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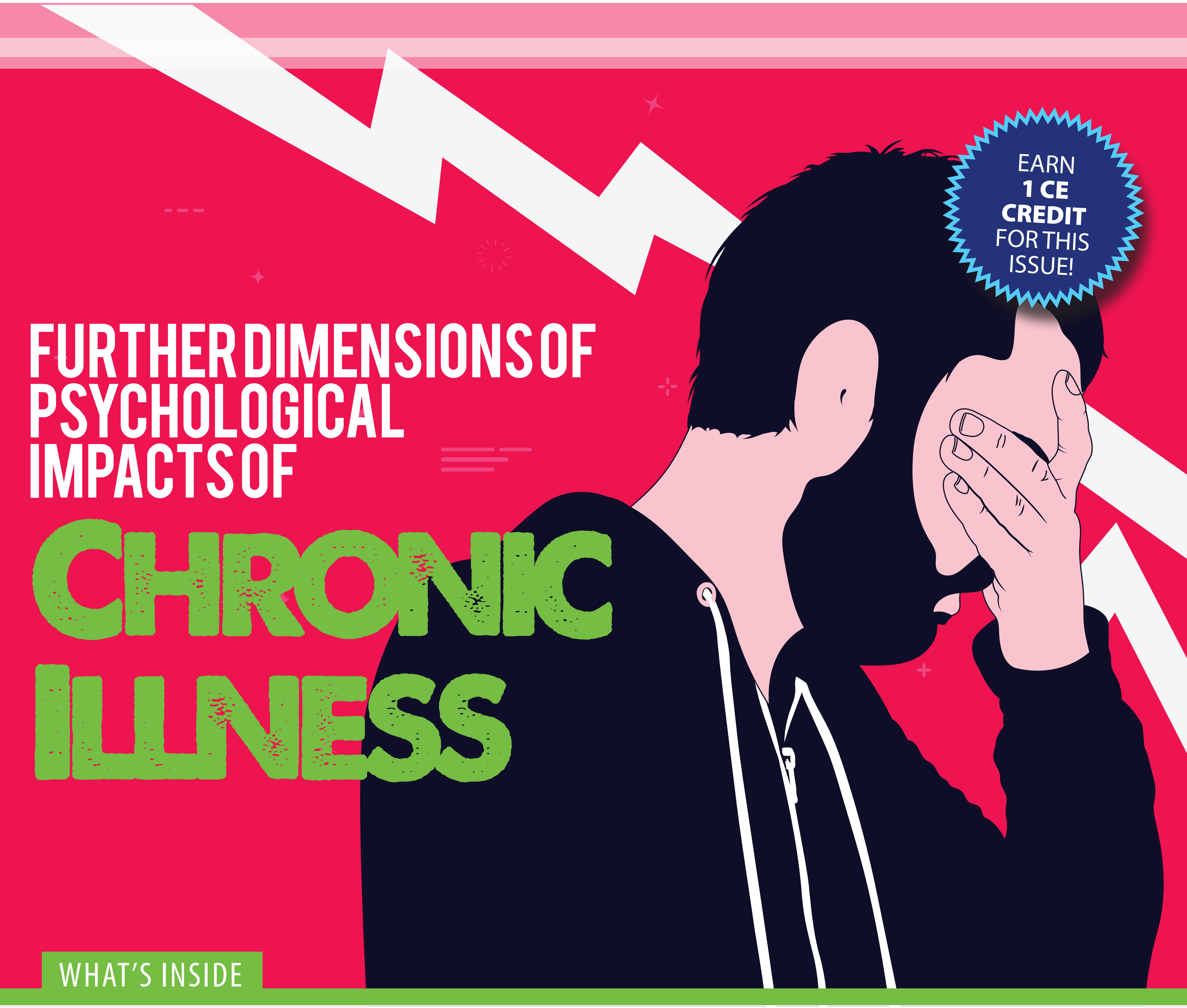

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The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in *The Pennsylvania Psychologist* represent the opinions 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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WHY MASTERS-LEVEL LICENSURE IN PSYCHOLOGY? A SOCIAL JUSTICE PERSPECTIVE

JEANNE SLATTERY, PhD

We accomplished a lot this year, and I thank all of you involved in these changes. We've continued to address diversity and access issues in our association, winning Pennsylvania Psychological Association (PPA) Div. 31's Diversity Award. When you renew your membership, we are now asking you, if comfortable, to self-disclose how you identify, so we can tailor the organization to our members, monitor changes in our membership, and support people looking for psychologists with specific backgrounds. We have rewritten the rules governing our listserv, making a series of changes that are clearer and that we hope will foster a climate that is safer for all members of PPA. RxP is moving forward in the Pennsylvania legislature (HB 1000). As of this writing, we have 24 legislators cosponsoring this bill. By the time you read this, I expect there to be significantly more.

We are also exploring master's-level licensure, something that the American Psychological Association has been considering for at least the last half-dozen years now. There are many different reasons to consider this change, some described by Paul Kettlewell (2022) recently, but I want to consider this proposal from two perspectives close to my heart.

I am concerned when opportunities are available to one group and denied to another, and these opportunities are unrelated to ability. That's what I think we have with our current system. Think about what is necessary to go to graduate school in psychology and succeed: persistence, motivation, critical-thinking skills, strong writing skills, effective empathy and nonverbal listening skills, a desire to make a difference, and money. It takes money to perceive an ability to go straight to doctoral programs. At this point, a student pursuing a PsyD can expect to go about $200,000 in debt, probably more.

About 40% of my own undergraduate students qualify for Pell grants, which are awarded to students with "exceptional financial need" (U.S. Department of Education, 2022). In addition, about 35% of my students are first-generation students, often defined as students with "parents [who] did not complete a 4-year college or university degree" (Center for First-Generation Success, 2020). Many of these students have difficulty navigating the system and do not believe that they can afford graduate school and often do not pursue other kinds of funding, even when I tell them options are available.

Why does this matter? There are several consequences of a system where financially strapped, first-generation students believe they are incapable of earning a doctorate. Currently, our students end up going in other directions, especially toward clinical mental health counseling and social work. Although the Pennsylvania legislature believes that master's-level licensure will increase the number of psychotherapists in Pennsylvania, it seems more likely that we will cut the pie differently than we have currently done—with more psychology prepared master's-level therapists and fewer social workers and licensed professional counselors.

When students choose social work or clinical mental health counseling, they are less likely to end up earning a doctorate in psychology down the road. Those who do eventually go on in psychology will end up paying more for the privilege of doing so, as their master's degree will likely not be seen as fulfilling psychology's requirements. This seems unfair—block one door, then give them a penalty for not pursuing the "traditional" path—especially when we disadvantage those people who can least afford to attend a doctoral program from the start. Quoting Desmond (2023), in his thought-provoking Poverty by America, "consider all the raw talent and beauty and brilliance that we squander" by blocking some important possible contributors to our field from entering doctoral programs (p. 181).

Not having master's-level licensure means that our field is both less socioeconomically and racially diverse than it would otherwise be and that we are less likely to be relevant to and serve a diverse population of people seeking therapy. The more we increase the ultimate cost of graduate school, the more likely it is that

(Continued on page 4)

HAPPY 90TH ANNIVERSARY PPA! HOW WILL YOU CELEBRATE?

