have implications for the clients I served. It took being appointed to a state-wide committee to become more fully aware of additional supports and opportunities that are available to school entities. The purpose of this article is to inform the reader of the work of the School Safety and Security Committee, (SSSC) and the opportunity to serve as assessors of student assistance and behavioral support for school entities.

In June 2018, Act 44 amended the PA School Code and charged the Pennsylvania Commission on Crime and Delinquency (PCCD) to house the SSSC who was tasked "….with developing the criteria school entities are to use in performing school safety and security assessments, issuing a survey to school entities to measure school safety and security preparedness, and administering grants." Written into the Act, are the criteria for membership on the committee including "…A child psychologist who specializes in mental, social and emotional development of children recommended by the Pennsylvania Psychological Association." I was subsequently appointed by Governor Wolf to the committee. (As an aside, more evidence that PPA is judged by policy makers as relevant to serving the needs of the public.)

One of the primary tasks of the SSSC committee was to develop criteria that guide assessments required by school entities including security assessments (e.g., school buildings) and student assistance and behavioral health assessments. To be clear, the assessments are for the school entity as a whole, not for individual students. Members of the committee recommended individuals with relevant expertise to form workgroups who drafted criteria that were then approved by the committee.

Security assessment includes documentation of physical security measures and identification of vulnerabilities of a physical school building. Criteria for

behavioral health assessment include identifying the presence of interventions at the universal, at risk and intensive levels, access to mental health services, and access to community resources.

Criteria for assessors was also established. Depending on skills and work experience, potential assessors could meet the requirements for security assessors, behavioral health assessors or both.

School psychologists are among the professionals identified as meeting the requirements to be behavioral assessors yet few have applied. One barrier for some potential applicants appears to be the lack of a specific assessment measure. Two newly development tools should assist with this concern. *Baseline criteria* for the presence of behavioral health supports in the schools are presented at tier 1 level (basic needs met) to tier 2 and tier 3, each higher level indicating expanded support. For example, concerning the presence of SAP teams, Tier 1 lists at least one SAP team in the school entity, Tier 2, one SAP team at each level (elementary, middle, and high school) and Tier 3, one SAP team in each building. A companion assessment tool, the *School Safety and Security Assessment Toolkit,* provides a checklist based on the baseline criteria.

I encourage those interested in assessment at the systems level to consider becoming behavioral assessors. School psychologists are ideal for assessing behavioral level supports. Whether to become an assessor for your own district should be evaluated. If you are asked to complete the assessment and subsequent report, you may wish to request compensation if other work duties are not removed.

I would be happy to answer any questions about this opportunity. You can reach me at helena.tuleya-payne@millersville.edu .Ms. Carol Kuntz, Program Manager, School Safety, PCCD, carkuntz@pa.gov is also available for any application questions.

Below are links to relevant documents:

School Safety and Security Assessment Provider Registration Criteria. *Use this site to determine if you have the credentials and experience to apply:*

https://www.pccd.pa.gov/schoolsafety/Documents/Registration%20Criteria%20for%20Assessors%20-%20adopted%20Sept%2026%202018.pdf

School Safety Application. *You will be directed to create a Keystone login:*

https://portal.pccd.pa.gov/schoolsafety

Baseline criteria for behavioral health assessors:

https://www.pccd.pa.gov/schoolsafety/Documents/Assessment%20Criteria/Behavioral%20Health%20Baseline%20Criteria.pdf

School Safety and Security Assessment Criteria Toolkit

https://www.pccd.pa.gov/schoolsafety/Pages/Assessment-Criteria.aspx

Additional references:

Act 44: Public School Code of 1949-Omnibus Amendments

https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2018&sessInd=0&act=44

SPOTLIGHT ON THE PPA MEMBERSHIP COMMITTEE

At PPA, we are committed to strengthening the practice of psychology in Pennsylvania through our most valuable resource: OUR MEMBERS. The purpose of the membership committee is threefold: 1. To continue to increase the numbers of ECPs and Students in the Association to keep us strong and relevant; 2. To provide members with opportunities to interact, learn and grow through mentorship and networking, both across the state and regionally, through connecting hours and other networking opportunities; and 3. To recruit new members and student members of diverse backgrounds and disciplines, in order to remain diverse and engaged.

