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PSYCHOLOGISTS AND SELF-CARE

EARN **1 CE CREDIT** FOR THIS ISSUE!

WHAT'S INSIDE

Co-Sponsors Needed for HB 2607: Prescription Privileges for Psychologists

Representative Wendi Thomas just introduced HB 2607, the Prescription Privileges for Psychologists Bill. Please contact your State Representative and ask them to co-sponsor HB 2607.

In Pennsylvania, there is a growing national mental health crisis and a shortage of psychiatric specialists to meet the demand. Most psychotropics are currently prescribed by primary healthcare professionals, including physicians, nurse practitioners, and physician assistants; however, these professionals often have limited training in mental health treatment.

Prescribing psychologists can increase patient access to psychotropic medications, reduce long travel and wait times that countless patients currently must deal with, and ensure better follow-up care for patients already on psychotropic medications. Prescribing psychologists can manage medication treatment for most mental health disorders. Importantly, they must earn an additional post-doctoral masters degree emphasizing psychopharmacology and the biological basis of behavior, pass a rigorous national exam, and receive supervision in practice.

Currently, five states have prescription authority for psychologists: Iowa, Idaho, Illinois, New Mexico, and Louisiana. Also, prescribing psychologists have safely and effectively prescribed psychopharmacologic medications in the Public Health Service, Indian Health Service, and the US Military for more than 20 years.

The bill will define the educational requirements for a prescribing psychologist, the scope of practice of a prescribing psychologist, describe a collaborative agreement between the prescribing psychologist and provider, and identify the formulary for the medications that may be prescribed and the continuing education requirements for prescribing psychologists.

Click here ask your Representative to contact Representative Thomas' office to be added as a co-sponsor to HB 2607.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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ALSO INSIDE

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LIVING LIFE AS A PSYCHOLOGIST:

Psychologists' Well-Being and Treatment Outcomes

The authors thank Dr. Sandy Kornblith for his review of this article.

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Working as a psychologist "is a mental health hazard" according to Dr. Maria Di Benedetto (2015, p. 401). If work as a psychologist was a mental health hazard before the COVID-19 pandemic, it certainly has been more of a hazard since. Indeed, currently psychologists must continue to deal with many difficult patient emotions and behaviors and the other "ordinary stressors" that they have always had. Plus, the increased demand for psychological services precipitated by the pandemic has stretched their emotional and physical resources. In addition to these work demands, psychologists must deal with the same COVID-19 stressors (concern for one's personal health and the health of family members, schooling children at home, etc.) as their patients. COVID-19 has put us under a microscope by magnifying the consequences of self-care lapses.

In discussing the well-being of surgeons, Campbell et al. wrote, "In the classic training program we have taught how to perform surgery, but we have not taught how to live life as a surgeon" (2001, p. 702). Similarly, a question arises as to how sufficiently psychology training programs, professional organizations, and other institutions have taught trainees and psychologists to live life as a psychologist. Self-care should not be seen as self-indulgence, but as an integral part of professionalism in that it frees up personal resources that psychologists can then direct toward improving patient care. Teaching how to live life as a psychologist requires, among other things, teaching how to balance work and family life, how to create a supportive social environment, how to regulate one's feelings and emotional states, and how to internalize a perspective that balances self-criticism and self-compassion.

Many of us learned self-care skills imperfectly through trial and error. As a younger psychologist, I (SJK), like many in my cohort, worked too hard, attempted to project confidence, and suppressed feelings of frustration and doubt over my life as a psychologist. But I was fortunate to encounter role models and self-care pioneers who were courageous enough to say aloud, "living life as a psychologist can involve a lot of pain," and then deliberate on how to make things better.

Fortunately, self-care is moving from the shadows and entering the forefront of discussions on professional competence. Its importance has been bolstered by recent evidence that supports the long-held clinical impression that the well-being of psychotherapists impacts their abilities to deliver quality services. For example, Simionato et al.'s 2019 review suggested that psychologists' burnout may inhibit their ability to engage fully with patients, show empathy, or identify the emotions of their patients, all of which are facets of professional relationships that are linked to good patient outcomes.

In addition, psychotherapists' self-rated well-being appears to be linked to their perceptions of patient outcomes and the quality of care (Green et al., 2014; Hammond et al., 2018; Salyers et al., 2015). Also, Nissen-

Lie et al. (2013) found that psychotherapists with significant personal burdens had a more difficult time in building working alliances with patients. She concluded that "patients are particularly sensitive to their therapist's private life experiences of distress which presumably is communicated through the therapist's in-session behavior" (p. 483). In addition, Delgadillo et al. (2018) found that psychotherapists with high burnout scores had patients who scored lower on treatment outcomes measures of depression and anxiety. Data on physicians' mental health and outcomes showed a similar link between burnout and indices of quality patient care (e.g., Eckleberry-Hunt et al., 2017). In addition to impacting the quality of patient care, burned out or impaired health care workers are more likely to leave their professions, thus depleting the health care workforce at a time when the demand for their services is so high.

The strongest factors linked to burnout are workload and time pressure including the nature of the work (respondents often identified administrative tasks as contributing to burnout), or the mismatch between an individual's skill or resource level and the job demands (McCormack et al., 2018). This finding appears especially relevant to psychologists today who are seeing large demands for their services.

Social support is inversely related to burnout (Yang & Hayes, 2020). Psychologists working in institutions or agencies may find support if they work in a team that values cooperation and workforce cohesion. Solo practitioner psychologists may find support when they participate in consultation groups, journal clubs, or other interactive professional activities.

Age is also inversely related to burnout (McCormack et al., 2018). Perhaps older psychologists have learned better self-care skills, perhaps the most distressed psychologists have dropped out of the profession, or perhaps older psychologists have created practices more in line with their aptitudes and personalities. Older psychologists may have had the opportunities to build independent practices where they have greater control over their caseloads and more schedule flexibility. Early career psychologists often start their careers in agencies where they have more administrative work, more responsibility for patients with extensive needs (limited resources or supports to address those needs), and limited opportunities for professional growth (Dorociak et al., 2017).

Studies on the relationship between gender and burnout have found mixed results, although age interacts with gender because a higher percentage of young psychologists are women. We found no data on burnout for ethnic minority psychologists. However, they may have more distress due to minority stress or because they are more likely to be early career psychologists. This may also be a function of intersectionality whereby younger minority psychologists are also more likely to be women.

Some psychologists may be more predisposed to burnout than others. Yang and Hayes (2020) reported a link between well-being, self-efficacy, extraversion, emotional coping skills, and mindfulness. In addition, Kaeding et al. (2017) suggested that early maladaptive schemas ("beliefs and patterns that are developed in childhood/adolescence and influence our interpretations and perceptions of others, the world, and ourselves," p. 1783) may be related to burnout. Among psychology trainees, Kaeding et al. (2017) found a link between burnout and an "unrelenting standards" (perfectionist) schema. Among psychologists, Simpson et al. (2018) found a link among burnout, unrelenting standards, and self-sacrifice ("the tendency of psychologists to sacrifice their own needs, seek approval from supervisors and colleagues, and set high self-internalized expectations," p. 41).