ANN MARIE FRAKES, MPA, EXECUTIVE DIRECTOR

The Pennsylvania Psychological Association has grown from a small meeting of psychologists in the early 1930s to a strong, statewide professional association with more than 3,000 members. According to *A Brief History of PPA*, in 1931, Ms. Florentine Hackbusch, MA, a field representative for the Pennsylvania Bureau of Mental Hygiene, reached out to psychologists with the goal of creating a society that would help "set-up some standards for psychologists who would be recognized as qualified examiners in mental deficiency." Together with Dr. Mary Vanuxem, a psychologist at Laurelton State Hospital, Ms. Hackbusch organized a meeting of psychologists at the Abraham Lincoln Hotel in Reading, PA. During that meeting, plans to build the framework of a formal organization of psychologists were introduced. For reasons unknown, those plans did not move forward. In 1932, Ms. Hackbusch convened a second meeting with a smaller group to discuss plans for a statewide organization. Finally, a third meeting, held on June 16, 1933, at the State Education Building in Harrisburg, resulted in the establishment of the Pennsylvania Association of Clinical Psychologists (PACP), which we now know as the Pennsylvania Psychological Association (PPA).

So, this is why we recognize June 16 as the official anniversary of PPA. Please click this link to read *A Brief History of PPA* in its entirety or better yet, track down former PPA President and Historian, Dr. David Zehrung, for a PPA history lesson at PPA2023, our annual convention.

In honor of this milestone anniversary, here are some ideas how you can personally celebrate 90 wonderful years of PPA:

1. Invite psychologists you work with or know to join PPA. Tell your friends and colleagues what you love so much about PPA and why you continue to be part of PPA. Membership in PPA continues to hold steady. We are happy to report that our total membership is currently 3,064. That includes 2,366 dues-paying psychologists, 508 doctoral students in psychology, and 190 undergraduate psychology majors. Remember that dues for early career psychologists (ECPs) have been restructured to make joining PPA much more affordable for new psychologists. Thank you to all our members for your continued support. We couldn't do it without YOU!
2. Invite doctoral students in psychology to join PPA! Encourage your practicum students and interns to join PPA/PPAGS. Becoming a member of PPA could make a difference in their careers. To encourage sustained graduate student involvement in PPA, effective on July 1, 2020, all psychology doctoral students are eligible for FREE membership in PPA from the time they enroll in the program until graduation.
3. Encourage college students who are psychology majors to join PPA. Psychology majors need to learn and understand what it takes to become a psychologist. PPA offers opportunities that will help them in obtaining this practical knowledge. This category of membership was introduced on July 1, 2020. Undergraduate psychology majors from approximately 265 colleges and universities across PA, just like our doctoral students, are eligible for FREE membership in PPA from the time they declare their major as psychology until they graduate. Again, this program is possible because of the continued support of our professional members.
4. Join a SIG! The creation of Special Interest Groups (SIGs) has taken off within PPA. The purpose of a SIG is to provide opportunities for networking and the sharing of ideas between members in an identified interest area related to the practice of psychology. We currently have 19 official SIGS with over 1,000 members signed up and several hundred actively taking part. Click here to learn more about our SIGS and how you can join one or more. If you have an idea for a SIG and would like to serve as SIG leader, please send an email to erin@papsy.org.

5. Join a PPA Committee! PPA has approximately 20 active committees that need the support of our members. PPA committees were formed so members would have direct responsibility for a particular activity or business function of the association. Some of the committees that currently need new and/or more members are:
    - Electronic Media Coordination Committee (EMCC)
    - Membership
    - Nominations and Elections
    - Publications
    - Awards

Send an email to annmarie@papsy.org if you are interested in serving as a member of a committee this coming fiscal year or would like to be considered for a committee chair in the future.

6. Run for a position on the PPA Board of Directors! If you have experience serving as a chair of a PPA committee, we would like to talk to you about taking the next step in becoming a member of the Board of Directors. Dr. Jeanne Slattery will be chairing the Nominations and Elections Committee starting July 1, 2023. Meanwhile, send an email to annmarie@papsy.org, letting us know of your interest in running.
7. Become a Sustaining Member of PPA! The first 300 members who make a sustaining member gift of $100 or more will receive a special 90th anniversary pin. Your gift helps to support programming and membership benefits for our members who are graduate students, undergraduate students, and early career psychologists. Click here to donate.

It is my honor and privilege to serve as executive director of PPA. Thank you for this opportunity. Please call me at 717.510.6355 or send an email to annmarie@papsy.org with any ideas, concerns or questions you might have. Thank you for your dedication to and continued support of PPA.

WHY MASTERS-LEVEL LICENSURE IN PSYCHOLOGY? A SOCIAL JUSTICE PERSPECTIVE

(CONTINUED FROM PAGE 2)

psychologists will choose to practice in wealthier parts of our state to recoup their expenditures during graduate school.

Ultimately, I see this as an issue of justice. Our ethics code advises us that "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases … do not lead to or condone unjust practices" (American Psychological Association, 2017, p. 4). When we set up the rules such that they advantage some groups over others, we have failed one of our most basic ethical guidelines. Instead, greater access to licensure for those completing master's-level programs in psychology will improve opportunities for underrepresented groups (e.g., financially disadvantaged students and racial minorities), may lead to increased numbers of these people among doctoral psychologists, and remove an arguably unjust practice.

My thanks to my first readers: Helena Tuleya-Payne, Paul Kettlewell, and Cathy Petchel.

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ACT 26 SETS PAYMENT LIMITS FOR COPYING RECORDS

RACHAEL BATURIN, MPH, JD, *Director of Government, Legal, and Regulatory Affairs*

Under 42 Pa.C.S.§6152 and 6155 (relating to subpoena of records; and rights of patients), the Secretary of Health is directed to adjust annually the amounts that may be charged by a health care facility or health care provider upon receipt of a request or subpoena for production of medical charges or records. Because the law specifically references "health care providers," as opposed to just physicians, PPA believes that the law applies to psychologists.

Effective January 1, 2023, the following payments may be charged by a health care facility or health care provider for production of records in response to a subpoena:

	Not to Exceed
Search and retrieval of records	$27.14
Amount charged per page for pages 1–20	$ 1.83
Amount charged per page for pages 21–60	$ 1.36
Amount charged per page for pages 61–end	$ 0.47
Amount charged per page for microfilm copies	$ 2.70

In addition to the amounts listed, charges may also be assessed for the actual cost of postage, shipping, and delivery of the requested records.

In addition, the Secretary sets a flat fee for the purpose of supporting a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program or a request made by a district attorney. The flat fee that can be charged by a psychologist for a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program is $34.40 plus charges for the actual cost of postage, shipping, and delivery of the requested records. The flat fee that can be charged by a psychologist for a request made by a district attorney is $27.14 plus charges for the actual cost of postage, shipping, and delivery of the requested records. Requests from independent or executive branch agencies of the government are exempt from the record copying fee requirements. This law does not apply to copying required by insurance companies to monitor services under an insurance contract.
The rate is increased annually according to the Consumer Price Index.

The law does not alter the requirement that psychologists must have a signed release from the patient before releasing the information to a third party.

WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT RECORD RETENTION

MOLLY COWAN, PsyD, *Director of Professional Affairs*

One of the common categories of questions that members contact me about is record retention. On the surface, it seems like there should be a straightforward answer to the question "How long do I need to keep patient records," but like many questions I get, the answer is "It depends."

Legally in Pennsylvania, 49 Pa. Code § 41.57(d) requires psychologists to maintain records for a minimum of 5 years after the last date of service. However, it also stipulates that psychologists abide by other applicable record-keeping requirements, even if the other requirements are longer than 5 years. However, with the increase in interjurisdictional practice, it is important to recognize that psychologists must follow the record retention rules in the jurisdictions where the client is located, which may be longer than 5 years.

In addition to the legal requirements relating to record retention, there are other important factors to consider. For psychologists working with insurance companies, there are also contractual obligations to follow. Many private insurance companies specify a minimum amount of time records must be kept; often this is 7 years, but psychologists should be familiar with this aspect of their contracts with insurers, as the required length is determined by each individual insurance company.

