The Pennsylvania
Psychologist
SEPTEMBER 2022
VOLUME 82, NUMBER 7

PSYCHOLOGY & WAR

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VOLUME 82, NUMBER 7 SEPTEMBER 2022

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in *The Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

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.*

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WHEN SHOULD WE ADVOCATE?

JEANNE M. SLATTERY, PhD

I have been following the discussions on the listserv on our role, if any, in engaging with the media to advocate for political change. One writer asked whether we see the difference between speaking with the media "about depression, PTSD, stress management, or any other very clearly psychological topic," as opposed to less directly relevant topics, such as "abortion or gun control."

Our knowledge of the research on abortion, gun control, transgender, and other subjects some of which was collected by psychologists, can render us especially important experts to consult on these issues. The research is clear that there are significantly more firearm deaths (i.e., homicide, suicide, and unintentional death) in the United States than in other high-income nations (for 5- to 14-year-olds, for example, respectively 18.5, 11.2, 12.2 times as much; Hemenway, 2017b). Similarly, there are more deaths in states with high rates of gun ownership than in those with lower rates. We are a significant outlier relative to the rest of the world on gun violence: Access to guns makes us less safe rather than safer (Hemenway, 2017a). Research can also help us make decisions and advocate effectively about transgender, abortion, and other issues.

As Nadal (2017) observed, psychologists have expertise that has been brought to bear in a variety of diverse spheres: segregation in schools (Mamie and Kenneth Clark), marriage equality (Gregory Herek and Ilan Meyer), mental health of LGBTQ+ people (Evelyn Hooker), the impact of sexism on women (Karen Horney and Carol Gilligan), stereotype threat (Claude Steele), and the impact of microaggressions (Derald Wing Sue and his colleagues). We have much to contribute beyond psychotherapy and understanding psychopathology.

THE ETHICS OF ADVOCACY

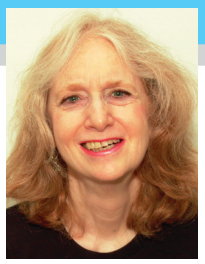
The American Psychological Association's (APA, 2017) ethical principles conclude that our work, presentations, and interviews with the media should be based on the established scientific and professional knowledge of psychology (Standards 2.04 and 5.04). When I give an interview to the media based on my professional knowledge, training, or experience, I am within our ethical standards. If I represent myself as a psychologist but base my actions solely on my individual opinions, I am acting outside our ethical standards. As Gail Post said, "citing research about the greater likelihood of suicide or homicide by firearms when they are present in the home is quite different than getting on a soapbox and shouting about how much [we] hate guns!" (personal communication, June 26, 2022). She continued, "Our credibility rests on our ability to put our feelings aside when sharing information – whether in the therapy room or on public media."

A similar complaint was made by dissenting justices on the recent ruling in *Dobbs v. Jackson Women's Health Organization* (2022): "The majority has overruled Roe and Casey for one and only one reason: because it has always despised them, and now it has the votes to discard them. The majority *thereby substitutes a rule by judges for the rule of law"* (p. 33, italics added). We need to guard against confirmation bias as we look at data and avoid making the same mistake – if the justices in the majority were indeed influenced by opinions rather than law.

Others on this same thread enlarged the discussion to include talking about these issues in the therapy room. When is this appropriate? When is it indicated? Talking about an issue and the research relative to it makes sense when we are supporting our clients' therapy goals, but when we hijack our clients' treatment and use it to meet our own goals, we are undermining their autonomy (APA, 2017). Are we shutting down discussion and exploration of these issues or are we encouraging it – with appropriate data? And, as the first writer said, "I would think that a client seeing their psychologist on television or quoted in the paper speaking about treatment for depression would have a very different impact than their speaking about abortion" – which may be either negative or positive.

Successful advocacy seems to require both humility and assertiveness. We have to acknowledge the limitations of the data, while remaining assertive in discussing and acting on what is known. We need to consider our clients' needs, but also those of our profession and communities.

Continued on page 8



THE BASICS OF ADVOCACY

TANYA VISHNEVSKY, PhD

JULIE MERANZE LEVITT, PhD

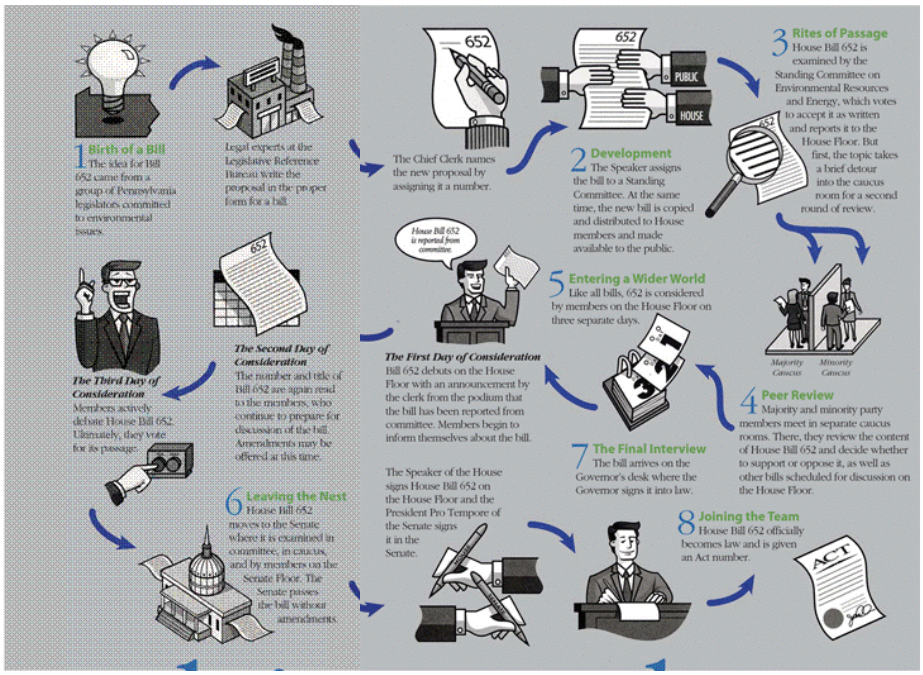
As a follow up to the virtual PPA Webinar: Psychologists Advocating for the Practice of Psychology (on February 25), this article will serve as a brief introduction to the workings of the Pennsylvania government. We aim to provide members of PPA a better understanding of why our advocacy for good law is important for the health of Pennsylvanians and how advocacy can work to counteract thinking and practices that are detrimental to the profession of psychology and to the needs of the larger community. It is our hope that this information whets your appetites, dear PPA members, and offers multiple options for how you can become engaged.

OVERVIEW OF THE PENNSYLVANIA GOVERNMENT

The government of the Commonwealth of Pennsylvania is composed of three branches: executive, legislative, and judicial. The executive branch is composed of the governor (currently Tom Wolf), lieutenant governor (currently John Fetterman), attorney general, auditor general, and state treasurer, and their staff. The governor has a cabinet of department secretaries that are tasked with moving their agenda forward.

The legislative branch is comprised of the PA House and PA Senate. The Pennsylvania General Assembly is the bicameral (i.e., two branches) state legislature made up of 253 members (203 House Representatives and 50 Senate Members). It is the second-largest state legislature in the nation, behind New Hampshire, and the largest full-time legislature. Currently, the Republican Party holds the majority in both legislative chambers: 109-93 in the House, with one vacancy and 28-21-1 in the Senate.

The website for the PA General Assembly (www.legis.state.pa.us) is a wonderful resource for learning about what is happening in the PA government. You can search for specific bills, get information about what has recently passed the House and Senate floors, and find your legislator. In addition, our very own Rachael Bauturin writes "The Bill Box" in every issue of The Pennsylvania Psychologist and on the PPA website (https://www.papsy.org/page/PendingLegislation), highlighting bills in the House and Senate that are relevant to psychologists, as well as PPA's position on the bills. As you can see from the



The Life Cycle of a Fictional House Bill (Taken from the PA Office of the Chief Clerk House of Representatives, http://www.pacapitol.com/Resources/PDF/Making-Law-In-PA.pdf.)

infographic, there are many steps before a bill becomes law. As psychologists, we have numerous opportunities to be involved in creating and/or modifying a bill, supporting a bill in getting passed, or opposing a bill.

LOCAL GOVERNMENT MATTERS

Local government is important because it affects us all whether we live in cities, towns, or rural areas. In addition, it is frequently where new ideas and new ways of making government responsive to needs of people are percolated. Local people can start by focusing on local issues and then widening the focus to regions and eventually across the state. Our state is particularly important because it is a big state, both geographically and in population size, and what is legislated here may have influences in other states and nationally. Knowing local leaders allows us to tackle bigger issues involving our field, such as social justice concerns about disparities in health care. Such laws can have an important impact in the lives of our clients and the community at large.

HOW TO GET INVOLVED

There are many ways for psychologists to get involved in advocacy work. There are opportunities to connect with local legislators, including calling or emailing their office, attending fundraising events and town hall meetings, and speaking with their staff in our legislators' offices. As psychologists, our opinions are very valuable to our representatives; typically, they are receptive to establishing a relationship because our expertise increases their understanding of community issues, inequities of service provision, and mental health needs.

At first, establishing relationships with legislators may seem intimidating. We may not see direct advocating as part of our work or, conversely, may see decision making by legislators as a matter of their own expertise. To the contrary, legislators have limited scopes of knowledge and benefit from working with their constituents and others with expertise in particular areas.

Like working with clients, working with legislators requires knowing something about the person with whom we meet, what kinds of legislative decisions the person has made in the past, and what is particularly important to the legislator in terms of issues they care about. This kind of data can be found on their legislative website. It helps to craft our pitch in terms of what makes legislation we propose fit within their interests, interest groups with which they identify, and for populations they serve. The difference between working with legislators rather than working with clients is that we need to be more direct about our own involvement with the legislation, providing examples we have from our own experiences with clients, and we need to be prepared to support what we, as experts, think is important and is supported by the literature. We also must be succinct in our arguments and be prepared to answer questions, or, conversely, to secure answers when we do not have a response to questions asked of us.

Getting to know legislators takes time and first visits may not be the most persuasive. It takes time and the opportunity over several visits for legislators to develop a trust and rapport with us and respect us for our expertise. Also, meeting in different contexts helps build trust, like attending fundraisers or hearing someone speak at events. Writing letters about issues important to you helps to educate legislators, as do phone calls and email messages.