In 2020-21, PPA membership exceeded more than 3,000! We launched our Mentorship program, PPA Connect, which is designed to allow PPA members the opportunity to engage with each other. PPA Connect allows established psychologists, early career psychologists, graduate students, and undergraduate students to serve both mentor and mentee roles. Last, but not least, all our dues paying members, especially our mid-career and established psychologist members, should know that their membership dues help to support our undergraduate and graduate student members, the future of Psychology in PA! Their continued support makes our FREE student memberships possible!

If you think you might have an interest in joining us, please don't hesitate to reach out to Michelle Wonders, Chair, at michellewonders01@gmail.com.

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 CAT 1 CME.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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

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

TALKING ABOUT VACCINES IN SESSION

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

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the two of us, respondents to this vignette included Drs. Allison Bashe, Claudia Haferkamp, Sam Knapp, Deb Kossmann, Don McAleer, Jay Mills, Max Shmidheiser, and Dave Zehrung. Rather than immediately reading our responses, consider reviewing and carefully working through the vignette first.

Sr. Healer, unaware of the last-minute uzie entered treatment with somewhat vague treatment goals, although Dr. Available believed her symptoms stemmed from (possible) child sexual abuse. Dr. Available initially met with Suzie via teletherapy, but Suzie's internet was unstable in her home and car and, thus, treatment floundered. Suzie requested that they meet in person, as she was very "clean," although unmasked in the community. Dr. Available was fully vaccinated and acquiesced to this request against her better judgment.

Suzie did disclose a history of child sexual abuse. At the end of their first in-person session, Dr. Available strongly urged Suzie to get vaccinated if she wanted to continue in-person treatment. Before their next session, Suzie called to cancel, saying that she felt pressured to get vaccinated against her better judgment and that she would be looking for another therapist.

The Problem with Boundaries

Boundaries keep us safe and, as many of us argued, should be really firm initially, as it is difficult to walk back from too loose a boundary. Unfortunately, boundaries have loosened considerably during COVID. Now clients have our cell numbers as back-ups for when either party experiences internet problems, and they are texting in between sessions. Before COVID, we knew the rules, and we'd seen and responded to many common clinical dilemmas before. We had thought through many of the possible consequences of such dilemmas. As things reopen, rules continue to change, and people often have shifting and unclear boundaries. These changing rules and boundaries put all psychologists, including Dr. Available, at risk. Further, this has been a time period when many clients and therapists have shared similar concerns about COVID and are unsettled.

In order to do the work she faced, Suzie needed to feel comfortable, which Dr. Available may have been considering when she agreed to meet in person despite Suzie's vaccination status (an issue of beneficence). On the other hand, Dr. Available must also feel safe and comfortable, otherwise her discomfort would likely compromise her competency during treatment. As several people observed, "the therapist always has to sit in the most comfortable chair." Safety may come with costs, however. One of us had a client's weapon accidentally revealed during a session. When asked to take the weapon to the car, the client never returned. Unfortunately, Dr. Available's request regarding vaccination may have interacted with Suzie's anxieties about talking about child abuse and possibly reinforced feelings that adults and people in authority are untrustworthy.

But we aren't only talking about Suzie's and Dr. Available's comfort levels, we must also consider the needs of other people who may be influenced by our client's decisions (public beneficence): our aging office mates, other clients who may be immune-compromised, and their families and friends. Perceptions of the riskiness of a decision may shift across time as we gain additional information about the

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

people who may be affected by Suzie's vaccination status and as the science and the recommendations made by the Centers for Disease Control and Prevention's recommendations shift. As Dr. Haferkamp observed, it is difficult enough to set good boundaries around limiting COVID exposure in our *personal lives, much less in the more complex environment of the therapy room.*

What Role does Education Have in the Therapy Room?