Clearly, psychologists are at a great risk for burnout, and we need to plan for our own self-care in an intentional way that accounts for these "mental health hazards" inherent in our work. However, questions arise as to how quickly or how well psychology trainers are integrating a self-care perspective into their training programs. Despite some noticeable exceptions, informal surveys of psychologists' first role models—their graduate school instructors or internship supervisors—suggest that many psychology trainers have attitudes about self-care that differ little from psychologists in practice. That is, they may view self-care as the equivalent of emergency room medical care. It typically happens less

often as a routine practice and more often as a response to an urgent situation. When I (JLS) asked graduate school faculty about teaching self-care, many sent me lists of the self-care activities in their curriculum, but even those responding acknowledged difficulty in integrating self-care deeply into the students' training.

The following articles in this issue consider myths that impede the implementation of an effective self-care philosophy, the benefits of deliberate self-reflection, examples of resilience in the face of challenges, the importance of setting limits, and the role of social support or social nutrition in promoting self-care.

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MYTHS THAT IMPEDE ADEQUATE SELF-CARE

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Although self-care has become more accepted as an essential element of effective psychological practice, a gap still exists between the rhetoric of self-care and its actual implementation, maintained in part by the persistence of self-care myths. Like many myths, these may have a grain of truth to them. Nonetheless, they distort the meaning of self-care, impede the self-care of psychologists, and lower the quality of patient care. Table One summarizes these myths.

Myth One: Self-Care Consists Only of Distractions and Balance

Some believe that self-care consists only or primarily of short-term diversions such as taking vacations, taking up hobbies, or purchasing luxury items. At its extreme form, self-care advertising by the beauty industry has prompted "images of . . . women taking bubble baths" (Puzio, 2021, p. 1). Of course, having interesting hobbies can enrich our lives, vacations have value if they leave one refreshed, and one can justify indulgences—including bubble baths—if they are not exploitative or wasteful. This myth, however, overemphasizes one element of self-care and ignores the need to process and reflect on the day-to-day stressors inherent in the work of a psychologist. Ignoring or suppressing negative emotions are ineffective ways to regulate emotions. Self-care is a 50/50 proposition (Sternlieb, 2013), meaning that it does involve rest (and distractions), but it also requires dealing with the emotions generated in our day-to-day lives.

Myth Two: Self-Care Is a Private Matter That Is Best Done Alone

Of course, every psychologist needs to decide how to tailor their self-care strategies for themselves. Nonetheless, effective self-care has a strong social aspect to it. Psychologists who have strong social supports tend to have lower rates of burnout (McCormack et al., 2018; Yang & Hayes, 2020). Johnson et al. (2012) called these supportive networks a competent community, and they believed that they lead to a higher quality of patient care. In one survey of the needs of psychotherapists in private practice, all participants reported on the benefits of having a supportive network (Vivino et al., 2018). One participant stated, "I've always found that a few close friends that are in the profession can save your life because they know you and can laugh with you through the tears and they can really inform you." Colleagues can also function as an "early warning" mechanism if they see someone making a pattern of poor decisions or deteriorating psychologically. Conversely, responsible psychologists support others as well as receiving support from others. Psychologists can further their goals promoting public mental health by supporting their colleagues.

Myth Three: Self-Care Is Relevant for Only a Few At-Risk Psychologists

Concerns about "drunken doctors" who were delivering consistently substandard services prompted the early self-care initiatives in the health care professions. Arnold-Foster et al. (2022) referred to the emphasis on only a few impaired professionals as the medicalization of self-care. It is true that some of our colleagues will fail to meet minimal standards of competence due to a physical

illness, mental illness, or substance use. Nonetheless, this perspective fails to consider that all psychologists can improve the quality of their services by investing in self-care, as shown by the studies referenced in the first article of this series. Finally, the medicalization approach stigmatizes those who pursue treatment for impairments and may even stigmatize those who value self-care, so that self-care appears relevant only for those psychologists who feel exceedingly stressed out or taxed, instead of something that all psychologists should embed in their daily routine and consider on good days as well as bad ones.

Myth Four: Self-Care Distracts Psychologists From Their Obligations of Self-Sacrifice and High Standards

Any skill worth having requires some self-sacrifice and delayed gratification, and the dedication of frontline health care workers during the pandemic has inspired all of us. Furthermore, we all have had limited time periods where a confluence of unanticipated professional and personal demands requires us to stretch our resources. Nonetheless, self-sacrifice is not a virtue if it unnecessarily harms oneself or others.

Of course, psychologists should strive for high standards of performance. But unrelenting standards or extreme perfectionism can be demoralizing and is associated with higher rates of burnout (Simpson et al., 2019). Psychologists do their best when they are mindful, show self-compassion, and love themselves, even as they continually seek feedback on how to improve their services. As summarized in the article title by Dr. Helen Nissen-Lie et al (2015), "love yourself as a person, doubt yourself as a therapist."

Myth Five: Self-Care Is Entirely an Individual Responsibility

Because the self-care of psychologists is related to patient outcomes, the agencies, organizations, and institutions that regulate psychology should prioritize self-care and offer resources that promote self-care. Training programs, for example, can embed self-care concepts throughout their training modules, and internship programs can create a culture that values self-care. PPA is taking a lead on this by promoting social networking opportunities and special interest groups that can expand the competence community of psychologists. Current PPA special interest groups include late career psychologists, psychologists practicing in rural areas, international students, and early career psychologists. Other PPA communities, including psychologists working in integrated care settings and members of the LGBTQ+ community, hold connecting hours to interact informally with peers. More information about how to join these groups is available at http://www.papsy.org/page/SIG. PPA also started a book club to allow members to connect socially around a common theme.

Myth Six: Self-Care Takes Too Much Time

Some psychologists react to discussions of self-care with disgust or disdain because they perceive it as an unwanted imposition or obligation to engage in certain activities that, eventually, will only make their lives more stressful. They argue that they would rather leave the office at 8 p.m. rather than stay until 9 p.m. because they added minibreaks throughout their workday. Like other myths, this has an element of truth to it. If a vacation does not leave you refreshed or add to your reserve of pleasant memories, then it was not really a vacation. A hobby that is only an obligation really is not much of a hobby, and so on. Psychologists need to find activities that work for them.

But let us consider an alternative idea, which is that the lack of self-care takes too much time. Consider, for example, the experiences of psychologists who had just had an extremely difficult patient encounter, or who feels chronic stress when dealing with a difficult patient. It seems that it would be a more efficient use of time (as well as better for the patient and the psychologist) for the psychologist

to spend some time debriefing with a colleague or stepping back and reflecting on the experiences with a goal of getting a different perspective or a way to recenter one's emotions. The failure to do so may mean that unresolved feelings may leak into and disrupt one's future professional and personal relationships.

No one self-care activity or set of activities is right for everyone. A commitment to self-care could involve miniexperiments to find which activities are most nourishing. Psychologists can experiment with talking a brief walk between patients, engaging in brief guided imagery exercises, or taking more intentionally nutritious snacks during their breaks in the day. No one activity is always optimal for every psychologist. What we suggest is that psychologists monitor their moods, energy, and enthusiasm levels carefully; plan to modify their lifestyles to reduce their stress or invigorate them; and proceed accordingly with the goal of learning for oneself what is effective and what is not.