Another way to get involved and build momentum for a position is by educating the public. This can be by writing op-eds, articles for various media outlets, or speaking directly to reporters or journalists (https://www.helpareporter.com/sources/). Psychologists also can provide expert testimony to the General Assembly. As there are no current psychologist-legislators in Pennsylvania, legislators may be prepared to learn from our understanding of the issues involved in positive mental health development and services needed under a variety of circumstances. Legislators have many strengths and part of their strengths entail being generalists. We offer specific understanding about mental health throughout the lifecycle and in different-sized and constituted communities. In addition to understanding the life cycle, our expertise includes the education of children, as well as trauma in the community and in the larger world.

PPA specifically provides multiple avenues to get involved in advocacy work. The members of the Legislative and Governmental Affairs Committee (LGAC) may make suggestions about existing legislative initiatives and what could strengthen a bill currently being considered in the House or Senate. Part of the LGAC's mission is to offer opinions on what should be legislative priorities and educating PPA members to better understand the thrust of proposed legislation. When there are opportunities to meet with legislators (such as on PPA Lobby Day in Harrisburg), PPA members play a pivotal role in advocating for legislation and funding that benefits the field of psychology and the greater community.

The Pennsylvania Psychological Association Political Action Committee (PennPsyPAC) is another way to make an impact. The committee was organized to advocate in the political arena for the advancement of PPA's mission: "o effectively communicate to the public, policy makers, and membership, the value of evidence-based and ethical practice; to support the lifelong learning of competent and ethical psychologists; and to promote and connect our membership to foster a community of professional psychologists. As a political action committee, PennPsyPAC can legally make campaign contributions in support of those candidates who support psychology's agenda. In addition, PennPsyPAC provides funding to educate and assist psychologists in their individual grassroots' political advocacy on behalf of psychology.

In short, there are many opportunities for psychologists to make a difference in the Commonwealth of Pennsylvania and beyond. Many of the ways to get involved require little time and effort. Small steps, such as calling a local legislator, have a far-reaching impact if this leads to a long-term relationship. Each of our individual contributions really do count!

In a separate article later this year, we will look at specifics in building relationships with legislators for the purpose of developing the legislation that best serves the public. Please write to us about your interest in learning more about advocacy work. We want to hear from you.

A SNAPSHOT: ACCESSIBILITY CHECKUP FOR MENTAL HEALTH PRACTICES

ELIZABETH ROY, MA

JADE LOGAN, PhD

Approximately 1 in 4 adults in the United States report living with a disability; this equates to approximately 61 million people (Okoro et al., 2018). Of those individuals, 17.4 million experience frequent mental distress, characterized by at least 14 self-reported mentally unhealthy days out of 30 (Cree et al., 2020). Thus, it is becoming clear that mental health services are crucial to individuals living with disabilities to ensure quality of life and successful coping. Given the need for mental health services, it is important for psychologists to consider how accessible these services are to the population. While several mental health professionals specialize in treating individuals living with a disability, all mental health professionals are likely to encounter someone living with a disability at some point in their professional career. Therefore, it is important to consider accessibility issues that may arise.

For the purposes of this column, we wanted to explore potential accessibility concerns that revolve around structural issues (e.g., lack of wheelchair access to and within buildings), sensory issues, and other potential barriers. In reference to structural issues, we share the interaction below.

You have just been scheduled for an intake with a client. Upon entering the waiting area, the administrative assistant calls you and asks you to make room for a wheelchair in your office. You look around at your small 6′ × 5′ office space and realize unless you move a chair into the office next door, there is no way a wheelchair will fit. You quickly ask your suitemate if you can place your therapy chair in her office to make room for a wheelchair. You go to the waiting room to bring your client to your office and realize that the doorways just barely allow her to safely pass through. Upon entering your office, she states "You don't have a couch or a chair? I prefer not to sit in my wheelchair for sessions."

Reflecting on the example above, one can see the various mistakes and assumptions of the psychologist and accessibility issues of the building and space. While there was and often is not any ill intent, the impact on the client is felt and can lead to the client discontinuing treatment. People living with disabilities are often taking a frightening and unknown step into treatment. Providing a space and developing an attitude of inclusion will allow the population to feel welcome as they begin their therapeutic journey.

While accessibility issues can revolve around external/structural issues (e.g., lack of wheelchair access to and within buildings), ableism also plays a major role. Ableism is defined as discrimination in favor of able-bodied people. Research has found that people living with a disability regularly experience microaggressions (Keller & Galgay, 2010). These experiences have fallen under the categories of (1) denial of personal identity, (2) denial of disability experience, (3) denial of privacy, (4) helplessness, (5) secondary gain, (6) spread effect, (7) infantilization, (8) patronization, (9) second-class citizen, (10) desexualization. While review of each of these microaggressive acts is beyond the scope of this column, we wanted to suggest potential review of these materials as you are evaluating accessibility concerns at your practice.

Structural Barriers

Next, we want to turn to a few things to consider when you are evaluating structural barriers to treatment. When thinking of the building you are seeing clients in, take a moment to consider how easily, or not, an individual with a mobility issue may be able to access the building. Check if the entrance has accessible parking nearby with a curb cut out on the sidewalks to allow access to the door. If the building has stairs or a step to get inside, consider the installation of a ramp to ensure that everyone can make it into the building. The installation of an activation switch door button will allow individuals to access the facility if they are unable to open a door manually. Consider what the inside of the building looks like as well. Will someone utilizing a wheelchair fit comfortably through any hallways and doorways? Will there be room for this person to wait in the waiting room

and park their wheelchair in the session room? Low chairs and couches or ones with unsupportive cushions could make it difficult for some individuals with mobility issues to get up from the furniture. Finally, when examining the bathroom, ensure that there is an accessible stall with handrails.

Sensory Barriers

At the onset of treatment, clients are often asked to read and sign a stack of consent and privacy forms. Intake paperwork is often written in standard 12-point font and is single-spaced. It is important to consider alternatives for individuals with low vision or who are visually impaired. It is recommended that practitioners have intake paperwork with larger font sizes (16–20 point) and more line spacing (American Council of the Blind, 2011). In the age of telehealth, practitioners may have paperwork in electronic forms that a client can more seamlessly make bigger to meet their own needs. Yet another option is to verbally read the consent forms to a client or have a prerecorded reading of the documents that the individual can listen to. In reference to individuals who have partial hearing loss or are deaf, check with them for their preferred way of communication. This could include using an American Sign Language (ASL) interpreter or writing or typing back and forth. It would be helpful to gather this information during the initial screening phase to have time to contact any outside services before meeting the client for the first time.

Other Barriers

A lack of training in working with individuals with disabilities, including physical, sensory, developmental, and intellectual disabilities, could contribute to the deficit in awareness of specific accommodations needed to make a practice accessible. Training in this area is relevant to all clinicians as our clients will have comorbid disabilities and mental health concerns. It is crucial to examine populations of individuals with disabilities when conducting research studies for the effectiveness of different treatments.

While the above list of barriers is by no means exhaustive, our hope is to start the conversation. When considering your practice, what might you do to make it more accessible to people living with a disability? While some changes might be cost prohibitive, others do not cost anything, such as reviewing your intake practices and considering asking questions during a phone screen to determine potential issues with accessibility. If the therapist (or administrative assistant) in the scenario above inquired about accessibility, they would have been more prepared. The psychologist could have found an alternative office space that allowed for wheelchair access and a couch or chair. When thinking of those with hearing and/or vision impairments, materials such as larger print intake paperwork, audio recordings, ASL, or another form of communication would be available upon entering the therapeutic space. Disability is often described as the forgotten "ism," and we have the power to make changes in the future to benefit our clients who have a disability as one of their intersecting identities.

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WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT CONTINUING EDUCATION

MOLLY COWAN, PsyD
Director of Professional Affairs

In Pennsylvania, psychologists are required to complete 30 hours of continuing education each renewal period, including 3 credits in ethics, 2 credits on child abuse recognition and reporting, and 1 credit on suicide prevention. Each renewal period runs from December 1 of an odd-numbered year to November 30 of the next odd-numbered year, consistent with the biennial licensure renewal (the current period is December 1, 2021 through November 30, 2023). The continuing education credits must be dated within the current biennium unless you are using carryover credits. Psychologists may carryover up to 10 hours in excess of the 30 from the immediately preceding biennium, although carryover credit cannot be used to fulfill ethics, suicide, or child abuse reporting requirements.

Psychologists should be careful to check that their CE credits come from providers approved by the State Board of Psychology. According to 49 Pa.Code §41.59 (d)(3), approved sponsors include accredited universities (as long as the course relates to the practice of psychology and generates semester/quarter credit), APA and APA-approved sponsors (including PPA), sponsors approved by the American Medical Association that directly relate to the practice of psychology, and other sponsors approved by the Board on a biennial basis.

With regard to the required specialized topics, there are also criteria that must be met. To count toward ethics credit, the word *ethics* or a derivative (e.g., ethical, ethically) must be in the title or the course completion certificate must specify it counts toward ethics credit hours. Similarly, for the suicide prevention credits, the word *suicide* or a derivative must appear in the title or the completion certificate must specifically state the course counts toward suicide prevention credits. Courses that could count toward both ethics and suicide prevention (i.e., one titled "Ethical Strategies for Working With Suicidal Ideation") can only count toward one of the requirements (ethics credits OR suicide prevention credits), not both. Child abuse recognition and prevention credits must be from an approved Act 31 provider; those credits will be sent directly to the State Board from the CE provider, so the provider will require your license number. You can verify the credits were sent to the state by logging into your account in the PALS system (www.pals.pa.gov).

It is also worth noting that psychologists authorized to practice under PSYPACT also must complete 3 CE credits annually related to the use of technology in psychology. The time frame for completing these credits is based on the date the provider was authorized for PSYPACT rather than their licensure biennium.

There are other ways to earn CE credit that are counted by the State Board. These include completing a college course that has a PSY prefix and generates credit hours, teaching at a regionally accredited college, presenting CE workshops for approved sponsors, and professional writing. Psychologists may earn up to 15 CE hours each biennium through teaching but may only receive credit for the same course or workshop once every 4 years. If there are multiple instructors, the amount of CE for each instructor is determined by dividing the overall number of CE hours by the number of instructors (e.g., a 3-hour workshop presented by 3 people would be 1 CE hour per instructor). There are also specific guidelines for what counts as professional writing (PA State Board of Psychology, 2022).

One frequent question that comes up is whether CE must be completed in person. Some of the confusion about this likely came from the COVID waivers that used different wording that the State Board does with regard to CE. The waivers allowing for all credits to be completed via home study is no longer in effect for psychologists; meaning that for the current biennium and beyond, only up to 15 credits may be completed via home study courses. However, the State Board considers webinars that are live with the ability to interact with the instructor (e.g.,

a live Zoom webinar with chat or Q&A feature) as equivalent to in-person events. There is no requirement that psychologists attend in-person CE; the requirement is that at least 15 of the required credits must be completed at live events with interaction with the instructor(s) (PA State Board of Psychology, 2022).

