The Pennsylvania
Psychologist

DECEMBER 2022

VOLUME 82, NUMBER 10

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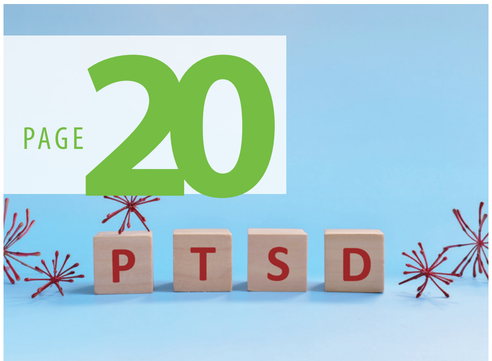

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HOW WOULD YOU SPEND $100M?

JEANNE SLATTERY, PhD

If you had $100 million to improve adult mental health in Pennsylvania, what would you do?

Governor Wolf asked this question of about two dozen professionals and consumers from across the state of Pennsylvania serving on the Behavioral Commission on Adult Mental Health. (PPA nominated me.) Our Commission met for roughly 17 hours over the course of a month gathering data, listening to Pennsylvanians, and struggling to allocate funding wisely. This process was especially difficult, as we were given one-time money, with no guarantee that funding would be continued during the next fiscal year. And, with about 9 million adults in Pennsylvania, this meant we had about $11 per adult Pennsylvanian to work with.

I asked you the same question that our Commission was struggling with. You suggested a range of strategies: increase county subsidies, loan forgiveness programs, and employee salaries; fund services for people who are homeless, underinsured, in crisis, or in transition; increase services to underserved communities; support RxP, trainings in evidence-based treatments, preventative care, and integrative/collaborative care initiatives; modernize our "archaic, inefficient, expensive, penal system"; update technologies and infrastructure in the system; train trauma-informed therapists and police officers; and fund annual mental health "check-ups." Throughout, you were concerned about workforce shortfalls and social determinants of health, while wanting services that would prevent the need for more intensive services later. As Julie Radico observed, this conversation

1. [was] very thoughtful, informative, and [spoke] to the breadth and depth of the work in which psychologists are involved.
2. helped me once again appreciate how complex our mental/health systems truly are.
3. reminded me how powerful brainstorming in a group can be.

In my meetings with the Behavioral Health Commission on Adult Mental Health, one theme we heard repeatedly stemmed from the difficulties recruiting and retaining employees. This concern was true at all points in the spectrum, from certified peer support professionals to licensed professionals. It is truly a seller's market. We allocated $37M for loan forgiveness programs for people working with underserved populations, tuition assistance for people entering behavioral health careers, and opportunities for entry-level staff to attain higher education.

Many people expressed concerns about our criminal justice system. The warden for the Dauphin County Prison, for example, noted that about 45% of people in the county jail were diagnosed with a mental health disorder or on psychiatric medications. Many people observed that a significant number of inmates are inappropriately housed there, as there is no more appropriate place for them to go. We recommended $23.5M for specialty courts for justice-involved people, coresponder models (i.e., mental health professionals working with police departments and other first responders), training for first responders for compassionate handling of behavioral health crises, and diversion programs and re-entry services.

We allocated $39M to expand services to better meet the needs of all Pennsylvanians. Our recommendations included programs to integrate primary care and mental health/substance abuse treatment, strengthen crisis and crisis residential services, and improve peer support and recovery services. In each case, we focused on those initiatives with demonstrated evidence of positive outcomes, programs that will intervene earlier in the process and prevent more intensive services down the line.

Finally, we allocated $500,000 to evaluate the impact of our recommendations, suggested that this Commission continue to consider and address ways of strengthening the mental health system, and recommended that the county system, which had 10% of its funding cut in 2012 and has not received an increase since then, receive increased funding in line with the cost associated with providing critical behavioral health services.

Serving on this Commission was eye opening. I appreciated working with professionals and consumers with different experiences and perspectives than my own and seeing sane and collegial legislators who were passionate about mental health issues. These legislators were clear and vocal about strategies for getting funding passed by the legislature. Many constituent testimonials were effective, especially those that were succinct, albeit not necessarily brief, and included specific examples and data. Although many around the table vocally defended their pet issue, we

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IS IT TIME TO RECONSIDER LICENSURE FOR MASTER'S-LEVEL PROVIDERS?

PAUL KETTLEWELL, PhD, ABPP

For the past 40 years, the American Psychological Association (APA) has advocated for the doctoral degree as the minimal educational requirement for licensure for those with graduate training in psychology. Consistent with that APA recommendation, Pennsylvania adopted the Professional Psychologist Practice Act in 1986, which eliminated licensure for master's-level psychologists. Individuals who obtained master's degrees prior to deadlines established in that 1986 legislation were "grandfathered" as licensed psychologists. After that legislation, the only option for those with master's degrees in psychology who want to practice in Pennsylvania has been as a licensed professional counselor (LPC) or social worker.

For about the last 5 years, leaders in APA have been reconsidering APA's long-standing position. Several APA boards and committees have reviewed this issue and adopted guidelines for master's-level training in current areas of health psychology. The purpose of this article is to review some key issues and consider possible pros and cons of changing our licensing law.

What Obligation Does PPA Have to Support APA Recommendations?

The short answer is none. Each state is responsible for developing its own licensure regulations. Although it is wise to seriously consider recommendations from APA, it is unclear when or if APA will make a specific recommendation for a new model licensing law.

Critical Issues/Challenges for Psychologists to Consider

- **Competencies and Scope of Practice:** Designating competencies (required skills) and scope of practice for both doctoral-level psychologists and those with master's degrees in health service psychology will be critical.
- **Title:** Most of us would support using the title of psychologist for those with doctoral degrees and another for those with master's-level training in psychology. Developing titles that will be both clear within the profession and to the public will be a challenge. Options already used in other states include "psychological assistant" or "psychological associate."
- **Would Supervision Be Required?** When would supervision be required, who would provide that supervision, and how long would supervision be required?
- **Making Sure That We Continue to Support School Psychologists:** School psychologists with master's degrees have been practicing in Pennsylvania for many years. We do not want to pass a licensing law that would limit or hamper their ability to continue to practice.
- **Heavy Lift of a New Licensing Law:** Changing the licensing law would require developing appropriate and detailed draft legislation, finding supportive legislators, and dealing with groups who might be in opposition.
- **Stakeholders:** Who are the key stakeholders in Pennsylvania and how do we best consider their perspectives?

Are There Sufficient Reasons to Pursue Master's Licensure?—Pros and Cons

Con Arguments : Some resistance to this proposed change

- **Diminishing the value of the doctoral degree:** There is concern that licensure for master's-level providers will diminish the perceived value of the doctoral degree in psychology.

- **Confusion for the public:** Will the public be able to understand the difference between doctoral-level psychologists and master's-level providers? The public already has some confusion about differences between psychologists, psychiatrists, social workers, and counselors. This may add more confusion.
- **Insurance companies might reduce reimbursement:** Will this lower the reimbursement that insurance companies provide for psychological services? Would this create unfair competition or diminish earning potential?
- **Should PPA support two major legislative proposals at the same time?** PPA has committed to getting legislation passed supporting prescription privileges for appropriately trained psychologists (RxP). Nobody is suggesting that master's-prepared individuals obtain prescription privileges. Nevertheless, is it reasonable for PPA to now support both of those legislative efforts: master's licensure and RxP?

Pro Arguments:

Some support for this proposed change

- **Improving access to care:** Master's licensure is one method of improving access to mental health care, a serious problem in our country.
- **Avoiding the consequences of a possible limit for future use of LPC by those with master's degrees in psychology:** The Council for Accreditation of Counseling and Related Education Programs (CACREP) has advocated that only those specifically with master's degrees in counseling should be able to become licensed professional counselors (LPCs). Although this is not the case in Pennsylvania now, removing a path to licensure for those with master's degrees in psychology would be harmful to the field, to the universities and departments training them, and the public. Even if the LPC path for master's in psychology remains open, is the LPC label and current associated oversight the best path for master's psychology graduates?
- **Need to advocate for those with master's degrees in psychology:** If we continue to offer master's-level training, we should provide a path for licensure.
- **Helping diversify our psychology work force:** Master's licensure will likely add to racial and cultural diversity of our work force and include more providers who may be first-generation college students. This would broaden our workforce to reflect the diversity more adequately in our society. It would also offer these psychologists a pathway to doctoral-level licensure, one that is currently circuitous at best.

My Perspective

The primary issue that tips the scale for me to support master's licensure is our country's vast unmet needs for mental health services. The frequency of mental disorders in the United States is approximately 20% (Center for Behavioral Health Statistics and Quality, 2016; Merikangas et al., 2010), while approximately 50% of those in need of treatment do not receive any care (Reinert et al., 2021). Lack of access to care is the "elephant in the room"—the most serious problem facing mental health service delivery. A primary contributor to that problem is a shortage of qualified mental health providers. Training master's-level psychologists well and including a path for licensure is a meaningful way to help address that problem.

Additionally, there is a key similarity between the RxP and the master's licensure initiatives. The most compelling argument in favor of both initiatives is that they both address the lack of access to quality care.

I believe that it is our responsibility to address master's-level licensure and now is our time to do so.

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2021-2022 PENNSYLVANIA LEGISLATIVE SESSION ROUNDUP

RACHAEL BATURIN, MPH, JD

As this year comes to an end, so does Pennsylvania's two-year legislative session. As always, PPA has been continuously advocating for the practice of psychology and psychologists during this year's session. This article will highlight some of the key pieces of legislation that PPA focused its advocacy efforts on this year as well as additional advocacy that PPA did on behalf of the practice of psychology.

There were four pieces of legislation that PPA supported and advocated for which were signed into Pennsylvania law this session:

Act No. 146 of 2022 - Streamlines Prior Authorization Review Process

Act No. 146 of 2022 streamlines the prior authorization review process for Pennsylvanians to protect access to health care. This new law lays out the standards for the review of prior authorization requests and codifies that there may be no prior authorization required for emergency services, consistent with the federal No Surprises Act. In addition, oversight of appeals of prior authorization denials will be handled at the state level when Pennsylvania resumes authority over external reviews. The major provisions of this law will take effect beginning in January 2024.

