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Psychologist

JUNE 2022

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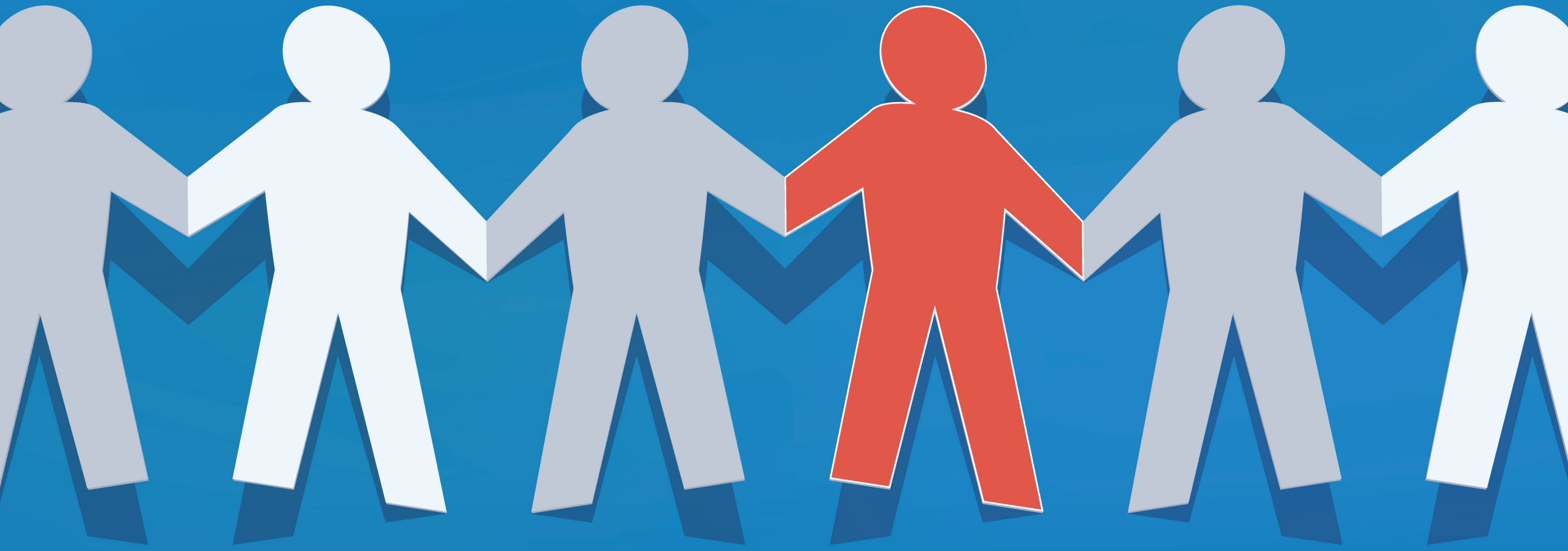
# CAREGIVERS & CAREGIVING



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If you are interested in submitting an article to be published in *The Pennsylvania Psychologist* please contact Publications Chairperson, Helena Tuleya-Payne, DEd at *publications@papsy.org*.

**Publications Committee Chairperson:**
Helena Tuleya-Payne, DEd
**Graphic Design:**
Graphtech, Harrisburg
**Copy Editor:**
Michaelene Licht

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# PSYCHOLOGISTS AS LEADERS IN ADDRESSING MENTAL HEALTH DISPARITIES

BRAD NORFORD, PhD

*By the time you read this column, our annual convention will have passed and I will soon be handing the president's gavel over to our president-elect, Jeanne Slattery. It truly has been an honor and a privilege to serve as PPA's president this past year. Thank you for electing me!*

In this, my last column, I will highlight mental health disparities—a concern to most psychologists and an issue that drew many of us to this field. In these challenging times, psychologists are counted on as leaders for information, policy direction, and hands on intervention designed to eliminate mental health disparities.

The American Psychological Association defines health disparities as "preventable, adverse differences in health experienced by socially disadvantaged populations in comparison to more advantaged populations." Socially disadvantaged populations are often comprised of individuals of low socioeconomic status, individuals with disabilities, and individuals living in very rural settings as well as groups who are racial and ethnic groups, and/or sexual and gender minorities. "Health disparities are caused by persistent, systematic, unjust policies and practices that increase a group's risk for poorer health and limit access to quality care" (APA, n.d.b).

The pandemic clearly has heightened societal awareness of our national mental health care crisis. Has there ever been another time in our history when so many people have reached out for therapy or when media has been so seeking of psychological commentary? The fortunate news is that reduced stigma about seeking services and openly discussing mental health issues has grown dramatically.

At the same time, shortages of mental health professionals to meet this need have been significant and even more so for socially disadvantaged populations. Access to psychologists who accept Medicare and Medicaid can be daunting for our seniors, individuals with disabilities, and low-income communities. Difficulty obtaining psychoactive medication and appropriate follow-up care, a dearth of quality inpatient care for those in crisis, as well as residential treatment for the seriously mentally ill and those battling opioid and other addiction, combine for the unfortunate phrase of, "The system is broken."

This is where we come in—and have been! Psychologists are well positioned to be drivers of change in the realm of mental health disparities. Following are some of the ways in which we can continue to extend our professional work to reduce mental health disparities in a manner that aligns with our principles of Beneficence, Responsibility, Justice, and Respect:

1. Continuing to educate ourselves on social determinants of health through CE, readings, and podcasts.
2. Extend our expertise to reduce stigma of "psychology" through community talks, media engagement, advocacy work, teaching, mentoring, political involvement, and supporting policy change.
3. Continue to strive for equity and awareness in our own workplaces and organizations so that we better serve the needs of others—coworkers and their families, students, patients—and create greater access and diversity.
4. Increase pro bono work, and personal and financial support for underfunded mental health entities.
5. Respond to PPA and APA legislative alerts, all of which benefit both the public and the practice of psychology.
6. Take note of APA's initiatives focused on reducing mental health disparities (APA, n.d.a) through the use of psychological and behavioral research and services that are culturally and linguistically competent. Examples of

these efforts include:

   a. Advancing population health: The APA Council passed a measure for working within and across diverse systems to advance population health (APA, 2022). This measure focuses on improving the health, health equity, safety, and well-being of entire populations, including individuals within those populations. The policy also advocates for prevention and early intervention strategies and urges psychologists to enlist and educate a diverse array of community partners.
   b. Formal recognition of Master's-level training: APA Council has approved the standards of accreditation for Master's-level programs in Health Service Psychology (APA, 2021b). Master's-level clinicians significantly impact the psychological workforce available to underserved populations. APA accreditation will help ensure that that workforce is trained in evidence-based practices.
   c. Combating racism: APA Policy on Racism Council adopted a policy on racism entitled Harnessing Psychology to Combat Racism, Adoption of a Uniform Definition and Understanding (APA, 2021c).
   d. Care for sexual minorities: APA Council adopted as policy the Guidelines for Psychological Practice with Sexual Minority Persons (APA, 2021a).

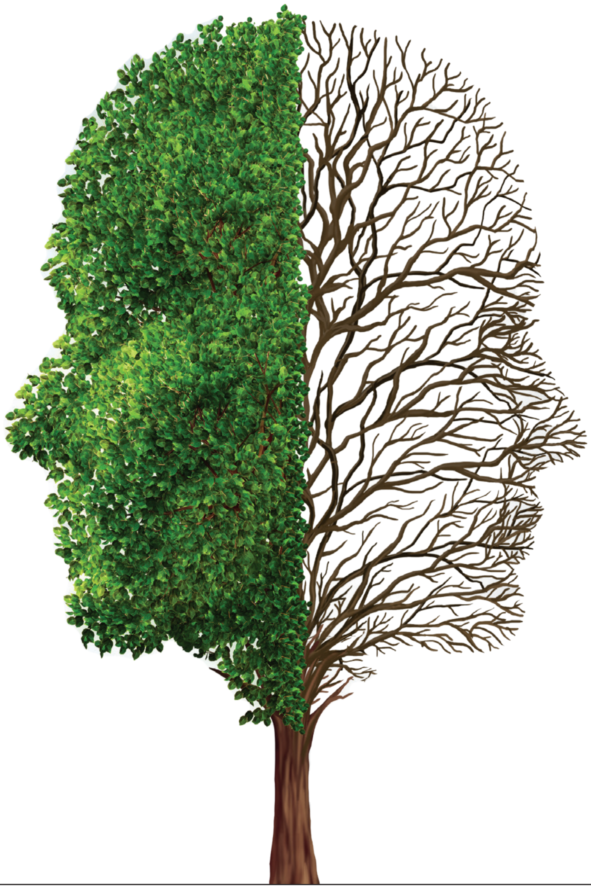
7. Join PPA committees and Special Interest Groups that address mental health disparities and/or equity, diversity, and inclusion initiatives.

8. Support prescriptive authority for psychologists (RxP) in Pennsylvania: Due to a lack of psychiatrists, serious issues of access to psychotropic medication exist for residents in many rural counties in Pennsylvania. Even in populated areas where psychiatric practices are present, there remains an access to care issue in that relatively few psychiatrists are within the financial capabilities of most families. Both situations result in the majority of prescriptions for psychotropic medication being written in primary care settings, a setting in which practitioners typically have less training and less expertise than prescribing psychologists (Cooper, 2020). PPA and the RxP Committee are working to gain legislation for prescriptive authority for psychologists willing to complete the rigorous accreditation process.

9. Support continuation of telehealth: Telehealth has greatly improved access to psychotherapy. This is particularly true for people who experience health disparities exacerbated by transportation issues, who have physical or health impairments, who do not have local access to specialists or linguistically aligned professionals, and are circumventing complicated employment childcare issues. PPA has been instrumental in three legislative aspects of advancing telehealth access to all Pennsylvanians: Ensuring insurance coverage for telehealth beyond the pandemic, expanded broadband access in all areas of the state, and gaining passage of PSYPACT legislation in Pennsylvania allowing for psychotherapy across state lines.

Psychologists have advanced knowledge of health care disparities and incremental strategies to help socially disadvantaged populations through public education, intervention services, advocation for health care reform, and training the next generation of psychologists.

Thank you to all of you for both belonging to and contributing to this great organization. Have an enjoyable and enriching summer!



## REFERENCES

American Psychological Association. (n.d.a). Health care reform. Retrieved April 17, 2022, from https://www.apa.org/advocacy/health-disparities/health-care-reform.pdf

American Psychological Association. (n.d.b). Health disparities. Retrieved April 15, 2022, from https://www.apa.org/advocacy/health-disparities.

American Psychological Association. (2021a). APA guidelines for psychological practice with sexual minority persons. https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf

American Psychological Association. (2021b). APA moves step closer to accrediting master's programs in health service psychology. https://www.apa.org/news/press/releases/2021/03/master-programs-health-service-psychology

American Psychological Association. (2021c). APA resolution on harnessing psychology to combat racism: Adopting a uniform definition and understanding. https://www.apa.org/about/policy/resolution-combat-racism.pdf

American Psychological Association. (2022). Psychology's role in advancing population health. https://www.apa.org/about/policy/population-health-statement.pdf

Cooper, R. R. (2020) Comparing psychopharmacological prescriber training models via examination of content-based knowledge [Master's thesis, Harvard Extension School]. Digital Access to Scholarship at Harvard. https://dash.harvard.edu/handle/1/37365636

# A SAFE AND MEANINGFULLY CHALLENGING PLACE FOR ONGOING DIALOGUES

DR. LAVANYA DEVDAS, PhD, MSW

As the days for the PPA2022 convention were nearing, I was excited to reconnect with familiar faces and hoped to forge new connections. I was also restless about what it would be like to meet people after a long hiatus. The joys of connecting with familiar faces and rich conversations over lunches and dinners felt affirming and energizing. I share this as a psychologist who is also a woman of color because it helps me to see the safety of a space as gray. The affirmations and the energizing conversations with colleagues and friends at workshops, lunches, and dinners together constitute a safe space. There is a vital and growing need to emphasize creating a safe space as being critical to well-being (Johnson, 2021; Scott, 2021). This also includes a sense of community, camaraderie, and support. Ranging from the keynote address by Dr. Christopher Liang (2022); workshops on clinical and multicultural topics; to social hours, luncheons, and dinners, there was a key theme that felt deceptively simple and yet one of the hardest things to do: Openly and actively listen regardless of whether we agreed or agreed to disagree. There was also a key component: Asking open-ended questions from a beginner's mind and with a sense of curiosity. As a psychologist whose identity also intersects as a woman of color, to be heard and seen by colleagues, psychologists, and friends and having a safe space among allies is a safe space. What I also saw at this convention was a turn toward a brave space (Ali, 2017).