After each license renewal cycle, the State Board randomly audits some licensees to ensure they have completed the required CE. Psychologists who cannot provide documentation of the required CE may face penalties including warning letters, fines, and/or disciplinary action depending on how many credits they are missing and whether it is a repeated offense. The State Board requires psychologists to keep copies of the documentation showing completion of the required CE (49 Pa.Code §41.59(c)) for at least two biennia (4 years). Copies should be retained longer if you have used or are planning to use carryover credit. One suggestion for documenting CE completion is to create a document with the title of the course, the date it was completed, the sponsor, and relevant notes (e.g., live vs. home study, whether it counts toward special requirements). Then keep a folder—either on your computer or a paper file)—with the necessary documentation: certificates of completion for workshops/webinars/home studies, transcripts for college courses, presenter certificates for workshops you presented, letters from the department chair for courses taught, and title pages with relevant information for books and journal articles. Another word of caution: Don't wait until the last minute to complete your required CE and be sure to double-check the math to ensure you have met your requirements!

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CONTINUED: WHEN SHOULD WE ADVOCATE?

Sometimes our failure to advocate seems a cop-out: We can choose to not know rather than face difficult problems.

We live in divided times. Even on the most difficult topics; however, psychology can help us understand the views and feelings of people with whom we disagree and find reconciliation among groups. We cannot expect "quick fixes"; we must commit to ongoing, engaged conversations (Singleton, 2021). The more we talk with each other, the more we will learn.

WHAT IS PSYCHOLOGY?

One of the qualities that I love about psychology is that our field includes the whole of the human experience. Although many of us focus on mental health, not all of us do. Nonetheless, our particular expertise in designing and analyzing research, in critically thinking about the data, and recognizing and valuing diverse perspectives makes us particularly important advocates for social change; however, we must be willing to be curious about our world rather than accept what has always been done. We have to listen well, but also use the power of our positions to take a stand when indicated. And, we must be willing to speak out!

I am grateful to Bob Griffin, Gail Post, Elaine Rodino, Brett Schur, and others, whose posts helped me frame these arguments, and to Carly Cornell, Anne Murphy, Savannah Taylor, and Helena Tuleya-Payne, whose comments strengthened this piece.

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the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF AUGUST 10, 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 11/16/21	
HB 729	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Brian Sims (D)	Support		Referred to Health 3/3/21	
HB 972	Act providing for sport activities in public institutions of higher education and public school entities to be expressly designated male, female, or coed, and creating causes of action for harms suffered by designation.	Rep. Barbara Gleim (R)	Oppose	Referred to Education 4/21/22	Passed the House 4/12/22 (115-84)	
HB 1075	An Act amending Title 64 (Public Authorities and Quasi-Public Corporations), establishing the Pennsylvania Broadband Development Authority to provide broadband Internet access to unserved and underserved residents, and providing for powers and duties of the authority, for financial assistance, and for grants.	Rep. Pam Snyder (D)	Support		Referred to House Consumer Affairs 4/1/21	
HB 1420	An Act amending the Human Services Code, in general powers and duties of the Department of Public Welfare, providing for COVID-19 mental health public awareness campaign.	Rep. Wendi Thomas (R)	Support	Referred to Appropriations 1/26/22	Passed the House 6/14/21	
HB 1690	An Act addressing the shortage of mental health services in underserved areas.	Rep. Michael H. Schlossberg (D)	Support		Referred to Health 6/24/21	
HB 2071	Amends Title 64 (Public Authorities and Quasi-Public Corporations), establishing the PA Broadband Development Authority to provide broadband Internet access to unserved residents, and providing for powers and duties of the authority.	Rep. Martin Causer (R)	Support	Third consideration and final passage 12/15/21	Final passage 12/13/21 (202-0)	Act No. 96

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 2607	An Act amending the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act, further providing for definitions, and providing for conditional prescription certificate, for prescription certificate, for prescribing practices, for prescriptive authority, and for coordination with the State Board of Pharmacy.	Rep. Wendi Thomas (R)	Support		Referred to House Professional Licensure 5/23/22	
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	

Special Section: Psychology and War

INTRODUCTION TO THE SPECIAL SECTION: PSYCHOLOGY AND WAR

HELENA TULEYA-PAYNE, DEd

The ravages of war are typically reported using metrics such as number dead, injured, and individuals displaced. The mental health toll on combatants and civilians may be harder to quantify but are no less real. In their overview of documented mental health consequences for the general population due to war, Murthy and Lakshminarayana (2006) reported that the incidence and prevalence of mental disorders increases with the most vulnerable groups being women, children, the elderly and individuals with disabilities. The authors reviewed research in several areas where conflicts exist and found that depression, anxiety, PSTD and somatization were frequently found.

In this issue, psychological impacts of conflict are discussed. Cornell and White review categories of trauma that stem from war, including vicarious traumatization that occurs from second-hand exposure. One example of this type of trauma might be seen in military-connected children with an active-duty parent. Woika discusses supports that schools can provide to these children. Another type of student, military attending higher education, benefits from institutions that recognize and prepare for the mental health needs this group may need as discussed in an article by Robenalt and Andino.

Yeomans raises the interesting question of whether "moral injury," originally seen as a normative, should be considered as part of the DSM nosology; veterans have advocated such a move as part of treatment.

Is war inevitable for the human race? Starkey presents a case for taking action to avoid conflicts involving examination of the heuristic of "the other" as enemy.

Psychological disorders are not inevitable for those experiencing war. Murthy and Lakshminarayana pointed out that even in war-torn areas, many demonstrate resilience in the face of trauma and cite religious and cultural practices as mitigating factors. Obilo-Azadegte & Monteiro discuss resilience and post-trauma growth for individual exposed to traumatic events such as war.

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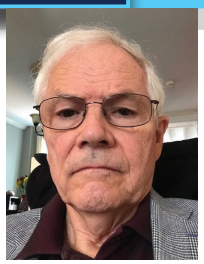

THE IN-GROUP/OUT-GROUP DISTINCTION CONTRIBUTES TO WAR

DAVID STARKEY, PhD

Psychologists working with military veterans see the devastating impact of war on the individual psyche, including trauma, guilt, and inability to adapt to society after engaging in the brutality and savagery of war. But do we realize just how brutal and savage war is? And if we do, why aren't we, professionals who see the effects of war and write about the damage that it causes individuals, more concerned with trying to stop it? For me this is a curious thing. We protest many things, and rightly so, but perhaps the worst thing of all, the ones that cause the most suffering, trauma and death, largely get a pass. In this time of increasing global tensions, we would do well to think about the psychology of war and about ourselves in relation to war. Perhaps then, in addition to techniques about treating the victims of war, we will think about ways to avoid war itself, or at least avoid being complicit in its development.

During the Vietnam War, Americans saw a glimpse of the horror of war. Journalists were allowed to present more or less freely what they saw, as in the famous photograph of children scarred from napalm fleeing naked in a stream of refugees. How could we not recoil in horror? The protests lasted for 8 long years. Fifty thousand American youth and 2 million Vietnamese, largely civilians, died, but eventually mass protests and unrest in America helped to end it.

The "forever wars" in Iraq and Afghanistan, resulting in the deaths of hundreds of thousands (Burnham et al., 2006) saw initial large protests, but fell off as the war progressed, in contrast to the protests of the war in Vietnam (Posner, 2007). Two general reasons have been offered for this change. After Vietnam, the picture of war as seen by Americans was radically altered. Reporters were strictly controlled and "embedded" with military units, not free to roam about. War became "sanitized," the menacing enemy distant and impersonal, a common factor in war reporting (Fussell, 1989). Second, the draft ended. Some suggest that when young people were no longer personally threatened by war, they were free to ignore it. Wars fought by professional soldiers and drones allowed daily life to continue without the intrusion of the horrors of war. But war has not gone away. In the 21st century alone, over 4 million people have been killed and millions more displaced by war (Ray, 2022).

There is no single theory of war, and we are far from understanding it (Ehrenreich, 2020). However, one cognitive trait, the tendency to categorize people into "us versus them" may offer a place to start in understanding what makes war possible (Benton, 2013). This mental act leads us to categorize others who are perceived as different or who do not think like us as "not us" or "them," and therefore less than us, and undesirable. In times of war, government propaganda adds to this illusion (Didion, 2003). Other people

or groups become stereotyped as "evil doers" or "radicals," who can be disposed of or dismissed as if they were not, like everyone else, human beings.

Dehumanization of the "other" makes us think that war and hatred are justified. Some say this results from an evolutionary ability meant to help us survive, to respond quickly to dangerous situations, or to increase the likelihood of finding a mate, impulses that have outlived their usefulness in modern society (Pinker, 1997). Pinker cites a study, unlikely to be approved today, in which a group of "well adjusted middle class American boys" was selected to participate in a summer camp. Divided into two groups, they competed in sports and other games. Within a few days, with limited supervision, they raided each other's living quarters and fought with sticks, rocks, and bats (Sherif, 1966). The researchers had to intervene, not unlike the famous Stanford Prison Experiment (Zimbardo, 1971) when young men divided into prisoners and jailors devolved into a situation not unlike Lord of the Flies.

Much research shows that the tendency to create "in" groups and "out" groups is a nearly universal phenomenon, although their formation can be quite arbitrary. When people are divided into groups on the basis of overestimating or underestimating dots on a screen or showing a preference for the paintings of Kandinsky or Klee, each group tends to dislike the other and think less of them (Tajfel, 1981). While this does not necessarily lead to violence, in collective conflicts, this kind of thinking is almost always present.

"Us versus them" has an early origin and may be a basic function of the human psyche that is only partly influenced by the environment. Infants' object preferences and acts of giving reflect preference for native over foreign language speakers (Kinzler et al., 2012). This suggests that we form categories among people based on language even in infancy, looking for safety in those like "us."

There is some reason to believe that children can change and become more inclusive if they perceive it to be in their best interest. Five-year-olds are more generous with others wearing the same colored outfits, but this tendency diminishes when they know that the "others" might at some point in the future switch sides (Engelman, 2013). Possible inclusion in the group in the future decreases the likelihood of conflict.

Overcoming "us versus them" requires more than overcoming cognitive biases. Despite our best efforts to remain rational in relation to human conflict, both our own emotions and societal forces play a role. If our peers or colleagues are caught up in the passions of the moment, creating an "us versus them" situation, there is a strong tendency for us to follow suit. Few can resist the temptation to conform to strongly held beliefs about a bad "other." Whether through genes, cultural conditioning, or the way our minds tend to perceive reality, we all too readily accept the existence of an enemy who threatens us and needs to be destroyed. Logic and reason can be overcome by this dynamic, and those who raise questions become a "them" as evil as the actual enemy being fought against (Didion, 2003).