Although insurance companies often independently set the required length of time for record retention, Medicare Advantage plans require records be retained for at least 10 years. As psychologists may work with both commercial plans and Medicare Advantage plans provided by the same company, psychologists must pay attention to which plan a client is covered by. For example, Highmark Choice Company and Highmark Senior Health Company are both Medicare Advantage programs that require records be kept for 10 years, while non-Medicare Advantage Highmark plans have different contractual requirements depending on the jurisdiction in which they are based.

From a risk management perspective, there are additional factors to consider. In Pennsylvania, a child has 2 years after turning 18 to file a lawsuit against a health care provider. Although this is unlikely, because in most cases a parent would have already filed a complaint before that time, some psychologists choose to retain treatment records for minors until 2 years after they turn 18 (or 5 years, whichever is longer) to be able to defend themselves should a lawsuit be filed (Knapp & Baturin, 2014).

Another risk management issue to be aware of is the False Claims Act. The False Claims Act relates to whistleblowers who report fraud against the government—this could include any government program including Medicare or Tricare. The nuances of the Act are complex, but the important thing to note is that cases can be filed up to 10 years after the alleged wrongdoing (Thompson & Lisitano, 2019). The likelihood of facing a suit under the False Claims Act is probably rather small, but if a case is filed, having records that go back 10 years could help the psychologist's defense.

There are practical considerations as well. For psychologists working in a group, hospital, school, or other multidisciplinary setting, there may be organizational requirements and applicable state regulations for record retention as well that psychologists must follow. Historically, many psychologists would securely dispose of records when legally allowed to preserve storage space. With the advent of electronic records, the physical space required to retain records has decreased significantly, and some psychologists opt to retain their records indefinitely; while others opt not to related to clinical and other considerations. Regardless of whether you choose to dispose of records as soon as minimally possible given the factors addressed here or retain them for a longer period, it is important to identify a plan for the eventual secure disposal of records that ensures client confidentiality.

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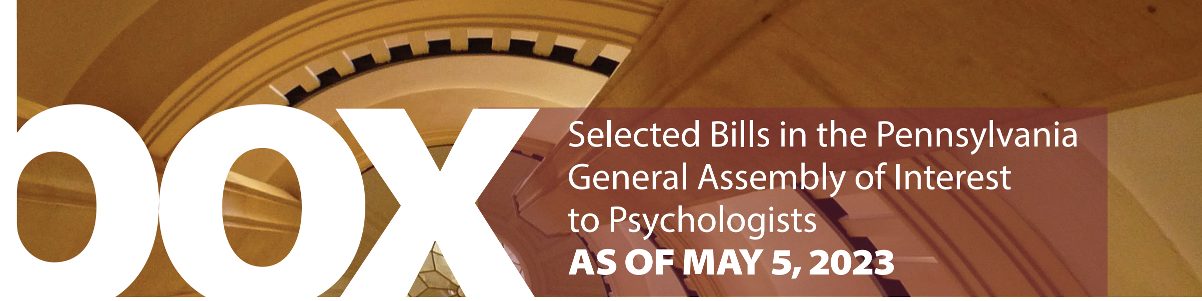
the bill box



Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

AS OF MAY 5, 2023

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	
SB 59	Providing for the establishment and funding of a center to conduct research on gun violence in this Commonwealth.	Senator Hughes	Support	Referred to State Government 1/19/2023		
SB 119	Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in public assistance, providing for behavioral health and physical health services integration.	Senator Phillips-Hill	Support	Referred to Health and Human Services 1/18/2023		
SB 178	Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," in general provisions, repeals and effective date, providing for acute care mental health bed registry and referrals.	Senator Barlotta	Support	Referred to Health and Human Services 1/19/2023		
SB 276	An Act amending the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, in general provisions, providing for duty to warn.	Senator Langerholc	Still reviewing bill language	Referred to Health and Human Services 1/31/2023		
SB 445	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, providing for Collaborative Care Model and Primary Care Behavioral Health Model Implementation Program; and making an appropriation.	Senator Farry	Support	Referred to Health and Human Services 3/14/2023		
SB 258	An Act amending the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, in general powers and duties of the Department of Public Welfare, providing for COVID-19 mental health public awareness campaign.	Senator Farry	Support	Referred to Senate Health and Human Services 1/31/2023		
SB 605	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Senator Collett	Support	Referred to Senate Heath and Human Services 4/19/2023		
HB 341	An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in intermediate units, repealing provisions relating to psychological services; in professional employees, further providing for definitions and providing for school social workers; and, in school health services, further providing for health services and providing for school counselors, school psychologists, school social workers and school nurses.	Rep. D. Miller	Support		Referred to House Education Committee 3/13/2023	
HB 1000	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 prescription certificate, for prescribing practices, for prescriptive authority and for coordination with State Board of Pharmacy.	Rep. Frankel	Support			
HB 849	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Rep. Schlossberg	Support		Referred to House Human Services Committee 4/10/2023	
HB 575	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Benham	Still reviewing bill language		Referred to Health 3/20/2023	

INTRODUCTION TO THE SPECIAL SECTION: Further Dimensions of Psychological Impacts of Chronic Illness

The theme of psychological impacts of chronic conditions inspired many article submissions leading to a second issue on this topic. In this issue, Chung and Chung explore the impact of chronic conditions on women and suggest treatment interventions. Romano and Browning discuss the effects of stroke on a family system by applying the theory of family therapy and using a case study. Tuleya-Payne explains the role of school psychologists in working with students with chronic conditions, such as intellectual disabilities, ADHD, and other health impairments, throughout their years at school and intervening early to mitigate adverse academic and social behaviors down the road. Flaherty and Marion explain the challenges to treating addiction as a chronic condition and highlight the great opportunities that could emerge from shifting substance use training and changing our clinical perspectives. Gulick et al. cover the psychological effects of coronavirus and offer treatment recommendations. Healey et al. explore the concept of framing chronic conditions as a systemic occurrence rather than a personal experience. Finally, Hammer et al. provide advice for how psychologists can bridge the gap in caregiver resources, education, and support for families of young adults experiencing chronic conditions.

FAMILY MANAGEMENT FOR CAREGIVERS OF YOUNG ADULTS WITH CHRONIC CONDITIONS:

Implications for Practice

SHANNON N. HAMMER, MS; JANET A. DEATRICK, PhD, FAAN; LAMIA P. BARAKAT, PhD

Family management describes how illness is integrated into everyday family life and is expected to shift from caregiver led (in childhood) to child led (in adulthood) as youth with chronic conditions learn new skills for self-management and expand their social networks (Beacham & Deatrick, 2013; Knafl et al., 2021). However, for a subset of youth with chronic conditions, continuing and even worsening of physical and psychosocial effects of the condition and its treatment disrupt achievement of developmental milestones and delay mastery of skills that promote independence in self-care (Gray et al., 2018). Due to the persistent nature of childhood chronic conditions, it is therefore not uncommon for youth with chronic conditions to warrant continued support into young adulthood and beyond (Deatrick et al., 2018; Gray et al., 2018). As such, primary, often maternal, caregivers are tasked with a progression of caregiving responsibilities that extend beyond normative expectations (Deatrick et al., 2018; Palma et al., 2015). As existing challenges to family management persist and new challenges emerge, family management becomes increasingly difficult for caregivers of young adults with chronic conditions, to which caregivers often report feeling isolated without adequate knowledge or resources to optimize their family management efforts (Palma et al., 2015). Psychologists and other health care clinicians can fill these critical gaps in caregiver resources, education, and support.