I became familiar with the term the brave space as I was reading an article by Diana Ali (2017) that touched on intent and impact, having the courage to have difficult conversations, and people having a choice to step in and out of conversations. This is also the meaningfully challenging part for me as a psychologist and a woman of color whose background is an amalgamation of social work experience and intersecting identities in India and a psychologist who does individual, group, and community-based work in the United States. I bring this up for several reasons: My identities are privileged and marginalized depending on context, social location, and the nature of conversations and with whom am I having the conversation. For instance, some of my conversations centered around being receptive to comments related to governance between two countries. I bring this up to normalize the shock, disbelief, and confusion I experience, and awe at the unintentionally harmful impact and the good intent to strike up a conversation. To offer my perspective, I am a psychologist who appreciates conversations about the different isms, visible and invisible identities and respect for all the seen and unseen identities and to reference context. But to start a conversation multiple times with what happens in the governing system of a country because of my affiliation is a great opportunity to assess for assumptions that may overpower the intention to start a conversation. I am placing the aforementioned example in the framework of brave space because I also saw an amazing number of psychologists who were open about channeling their respective privileges to be stronger allies, be open to mutual feedback, and to keep having corrective and healing conversations. This for me is a communal aspect of brave space.

I also took a chance at this corridor of brave space. I, alongside many, attended the workshop on Diversity, equity, and inclusion: Leading the way by Dr. Jade Logan and Dr. Jeffrey Sternlieb (2022). The importance and critical meaning conveyed by silence when someone does not ask open-ended questions was an important concern I experienced and expressed. During the break, I walked with an ally and walked past a couple of psychologists whom I knew. I was mentally exhausted and needed to find my safe space. But as I was walking by, I could not help but wonder did one or both feel ignored? Would they understand and check in? Do I need to check in? There were these nagging questions that I also contended with as a woman-of-color psychologist because to be understood and respected are the two important components of the brave space central to me.

Trusting the friendships, support, and allyship, the healing, safe, and brave space at this convention helped me realize the importance of recharging and not checking in with others when a self-check-in is what is needed. It reminds me of mindfulness, being aware of the presence of the heart (Kabat-Zinn, 2010). I also resonated with what Dr. Howard Stevenson (2022), one of the panel speakers, shared during the panel discussion on culturally informed treatment is ethical treatment. The effective integration of culturally informed and ethically informed treatment: That in challenging moments, the mindful attention needed to be on the breath, body, and within.

## REFERENCES

Ali, D. (2017). Safe spaces and brave spaces historical context and recommendations for student affairs professionals. *National Association of Student Personnel Administrators (NASPA), 2*. https://www.naspa.org/images/uploads/main/Policy_and_Practice_No_2_Safe_Brave_Spaces.pdf

Johnson, K. (2021). *Radical friendship: Seven ways to love yourself and find your people in an unjust world*. Shambhala Publications, Inc.

Kabat-Zinn, J. (2010, May 2). What is mindfulness? [Video]. Greater Good Science Center. https://greatergood.berkeley.edu/video/item/what_is_mindfulness

Liang, C. T. H. (2022, May 18–21). A psychology that looks more like us, works more for us [Keynote address]. Pennsylvania Psychological Association Annual Convention, Poconos, PA, United States.

Logan, J., & Sternlieb, J. (2022, May 18–21). Diversity, equity, and inclusion: Leading the way [Conference presentation]. Pennsylvania Psychological Association Annual Convention, Poconos, PA, United States.

Methikalam, B., Knauss, L, Logan, J., & Stevenson, H. (2022, May 18–21). Diversity & inclusion lunch–culturally informed treatment is ethical treatment: The effective integration of culturally informed and ethically informed treatment [Panel discussion]. Pennsylvania Psychological Association Annual Convention, Poconos, PA, United States.

Scott, E. (2021). How to create your own 'safe space.' Retrieved May 20, 2022, from https://www.verywellmind.com/how-and-why-you-should-create-a-safe-space-for-yourself-3144981

# RESPONDING TO REQUESTS FOR MENTAL HEALTH RECORDS

RACHAEL BATURIN, MPH, JD

*Psychologists can receive requests for mental health records from a variety of sources. This article will review the basics on how to respond to a request for mental health records.*

## Request for Mental Health Records From Patients

From time to time, a psychologist may receive a request from patients for a copy of their mental health records. Federal law (HIPAA's Privacy Rule) provides that patients have a right to access the information that is contained in their mental health record. In Pennsylvania, patient access to mental health records varies depending on the treatment setting (i.e., drug and alcohol, MH/MR program, a hospital or private practice). So, considering these laws, patients do not automatically have a right to a physical copy of their mental health record. Psychologists also have a right to withhold the mental health record if it would be clinically contraindicated and it would harm patients.

When patients make a request for their mental health record, it is important to ascertain why they are making the request. Many psychologists prefer to sit down and review the record with their patients as patients may not understand the information contained in the record and it may help patients therapeutically to review the content with their psychologist. Others prefer to give patients a treatment summary. Lastly, some psychologists will just give a physical copy of the mental health record to their patient, especially if the patient is difficult and will pursue legal action to get a copy of the mental health record. Psychologists should document any request for mental health records made by their patients.

## Request From Insurance Companies

Psychologists sometimes get requests for mental health records from insurance companies. Oftentimes this record request is regarding audits or risk adjustments. Psychologists may comply with this request because as part of the insurance contract with the patient, the patient agrees to allow release of this information to the insurer for these specific purposes. Out-of-network providers should get consent from the patient before complying with such a request for mental health records.

## Request for Mental Health Records Through a Subpoena

A subpoena is a legal document that anyone can go to the prothonotary's office at the courthouse to obtain by paying a small fee. Psychologists may receive a subpoena in the mail from their patient's attorney or the attorney for the other side. In either case, to release the mental health records to the attorney, the psychologist must have the subpoena and a signed release of information (consent) from the patient. The duty is on the attorney to obtain the release of information from the patient. It is not the responsibility of the psychologist.

If you receive the subpoena and release of information, then you may send the requested mental health record to the attorney. If you only receive the subpoena without a release of information, then you must write to the attorney stating the following, "I am in receipt of your subpoena; however, under Pennsylvania law, I need a subpoena and release of information (consent from the patient) before I can release mental health records." It is important that you respond in a generic way to the request because you have not received consent from the patient, and you cannot acknowledge that this person is one of your patients.

## Request for Mental Health Records Through a Court Order

A court order is a legal document that is signed by the judge requesting that certain information be provided to a specific person named in the court order. If you receive a court order, you must comply and send the records to the person named in the order. If you have concerns about the court order, you can contact the judge and the attorneys involved in the case to express your concerns before sending the mental health record.

## Request for Mental Health Records From an Executor

On occasion, psychologists may receive a request for mental health records from the executor of your patient's estate. According to the Pennsylvania State Board of Psychology, a patient's confidentiality goes with them to the grave unless there was a release signed before their death. Therefore, the executor is not entitled to obtain a copy of the mental health records unless he/she obtains a court order from the judge ordering the psychologist to release the mental health record to the executor.

## Request for Mental Health Records From a Coroner

If you receive a request for mental health records from the coroner's office, it is treated the same as if it was a court order from the judge. Psychologists should just send the records to the coroner's office. The confusing thing about this request is that the request comes as a coroner's subpoena. Even though it is called a subpoena, it is treated the same as if it was a court order from a judge.

## Request for Mental Health Records From an Administrative Agency (e.g., Workers' Compensation)

If you receive a request for mental health records from an administrative agency like Workers' Compensation, it is treated the same as if it was a court order from the judge. Psychologists should send the records to Workers' Compensation. The confusing thing about this request is that the request also comes as a subpoena. Even though it is called a subpoena, it is a court order because it is signed by the administrative judge.

It is also important to note that some administrative agencies will also send requests for mental health records from a case worker or field office worker (e.g., Social Security Administration). If you receive this type of request, then you are required to get the consent of your patient before responding to the request.

In summary, psychologists may receive requests for mental health records from a variety of sources and it is important to understand how to reply to each request. Psychologists should always make sure to document the date of the request and how you responded to it. It is also important to retain all original documentation in relation to the request. If you are unsure of how to reply to the request for mental health records it is always a good idea to consult with colleagues, PPA staff, or your malpractice carrier before complying with the request. ◆

# WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT INTERJURISDICTIONAL PRACTICE

MOLLY COWAN, PsyD

*Practicing across state and international lines has become very common, particularly during the COVID-19 pandemic. When considering working with a client located in another jurisdiction, it is important to understand the regulatory, legal, ethical, and clinical issues involved.*

From a regulatory perspective, the location where the client is located at the time of service has jurisdiction, so the psychologist would need to have authorization to provide services in that location, whether through full licensure, the Psychology Interjurisdictional Compact (PSYPACT), or temporary authorization to practice.

PSYPACT was created to "facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries" (PSYPACT, n.d.). As of May 1, 2022, PSYPACT was effective in 28 states, enacted and not yet effective in 3 additional states, with legislation introduced in 6 other jurisdictions. Psychologists licensed in a PSYPACT state can apply for Authorization to Practice Interjurisdictional Telepsychology (APIT); once approved, the psychologist can provide telepsychology to clients located in any PSYPACT jurisdiction.

In addition to PSYPACT, many states allow for limited practice; some require notifying the board of that state prior to providing services, while others do not. For example, Oregon has a visitor's permit for psychologists who do not intend to seek full licensure in Oregon that is valid for no more than 30 days in a 12-month period. Temporary practice was further complicated by COVID-related waivers, as some states (including PA) eased rules related to interjurisdictional practice to help ensure continuity of care during the public health emergency; however, states varied regarding the nature of the waiver and when they expired. Psychologists can determine rules for individual states by contacting that state's board that oversees psychological practice.

Beyond rules based on the client's location, some states also have regulations in place that limit the amount of time a psychologist physically located in their state (but not licensed in their state) can practice via telehealth to clients physically located in a state where the psychologist is licensed. For example, California code limits a psychologist licensed in another state who moves to California to provide psychological services while located in California without obtaining a license for no more than 30 calendar days per year, regardless of where the client is located (California Business and Professions Code, 2018). This tends to be more of a concern when the psychologist will be physically located in another jurisdiction for a longer period of time rather than a few sessions while out of state for a few days, but it is still important to understand the relevant regulatory issues. Of note, if practicing under PSYPACT, the psychologist must be physically located in the designated home state at the time of the service (PSYPACT, n.d).

When regulatory issues have been sufficiently addressed, psychologists also need to be aware of how legal concerns such as mandated reporting differ across jurisdictions. What needs to be reported and to whom varies, and psychologists working with clients in another location need to be familiar with that jurisdiction's laws regarding scope of practice, child abuse reporting, duty to warn, and so forth.

Ethically, when working with clients located in another location, psychologists should consider both ethical principles (e.g., beneficence and nonmaleficence) and the relevant standards in the APA Ethics Code (e.g., Standard 2.01 Boundaries

of Competence). Certainly, the pandemic accelerated the pace for psychologists to become competent with telepsychology and technology, as well as the important ways to adapt informed consent and documentation procedures. Post-pandemic, it will be important for psychologists to readjust to "typical" procedures for telepsychology (e.g., using HIPAA-compliant platforms). In addition to the APA Ethics Code, psychologists using telepsychology should be familiar with the APA Guidelines for the Practice of Telepsychology (https://www.apa.org/practice/guidelines/telepsychology).

Clinically, it is also important to consider the appropriateness of telepsychology for individual clients. Not all clients will benefit from telepsychology, and some prefer in-person sessions; it is necessary to assess each situation to determine whether to work with—or continue to work with—a client via telepsychology. In a crisis situation, good clinical care will likely be more important than the adherence to interjurisdictional regulations, but this would be different for ongoing "business as usual" practice (Novotney, 2018). When considering working with clients who have moved to a different jurisdiction or accepting clients who are located elsewhere, psychologists need to consider who to contact in case of an emergency, how to account for issues with technology, whether their malpractice carrier will cover the service, and whether the client's insurance will reimburse for the service, all of which may differ from traditional in-person care.