Pinker (1997) finds reason to hope. He suggests that increases in literacy, education, and communication make propaganda and false claims about others less believable. This is a hope that has yet to be realized. As psychologists, we must accept responsibility for reducing conflict in our personal and professional lives. We all tend to create divisions, thinking that we have the right beliefs or opinions and "they" do not. Understanding cognitive biases that create an "us versus them" can help to reduce conflict between individuals and groups. Research into conflict and conflict resolution, if decision makers take the results seriously, can do the same for larger groups and even nations. Above all, we must remember that there is no "good" war, and that the "other" is also us.

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WAR'S INTERGENERATIONAL EFFECT ON CIVILIANS AND VETERANS

CARLY CORNELL
NATALIE C. WHITE, PsyD

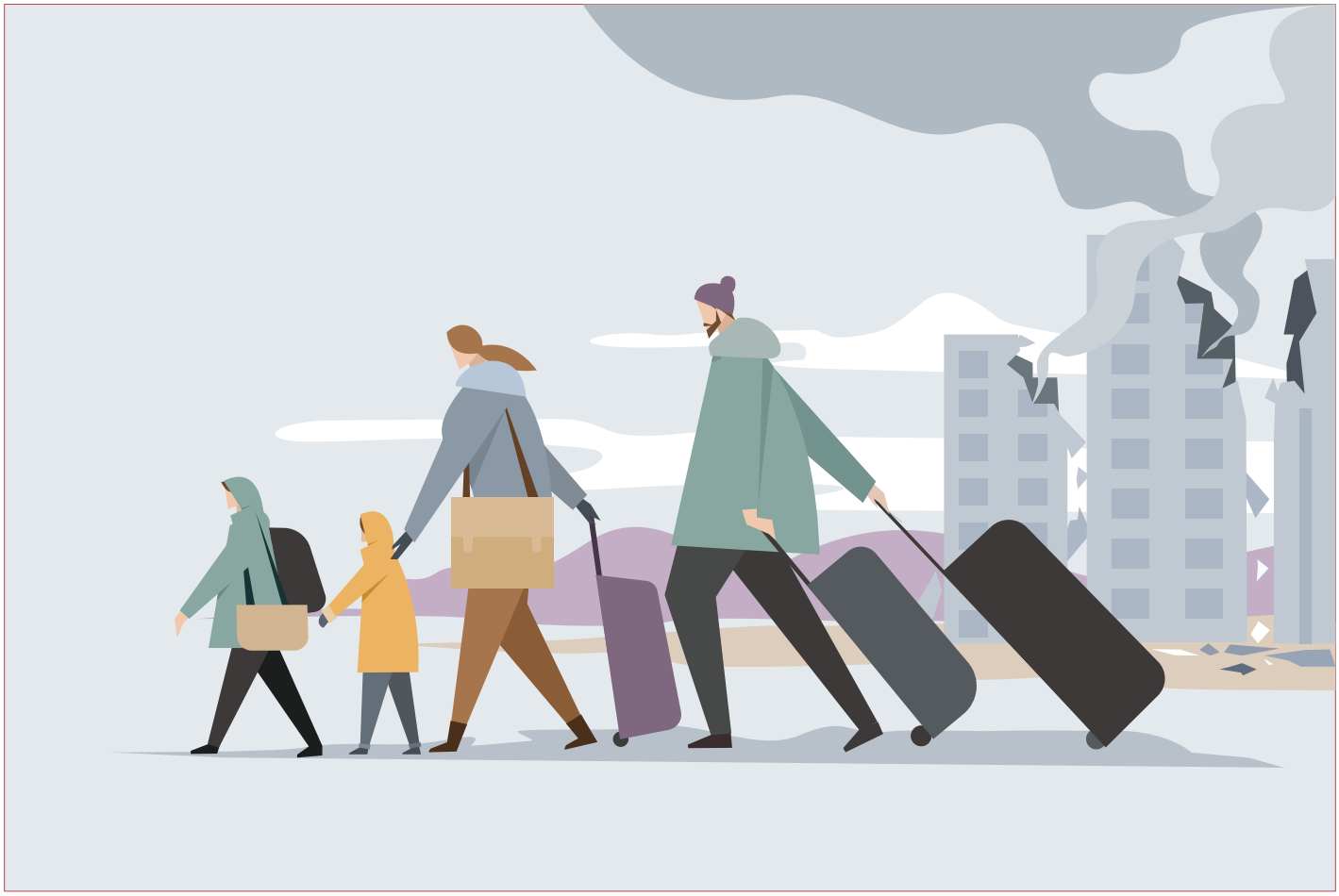
In any disruption of peace, conflict arises and it causes spikes in adrenaline. However, repeated and prolonged exposure to violence can chip away at an individual's well-being. From an aerial view, when entire communities experience trauma, behaviors and attitudes shift, which in turn shift the cultures of future generations. Despite war and trauma serving as heavy and often devastating topics, there is a silver lining. This article provides a brief overview of the various categories of trauma that stem from war and that influence war-stricken communities. Afterward, we discuss buffers that aid recovering communities in healing with resilience.

COMBAT TRAUMA

It is not uncommon for returning military service members and veterans to hear "you've changed" from their loved ones after returning from war. Military service in a combat zone, which involves persistent potential for personal danger, separation from loved ones and communities, and possible exposure to death, trauma, and atrocity, can result in significant shifts or transformations in belief systems—including those related to safety, relationships, spirituality, and work ethics—emotional experiences, and physical functioning (Fala et al., 2016). Among the signature injuries of war is posttraumatic stress disorder (PTSD), which manifests in such symptoms as nightmares; sleep disturbances; high levels of anxiety, depression, and intense anger; emotional detachment from others; lack of positive emotional experiences; tendencies toward isolation and avoidance of trauma reminders; and marked hypervigilance (American Psychiatric Association, 2013). These concerns are often felt by veterans' family members and loved ones, and research suggests that veterans' trauma symptoms can result in interpersonal distress between them and their spouses and children (Monson et al., 2012). Veterans may also become less involved in their communities to avoid trauma reminders or conflict. Social withdrawal prevents them from sharing valuable knowledge with others, such as the true costs of war, life lessons from their time in the military, and advice on work ethic. Moreover, it might lead them to feel alienated and misunderstood by a society they fought to defend. Although PTSD causes impairments in many areas of life, individuals who face trauma and suffering can also experience positive or "posttraumatic growth" (Tedeschi et al., 1998). Furthermore, several evidence-based treatments, such as eye movement desensitization and reprocessing therapy and cognitive behavioral therapy, can alleviate mental health concerns associated with trauma exposure.

VICARIOUS TRAUMATIZATION

When a helper, such as a mental health clinician or a health care worker, experiences trauma secondhand over time and that trauma gradually changes the helper's worldview, the helper is experiencing



vicarious traumatization (Pearlman & Saakvitne, 1995). For instance, if a psychologist were treating military veterans who shared memories of rape; taking hostile fire; and death, including of comrades, innocent civilians, and children, the psychologist might start to experience their own trauma reactions. Signs of vicarious traumatization include intrusive thoughts and images, poor concentration, and feelings of discouragement, exhaustion, irritability, or hopelessness, which are often symptoms seen in individuals diagnosed with PTSD (Pearlman & Saakvitne, 1995). The experience of repeatedly listening to traumatic events associated with war can negatively impact the psychologist's daily and relationship functioning, view of the country where the war took place, willingness to allow their children to enlist, and ability to play war-related video games or watch military films.

Although vicarious traumatization is a negative outcome, vicarious resilience refers to a positive response from listening to secondhand trauma. Regarding the latter, the helper feels inspired by the way a client copes with the traumatic incident, and the helper proceeds to use this inspiration to motivate others. Nevertheless, coping retrospectively with trauma is not a linear process; an individual can experience both vicarious traumatization and vicarious resilience at different points depending on life circumstances, such as workload, current personal and workplace stressors, and self-care behaviors.

CIVILIAN TRAUMA

Those who live in a war zone for any amount of time are subject to civilian trauma. Symptoms include flashbacks, nightmares, intrusive thoughts, emotional numbness, avoidance, social isolation, hypervigilance, irritability, outbursts, panic, poor memory and concentration, depression, and suicidal thoughts (Vincenzes, 2013). In a study of individuals who experienced non-military trauma, participants who had experienced multiple traumatic incidents displayed different symptoms of PTSD than participants who had experienced one single incident (Hagenaars et al., 2011). The former felt more shame, guilt, anger, dissociation, and skepticism in relationships than the latter. In war zones where trauma occurs frequently, it is likely that many civilians will experience multiple traumatic events and potentially more significant negative outcomes.

In the cruelest cases of wars, civilian involvement could include anything from "rape of women, using civilians as human shields, child soldiers, genocides, internally displaced peoples (IDP), refugees, etc." (Musisi & Kinyanda, 2020). In addition to war crimes, violence and weaponry destroy infrastructure, houses, and any buildings to which civilians are attached. War also impacts the economy by demanding higher production of weapons and military supplies while abating resource production for civilians. Multiple exposures to violent war crimes and stressors associated with combat zones put civilians at high risk for developing PTSD or other trauma-related concerns. Such experiences can leave lasting intergenerational effects.

INTERGENERATIONAL TRAUMA

An individual might experience trauma that trickles down their family's lineage. If this trauma affects offspring and future generations who have not directly experienced the traumatic event, the family experiences intergenerational trauma. For example, a couple who lived in a war zone might move away and have children. The parents, who now live with anxiety, anger, and depression, have trouble trusting and connecting with others, have tendencies toward isolation, and find it difficult to raise and discipline their children consistently. Consequently, children can go on to develop similar mental health concerns and insecure attachment styles, which they then pass on to their own children. When parents have trouble regulating their own emotions, they might also struggle to teach their children how to do so, which could result in children developing poor coping skills or lack thereof (DeAngelis, 2019).

BELONGINGNESS AS A BUFFER TO TRAUMA

Junger (2016) writes about the sense of community that can emerge from a traumatic event, such as war. He explains that it is not uncommon for war to feel more comforting than peace. He argues, "hardship can turn out to be a great blessing and disasters are sometimes remembered more fondly than weddings or tropical vacations. Humans don't mind hardship, in fact they thrive on it; what they mind is not feeling necessary" (Junger, 2016, p. xvii). War can be devastating, traumatic, and costly to people and societies, but resilience is possible and even probable. People who come together as a "tribe" during hard times come out stronger than ever. Actively targeting the potential for intergenerational trauma and breaking the chain can prove highly effective. The earlier clients pursue intervention, the more time they have to eradicate trauma-related thoughts and behaviors from their parenting styles, and the less children will be exposed to the impacts (Devakumar et al., 2014). Furthermore, when a child's mother has a supportive environment, she has better well-being and has more energy and patience for caregiving, which in turn results in stronger resilience for children (Devakumar et al., 2014). Parents can also employ a positive strategy by establishing happy family traditions, conducting acts of kindness, frequently telling their children they are loved, and allowing their children to have other role models, such as their grandparents, aunts, or uncles, if parents are struggling to provide the secure attachment that children need.