Common caregiver-reported challenges to family management that emerge in young adulthood include: (1) supporting young adults' independence; (2) improving how the family functions; (3) promoting the young adults' well-being and psychosocial functioning; (4) balancing self-care with parenting and caregiving roles across the family; and (5) connecting the young adult to developmentally appropriate resources and services (Hammer et al., 2022). Caregivers face societal barriers that diminish their abilities to effectively navigate such challenges, including limited access to age-appropriate services, a shortage of multidisciplinary transition programs, and gaps in insurance coverage (Gray et al., 2018). Further complicating family management, caregivers may find that previously effective approaches to problem- solving these caregiving challenges are not as effective for their young adults, which may threaten their confidence in their condition management abilities and increase their concerns about their child's condition in the future (Deatrick et al., 2018).

The Family Management Styles Framework (FMSF) has been used for over 30 years to guide clinical assessment and intervention, as well as research, across health conditions including cancer, the lifespan, and cultural contexts (Knafl et al., 2021). The FMSF conceptualizes caregivers' efforts to incorporate management of chronic conditions into family life, the interrelated responses of family members, and the impact of family management on the family and its members. The FMSF is grounded in the assumption that families develop distinct patterns of family management, ranging from family focused to condition focused. These patterns have been identified for caregivers of youth with chronic conditions and confirmed for caregivers of childhood brain tumors survivors (Deatrick et al., 2018). While family-focused caregivers with family-focused family management generally place an emphasis on integrating their child's chronic condition into existing family activities and routines, caregivers with condition-focused family management typically revolve family activities and routines around managing the demands of their child's chronic condition, causing disruption to daily life and child and family development and well-being. Across condition-focused and family-focused family management patterns, caregivers identify similar challenges to family management. However, caregivers with condition-focused family management more commonly focus their problem-solving efforts on achieving ideal in contrast to practical outcomes for their child with the condition, without considering the impact on themselves or other members of their family. Consequently, research has found that caregivers with condition-focused patterns of family management report poorer family functioning and quality of life outcomes for themselves and their young adult children, compared to those with family-focused patterns (Deatrick et al., 2018).

Comprehensive assessment of family management and targeted family-centered care interventions are critically important to support caregivers of youth with chronic conditions in childhood and into adulthood (Park et al., 2018). Psychologists are an asset to both families of youth with chronic conditions and their multidisciplinary care teams due to their knowledge of human development and specialized training in family systems, as well as individual and family behavior patterns. Through multidisciplinary collaboration with the child's health care team, psychologists provide guidance around how to adopt a family-focused approach to managing chronic conditions across the lifespan. Furthermore, in working directly with families of youth with chronic conditions, psychologists: (1) use early intervention to support the involvement of youth in health care decision-making and promote the adoption of self-management skills needed for youth to more independently manage the condition in adulthood by encouraging families to systematically scaffold their condition management efforts over time; (2) strengthen families' problem-solving skills to support their ability to effectively manage their child's condition in a developmentally appropriate manner; and (3) partner with young adults and their families to advocate for local, regional, and national family-centered policies, practices, and systems (Beacham & Deatrick, 2013; Deatrick et al., 2022). Specifically, more effective family-focused problem solving encourages caregivers to break down seemingly insurmountable challenges into smaller, more achievable goals, consider common antecedents and consequences to persistent challenges, and differentiate between what can and cannot be controlled (e.g., medical late effects may not be changeable, but the family's response is modifiable).

In conclusion, caregiver-reported challenges to family management of their young adult children with chronic health conditions are significantly related to family functioning and quality of life outcomes. Psychologists are well positioned to provide essential leadership in multidisciplinary clinical care and research with young adults with chronic conditions and their families. Of particular importance is guiding caregivers in adjusting family management to meet the changing needs of their youth, their families, and themselves and advocating for resources and support in their communities. In this way, caregivers are empowered to promote youth, caregiver, and family development and well-being more effectively.

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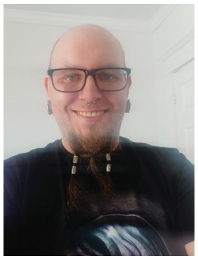
REFRAMING CHRONIC PAIN AS SYSTEMIC IMPACTS



SEAN HEALEY, PsyD; RICHARD KUTZ, PsyD; TYSHAWN THOMPSON, MA; Padraic Toolan

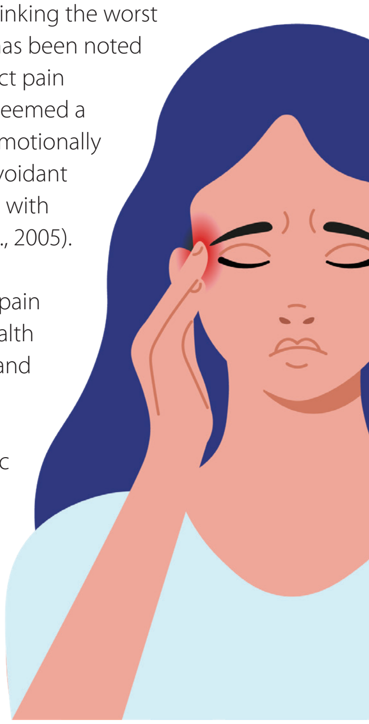
Chronic pain is usefully understood as involving and impacting two distinct but inter-related systems. First, the experience of chronic pain arises from and influences a complex interplay of psychological, physiological, and behavioral functioning in the individual patient. Second, because the patient is located within multiple social and cultural contexts, the consequences are operationalized within the patient's life domains, which are inherently social and systemic in nature. Interpersonal, family, occupational, and socioeconomic impacts occur to include on the health care system itself.

The data support such a broad categorization. According to the Centers for Disease Control and Prevention, data compiled in 2016 revealed that 20.4% of Americans live with chronic pain with notable adverse consequences including diminished mobility, daily activity, and life satisfaction and increased incidence of anxiety, depressive disorders, and opioid dependency (Dahlhamer et al., 2018). Meanwhile, based on data from 2010 by the National Academy of Sciences, the economic costs of chronic pain in the United States were estimated at $560 to $630 billion per year (more than heart disease and cancer) based on health care expenditures ($261–$300 billion) and labor/productivity losses (Smith & Hillner, 2019).

Biopsychosocial theory and the subfield of psychoneuroimmunology (e.g., Coe, 2010) are distinct and useful explanatory models of human health and functioning. Both posit "mental health" as the product of the integration of body systems rather than as a Cartesian "carve out." In this way, the nervous system is understood to interact with the body, including the immune system creating a "neuroendocrine-immune crosstalk" that results in reciprocal behaviors (Adelman & Martin, 2010). Thus, for persons with chronic pain who experience ongoing heightened immune system activity, a less effective nervous system may lead to common "sickness behaviors" of depression, lethargy, anorexia, somnolence, decreased libido, poor hygiene, and others (Hart & Hart, 2019). Chronic pain and its mental and behavioral sequelae are best represented through the term "multi-morbidity" to accurately represent the complex systems response of bio-behavioral networks and socioenvironmental networks interacting and impacting one another (Sturmberg, et al., 2017).

Patients with chronic pain frequently struggle in silence due to the invisible nature of the condition and real or assumed disbelief by others. Patients' experience of chronic pain will vary widely. In some cases, personal strengths and unrecognized resources may become evident. In other cases, the patient's experience of internal guilt, frustration, grief over loss of function, clinical depression, anxiety of exacerbating pain, and cognitive dysfunction may result. Although chronic pain is not identified as a direct cause of cognitive impairment, it is correlated with poor performance on long-term memory, selective attention, processing speed, and executive functioning tests (Nadar et al., 2016). The impact of cognitive functioning has a direct reciprocal impact on physical functioning. Upward of 40% of the variance in physical functional status and 30% of the variance in affective symptoms may be attributed to how one thinks about their pain (Feldman & Christensen, 2020). For example, pain catastrophizing (thinking the worst about one's pain) has been noted to negatively impact pain symptoms and is deemed a maladaptive and emotionally and behaviorally avoidant strategy for coping with pain (Edwards et al., 2005).