If a client is traveling or moving internationally, the situation can be even murkier. When thinking about working with someone internationally, you should make an effort to determine the laws and regulations in that country. Depending on the country, that can be difficult. APA (2017) compiled a list of international psychological associations, which can be a helpful starting point. However, there is significant variability among countries, as some would say there is no regulation regarding whether a psychologist licensed in Pennsylvania could provide telepsychology services to a client located in their country, some would say the psychologist could see the client but not use the title "psychologist" while doing so, and some would require the psychologist to obtain a license in their country. For European countries, the European Federation of Psychologists' Association website (https://www.europsy.eu/) is also a helpful resource. Additionally, it is important to understand whether the country follows HIPAA or Europe's general data privacy regulations (GDPR), which are much stricter.

In an ever-global world, interjurisdictional practice will continue to grow and change. Psychologists should work to ensure that they are up to date on relevant regulatory, legal, ethical, and practical concerns to remain competent and provide good psychological care to clients.

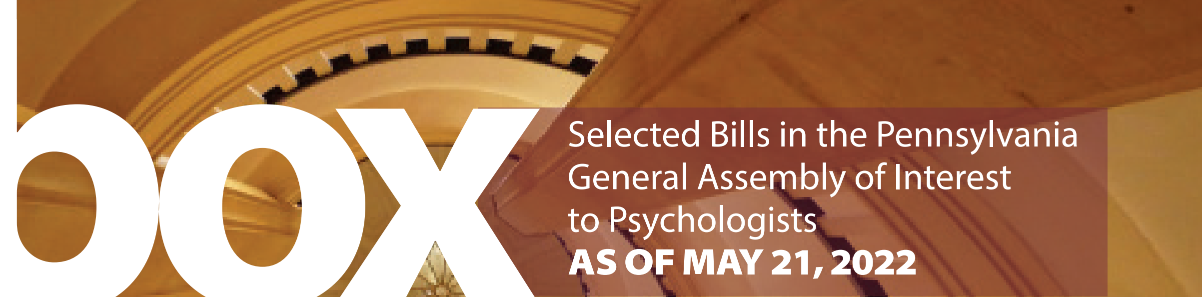
## REFERENCES

American Psychological Association. (2017). Directory of national associations of psychology. Washington, D.C.: Office of International Affairs. https://www.apa.org/international/networks/organizations/national-orgs#s

California Business and Professions Code, CA Bus & Prof Code § 2912 (2018). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2912&lawCode=BPC

Novotney, A. (2018). Should a clinician use telehealth to see patients while traveling? *Monitor on Psychology, 49*(11), 33–35. https://www.apa.org/education-career/ce/telehealth-traveling.pdf

PSYPACT. (n.d.). Practice overview. Retrieved April 29, 2022, from http:// psypact.site-ym.com



# 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 | 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 |  |
| 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 |  |
| 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:

## Caregivers and Caregiving

CARLY CORNELL

Whether it be said by Sartre himself, the many theorists of existential psychotherapy, or legendary reggae singer Bob Marley, one commonly agreed upon pillar to human happiness is the ability to love and be loved. Human empathy has stretched across centuries, and our field would not be possible without it. However, in a field where compassion fatigue could be so easy to fall into, we have laws and ethics codes to set boundaries and protect our mental health so we can continue helping others sustainably. Caregiving is the next level of human compassion. There are often fewer boundaries, both spatially and emotionally. Such an arrangement brings evident risks and benefits. On one hand, compassion fatigue could skyrocket quickly, and the caregiver sometimes feels obligated to make sacrifices to care for the loved one. On the other hand, many caregivers say that it is the best experience they could ever imagine to feel such immense love for another, which is the exact feeling that so many people strive for to make meaning in life.

As clinicians, it is our duty to provide for caregivers who come to us for emotional support, coping skills, and boundary-setting suggestions. In this issue, Sherry et al. introduce methods for neuropsychologists to communicate a loved one's cognitive impairment diagnosis with a caregiver. Mathsyssek and Boyer discuss compassion fatigue in animal rescue workers. Woika and Woika examine the different ways parents react when their children are born with diverse attributes, such as a non-heterosexual sexuality, deafness, dwarfism, neuroatypical conditions, genius IQs, and so forth, and how these reactions impact the child's life. Molnar recounts her story of caregiving for her mother, who struggles with serious mental health disorders and provides resources for coping with adversity. Finally, Tuleya-Payne provides an overview of gender affirmative care in schools and the importance of advocating for the rights of gender diverse youth.

# NEUROLOGICAL SERVICES INFORM the Care of Loved Ones With Cognitive Impairment

NATALIE SANDEL SHERRY, PsyD, ABPP-CN
SARAH KOHNEN, MA
ROBERT FERGUSON, PhD

The aging population in the United States poses a major challenge to our health care system and society with the increased prevalence of neurodegenerative disease and illness. The World Alzheimer's Report (Prince et al., 2015) estimates that 75 million people globally will have dementia by 2030, and this number is expected to double every two decades. This does not include the multitude of other potential sources of cognitive impairment prevalent among adults (e.g., traumatic brain injury, brain tumor, cerebrovascular accident). Many families with loved ones who are cognitively impaired assume the role of informal caregiver and shoulder a great deal of responsibility and stress navigating the complexity of the caregiver relationship. Familial caregivers may lack the expertise to appreciate the nature of certain cognitive impairments and behaviors. They may find themselves questioning how to balance their loved one's independence, while also ensuring their safety and planning for their future. The use of neuropsychological services can help caregivers of loved ones navigate these complex situations and provide access to psychological resources and other services for the caregiver.

## What Is Neuropsychology?

Neuropsychology is the scientific practice of evaluating the relationship between the brain and human behavior. With historical influences including the screening and diagnosis of soldiers with brain injuries following World War I, modern day neuropsychologists aim to contextualize a person's cognitive function using standardized assessment tools (Lezak et al., 2004). The cognitive-behavioral focus is what separates neuropsychological assessment from other neurodiagnostic tools (e.g., magnetic resonance imaging, computerized tomography scan). Conceptualizing a patient through a neuropsychological evaluation aims to provide insight into cognitive strengths and weaknesses, behavioral and personality factors, and functional capacity.

## Characterizing Cognitive Impairment in Adults

Performing a cognitive and behavioral evaluation of individuals with suspected or known cognitive impairments provides valuable information to families about the level of severity of cognitive impairments, their nature, and the expected prognosis for their loved one. Some neurological disorders may result in abrupt onset of cognitive impairment and disability (e.g., stroke), others may involve progressive worsening of symptoms (e.g., dementia), or even waxing and waning of symptoms (e.g., psychiatric illness). A neuropsychological evaluation can objectively capture the cognitive change, prognosticate on the progression, and provide supportive guidance to caregivers to plan for current and future needs.

Serial neuropsychological testing can also be beneficial to caregivers to assist in the monitoring and tracking of cognition over time. Establishing a baseline in the first evaluation serves as a future intraindividual comparison point for subsequent evaluations. Through repeated testing, the neuropsychological test results can be compared across multiple time points to identify and educate caregivers on areas that may have worsened, remained the same, or in some cases improved. This knowledge helps to alleviate the anxiety of the caregiver by eliminating the need for the caregiver to judge whether cognitive change has occurred and utilizing objective test results to establish the level of supervision.

## Caregivers of Loved Ones Are in a Dual Role

Informal caregivers of loved ones are likely not professionally trained to provide care to individuals with cognitive impairment. These caregivers also likely have established interpersonal dynamics with loved ones that may be threatened when they must take on the role of caretaker. Consider the spouse who has been married to their significant other for 30 years and starts to notice signs of progressive memory decline and personality changes. They now must assume the role of partner and caretaker, and may have to assume new roles (e.g., managing the finances). They likely have no prior experience to help understand the level of independence their partner should have and where to go for support in future planning. This can be even more cumbersome to disentangle when the loved one is unaware of their cognitive impairments.

Caregivers of loved ones may also notice sensitive behavioral or personality changes that can be difficult to address with other health care providers. Neurological disease can manifest as changes in personality, libido and intimacy, emotional expression, and other behaviors central to a person's identity and role in a relationship, which may be devastating to relationships with loved ones. Through neuropsychological evaluation, these sensitive behaviors can be discussed with a psychologist who can provide information on the etiology of behavioral changes as well as support and guidance to the caregiver. Neuropsychologists can connect caregivers with community resources and access to their own mental health resources.

## How to Use Neuropsychological Test Results in Therapy With the Caregiver

Psychologists working with caregivers and patients with newly diagnosed cognitive impairment can benefit greatly from a neuropsychological assessment of the patient. The neuropsychological testing report can identify level of functional independence, what specific domains of neuropsychological function are impaired, and the severity of each impairment within respective domains. For example, if a patient with an aggressive brain tumor, such as glioblastoma multiforme of the right frontal lobe, is found to have significantly low scores on tests of motor reaction time and initiation, but scores average or in higher ranges on tests of speech perception, this would likely translate to restriction in driving but emphasizing verbal communication to optimize daily function.

Ideally, the neuropsychological report should include both narrative descriptions and standardized test scores. Standard scores allow comparisons across tests and domains to help determine relative strengths and weaknesses in various cognitive abilities in addition to immediate comparison to age-adjusted norms. This helps the treating psychologist to determine the level of impairment compared to the broader health of the nonimpaired population. This information is helpful to guide the psychologist, loved one, and caregiver to direct efforts in treatment planning.

A critical step in treatment is education about the basic cognitive domains measured by neuropsychological tests and how they manifest in patient behavior. For instance, with frontal lobe dysfunction, the executive function of motor initiation can be delayed or completely impaired. This can be misattributed by the caregiver as inattentiveness, volitional passivity, or lack of motivation. Instructing the caregiver that damage to an executive function (initiation of goal-directed behavior, such as putting on a jacket to go to a doctor's appointment) can allow an opportunity for the caregiver to be the "surrogate executive" and cue the initiation of putting on the jacket. Recent research demonstrates that caregiver mastery (perception of control over the care situation) is associated with time of patient death in cases of glioblastoma—that is, longer survival time (Boele et al., 2022). Coaching family caregivers in skills of cognitive-behavioral functioning can enhance a sense of caregiver mastery. Using neuropsychological testing and translating this to adaptive, therapeutic cognitive rehabilitation strategies is detailed in numerous sources and reviews (Pedrotty et al., 2021).

## REFERENCES

Boele, F. W., Weimer, J., Zamanipoor Najafabadi, A. H., Murray, L., Given, C. W., Given, B. A., Donovan, H. S., Drappatz, J., Lieberman, F. S., & Sherwood, P. R. (2021). The added value of family caregivers' level of mastery in predicting survival of glioblastoma patients: A validation study. *Cancer Nursing, 10.1097/*NCC.0000000000001027. Advance online publication. https://doi.org/10.1097/NCC.0000000000001027

Lezak, M. D., Howieson, D. B., Loring, D. W., & Fischer, J. S. (2004). *Neuropsychological Assessment*. Oxford University Press.

Pedrotty, M., Wong, T. S., Wilde, E. A., Bigler, E. D., & Laatsch, L. K. (2021). Application of neuropsychology and imaging to brain injury and use of the integrative cognitive rehabilitation psychotherapy model. *NeuroRehabilitation, 49*(2), 307–327. https://doi.org/10.3233/NRE-218028

Prince, M. J., Wimo, A., Guerchet, M. M., Ali, G. C., Wu, Y. T., & Prina, M. (2015). World Alzheimer Report 2015. *The global impact of dementia: An analysis of prevalence, incidence, cost and trends*. Alzheimer's Disease International.

# COMPASSION FATIGUE IN ANIMAL RESCUE WORKERS

CHRIS MATHYSSEK, PhD
KRISTA BOYER, PsyD, MBA

When considering the concept of compassion fatigue, thoughts of nurses, first responders, and mental health professionals often come to mind as being the most vulnerable; however, there is a sizeable population of largely unpaid and sometimes unnoticed helpers that are at very high risk for developing compassion fatigue. These helpers fall into the category of animal welfare or rescue workers. There are an estimated 14,000 shelters and pet rescue groups in the United States, most of them small, all-volunteer-run groups, which provide care for approximately 8 million animals per year (Allen, 2014), suggesting that even by conservative estimates, several hundred thousand Americans are or have been involved in animal rescue work.

Compassion fatigue describes the chronic stress that is caused by witnessing the suffering of others who are in one's care (Cocker & Joss, 2016). It can best be understood as an imbalance or the negative "net result" between positive and negative experiences in the helping professions, such as animal rescuing. Compassion satisfaction describes the positive experience associated with the work and refers to the sense of pleasure that one derives from helping others (Cocker & Joss, 2016). Burnout and secondary traumatic stress are two dimensions that contribute to the negative experience, and describe the perceived inability to achieve one's desired helping goal, and the feelings of guilt and distress that stem from an inability to save or provide adequate help to a person or animal in need (Cocker & Joss, 2016).