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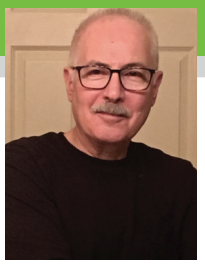
Self-Care Myths

Issue	Problems	Alternatives
Self-Care Only Involves Distractions	This fails to address day-to-day challenges in the lives of psychologists.	Good self-care invovles mindful attention to everyday experiences.
Self-Care Is Best Done Alone	Psychologists' well-being is linked to the strength of their interpersonal connections.	Opportunities for networking will help improve self-care and quality of services.
Self-Care Is Only for a Few Who Are Impaired	This stigmatizes those who focus on self-care and wrongly implies that "ordinary" psychologists have no self-care needs.	Self-care is seen as a fundamental obligation that is for all psychologists.
Self-Care Distracts From Self-Sacrifice Obligations	Self-sacrifice ceases to be a virtue when it involves unnecessary harm to others.	The highest obligations of psychologists are to deliver high-quality services.
Self-Care Is Entierly an Individual Responsisbility	This absolves institutions and agencies of their responisibility to care for patients by ensuring an adequately prepared workforce.	The organizations and institutions that regulate psychology can establish polocies or offer resources that promote self-care.
Self-Care Takes Too Much Time	Self-care, if done properly, may involve a little push initially, but typically involves activities that are inherently reinforcing or rewarding.	No one set of predetermined activities or strategies is appropriate for everyone. Psychologists need to choose and adapt activities and strategies appropriate for them.





STORIES OF CHALLENGE AND RESILIENCE

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Now, more than ever, we need to think about self-care with a sense of urgency. We need to put emotional housekeeping (Sternlieb, 2008) in the forefront of our minds. It is good for us, and it is good for our patients. Also, according to Dr. Leisl Bryant, a risk management consultant for the Trust, "self-care might be the most foundational, most all-encompassing risk management tool of all" (2019, p. 13).

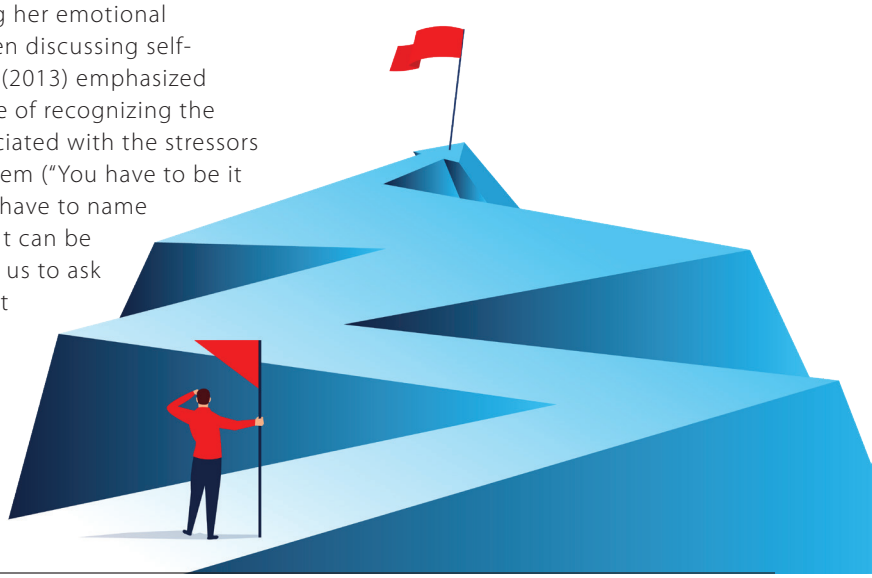
Unfortunately, we may become so close to our situation that we fail to step back and consider the impact that the stressors have on us until the situation has become urgent. One could think of this as analogous to high blood pressure. It can be deadly but occur outside of our conscious awareness. Fortunately, through self-awareness and support from others, psychologists can survive or even grow from these challenges.

Some of the stressors come from the day-to-day interactions with patients. Others occur when personal life events intrude on our lives. Consider the experiences of this health care professional:

She tried to show empathy and concern for her patients who experienced difficult pregnancies, pain, miscarriages, and loss. But, at the same time, her marriage was falling apart, and her daily life was filled with "acrimonious accusations, feelings of isolation and loneliness, and constant bickering" (Farid, 2019, p. 1045). She wrote, "I tried to give as much of myself as I could, but I felt like I had a finite limited reserve of empathy. Between the catastrophe of my personal life and the needs of my patients, I was scraping the bottom of the barrel" (p. 1045).

She was in an emotional fog; feeling upset and disoriented without fully understanding why and was in what Dr. Sandy Kornblith calls a zero place, where she felt cut off from all the ordinary sources of support and enjoyment in life. However, she regained her empathy and ability to connect with patients only after acknowledging her emotional depletion. When discussing self-care, Sternlieb (2013) emphasized the importance of recognizing the reactions associated with the stressors and naming them ("You have to be it to see it;" "You have to name it to tame it"). It can be worthwhile for us to ask ourselves: What stressors do I have? What emotions am I feeling? How are these emotions keeping me from fulfilling my core goals? What supports can help me to reach these goals? Readers can use the sample questions in Table One as an informal aide for self-care awareness.

Recognizing our emotions may be difficult for many psychologists, many of whom impose perfectionistic standards on themselves (see previous article on myths of self-care). In one of our previous workshops, we (Jeff Sternlieb and Samuel Knapp) asked participants to write a haiku about



their emotional states and experiences. Participants found this helpful as it forced them to examine their feelings and put them down on paper.

Effective self-care has a strong social aspect to it. Psychologists with strong social supports have lower rates of burnout (McCormack et al., 2018; Yang & Hayes, 2020). The greatest benefits occur when psychologists have social supports both in their personal and professional lives. Consider the situation faced by a graduate student in psychology who sustained a concussion and what a difference her social supports made:

She wrote, "I could not drive, could not use a computer, could not regulate my emotions, and could not think clearly. . . [yet my first] instinct was to throw all my resources into maintaining a façade of competence" (Lukens, 2015, p. 32). Fortunately, as a doctoral student, she had supervisors and friends who could walk her through the steps needed to transition her caseload and defer academic requirements until her health improved.

One could imagine the disasters that could have occurred if a psychologist who lacked those supports tried to "soldier on," despite the limitations caused by a concussion. Her use of the metaphor of the façade is particularly appropriate. What is true of ourselves as well as our patients is that many of us can put up a good façade. However, we may find much disarray once we step into the front door. Façades have weaknesses, and we should never face the tough questions in our life alone.

Although identifying and naming our emotions is the first step, it is also important to process the emotional stressors of our work, ideally with the support of others ("You have to share it to bear it;" Sternlieb, 2013). Consider the experiences of this trainee:

This trainee had a patient attempt suicide while in treatment with him. Although the patient was hospitalized for injuries sustained during the attempt, she survived. Nonetheless, the trainee was overwhelmed with doubt. "All the questions came rushing to my head—what did I do wrong? What did I miss?" His supervisors were supportive, and a review of his work (including videotapes of sessions) showed that his treatment was reasonable given her condition. Nonetheless, the trainee stated, "If I hadn't received such support, I might have quit" (DeAngelis, 2001, p. 70).

Survey data showed that 29% of PPA members had at least one patient attempt suicide while in treatment and 6% had a patient die from suicide in 2020 (Leitzel & Knapp, 2021). Psychologists often experience extreme distress or depression following the deaths of their patients by suicide. But the support of others can make this experience tolerable. PPA has a peer grief support group that meets virtually on a monthly basis to offer support for psychologists who have lost a patient to suicide, who are dealing with the death of a loved one, or who are coping with any significant loss. More information, including how to RSVP for the next meeting, is available at http://www.papsy.org/page/SIG under Peer Grief Support.