When communities become battlegrounds, the first-hand combat exposure that soldiers encounter, the vicarious traumatization that helpers face while working with veterans or civilians exposed to war, and the trauma that civilians in war zones experience all increase risk of intergenerational trauma for the community at war. During such disasters, people can come together and support each other in times of need. With awareness and effort, parents can work to filter out the intergenerational trauma that spreads to their descendants, who can continue shining the light of hope and tribe mentality for years to come.

As mental health professionals, one of our jobs is to engage in regular self-care to prevent or cope with vicarious traumatization. We can admire clients who have coped positively with their trauma and gain inspiration from them so we can encourage our future clients. We can encourage clients who have experienced trauma to share optimism, security, warmth, and affection with their children, who can continue sharing these values with their loved ones and the greater community.

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CAN PSYCHOLOGISTS DO ANYTHING ABOUT WARS?

SAMUEL KNAPP, EdD, ABPP

I come from a family of veterans. My father was a Major in World War II assigned to the American Air Force in England where almost half of his fellow soldiers had died. My older brother was a Colonel and was one of the oldest (if not the oldest) American soldier with boots on the ground when the United States invaded Iraq. He was awarded a bronze star. Both sacrificed a great deal. I am proud of their service and our nation owes them and other veterans a debt of gratitude.

Yet I am skeptical of the ability of wars to solve most international problems, and I believe that we need to avoid wars if possible. Many psychologists are currently invested heavily in social justice, as they should be, because inequalities degrade the quality of life for so many. However, those of us who want to improve lives of people through health equity, quality education, and the other accoutrements of a life worth living, need also to consider the devastation that wars can cause.

Americans may be used to wars occurring in distant lands and feel insulated from the effects of that war. But for those in the war zone, life can be precarious and horrible. The brutality of the war in Ukraine is not an exception; it is the norm. In addition to the direct suffering caused by wars through casualties and direct deaths, wars can disrupt economies, upset economic supply chains, and destroy the infrastructure resulting in long-term death and suffering due to malnutrition and lack of adequate health care. As with many catastrophes, wars disproportionately impact the poor.

Some may claim that wars are inevitable or a product of nature that cannot be changed. Similar arguments were once made about the inevitability of disease, slavery, the subjugation of women, and so on. But wars are not inevitable. Europe provides an example. For centuries, the English, Dutch, French, Spanish, Germans, and other Europeans fought periodic wars with each other. Yet, since 1945, these countries have been at peace with each other, have integrated their economies, and strengthened their interdependence on each other. Although Germany (or Prussia) fought seven wars with France from 1806 to 1945, the current likelihood of a war between these two countries is nil. Economic cooperation as opposed

Continued on page 18

THE EVOLVING CONSTRUCT OF MORAL INJURY

PETER D. YEOMANS, PhD

For the last 40 years, the psychological effects of warfare have primarily been understood in terms of the construct and diagnosis of posttraumatic stress disorder (PTSD). However, moral injury has emerged as a complementary, overlapping, yet distinct construct that invokes a different lens for conceptualizing and responding to distress associated with military service. Over the last 25 years, a definitional process in the literature has seeded still nascent efforts to build theory, refine assessment, and develop intervention.

The definition of *moral injury* continues to evolve. Though Jonathan Shay, a psychiatrist with Veterans Affairs, is rightly credited with coining the term, the first significant insight (in modern times) to the moral pain of veterans could be attributed to Peter Marin (Marin, 1981). Tasked with a writing assignment on cinematic portrayals of the Vietnam War, Marin emerged from interviews with Vietnam War veterans inspired to document the central theme he was hearing – the burden of moral pain. "Veterans have learned…the dead remain dead, the maimed are forever maimed, and there is no way to deny one's responsibility, for those mistakes are written, forever, and as if in fire, in other's flesh" (Marin, 1981, p. 128). It was not until the late 90s that Shay began to write about moral injury as "a betrayal of what is right by a legitimate authority in a high stakes situation" (Shay, 2014, p.182). Importantly, Shay also posited that moral injury should never be eligible for the *DSM* as a diagnosis, as the very nature of this pain was a normative response of human moral sensitivity encountering the brutality of warfare. Litz, a psychologist at the Boston VA Medical Center, subsequently added an essential dimension to our understanding of moral injury by constructing a definition more focused on the perception of having violated moral codes: "Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations… [where there is] a discrepancy between one's morals and the experience" (Litz, et al., 2009, p. 700). Other definitions have been offered by combat veterans themselves: "Damage done to our moral fiber when transgressions occur by our hands, through our orders, or with our connivance" (Boudreau, 2011, p. 749). Today, the research literature reflects both these subtypes of moral injury: betrayal-based or perpetration-based (Jordan et al., 2017).

Other definitions of *moral injury* are couched in a less clinical paradigm and instead posit a more social and communal context: "Moral injury is rooted in the unfair distribution of appropriate moral pain" (Antal et al., 2021, p. S79). Peck (1983) wrote, "If we must have a military at all, it should hurt" (p. 232) to say that the brutal nature of warfare generates distress. The nature of this suffering is normative and inevitable, not pathological. It is the product of the healthy conscience of someone who either will not or cannot avoid applying their moral sensitivity to a reckoning of their actions or those of others. Antal's use of the words *unfair distribution*, reminds us that experiences of moral injury occurred in the context of military service on behalf of the nation. Though service members may have some degree of agency even while under orders, they are acting in the context of public service as determined by a government elected by the people. However, today, the U.S. public is less connected to service members and veterans than ever before. Indeed, a recent study found that "only about one half of one percent of the U.S. population has been on active military duty at any given time during the past decade of sustained warfare" (Pew, 2011, para 7). Therefore, the inevitable moral burden of warfare sits disproportionately on the shoulders of our service members and veterans.

Particularly since the arrival of COVID-19, moral injury has also been considered as a construct to capture the experience of health care workers unable to practice medicine according to their standards. The need to make difficult and morally untenable triage decisions in an overwhelmed emergency room or the inability to provide sufficient care due to lack of materials or staffing has generated

reflections on whether we might think of the guilt and betrayal felt in such situations as moral injury (Hines et al., 2021). Certainly, this warrants further consideration. Although feeling betrayed by one's leadership is perhaps common to both service members and to health care practitioners, the degree of violation of one's own moral code between these two groups is incomparable. Health care workers are trying to save lives but are sometimes unable to do so. Service members are sometimes in the business of saving lives, but they are trained to kill, which can be experienced as a transgression of the most fundamental of our moral codes.

Recent literature calls for better definitions of moral injury and associated concepts, such as moral distress and moral pain (Maguen & Norman, 2021). There is a growing argument that moral injury should be added to the psychiatric nosology of the *DSM,* despite the construct's original assumption as being normative and even healthy, though painful. Some veteran advocacy groups argue it should be considered as a condition eligible for compensable disability.

Behavioral health care providers, health care workers, chaplains, and clergy may never fully agree on the assumptions behind this term and its scope of application. Meanwhile, assessment tools and interventions continue to be developed. Whether moral injury is ultimately recognized as clinical pathology or as normative, as intrapsychic or as communally determined, as specific to warfare or as ubiquitous in other settings, will powerfully determine the development of future assessment and intervention models.

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CONTINUED: CAN PSYCHOLOGISTS DO ANYTHING ABOUT WARS?

to cut-throat economic competition prove to be better for both societies in the long run, which is an example of a non-zero-sum strategy where both parties benefit (Wright, 2000). Nothing inherent in Europeans make them fight with each other. Democracies engage in fewer wars than non-democracies (Pinker, 2011).

In addition, many times cool heads and diplomacy have kept international tensions from erupting into a war. An incident in American history is an example. In the 1840s, tensions between the United States and England over boundary disputes in the Pacific Northwest led to violence in the region, and indignant citizens in both countries argued for war. A slogan "Fifty-four forty or fight" became popular in the United States, referring to the parallel where Americans claimed the border should be. But American and British diplomats knew how destructive and pointless such a war would be—and agreed to a compromise and setting the border on the 49th parallel (Boyer et al., 2005). Many other similar examples could be given.

I am not arguing for unilateral disarmament, nor am I pretending that there are no evil leaders who could do great harm. But we should not let the perfect be the enemy of the good. Just because all wars cannot be avoided does not mean that some wars cannot be avoided. Psychologists can take several steps to reduce the likelihood of unnecessary wars:

- Support politicians who value international cooperation.
- Avoid hyper-nationalistic attitudes that often oversimplify complex issues and ignore the perspectives of those from other countries.
- Support nonprofit organizations that promote better living conditions and democratic governments overseas.
- Learn more about the real American and world history—not sanitized and jingoistic interpretations.
- Continue to work for social justice and to address those conditions that lead to despair, distrust, anger, and violence wherever they may appear.

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TRAUMA, RESILIENCE, AND POSTTRAUMATIC GROWTH

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Trauma is a severe psychological wound prevalent in our world today, as individuals and whole communities are impacted by their exposure to and experiences of traumatic events. These events include but are not limited to acts of sexual abuse, physical abuse, neglect, war, terrorism, gun violence, and natural disasters. According to the Substance Abuse and Mental Health Association (SAMHSA), 1 in 7 children have experienced child abuse or neglect in the past year, 14 youth die from homicide each day, and over 1,300 receive treatment in emergency departments for injuries related to violence (SAMHSA, 2022). Additionally, the Department of Veteran Affairs reported that 6% of the population will develop posttraumatic stress disorder (PTSD) in their lifetime, and about 12 million adults in the United States have PTSD during a single year (U.S. Department of Veterans Affairs, 2022). Trauma is overwhelmingly present in our society, and it is important for both mental health professionals and laypersons to have a basic understanding of how it impacts our capacity to be resilient.