Symptoms commonly associated with compassion fatigue include unhappiness and depression, sleep difficulties, feelings of anger and irritability, rumination, social withdrawal, and apathy. As a consequence, compassion fatigue is commonly associated with an overall lower quality of life, as well as withdrawal from animal rescue work (Smith, 2008).

These consequences are not just

problematic for the individuals, but they also have broader societal consequences, as animal rescue workers and volunteers fulfill an important role in our modern-day society. Many people who are otherwise uninvolved with animal rescue work consider themselves animal lovers, as evidenced by the 90.5 million U.S. households that have pets (HumanePro, n.d.). Unsurprisingly, many people have an emotional response to seeing a neglected dog or hearing about an animal hoarding case. Many people feel unable to help the animal themselves, but they are relieved when they see another person or organization stepping in to render aid. This role is fulfilled by animal rescue workers, who are often volunteers. No government agency is responsible for the well-being of surrendered or abandoned animals, and when funded agencies such as police departments are involved in a rescue, they often rely on local animal rescue groups for the care of the affected animals. The societal need already exceeds the capacity that many rescue groups have; therefore, losing animal rescuers to compassion fatigue is a systemic issue.

Many animal rescue workers are very aware that they fulfill a much-needed role in society and that the need is chronically much higher than the capacity and available resources of rescue groups. As such, animal rescue workers and volunteers face a perfect storm: They have deep affection for animals, which motivates them to rescue animals in the first place, yet renders them especially vulnerable to the emotional impact of seeing suffering animals; they face chronic demands on their time and/or financial resources—especially via commonly used social media sites; and they are aware of the systemic reliance on them to provide care for animals in need, which can make it difficult for them to decline requests for help (Figley & Roop, 2006). Under such demanding circumstances, it can be difficult to experience much compassion satisfaction, while feelings of guilt, regret, frustration, and shame can become prevalent for being unable to respond to all requests for help. Jackie Efrati (personal communication, February 25, 2022), long-time animal rescuer and volunteer with Animal Lifeline Pittsburgh says "It's relentless. It's 24/7. You come to avoid reading your emails and checking social media for fear of yet another request. And many people don't respond kindly when you are unable to help."

But the emotional impact is not limited to seeing injured or suffering animals. In animal rescue work, most animal care interactions are time limited, as animals move from the animal shelter or foster home to an adopter. Often, animal rescue workers form an attachment to these animals, sometimes a very close one, making the "adopting out" process emotionally very difficult, especially for foster parents who cared for the foster animals like they do for their own pets. In short, animal rescue workers face many unique challenges and stressors that can contribute to the development of compassion fatigue (Figley & Roop, 2006).

## Clinical Consideration in Working With Animal Rescue Workers With Compassion Fatigue

- Psychoeducation about compassion fatigue can increase awareness and normalize the distressing experience for animal rescue workers.
- Acknowledging the unique stressors and challenges that can be associated with this type of work can be validating to clients with compassion fatigue. This may also allow clients to share more freely about animal-related grief or traumatic experiences.
- Treatment interventions for compassion fatigue are generally aimed at creating a more balanced experience, which can be achieved by reducing the animal rescue-related distress, and/or by increasing the satisfaction with their experiences (Smith, 2008).
- Mindfulness skills can help the client stay present when they have positive rescue experiences, increasing their compassion satisfaction, and also reduce the sympathetic nervous system activation that the stressful aspects of this work brings about.
- The chronic demand on time and resources of animal rescue workers makes boundary- setting and assertiveness skills important focuses in compassion fatigue interventions.
- An integration of compassion for animals with compassion for oneself is an integral part of interventions to address compassion fatigue; therefore, self-compassion practices should be a central focus of treatment for animal rescue workers (Smith, 2008). Clarifying misconceptions about self-compassion and addressing barriers to applying self-compassion is critical.
- Difficulty in maintaining a clear self-other distinction has been identified as a crucial element in compassion fatigue. If this distinction is blurred, the helper will absorb and experience the suffering of the other as their own, as shown in self-report and neuroimaging studies (Hofmeyer et al., 2020). Emotional boundary-setting skills and emotional self-regulation skills can be helpful tools for this.

Animal rescue workers are at an elevated risk for compassion fatigue, and the subsequent mental health concerns are often unacknowledged by others. Given the large number of animal rescues that occur per year, psychologists are advised to be sensitive to the negative costs of caring that can accompany animal rescue work.

## REFERENCES

Allen, G. (2014, December 31). No-kill shelters save millions of unwanted pets—But not all of them. National Public Radio. https://www.npr.org/2014/12/31/374218425/no-kill-shelters-save-millions-of-unwanted-pets-but-not-all-of-them

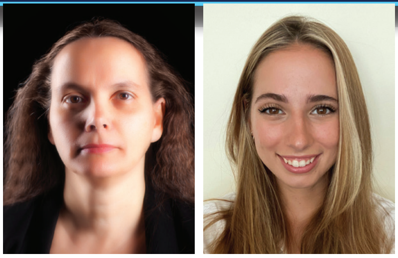
Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International journal of environmental research and public health, 13*(6), 1–18. https://doi.org/10.3390/ijerph13060618

Figley, C. R., & Roop, R. G. (2006). *Compassion fatigue in the animal-care community*. Humane Society Press.

Hofmeyer, A., Kennedy, K. J., & Taylor, R. (2020). Contesting the term 'compassion fatigue': Integrating findings from social neuroscience and self-care research. *Collegian, 27*, 232–237.

HumanePro. (n.d.). Pets by the numbers. Retrieved February 15, 2022, from https://humanepro.org/page/pets-by-the-numbers

Smith, P. (2008). Healthy caregiving: A guide to recognizing and managing compassion fatigue. Presenter's guide. Compassion Fatigue Awareness Project.



# WHAT'S THE DIFFERENCE? DIVERSITY IN PARENTING

SHIRLEY A. WOIKA, PhD
ISABELLE Q. WOIKA, BS

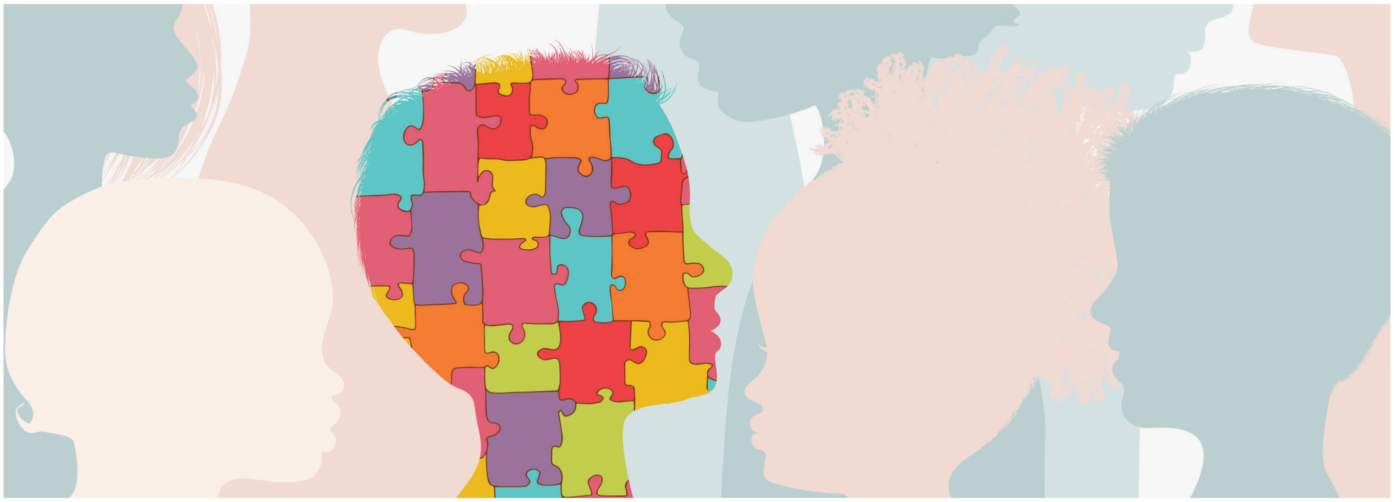
Expectant parents often question and wonder about the possibilities of what their new baby may be like. New parents ponder the simple thrills of eye color, gender, height, and personality type of their little one. Parents are usually full of hope and excitement that their child will be incredible and just like themselves. Yet, an often unspoken hope some parents have is the wish for their child to just "be normal." What happens to the child who is born abnormal or different? What happens when children turn out to be vastly different from the very people who created them?

As the primary caretakers of their children, parents may find themselves in need of assistance as their children navigate their way through developmental stages. When a child has a disability or other difference, caretaker demands are more intense and parents often feel unprepared for their role. School psychologists and other mental health professionals are uniquely positioned to assist parents in their role of caretaker. For some parents, the journey from awareness to acceptance of a child with a difference is similar to progressing through the stages of grief, and psychologists are well equipped to help parents navigate this process.

A useful resource can be found in the book *Far From the Tree* by Andrew Solomon. This nonfiction book, published in 2012, has won numerous awards including the National Book Critics Circle Award and the New York Times Book Review Top Ten Book of 2012. The author is a professor of clinical medical psychology at Columbia University Medical Center and a lecturer in psychiatry at Yale University. In this book, he explores the relationships between parents and their children who differ from them in some significant way. The title is a reference to one's family tree and to the adage the apple doesn't fall far from the tree. Children are usually a lot like their parents, but Solomon's book focuses on those apples that have fallen somewhere else—far from the tree. The book examines the transformative process that parents go through from learning that their children have a condition that is alien to them to a place of tolerance and acceptance. Some eventually celebrate the difference.

In the first chapter, Solomon talks about some of his own experiences growing up gay with straight parents. He describes this as a horizontal identity—something that he shared with a peer group but not with his family. Solomon explains his own difficulties coming to terms with his sexual identity. His parents, like many others, believed that their way of being happy was the best way of being happy. He reflects on how isolating an exceptional identity can be. Subsequent chapters in the book dive into a variety of topics scattered with firsthand experiences collected through parent interviews with over 300 families.

Historically, disability has been viewed through a deficit model lens, but Solomon's chapter on deafness really challenges this perspective. One in a thousand newborns is born profoundly deaf making it a low-incidence disability. About two in a thousand will have a less severe hearing impairment, and another two or three



in a thousand will lose their hearing before they turn 10. More than 90% of deaf children have hearing parents. From a deficit model, deafness should be cured, and many families are taking advantage of technological advances such as cochlear implants. Deaf with a lowercase "d" is a pathological term describing a physiological condition while Deaf with a capital "D" reflects a culture to be embraced. Children with hearing aids and implants have been referred to as culturally homeless—not fitting in either the Deaf community or the hearing world. Some members of the Deaf community feel strongly that deaf children should be raised by Deaf parents, and some hearing parents fear they may lose their deaf children to the Deaf community. There are debates about whether a deaf child should use oral language or sign, and if sign language is chosen, then there are debates about exact signed English versus American Sign Language, and so on. Understanding these issues is necessary in order to help parents navigate them.

Both authors of this article have a first-degree relative with dwarfism. Although they have lived experience with dwarfism, they found Solomon's chapter on the topic to add some additional insights. There are varied approaches to difference. Some families make no accommodations for a dwarf child, arguing that the child will have to function in an average-sized world. Other families feel that a child should be accommodated at home. Both authors have attended Little People events. The feeling of being the outlier was initially uncomfortable. As average-sized individuals, it felt out of place to be surrounded by Little People. It took some time to adjust. As individuals who think of themselves as sensitive to difference, saying statements like "Why is the banquet table so low?" aloud before catching oneself was humbling. To suddenly be the minority in the room was eye opening. A quote from a parent in the book sums up the transformative experience of parenting a dwarf child: "I adore Rose and I can't imagine life without Rose. I wouldn't trade her for the world. But I'm very tall; I'm thin; I was a ballet dancer. I imagined those experiences for her. When you have a child who can't share those things, you mourn the loss of an imagined life. On the other hand, I have an almost violently passionate feeling of who she is."

Other intriguing topics in Solomon's book include Down syndrome, autism, childhood schizophrenia, multiple disabilities, transgender children, prodigies, children of rape, and children who have committed crimes such as school shootings. The author interviews parents and children in order to paint a picture of their journey. The stories of parents and children finding their identities, told through their own words and experiences, is worth the read. We can all do more to improve our own understanding of difference.