In these and similar situations, many psychologists have had to reflect on their reactions and often must consider the role that embarrassment or misplaced shame might have in their reactions. All conscientious psychologists want to deliver competent services and when they fail to do so (or when they perceive that they are failing to do so), they may feel shame or guilt. These emotions are similar in that they both involve the perception of the violation of a social norm. However, they differ in significant ways. Guilt is a prosocial emotion that involves recognition of the wrong and a desire to rectify it either by apologizing to the offended person, striving to do better next time, or otherwise compensating for the wrong. Shame, on the other hand, involves a global condemnation of oneself and a tendency to withdraw. Guilt involves a condemnation of what we did. Shame involves a condemnation of who we are (Tangney et al., 1996).

Shame holds a double curse. Not only is it a burdensome emotion itself, but it creates additional stressors when it prompts psychologists to keep secrets from others, such as the student with a concussion whose immediate reaction was to hide her health problems from others. But it was a liberating experience for these professionals to share their problems and get the assistance needed. Thus, isolation and shame are a toxic combination, while maintaining connections, promoting sharing, and social support are, in contrast, socially and psychologically "nutritious" and likely to promote our well-being.

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Sample Self-Care Questions

1. How would you rate your emotional well-being today?

Strong Well-Being Distressed

1 2 3 4 5 6 7 8 9 10

2. How would you rate your mindfulness (attentiveness to your clients) today?

Mindful (Attentive) Distracted

1 2 3 4 5 6 7 8 9 10

3. How well did you do in implementing your values today?

Values Implemented Values Not Implemented

1 2 3 4 5 6 7 8 9 10

4. To what extent do any emotional barriers impede your well-being (e.g., excessive self-criticism or lack of self-compassion)? If so, what are they and how did they arise?

No Barriers to Well-Being Strong Barriers

1 2 3 4 5 6 7 8 9 10

5. Did you have sufficient resources to meet daily demands? If not, how can you ensure adequate resources?

Sufficient Resources Insufficient

1 2 3 4 5 6 7 8 9 10

6. Are you establishing an adequate work-life balance? If not, what barriers keep you from doing so?

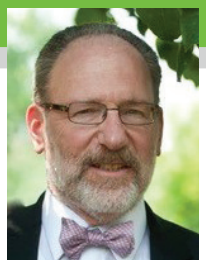
Balanced Not Balanced

1 2 3 4 5 6 7 8 9 10

7. To what extent do you cultivate or nurture your relationships with your professional or personal support system? What can you do to cultivate or nurture those relationships?

Well Nurtured Neglected

1 2 3 4 5 6 7 8 9 10



WITNESSING HISTORY IN REAL TIME: The Gift of Social Isolation

Jeff Sternlieb, PhD, *Metaworks, Wyomissing, PA*

"How are you?" "Are you OK?" We often say and hear these inquiry-type greetings that are typically meant as a social lubricant—I see and recognize you. Often, all we expect in return is: "Fine, how are you?" After all that we have experienced this year, this may be more than just a friendly greeting in passing, but a real question—an opportunity to check in with ourselves or even each other. Just coping is not sufficient! Maybe it is time, whether we need it, to make some alone time before it is less available.

The Emotional Backdrop

The years of COVID-19 have been filled with uncertainty, anxiety, fear, and struggles with more isolation than we are used to. We have experienced more separation from friends and family than we prefer and more aloneness, which sometimes can lead to loneliness, and loss—much too much loss. COVID-19 has led to multiple disruptions in our professional and personal lives, and it is inevitable (and undeniable?) that we have felt the double burden of taking care of our patients along with taking care of ourselves and family and friends. The psychologist in the family (and in the organization) is the family's psychologist! Who takes care of us?

Two Ironies of Human Nature

One of the ultimate ironies in these past years of the pandemic is how much we all seem to miss our pre-COVID lives filled with such busyness that we barely had time to think. And now, during this time where we had so much less structured time, we couldn't wait until the busyness returned (the old normal), and we still may not have taken advantage of the solitude to set aside some time for reflection! A related irony is that many people took advantage of having extra time at home to clean out their closets, but we may have left our emotional closets cluttered.

A Crisis Is a Terrible Thing to Waste!

It is an oft repeated phrase that crises create opportunity. COVID-19 may not feel like a crisis in the ways we often think about crisis. It is not an acute event. It has been much more of a chronic, cumulative, drip-by-drip erosion of our sense of normalcy that does not seem overly dramatic like so many natural disasters—earthquake, tsunami, volcano eruption, for example. The mind-numbing numbers of people who have died; the lines of cars at food banks measured in miles not people; the numbers of people who have lost jobs, lost businesses, or have filed for unemployment benefits; and the continuing travesty that is systemic racism are too overwhelming and too abstract for the magnitude of impact to fully register. That is unless we have witnessed and suffered and been touched personally by any one or more of these disasters. As we are beginning to emerge from under the cloud that this multidemic has been, and before we say goodbye to our solitude, we might consider what the impact has been on each of us, on our mood, on our relationships, and on our ways of managing this once-in-a-lifetime experience.

A Starting Point

Let's begin by acknowledging that we are social animals and that we all struggle with the physical limitations of being with others safely. In addition, there is a parallel need we all have to comfortably be with ourselves. While everyone has their own style or patterns of responding to crises, I would like to suggest a few guidelines to consider.

First, active is better than passive. For

example, writing or talking with others is much more effective than thinking about what we have experienced. Introspection is a start; putting our thoughts and feelings into words give it meaning that can be shared or even more privately explored. Reminder: Writing is different than typing! I strongly suggest using a journal rather than any online tool.

Second, combine going outside with exploring the inside. At a time when remote gadgets or virtual connections dominate much of what we do, exploring our physical world may be more important than ever. When we feel unmoored, nature is particularly grounding, and any opportunity that we can create to be outside in nature helps not only with grounding, but also with perspective.

The "going inside" part takes whatever route you would find useful. Identify and examine your own internal voice: Is it too harsh? Honest? Exaggerated in either direction? Where does it come from? What will it take to make it more useful? If this year has been marked by loss, mourning the passing of loved ones may be primary. If you are unsure about a starting point, a meditation or mindfulness practice can assist to recognize the wide range of thoughts and feelings we experience without the often-unconscious filters of judgment and social desirability. Some people combine the "going inside" with an outside experience by walking a labyrinth. A labyrinth is not a maze; it can function as a walking meditation with one path in and one path out, and there are labyrinths all over the state. You can set an intention for a focus or walk being open to whatever emerges.

No matter what your process looks like, the goal is to acknowledge that the post-COVID "normal" will be new. It will be valuable to check in with ourselves to identify how the experience may have changed us. In what ways does the life we have been living continue to meet our goals, support our values, and provide sufficient meaning? Below are a few resources that may be useful in each of your journeys.

Following basic areas of functioning: the body (e.g., exercise, nutrition), nurturing relationships (e.g., peer support and consultation, mentoring relationships, friends and family), setting boundaries (including an empowering Bill of Rights for Psychotherapists), restructuring cognitions (with a nod to Albert Ellis), and healthy escapes (e.g., rest, relaxation), with specific ideas intended to be applied at work and other ideas to be used in one's personal life. A chapter on mindfulness integrates the aforementioned areas of functioning, highlighting the benefits of these practices within a self-care framework, briefly

introducing meditation, self-compassion, gratitude, and transitions and rituals. The mindfulness chapter is quite brief and will likely be disappointing to psychotherapists who already know about and engage in these practices. Nevertheless, it is a worthwhile summary of the value of mindfulness in self-care. In addition to focusing on the self, Norcross and VandenBos (2018) provide ideas for changing one's environment, from fascinating research on creating balance in the ratio of wood to office space surface that people find comforting, to quitting a job when experiencing burnout. They also include an entire chapter on the benefits of one's own personal therapy as a method of self-care. Despite their acknowledgment that some may find the topic of spirituality and mission to be offensive or unclear, the authors explain in the chapter that this is not about religious pursuit per se, but about recognizing that psychotherapy is a calling that provides meaning and purpose. Indeed, the entire book is filled with quotes from a wide range of spiritual leaders, as well as various spiritual practices, which are balanced by quotes from master clinicians from a variety of theoretical orientations. Lastly, a chapter on creativity and growth, which includes particularly important points about diversifying self-care to include more than one category and discouraging the goal of perfection while encouraging the goal of self-kindness regarding self-care.