Disbelief and invalidation of the pain experienced by health care professionals and those within the family and social networks of chronic pain patients undermine their lived experience and invite despair and compromised coping and



behavior. Koesling and Bozzaro (2021) emphasize that patients with chronic pain suffer socially as they feel less capable of partaking in social events and become more withdrawn, self-isolative, inactive, and despondent. For example, these authors note such a patient might walk with a cane, although they don't need it, to legitimize their reality that they endure pain when walking. Even more concerning, such patients may report having suicidal thoughts to be believed (Koesling & Bozzaro, 2021). Whereas chronic pain patients often experience anger, fear, guilt, and depression along with their pain, it is well established that the ability for more realistic appraisal of their adaptive emotion regulation and coping are vital to improving their overall health and well-being (Linton et al., 2011).

A truly biopsychosocial understanding of the consequences of chronic pain also necessitates how interpersonal functioning and the social milieu are reciprocally impacted by this debilitating condition. It is important to recognize that multi-morbidities for the patient may or may not exist. It is also crucial to understand that the patient's perception of and coping with chronic pain naturally occur along a continuum that is also socially and culturally situated. Chronic pain sufferers often live an inactive lifestyle that results in a downward spiral of continued inactivity, worsening pain, and emotional distress. Thus, chronic pain may play out not only in terms of the individual's psychological functioning but also in the patient's interpersonal experience and network(s) (Kube, 2013).

It is well established that more severe pain and/or poorer coping with pain can manifest in idiosyncratic ways ranging from increased "caregiver burden" to unnecessarily removing responsibilities from the patient that will result in diminishing biopsychosocial functioning and self-concept (Williams, 2010). Recently, there has been increasing attention paid to how primary relational support or the lack thereof affects the patient, family, and their relationships (Cano et al., 2018). In this study, dyadic interventions emphasizing mindfulness and acceptance-based strategies proved helpful for both partners and their joint assessment of the relationship's health. Increasingly, we've recognized that chronic pain affects child family members. One notable post-hoc, mixed-methods study (including a meta-analytic component) revealed poorer outcomes for these children including "overall health, parental report of internalizing and externalizing concerns, family functioning and parent-and teacher-report of social competence" (Higgins et al., 2015, p. 2263).

Since Bonica's (1953) foundational study emphasizing that chronic pain is a condition in itself distinct from an injury or associated medical condition from which it emerged, there is a growing evidence base on the biopsychosocial nature of chronic pain and its consequences. Professional psychology has taken a primary role in developing a fuller understanding of the origins and consequences of chronic pain as well as the development and implementation of effective treatment interventions. As such, professional psychology has demonstrated its value in the promotion of the health of the chronic pain patient and the health care system as well.

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WOMEN WITH CHRONIC PAIN: Implications for Psychotherapy

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Chronic pain, which is persistent or recurrent pain lasting for over 3 months, affects over 28 million women in the United States (Dahlhamer et al., 2018). Some common forms of chronic pain experienced by women are musculoskeletal pain, rheumatoid arthritis, migraine, fibromyalgia, and bladder pain syndrome (Casale et al., 2021). Considering that gender differences exist in the occurrence and maintenance of pain due to physiological, psychological, social, and cultural factors (Casale et al., 2021), this article examines the impact of chronic pain on women and therapeutic services that should be considered for this population.

IMPACT OF PAIN ON WOMEN

Chronic pain affects many areas of women's lives. It has detrimental effects on sleep quality of women by either disturbing their sleep or reducing the duration of sleep. Low sleep quality leads to physical fatigue and poor cognitive functioning (Andersson & Hovelius, 2005; Hill & Harrell, 2020). Pain also interferes with the functional ability of women in completing many essential tasks such as taking care of self and household chores, meeting work demands, and participating in leisure activities and physical exercise (Andersson & Hovelius, 2005). These functional limitations make both daily and future planning distressful due to the fear of the unknown and uncertainties. Consequently, many women with chronic pain lack confidence in fulfilling the role of motherhood. Interviewing 20 mothers with multiple sclerosis, Parton et al. (2018) found that even though these mothers made effort to take care of their children by neglecting their own personal needs, many still perceived themselves as "damaging" and "unreliable" mothers due to the concern of harming their children and the unpredictability of their health conditions.

Other challenges women with chronic pain encounter are starting and maintaining romantic relationships. The sexual function of women with chronic pain has been impeded by the fear of triggering pain during sexual activity (Breton et al., 2008). Low satisfaction in marital or romantic relationships may contribute to bitterness, indifference, cheating, and breakups (Hill & Harrell, 2020).

Since sexual life and motherhood are hindered by pain, women with chronic pain may struggle with their identities as a woman, a partner, and a mother (Hawkey et al., 2022). High prevalence of depression and anxiety among women with chronic pain has been well documented (Hill & Harrell, 2020). The depression is partly due to the daily functional limitations and lack of understanding from others when their pain is hard to accurately describe (Hawkey et al., 2002). Anxiety is intensified by the fear of financial insecurity due to unemployment or being on long-term sick leave, a sense of powerlessness, and worries of being harassed and rejected by the community (Andersson & Hovelius, 2005).

IMPLICATIONS FOR PSYCHOTHERAPY

Casale et al. (2021) stated that gender-specific intervention for women with chronic pain is needed because multifaceted factors contribute to gender differences in chronic pain. This implies that psychotherapists should provide assessment and treatment services to the population based on the cultural model of disability, recognizing women with chronic pain as a cultural group because their unique experiences, challenges, and needs may not be shared by other groups (Chung & Rubin, 2016). Since chronic pain affects every aspect of a woman's life (Hill & Harrell, 2020), the clinical assessment must be comprehensive enough to address not only their needs in all domains (e.g., physical, mental, social, and employment), but also the needs of close family members so that appropriate services can be arranged or referred. Assessment should include the history of abuse and posttraumatic stress disorder because they

are significant predictors of the pain and depression experienced by the population (As-Sanie et al., 2014).

Passive coping strategies such as withdrawing from social activities and relying on health professionals for pain relief usually lead to poor mental health (Aili et al., 2019). Therefore, women with chronic pain should be helped to empower themselves with active coping strategies that tend to be adaptive in nature. Psychotherapists play an important role in recommending best practice pain management strategies for women. For example, physical activities such as Pilates and physical therapy intervention have been found to reduce pain, increase physical activity level, and improve body movement and self-efficacy for exercise (Cederbom et al., 2014; Hill & Harrell, 2020). Compared to classical massage therapy, psycho-regulatory massage therapy has been shown more effective in relieving women from pain and depression (Baumgart et al., 2020). Some multidisciplinary pain management programs for women with chronic pain are found to reduce pain intensity and improve sleep quality, mood, emotion expression, and sexual functioning (Aboussouan et al., 2021). Cognitive-behavioral treatment has also been reported to enhance sexual functioning of women due to constructive cognitive shifts and improved involvement and communication with partners (Breton et al., 2008). In addition, acceptance and commitment therapy is found to be effective in enhancing life quality and reducing pain, depression, and anxiety in women (Finnes et al., 2021; Hill & Harrell, 2020). Finally, group-based intervention can increase women's competency and confidence in managing pain and problems related to illness by providing recognition, mutual support, information exchange, and a sense of belonging (Shoebotham & Coulson, 2016).

CONCLUSION

About 28 million women in the United States live with chronic pain. It is imperative to recognize the unique challenges and needs experienced by these women. To provide effective psychotherapy for the population, clinical assessment should be gender specific and comprehensive, covering all life dimensions including mental, emotional, physical, social, vocational, and family needs. Some best practices recommended for the population are physical therapy and exercise, psycho-regulatory massage therapy, multidisciplinary pain management treatment, cognitive behavioral therapy, acceptance and commitment therapy, and group therapy.