Act No. 96 of 2021 - Improvement of Broadband Access

Act No. 96 of 2021 improves access to high-speed internet in underserved communities by creating the Pennsylvania Broadband Development Authority, a single point of contact for federal broadband funding.

Act No. 21 and Act No. 73 of 2021 and Act No. 14 of 2022 - Extension of COVID-19 Waivers

Act No. 21 and Act No. 73 of 2021 and Act No. 14 of 2022 extends the COVID-19 waivers associated with an array of regulatory statutes, rules, and regulations to aid in Pennsylvania's recovery from the COVID-19 pandemic. This included the waivers from the Department of State regarding supervision and telehealth and the waivers from the Department of Human Services.

Act No. 48 of 2021 - Regarding Financial Exploitation of Older Adults

Act No. 48 of 2021 gives the Attorney General's office concurrent jurisdiction to investigate individuals who use their position of trust to financially exploit older adults and care-dependent people.

In addition, PPA advocated for several other bills this session. These bills focused on issues associated with the practice of psychology (prescription privileges, integrated care, telehealth, scope of practice, school psychology, behavioral health workforce issues, etc.) as well as advocating for patients (prohibiting conversion therapy). (Please see the Bill Box for a complete list of these bills.) Below is a summary of some of the key bills PPA focused on this session.

HB 2607 - Establishing Prescriptive Authority for Psychologists

This session, Rep. Wendi Thomas introduced Pennsylvania's first prescription privileges bill, HB 2607. This bill would amend the Psychologists Practice Act to allow psychologists who obtain an additional masters degree in psychopharmacology the ability to prescribe/deprescribe medication to patients. The bill was introduced in the Pennsylvania House of Representatives, and it had over 40 cosponsors. PPA will be working with the General Assembly to reintroduce this bill in the upcoming session.

HB 2686 - Providing Funding for Integrated Care

This session, Rep. Wendi Thomas introduced legislation that would provide funding for those who who are looking to provide integrated care to patients. The original bill only allowed funds for those who were providing care through the Collaborative Care Model. PPA advocated that the bill be expanded to include funding for both the Collaborative Care Model and the Primary Care Behavioral Health Model. The bill was amended to include this more expansive language. PPA will continue to support this bill when it is reintroduced next session and PPA will make sure that the more expansive language is included in the bill when it is reintroduced.

SB 705 - Providing Insurance Coverage for Telehealth

This session, Senator Elder Vogel reintroduced his telehealth bill, which would require insurance companies to reimburse for telehealth services. This bill passed the Senate and was referred to the House Insurance Committee. PPA will continue to work with Senator Vogel's office if he reintroduces this bill in the upcoming session.

HB 19 - Behavioral Analyst Legislation

This session, Rep. Tom Mehaffie reintroduced legislation that would create licensure for behavioral analysts and assistant behavioral analysts in Pennsylvania. PPA worked closely with his office to make sure that this bill did not infringe on the scope of practice of psychologists. This bill will be reintroduced next session and PPA will continue to monitor it to make sure that the language that we added to the bill will continue to be included in any future drafts of the legislation.

PPA also presented testimony before the House Education Committee and Human Services Committee on ways to encourage and support scientific research-based practices in addressing the mental health needs of the students in public schools in Pennsylvania. Moreover, PPA had representatives serve on the Pennsylvania Commission on Crime and Delinquency's School Safety and Security Committee (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), the Financial Exploitation of Older Adults Task Force (charged with providing recommendations to the General Assembly on how to combat financial exploitation of older adults), and the Behavioral Health Commission for Adult Mental Health (charged with providing recommendations to the General Assembly on the allocation of one-time $100 million funding to address adult behavioral health needs).

Lastly, PPA also monitored regulatory activities by attending State Board of Psychology Meetings and Medical Assistance Advisory Meetings and monitored insurance activities regarding telehealth reimbursement and other insurance practices.

WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT STRESS

MOLLY COWAN, PsyD

It's the time of year when many of us get caught up in the flurry of activity related to the holidays, the end of the year, and seemingly never-ending "to do" lists—both personal and professional. It's also easy to be overwhelmed by stressors—the dark, cold days of daylight savings time; the continued impact of living in a pandemic; the continued demand for our services coupled with increased frustration in navigating "the system;" the challenges of loving family members who are easier to love when we're not sharing the same space; and the pressure to create memorable holiday times without creating entitled, ungrateful monsters. This isn't just me, right?

Stress can contribute to heart disease, high cholesterol, headaches, increased risk for stroke, difficulty concentrating, digestive issues, difficulty sleeping, anxiety, and depression (APA, 2022a). Making significant lifestyle changes are not easy, and it can be difficult to prioritize oneself over a laundry list of competing demands.

APA (2022b) identified strategies for dealing with chronic stress including setting limits on our time commitments, utilizing our support system, enhancing the quality of our sleep, and striving for a positive outlook. The authors also suggest making one health-related change to focus on—do you want to drink more water every day? decrease your caffeine intake? commit to a brief walk at lunchtime? Even small changes can show health benefits. Set your SMART—specific, measurable, achievable, relevant, time-limited—goal and get started. Committing to drinking 64 ounces of water every day is easier to focus on than a vaguer "I want to stay hydrated." It can also be helpful to take advantage of tools such as habit journals, phone reminders, and other external prompts (like water bottles labeled for each hour of the day or fitness trackers that buzz if you've been stationary too long).

There are other small daily changes that can lead to strong mental and physical health benefits. One of these is being purposeful about our social media and news consumption. Social media use has been linked to increased emotional distress, but for many of us, it is unrealistic to fully abstain from social media and our phones (Huff, 2022). This is an area where small daily habit changes can be useful. Consider turning off notifications to decrease the temptation to respond to every "ding" throughout the day. It can also be useful to take technology breaks during the day; some families have adopted "phone free Sundays" or a no-screen policy at mealtimes (you too, adults!). When you want to consume social media, set a timer to help decrease the likelihood of extended doomscrolling.

Another potential shift to consider is increasing your focus on gratitude. Research links increased gratitude and thankfulness to a greater willingness to forgive, improved sleep, stronger relationships, decreased stress levels, and decreased risk of depression, anxiety, and substance abuse (NAMI, n.d.). For those like me concerned about raising good humans, gratitude has also been linked to a decreased focus on social comparison, as well as decreased materialism and increased generosity in adolescents (Chaplin et al., 2019). One way to develop the habit is to spend a few minutes each night writing down at least three things you are grateful for that day; it does not need to be lofty, inspiring things—feel free to take notice of getting green lights on the way to work when you were running late, particularly great hair days, or cleaning out your email inbox.

The helping professions can be particularly vulnerable to chronic stress. Adames et al. (2023) provide 10 reminders to help clinicians maintain healthy personal relationships, including remembering that we do not have a limitless supply of empathy and care, making time to be alone to clear our minds and transition into our personal lives each day, cultivating interests outside of our professional lives, engaging in our own therapy, cultivating a supportive network of colleagues, and "giving ourselves permission to be human" (p. 183).

How do we give ourselves permission to be human? A great start is working on our self-compassion. Kristin Neff identified three components to self-compassion:

self-kindness, common humanity, and mindfulness (Allen & Leary 2010). Most people tend to be much harder on themselves than they are on others. In a nutshell, self-kindness is extending the same grace we would extend to others to ourselves. Common humanity is the recognition that our experiences are part of the human experience; realizing we are not alone reduces feelings of isolation and promotes healthy coping strategies. Finally, mindfulness as a component of self-compassion "involves taking a balanced perspective of one's situation so that one is not carried away with emotion" (p. 108).

We are all trained to help people work through their stressors, achieve personal goals, and care for themselves, but we're also human. How often do we fail to follow our own advice when it comes to our own lives? I encourage each of you, as we turn the calendar to a new year, to commit to one small habit to weave into your daily life to improve your well-being…and if you screw up, be gentle with yourself and try again the next day. We've got this!

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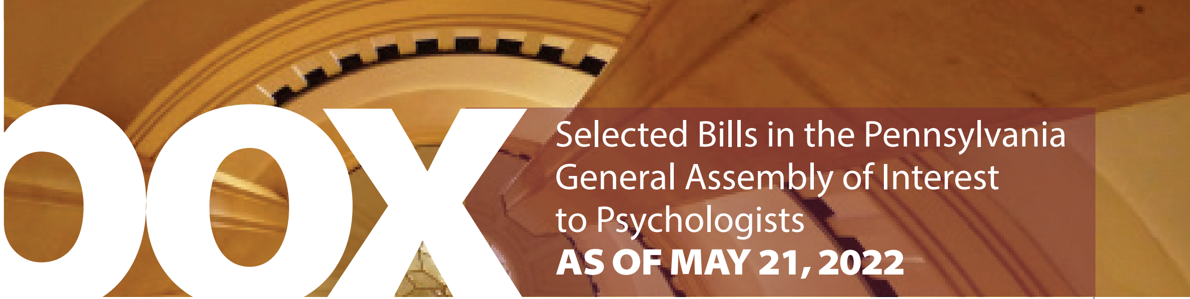
How Would You Spend $100M (Continued from page 2)

developed a shared perspective over our time together.

In my last column, I ask you to consider advocating for the public, to use your psychological knowledge to make a difference to your clients and communities, as I did on this Commission. There are many places where you can advocate: in conversations with friends, family, and acquaintances; when teaching; in Op Eds; and with the legislature. You can advocate for your favorite social justice issues, for better insurance reimbursements, or for the mental health system as a whole. Together, we can make a difference!

My thanks to everyone who contributed to our local discussion, including Gary Ames, Tim Barksdale, Rebecca Billings, Richard Blackfoot, Liz Campbell, Freeman Chakara, Deb Derrickson Kossmann, Eric Franzone, Dana Fry, Aviva Gaskill, Robin Hornstein, Lauren Krug, Marolyn Morford, Louis Moskowitz, Lisa Osachy, Julie Radico, Steve Ragusea, Sam Schachner, Brett Schur, Kerrie Smedley, Keren Sofer, Marijana Stovic, Tanya Vishnevsky, Meredith Weber, and Ed Zuckerman. You make my life better and my work easier. Thank you.