Overall, the content and writing style did indeed reflect the value of introspection, an intellectual quality, and an emphasis on relativism. The inclusion of scientific data reflects the empirical aspects of psychological research. The self-care checklists that summarize each chapter provide specific strategies for practice. And the personal accounts of the authors provide elements of humility and real-world experiences that allow the reader to connect with the content.

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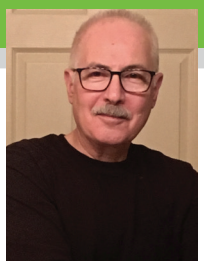
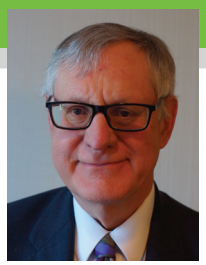


SOCIAL NUTRITION

Sandy Kornblith, PhD, *Allegheny Mental Health Associates, Pittsburgh, PA*
Samuel Knapp, EdD, ABPP, *Sunnyvale, CA*
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Consider this case:

Many years ago, a patient of mine (Sandy Kornblith) reported benefitting from time spent with friends and other socially engaging people. Such activity reliably lifted his mood, in sharp contrast to times spent alone, sometimes for days, wherein he felt depressed and frequently engaged in a corrosive pattern of ruminative hypercritical self-evaluations of his inadequacies and failings. Therefore, I prescribed activities involving interaction with others that uplifted his mood considerably.

As the patient obtained insight on the link between mood and contact with others, which I began referring to as social nutrition, it became obvious to both of us that such efforts to get together with people required adequate planning and time management so that friends could plan to be available. Last minute offers to meet for dinner were often unsuccessful, while adequately planned social activities were commonly more successful. The logistical planning of his social nutrition became an important coping skill. As I began to think about the other psychotherapy patients that I have treated, it became evident that social nutrition might be a crucial factor in their overall satisfaction with their lives.

Social contacts are not only essential for healthy living, but they are also integral for managing the difficulties of typical life experiences. Further, naming these life essentials using a nutrition metaphor captures their importance in ways that literally allows a psychotherapist to prescribe activities that fit this category. Finally, when we recognize the emotional arithmetic of social contacts, we are more likely to recommend building and maintaining social relationships. When we share positive experiences with others, our joy multiplies. When we share difficult or challenging situations with others, our pain divides.

The opposite of social nutrition is loneliness, which is the subjective discrepancy between perceived and desired social contact. Loneliness is a subjective state, although social contacts can be quantified. Some introverts can do quite well with a limited amount of social contact, while extroverts might need much more. Just as people need food to survive, they also need social nutrition to thrive and flourish. Loneliness can harm people as much as failing to exercise or being overweight. The lack of social connections increases the risk of Type 2 diabetes, susceptibility to cold viruses, impaired pulmonary function, and coronary heart disease and stroke. Socially connected people also live longer (Holt-Lunstad, 2021).

Isolation can increase the impact of stressful events. Social nutrition can mitigate the impact of stress by increasing resources

and help psychologists to reappraise their professional challenges. Without adequate support, stress can increase the likelihood of nonproductive responses such as smoking, abusing alcohol or drugs, or losing sleep. It can also activate physiological responses through the sympathetic nervous system and the hypothalamic-pituitary-adrenal cortical axis, and if prolonged, stress can increase the risk of physiological and psychological disorders (Cohen, 2004).

These insights on social nutrition have important implications for the lives of psychologists. Psychologists need meaningful contact with others for both personal and professional reasons. Ideally, one will be embedded socially in both personal and professional networks. Although we lack data on the direct impact of loneliness on the functioning of psychologists, several sources of data suggest a strong link. The likelihood of burnout declines among psychologists with strong social networks (Yang & Hayes, 2020; McCormack et al., 2018). Medical practices with good teamwork tend to get better patient outcomes (Hickson & Entman, 2008), and anecdotal reports from risk management experts in psychology link social isolation with an increased risk of being the subject of a disciplinary action by a licensing board (Knapp et al., 2013). Well-functioning psychologists tended to have strong social networks and close professional relationships (Coster & Schwebel, 1997; Dlugos & Friedlander, 2001). Using one measure of sociability, membership in a state psychological association, Knapp and VandeCreek (2012) found that membership was negatively associated with being disciplined by the state board of psychology, a finding that Schultz (2017) confirmed in a follow-up study. Finally, Johnson et al. (2012) emphasized the importance of a competence network, or a group of individuals or institutions that provide social support, information, and feedback for psychologists.

Psychologists who have adequate social nutrition are more willing to pursue new opportunities or accept difficult challenges, such as taking a new job or refocusing their areas of practice, because they know that they have an emotional safety net to fall back on. The social support can be instrumental, informational, or emotional. Instrumental refers to "the provision of material aid," which could be as simple as allowing a colleague to borrow a psychological test. Informational refers to "the provision of relevant information," such as sharing information on useful continuing education programs or nuances of insurance billing. Emotional refers to "the expression of empathy, caring, reasoning, and trust and provides opportunity for emotional expression and venting" (Cohen, 2004, pp. 676–677). Emotional support could occur through formal consultations but more frequently through seemingly casual daily exchanges with others.

How then can psychologists increase their social nutrition? Psychologists, like all persons, benefit when they nurture social relationships with family and friends. However, professional relationships are important as well. As with the patient treated by Dr. Kornblith, ensuring adequate social nutrition requires some planning and effort. When a psychologist is new to a community it may take some time to break into an existing social network. Nonetheless, psychologists can consider ensuring their social nutrition by:

- participating with local community groups, such as those dealing with suicide prevention, brain injury, autism, or another area of interest
- volunteering with community groups (e.g., houses of worship) to promote discussion groups on relevant topics, such as dealing with pandemic stressors, parenting issues, or confronting prejudice
- joining state and local psychological associations and participating regularly, including being a committee member, committee chair, or officer
- offering to give a continuing education program
- staying connected with former colleagues or your friends or teachers from graduate school
- offering to be a resource to other psychologists; making yourself available as a consultant
- mentoring younger psychologists

- participating in a Balint group, if the opportunity arises
- joining one of PPA's special interest or book discussion groups
- nourishing one's own personal relationships with family and friends outside of work

Perhaps most important, we can combine the strengthened social networks with other self-care activities: taking vacations, taking a weekend off from all work, or visiting local museums or nature preserves (some areas of natural beauty may be very close to your home). Even something as simple as taking brief minibreaks during the day may be refreshing. It could be as simple as taking 5 minutes between patients to walk outside, read an inspirational passage, or listen to good music. Nor should we forget the importance of getting enough nutrition, sleep, and exercise. Whenever we recommend a self-care strategy to our patients, we may consider whether we are doing the same thing ourselves.