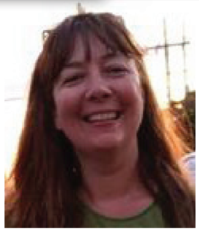
The emotions and burdens children may feel from being different from their own parents is something that may follow them for life. It is now more important than ever to be there for our children and to try to understand their differences. Our society is diverse and gaining an understanding of diversity from our own children may be the key to becoming a more understanding and educated population. Even if our apples fall farther from the tree than expected, we should walk the extra mile to pick them up, polish them off, and help them to shine.

A parent of an adult child, profoundly disabled due to a severe form of cerebral palsy, is quoted in the book as saying, "if any parent could ask for just one thing for their child, what would it be? Not that they go to Harvard, but that they be happy. Alix is happy most of the time. So if I'd had only one wish, that's what it would have been, and I'd have gotten it."

The book itself is 962 pages. If you cannot commit the time, consider watching the 2017 documentary by the same name. The video is an hour and 33 minutes in length.

## REFERENCE

Solomon, A. (2012). *Far from the tree: Parents, children and the search for identity*. Scribner.



# WISE HEARTS AND LONE MONKEYS:

## Caregiving and Resources for Surviving Adversity

CHRIS MOLNAR, PhD

Do you know where the heart pumps oxygenated and glucose-rich blood to first? In a radical act of self-care, it first nourishes itself, specifically the coronary circulation, to ensure the survival of the entire body. And unlike many a caregiver the healthy heart rests between beats and flexibly exerts just the right effort and rhythm too. As well, it is the force behind a continued releasing of that which does not support life. We who are in the role of the caregiver for others with chronic health challenges can learn much from the wise heart about resourcing ourselves and creating conditions for wellness.

In the last decade, I have assumed the role of caregiver for a chronically and seriously mentally ill (SMI) parent with many posttraumatic sequelae. No one knew of the trauma that precipitated her "nervous breakdown" in the 1970s when she was a single and underresourced mother to me and my brother. Her extensive trauma history was discovered because my first job out of college was with Edna Foa, PhD, interviewing assault survivors as part of a prospective study of posttraumatic stress disorder (PTSD). I started having reexperiencing symptoms of my mother falling apart when I was a child. This prompted me to ask my mom in behaviorally specific ways about what I learned was an extensive trauma history. No one detected the precipitant of her "nervous breakdown" at the time. Had someone asked behaviorally specific questions that are known to improve detection of trauma (Craner et al., 2015), then she might have received needed care.

When kids raise kids there is much adversity. Indeed, my score on the Adverse Childhood Experiences (ACEs) Scale is high. I have directly experienced repression in childhood and then the pain of remembering as an adolescent too. I have experienced many of the well-known adverse health sequelae known to be linked to both high ACEs (Finlay et al., 2022) and repression (Molnar, 2003). My brother and I were raised by a village of caregivers after my mother ended up homeless when I was nine. She was exposed to multiple traumatic events from which she never recovered. She never accessed the health care she needed to function posttrauma.

Without doubt, the most essential resource on which I have relied as a practicing psychologist, who is also a caregiver for a parent with SMI, has been the support of friendly peers with doctorates in a range of health care professions. A personal mindfulness practice connected me with a community of mindful therapists with whom I practice mindful case consultation (Molnar, 2014). Through mindful care consultation with peers, I discovered a personal risk factor for burnout related to my conditioning. Clients who present in helpless and dependent ways, like my mother, used to evoke a habit on my part of working harder than them to meet their goals. I no longer fall into this habit; instead, I implement motivation enhancement to support development of competence in clients (Molnar, 2011, 2013).

My mother would be homeless and probably dead without me in the role of her caregiver. If you are in a position like mine, or guiding someone who is, next I describe some of the steps needed to access resources for people with limited resources and SMI. Start with a nurse navigator to assist in navigating the complex system that most with SMI cannot. Search for a visiting nurses association (VNA) in the county where the person with needs lives. Establish power of attorney (POA), both durable and health care, to manage affairs. Complete authorization forms required to communicate on behalf of the person for whom you are caregiver. This includes forms to become an authorized representative for the Social Security Administration (SSA) that does not recognize POA. Create an online Commonwealth of Pennsylvania Access to Social Services (COMPASS) account. You will need a birth certificate, Pennsylvania identification, Social Security number, and documents listing all assets for the person needing assistance. You may encounter waits for things like a duplicate birth certificate, nonexpired identification, and historical financial documents. Establish a relationship with a physician because you will likely need documentation from one to access needed services.

I have been shocked and alarmed by how difficult it is to access resources to keep my mom alive, let alone get her essential mental health care. I am highly resourced with a PhD in psychology. Despite excellent education and experience, it has been hard for me to complete the paperwork, often online, to access resources. Plan on hours of phone time to access needed care along with a scarcity of health care aides with training in mental health care. Finding a home health care aide with training to serve the SMI has not yet been possible. My mother's trauma aftermath has included distrust and aggressive rejection of all health aids to date. Without an aid trained in mental health, my mother is often dehydrated, malnourished, and physically delirious. I am still waiting for a neuropsychological assessment to conduct a difficult differential diagnosis to determine if delirium from dehydration and malnourishment or a budding dementia is arising on top of SMI symptoms (Downing et al., 2013).

My heart breaks for people who do not have caregivers, let alone internet access or the cognitive capacity to complete forms needed to access Medicaid benefits. Expect to wait years for subsidized housing—I had to hire a lawyer to get needed documentation to access it for my mom. That process resulted in a flashbulb memory of the freezing cold and snowy pandemic day when we completed POA forms outside with a lawyer, her notary public assistant, my mom, my brother, and his friendly neighbor who served as witness.

It really is true, as Harry Harlow, PhD, said: "A lone monkey is a dead monkey" (L. S. Benjamin, personal communication, August 1, 2008). In my mom's case, she is not completely dead, but also not living much of a life for a very long time. This experience deepens my appreciation of belonging to a wise-hearted community where self-care is befriended.

## REFERENCES

Craner, J. R., Martinson, A. A., Sigmon, S. T., & McGillicuddy, M. L. (2015). Prevalence of sexual trauma history using behaviorally specific methods of assessment in first year college students. *Journal of Child Sexual Abuse, 24*(5), 484–505.

Downing, L. J., Caprio, T. V., & Lyness, J. M. (2013). Geriatric psychiatry review: differential diagnosis and treatment of the 3 D's - delirium, dementia, and depression. *Current psychiatry reports, 15*(6), 1–10.

Finlay, S., Roth, C., Zimsen, T., Bridson, T. L., Sarnyai, Z., & McDermott, B. (2022). Adverse childhood experiences and allostatic load: A systematic review. *Neuroscience & Biobehavioral Reviews, 136*, 104605.

Molnar, C. (2003). A taxometric analysis of the latent structure of the repressor personality construct [Doctoral dissertation, The Pennsylvania State University]. Penn State Electronic Theses and Dissertations for Graduate School.

Molnar, C. (2011, December). Waking up with mindfulness for self-care. *The Pennsylvania Psychologist*, 14–15.

Molnar, C. (2013, December). Creating conditions to support ethical clinical decision making and practices. *The Pennsylvania Psychologist Quarterly*, 9–10.

Molnar, C. (2014, June). Peer groups as a reflecting pool for enhancing wisdom. *The Pennsylvania Psychologist Quarterly*, 9–10.

# GENDER AFFIRMING CARE IN SCHOOLS

HELENA TULEYA-PAYNE, DEd

In February 2022, Texas Governor George Abbott ordered the Department of Family and Protective Services to investigate as child abuse any reported instances of minors (individuals under age 18) undergoing sex reassignment procedures or taking hormones. Governor Abbott's directive put a spotlight on the challenges facing transgender and gender-diverse youth, their families, and medical providers. The specific medical treatments described in the governor's order as child abuse are only some of the procedures that come under the general category of gender-affirmative care or gender-affirming care. This article will examine the scope of gender-affirmative care, implications for supportive school environments, and the importance of advocacy for gender-diverse youth.

Diane Erensaft is a clinical psychologist who has written extensively on gender diversity. In a 2017 article comparing different approaches to the care of transgender and gender-diverse children and youth, Dr. Erensaft described the gender-affirmative model as "a method of therapeutic care that includes allowing children to speak for themselves about their self-experienced gender identity and expressions and providing support for them to evolve into their authentic gender selves, no matter at what age. Interventions include social transition from one gender to another and/or evolving gender nonconforming expressions and presentations, as well as later gender-affirming medical interventions (puberty blockers, cross-sex hormones, surgeries)" (p. 6).

A panel of medical and psychological health care providers, convened in 2021 to discuss the ethics of treatments for transgender children and youth, described the scope of gender-affirming care. Social affirmation involves support for how a person presents themselves (e.g., dresses, names, pronoun preference) that conforms to their gender identity. Medical affirmation may involve hormone blockers described as a reversible procedure that puts a pause button to allow the individual to be cognitively and emotionally ready to consider whether to proceed to irreversible procedures, such as cross hormones. Surgical affirmation, typically used post-puberty, involves surgical procedures with outcomes that align with gender identity. The panelists stressed the importance of a developmentally informed, family-centered, child-focused approach. They encouraged families to allow the individual to tell their own story and to respect when the individual is ready to share their decision. The panel also emphasized the role systems of care play in assisting the individual to become their authentic selves.

Clearly, schools are systems of care in which transgender and gender-diverse individuals participate. School psychologists, along with the general school community, play a role in the social affirmation aspect of gender-affirmative care. An example of a state agency that provides guidance for school personnel is the Massachusetts Department of Elementary and Secondary Education, which houses a wealth of information on LGBTQ+ issues written in plain, easily understood language (2016, 2021). The department's Office of Support for Students and Families (SFS) provides guidelines on issues ranging from names on school records to restroom policies. For example, concerning what name should schools accept when a student presents a name different from their birth name but consistent with their gender identity, the guideline based on Massachusetts state law is that the school accept the name that the student requests. In addition, the SFS provides helpful, real-life scenarios to illustrate each guideline. Information found in the Pennsylvania Department of Education's Pennsylvania Equity and Inclusion Toolkit (2017) includes recommended practices for supporting transgender and gender-diverse students but is less extensive and generally directs the reader to research and guidelines from other sources.

Our professional organizations have been active in developing policy statements and other relevant information in assisting mental health professionals in the schools toward developing supportive environments. In 2015, the American Psychological Association (APA) and the National Association of School Psychologists (NASP) developed the document Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools. This document sets forth a series of research-based statements concerning the status of gender diverse youth, (e.g., increased incidence of anxiety, depression and self-harming behaviors including suicide and increased likelihood of being the targets of bullying and intimidation). The resolution includes policy recommendations such as maintaining the privacy of transgender and gender-diverse children and youth.

NASP published an excellent resource for school psychologists that fleshes out concepts and recommended actions. The document Safe Schools for Transgender and Gender Diverse Students (2014) includes recommended behaviors for school psychologists, which include modeling acceptance and respect and responding to bullying and harassment whether perpetrated by other students or staff. (The APA/NASP resolution indicated that staff are less likely to intervene when trans and gender-diverse students are bullied.) The Safe Schools resource includes developmental aspects of gender identification. For example, children under nine who assert a gender not aligned with that assigned at birth most often do not "persist in asserting that gender in adolescence or early adulthood." The statement continues that for this age group, "only reversible social transitions are recommended (e.g., clothing, hair styles, activity preference.)" For youth 11 and older, asserted gender typically persists and medical care involving hormone blockers may be appropriate in addition to social affirmative care.

School psychologists and other mental health professionals need to stay vigilant concerning regulations passed at the state level that may restrict the level of care the LGBTQ+ community receive. The American Medical Association, American Pediatric Association, and American Psychiatric Association all support gender-affirming care for transgender youth. Despite their recommendation, state legislatures are passing regulations to restrict care. Recently, Alabama has made it a felony for providers to give medical-affirmative care to youth under 19. In that state, it will soon be against the law for schools to withhold from parents if a child confides to school personnel that they are transgender.

It is unclear whether legislators understand the impact of their "no" votes on providing gender-affirming care to transgender and gender-diverse individuals. These groups may not realize that counseling and family support are part this model of support. If Pennsylvania would ever adopt the Texas regulations, would we as mandated reporters need to contact Child Protective Services if we learn of parents seeking gender-affirming medical care for their adolescent?