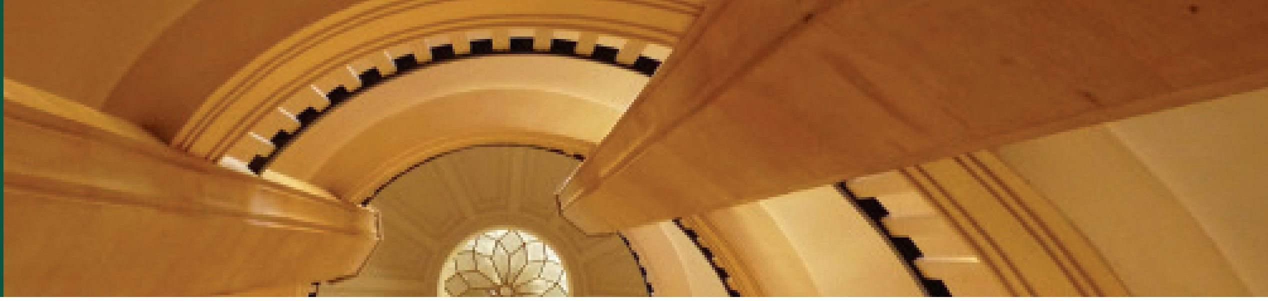


the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

AS OF MAY 21, 2022

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 19	Amends the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, further providing for definitions for respiratory therapists, for perfusionist, for genetic counselor and for prosthetists, orthotists, pedorthists and orthotic fitters; providing for behavior analysts and assistant behavior analysts; and further providing for licenses and certificates and general qualification.	Rep. Thomas Mehaffie (R)	Neutral	Referred to Consumer Protection and Professional Licensure 2/7/22	Third consideration and final passage 2/7/22 (134-66)	
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 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 Senate Consumer Protection and Professional Licensure 3/25/21	Passed the House 3/24/21	
HB 681	An Act prohibiting enforcement of covenants not to compete in health care practitioner employment agreements.	Rep. Torren Ecker (R)	Support		Removed from the table 11/16/2021	
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 3/3/21	
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 Education 4/21/22	Passed the House 4/12/22 (115-84)	
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 Appropriations 1/26/22	Passed the House 6/14/21	
HB 1690	An Act addressing the shortage of mental health services in underserved areas.	Rep. Michael H. Schlossberg (D)	Support		Referred to Health 6/24/21	
HB 2071	Amends Title 64 (Public Authorities and Quasi-Public Corporations), establishing the PA Broadband Development Authority to provide broadband Internet access to unserved residents, and providing for powers and duties of the authority.	Rep. Martin Causer (R)	Support	Third consideration and final passage 12/15/21	Final passage 12/13/21 (202-0)	Act No. 96



Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 2607	An Act amending the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act, further providing for definitions, and providing for conditional prescription certificate, for prescription certificate, for prescribing practices, for prescriptive authority, and for coordination with the State Board of Pharmacy.	Rep. Wendi Thomas (R)	Support		Referred to House Professional Licensure 5/23/22	
HB 2686	An act providing for Collaborative Care Model and Primary Care Behavioral Health Model Implementation Program; and making an appropriation.	Rep. Wendi Thomas (R)	Support		Re-committed to Appropriations 9/14/22	
SB 40	An act providing for behavioral health services and physical health services integration in public assistance.	Senator Kristin Philips-Hill (R)	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	Passed the Senate 6/24/21 (46-4)	Referred to House Judiciary 6/24/21	
SB225	An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, in quality health care accountability and protection, further providing for definitions, for responsibilities of managed care plans, for financial incentives prohibition, for medical gag clause prohibition, for emergency services, for continuity of care, for procedures, for confidentiality, for required disclosure and for internal complaint process, providing for internal complaint process for enrollees, further providing for appeal of complaint, for complaint resolution, for certification and for operational standards, providing for utilization review standards, further providing for internal grievance process, for external grievance process and for records, providing for adverse benefit determinations, further providing for prompt payment of claims, for health care provider and managed care plan protection, for departmental powers and duties and for penalties and sanctions, providing for regulations and further providing for compliance with national accrediting standards and for exceptions; making repeals; and making editorial changes.	Senator Kristin Phillips-Hill (R)	Support	Passed Senate 6/29/22 (50-0) Senate concurred in House amendments, 10/26/22 (48-0)	Passed House 10/26/22 (199-0)	Presented to the Governor, 10/27/22
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	Third consideration final passage in Senate 10/26/21 (46-4)	Currently in House Insurance Committee 10/27/21	

INTRODUCTION TO THE SPECIAL SECTION:

Chronic Illness: Psychological Impacts

CARLY CORNELL

As psychologists, it is our perpetual goal to help people with mental illness. However, what do we do when a client has both a mental illness and a chronic physical one? We may feel helpless because we are not medical doctors. We may feel frustrated that medicine and lifestyle changes cannot "cure" all our clients and rid them of their symptoms forever. We may feel burnt out because chronic illness will inevitably remain part of our client's struggles in the long run.

According to the National Health Council, physical and mental chronic illness, which is typically "incurable and ongoing," affects approximately 40% of Americans (National Health Council, 2019, par. 2). Chronic illnesses can include long-term physical conditions, such as strokes, cancer, or heart disease, or mental health disorders such as depression. These conditions last longer than 3 months and typically limit an individual in performing their usual activities.

Even though we cannot cure clients of their physical illness, we can still show them they are not alone in their struggles. We can learn about our clients – frontline workers and COVID survivors, as discussed by Silverman, the link between suicidal ideation and chronic illness, as discussed by Knapp, and clients with severe and enduring eating disorders, as discussed by Dalzell – and learn what they are going through. We can work with clients with disfigurement, as discussed by Deguire, to help them cope with the difficulties they may face in life. We can also do our part to advocate for the needs and rights of those living with chronic illness. Such advocacy is discussed by Hasek in regard to workplace advocacy and by Winnick and Woika in regard to school advocacy and coordination. We can also share resources, such as the digital apps recommended by Zuckerman. We can work together with our clients to help them and the rest of the world adapt to the reality that over 133 million Americans are facing every day (National Health Council, 2019, par. 2).

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REDEFINING RECOVERY:

Why We Need a New Paradigm for Severe and Enduring Eating Disorders

HEIDI DALZELL, PsyD

When we think of eating disorders, often what comes to mind is a teen or young adult whose eating disorder has developed following a life transition. That is a common (and treatable) presentation, with about 88% of these clients recovering fully (Wentz et al., 2007). We now know that eating disorders affect a diverse range of people of all identities and ages. One such group are those persons who struggle with long-term battles with eating disorders, a presentation called severe and enduring eating disorders (SEED). SEED come at a great cost to family, treatment providers, and, of course, the client. These costs are psychological, physical, and social.

As a specialist in midlife eating disorders, I often work with clients whose eating concerns span most of their lifetime or who live in a "semirecovered" state. As with any long-standing concern, it's common to lose hope and "burn out" on these clients. Sessions are often repetitious, and clients can feel stuck and unable to move forward. Many of these clients have had years of outpatient therapy and hospitalizations with goals such as weight restoration and symptom reduction.

While there are no standardized diagnostic criteria for SEED, Strober et al. (1997) have proposed several criteria: (1) being consistently ill for 10 or more years, (2) having experienced at least one recognized therapeutic treatment, (3) displaying severe impairment across a number of life domains, and (4) demonstrating low motivation for recovery. While a SEED diagnosis may apply to any eating disorder, most people with enduring conditions present with some form of restrictive eating, which takes a toll on physical health. Many maintain a body weight well below what it should be. They may also use compensatory behaviors, such as purging or overexercising. Psychologically, people with SEED experience a significant degree of self-hatred and sense of being a burden.

If you encounter a SEED client in your practice, you may be surprised at how physically resilient they are. While active starvation results in cognitive inflexibility (another challenge in therapy), they are often physically healthy for many years into the eating disorder. This often increases their denial around the potential for long-term health consequences and lowers motivation further. In midlife, many clients do begin to show signs of the physical consequences of self-starvation and/or purging such as cardiovascular problems, slowed digestion (gastroparesis), constipation, kidney problems, and anemia (Himmerich et al., 2021). Clients who for many years appeared physically healthy may suddenly show signs of pronounced physical problems. Many of these, such as gastroparesis, can become a focus and a rationale for the disordered eating, further contributing to the problem. Osteoporosis is also common, particularly with long-term self-starvation. This condition causes bones to become weak and brittle and even mild stressors such as bending over or coughing can cause fractures. These physical effects of starvation and/or purging do not necessarily motivate clients to make changes in long-standing patterns of starvation and symptom use.

There are also psychological concerns associated with long-standing eating disorders. As with other addictions, people may become "stuck" at a developmental place similar to when the disordered eating began. This can lead to chronic underachievement; many people are not as successful as they could have been working in occupations that are less demanding than they could handle. Eating disorders affect focus and attention and can compromise academic achievement.

The social and emotional tolls of SEED are great. Eating disorders rob people of a full life. People with severe eating disorders spend significant amounts of time planning meals or how to avoid them and obsessing about their bodies. They bow out of social obligations to attend to these obsessions. Relationships fall away, reinforcing the importance of the eating disorder in the person's life. The eating disorder itself becomes the primary relationship, often assuming importance above family and friends. It's a vicious cycle that affects quality of life.

Eating disorder treatment paradigms typically focus on symptom management and weight restoration. Inpatient eating disorders also tend to serve a younger population. Part of the problem is that traditional eating disorder programs cab be stigmatizing and be a poor fit developmentally. Upon referral to such settings, my clients have been asked questions like, "Back again"? They may be called "frequent flyers" or asked "How do you have an eating disorder at your age?" There may be multiple treatment "failures," subjecting the client to demoralization and worsening symptoms.

Some authors have recommended palliative treatment and comfort care, a hospice-like approach that may contribute to the sense of hopelessness of this population and does not allow for the possibility of growth and change.