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PSYCHOLOGY'S GREATEST OPPORTUNITY: Treating Substance Use and Addiction as a Chronic Illness

MICHAEL T. FLAHERTY, PhD; TOD R. MARION, PhD

So often, psychologists find working with substance use both challenging and frustrating. Our roles are too often reduced to making a diagnosis or to measuring the severity of the illness upon which to build a treatment plan. Left frustrated by our limited contributions, we often leave the setting and person to return to other more gratifying work, where therapeutic progress can be more be attainable. By doing so, we sadly miss the greater opportunity we have for the person, family, community—or for ourselves as practicing psychologists.

Our training as psychologists offers much to both the science and specialized treatment of substance use and addiction (McCarty, et al., 2020; Miller & Brown, 1997). We are taught to holistically understand each person physically, psychologically, and even spiritually, grounded in the basics of physiology, neurology, pharmacology, and personal health. Some now go even further, specializing in intergenerational predisposition and vulnerability to substance use, or work with the emerging science on the attainment and sustainability of personal recovery. Yet, with all our preparation, skill, and the potential roles, in 2021, psychologists ranked fifth of all professions conducting substance use in assessment and treatment in outpatient settings, and 19th of all professionals addressing substance use at any level at which it presents (Health Resources and Services Administration, 2022a). These numbers are even lower in private practice. Using the Psychologist Finder from the PPA website, the following number of psychologists identified the following as their specialty: children (57), mood disorders (39), neuropsychology (33), chronic illness (21), substance use disorders (6), older adults (4), and alcoholism (2). Indeed, given societal needs, there are many opportunities for psychologists in prevention, education, and treatment at varied locations such as jails, nursing homes, and medical settings; working with substance use in special populations such as youth, veterans, cultural minorities, older adults; and assisting sustaining recovery in all.

THE CHALLENGE TODAY

The defense most often heard from psychologists as to why we don't address substance use and addiction more often is that we fear that we have not been properly prepared to treat it. In one study, Cellucci and Vik (2001) found that of 144 Idaho licensed psychologists, 89% had regular contact with substance users in their practice, but that most rated their graduate preparation as "inadequate." Aanavi and colleagues (2012), reported that of 1,200 national psychologists, 91% of those who responded addressed substance use in their practice, while most had little or no preparatory education (74%) or training (54%) in substance use. Others do have the training but lack the desire to use it.

The reality however remains clear: Overdose deaths continue to reach record levels each year. Today, over 41 million of our fellow citizens age 12 or older suffer with alcohol or other drug use and addiction, and only 6.5% receive treatment (Substance Abuse and Mental Health Services Administration, 2021). Even then, few get the treatment they need (Health Resources and Services Administration, 2022b).

ADDICTION AS A CHRONIC ILLNESS

As we entered the 21st century, the way addiction was understood radically changed from being an acute illness to a potentially chronic illness. The acute illness model understanding and its approaches (e.g., limited episodes of treatment, incarceration as cure, blaming patients, varied treatment approaches) were debunked for more modern understanding that aligned addiction with criteria and severity of a chronic illness. Drug use itself was seen as having the potential to become a chronic illness (McLellan, et al., 2000; Institute of Medicine, et al., 2006). Today the American Society of Addiction Medicine defines addiction as a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experience (American Society of Addiction Medicine, 2019).

OPPORTUNITIES ALONG A CONTINUUM OF CARE

While not everyone's using becomes chronic, the "chronic" framework opens all substance use and addiction to an understanding of an illness along its trajectory, that is, to be addressed along a continuum of care, as other chronic illnesses. Whether assessed within a cultural context, with possible inherited vulnerability or just from more recent excessive use, substance use most often progresses through growing dependence, physical tolerance, and severity. As with all chronic illnesses, treatment and recovery begin by accepting the illness. To strengthen intervention, psychologists James Prochaska and Carlo DiClemente (1986) pioneered a stages of change model for those using substances, moving from precontemplative to contemplative decision making to taking positive actions to improve one's health. Here psychologists can work constructively within each stage of change. Additionally, psychologists can use this same model to work with other co-occurring chronic conditions (e.g., diabetes, HIV, depression, irritable bowel, pain). Psychologists understand and work well with the mind-body relationship.

Substance use considered as a potential chronic illness introduces a care continuum that includes education, prevention, brief screening, intervention, patient matching, and treatment at all levels of care (Mee-Lee, 2013) and recovery. Additionally attaining and sustaining recovery, working with high-risk, diverse populations, and community public health efforts at harm reduction are all new opportunities. Having a list of colleague experts for collaboration while working collegially with the long existing fellowships or those in recovery will only strengthen outcomes. For those so inclined, health policy awaits to be better informed by this broader understanding as each community seeks to improve population health.

THE CHALLENGE

Based on society's needs and existing data from psychologists, the first task is to become better informed about the nature and types of substance use, addiction, treatment, and recovery. Our graduate preparation and continuing education must prepare us for what awaits in our real-world practice. Additionally, the medical "stigma" of addiction needs to be torn down so that we always can find the person within the illness. PPA now also offers opportunities through a Special Interest Group (SIG) on addictions at ppa@papsy.org, "myPPA."

The illness, chronic or not, needs to be understood as a struggle for the patient,

requiring a compassionate, well-informed professional. Families or others who care for and love someone who is struggling are also suffering and need help (Dopp et al., 2022). Knowledge of medications and related trauma remain critical. As one progresses through treatment, more in-depth psychological augmentation will become available to strengthen recovery. Psychology can cover it all.

PSYCHOLOGY'S OPPORTUNITY

In America, we have approximately 106,500 practicing licensed psychologists (Health Resources and Services Administration, 2022a). Based on current trends, predictions are for a 5% increase in the number of psychologists by 2030. Mental health counselors, addiction counselors, and social workers, all who already vastly outnumber psychologists, are predicted to grow by more than 30% over this same period. Peer supports or the use of those with personal experience are also growing as a rapidly developing new workforce.

By understanding society's needs, particularly in public health, psychologists' training and skills make us an essential part of our nations's substance use solution. We can't overlook this 21st century challenge. What an opportunity awaits.

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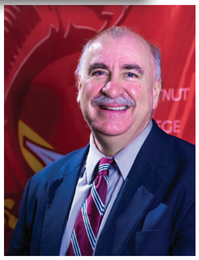
Special Section:

FURTHER DIMENSIONS OF PSYCHOLOGICAL IMPACTS OF CHRONIC ILLNESS



THE EFFECTS OF STROKE ON FAMILY SYSTEM

OLIVIA ROMANO, MS; SCOTT BROWNING, PhD, ABPP

Each year, about 795,000 people in the United States have strokes, making stroke a leading cause of death and disability in the United States (Centers for Disease Control and Prevention [CDC], 2012). A stroke occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts resulting in parts of the brain becoming damaged (CDC, 2022). A stroke can cause lasting brain damage, long-term disability, or even death. Many patients surviving a stroke suffer from mental and cognitive impairment that leads to months and sometimes years of rehabilitation (Jokinen-Salmela et al., 2015). A stroke can leave long-term impairments of motor, sensory, and/or cognitive functions (Bauman, 2012). Consequences of difficulties in cognitive and emotional function can negatively impact interpersonal relationships, social isolation, communication difficulties, and challenges in transportation and employment. Since a majority of stroke survivors return home, their families also experience psychological distress and repercussions of the stroke. A review of 78 studies published in the American Heart Association in 2009 found up to 54% of families said stroke had a negative impact on their relationships.