So, what is trauma? According to the Diagnostic and Statistical Manual, Fifth Edition, TR, trauma is "exposure to actual or threatened death, serious injury or sexual violence" (DSM-5-TR, 2022, p. 271). Trauma, however, cannot be reduced to a single set of symptoms; it overwhelms our entire system and impacts our memory functioning, emotional regulation, interpersonal relationships, self-esteem, and so much more. Although individuals possess the capacity to be resilient in the face of trauma, they develop resilience in the context of a healthy support network. In discussing resilience across cultures, Tummala-Nara (2007) stated, "while both individual attributes and developmental transitions are important contributors to resilience and coping, both are also influenced by salient qualities of family, social support network, and community and by prevailing cultural beliefs and values" (p. 36). In discussing trauma and resilience, it is essential not to lose sight of the role that family and social support play in an individual's ability to cope, especially as it relates to people and cultures that are traditionally collectivist. Additionally, notable scholars in the field of trauma, including Judith Herman, Bruce Perry, and Bessel Van der Kolk, have all spoken about the power of healing relationships in recovery from trauma. Some may even go beyond resilience to experience posttraumatic growth.

What is resilience and why is it important? According to the dictionary of the American Psychological Association, resilience is defined as "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (APA, 2022, Resilience section). However, accessing the necessary tools to help manage stress and adversities can be challenging and it therefore must be cultivated. Children are not automatically resilient. Connor (2006), in her assessment of resilience after trauma, noted that greater resilience is predictive of improvement in clients with PTSD. Additionally, she said, "resilience is now recognized to be one of the most important factors in assessing both healthy and pathologic adjustment following trauma" (Connor, 2006, p. 46).

Bessel Van der Kolk, in his book, *The Body Keeps The Score*, referred to the process of changing posttraumatic reactions as "limbic system therapy"

referring to attending to our basic needs by engaging in activities such as sleeping, eating, and connecting with loved ones (2014, p. 190). These simple steps, in addition to doing the therapeutic work and utilizing one's strengths, all promote resiliency. In describing resiliency factors, APA named three major ones: "the way in which individuals view and engage with the world, the availability and quality of social resources, and specific coping strategies" (APA, 2022, Resilience section). Additional factors that promote resiliency are protective factors; these include a safe, stable, and nurturing relationship with family members, positive friendships and peer networks, economic and financial help, and community connections (Centers for Disease Control and Prevention, 2021).

Posttraumatic growth is identified as the next step following recovery from trauma. This process includes meaning-making and often involves a newfound cause, advocacy effort, and in some cases, a new career path of helping other survivors. The form or shape this takes ultimately depends on the individual and the resources they have at their disposal. Maitlis (2020) distinguished between resilience and posttraumatic growth, stating that resilience emphasizes stability following trauma while posttraumatic growth refers to the continued increase in psychological functioning. Whether it is a process or an outcome (Maitlis, 2020), the possibility of achieving posttraumatic growth following a traumatic experience is a message of hope and survival. This message should be promoted by educators, clinicians, and others who are instilling hope and changing the narrative about what recovery can look like in the aftermath of trauma. In her book, *Trauma and Recovery,* Judith Herman (1997) describes three stages of trauma recovery: Safety, Remembrance and Mourning, and Reconnection. These stages are crucial in the healing process. They can support survivors in moving away from relieving their experiences; moving toward processing their thoughts, feelings, and sensations; regaining a sense of power and control; and reconnecting with their loved ones and society at large.

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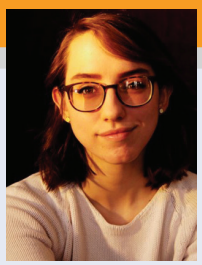

SUPPORTING MILITARY-CONNECTED STUDENTS IN SCHOOLS

SAVANNA WOIKA, MEd

Most student support professionals agree that trauma plays a huge role in the lives of students who experience it: in families dealing with domestic abuse or poverty, in students who have experienced natural disasters or crises, in cases of severe or prolonged bullying. One group of students that is frequently left off the list for many educators is military-connected children, who are more likely to experience traumas such as frequent moving, separations, and parental injury or death. Unless a school is very close to a military base, educators may not think about how military service affects students, but the reality is that military-connected students live all over the country and the world. Military-connected students might live with family while their parents are deployed, move to a nonmilitary town after their parents' contract is up, or relocate following the death of a parent. Over 2 million students in the United States have at least one active duty parent, and despite the high probability of encountering military-connected students, many school professionals may be unprepared to support these students (Chartrand et al., 2008).

So, what should school psychologists know about military-connected students?

MILITARY CULTURE

The first thing is to develop a sense of military culture. Information about the specific branches is available at sources such as MilitaryOneSource.mil.

Military careers frequently involve deployment, when the service person is sent to work somewhere else for a few months to a little over a year. Military-connected students will probably also experience their parents going on detachments, which are shorter work assignments a few days to a month. Families of military personnel generally do not move during deployments or detachments. However, military families do move frequently, either for temporarily assigned duty or permanent change of station, when families are permanently moved to a new location. On average, these students move every 3 years. Families experiencing permanent change of station have probably completed a Family Care Plan (Department of Defense, 2010). It is helpful to make sure that military-connected families have completed their care plan, or have a copy placed in the student's record.

The frequency of moves and multiple parental absences have the potential to be traumatic. Research shows that transitions can be particularly challenging for students who are of minority status, have previously displayed behavioral problems, have low academic achievement, or are of low socioeconomic status (Anderson et al., 2000). Additionally, students who have negative perceptions of their academic competence, experienced social anxiety, have negative attitudes about moving, and experienced moving during the school year rather than at the beginning of it may also have more difficulty navigating transitions (Blaisure et al., 2012). Students experiencing these factors may need more support, such as frequent check-ins, more structured social supports, and more leniency with assignment deadlines and learning routines.

EXCEPTIONAL STUDENTS

Students in special education can be particularly affected by geographic transitions. Since regulations may be different from state to state, there is an Interstate Compact (a legal agreement between states) that assists with some aspects of military student transitions. For example, the Interstate Compact on Educational Opportunity for

Military Children requires schools to immediately place military-connected students based on their unofficial records and current educational plans, such as copies of the Individualized Education Program (IEP) or unofficial transcripts, rather than waiting for official records to come through from their previous school. If there is any mismatch between the services students have been receiving and services that a school is able to provide, open discussions with parents are important.

Sometimes schools want to complete their own evaluation for inclusion in special education. Since military-connected students move frequently, they are more likely to have been frequently evaluated and reevaluated. Evaluations are stressful in their own right, which is exacerbated by the further social challenge of being pulled out of classes when new students are trying to build new connections. Using existing data for special education decision making might be considered unless a reevaluation is necessary.

There are two military-specific services that are of assistance for military-connected students and their families: the Exceptional Family Member Program (EFMP) and School Liaison Officers (SLOs) (Jagger & Lederer, 2014). When a military-connected student receives a medical, behavioral, or educational diagnosis, their service person is required to register them with the EFMP. This program provides community support, as well as housing, medical, educational, and personal services. The other resource is the SLO, a military employee assigned to help families navigate military-related school transitions. Schools may need to encourage families to reach out for the services offered by an SLO or the EFMP.

MILITARY-CONNECTED STUDENTS AND TRAUMA

Parental absence may be experienced as relational trauma. Military-connected students are more likely to experience parental injury or death than students in the general population. It is important to recognize the symptoms of trauma including internalizing and externalizing behaviors. Internalizing behaviors include crying, clinginess, being withdrawn, decreased participation, expressing fears and worries, changes in sleep patterns, and somatic complaints. Externalizing behaviors that hint at trauma may include increased fighting, impulsive behaviors, defiance, experimentation with alcohol and drugs, and argumentativeness or irritability (Andres & Moelker, 2011; Cozza et al., 2005).

Military-connected students are supported using trauma-informed practices and changes in interactions with school personnel. For example, establishing reliable structure and routines, and being conscientious about letting students know ahead of time when those routines may experience disruption, can help these students feel that school is a predictable and safe place. Teachers should be made aware when a student is military connected. Teachers may need to provide more structure, be more lenient with emotional and behavioral problems, allow more time for adjustment before expecting the student to participate typically in classes, or allow breaks or calming resources. Information about diagnoses such as posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (C-PSTD) may be helpful for the educators serving military-connected students.

LEARN MORE

Information about resources to support military-connected students is located at the School Resources website: https://schoolresources.militaryfamilies.psu.edu.

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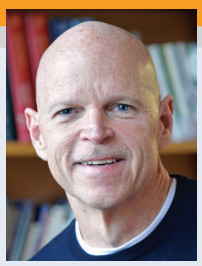

SOCIAL AND EMOTIONAL LEARNING: NAVIGATING PUBLIC DISCOURSE IN SCHOOLS AND COMMUNITIES

COMMENTARY BY TIM KNOSTER, EdD, EdS
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The intent of this commentary is straight forward. However, navigating the realities associated with this topic is nuanced, messy, frustrating, and, frankly, somewhat unsettling. I would much rather be providing guidance on how to situate social and emotional learning (SEL) within the context of multitiered frameworks along with the array of approaches schools can use to embed trauma-informed practices into the ebb and flow of their daily operations. Alas, while this would be ideal, that is for another day.

The degree of unrest that has emerged across communities as a result of deliberate or inadvertent misrepresentation of what SEL is… and is not… is concerning. Let's start by separating a few facts from misrepresentations based on my understanding of SEL that aligns with the Collaborative for Academic, Social, and Emotional Learning (CASEL; https://casel.org/) coupled with what I view as some of the more challenging fallacies being promoted today.

SEL Misrepresentations Based on Fiction	Some Basic Facts About SEL
SEL is nothing more than a coded approach to promote critical race theory in our schools and make our white children feel badly about themselves and our country.	SEL is comprised of essential life skills that our students need today as well as in the future to become contributing adults in our increasingly diverse society.
SEL promotes indoctrination of our children in to alternative, non-Christian lifestyles.	SEL is about developing degrees of self-awareness as well as awareness of others' life experiences and perspectives to enhance our ability to respectfully problem-solve situations on the job, within our family, and with other people in our community.
SEL is just another example of our schools, and ultimately our government, doing things to our kids as a grand social experiment with no evidence of those things being helpful.	The value of SEL is very well documented, and student learning of these life skills can be facilitated in many ways in schools, including but not limited to, implementation of an evidence-based SEL curriculum.
SEL is a deliberate strategy to take away power from the white majority in the United States and shift that power to others that don't look like or act like those of us who are currently in that white majority.	Effective implementation of SEL helps build resiliency in a manner that enhances equity by helping to level the playing field of access to educational opportunity for each and every child.

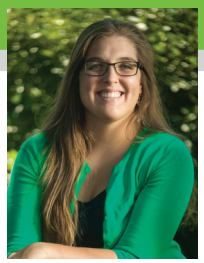
The above comparisons are by no means intended to be exhaustive. Rather, it is intended to simply distill some of the basic facts associated with SEL to help offset some of the more volatile misrepresentations emerging at school board meetings and in other common spaces. As we can all relate, not so long ago it was understood that two individuals or groups of people could have different perspectives or opinions about a common set of facts. Unfortunately, this is no longer the state of affairs in public discourse given the emergence of "alternative facts" and the promotion of "fake news" that has not surprisingly spilled over into discussion and debate concerning SEL. As we attempt to navigate discussions, debates, and arguments about SEL, it can be helpful to consider a few basic ideas as starting points to inform our approach.