I propose that we redefine recovery using

Continued on page 17

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SUPPORTING WORKPLACE MENTAL HEALTH FOR EMPLOYEES WITH A CHRONIC ILLNESS

WILLIAM HASEK, PhD, ABPP

Since the pandemic, workplace mental health has become a topic of interest. Companies focused on mental health will have an easier time attracting talent, as employees view mental health as one of the most important factors when considering a job offer (Deloitte, 2022; Lyra, 2022; Modern Health & Forrester Consulting, 2021). People with chronic illnesses face unique workplace challenges. With 60% of the population reporting at least one chronic illness (Centers for Disease Control and Prevention, 2022), these employees make up a significant portion of the workforce.

Workers have little faith that their companies can assist these employees. A recent survey showed 59% of workers believe management is not competent in supporting employees with chronic health conditions, and 88% of those surveyed believe they themselves are not competent either (Cancer and Careers, 2019). With support, people with chronic illnesses can contribute just as much as their peers, and maintaining a stable job can prevent their health from deteriorating, as unemployment is associated with worse mental health outcomes (Strandh, et al., 2014) and alarming increases in mortality (Gerdtham & Johannesson, 2003).

Many individuals with chronic illness are too healthy to qualify for disability but not healthy enough to work the same way as their peers. As a result, they face discrimination in hiring and promotion decisions. They find themselves trapped in jobs because they need to maintain health insurance (Chute & Wunnava, 2018). And even if they find gainful employment, they continue to face stigma and may struggle to maintain consistent schedules. They experience a taxing process of impression management and rely on compensatory behaviors, such as pushing through the pain and working long hours—behaviors that could exacerbate their illness (Beatty, 2012; Beatty & Joffe, 2006).

Workplace stress is often a topic in therapy for people with chronic illnesses, but the literature provides clinicians with little guidance. Cognitive behavioral therapy (CBT) can benefit their overall mental health (Ehde et al., 2014; Taylor, 2006;), but CBT has not demonstrated effectiveness in reducing their workplace stress (Bergström et al., 2012; Dalgaard, et al., 2017). One promising study (McGonagle et al., 2014) demonstrated that a brief coaching intervention improved self-evaluations and resilience, but this study did not look at other outcomes, such as performance ratings. Obviously, more work needs to be done, and this should be a focus of research moving forward.

Future research should also include qualitative studies (Beatty, 2012). Many people find a sense of purpose in work, and changes in their ability to work can lead to a feeling that their life has lost a source of meaning. Many symptoms of chronic illness are invisible. The choice of whether to disclose one's illness is complex, and learning to advocate for oneself can be challenging. Qualitative research could help psychologists integrate these shifts in identity, meaning, and goals into the therapeutic process.

Given the lack of research, it is difficult to make treatment recommendations, but some strategies appear promising. Clinicians can help clients acknowledge their work limitations, process their feelings about disrupted career goals, and develop an alternative vision for their professional future. Alongside that vision, clinicians should work with clients to develop a realistic plan to achieve their new career goals. Clinicians should develop a basic knowledge of employment laws to assist their clients in understanding their rights. Assertiveness training could help clients feel empowered to advocate for themselves.

Beyond therapy, psychologists should also consult to organizations. Many organizations assume they do not need a special approach for those experiencing a chronic illness, offering employees the same accommodations they offer those who are acutely ill—namely, sick leave and short-term work reductions. This leads to uncomfortable situations where employees with chronic illnesses have to reapply continually for temporary accommodations (Beatty & Joffe, 2006).

There is a clear need for workplaces to acquire greater awareness of chronic illness. Psychologists could address this by collaborating with other health professionals to offer workshops on various health conditions, their potential impacts on job performance, and best practices for accommodation. To amplify the voices of those with chronic illness, psychologists could partner with Employee Resource Groups (ERG). An ERG is a volunteer-based, employee-led group within a company that advocates on diversity issues. These groups should include employees with chronic illnesses in their membership and develop a platform that incorporates their concerns.

Psychologists could also collaborate with human resources (HR) departments to create a formal set of policies for addressing chronic illness. HR should be encouraged to offer clear guidelines on accommodations and how they can be requested. At the same time, research suggests that HR should grant managers the latitude to negotiate informal arrangements with their team members based on their unique needs (McGonagle, 2021). It may also be beneficial for HR to create alternative career paths that allow people with chronic illness to advance, but without taking on types of work that could worsen their health.

Changes to policy must be accompanied by a supportive organizational culture. Psychologists could facilitate this culture shift through coaching leaders. General coaching around emotional intelligence provides a strong foundation of skills to build trust and engage in open, honest conversation. Psychologists could build on this foundation by coaching leaders on how to apply these skills with employees who have a chronic illness (McGonagle, 2021).

With rates of chronic illness set to increase, society as a whole has an interest in addressing these workplace issues. Companies have a financial interest, as chronic illnesses already cost the United States 19.6% of its gross domestic product—much of which is related to lost productivity. That cost will only increase as time goes on (O'Neill Hayes & Gillian, 2020), and it could be minimized through proper accommodation and support. Workers with chronic illnesses have a personal stake, as they want meaningful employment (Meister & Wollfrey, 2021). Psychologists are uniquely positioned to be a voice for change, but to do so we must challenge ourselves to speak directly to the challenges faced by those with chronic illness—in clinical settings and beyond.

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DISFIGUREMENT:

A Call for Awareness

LISE DEGUIRE, PsyD, *DrLiseDeguire@verizon.net*

When I was 4 years old, I survived a fire that burned away my lower lip, chin, and neck, permanently scarring two-thirds of my tiny body. Over decades, I endured approximately 75 procedures, vastly improving my appearance but still leaving me noticeably scarred. I am also a clinical psychologist, author, and speaker.

The disfigured community, of which I am a proud member, includes people with acquired disfigurement (survivors of burns, accidents, cancer, etc.) and people born with disfigurement (birthmarks, cleft palates, neurofibromatosis, etc.). We endure unwanted staring, social avoidance, bullying, discrimination, dating challenges, and online harassment. Alarmingly, a United Kingdom survey of more than 800 disfigured people found that one-third of the respondents had been the victim of a hate crime (Changing Faces, 2017).

Disfigurement is a condition whose damage can be vastly ameliorated by social acceptance. Yes, there can be trauma associated with disfigurement and self-image issues. Psychotherapy can be helpful in treating these conditions. However, many people report that their biggest issue is how others see them, which is not something that psychotherapy can fix.

Film and TV strongly contribute to the problem. From an early age, many children watch movies in which the villains are portrayed as scarred or somehow wounded. Beauty and the Beast features a character (Beast) who is rendered hideous when he is mean and restored to handsome when he learns to be kind. The Lion King features an antagonist who is literally named Scar for his facial wound. Darth Vader, in Star Wars, is eventually unmasked as a burn survivor. Voldemort, in Harry Potter, is another disfigured villain. Repeatedly and relentlessly, disfigurement is used as a cheap trope to signal to the audience that a character is bad.

Is it any wonder that people are biased against the disfigured?

Until recently, prejudice toward the disfigured was hypothesized to be innate, due to an in-born fear of "catching" whatever affliction caused the damage. Recently, however, Dr. Anjan Chatterjee proved otherwise. Working with a hunter-gatherer tribe in Tanzania, he found that people unexposed to Western culture did not harbor negative feelings toward the disfigured. Thus, we now know that negative attitudes about disfigurement are learned in society (Workman et al., 2022).

Dr. Kathleen Bogart (2020) described a model used to explain disability and/or disfigurement: moral, medical, and social. The moral model posits that disability represents punishment for moral failure or sins. This moral model shows up repeatedly in the negative film and TV depictions of scarred characters.

The medical model says that disfigurement is caused by medical issues, which are the patient's burden to treat and heal. However, most disfigurement cannot be truly healed, only ameliorated. The medical model also leaves the burden of the disability and/or disfigurement entirely in the hands of the patient and their doctor (Bogart, 2020).

In contrast, the social model states that disability is a social issue, which we should all work together to improve. The problem does not lie with the disfigured person; the problem lies with the world around the disfigured person (Bogart, 2020).

Lest that sound too idealistic, think about people who need reading glasses, which likely includes many of you reading this article. Many people are far-sighted, which is a disability. However, because society has adapted, minor visual issues are not considered to be a disability. We can wear eyeglasses, which we can easily purchase at the drugstore. As we age, we can even change the fonts on our cell phones and use a flashlight to brighten the seemingly ever-shrinking menu. There is no negative stigma for far-sighted people, even though truly, they also have a disability (Bogart, 2020).

Disfigured people are not sitting around "waiting on the world to change." The community of burn survivors is capably led by the Phoenix Society, which offers many resources on social re-engagement, coping with staring, dating, discrimination, and all the pitfalls awaiting those who look different. We learn how to hold our heads high, make eye contact, be friendly, and engage people who might otherwise shun us. These coping skills are crucial to help the facially different lead empowered lives.

Still, the burden should not rest solely on the shoulders of the facially different (a term many of us prefer). Like other marginalized groups, it should not be left entirely to us to convince society to treat us better.

I frequently present to schools and workplaces about disfigurement issues, beginning with how we are portrayed on screen. I show photos of Freddie Krueger, Scar, The Joker, Voldemort, The Beast, The Phantom, and Darth Vader. The most frequent reaction from the audience is astonishment. Most people have sincerely never noticed these unrelenting negative portrayals of scarred characters as being evil. That is how pervasive this trope is. It is so pervasive that you probably never thought about it.

There are simple ways to help. If you see a scarred character in a film who is evil, point out this prejudice to others. Educate your children. The more people who notice the bias the better; that is how bias becomes societally unacceptable. That is how change can begin.

People frequently ask me how to talk to someone who is disfigured. I scratch my head because the answer is: the same way you talk to anyone. Be warm, make eye contact, and introduce yourself. Do not immediately ask "What happened to you?" For context, imagine that you are consulting a psychologist for an initial meeting, and you are also obese. You might expect, at some point during the session, the psychologist would inquire about your health, which would include questions about your weight. However, you would not want the psychologist's first question to be, "How did you become so overweight?"