Family therapy can offer a variety of beneficial evidence-based interventions for families that are coping with chronic and life-altering illness. Therapy based on the Medical Family Therapy model has been found to be beneficial for families who are experiencing chronic illness in their family, as these types of issues affect the entire family system and are best addressed as a family-level issue rather than an individual problem (Zak-Hunter et al., 2014). Strokes can affect the mental health of the patient as well as affect the relationships with children and their partners and impact family dynamics. Specifically, this may lead to role changes within the family system and ultimately lead to issues within the family dynamic. The therapist assists the family in openly looking at the changing roles. This type of work is best done in subsystems. Some topics are better with just the therapist. Some family therapy is still done with the whole family.

MEDICAL ILLNESS EFFECTS ON MENTAL HEALTH AND FAMILY

Medical illness within a family can cause immense psychological distress to all members of the family. Researchers have found that negative perceptions of illness by the parent about the impact of the illness on the family can be detrimental to the emotional well-being of the ill parent. Dewar (2001) found that ill parents must often confront their own fears and emotions about the illness itself while also facing concerns about the effect of their illness on family members. When ill parents worry that their family is being adversely affected, the result may be feelings of distress, identity problems, emotional upset, and even negative illness outcomes. This may cause the ill parent to be more emotionally closed off and try to hide their emotions to protect their family's emotional well-being.

This research suggests that the therapist needs to be able to help the family understand that they are a changed system. The new roles need to be acknowledged and coached. According to Bowen (1966), a family is a system in which every member has a role to play and follows the "rules" of each role. Thus, accepting the loss or change of role of every person in the family is challenging.

ROLE SHIFTS IN FAMILIES DUE TO MEDICAL PROBLEMS

Members of the system are expected to behave in ways that correspond with their specific roles, which is determined by relationship agreements. Within this system, patterns develop as members' behaviors are influenced by one another. Maintaining these patterns of behaviors causes homeostasis within the family system. This may mean that roles will need to change to preserve the stability in the family system. For example, if a wife is affected by an illness such as stroke and cannot care for the children in the ways she once could, the husband may need to take on more childcare responsibilities to maintain balance in the system. Role change in family systems can occur at micro-levels such as the one stated before, but role change can also take place at a more permanent, macro-level such as following the death or impairment of one of the members of the family. These types of role changes, which are not uncommon after a significant stroke, may not be as negotiable as those more micro-level changes and may cause additional distress or issues among family members and their relationships.

CASE STUDY

Let's examine a case to demonstrate some of the common dynamics. A family of four went through an unexpected traumatic event in their lives when the father had a stroke. At the time of the stroke, the family consisted of Lisa (mother, 35), Gary (father, 44), and their two sons James and Henry (3 and 6 years old, respectively). They are a White middle-class, Catholic family whose family roles were typical to the Western culture standards: father as the breadwinner and mother as the caregiver. Gary had an unexpected stroke that caused difficulties with both verbal communication and the processing of verbal information. Gary also suffered from paresthesia, which caused loss of sensation on the left side of the body and required physical therapy to retrain him in how to use the left side of his body. He was hospitalized for 3 months until moving to partial hospitalization, where he received neurology care and physical therapy for a large portion of the day. After a year, Gary made great progress in recovery and was able to communicate better than the doctors had first expected. However, he still struggled with speaking full sentences and understanding certain words; he had lowered stamina, which caused Gary to take several naps a day. Although Gary made great progress in his recovery, he was far from how he functioned before the stroke. It is in understanding predictable family interactions that therapists help families by normalizing some of the problems that are being experienced.

Post-stroke, Gary was no longer providing money to the family, was not able to carry groceries, and needed assistance on certain daily activities (e.g., making meals, paying bills, helping the boys with homework and sports). Lisa had to manage Gary's business and take on the role of the breadwinner while also taking over additional roles, such as taking the boys to their sporting events or completing housework that used to be roles of which Gary would manage. The older son took over parenting the younger son when their mother was busy by reprimanding him if he did something wrong or teaching him how to play games. This caused tension between the family as the boys felt that there was a hierarchy between the two, Gary felt he lost all his responsibilities, and Lisa felt overworked having to take on all financial and parenting responsibilities. At some point in treatment, the therapist needs to move from assessing the effect of the stroke on the individual to the effect of the stroke on all family members.

In a session with the couple, Lisa is told, "We know that Gary is continuing to improve, but we need to understand how you are adjusting. Not just the sadness for Gary, but what has changed in your role?" This question is necessary, not to shame Gary, but for Lisa to recognize that she may be losing some of her "traditional mother role." Interventions such as these aim to achieve each person feeling that they are themselves, a changed version, but still oneself. Gary still needs to feel important to the family and able to help (at some level), and Lisa still needs to recognize herself in this new role. Specifically for the family, this may mean beginning to give Gary smaller parenting roles that he can do, such as monitoring the children or teaching them a task he remembers how to do. This may be talking to the boys about how to improve in their sports rather than showing them or directing Lisa on how to complete the housework or a task at his business. It may also be beneficial to this family to give the youngest child some responsibilities that the oldest child had to create more balance within the hierarchy of the relationship. This would also benefit Lisa because then she will have help in taking some responsibilities off her plate.

To directly address the distress created by role swapping, there should be open conversations regarding the roles and how they affect each family member. It is important to address the inevitability of the role change. This may include discussing the importance of role change due to the circumstances to maintain balance in the family system. The therapist has to walk the line between discussing what the roles mean to the system and how roles can be evenly distributed to prevent burden, overwhelm, or jealousy.

Family therapy with the family of a stroke victim allows both the individual and family needs to be addressed. While the ongoing improvement of the victim themselves is the most profound factor in these situations, the shifting roles in the family need to be understood and addressed. As Medical Family Therapy has demonstrated, it is through comprehensive attention that all members of the family adjust and confront the many difficulties caused by a stroke.

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Special Section:
FURTHER DIMENSIONS OF PSYCHOLOGICAL IMPACTS OF CHRONIC ILLNESS




PSYCHOLOGICAL EFFECTS OF COVID-19 AND PRELIMINARY TREATMENT RECOMMENDATIONS

SARAH H. GULICK, PsyD; STEVEN MANDEL, MD; EDWARD A. MAITZ, PhD; CHRISTOPHER R. BRIGHAM, MD

The SARS-CoV-2 virus has impacted the mental health of many, regardless of whether an individual has been personally infected by the virus. There has been an increase in alcohol use (Pollard et al., 2020), domestic violence (Kofman & Garfin, 2020), and suicide (Sher, 2020). Social distancing, fear of infection, and chronic isolation have undoubtedly had an impact on the population's mental health. One in three patients infected by COVID-19 may have lasting neurological or psychological symptoms (Cooney, 2020). While the literature on psychological symptoms post-COVID-19 continues to evolve, some have suggested that there may be a bidirectional relationship between COVID-19 and mental health (Toubasi et al., 2021). A recent meta-analysis examined 16 international studies on mental health and COVID-19 (Toubasi et al., 2021); prior psychiatric diagnosis was associated with increased mortality and severity in COVID-19 patients. This suggests there may be a genetic predisposition to suffering persistent psychological problems post-COVID-19. There may also be pre-existing psychological or personality factors that may predispose someone to develop psychological issues post-COVID-19.

In a recent study conducted in Italy, 402 patients recovering from COVID-19 were assessed approximately 1 month post-hospital treatment (Mazza et al., 2020). Psychiatrists conducted unstructured interviews with patients, and self-report questionnaires were administered to patients to assess psychological symptoms. Approximately 55.7% of patients scored in the clinical range in at least one psychopathological domain (e.g., posttraumatic stress disorder (PTSD), depression). PTSD, depression, anxiety, obsessive compulsive symptoms, and insomnia were all reported at a greater than expected rate. Patients who appeared to be at an increased risk included females, patients with a previous psychiatric diagnosis, and patients who were being treated at home. Younger patients exhibited higher levels of depression and sleep disturbances.