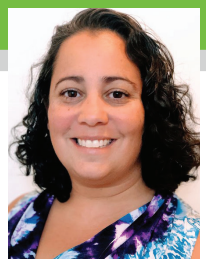
First, promotion and prevention rather than reactive intervention should be the foundation of marketing the value of SEL amongst constituencies in our communities. As the old adage goes, an ounce of prevention is worth more than a pound of cure. In this day and age, it is essential to develop and implement marketing plans related to important features of educational programming, and this is most certainly the case for SEL. However, it would be naive to think that proactive marketing alone will sufficiently influence opinions.

Second, it is important to realize that there is a vast difference between someone who could be described as a healthy skeptic based on their limited knowledge as to what SEL is and is not as compared with someone (or group of individuals) who is simply cynical and will utilize a general lack of understanding amongst those healthy skeptics to foment discontent and further an ideological agenda. It can prove helpful to differentiate how we interact with healthy skeptics versus cynics in that healthy skeptics are more likely to be open to factual information to inform their opinions, where the most head-way that we may realize with cynics is to mitigate their effect on the healthy skeptics.

Last for this brief commentary, we need to use language that is relatable and will resonate with the people in our communities in which our schools are located. Specifically, framing SEL in terms of basic life skills can help in this regard. Further, talking about these basic life skills emphasizing resiliency and employability as is reflected in Pennsylvania's Career Ready Skills can be helpful as it frames these life skills in a manner less burdened by educational jargon (that some might consider elitist). Keep the words we use simple and real — so to speak — to curry constructive engagement and support from the broadest array of people feasible (with emphasis on the healthy skeptics). This can concurrently lessen the chance of inadvertently providing resources (think verbal ammunition here) that can be used against us in our endeavors by a vocal minority of cynics that we cannot ignore, but must navigate in our settings.

There are, of course, additional factors to be thought through as we organize our activities to support SEL in our schools. However, I am hopeful that the information that I have shared here proves helpful as a starting point — or food for thought — in organizing a game plan that makes sense across the diverse array of schools and communities in the Commonwealth.





SERVING MILITARY STUDENTS' MENTAL HEALTH NEEDS IN HIGHER EDUCATION

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MINDY S. ANDINO, EdD (SHE/HER/ELLA)

Upon implementation of the Post-9/11 GI Bill in 2009, people in the military are able to obtain funding benefits for higher education (Office of Public and Intergovernmental Affairs, n.d.). According to Student Veterans of America (SVA, 2020), more than 1 million military students are currently utilizing their GI Bill benefits to obtain a degree in higher education. These students are often entering into higher education later in life than the "traditional" student population on most university campuses. Additionally, many of these veterans are married (52%), a single parent (19%), have children (46%), or are working full or part time (74%; SVA, 2020). On the other hand, a "traditional" college student is stereotypically under the age of 24, White, cisgender, living on campus, and working part time or unemployed (National Center for Educational Statistics, n.d.). Many of these differences in experiences can impact military students' level of comfort and willingness to access appropriate resources on campus.

Military students can experience some advantages compared to their peers in a college environment, such as increased life experience/training, self-discipline, leadership skills, and access to financial resources and health care. However, many of these benefits are overshadowed by the struggle of being a "nontraditional" student, additional personal responsibilities (children, employment), and physical health concerns (Jed Foundation, n.d.). More specifically, military students have an increased risk of developing mental health symptomatology that could impact daily functioning, such as increased anxiety, depression, suicidal ideation, and posttraumatic stress disorder (PTSD; Rudd et al., 2011). Rudd et al.'s (2011) survey indicated that nearly half of all military student participants reported PTSD symptoms, with a quarter displaying significant depression symptoms.

Although military students display increased mental health risk, some are hesitant to engage in professional services or use resources on campuses. Some barriers include increased stigma surrounding mental health within the military community, feeling a lack of understanding and/or compassion from faculty and staff, and a lack of specialized mental health treatment options (Fortney et al., 2016; Szitanyi, 2022). On the other hand, if military students attempt to obtain mental health services from an outside provider, such as Veterans Affairs (VA), military students could be hesitant to utilize them if facility access and wait times are inconvenient.

Similarly, in higher education settings, Kognito's (Albright & Bryan, 2018) survey indicated that many faculty and staff do not feel appropriately trained to assist military students. Although 95% stated it was part of their role to help support the military student population, 70% of faculty and staff stated they believe they were not adequately prepared to recognize signs of distress among their military students, and 75% reported feeling unprepared to approach a student about a witnessed concern (Albright & Bryan, 2018). This perceived lack of specialized training could perpetuate the barriers noted by military students. It is reasonable to believe that students who feel disconnected and misunderstood by their campus community would be less likely to use supports that would improve their mental health and academic success.

Potential methods that higher education settings can utilize to improve military students' experiences include the following.

EDUCATING FACULTY AND STAFF

A 2021 study by Boston University's School of Public Health, in collaboration with the Mary Christie Foundation and the Healthy Minds Network, determined that over half of the faculty assessed were not aware of gatekeeper training being offered at their institution, with only 28% noting participating in one. Gatekeeper training aims to develop a greater understanding of the mental health needs of the military and resource referrals. Low participation suggests the need to provide more university-wide training and to promote the implementation of this training during on-boarding and during certain intervals of employment. Providing training that focuses on "nontraditional" student populations would more appropriately identify students at risk.

One targeted means to educate the

campus community is the development and implementation of Green Zone Training. Modeled after the Safe Zone program that provides safe spaces for members of the LGBTQ+ community, the Green Zone Training works to develop a visible and educated network across the institution resulting in a more military-friendly campus and increasing military student success, retention, and sense of belonging. The Green Zone Training provides participants with a basic knowledge of concerns and issues facing military students and resources available on campus and in the community (Nichols-Casebolt, 2012). After completing the training, participants can place a placard on their office door indicating that they are Green Zone trained, creating a visible network for military students.

PROMOTING SPECIALIZED MENTAL HEALTH SUPPORTS

In addition to advocating for university-wide training experiences for faculty and staff, it is important that university counseling centers are appropriately constructed to manage the influx of those with specialized mental health needs, such as military students. It may be helpful for mental health providers to develop relationships with already present military student support services, which would allow mental health care to be brought directly to students at risk. If universities are unable to provide targeted supports, the Steven A. Cohen Military Family Clinic at the University of Pennsylvania provides mental health care for veterans, service members, and their families at no cost throughout the region (https://www.med.upenn.edu/mfc/).

BUILDING DIVERSITY

As we press forward, faculty and staff should reflect the diversity of the students they are serving and adapt programming to meet their needs. As with other types of issues, advocating for diverse faculty and staff may allow students, especially those within "nontraditional" and marginalized communities, to feel comfortable in speaking with those who can more directly understand their experiences.

Intentionally building culturally competent approaches and implementing cultural humility when working with all students helps to support resilience. Educating campus faculty and staff, promoting specialized mental health supports, and building diversity are ways institutions can intentionally foster military students' comfort and willingness to access appropriate resources on campus.

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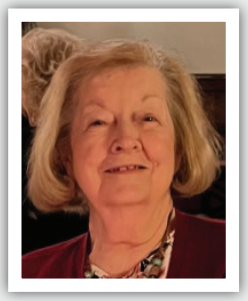
IN MEMORIAM

KATHRYN L. VENNIE, DBH, MS

(FEBRUARY 28, 1939 – AUGUST 29, 2022)



Dr. Kathryn L. Vennie, 83, of Hawley, died on Monday, August 29, 2022, at Regional Hospital of Scranton surrounded by her family.

Born on February 28, 1939, in Pelham, NY, she was the daughter of the late Joseph and Eleanor (Lynn) Quinnan. She graduated from Pelham Memorial High School, class of 1956, and received a Bachelor of Science degree from Marywood University. She continued her studies and received her Master of Science Degree from Marywood in 1971. She became a Licensed Clinical Psychologist. Having a desire to continuously learn, in 2016 she earned her Doctorate from Arizona State University in Behavioral Health and was a member of The Honor Society of Phi Kappa Phi, ASU Chapter.

In her early career Kathryn taught school at Delaware Valley School District and then the newly formed Wallenpaupack Area School District. In 1981, Kathryn began her own psychology practice caring for many over the years. Her primary office was in the Lake Wallenpaupack area, with additional offices in Clarks Summit and Stroudsburg throughout her career. Dr. Vennie continued seeing patients right up to her passing. She was a long time member of the Pennsylvania Psychological Association, the American Psychological Association, and several other organizations.

To read the full obituary visit: https://bit.ly/3Rzk8au

2022

VIRTUAL FALL CONFERENCE

Thursday, September 22 - Friday, September 23

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Conference Schedule

Course descriptions and objectives are available online at www.papsy.org/page/SpringFall

Thursday, September 22

7:00 pm - 8:30 pm

Understanding the Dobbs Decision and What It Means for Practicing Psychologists Post-*Roe v. Wade*

Alan Nessman, JD; Rachael Soule, JD

Member: $40; Non-Member: $80; Students: Free

1.5 CE Credits - Intermediate

Friday, September 23

9:00 am - 12:00 pm

Ethical Considerations for Interjurisdictional Practice

Molly Cowan, PsyD; Alex Siegel, JD, PhD

Member: $75; Non-Member: $150; Students: Free

3 Ethics CE Credit - Intermediate

12:30 pm - 3:30 pm

Five Strategies to Update Your Practices With Suicidal Patients

Samuel J. Knapp, EdD

Member: $75; Non-Member: $150; Students: Free

3 CE Credits - Intermediate; meets Act 74 requirement

4:00 pm - 6:00 pm

Child Abuse Recognition and Reporting (Act 31)

Molly Cowan, PsyD; Rachael Baturin, MPH, JD

Member: $50; Non-Member: $100; Students: Free

2 CE credits - Introductory; meets the Act 31 requirement

All Access Pass

Planning on attending all of the sessions at PPA's 2022 Virtual Fall Conference? **Register at the All-Access Pass rate** (available to members only)

All Access Pass: $199

savings of $40 over registering for all sessions individually

CE Information

PPA's 2022 Virtual Fall Conference is sponsored by the Pennsylvania Psychological Association and will provide up to 9 CE credits. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. More information is available online.

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

PPA pays an honorarium to Conference speakers. There are no identified conflicts of interest for speakers for the 2022 Virtual Fall Conference.