Our discussion came back to an issue we have been circling throughout COVID: to what degree should we be attempting to educate clients during treatment? Most of us engage in some psychoeducation about sex, pain, relational health, etc. How is talking about vaccinations and masking different from talking about these issues – as most of us agreed it was?

Talking about sex, pain, and relational health is often relevant to a client's treatment goals, while talking about vaccinations and masking may not be. It would have been different if Suzie had specifically asked, "Do you think I should get a vaccine?"

Even when we are talking about science, we may still be proselytizing and intentionally or unintentionally abusing our therapeutic power (infringing on a client's autonomy) with possible negative consequences. Instead, as Dr. Haferkamp observed, we need to feel out our clients' concerns, engage in active listening, and validate their feelings, concerns, and fears.

Of course, some clients are more open to differences in opinion than others, due to their dogmatism, suspicions of others who are different from them, and partisan attitudes (Knapp et al., in press). Knapp and his colleagues recommend against intervening to change vaccination attitudes under these circumstances. Further, Dr. Available may have misevaluated her relationship with Suzie and how her intervention would be perceived. Especially early in treatment, therapists tend to be less accurate in their judgments about the strength of the therapeutic alliance (Castonguay et al., 2006).

What About Politics?

For some of us, vaccinations mean a return to normalcy, a commitment to protect loved ones and our communities, and a willingness to trust science and physicians. For others, vaccinations are seen as infringements on personal liberties to address an issue that is no more dangerous than the common flu (Knapp et al., in press). Not surprisingly, these differences in attitudes are related to race, educational levels, and political affiliation (Leonhardt, 2021). In addition, people recommending vaccinations may be tainted by the political party they are perceived to belong to rather than their actual affiliation. Although Democrats are more likely to get vaccinated, so are educated health professionals (Leonhardt, 2021); therefore, some psychologists encouraging vaccinations may be miscategorized.

Conclusions

Dr. Available stepped into a difficult situation without thinking it through carefully, perhaps because of her own stress and confusion about COVID and vaccinations and her desire to meet Suzie's need for in-person therapy. Suzie's decision to end treatment may have been related to negative feelings associated with Dr. Available's presumed political party, an attempt to avoid discussing issues of child abuse, or feeling patronized and controlled. Dr. Available was trying to do good, but as Dr. Mills argued, one of the consequences of failed attempts at beneficence is that we kick ourselves for our mistake. However, when a client leaves therapy prematurely, it does not necessarily mean that a mistake was made or therapy was a failure. What could Dr. Available have done differently?

1. **Set clear boundaries from the beginning.** As this appears to have been a divergence from Dr. Available's typical boundaries, it would have been helpful if she had considered her decisions more carefully, including likely consequences of her decisions.
2. **Evaluate the strength of their therapeutic alliance.** Talking about vaccinations with clients isn't wrong, but it may be ill-advised or ill timed, especially when the therapeutic alliance is relatively weak. Listening carefully to clients can help them reflect on their attitudes and behaviors (Knapp et al., in press). People are more likely to continue talking to people they perceive as receptive and willing to listen to them even if they disagree, especially those who frame their ideas positively; explicitly acknowledge understanding; find points of agreement; and hedge to soften claims (Yeomans et al., 2020).
3. **Effectively communicate about vaccinations.** Dr. Available might choose to talk about vaccinations anyway. If so, her message would have been more effective when she was transparent and candid in her message, framed her message positively, encouraged prosocial values like empathy and responsibility to the larger community, and framed socially-desirable behavior as normative (Knapp et al., in press). In addition, being transparent about Dr. Available's comfort level meeting with Suzie in-person would be important. The National Academies of Sciences, Engineering, and Medicine (2020) recommend avoiding repeating misinformation, even to debunk it, as this may unintentionally strengthen the myth.

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CE QUESTIONS FOR THIS ISSUE

EARN 1 CE CREDIT FOR THIS ISSUE!