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CLASSIFIEDS

MICHAEL J. KOZAK, PhD:
A Tribute to a Man of Great Consequence

Chris Molnar, PhD

Michael J. Kozak, PhD, was born (May 1952) and died (March 2019) in Philadelphia. His contributions to the field of psychology began as an undergraduate when he focused on reversing learned helplessness (Seligman et al., 1975). In graduate school, he invented Applied Tension (AT) treatment to address the vaso-vagal syncope reflex that can cause fainting in people diagnosed with blood injury and injection (BII) phobia (Kozak & Montgomery, 1981; Kozak & Miller, 1985). Details of his academic lineage are summarized in Molnar (2020). Michael is referred to as "mjk" henceforth because he signed communications with his lowercase initials. This habit revealed his unassuming nature, efficiency, and even a way of being.

If you read mjk's seminal early publications about AT you will see the birth of emotional processing theory (EPT) applied to a specific fear. He further codeveloped EPT (Foa & Kozak, 1986) to account for mechanisms underlying exposure therapy. With great clarity, EPT explained that to treat anxiety, obsessive-compulsive disorder (OCD), and posttraumatic stress disorder (PTSD), the client must be supported in activating the fear associative network. Once this "fear structure" that is composed of stimulus, response, and meaning elements (Lang, 1979) is activated, the clinician can facilitate the integration of corrective information. Such information reflects actual current associations as opposed to past learning or imagined future contingencies in the client's representation of experience. Over time, EPT's utility in processing emotions broadly writ (c.f., Foa & Kozak, 1991) has been widely appreciated and applied to many other conditions in which maladaptive emotion occurs. This includes, but is not limited to, emotion dysregulation associated with maladaptive inter- and intrapersonal behaviors driven by conditioned avoidance of fear (Newman et al., 2004) and loss (see Hayes et al., 2015).

When I served as president of the Philadelphia Behavior Therapy Association (PBTA), mjk was honored with PBTA's Lifetime Achievement Award. The award ceremony was followed by a continuing education (CE) event about yet another of the important paradigms to which he contributed with many colleagues (Kozak, 2014). This was his swan song contribution, before his retirement from several leadership positions at the National Institute of Mental Health (NIMH): the Research Domain Criteria (RDOC: https://www.nimh.nih.gov/research/research-funded-by-nimh/rdoc). The RDOC were intended to support identification of valid dimensions of psychopathology (Cuthbert & Kozak, 2013) and ultimately development of more effective treatments. In my opening remarks, I highlighted tributes I received from luminaries who, like mjk, have substantially contributed to clinical science and practice and improved the lives of many (see Molnar, 2014).

Unified Protocol creator, David Barlow, PhD, ABPP, wrote, "Michael is one of those rare clinical psychologists who has contributed across all four major roles typically describing the work of clinical psychologists: clinical research, direct clinical service, teaching and supervision, and administration and policy development. We are all aware of Michael's enormous contributions to clinical science, both theoretical

and empirical. But not all may be aware as I am of his substantial contribution in facilitating the work of others. Over a decade ago I proposed a new unified trans-diagnostic approach to the treatment of emotional disorders. … Michael, in his capacity as (NIMH) Program Officer and seeing some promise in our ideas advocated for … our program … It is safe to say that this new approach to treatment would not now be in existence without Michael's belief in our vision."

Michael Liebowitz, MD, wrote, "Michael was an integral part of my collaboration with Edna Foa to compare the effects of medication and exposure and response prevention for OCD. … He also trained my staff in CBT techniques for OCD, and they still say he was the one of best supervisors and trainers they ever encountered."

Gregory A. Miller, PhD, and one of mjk's best friends wrote, "Mike was a year ahead of me in grad school. We were cotherapists, supervised by our advisor Peter Lang, in my first real case, treating a textbook spider phobic. Exposure therapy was in its infancy, and I was skeptical. But Mike was already a creative and fearless therapist and a terrific role model for me. Using a dead tarantula and then small, live spiders Mike brought in, we fixed that phobia, a complete success.

Later … in our treatment of vasovagal syncope, supervised by David Graham, Chair of Internal Medicine and a pioneer in psychosomatic medicine … Mike was showing me the ropes … using a treatment he developed … (AT).

Also in grad school I observed Mike's sessions serving as a cotherapist with Jack Rachman, at the beginning of the development of exposure therapy for OCD. Jack spent a summer in our lab and inspired us in a number of ways, including appreciation of fine wine, which became one of Mike's many areas of expertise".

H. Blair Simpson, MD, PhD, wrote, "Mike Kozak is one of the best therapists and supervisors I ever knew. Patient with me (his supervisee), clear in his instruction, full of empathy for the patient, yet tough. He taught me to have great respect for the disease (OCD), to inspire trust and hope in patients (through demonstration of clinical expertise), and to positively communicate to patients their responsibility for the treatment outcome. His ability to use his rational mind to discipline his behavior and emotions was an object lesson in and of itself.

He was also an outstanding scientific colleague — always did what he said he would do, pulled his weight and more in a team, provided incisive intellectual contributions, and superb interpersonal advice."

Close friend and colleague Adele Hayes, PhD, wrote, " EPT … proposed more than 30 years ago is still a foundation of (many) cognitive-behavioral treatments for anxiety and related disorders. I and others are also applying an adapted version of exposure and EPT to the treatment of depression. EPT… has become a classic and is continuing to evolve as new theoretical and empirical knowledge emerges. Not many theories or treatments have such longevity. Michael was a deep thinker, and he always had a unique and interesting perspective. He brought that to his theoretical work, his patients, and to his friends and colleagues. What a rare treat."

I had the good fortune to have an office next to mjk's from 1992 to 1995 in Philadelphia. I experienced him as a generous mentor who became a good friend. He cared both for my personal and professional development, as was the case for the many of us he mentored both formally and informally. I have gratitude for an internalized mjk who lives on in my heart-mind and contributes to my sense of faith in and hope for a world where the causes and conditions for peace of mind and compassionate action are possible. I had many engaging conversations with him about EPT, imagery, OCD, the etiology of anxiety disorders, and psycho-physiology. He always listened with kindness and positive regard and then responded with wise guidance in support of further idea development and refinement. He was subtle yet profound in his influence. He often compassionately remarked, "Oh so you care about the truth" when I expressed frustration with unsubstantiated conclusions in scientific manuscripts. Many have favorite mjk quotes. A personal favorite is, "In the big picture of life there is little of great consequence." Clients love this one when it is offered at the right time during psychotherapy. I know he told me the source but I do not recall it — I hear it in mjk's tone still. Perhaps the original source is John Ruskin's, "What we think, or what we know, or what we believe is, in the end, of little consequence." My last lunch with him shortly before he died was typical of every interaction with him: We discussed great movies and art, good food and wine, wise financial planning, and Buddhist psychology — in particular the heavenly abodes and their essential role in reducing unnecessary suffering.

So much more could be written of mjk's contributions to science and humanity, yet time and space are limited. MJK (caps intended) was the epitome of a "clinical scientist" operationalized, in part, as one whose work contributes to "reform the mental health care system and advance public health" (McFall et al., 2015, p. 87). MJK, beloved by so many, embodied integrity and compassion in his actions. The fruits of his life's work will undoubtedly continue to nourish many and continue to alleviate suffering for many. May we all aspire to serve as he did. Historians will view his contributions to psychology as of great consequence.