Mental health providers and school personnel are advised to keep abreast of state and local efforts to restrict gender-affirming care. It may be helpful to proactively present information sessions for legislators concerning the benefits of gender-affirming care as well as the risks in failing to provide it. School psychologists may wish to evaluate their own understanding of issues concerning transgender and diverse individuals and seek professional development for themselves and their colleagues.

## REFERENCES

American Medical Association Section Meeting (2021, November). Issues of ethical importance: health care of pediatric LGBTQ+ patients. [Video] YouTube. https://www.youtube.com/watch?v=0DiamS_44Wk

American Psychological Association & National Association of School Psychologists. (2015). *Resolution on gender and sexual orientation diversity in children and adolescents in schools.* Retrieved May 31, 2022, from https://www.apa.org/about/policy/orientation-diversity

Ehrensaft D. (2017). Gender nonconforming youth: Current perspectives. *Adolescent health, medicine and therapeutics, 8*, 57–67. https://doi.org/10.2147/AHMT.S110859

Massachusetts Department of Elementary and Secondary Education. (2016). *Principles for ensuring safe and supportive learning environments for lesbian, gay, bisexual, transgender, queer and questioning students.* https://www.doe.mass.edu/sfs/lgbtq/Principles-SafeEnvironment.html

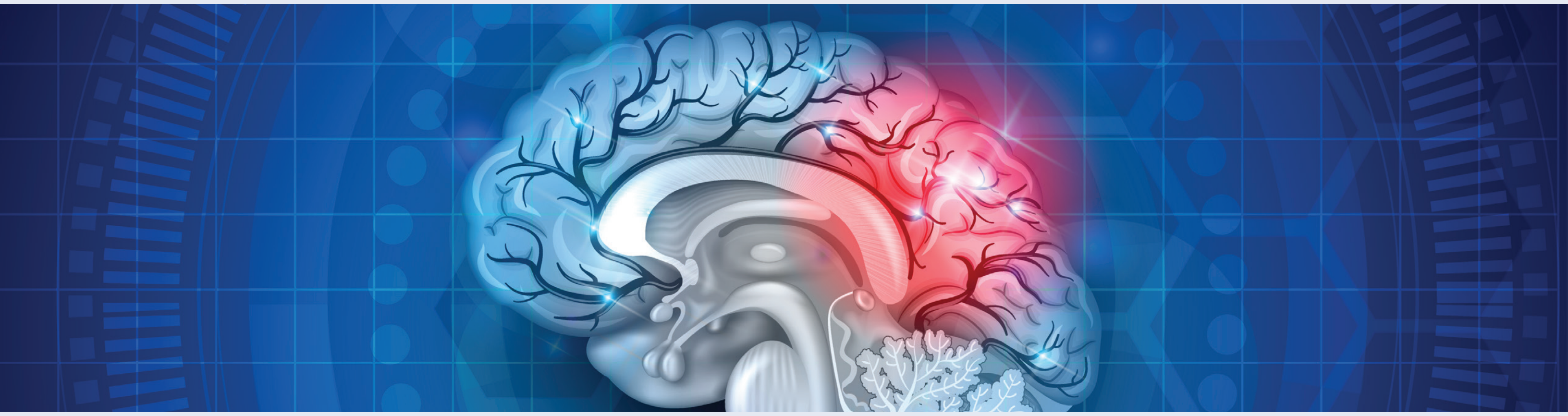
Massachusetts Department of Elementary and Secondary Education. (2021). *Guidance for Massachusetts public schools creating a safe and supportive school environment*. https://www.doe.mass.edu/sfs/lgbtq/GenderIdentity.html

National Association of School Psychologists. (2014). Safe schools for transgender and gender diverse students [Position Statement]. Bethesda, MD: Author.

Pennsylvania Department of Education. (2017). Pennsylvania equity and inclusion toolkit. https://www.education.pa.gov/Documents/K-12/Safe%20Schools/EquityInclusion/PA%20Equity%20Inclusion%20Toolkit.pdf

# SPORTS-RELATED CONCUSSION AND ADVOCACY BY SCHOOL PSYCHOLOGISTS

R. BRANDON CONAWAY, MSEd; AKSHITA NAYYAR, MSEd, PhD; KIRSTIN FRANKLIN, BS; CLYNIECE HODGE, MSC; KELLY EYLER, MSEd; MARIA TINA BENNO, MSEd; ERICA BEIDLER, PhD; ARA J. SCHMITT, PhD



According to the Centers for Disease Control and Prevention (CDC), concussions are a mild form of traumatic brain injury (TBI) resulting from a forceful impact to the head or body (CDC, 2021). There are numerous psychosocial and physical consequences of concussions that are crucial for practicing school psychologists to understand, identify, and help manage in clinical practice. The sudden movement of the head and brain may produce brain chemical changes, brain cell damage, and cognitive symptoms such as confusion (CDC, 2021). Although not typically life threatening, concussions are common among youth involved in sports in the United States. Among the 50% of high school students involved in sports in the United States, approximately 5 to 15% of those student-athletes have experienced a concussive injury in high school (Semple et al., 2015). Concussions sustained during sports are often denoted as sports-related concussions (SRCs), which occur during both helmeted and nonhelmeted sports activities (Herring et al., 2021).

The highest rates of SRC are evident in contact and collision sports (Meehan et al., 2011). With respect to female athletes, soccer (highest concussion risk), softball, cheerleading, and basketball are high-risk concussion sports (Herring et al., 2021; McGroarty et al., 2020; Semple et al., 2015). For male athletes, American football (highest concussion risk), rugby, lacrosse, wrestling, ice hockey, and soccer are sports associated with high concussion risk (Germann et al., 2021; Kerr et al., 2019). Overall, concussions are more prevalent in female athletes as compared to male athletes, with higher rates of concussive injuries being reported in sporting competitions versus sport practice (Halstead et al., 2018; Kerr et al., 2019).

Approximately 14 to 30% of athletes who endure SRCs develop physical, emotional, and cognitive symptoms that persist 3 months or longer (Anzalone et al., 2021). Physically, athletes most commonly endure headaches, dizziness, and nausea. Cognitively, athletes may experience confusion and typically short-lasting deficits related to memory, reaction time, executive functioning (e.g., planning and organization, initiation), and processing speed (e.g., quickly understanding novel concepts and making decisions; Anzalone et al., 2021; Gessel et al., 2007).

Symptoms resulting from concussions may often adversely impact academic performance of student athletes through functional impairment within the school environment. Concussions in school-aged children can negatively impact cognition as indicated in assessment of intelligence, processing speed, and long-term memory (Anzalone et al., 2021). Student athletes may also concurrently experience lower energy levels, mental health difficulties (e.g., depression and anxiety), and concentration and working memory difficulties, all of which negatively impact retention of information and general school performance (Lowry et al., 2019). School personnel who serve student athletes, such as school psychologists, can positively impact the academic and psychological recovery course of student-athletes through managed recovery procedures.

The Pennsylvania Safety in Youth Sports Act (2011) outlines standards for managing concussions from high-impact sports. This Act stipulates that school systems must have removal-from-play procedures, as well as return-to-play procedures. For example, for a concussed student-athlete to return to play, written clearance from a licensed or certified medical professional is required.

Germane to this article, Beidler et al. (2020) obtained and examined the sports-related concussion protocols of Pennsylvania high school athletic departments. In addition to identifying procedures for removal-from-play and return-to-play procedures of the high schools, they also coded for protocol elements related to the educational management of concussion and presence of concussion management teams. Of the 184 Pennsylvania Interscholastic Athletic Association (PIAA) participating high schools that took part in the study, results showed that only 13.6% indicated the use of a concussion management team, 32.6% referenced the need for potential academic adjustments for their student-athletes, 14.7% indicated referral to the team's academic point person, and 4.9% referenced that return-to-learn procedures may involve a graduated approach (Beidler et al., 2022). Reported in print for the first time in this article, Beidler and colleagues' data collection also explored whether school psychologists were referenced as members of the school-based concussion management team. Only 1.1% of the schools included district school psychologists on the concussion management team when students required academic accommodations. Taken together, these data suggest that much work needs to be done to connect high school athletic departments to the academic support systems (i.e., multitiered systems of support; MTSS) present within their own school buildings to manage the potential negative educational consequences of concussion.

We believe that school psychologists are in a prime position to argue for the formation of concussion management teams within their school systems and to participate on those teams given their expertise and training in the psychoeducational consequences of illness and injury (Canto & Pierson, 2015). School psychologists are the school professionals most keenly aware that students who have experienced a concussion require managed recovery procedures to facilitate the transition of their student-athletes back to the classroom. Concussed students may require academic adjustments such as extra time for assignments and tests, frequent breaks, and assistance managing any missed work due to the injury. School psychologists can advocate within their systems that students who experience concussions can be managed through existing academic procedures, like academic and social-emotional/behavior supports offered through multi-tiered, problem-solving frameworks (Solesbee & Davies, 2021). Helpfully, Davies (2016) outlines a progressive eight-step return-to-learn protocol for students who require a higher level of services in school following a concussion. Finally, school psychologists assist in service coordination and act as liaisons between their school systems and the Pennsylvania-based BrainSTEPS organization (https://www.brainsteps.net/default.aspx) which provides valuable assessment and intervention resources, and even provides direct consultative services to school districts when faced with the school-based management and education of children with head injuries.

## REFERENCES

Anzalone, C., Bridges, R. M., Luedke, J. C., & Decker S. L. (2021). Neurocognitive correlates of persisting concussion symptoms in youth. *Applied Neuropsychology: Child*. Advance online publication. https://doi.org/10.1080/21622965.2021.1961260

Beidler, E., Welch Bacon, C. E., Hattrup, N., Powers, C., Saitz, L., & Valovich McLeod, T. C. (2020). Going beyond the state law: Investigating high school sport-related concussion protocols. *Journal of Athletic Training, 57*(1), 3–43. https://doi.org/10.4085/1062-6050-0505.20

BrainSTEPS (n.d.). *About BrainSTEPS – The brain injury school consulting program*. Retrieved June 1, 2022, from https://www.brainsteps.net/

Canto, A.I., & Pierson, E. E. (2015). Concussion management in schools: Issues and implications. *School Psychology Forum: Research in Practice, 9*(3), 162–164.

Centers for Disease Control & Prevention. (2021, May). *Mild TBI & concussion*. CDC. https://www.cdc.gov/traumaticbraininjury/concussion/index.html

Davies, S. (2016). *Managing Concussions in Schools: A Guide to Recognition, Response, and Leadership*. Springer Publishing Company.

Germann, D., Cancelliere, C., Kazemi, M., Marshall, C., & Hogg-Johnson, S. (2021). Characteristics of adolescent athletes seeking early versus late care for sport-related concussion. *The Journal of Canadian Chiropractic Association, 65*(3), 260-274.

Gessel, L. M., Fields, S. K., Collins, C. L., Dick, R. W., & Comstock, R. D. (2007). Concussions among United States high school and collegiate athletes. *Journal of Athletic Training, 42*(4), 495–503.

Halstead, M. E., Walter K. D., & Moffatt, K. (2018). Sport-related concussion in children and adolescents. *Pediatrics, 142*(6), 1–24. https://doi.org/10.1542/peds.2018-3074

Herring, S., Kibler, W.B., Putukian, M., Solomon, G.S., Boyajian-O'Neill, L., Dec, K.L., Franks, R. R., Indeliicato, P. A., LaBella, C.R., Leddy, J.J., Matuszak, J., McDonough, E.B., O'Connor, F., & Sutton, K.M. (2021). Selected issues in sport-related concussion (SRC/mild traumatic brain injury) for the team physician: A consensus statement. *British Journal of Sports Medicine, 55*(22), 1251–1261. https://doi.org/10.1136/bjsports-2021-104235

Kerr, Z. Y., Chandran, A., Nedimy, A. K., Arakkal, A., Pierpoint, L. A., & Zuckerman, S. L. (2019). Concussion incidence and trends in 20 high school sports. *Pediatrics, 144*(5), 1–13. https://doi.org/10.1542/peds.2019-2180

Lowry, R., Haarbauer-Krupa J. K., Breiding M. J., Thigpen S., Rasberry C. N., & Lee, S. M. (2019). Concussion and academic impairment among U.S. high school students. *American Journal of Preventive Medicine, 57*(6), 733–740. https://doi.org/10.1016/j.amepre.2019.08.016

McGroarty, N. K., Brown, S. M., & Mulcahey, M. K. (2020). Sport-related concussion in female athletes: A systematic review. *Orthopaedic Journal of Sports Medicine, 8*(7), 1–12. https://doi.org/10.1177/2325967120932306

Meehan, W. P., Taylor, A. M., & Proctor, M. (2011). The pediatric athlete: Younger athletes with sport-related concussion. *Clinics in Sports Medicine, 30*(1), 133–144. https://doi.org/10.1016/j.csm.2010.08.004

Semple, B. D., Lee, S., Sadjadi, R., Fritz, N., Carlson, J., Griep, C., Ho, V., Janng, P., Lamb, A., Popolizio, B., Saini, S., Bazarian, J. J., Prins, M.L., Ferriero, D. M., Basso, D. M., & Noble-Haeusslein, L. J. (2015). Repetitive concussions in adolescent athletes – translating clinical and experimental research into perspectives on rehabilitation strategies. *Frontiers in Neurology, 6*(69), 1–16. https://doi.org/10.3389/fneur.2015.00069

Solesbee, C., & Davies, S. C. (2021). Data-based decision-making within an MTSS framework for students with concussion/TBI. *Communiqué, 50*(4), 18–20.