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

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of **$25 for members ($50 for nonmembers) and mail to:**

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

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

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

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

Painless Ways to Keep Up with Research

1. **Psychologists should only read journals from cover to cover in order to keep up with current research.**
   TRUE
   FALSE

Tackling Misinformation: A Tale of Collaboration

2. **Parents frequently turn to the Internet and social media for information.**
   TRUE
   FALSE

3. **The Collaborative for Science-Based Information on Children, Youth, and Families (CSICYF) is part of APA.**
   TRUE
   FALSE

Educating Clients about Decentering from Responsibility for Their Oppression

4. **Use of the passive voice, instead of the active voice, is a useful strategy for clients and psychologists when promoting the client's decentering from responsibility for oppression.**
   TRUE
   FALSE

5. **The Healing Ethno and Racial Trauma (HEART) framework is relevant only for clients from marginalized and ethnic groups.**
   TRUE
   FALSE

Post-Acute Sequelae of COVID-19: Considerations for Psychologists

6. **The severity and duration of persisting symptoms in the post-acute phase of COVID-19 appear to be less than what is seen in other common community-acquired infections such as seasonal influenza and bacterial pneumonia.**
   TRUE
   FALSE

7. **Clinical course and recovery time following COVID-19 are highly variable and may involve fluctuating patterns of symptoms along time.**
   TRUE
   FALSE

The Time Has Come for Do-It-Yourself Mental Health Stream and TV

8. **CBT self-help for eating disorders**
   a. Has never been tried
   b. Has a small effect size
   c. Has a moderate effect size
   d. Has a large effect size

9. **Self-help in an Acceptance and Commitment Therapy model for anxiety**
   a. Has never been tried
   b. Has a small but persistent effect size
   c. Has a large effect size

Conjoint Behavioral Consultation (CBC): Expanding Parent and Teacher Skills

10. **The state of CBC in which the consultant and consultees explore environmental variables that affect the achievement of desired goals is**
    a. Needs Identifications stage
    b. Needs Analysis stage
    c. Plan Implementation stage
    d. Plan Evaluation stage
    e. Pre-Consultation stage

11. Which of the following would be considered a "Relational Objective" of Conjoint Behavioral Consultation?

a. Obtain comprehensive, functional progress monitoring data
b. Improve skills, knowledge, and behavior of families and educators for immediate and ongoing problem-solving Plan implementation stage
c. Establish intervention plans across home and school and program for generalization and maintenance of intervention effects
d. Promote perspective taking, shared ownership of educational goals, and joint responsibility for problem solution
e. Identify specific functional relationships between problem behaviors and environmental variables

Social Justice Imperative in School Psychology Training and Practice: A second interview with Celeste Malone

12. Dr. Celeste Malone emphasizes the need for social justice curriculum in school psychology programs in order to

a. Safeguard that all children are treated with equity
b. Contribute to helping children from underrepresented cultures see the worth of their own groups, the richness of their background, within the broader culture
c. Set up systems that will continue to monitor service delivery and its appropriateness for all children
d. Assure that Psychologists of Color have an equal place at the table in assessing needs of their groups
e. All the above

13. Dr. Malone stresses

a. Supporting communities in which there are underrepresented people, providing services and cultural opportunities that support the richness of their culture
b. Promoting programs that offer new opportunities for underrepresented people to examine and promote their views of needs and modifications of existing programs now in place
c. Actively recruiting school psychology students from underrepresented cultures
d. Actively recruiting faculty for school psychology programs from underrepresented cultural groups
e. All the above

Ethics in Action: Talking About Vaccines in Session

14. When trying to change someone's mind

a. It doesn't matter what our relationship is with that person
b. We are most effective when we are most forceful
c. Sometimes active listening and validation can be most effective in promoting change
d. All the above

15. Which of the following things may have decreased Dr. Available's risk of making a poor decision?

a. Setting clear boundaries that she found more comfortable
b. Communicating more thoughtfully and strategically with Suzie
c. Consulting with peers before making a decision
d. All the above

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, September 2021

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

1.	T	F	5.	T	F	9.	a	b	c	13.	a	b	c	d	e
2.	T	F	6.	T	F	10.	a	b	c	d	e	14.	a	b	c	d	
3.	T	F	7.	T	F	11.	a	b	c	d	e	15.	a	b	c	d	
4.	T	F	8.	a	b	c	d	12.	a	b	c	d	e				

Satisfaction Rating

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

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

Please print clearly.