Like everyone, facially different clients first need a strong connection with their therapist. Clinicians must be attuned listeners to truly understand the world of disfigurement: the pain of being stared at, the bullying, the fear of dating. Once that therapeutic bond is established, psychologists can help their clients in many areas: self-image, self-confidence, socializing, and peer group connections.

At times, clients may overly interpret social rejections as being entirely due to their disfigurement. A trusted clinician can point out that normal-faced people are also occasionally rejected, and that rejection can be a universal, albeit extremely painful, experience. Clinicians can help prepare and practice responses to intrusive comments. "What happened to you?!" is a common question for the facially different. Feeling prepared for this question can lower anxiety about socializing. Additionally, clinicians can use their usual therapeutic tools to treat social anxiety, posttraumatic stress disorder, insomnia, and depression, all of which can be associated with disfigurement.

It is vital to remember, however, that many of the difficulties disfigured people face are due to how others treat them, due to prejudice, and not necessarily to any prior psychopathology to the client. This is parallel to how we conceptualize minority clients who are dealing with racism. Help your client to conceptualize these social problems as existing outside themselves and help them develop appropriate coping strategies.

Behind the scars or misshapen features, the facially different are, of course, just like anyone else. We are most assuredly not evil. We long for warm inclusion and to be welcomed for the "content of our characters," as the great Dr. King once said. Your awareness can help.

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Redefining Recovery: Why We Need a New Paradigm for Severe and Enduring Eating Disorders

(Continued from page 12)

a quality-of-life paradigm. This can be a more collaborative approach and allow clients to reimagine "recovery" through a different lens. Some questions that we can use to shift to such an approach are:

1. What does recovery mean to you? Is it weight-based or is there something else you'd like in your life, such as more friends, meaningful work or volunteering, and so forth?
2. What would your life look like without the eating disorder?
3. Who are you without your eating disorder?
4. What are the negative aspects of your eating disorder?
5. How has your eating disorder become a primary relationship? What would it be like to shift this?
6. Imagine a day without obsessing about food and eating. How would you spend your time and energy?

Once a client has identified these factors, much of the therapeutic work can support them in pursuing these new recovery goals. It becomes less about what to eat and not to eat, and more about a life that is satisfying.

Each client may have differing factors that contribute to a meaningful life. For example, many of my clients want to improve social relationships, decrease isolation, focus on academics, or seek greater spiritual fulfillment. Connection often enables a sense of increased fulfillment. It can also result in a greater degree of hopefulness, which can help people cope with chronic eating disorders.

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CHRONIC ILLNESS AND SUICIDE

SAMUEL J. KNAPP, EdD, ABPP

Suicidal ideation increases when patients have chronic illnesses and especially if they have multimorbidity (comorbid physical or mental health issues; Kavalidou et al., 2017). However, no two persons respond to chronic illnesses in the same way. The likelihood that chronic illnesses will lead to suicide depends on the impact of the illness on the patients (e.g., whether the illness creates chronic pain or a disability), the context in which the illness occurs, patients' resilience and social resources, and their interpretations of the illness.

Suicide risks increase when patients have chronic pain that they cannot adequately control or when they have restrictions in their activities of daily living. The rates of suicide for patients with chronic pain especially increase if patients become unemployed or disabled (Racine, 2018). Psychologists can assess restrictions on activities of daily living by asking patients, "Do you have any health problem that keeps you from working, going to school, keeping house, or doing some other activity you want?" Approximately, 14% of the population have multimorbidity, and 25% report at least one limitation in their activities of daily living (Onyeka et al., 2020). Some of the restrictions in daily living may be relatively minor, such as persons with knee problems being unable to go on frequent long hikes the way they used to, or severe, such as having to always stay at home except for medical appointments or requiring extensive assistance with personal care. Older adults report more functional limitations, although the impact of these limitations varies according to the patients' social support networks and their financial resources. Nonetheless, those with severe physical limitations died three times as often from suicide compared to those without such limitations (Onyeka et al., 2020).

The desire for suicide often co-occurs with thoughts of perceived burdensomeness (e.g., "I am a burden to others, and they would be better off if I were dead"), thwarted belongingness (e.g., "I do not feel like I belong or fit into an important social group"), or entrapment (e.g., "My pain is intolerable and there is no foreseeable end to it;" Kirtley et al., 2020). Perceived burdensomeness may increase if patients must depend heavily on others to complete their activities of daily living. Thwarted belongingness and isolation may increase if patients have limitations on their mobility and cannot maintain quality social relationships. A sense of entrapment may occur among patients with chronic physical or emotional pain that they have been unable to manage. Also, some of the same thinking patterns found in patients with chronic pain—catastrophizing or ruminating—are commonly found among suicidal patients. They may catastrophize or exaggerate the consequences of their illness; ruminate on their illnesses, pain, and physical limitations; or be unable to divert their attention away from their illness (Rogers et al., 2021).

Suicides occur when the desire for suicide combines with the capability of killing oneself. Chronically ill patients may acquire that capability for suicide if they gradually lose their fearlessness of death through repeated exposures to pain and suffering. Also, many chronically ill patients have access to high doses of prescription medications, which they could take to kill themselves. Patients who are prescribed benzodiazepines or opioids have an increased risk of dying from a drug overdose.

Evaluations of chronically ill patients need to consider the interaction of social, physical, and psychological factors. For example, patients in chronic pain may develop insomnia or become more irritable and alienate others, thus increasing their social isolation and sense of thwarted belongingness. Patients with functional limitations may set unrealistic goals for their recovery and then harshly criticize themselves when they fail to meet these goals. Their illness may even prevent them from being employed to their full capacity, or employed at all, thus increasing financial insecurity and distress.

Treatment Considerations for Professional Psychologists

Psychologists who evaluate patients with chronic medical illnesses may wish to consider the following:

- Chronic physical illnesses increase the risk of suicide, especially among patients who have chronic pain that they cannot adequately control or who cannot perform their usual activities of daily living.
- Every patient is unique, and psychologists should not estimate the risk of suicide based on patient demographics or the presence or lack of a chronic illness alone.
- Brief screening questionnaires, such

as the PHQ-9, may be indicated for patients with chronic illnesses to detect suicidal ideation or a mental disorder.

- Psychologists who assess patients with chronic illnesses should look for thinking patterns related to suicide, such as perceived burdensomeness, thwarted belongingness, a sense of entrapment, and absolutistic or catastrophic thinking. Often, chronic illnesses co-occur with insomnia or social isolation.
- Physicians need to carefully monitor patients who are receiving prescribed opioids, benzodiazepines, or other potentially dangerous medications.

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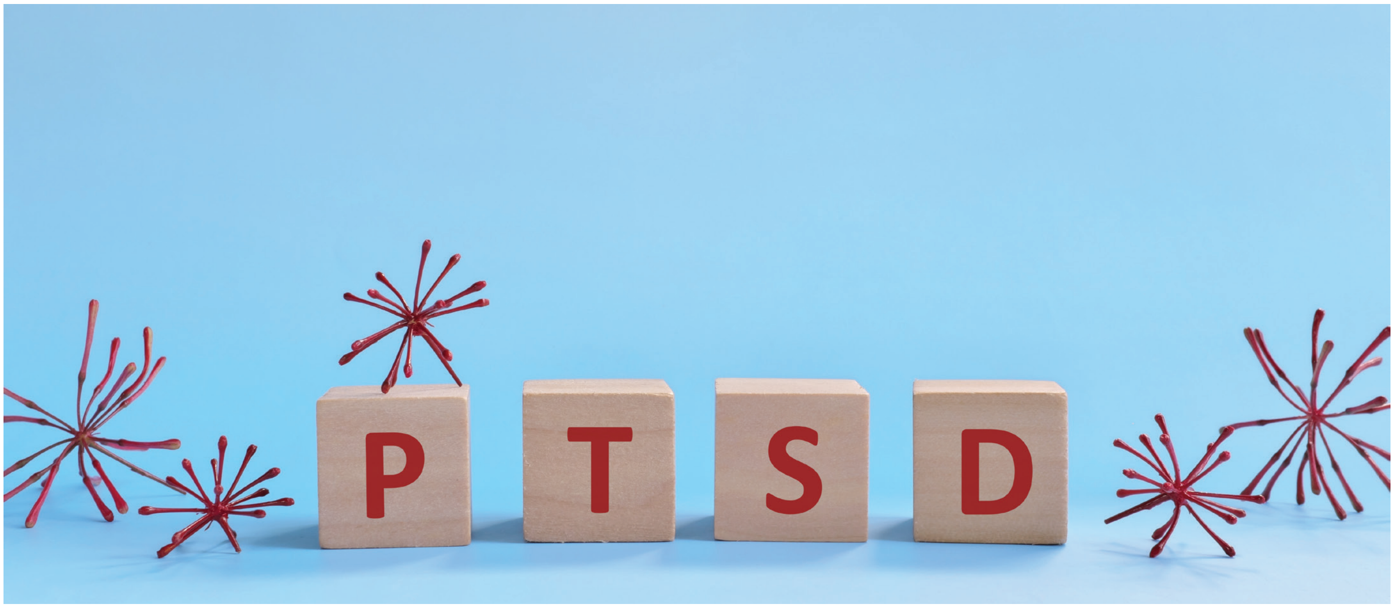
CARING FOR SURVIVORS OF COVID AND HEALTH CARE PROVIDERS DURING THE PANDEMIC

DINA GOLDSTEIN SILVERMAN, PhD, HSPP

The COVID-19 pandemic brought forward numerous societal problems to the fore, among them the need to address the mental health of frontline health care workers and that of patient survivors of critical-level care. Beyond reducing anxiety and depression symptoms, psychologists can tailor existing interventions to increase resiliency, reduce burnout, and help these vulnerable populations achieve posttraumatic growth.