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IN MEMORIAM

GERALDINE KOVSKY LINCOLN GROSSMAN

(NOVEMBER 17, 1923 – APRIL 30, 2022)

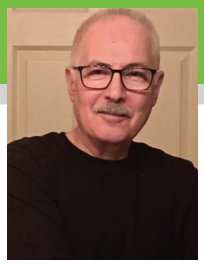
Born Nov. 17, 1923, Geraldine grew up in Oak Lane and graduated from Olney High School in 1940. She studied economics and graduated from Goucher College in Towson, Md., in 1944, attended Bryn Mawr College, and earned a master's degree in clinical psychology at Temple University in 1954.

Ms. Lincoln Grossman had strong convictions about social reform and headed groups that supported women's rights and denounced political developments that she considered problematic. But she was generally tolerant of individual viewpoints and sympathetic to human frailty.

Ms. Lincoln Grossman was a member of the American Psychological Association, Pennsylvania Psychological Association, American Family Therapy Association, and the American Association for Marriage and Family Therapy.

To read the full obituary visit: https://bit.ly/3FEx7CT





ONE LAST THING:

Learning Self-Compassion and When and How to Say "No"

Samuel Knapp, EdD, ABPP, *Sunnyvale, CA*
Jeff Sternlieb, PhD, *Metaworks, Wyomissing, PA*
Sandy Kornblith, PhD, *Allegheny Mental Health Associates, Pittsburgh, PA*

This series of articles on self-care has covered many topics including the research on psychotherapist well-being and patient outcomes, myths or false beliefs that impede self-care, the benefits of deliberate self-reflection, ways to cope with stressful events, and defining and explaining the importance of social nutrition. But these short articles do not allow us to cover all the stories, observations, and feelings related to self-care. As we wrote these articles, we struggled to decide what to include and exclude, what to highlight, and what to summarize. In our discussions we continually used the phrase, "one more thing." We had to discard most of the "one-more-things," but one was so salient that we believed it deserved special attention: the way that our attitudes may degrade our day-to-day emotional lives. The emotional lives of our patients are filled with poor moods, self-hatred, disturbed relationships, traumatic memories, and severe crises (Hayes & Vinca, 2017). Effective psychotherapists need to manage their reactions to patients to help them and to avoid a downward spiral of emotions themselves. Certain attitudes or frames of mind may facilitate a healthy emotional response, while other attitudes may facilitate an unhealthy one.

Consider this real-life example:

> A highly competent and experienced psychologist was treating a seriously suicidal patient and was following the protocols recommended by experts in suicidology. Nonetheless, the patient remained highly suicidal and the psychologist was feeling increasingly distressed at her "failure" to reduce the risk of suicide. Then a consultant urged her to accept the possibility that the patient may, despite all her efforts, die from suicide and that such a death would not be her fault. The consultant paraphrased the words of noted suicidologist David Jobes, "while I cannot guarantee a nonfatal outcome, I can nonetheless provide the best possible clinical care to the suicidal patient" (2016, p. 49, italics in original). "Your job is not to save the patient's life," the consultant said, "but only to deliver a high quality [not perfect] service. The patient ultimately decides whether to live or to die."
>
> A light went on in the mind of the psychologist. She had realized that she bordered on becoming demanding or frantic in the sessions. The psychologist had an implicit assumption that she had to be perfect when dealing with the patient and that the patient's failure to improve was due to imperfections in herself. When she relieved herself of the burden of being personally responsible for the patient's life, her natural empathy shown through, and the patient began to improve, albeit slowly.

In the Collaborative Assessment and Management of Suicide (CAMS), the evidence-supported treatment for suicide, Dr. David Jobes noted the importance of being honest with patients and acknowledging that they always can kill themselves. In an example of his informed consent process with patients, Dr. Jobes wrote:

I would rather not debate with you whether you can kill yourself; instead, I would propose an evidence-based treatment designed to save your life. The research shows that most suicidal people respond to this treatment within 3 months. So why not give it a try (2016, p. 5).

Although this case had a positive outcome, sometimes highly competent psychotherapists delivering excellent services cannot achieve positive patient outcomes. We are not perfect and no amount of self-sacrifice on our part is going to change that fact. We cannot always remove the anguish of our patients; our failure to relieve our patient's suffering is not a measure of our self-worth, and we should not feel shame if our patients fail to improve.

As someone who has spent a lot of time working with, writing about, and teaching about suicidal patients, the acceptance of our less-than-absolute responsibility for producing good patient outcomes was a hard attitude shift for me (Samuel Knapp) to make. However, this important attitude shift applies to more situations than just the treatment of suicidal patients. Maintaining that perspective requires continual self-awareness and attention to our internal dialogue. Psychotherapists need to attend to their inner lives to maintain a sense of therapeutic presence characterized by "being aware of and centered in oneself while maintaining attachment to and engagement with another person" (Hayes & Vinca, 2017, p. 86).

Two factors that could impede the sense of presence are excessive self-sacrifice and unrelenting standards or perfectionism. In his discussion of ethics, Aristotle identified virtues as character traits that avoid excesses, or which follow "the observation of the mean" (p. 68). Just as one may view courage as the middle between recklessness and cowardice, one may view caring for others as the middle between excessive self-sacrifice and selfishness. Cowardice is the absence of courage, just as selfishness is the absence of concern for others. But courage without consideration for the context or consequences of one's behavior (recklessness) is like excessive self-sacrifice, where the actors have not adequately considered the implications or impact of their behavior. Sacrifice without consideration for the totality of its impact has been called unethical altruism or runaway altruism. It is possible for seemingly altruistic acts to be unethical.

Caring, or the appropriate balance between excessive self-sacrifice and selfishness, includes the permission—or an obligation—to say "no" to some requests. This may mean turning away some patients or saying no to burdensome requests from other patients. For example, it may be possible for us to schedule a patient for 9 p.m. and such a time may be convenient for some of our patients. But we need to consider the impact of the schedule on our well-being. We could ask ourselves, for example: Will I be sufficiently alert at that time to deliver a good quality of service? Will I be sufficiently alert the next day to deliver good services to my other patients? Or even why am I stretching the boundaries of my availability for this patient?

It may be worthwhile for us to consider why we failed to say "no," in situations where it was clinically or personally indicated to do so. Do we associate saying "yes" with being a good person? Are we afraid of the social disapproval if we were to say "no?" Do we overinvest ourselves in how much our patients like us in a codependent kind of way? Do we have other psychologically unhealthy reasons for failing to say "no?" Have we considered legitimate ways to meet legitimate needs without agreeing to an unwarranted request? For example, a physician requested a psychologist to take a referral even though the psychologist knew the identified patient sufficiently well enough that it could be clinically contraindicated to accept her as a patient. The psychologist can say "no" to the request but still address the legitimate concerns of the referring physician by giving detailed reasons why she denied the request and searched out appropriate alternatives for the physician.

Similarly, one could describe drive, or striving for excellence, as an intermediate position between being lax and perfectionistic. Perfectionism, or striving for excellence without allowing for human error, fatigue, limitations of information, or other inevitabilities, sets one up for failure, shame, and discouragement. Perfectionist strivings, unless balanced with self-compassion, could even lead to poorer performances. Effective psychotherapy often requires a give and take wherein psychotherapists need to give feedback, get feedback from patients, admit their cultural limitations, involve patients heavily in the development of their goals, defer to patient preferences whenever appropriate, or otherwise take steps that implicitly demonstrate the limitations of their knowledge or expertise. For example, one psychotherapist accepted a patient who was a devout Seventh Day Adventist who incorporated many religious references in her psychotherapy sessions. The effective psychotherapist did not pretend to know much about Seventh Day Adventism and often sought guidance from the patient as to the implications of her comments or the context in which she made them. The psychotherapist always accepted the

patient as an expert on her own culture as well as her condition and allowed the patient to educate her when appropriate.