Name _____

Address _____

City _____ State_____ Zip _____ Phone ( ) _____

Email _____

Signature _____ Date _____

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

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

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Fall Conference MAX
September 24-25, 2021
Lancaster Marriott at Penn Square
Lancaster, PA

Attending in person? **PPA members** can purchase the All-Access Pass for $495 and save over $200!

CONFERENCE SCHEDULE

Course descriptions are available online
Pricing includes CE credit, beverage & snack breaks
For non-member pricing please visit www.papsy.org

FRIDAY, SEPTEMBER 24

8:30 - 11:30 a.m.
W01 - Recent Advances in the Assessment, Clinical Management, and Treatment of Suicide Risk
In-person only: $120
In-person Presenter: M. David Rudd, PhD
3 CE Credits

8:30 - 10:30 a.m.
W02 - Medical Marijuana Research in Pennsylvania (Virtual Presenter)
In-person: $80
Virtual: $50
Virtual Presenter: Kent Vrana, PhD
2 CE Credits

10:45 a.m. - 12:15 p.m.
W03 - Using Ethical Principles to Maximize Positive Therapy Outcomes (Virtual Presenter)
In-person: $60
Virtual: $37.50
Virtual Presenters:Samuel Knapp, EdD, ABPP; Randy Fingerhut, PhD
1.5 CE Ethics Credits

12:30 - 2:15 p.m. - Lunch (meal included)
W04 - Neuropsychology of COVID-19 Long Haulers: Research and Case Examples
In-person only: $90
In-person Presenter: Tad Gorske, PhD
1.5 CE Credits

2:30 - 4:00 p.m.
W05 - Positive Risk Management (Virtual Presenter)
In-person: $60
Virtual: $37.50
Samuel Knapp, EdD, ABPP (Virtual); Molly Cowan, PsyD (In-person)
1.5 CE Ethics Credits

2:30 - 5:30 p.m.
W06 - Recognizing and Responding to Non-Death and Disenfranchised Losses (Virtual Presenter)
In-person: $120
Virtual: $75
Virtual Presenter: Andrea Croom, PhD
3 CE Credits

2:30 - 5:30 p.m.
W07 - Positive Multiculturalism: Does being white make a person part of the problem with race in America?
In-person only: $120
In-person Presenter: David Palmiter, PhD
3 CE Credits

4:15 - 5:45 p.m.
W08 - The Truth about Lies: Dealing with Dishonesty in Therapy
In-person only: $60
In-person Presenter: Ari Tuckman, PsyD, CST
1.5 CE Credits

CONTINUING EDUCATION CREDITS

The 2021 Fall Conference MAX is sponsored by the Pennsylvania Psychological Association and will provide up to 15 CE credits. The Pennsylvania Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. More information is available online.

PPA's Act 31 program is approved by the Department of Human Services (formerly the Department of Public Welfare) and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement. PA CE Provider Number: CACE000007

PPA pays an honorarium to Conference speakers. There are no identified conflicts of interest for speakers for the PPA Fall Conference MAX.

SATURDAY, SEPTEMBER 25

9:00 a.m. - 12:00 p.m.
W09 - Brain Injury 101: An Overview for Psychologists
In-person only: $120
In-person Presenter: Max Shmidheiser, PsyD
3 CE Credits

9:00 a.m. - 12:00 p.m.
W10 - Psychology in the Time of COVID: Self-Care Following Systemic Trauma
In-person: $120
Virtual: $75
In-person Presenter: Samuel Schachner, PhD
3 CE Credits