Safety in Youth Sports Act, 101 P.L. § 563. (2011). https://www.legis.state.pa.us/cfdocs/legis/li/ucons

# BEVERLY GOODWIN, PhD

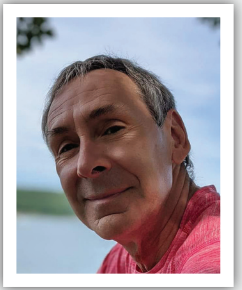
(JUNE 12, 1953 – MAY 17, 2022)

Dr. Goodwin was a professor emeritus in Indiana University of PA's Psychology Department. She began her career at IUP in 1986 and retired from IUP in 2020. She devoted her career to providing clinical training in the PsyD in Clinical Psychology program. During her time at IUP, she served as both the Director of the Center for Applied Psychology (1997-2003) and the Director of Clinical Training (2003-2010). Beverly also provided clinical services in Pittsburgh, primarily to women of color, and published on issues specific to women of color and the inclusion of women of color in psychology education.

Even more than her professional contributions, her friends and colleagues remember Beverly as a woman with a great laugh, who often told jokes and stories, and spread positive energy to everyone around her. She is survived by her husband Ray.

# DAVID JOHN LAPORTE, PhD

(MAY 9, 1954 – MAY 13, 2022)



David John LaPorte, PhD, aged 68 years old, and born in Reading, PA, on May 9, 1954, passed away in his home on May 13, 2022, surrounded by his loving daughter, her partner, and his wife in Pittsburgh, PA, after a prolonged struggle with cancer.

Dave was a passionate learner who earned a PhD in Neuropsychology at Temple University. Throughout his career as a professor at Indiana University of Pennsylvania, he inspired and mentored thousands of students with his wit, insight, and love for psychology and the brain. Additionally, he had a successful private counseling practice helping countless individuals who struggled with mental health and other cognitive challenges.

To read the full obituary visit: https://legcy.co/3xkNVfX

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# BECOMING AN ADVOCATE

KRISTA BOYER, PsyD

"As we work through the therapeutic process, I am going to ask that you make room for some discomfort." These are words that I often use when I orient my clients to therapy. I explain that there tends to be discomfort when we grow and change and that if we are willing to gently make room for that discomfort, it will allow us to live a life that is congruent to our values. I noticed that this rings true for the advocacy efforts that I recently have been participating in as a member of the Prescription Privileges for Psychologists (RxP) committee. We are currently at the point where we are contacting legislators to secure cosponsors for the RxP bill. I feel excited but, also outside of my comfort zone. I have never spoken with legislators, and I generally do not like asking others for favors.

Even though I participated in trainings regarding the legislative process and collaborated with a supportive committee, I noticed that I felt a measure of self-doubt and unease when presented with the challenge to approach my state representative. I was intimidated and noticed all sorts of resistance on my end but needed to remind myself why I was doing this. That moment of reflection was enough to make space for the temporary discomfort that emerged.

I joined the RxP committee after seeing the effect that the severe shortage of psychiatric care had on my clients and the community where I live. Long wait times for psychiatric visits cause missed work time, strained relationships, consequences from unmanaged aggression, and the development of chronic medical issues. I also felt helpless when my clients would frequently ask, "why can't you just prescribe my medication since you know me best?"

Importantly, 31 counties in Pennsylvania have limited access to psychiatric care. There are currently five states that grant appropriately trained psychologists prescriptive privileges, and an analysis conducted by Muse & McGrath (2010) indicate that "in the majority of content areas pertaining to the prescribing of psychoactive medication to mental health clientele, pharmacologically trained psychologists are better prepared than practitioners in other prescribing professions" (p. 102). Another frustration is seeing my patients who are worse off from a prescriber who did not consider all patient factors in prescribing psychotropic agents. In many of these cases, the clients experienced negative side effects with very limited therapeutic response, while the conditions they were being treated for could have more efficiently been addressed in psychotherapy. Smith (2012) reports that "some mental health professionals support granting prescription privileges to appropriately trained psychologists as one means of reducing inappropriate prescribing. By offering both therapy and medications, a prescribing psychologist could choose the best approach for the patient" (p. 38). Said briefly, the power to prescribe also grants the power to unprescribe medication.

Because of those factors (and more), I called my representative to advocate. When the conversation started, I was aware of my nervousness; however, this quickly faded as the conversation progressed. I soon realized that legislators and psychologists have a lot in common in that both are high in social responsibility. My representative demonstrated care and concern for his constituents and a desire to do what is best for them. By the end of the call, I had secured a cosponsor, and this increased my confidence in my advocacy skills and I began reaching out to more representatives. I soon realized how much I enjoyed connecting with and educating legislators and felt a sense of achievement as I built momentum for our cause that I care so deeply about.

As I did this, I realized how the advocacy process draws on much of the same skill set that we as psychologists already possess. Much of advocacy is relationship building, collaboration, research abilities, the use of assessment skills, and applying the same type of persistence and patience required to assist our clients to achieve their treatment goals. I ended up speaking to many different offices. Some were more willing to hear me out than others, but I remained flexible and diligent similar to working with clients at varying stages of change.

As I am writing this now, I was able to get multiple cosponsors signed on, and several are considering. No one that I contacted told me "No." What is most important is that my efforts are building awareness through education.

This process took time, effort, and perseverance but I am grateful that I made room for advocacy because if I did noy try, nothing would have happened. Remember that psychologists are uniquely positioned to inform and advise policymakers, and we are experts in mental health issues. Now more than ever the current climate is calling for us to be advocates, and we have the skills and ability to create deep change. Psychologists have an ethical commitment to social change and political advocacy. We continually ask our clients to push beyond their boundaries during the change process, and we can be models for that as we assume the challenges of advocacy work.

Some tips to guide advocacy work:

- Advocacy work takes courage and perseverance guided by our values.
- Begin to cultivate a relationship with your legislators and their staff.
- Remember your legislators want to know what is important to their constituents, and psychologists are experts in the treatment of mental health and behavioral health issues.
- Create an outline of talking points summarizing how the issue affects constituents. Relevant and accurate statistics and numbers are quite important, but a good narrative story usually has the largest impact.
- Make a clear request.
- Tap your network as there is power in numbers. You also may come to find that people in your circle have an established relationship with a legislator, which can help secure support.
- If you want things to remain the same, do nothing.

## REFERENCES

Muse, M., & McGrath, R. E. (2010). Training comparison among three professions prescribing psychoactive medications: Psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. *Journal of Clinical Psychology, 661*(1), 96–103.

Smith, B. (2012). Inappropriate prescribing. *Monitor on Psychology, 43*(6).

# PENNSYLVANIA PSYCHOLOGICAL FOUNDATION

## Education Awards Committee

### Role of the Pennsylvania Psychological Foundation (PPF) Education Awards Committee:

The PPF Education Awards Committee is an amazing group of people who work together to review applications and select recipients for the annual Student Awards at Convention. The committee members follow guidelines in reviewing student applications for the awards and provide feedback on candidates throughout the selection process. The committee then meets virtually to choose recipients of each award. It is an incredibly satisfying way to give back to the student population of our association and make a meaningful impact on our membership!

### Exciting Work Done This Year:

For Convention this year, the PPF Education Awards Committee was able to secure awards for 13 recipients (wow!) and advocated to increase the award amount to $5,000 each (double wow!!). This would not have been possible without the generous donations from our membership at large, so thank you.

### How You Can Get Involved:

The number of awards and monetary amount that is given relies heavily on the contributions of our membership. This year, thanks to wonderful fundraising efforts of the PPF Board and PPA's donation match, we were able to provide tremendous financial assistance to incredibly deserving candidates. One way to get involved is by donating, if you're able, to PPF's Education Awards. Additionally, if you are interested in becoming a part of the committee, please contact Whitney Quinlan, Chair at whitneyquinlan92@gmail.com. We are always looking for enthusiastic individuals to join the review process, which runs from approximately January through March.

# RESPONDING TO A GRIEVING FAMILY MEMBER

## FOLLOWING A SUICIDE

JEANNE M. SLATTERY, PhD, LINDA K. KNAUSS, PhD, ABPP, AND SAMUEL KNAPP, EdD, ABPP

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.

Malyana was a single mother raising her daughter, Sacha. In reading the newspaper, Dr. Grief discovered that Malyana, his client, had died by suicide earlier that week. Sacha (14) called to ask how her mother had been doing in therapy and whether she had been attending regularly. Sacha alternated between anger and tears during their short call. Dr. Grief wants to be helpful, but . . .

## Legal Precedents

Dr. Grief may wonder what his legal obligations or options are. However, the legal landscape is complex and unclear as we explain below.

In 1996, Pennsylvania's State Board of Psychology responded to a hypothetical question presented to them by opining that, without written consent, "a psychologist may not release to a deceased client's wife, confidential information about the deceased that was obtained by the psychologist during the course of a professional psychological relationship" (Lutz, 1996, p. 3). This would apply unless the patient had signed a release before their death or if a court ordered the release of the information. They further concluded:

> Although "privacy" as an individual right normally ends at death, the same is not true of confidentiality. This is because it would seriously undermine confidence in the therapeutic relationship *while it was occurring* if the patient knew that confidentiality would not be preserved following his death (Lutz, 1996, p. 3, italics in original).

The Pennsylvania State Board of Psychology's opinion regarding the record release after death was an "advisory opinion." As such, it indicated how the Board would think if it ever were confronted by such a case. It was not an opinion deriving from a real case before the Board, nor was it a regulation. In its *Lyness* decision (1992), however, the Pennsylvania Supreme Court ruled that licensing boards in Pennsylvania cannot issue advisory opinions; they can only "speak" through regulations or through their opinions concerning disciplinary cases before them. As a result, the legal status of the Board's advisory opinion on releasing records after death is unclear.

The HIPAA Privacy Rule protects individually identifiable health information for 50 years after a client's death, but does allow some exceptions (U.S. Department of Health and Human Services, n.d.). During this period, the executor can authorize disclosures of the client's health information or records following a subpoena.

The HIPAA Privacy Rule is superseded by state law if it is more protective of the patient from the standpoint of the patient. In the absence of a state law providing greater legal protection to the deceased patient (e.g., a regulation from the Pennsylvania State Board of Psychology, a court decision from the Pennsylvania State Board of Psychology, or a state statute or court opinion), HIPAA would allow psychologists to release information at the request of the executor. What is most relevant here is that the Pennsylvania State Board of Psychology has neither issued

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

a regulation nor adjudicated any case to supersede the HIPAA standard and, to our knowledge, no courts in Pennsylvania have ruled on this issue for psychologists.

## Further Complications

The issue of how to respond to information requests from family became further complicated when the consultation service of a major malpractice carrier, The Trust, began advising that, although confidentiality continues past death, psychologists in Pennsylvania could turn over the records of deceased patients based on the request of the executor. They noted the ambiguous legal status of the Pennsylvania State Board's opinion and argued that, from a risk management perspective, responding to survivors' requests for closure were of primary importance and the clinically appropriate and humane thing to do.

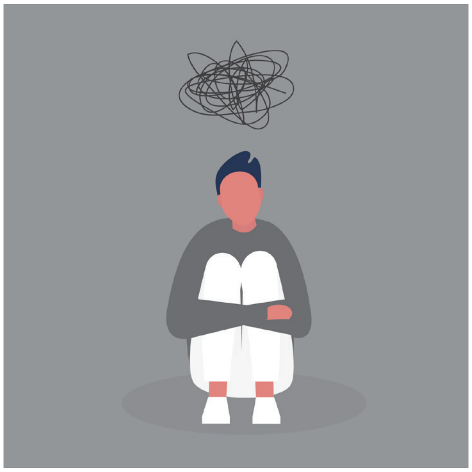
If a request for information comes from a grieving loved one who is the client's executor, for example, and the family member simply wants closure following the death of their loved one, psychologists can consult with their malpractice carrier for advice. If the malpractice carrier declines to offer advice, a psychologist can consider whether disclosing the information would help survivors and respect the wishes of the deceased.