We hope that these brief articles will help our readers to better appreciate the importance of self-care and self-awareness for us to live satisfying personal and professional lives as psychologists. They have focused on the need for self-care to be deliberate and comprehensive and involve self-reflection and involvement with others. We hope that these articles will help psychologists to reflect on how to live life effectively as a psychologist. Psychologists are no less impacted by all sources of stress than our patients. We can never know what challenges we may face nor the circumstances under which these challenges may appear.

We can, however, check in with ourselves at various times and in several ways. For example, at the end of each week, we might ask ourselves how stressful the past week has been on a 1-10 scale. We can then identify what was stressful and why and explore ways we are managing that stress. Similarly, we can ask ourselves what was satisfying during the last week, and we can explore why. We might also check in with ourselves monthly or even seasonally—at the two solstices and the two equinoxes. This also keeps us in touch with the physical world. Finally, an annual review of the past year along with plans for the upcoming year helps us to map our own journey with more deliberation and intentionality.

For comments on these self-care articles or self-care in general please feel free to contact the authors (Samuel Knapp, samuelknapp52@yahoo.com; Sander Kornblith, skornblith@gmail.com; or Jeff Sternlieb, jsternlieb@comcast.net).

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The home study selected for 1 CE credit in this issue of *The Pennsylvania Psychologist* is sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.

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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.

Living Life as a Psychologist: Psychologists' Well-Being and Treatment Outcomes

1. The available evidence, such as the study by Delgadillo et al. (2018), suggests that
- a. Psychologists with high burnout scores get poorer patient outcomes.
- b. Self-care paradoxically leads to poorer patient outcomes.
- c. Self-care is unrelated to patient outcomes.
- d. Self-care forms a "U"-shaped curve where psychologists who are the best and the worst in terms of self-care get the best outcomes.

2. Data from Yang and Hayes (2020) and McCormack et al. (2018) suggest that burnout is more common among psychologists who
- a. Have strong social supports
- b. Are early in their careers
- c. Work in independent practice
- d. All the above

3. According to Kaeding et al. (2017) and Simpson et al. (2018), traits that predispose psychologist trainees and psychologists to burnout include
- a. Unrelenting standards and excessive self-sacrifice
- b. Unrelenting standards and negative urgency
- c. Excessive self-sacrifice and anxiety sensitivity
- d. Anxiety sensitivity and negative urgency

Myths That Impede Adequate Self-Care

4. Johnson et al. (2012) called networks of supportive professionals
- a. The medicalization of self-care
- b. A 50/50 proposition
- c. A competent community
- d. Distraction from our professional duties

5. The phrase "medicalization of self-care" refers to the
- a. Emphasis on only a few impaired professionals
- b. Need to care for one's physical health
- c. Way that self-care is important for all health care professionals
- d. Relationship between well-being and emotional health

6. The myths of psychologist self-care include all the following EXCEPT, self-care
- a. Consists only of distraction and work-life balance
- b. Is a private matter that is best done alone
- c. Is entirely an individual matter
- d. Is a 50/50 proposition that requires work-life balance and dealing with the emotions generated by our work

Stories of Challenge and Resilience

7. According to Dr. Leil Bryant, self-care
- a. Is unrelated to professional risk
- b. Paradoxically increases professional risk
- c. May be the most foundational risk management tool of all
- d. Is only a luxury and not a professional obligation

8. The phrase "you have to name it to tame it" refers to the need to
- a. Share feelings with others
- b. Put a name to the emotional reactions generated by our work

c. The importance of social networks in promoting self-care
d. How institutions have some responsibility for teaching self-care to trainees

Witnessing History in Real Time: The Gift of Social Isolation

9. In reflecting on our social lives, Dr. Sternlieb suggests that psychologists

a. Focus only on their internal feelings
b. Focus only on their internal feelings without interference from others
c. Get "out of their heads" because too much reflection inevitably leads to ruminations
d. Combine exploring the outside with the inside

10. Some of the options to facilitate self-reflection could include

a. Walking a labyrinth
b. Being outside in nature
c. Engage in meditation or mindfulness practice
d. All the above

Social Nutrition

11. Loneliness is the same as social isolation

TRUE
FALSE

12. Evidence suggests that loneliness is associated with an increased risk of

a. Type 2 diabetes
b. Coronary heart disease
c. Susceptibility to cold viruses
d. All the above

Michael J. Kozak, PhD: A Tribute to a Man of Great Consequence

13. Emotional processing theory (EPT; Foa & Kozak, 1986) specifies that which elements of the fear associative network (aka the "fear structure") must be activated to facilitate the integration of corrective information in exposure therapy?

a. Stimulus elements
b. Response elements
c. Meaning elements
d. All the above

One Last Thing: Learning Self-Compassion and When and How to Say "No"

14. According to Dr. David Jobes, when treating suicidal patients, the obligation of the psychotherapist is to

a. Ensure a nonfatal outcome
b. Deliver the best possible clinical care
c. Intervene with all options available to absolutely ensure patient safety
d. None of the above

15. According to the methodology used by Aristotle, the appropriate balance between selfishness and excessive self-sacrifice would be

a. Courage
b. Caring
c. Unrelenting standards
d. Perfectionism

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The Pennsylvania Psychologist May 2022

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2.	a	b	c	d	6.	a	b	c	d	10.	a	b	c	d	14.	a	b	c	d
3.	a	b	c	d	7.	a	b	c	d	11.	T	F			15.	a	b	c	d
4.	a	b	c	d	8.	a	b	c	d	12.	a	b	c	d					

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Peer Grief Support SIG Meeting
3:00 - 4:30 pm

WEDNESDAY, JUNE 1, 2022
Addictions/Dual Diagnosis Psychologist SIG Meeting
7:00 - 8:00 pm

SUNDAY, JUNE 5, 2022
LGBTQ+ Connecting Hour
7:30 - 8:30 pm

FRIDAY, JUNE 10, 2022
Recognizing and Responding to LGBTQ+ Partner Violence: Ensuring Inclusivity
Webinar
12:00 - 1:00 pm

Home Study CE Courses

Act 74 CE programs
Essential Competencies When Working with Suicidal Patients—1 CE
Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE
Talking About Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide Among Adolescents—1 CE
The Essentials of Screening and Assessing for Suicide Among Adults—1 CE
The Essentials of Screening and Assessing for Suicide Among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs
Pennsylvania Child Abuse Recognition and Reporting—2 CE Version
Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General
Ethical Issues with COVID-19 (Webinar)—1 CE*
Ethical Responses When Dealing With Prejudiced Patients (Webinar)—1 CE*
Ethics and Self-Reflection—3 CE*
Foundations of Ethical Practice: Update 2019—3 CE*
Integrating Diversity in Training, Supervision, and Practice (Podcast)—1 CE
Interdisciplinary Collaboration in Assessing Capacity in the Elderly (Webinar)—1 CE
Introduction to Working With Chronic Health Conditions—3 CE
Legal and Ethical Issues With High Conflict Families—3 CE*
Mental Health Access in Pennsylvania: Examining Capacity (Webinar)—1 CE
Record Keeping for Psychologists in Pennsylvania—3 CE*
Telepsychology Q&A (Webinar)—1 CE
Why the World Is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

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