9:00 - 11:00 a.m.
W11 - Love in the Time of COVID: 365 Days in a Social Bubble - Stir Crazy or Crazy in Love?
In-person only: $80
In-person Presenter: Laurie Appel, PsyD
2 CE Credits

11:15 a.m. - 12:15 p.m.
W12 - Suicide Prevention and the Human Condition: Let's Talk About It
In-person only: $40
In-person Presenter: Nancy K. Farber, PhD
1 Suicide CE Credit

12:30 - 2:30 p.m. - Lunch (meal included)
W13 - Child Abuse Recognition and Reporting
In-person only: $110
In-person Presenters: Rachael Baturin, MPH, JD; Molly Cowan, PsyD
2 CE Credits

2:45 - 3:45 p.m.
W14 - Psychedelic-Assisted Therapy: An Overview of the Research and Regulations
In-person only: $40
In-person Presenter: Max Shmidheiser, PsyD
1 CE Credit

2:45 - 5:45 p.m.
W15 - Prescribing Psychologists: The latest on legislation and training (Virtual Presenters)
In-person: $120
Virtual: $75
Virtual Presenters: John Gavazzi, PsyD, ABPP; Jennifer Collins, PsyD, MSCP
3 CE Credits

4:00 - 5:30 p.m.
W16 - Malignant Narcissism & Power: Toward a Profile, Historical, Treatment, Forensic, & Ethical Considerations (Virtual Presenters)
In-person: $60
Virtual: $37.50
Virtual Presenters: Charles Zeiders, PsyD; Peter Devlin, MSW
1.5 CE Ethics Credits

LOCATION

The 2021 Fall Conference MAX will be held at the Lancaster Marriott at Penn Square: 25 South Queen Street, Lancaster, PA 17603.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Fall Conference MINI
October 8, 2021
Normandy Farm
Blue Bell, PA

PPA members can purchase the All-Access Pass for $250 and save up to $60!

CONFERENCE SCHEDULE

Course descriptions are available online
Pricing includes CE credit, beverage & snack breaks
For non-member pricing please visit www.papsy.org

All PPA Fall Conference MINI presentations are in-person only - there is no virtual attendance option

FRIDAY, OCTOBER 8

9:00 am - 12:00 pm

W01 - Understanding the APA Ethics Code
In-person only: $120
In-person Presenter: Molly Cowan, PsyD
3 CE Ethics Credits

9:00 am - 12:00 pm

W02 - Involving Minors in Decisions about Medical and Mental Health Care (Virtual Presenter)
In-person only: $120
Virtual Presenter: Mary Ann McCabe, PhD, ABPP
3 CE Credits

12:30 - 1:30 pm

W03 - Enhancing Suicide Assessments Lunch Included (Virtual Presenter)
In-person only: $70
Virtual Presenter: Samuel J Knapp, EdD, ABPP
1 CE Credit

2:00 - 4:00 pm

W04 - Act 31: Child Abuse Recognition and Reporting
In-person only: $80
In-person Presenter: Rachael Baturin, MPH, JD
2 CE Credits

2:00 - 5:00 pm

W05 - Effective Tools for Working with Cancer Patients and Caregivers
In-person only: $120
In-person Presenter: Susan Ryan, PsyD
3 CE Credits

We look forward to seeing you in-person at Normandy Farm!

LOCATION

The 2021 Fall Conference MINI will be held at the Normandy Farm Hotel & Conference Center: 1401 Morris Rd, Blue Bell, PA 19422.

CONTINUING EDUCATION CREDITS

The 2021 Fall Conference MINI is sponsored by the Pennsylvania Psychological Association and **will provide up to 7 CE credits.** The Pennsylvania Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. More information is available online.

PPA's Act 31 program is approved by the Department of Human Services (formerly the Department of Public Welfare) and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement.
PA CE Provider Number: CACE000007

PPA pays an honorarium to Conference speakers. There are no identified conflicts of interest for speakers for the PPA Fall Conference MINI.

The Pennsylvania
Psychologist

5925 Stevenson Avenue, Suite H • Harrisburg, PA 17112-1788

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
(In-Person)

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.

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