## Context Matters

In the absence of clear legal guidance or advice from a liability carrier, psychologists can base their decision on the context. If the relative had seen the psychologist in family therapy with the deceased client, it would be foolish to pretend that the family member knew nothing about treatment. This would argue in favor of a candid and compassionate discussion with the surviving loved one. In fact, in most cases, when the loved one knows about the psychologist, this information probably came directly from the client and suggests that the client would have approved sharing the information that the client was in treatment. Sometimes requests are for records needed to ensure death benefits. Such situations argue in favor of sharing records without requiring that survivors obtain a court order.

Although Sacha was a grieving daughter who wanted to process her mother's death, not all requests for information on a deceased patient are benign or free from conflict. In some cases, families may request information to contest a will or otherwise extend the conflict beyond the grave in a manner inconsistent with the client's wishes. In such cases, Taube (2018) suggests asserting privilege and requiring a copy of the court order before releasing such information. Still, setting a firm boundary and refusing to discuss the dead family member without a court order may increase the distress of a loved one as well as the psychologist's risk of a complaint.

A compassionate and concerned psychologist who validates the loved one's feelings and concerns, while maintaining the client's appropriate confidentiality (e.g., client material that would be harmful to share) may reduce risk of a malpractice suit. With permission of the client's executor, psychologists may discuss general therapeutic issues with the family (e.g., the nature of suicidality), share condolences, and help the family gain a sense of closure (Knapp et al., 2013). After this postvention, it would be wise to refer the loved ones to another psychotherapist to avoid a potential conflict of interest (D. Taube, personal communication, March 21, 2022). This may be a place to discuss concerns with supervisors, consultation groups, or one's insurance carrier, preferably before the contact with the loved one.



Patient deaths by suicide are especially stressful since survivors of suicide often have many emotional sequalae from being a surviving family member. Several studies support this conclusion. For example, Aronson et al. (2017) reported that spouses of soldiers dying by suicide had poorer postmortem adjustment than spouses of soldiers who died by other means. The stigma, shame, and self-recrimination following patient suicides takes a serious emotional toll on survivors, including clinicians.

People tend to draw attributions about intentionality based on the perceived goodness or badness of actions, inferring intent to harm about bad effects, without attributing intent to help for good ones (Feltz, 2007). Family members whose loved one was in therapy at the point of the suicide reported more negative and fewer positive attitudes toward the treating psychotherapist than those whose loved one was not in therapy at the time of death (Ward-Ciesielski et al., 2015). Of those survivors who had had contact with the clinician post-suicide, 42% felt the clinician had not told them all they wanted to know, 48% felt the clinician was withholding information, and 40% reported believing that information that may have been damaging to the clinician was withheld (Peterson et al., 2002). Further, 64% believed the clinician did not do all they possibly could to save their loved one's life; 72% believed the clinician made mistakes while treating their loved one.

Sacha, at 14, would probably not be the executor of her mother's estate, but the same issues apply. Again, a discussion with a caring and empathic psychologist—Dr. Grief or other psychotherapists or supportive adults—could help Sacha and other surviving loved ones to better understand the nature of suicide and the internal logic of suicidal persons. Having this information might help them navigate the difficult years ahead.

## Be Kind, But How?

Many of us learned that in graduate school to respond to requests where we did not have written or verbal consent with a statement, "I can neither confirm nor deny that . . . ." Such a response struck several of us as unkind, as it is legalistic; fails to address the loved one's basic questions and

concerns; and likely will activate schemas that increase the loved one's distress and consequently the risk of a complaint. This response would be an assimilation response in the ethical acculturation model (high professional and low personal ethics), rather than a more helpful integration response (high professional and personal ethics) (Handelsman et al., 2005).

We were reminded of Levinson et al. (1997), who reported that primary care physicians who had never been sued spent more time with their patients than those physicians who were sued, were more likely to make statements educating patients about what to expect, laughed and used humor more, and engaged in active listening with them. The differences were not in the amount of information shared, but in how these physicians talked to their patients. Small measures can have large, positive outcomes.

Dr. Kossmann suggested that reacting defensively will only make the situation worse and not be helpful for Sacha, while thinking this through clinically will be the most useful first intervention. Dr. Grief could see what kinds of support Sacha has—a therapist, another adult—and explain that while he cannot discuss details of her mother's treatment, he could direct her to access treatment and other supports to help herself. Although we do not know the nature of the clinicians' actions, 21% of survivors believed talking with the clinician about their loved ones' illness or treatment had been helpful; although another 20% of responses indicated that "nothing" the clinician had done was helpful. Having the clinician offer condolences was perceived as helpful (17%), as was having the clinician discuss their own pain and sense of loss (15%) (Peterson et al., 2002).

## What Could Have Been Done Differently?

We have focused on after-the-fact interventions, but other pre-suicide interventions could decrease loved ones' distress after the suicide. A clear process of informed consent beforehand could inform clients of your responsibility and intent to protect them from harm, an option to breach confidentiality if necessary to ensure patient safety, safety planning, and a treatment/safety process that could involve family members or significant others (Taube, 2018). Although not all clients want family members to be involved, including family members in the treatment of suicidal clients can be helpful not only to the client, but to family members as well. These concerns may be especially relevant when the suicidal client is a child or teen, where it may help parents to understand the nature of the boundaries on conversations between client, parents, and psychologist. Documenting our actions throughout treatment demonstrates our competent caring and that we made reasonable attempts to meet the standard of care (Taube, 2018).

Finally, while suicide is a significant stressor for loved ones, it is also a significant stressor for the treating psychologist, one that risks reducing the psychologist's emotional competence (Knapp et al., 2017). As a result, it would be wise to engage in intentional, heightened self-care in the aftermath of a client suicide. Having a safe place to process feelings and an empathic and supportive community is vitally important (Taube, 2018).

### REFERENCES

Feltz, A. (2007). The Knobe effect: A brief overview. *Journal of Mind and Behavior, 28*(3), 265–278.

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology, Research and Practice, 36*(1), 59-65. http://dx.doi.org/10.1037/0735-7028.36.1.59

Knapp, S. J., Vandecreek, L. D., & Fingerhut, R. (2017). *Practical ethics for psychologists: A positive approach* (3rd ed.). American Psychological Association.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). The Trust.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA, 277*(7), 553–559. https://doi.org/10.1001/jama.277.7.553

Lutz, J. W. (1996, April 3). Legal opinion: Does client privilege extend beyond the grave? Commonwealth of Pennsylvania, Department of State [Unpublished document].

Lyness v. State Board of Medicine, 529 Pa. 535 (1992). 605 A. 2d 1204. https://law.justia.com/cases/pennsylvania/supreme-court/1992/529-pa-535-1.html

Peterson, E. M., Luoma, J. B., & Dunne, E. (2002). Suicide survivors' perceptions of the treating clinician. *Suicide and Life-Threatening Behavior, 32*(2), 158–166. https://doi.org:10.1521/suli.32.2.158.24406

Taube, D. (2018). Suicidality: Clinical, ethical and risk management issues [Webinar]. The Trust.

U.S. Department of Health and Human Services. (n.d.). Health information of deceased individuals. HHS.gov. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/health-information-of-deceased-individuals/index.html

Ward-Ciesielski, E. F., Wielgus, M. D., & Jones, C. B. (2015). Suicide-bereaved individuals' attitudes toward therapists. *Crisis, 36*(2), 135–141. https://doi.org/10.1027/0227-5910/a000290

# CE QUESTIONS FOR THIS ISSUE

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

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

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

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

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

### Neurological Services Inform the Care of Loved Ones With Cognitive Impairment

**1. Cognitive impairment can have changes on behavior or personality functioning.**

TRUE
FALSE

**2. Caregivers' perception of control over the caregiving situation in loved ones with a brain tumor is related to patient survival time.**

TRUE
FALSE

### Compassion Fatigue in Animal Rescue Workers

**3. _______________ describes the positive experience associated with work and the sense of pleasure that one derives from helping others.**

a. Compassion fatigue
b. Compassion reward
c. Compassion satisfaction
d. Positive compassion

**4. Which of the following symptoms is commonly associated with compassion fatigue?**

a. Depression
b. Sleep difficulties
c. Social withdrawal
d. All the above

### What's the Difference? Diversity in Parenting

**5. "Horizontal identity" is best described as:**

a. Suppressing feelings of sexuality through adolescence
b. A trait that is foreign to our parents and therefore gains identity from peers
c. Choosing to invest more time in friendships than family relationships
d. Traits we have in common with our parents

6. **The *Far from the Tree* analogy as Solomon explains is most related to:**

a. Children who differ from their parents in significant ways
b. Children who are adopted
c. Adolescents who have been through traumatic experiences
d. Children who are forced to move far away from their home

### Wise Hearts and Lone Monkeys: Caregiving and Resources for Surviving Adversity

**7. Adverse Childhood Experiences (ACEs) are a risk factor for health problems in adulthood.**

TRUE
FALSE

**8. Use of behaviorally specific assessment questions to measure traumatic events improves detection of trauma.**

TRUE
FALSE

### Gender Affirming Care in Schools

**9. Gender affirming care is limited medical and surgical treatments.**

TRUE
FALSE

**10. Schools represent a system of care in meeting the needs of transgender and gender-diverse students.**

TRUE
FALSE

### Sports-Related Concussion and Advocacy by School Psychologists

**11. Among the 50% of high school students involved in sports in the United States, approximately 5 to 15% of those student-athletes have experienced a concussive injury in high school.**

TRUE
FALSE

**12. In Pennsylvania, school psychologists are frequently identified as members of school-based concussion management teams within school district sports-related concussion protocols.**

TRUE
FALSE

### Becoming an Advocate

**13. How many counties in Pennsylvania have limited access to psychiatric care?**

a. 12
b. 3
c. 31
d. 5

**14. Prescription privileges for psychologists grants the power to prescribe, but also to unprescribe unhelpful and unnecessary medication.**

TRUE
FALSE

### Ethics in Action

**15. A psychologist can always release the records of a client after death**

a. In response to a court order
b. To a spouse
c. To any family member
d. All the above

**16. According to Peterson et al., (2002)**

a. 64% of survivors believed the clinician did not do all they possibly could to save their loved one's life
b. Having the clinician offer condolences was perceived as helpful
c. Having the clinician discuss their own pain and sense of loss was perceived as helpful
d. All the above

# CONTINUING EDUCATION ANSWER SHEET

## *The Pennsylvania Psychologist, June 2021*

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

| | | | |
|---|---|---|---|
| 1. T F | 5. a b c d | 9. T F | 13. a b c d |
| 2. T F | 6. a b c d | 10. T F | 14. T F |
| 3. a b c d | 7. T F | 11. T F | 15. a b c d |
| 4. a b c d | 8. T F | 12. T F | 16. a b c d |

## Satisfaction Rating

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

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

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## Calendar

Wednesday, July 27
12:00 pm - 1:00 pm (1 CE Credit)
LIVE Webinar - Update: Subjective Distress, Vaccination, and Returning to Campus During COVID-19

Friday, August 26
12:00 pm - 1:00 pm (1 CE credit - qualifies for Act 74)
LIVE Webinar - Is Question-Persuade-Refer Helpful as a Suicide Prevention Method In Higher Education?

Friday, August 26
2:00 - 4:00 pm (2 CE Credits)
LIVE Webinar - Don't Let the "TR" Fool You: The DSM-5-TR is Far More Than a Text Revision

Friday, September 23
PPA's VIRTUAL Fall Conference
Full program will be available soon!

Thursday and Friday, March 30-31, 2023
PPA's VIRTUAL Spring Conference

Wednesday, June 21-Saturday, June 24
PPA2023 Convention
In-person at The Penn Stater Hotel & Conference Center in State College, PA

Thursday and Friday, October 5 - 6
PPA's VIRTUAL Fall Conference 2023

## Home Study CE Courses

### Act 74 CE programs

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

### Act 31 CE Programs

*Pennsylvania Child Abuse Recognition and Reporting—2 CE Version*
*Pennsylvania Child Abuse Recognition and Reporting—3 CE Version*
*Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE*

### General

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

***This program qualifies for contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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