"Charlotte," a 54-year-old African American single female, was referred to the ambulatory psychology service by her primary care provider for symptoms of posttraumatic stress disorder (PTSD) following a case of bilateral interstitial pneumonia secondary to Sars-Cov-2 in March 2020. At the time, she had required inpatient hospitalization, inclusive of intubation and mechanical ventilation, and after a month-long hospital stay, she would recover at a rehabilitation facility. She reported struggling with racing thoughts; early and middle insomnia; panic attacks, particularly triggered by wearing masks or using a continuous positive airway pressure machine; flashbacks; nightmares; irritability; depersonalization; and derealization. She also admitted recurrent anticipatory anxiety around in-person medical appointments that would result in frequent late cancellations or no-shows that compromised her follow-up care.

"David," a 40-year-old married European-American physician intensivist, self-referred for ambulatory psychotherapy due to worsening depression and anxiety



symptoms in September 2020. Prior to his self-referral, he had been stable on 20 milligrams of Prozac for decades, which he had begun taking for depression, prescribed by his family doctor while in medical school. He reported racing thoughts, early insomnia, poor sleep quality, increased irritability, numbness, and feelings of guilt, shame, and inadequacy. He also admitted being short tempered with his wife and the couple's young children, which contributed to his feelings of guilt. He noted being haunted by nightmares of dying patients and a preoccupation with self-defeating thoughts of making a critical error that would cost a patient's life. Working with these patients and many others led this writer to examine how to tailor existing interventions to unique pandemic stress.

There exists a robust body of literature on the impact of acute respiratory distress syndrome (ARDS) on the cognitive and psychological health of survivors. Research has demonstrated that intensive care unit (ICU) survivors may struggle not only with physical sequelae but with cognitive and psychological distress for years following their hospitalization (e.g., Herridge et al., 2011; Marra et al., 2018.) One-fifth of ICU survivors experience clinically relevant PTSD symptoms, and many endorse marked anxiety and depression in the first year of post-ICU recovery (Bienvenu et al., 2015; Tingley et al., 2020.) Early pandemic research suggested that those survivors of COVID-19 who required intensive care were also likely to be more susceptible to post-intensive care syndrome (PICS), inclusive of cognitive and psychological impairment (Tingley et al., 2020.) Such impairment may include difficulties with memory, comprehension, and executive functioning, as well as worsening anxiety and depression due to contact precautions and reduced access to rehabilitation services and spiritual care (Hosey & Needham, 2020; Turnbull et al., 2022). Several recent studies have suggested that a third to a quarter of COVID survivors, including those who did not experience ICU-level care, met clinical criteria for PTSD (Chamberlain et al., 2021; Janiri et al., 2021). Another study proposed that up to 30% of COVID survivors would meet criteria for PTSD due to increased risk of trauma associated with witnessing the demise of other patients; high rates of delirium, hallucinations, and delusions in ICU-level patients; breathing difficulties associated with severe COVID; deeper sedation and longer rates of ventilation than typical critical care treatment; isolation from loved ones; and continued contact precautions and protective personal equipment (PPE) usage by health care workers reinforcing isolation through limited communication (Green et al., 2022).

Treatment of Charlotte presented its own unique challenges, as it took place entirely by telemedicine with the exception of the in-person termination visit. In the initial intake session, Charlotte was introduced to the Prolonged Exposure Therapy model of treatment of PTSD as per Foa et al. (2019) to address her symptoms via in-vivo and imaginal exposure. Charlotte was able to identify areas where she would engage in phobic avoidance, and she was able to notice that she was particularly triggered by news coverage. In-vivo exposure required some creativity as Charlotte's medical history made her a particularly high-risk patient for re-infection and complications, so she would go to grocery stores during off-peak hours, practice going to smaller stores at strip malls with outdoor spaces, and wear a clear face shield in addition to a face mask during her outings. Imaginal exposure was facilitated with the use of various television medical dramas to imitate the sounds of the ICU in addition to reviewing her ICU experiences. Charlotte was also able to create a calming ritual, where she would meditate upon the words calm and safe as she donned and doffed her PPE prior to her shopping trips and medical appointments. Over the course of 10 sessions, Charlotte's scores on the PHQ-9 and the GAD-7 would subsequently decrease, and her primary care physician would reduce her dose of antidepressant medication in response to a marked reduction in her symptoms.

Working with David included using a mindfulness-based approach to reduce his symptoms. Like 78% of Americans, David was overwhelmed with pandemic stress in 2020 (American Psychological Association, 2020), with the pandemic exacerbating his symptoms of burnout such as depersonalization, emotional exhaustion, cognitive fatigue, disengagement, and anxiety (Hurst et al., 2022). David also struggled with moral distress and worrying about infecting his young family and about not being able to do enough to help his patients. A recent study suggested that moral distress experienced by many frontline health care workers exacerbates burnout symptoms and imperils psychological functioning (Norman et al., 2021). Relaxation training and meditation, as well as grounding techniques, were helpful to David. He was also engaged in cognitive restructuring around his self-defeating negative thoughts and engaged in behavioral activation strategies that helped him focus on meaningful time spent with his family and physical exercise to help with self-care.

The COVID-19 pandemic emphasizes existing societal inequities, highlights the acute need for mental health treatment for the public, and presents unique challenges to clinicians. By tailoring existing evidence-based interventions to serve the emerging needs of our populations, we can continue to meet the ongoing challenges presented by the pandemic.

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DIGITAL APPS FOR CHRONIC CONDITIONS

EDWARD ZUCKERMAN, PhD

What Are Apps?

Apps are computer programs that run on mobile devices like phones and tablets. If you check the weather, listen to podcasts or music, or read a magazine or newspaper on your mobile device, you are using an app tailored for that function and your device.

There are a million and a half of them available for download from the Apple App Store, Google Play Store, and the phone's manufacturer's store (Stastica, 2015). Around 35,000 of those apps are health related, which includes wellness, exercise, diet and nutrition, and so on. That still leaves a few thousand mental health apps from which to choose. And, new ones are added every day and old ones are modified or removed or just not updated. The biggest problems are that for 99% of the apps there is no information on the quality or efficacy beyond users' reviews and star ratings and it is hard to find the best app for each clinical situation. Fortunately, curated libraries of apps (see below) can address these limitations.

Apps Can Overcome Barriers

Many psychological conditions are chronic: either relapsing/recurrent or persistent. Although these conditions can be altered with treatment, under-treatment is the general state. A large part of that is lack of access for logistical, financial, and staffing reasons. Here is where apps come in.

They can serve underserved communities with their universal availability on smartphones, at all times, and at any distance. They can serve those living alone, physically less mobile, lacking transportation, with communication difficulties, and so forth. They are available to patients the other 166 hours a week for support, education, and monitoring. They can extend and expand what is being done in individual, family, and group therapies.

Apps require very little effort to use and, if well designed, require low reading skills and are highly motivating. People are more forthcoming and honest with an app because it is seen as safe, nonjudgmental, and patient. They are cheap and scalable. They may even ease entry into face-to-face (f2f) therapy. To summarize, they can do or help do what we have been trying to do for decades: give psychology away.

What Can They Do for Mental Health Treatment?

A lot: "NIMH [National Institute of Mental Health] classifies mental health apps into six categories based on functionality: self-management, cognition improvement, skills-training, social support, symptom tracking, and passive data collection. Mental health apps span all stages of clinical care provision, including immediate crisis intervention, prevention, diagnosis, primary treatment, supplement to in-person therapy, and post-treatment condition management." (Chandrashekar, 2018).

Apps are not coming for your job. But they will get smarter and probably more effective, so think of them as extenders and better tools. There are two areas where I think app-assisted therapy could have a large impact: patient education and data collection.

We often come to assume that the client understands their condition the way we do. All apps educate the user about the condition(s) they are aimed at and the interventions they use. It should do more than a Google search. The problem and its understanding should be clear, memorable, and motivating. A feedback loop for questions should use the client's language and be quickly responsive.

As the great medical philosopher, Gregory House, MD, said, "Patients lie." They do, and they also simply do not remember how they felt last week or when their symptoms flared or under what conditions. And, when asked, they confabulate. None of this furthers therapy or motivates clients. Instead, focus on the app's self-monitoring functions (accurate and complete data collection on target behaviors, contexts, and interventions). The app should prompt data entry and make it easy. It should provide graphic evidence of changes in the data, to both you and your client, and serve as the basis for joint clinical decisions on interventions.

Two Cautions

Currently, apps do not protect patient privacy sufficiently. None say they are HIPAA-compliant, and "industry standard" privacy protection is meaningless. The risks are small and must be balanced against the gains.

Only a few apps have any kind of research support for their effectiveness and the developers can only offer anecdotes, testimonials, and "scientistic" language. However, it is likely that most are better than no treatment or a waiting list. And they are likely to be more effective when adopted into f2f therapy.

Libraries of Apps

While the app stores have search tools, selecting an app to try from the thousands available will likely offer too many to evaluate. Fortunately, there are several libraries of curated and limited collections of apps and relevant search methods (filters). When you find an app, you will usually have to copy its name and search the app stores. Here are a few app resources to consider.

1. NYC WELL

https://nycwell.cityofnewyork.us/en/app-library/

Only 13 apps but the most popular, with clear simple descriptions, evaluations, and links to the stores. A good starting place to see the variety of approaches, goals, and methods among apps. NYC Well also has "free digital mental health resources for the duration of the COVIC-19 pandemic" at https://nycwell.cityofnewyork.us/en/covid-19-digital-mental-health-resources/. While some of the 14 programs overlap the above, they are all worth a look.

2. UCSF DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

https://psych.ucsf.edu/copingresources/apps

Links to 17 popular apps and therapeutic programs of which an app is a part: eight for meditation and relaxation, eight for coping with anxiety and depression, and one on insomnia.

3. PSYCOMPRO

https://pro.psycom.net/clinician-lifestyle-practice/mental-health-apps-how-to-use-in-treatment

The article Mental Health Apps: How to Use Apps as Treatment Adjuncts by Alexis Pellek summarizes issues such as privacy, choosing apps, and integrating apps into one's practice, and offers descriptions and links to apps and programs for half a dozen of conditions we think of as chronic: posttraumatic stress disorder, eating disorders, schizophrenia, substance use, and serious mental illness.