Need LIVE credits for your renewal? Attend on September 22 and 23 and these webinars will count for LIVE credit!

ethics in action

OUR "STUFF" CAN GET IN THE WAY OF GOOD PSYCHOTHERAPY

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

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

Dr. Wall, a Latinx psychologist, was treating Mr. Towne, a 31-year-old African American architect, for anxiety. Mr. Towne reported being stressed by the current political climate, feeling unsafe and targeted because of ongoing racial conflicts described in the media. Mr. Towne reported feeling "disappointed and somewhat betrayed but sadly, not surprised" by these.

Dr. Wall became anxious and unable to concentrate, especially as his own close cousin was recently the target of a hate crime. Unfortunately, his cousin was afraid to report it to the police, fearing she'd be deported.

Dr. Wall suggested relaxation techniques and other strategies to decrease symptoms; however, Mr. Towne became frustrated with treatment as he felt Dr. Wall deflected his feelings, making Mr. Towne wonder where Dr. Wall really stood.

Dr. Wall said that his political inclinations and their racial differences were irrelevant to treatment and that Mr. Towne was conflating distinct issues. He encouraged Mr. Towne to use treatment as a sanctuary where he could be totally open. Mr. Towne replied that was his intent in discussing his feelings and expressed disappointment in being invalidated by another BIPOC man. Dr. Wall emphasized the value of relaxation techniques, because politics agitated Mr. Towne. When Mr. Towne disagreed, Dr. Wall suggested that he may not be benefiting from treatment.

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

OUR OWN STUFF

Regardless of how hard we try, even good therapists may find their clients bringing something to psychotherapy that hits too close to home, just as Dr. Wall experienced. As Dr. Kossmann observed, when we are actively coping with trauma, we may shut down and become numb. With luck and support, we may recognize that we are being triggered and query ourselves as Dr. Schur does, "What can I do now to handle this so I don't negatively impact my client? What am I going to do after I leave the therapy room?" How can we self-monitor to use our anxiety and fears to deepen the therapeutic process rather than get in the way?

We might add, "What can I do (now/later) that would be the most positive/beneficial response to this particular client, responding to this situation, at this point in time?" For some of us, choosing to withhold a relative's fears about deportation might be the right choice, others might choose to self-disclose, while still others might find that a referral to another therapist would be appropriate and needed.

Self-disclosures can be a boundary crossing and put a psychologist at risk for ethical violations (Gutheil & Gabbard, 1993). Self-disclosures can be problematic, even when small, when they are too frequent (Glass, 2003). Nonetheless, self-disclosure can also be a very powerful intervention and may have clarified and countered Mr. Towne's misapprehensions about Dr. Wall's behavior and normalized Mr. Towne's concerns. One can also use one's own experience to inform an intervention, such as by pointing out, "Many people have felt as you do."

Unfortunately, many good psychologists may believe that self-disclosures are boundary violations and unethical. However, we agreed that self-disclosure could have been helpful in this situation – under the right conditions. As Dr. Hunt reminds her students, there are things that they can do to prevent harm and maximize the success of their self-disclosures. She suggests: (1) "Sit on it": Slow down and reflect on your proposed intervention for a few minutes to ensure that it is client centered; (2) make sure that what you are about to disclose is under good emotional control for you, not too raw or unprocessed; and (3) ensure that your decision to self-disclose has a good treatment rationale (e.g., modeling effective coping, validation, normalizing the "abnormal"). Dr. Wall did not self-disclose, which was probably the right choice as he did not appear to have reflected and his feelings were not under control. In fact, personal history with parallels to those of the client are best received when they occurred long ago and have presumably been well processed by the therapist (Moody et al., 2021). They suggested therapists use particular care when disclosing recent events.

RACIAL IDENTITY

Mr. Towne clearly expected that someone who was also from a marginalized group would understand him better and work with him more effectively. Unfortunately, both Mr. Towne and Dr. Wall made assumptions based on perceived similarities without checking them out first. Because Dr. Wall was feeling stressed and overwhelmed, he was unable to communicate his ability to understand and empathize; he was also unable to effectively acknowledge and address the tension in the room. Like other kinds of competence, multicultural competence can vary with situational catalysts in our lives (Knapp et al., 2017). As one of us quipped, these problems made Dr. Wall's work with Mr. Towne me-pathy (all about me) rather than empathy.

In addition, Dr. Wall was unable to tailor his interventions for Mr. Towne. If relaxation techniques had been appropriate, an app like Liberate (2021) might have been an excellent choice. Liberate, a meditation app tailored for African Americans and other members of the BIPOC community (e.g., using Black voices, discussions of microaggressions and oppression), is free for the first month, then $10/month. Liberate might have been especially useful for Mr. Towne but only after his anger and frustration had been heard and validated, but not as helpful with clients whose race was not such a valued and central aspect of their identity.

WHAT DO CLIENTS NEED FROM US?

As Dr. McAleer noted, often psychologists may believe that they need to do something in therapy. Similarly, our clients may expect rapid relief from their pain and want us to do something quickly. We need to slow down, recognize, and challenge these assumptions when they are counter-therapeutic. Sometimes, clients need to be heard first.

Clients need a safe space for the kinds of risks that they often must make in treatment. What was Dr. Wall doing to create that space? Dr. Lemmon suggested that this also must be a brave space, although it might need to feel safe enough to allow both client and psychologist to be brave. Although safety and courage may appear to be in opposition to each other, a synthesis between these two dialectics may be most useful.

Mr. Alicea suggested that we need to listen and be open to our clients' concerns with some cultural humility, a willingness to listen to clients and learn about their cultural heritage with respect, openness, and curiosity. We don't always have to solve the problem. Sometimes, clients just expect to be heard. He noted that, of course, there are things we aren't going to understand, even when we share identities, and argued we need to be able to acknowledge that. Even when there are a lot of apparent differences between a therapist and client, we can still be empathic and effective. On the other hand, our client's experience may resonate with our own very different experiences; these harmonics may help us understand them. As Dr. Knapp observed, however, understanding or

not understanding is a false dichotomy. It may be more helpful to consider how much we understand – and try to understand more.

CLINICAL OR ETHICAL?

As we finished discussing this case, it was easy to consider our work together primarily as a discussion of clinical strategies (e.g., paying attention to self-care, racial identity, strategies for self-disclosure). As Dr. Knapp observed, however, every clinical intervention has an ethical dimension to it. We often ignore the ethical dimensions – until a problem arises.

In this particular "clinical" case, a number of ethical issues were especially salient: Dr. Wall's failure to respect Mr. Towne's autonomy in setting treatment goals, boundary crossings, multicultural competence (i.e., cultural humility), and emotional competence. Underlying these overt concerns, we also considered the aspirational principles of beneficence and nonmaleficence (doing good and avoiding harm), fidelity (building trusting relationships), and justice (affording all clients access to quality services without bias; American Psychological Association, 2017). All good psychotherapy is embedded in strong ethical decision-making.

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CLASSIFIEDS

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.

The In-group/Out-group Distinction Contributes to War

1. **There is one single theory for war, the tendency to categorize people into "us versus them."**
   TRUE
   FALSE

War's Intergenerational Effect on Civilians and Veterans

2. **Although combat trauma, vicarious trauma, and civilian trauma tend to display devastating effects, it is possible for those dealing with trauma to experience positive growth.**
   TRUE
   FALSE

3. **When parents who have experienced trauma have a supportive social network, they feel better and have more energy for caregiving, which assists in mitigating intergenerational trauma.**
   TRUE
   FALSE

4. **Which of the following is a psychologist who has never lived in a warzone most likely be subject to?**
   a. Combat trauma
   b. Vicarious traumatization
   c. Civilian trauma

Can Psychologists Do Anything About Wars?

5. **Democracies engage in _____ wars than non-democracies.**
   a. More
   b. Fewer
   c. The same amount of

The Evolving Construct of Moral Injury

6. **Some have argued that moral injury is partially the result of a disconnected public.**
   TRUE
   FALSE

7. **Is moral injury a psychiatric diagnosis?**
   a. Yes, it has been added to the *DSM*.
   b. No, but it will appear in the next update to the *DSM*.
   c. Originally the construct was posited as nonpathological, so it cannot be included in the *DSM*.
   d. Though initially not considered a diagnosis, some argue in fact it should be considered one.

Trauma, Resilience, and Posttraumatic Growth

8. **Resilience comes naturally for everyone and doesn't have to be cultivated.**
   TRUE
   FALSE

9. **Posttraumatic growth includes learning to make meaning of the traumatic experience and improved psychological functioning.**
   TRUE
   FALSE

Supporting Military-Connected Students in Schools

10. The two main types of travel that might require an entire military family to change location are

a. EFMP and SLO
b. Deployment and detachment
c. Leave and liberty
d. PCS and TAD

11. If a new student arrives at your school and their military parent tells you they have been receiving special education services, you should first

a. Immediately enroll the student in appropriate courses and services, according to whatever records the parent may have.
b. Immediately contact the student's previous school and request an official transcript.
c. Ask for proof that the parent is a military member, such as a copy of their orders.
d. Enroll the student in medium-track courses until teachers and special educators can determine placement.

SEL: Separating Fact From Fiction Along With Guidance to Navigate Public Discourse in Our Schools and Communities

12. SEL helps to build career ready skills in our youth so that they can successfully live and work in our increasingly diverse communities in the commonwealth.

TRUE
FALSE

Serving Military Students' Mental Health Needs in Higher Education

13. Mental health stigma in the military community may deter military students from obtaining appropriate treatment.

TRUE
FALSE

14. A majority of higher education faculty and staff believe they are able to adequately recognize signs of distress in military students.

TRUE
FALSE

Ethics in Action: Our "Stuff" Can Get in the Way of Good Psychotherapy

15. Self-disclosures are always a boundary crossing.

a. Yes, they are always a boundary crossing.
b. They may be a boundary violation when self-disclosures are too frequent.
c. They may be a boundary violation, depending on the nature of the disclosure.
d. B and C

16. Slattery and Knauss suggest that the Liberate app may be especially appropriate for

a. All African Americans and BIPOC people.
b. African Americans for whom race is a valued and central aspect of their identity.
c. African Americans for whom race is an unimportant aspect of their identity.
d. No one, as it is no different than apps like Headspace and Calm.

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, September 2022

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

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

Please print clearly.

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Wellness Weekend
Inn at Leola Village
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PPA's VIRTUAL Spring Conference

Wednesday, June 21-Saturday, June 24, 2023
PPA2023 Convention
In-person at The Penn Stater Hotel & Conference Center
State College, PA

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

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PPA2024 Convention
Lancaster Marriott at Penn Square
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Home Study CE Courses

Act 74 CE programs

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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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