4. ONE MIND

https://onemindpsyberguide.org/

One Mind reviews about 250 mental health apps, using user-friendly multiple search terms (conditions, treatments) and filters by (cost, audience, etc.). One Mind also provides app toolkits, which are a collection of 14 apps, each opening to an infographic with 3 to 15 apps showing their names, logos, and a brief description (https://onemindpsyberguide.org/resources/app-toolkits/).

5. MIND-M-HEALTH INDEX AND NAVIGATION DATABASE

https://mindapps.org/

This website offers a brief background to how they evaluate apps. It nicely explains how their experts apply the 105 objective criteria from the American Psychiatric Association to apps to create the MIND database of 687 apps. To find an app, it offers 88 search filters and so will take time to learn, but if you need something specialized it is worth the time investment.

Next Steps

Download and test an app or three. Adopt and try-and-discard approach and enjoy your continual learning about how developers have handled the demands of the problem. Road test the app with a colleague or trapped family member. Better reactions and feedback will allow recognition and response to the app's limitations. Remember both you and the client must buy in to continue to use it. Do not focus on curing the problem. Apps are not therapy (yet?). However, an app that supports fuller understanding and amelioration is valuable.

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SPECIAL EDUCATION ELIGIBILITY DETERMINATIONS AND ACCOMMODATIONS FOR STUDENTS WITH CHRONIC MEDICAL ILLNESSES

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It is estimated that two out of five school-age youth in the United States have a chronic medical illness (Centers for Disease Control and Prevention, 2022). Students with chronic medical illnesses experience greater impairments in academic, physical, and social functioning (Pinquart & Teubert, 2012). Specially designed instruction or accommodations may be required for this group of students to progress in school and might be considered in high-stakes tests and the transition to post-high school education, vocational training, or job placement. There are federal laws that guarantee protections for students with chronic medical illnesses that meet eligibility requirements and demonstrate a need for specially designed instruction, related services, or other accommodations as a student with a disability. The purpose of this article is to provide all psychologists with information that will be helpful in supporting students with chronic medical illnesses through approaches and resources typically utilized and championed by school psychologists.

Students with disabilities may qualify for services in the schools through a 504 plan or an Individualized Education Program (IEP). Section 504 of the Rehabilitation Act of 1973 is widely recognized as the first civil rights statute for persons with disabilities. It prohibits discrimination on the basis of disability for any program that receives federal assistance to include schools. It is an unfunded mandate that requires equal access for students with disabilities.

IEPs are a product of the Individuals with Disabilities Education Act (IDEA, 2004). In addition to having a disability, the disability must adversely impact educational performance for a student to meet eligibility requirements for an IEP.

A 504 plan focuses on accommodations, while an IEP focuses on specially designed instruction in addition to accommodations. For example, a student who uses a wheelchair for mobility needs wheelchair-accessible transportation and may need assistance with toileting to participate in school. Students with a variety of conditions like asthma or dwarfism may require some accommodations in the school setting, but most students with these conditions would not require special education services. If a student in a wheelchair also has an intellectual disability and cannot benefit from the general education curriculum, then the student would be more appropriately served through an IEP. If only accommodations are needed, then a 504 plan is required. If specially designed instruction is needed (with or without accommodations), then an IEP is required.

Technically, all students with IEPs are also eligible for a 504 plan, but there is generally no need for two separate plans. Thus, these students are provided with services through an IEP because it provides greater protection for students.

There are strict timelines for completing evaluations to determine eligibility for IEPs for public schools. The evaluation must be completed within 60 calendar days from the date the signed consent form is received. An IEP team then meets to determine an educational placement for a student no more than 30 days after the completion of the comprehensive multidisciplinary team evaluation. The timeline for this process ensures students are evaluated and an eligibility decision is made in a timely manner. Moreover, this is completed at no cost to caregivers. Within private practice, no such timelines exist, and insurance may or may not cover the expense of a private evaluation. If a school team is provided with an independent outside evaluation, the school team may opt to complete additional assessments before making an eligibility determination. Once students are provided with IEPs, they are reevaluated every 3 years, or every 2 years if an intellectual disability has been identified. For students with 504 plans, the plan specifies the date the services start and the date services will be discontinued.

Let us look at a case study. Susan developed type 1 diabetes in 2020 at age 9. To manage her irreversible autoimmune disease, she injects insulin multiple times a day. Her blood glucose levels fluctuate throughout the day. Susan has average intelligence, average achievement, and grades of B or better in all courses. There are no social, emotional, or behavioral concerns. As she is achieving adequately in the general education setting, she does not require special education services. Her needs can be met through a 504 plan. Accommodations might include sending home an enhanced school meal menu that includes information on carbohydrates, permission to have fluids and snacks available at all times, trained staff to administer insulin, and professional development about diabetes for all teachers assigned to work with Susan. A schedule should be developed that acknowledges periods when she is most likely to have difficulty attending due to fluctuations in blood glucose levels and avoid her most challenging courses during these periods, along with flexibility in due dates for assignments and tests.

Although not all students living with type 1 diabetes will experience adverse impacts to their educational performance compared to healthy peers, school teams will need to determine what level of support is needed on a case-by-case basis (Guadieri et al., 2008). If Susan begins to struggle in her courses due to difficulties with concentration or processing speed resulting from persistently difficult-to-manage fluctuations in blood glucose levels, then the school team may need to determine if her academic performance is adversely impacted due to a chronic medical condition and if she demonstrates a need for specially designed instruction under the IDEA disability category of Other Health Impairment. In this case, specific educational goals might include the reteaching of content when Susan has recovered from a blood glucose fluctuation and ensuring that at least 80% of the instructional content can be recalled when assessed.

In closing, all psychologists may support students living with chronic medical illnesses by informing students and their families of the eligibility determination process and applicable federal laws, and by supporting efforts to coordinate across systems. Students with chronic medical illnesses may need supports now, and many vocational training or higher education systems may require a documented history of impairment when students seek accommodations or related services. Psychologists that gain familiarity with the eligibility determination process and applicable federal laws in supporting students living with chronic medical illness may provide essential information to families and across systems that may formulate educational and career plans for school-age students in addition to preparing for appropriate supports for a successful graduation and transition after high school.

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EFFECTS OF COVID POLICIES ON SCHOOL CHILDREN: A First Look

BARBARA GELMAN, PhD

We are living in unprecedented times. In Philadelphia, students received virtual instruction for up to 17 months beginning March 2020. Philadelphia schools began the 2022–23 academic year with a 10-day mask mandate in place for all students and a mask mandate for the entire year for preschoolers. Four academic years—2019–20, 2020–21, 2021–22, and 2022–23— have been impacted by COVID policies. What are the effects on learning and mental health due to remote instruction, quarantine, and masking? These questions will be studied for years to come, but for now, resources for this piece include newspaper articles and anecdotal reports from an "on the ground" school psychologist.

"Learning poverty," the share of children who cannot comprehend simple text by age 10, increased worldwide from 57% prepandemic to 70% in 2022 (World Bank, 2022). How did things go in Pennsylvania? The Pennsylvania System of School Assessment (PSSA) testing was on hiatus in 2020. Pennsylvania students lost proficiency across most grades during the pandemic and larger learning gaps emerged in historically underperforming students (Lott, 2022). Fewer students were in school and fewer students took the PSSA in 2021, with reductions consistently in the range of a drop of one-quarter to one-third fewer students taking tests. Between 2020 and 2022, student enrollment in Pennsylvania dropped nearly 3% (Allen, 2022). The drop in attendance in Philadelphia appears to have been larger, where there has been a decline in enrollment of 4% in district-run schools, 2% in charter schools, and 6% in alternative schools (Hagen & Mezzacappa, 2021). District officials projected a loss of 7,000 students in 2022–23.

PSSA testing resumed in Philadelphia in late 2021. In September 2022, the School District of Philadelphia reported that 34% of students in grades 3–8 scored proficient or advanced in reading and 16% scored proficient or advanced in math. These data indicate two-thirds of Philadelphia students are not proficient in reading and, far more, upward of 80% are not proficient in math. These statistics are consistent with reported larger drops in PSSA math versus reading scores, and results showing one-half to three-quarters of historically underperforming students scoring below basic math in 2021, up from 44% in 2019 (Lott, 2022).

There are concerns that COVID policies have contributed to delays in speech and emotional development. Young children rely on facial expressions and social interactions to develop normally. This process was interrupted in children who were isolated from peers and who interacted with people wearing masks. Speech pathologists have reported delayed speech in toddlers and contend this is due to children having been home with parents who met their needs rather than having to interact with peers requiring speech (Elliott, 2022). One speech therapist observed that some children walk away rather than respond when they do not get what they want. What appears like independence may be lack of interest. Given speech development at age 2 can predict academic success, delays in large groups of children could impact education down the road.

There is also concern about the effects of social isolation on teens. This psychologist cannot imagine the disappointment students felt when they were told their schools would remain closed for the 2019–20 school year. No school meant no peers, sports, proms, and graduations. She is aware some students in Philadelphia stayed at home for months. In counseling sessions, these students were encouraged to walk outside during the day for a half hour, sometimes their only time away from computer screens and phones. Even when in person learning resumed, isolation continued, as some students were quarantined based on their medical status or those in their households.

Students seemed happy to return to in-person instruction and, particularly, to see friends. Teachers reported limited attention spans, and meltdowns of kindergarteners, many of whom had not attended preschool, occurred regularly. Teachers in grades 1 through 5 told the psychologist some students were behind academically at least 2 years. The psychologist needed to carefully consider the absence of instruction when evaluating children. She noted that at least two clinic-based psychological evaluations, done remotely, missed diagnoses evident when children were seen in person.

Mental health concerns are being echoed around the country with professionals describing COVID fallout as full-blown trauma. The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association describe the current state of child and adolescent mental health as a national emergency. They report increases in emergency department visits for all mental health emergencies including suicide attempts (Giuffre, 2022). The Centers for Disease Control and Prevention released a report in April 2022 indicating one in three high school students felt sad or hopeless during the pandemic. One in three also reported increased drug or alcohol use. Perhaps it is no wonder; core ideas about society were reshaped. Instead of adults making sacrifices for children, children stayed home to prevent illness in older people. The long-term effects of this remain largely unknown.

What is the role for psychologists moving forward? In addition to observing, testing, and writing, we need to advocate for policies that promote learning and mental hygiene necessary for learning. Offering counseling to anxious kids is prudent. We have an ethical obligation to avoid practices that harm children. With courage and strength, we can recommit to putting children's welfare above all.

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ACTING ETHICALLY WHEN FACED WITH UNJUST LAWS

JEANNE M. SLATTERY, PhD; LINDA K. KNAUSS, PhD

This discussion is part of a series examining clinical dilemmas from an ethical perspective. In addition to the three of us, respondents to this vignette included Allison Bashe, Gina Brelsford, John Gavazzi, Claudia Haferkamp, Deb Kossmann, Kalei Mills, Brett Schur, and Ed Zuckerman. Rather than immediately reading our responses, consider carefully working through the vignette first.

Dr. Cautious, who works in Texas, provides affirming care for LGBTQ+ youth and their families. Given recent shifts in governmental policy, Dr. Cautious is concerned about being found guilty of failing to report "child abuse" when working with transgender and questioning youth. Dr. Cautious has called Dr. Consult, a graduate school friend living in Pennsylvania, for advice.

Some Context

The most recent national survey from the Trevor Project (2021) observed that 94% of the LGBTQ+ youth who responded reported that recent politics negatively impacted their mental health, with 32% of LGBT youth and 52% of transgender and nonbinary youth reporting that they had seriously considered attempting suicide in the past year. Teens were more likely to report suicidality than young adults. Both cisgender and transgender youth reported high levels of anxiety and depression; they were twice as likely to attempt suicide if they had been subjected to conversion therapy (27% vs. 12%). Fewer youth reported suicidality if their pronouns, name choices, and gender marker on legal documents were respected and if they had gender-affirming spaces available.

These concerns are more marked in Texas, where over half of transgender students (58%) were prevented from using their chosen name or pronouns, almost three-fourths reported being unable to use the school bathroom aligned with their gender (74%), and only 4% reported attending a school with a supportive trans/nonbinary student policy (GLSEN, 2021).

In February 2022, Attorney General Ken Paxton and Governor Abbott of Texas directed state child welfare officials to investigate parents allowing gender-affirming care for their minor children as potentially engaging in child abuse (Klibanoff, 2022). Later, the Texas Supreme Court made clear that neither had the authority to order any action against these families. Some observers express concerns that calling gender-affirming care child abuse could lead to it being weaponized in divorce cases, cause legal problems for professionals working with transgender and gender-diverse youth (TGD), and empower people to attack young TGD. Criminalizing gender-affirming care further stigmatizes an already vulnerable group.

Does this mean that Dr. Cautious is in danger of being prosecuted? So far, these decisions have only been aimed at professionals providing gender-affirming care to children and teens, not to those working with TGD adults. Nonetheless, Texas policy is not clear, and decisions are ongoing. Dr. Cautious' dilemma is emblematic of a larger issue, however, as legislatures are increasingly restricting individual rights (e.g., abortion, gender-affirming care) in Texas and around the country and limiting the scope and activities of professions (e.g., whether physicians can discuss firearms with their patients, a Florida law that was overturned by the courts; McCourt & Vernick, 2018), Dr. Consult may face similar dilemmas in the near future.

"I Won't Work With Trans Teens"

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

One way of side-stepping these problems is to simply advertise that we will not work with TGD children and teens. Such advertisements do not mean that we will not be working with them, just that they and their families may go "underground" and avoid discussing factors that may be related to their anxiety and depression. In effect, we may set up a pact of secrecy, which can undermine therapy. Similarly, Knapp (2022) argued that refusing to work with people who were suicidal would only mean that they would avoid talking about suicidality and receiving the support that such discussions might bring.

Resolving Conflicts Between the Law and Our Ethics Code

Martin Luther King (1968) asserted, "There are some things in our society . . . to which we should never be adjusted. There are some things . . . to which we must always be maladjusted if we are to be people of good will" (p. 11). Many may argue that there are now issues in the courts and legislature that we must be maladjusted to.

For example, Ransone (2022), writing for the American Academy of Family Physicians, observed that the Dobbs decision "negatively impacts our practices and our patients by undermining the patient-physician relationship and potentially criminalizing evidence-based medical care" (para. 4). We could make a similar argument in terms of working with children and teens in Texas. Strict adherence to Texas policy and decisions would violate the Ethics Code's aspirational principles of Justice and Respect for People's Rights and Dignity (American Psychological Association [APA], 2017).

A decision like that proposed by Attorney General Paxton and Governor Abbott sets up a two-tier and unequal set of services. TGD youth and teens would be prevented from accessing gender-affirming care; they and their families would be unable to question their identity in psychotherapy or respond to issues raised by their emerging identity. Informed psychologists may be hesitant to work with children and teens in Texas, regardless of whether these children and teens openly identified as TGD.

The APA is clear that when our "ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code" (Standard 1.02, APA, 2017, p. 4). Nonetheless, if enacted, laws and policies banning gender-affirming care will place psychologists in a quandary, where they must either follow the law and deny gender-affirming care or face disciplinary or criminal actions. Knapp et al. (2007) suggest that we seek creative ways to satisfy both legal and ethical obligations, and when this is impossible, either obey the law in a manner that minimizes harm to our ethical values or act on our ethical values in a manner that minimizes violations of the law. Regardless, we should "anticipate [possible outcomes] and be prepared to live with the consequences of [our] decisions" (p. 55).

Ethics in the Real World

Flynn et al. (2021) "encourage psychologists to consider their personal (and psychology's collective) responsibility to interrogate, contest, and disrupt structural injustice" (p. 1227) and refuse to be complicit with discriminatory laws. Some level of civil disobedience may already be common. A national survey of psychologists, many of whom had been members or chairs of Ethics Committees, reported 57% of the respondents acknowledged intentionally breaking a law or a formal ethical standard at least once "in light of client welfare or another deeper value" (Pope & Bajt, 1988, p. 828).

The kind of civil disobedience we have been describing is clearly an ideal, but one that many of us may find difficult to put into practice. Many physicians, for example, have conformed with bad laws and policies and failed to challenge even horrific ones (Wynia, 2022). Surely the same has been true for psychologists. Nonetheless, standing up for what we believe in and refusing to comply with unjust laws may be easier to do if we act as a profession rather than as scattered individuals (Flynn et al., 2021; Wynia, 2022).

Thus, many of us, regardless of where we fall on the political spectrum, may experience moral distress or moral injury in the coming years as we face impossible decisions that violate our deeply held moral values. Committing to your personal well-being, speaking up about your ethical concerns, acting from your principles, and contributing to a culture of ethical practice may lead, instead, to moral resilience (Ruston et al., 2016).

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

Redefining Recovery: Why We Need a Paradigm for Severe and Enduring Eating Disorders

1. Which of the following are characteristics of severe and enduring eating disorders?

a. Being consistently ill for 10 or more years
b. Having experienced at least one recognized therapeutic treatment
c. Displaying severity impairment across a number of life domains
d. Demonstrating low motivation for recovery
e. All the above

2. With treatment advances, 88% of younger clients fully recover from eating disorders.

TRUE
FALSE

Supporting Workplace Mental Health for Employees With a Chronic Illness

3. Brief health coaching interventions have been shown to have a positive effect on workplace mental health for people with chronic illness.

TRUE
FALSE

4. Many companies have established policies for accommodating employees with a chronic illness.

TRUE
FALSE

Disfigurement: A Call for Awareness

5. Prejudice against the disfigured has been proven to be innate, due to an evolutionary drive to avoid contamination from people who look different.

TRUE
FALSE

6. When interacting with disfigured people, it is advisable to ask them right away how they came to look different to reduce any awkwardness immediately.

TRUE
FALSE

Chronic Illness and Suicide

7. The risk of suicide increases among persons with chronic illnesses if they also have

a. Inability to complete activities of daily living
b. Chronic pain
c. Both a and b
d. None of the above

8. *Perceived burdensomeness* refers to the belief that

a. "Others would be better off if I were dead."
b. "I have intolerable pain that will never end."
c. "I am not a member of a valued social group."
d. All the above

Caring for Survivors of COVID and Health Care Providers During the Pandemic

9. Almost all COVID survivors in need of intensive care are expected to develop clinically relevant symptoms of posttraumatic stress disorder

TRUE
FALSE

10. Examples of moral distress that a health care worker might experience include worrying about inadvertently making a critical error that may potentially kill a patient.
TRUE
FALSE

Digital Apps for Chronic Conditions

11. Apps have many advantages in improving mental health including all but which of the following?
a. Almost universal availability because almost everyone has a smartphone
b. Availability for practice at all times of the day
c. The expense of continuing subscription costs
d. The teaching of generic skills like mindfulness, self-management, and relaxation

12. Before an app is made available at Apple's App Store or Google Play, its developers must demonstrate its safety, security, and effectiveness.
TRUE
FALSE

Special Education Eligibility Determinations and Accommodations for Students With Chronic Medical Illnessess

13. The Rehabilitation Act of 1973 is a federal law that provides eligible students with a disability with appropriate accommodations in school through a 504 plan.
TRUE
FALSE

14. A student only meets eligibility criteria for an Individualized Education Program under the Individuals with Disabilities Education Act if they have an identified disability and their educational performance is adversely impacted, demonstrating a need for specially designed instruction.
TRUE
FALSE

Ethics in Action: Acting Ethically When Faced With Unjust Laws

15. Advertising that you will not work with transgender and gender-diverse children and teens
a. Means you will not be working with them
b. May set up a pact of secrecy that will undermine therapy
c. Could reduce your number of referrals
d. Will increase the number of suicidal patients in your practice

16. Developing moral resilience may require
a. Speaking up about your ethical concerns
b. Acting from your principles
c. Contributing to a culture of ethical practice
d. All the above

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General

Ethical Issues with COVID-19 (Webinar)—1 CE*
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Foundations of Ethical Practice: Update 2019—3 CE*
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Introduction to Working with Chronic Health Conditions—3 CE
Legal and Ethical Issues with High Conflict Families—3 CE*
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