Kaseda and Levine (2020) hypothesized that, based on previous research on SARS and MERS patients, COVID-19 patients may demonstrate a similar prevalence of PTSD. They also reviewed literature on various neurological outcomes in COVID-19 patients, along with literature on PTSD associated with procedures that are occasionally required while treating COVID-19. For example, invasive ventilation can result in post-traumatic stress symptoms (Shaw et al., 2009; Twigg et al., 2008), and which is occasionally included in treatment for COVID-19. Kaseda and Levine (2020) found in their literature search that PTSD risk was elevated in MERS and SARS survivors, and PTSD has also been reported in COVID-19 patients. The authors warn that it may be challenging when assessing COVID-19 patients to disentangle the potential numerous causes of cognitive impairment and self-reported cognitive symptoms.

In a recent cohort study (Taquet et al., 2021), researchers examined 62,354 COVID-19 patients. Taquet and colleagues assessed whether a COVID-19 diagnosis predicted subsequent psychiatric diagnoses. They examined anonymized electronic health record data from 54 health care organizations in the United States. A COVID-19 diagnosis was correlated with a new psychiatric diagnosis within 14 to

90 days. Anxiety disorders, insomnia, and dementia were commonly found in patients recovering from COVID-19. Additionally, COVID-19 was associated with patients' psychiatric diagnosis in the previous year, suggesting that previous psychiatric diagnosis is independently associated with a greater risk of COVID-19 diagnosis. Further research is needed on the correlation between psychiatric history and the incidence of COVID-19.

Ferrario and colleagues (2021) examined hospitalized COVID-19 patients. Of the 181 patients, 47.5% underwent psychological assessment; acute stress disorder was the most common psychological issue (18.6%). Additional psychological issues included anxious and demoralization symptoms (26.7%), depression (10.5%), and grief (8.1%). Some patients were discharged home (38.4%) after recovering, and some patients received further rehabilitation in various other medical departments (41.9%). Patients who exhibited more severe psychological difficulties (35.9%) required further structured psychological treatment. Cognitive behavioral treatment was utilized, and specific interventions included cognitive restructuring, psychoeducation, relaxation techniques, grounding techniques, and in some cases, family meetings to focus on communication. Data were not collected on caregivers, but 60 of them participated in psychological support over the telephone. Caregivers reported a variety of psychological symptoms, such as anxiety, mood swings, and sleep disturbances.

As the evolving literature continues to demonstrate, psychological symptoms are being reported and observed in patients recovering from COVID-19 infection. While literature on the cognitive and psychological symptoms reported in COVID-19 patients is limited, literature on psychological treatment interventions in patients with COVID-19 is even more limited. A recent study (Li et al., 2020) examined the effectiveness of cognitive behavioral therapy (CBT) in patients diagnosed with COVID-19. A sample of 93 COVID-19 patients with no prior diagnosis of depression was used. Patients were separated into a control group (46 participants), which consisted of participants who received routine medical care, and an intervention group (47 participants) who received routine medical care plus CBT. The average age was 48 years, and the mean hospital stay length was 14 days. At baseline, 53.8% of participants had depression symptoms, 90% had anxiety symptoms, and 73% had stress symptoms. The mean values of depression, anxiety, and stress decreased significantly in both groups after the completion of the study. Participants in the intervention group had a larger mean reduction for depression and anxiety, suggesting that CBT can improve the psychological health of COVID-19 patients. However, patients with longer hospital stays were less likely to improve their anxiety level in the intervention group. The authors suggest that CBT should be focused on patients who have long hospital stays and a chronic disease history.

Some researchers have proposed the use of mindfulness-based practice to reduce psychological symptoms during the global pandemic. While literature on the use of mindfulness-based practice with recovering COVID-19 patients is limited, we can reflect on the existing literature on the benefits of mindfulness. Mindfulness-based cognitive therapy (MBCT) incorporates mindfulness practices and cognitive interventions, which are fairly easy to learn and practice at home (Segal et al., 2002). MBCT typically includes an 8-week group-based therapy in which mindfulness skills are taught (Gu et al., 2015). MBCT has been shown to be beneficial in treating PTSD (Khusid & Vythilingam, 2016), anxiety (Montero-Marin et al., 2019), and depression (Khusid & Vythilingam, 2016). Trauma-focused psychotherapies have also been

successful in improving cognition (Walter et al., 2010).

Further research on effective treatment interventions for lingering psychological effects in COVID-19 survivors is critical. One potential area of future research should focus on family interaction and communication within families impacted by a COVID-19 diagnosis. It will also be important to determine and consider at what point in time a diagnosis will be considered to have a low probability of reversibility.

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SPOTLIGHT ON THE EARLY CAREER PSYCHOLOGIST (ECP) COMMITTEE

MARIBETH WICOFF, PhD

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SCHOOL PSYCHOLOGISTS AND THEIR ROLE IN TREATING CHRONIC CONDITIONS

HELENA TULEYA-PAYNE, DEd

The theme of chronic illness should have special relevance for school psychologists. Historically, we have been associated with assessing and intervening with individuals with disabilities, often chronic conditions (e.g., intellectual disabilities, attention-deficit/hyperactivity disorder [ADHD], and other health impairments). This article reflects the skills and knowledge needed to support students with chronic conditions and in some cases, prevent them from starting.

In the late 1970s, my first professional experience with chronic conditions was at Elizabethtown Hospital for Children and Youth, a health care setting devoted to the rehabilitation and care of children with developmental disabilities and acquired conditions. I was assigned to two clinics, one for children with spina bifida and the other for children and youth with traumatic brain injury. My services to these populations differed. For the children with spina bifida, a condition that occurs in utero, I performed yearly psycho-educational assessments to examine any changes in cognitive functioning due to not well controlled hydrocephalus. In addition to physical impairments, these children often had learning disabilities, particularly in math. In working with caregivers, I stressed the importance of being partners with the schools to meet their child's educational needs that were often chronic in nature.

Children and youth with traumatic brain injury (TBI) came to the hospital for initial rehabilitation following care at a primary care facility. They often arrived in a middle coma stage. Frequent, ongoing assessment of cognitive functioning was completed to document emergence through the coma stages. The chronicity of impairment relied in part on the extent of injury but was also affected by learning and memory strategies implemented by the individual. A particularly meaningful activity for me was acting as liaison with the school that the individual would re-enter after rehabilitation. At the time, TBI was not well understood by the schools, and the expectations for the re-entering student did not consider memory, new learning deficits, physical fatigue, and emotional lability that the individual may be experiencing. Today, schools have resources such as BrainSTEPS (biapa.org/school-re-entry-4/) that aid in keeping deficits from becoming chronic, preventing longer lasting educational deficits.

My experiences at the hospital suggested to me that conditions thought to be

educationally chronic can be ameliorated by intervention. It might be argued that today's MTSS (multitiered system of support) is a framework that works to prevent chronic learning and behavioral deficits. It does so through the promotion of appropriate academic, behavioral, and social-emotional learning outcomes through systematic application of supports that increase as needed. At the universal level (Tier 1), all students are exposed to high-quality academic curriculum and behavioral expectations explicitly taught and assessed. For example, evidenced-based reading programs based on the "science of reading" promote skill acquisition to prevent specific learning disabilities. Interestingly, the Pennsylvania House of Representatives unanimously passed a bill that will require the State Department of Education to develop a teaching training course starting next year.

Students who do not respond to the universal programming at Tier 1 may be more at risk for developing chronic academic and behavioral problems. Tier 2 interventions are targeted for those students, and typically involve small group academic and behavioral programming. Students who have not made the expected progress in Tier 2 may then be enrolled in Tier 3 where the support is more intensive and delivered with more frequency. Usually, a team at this level may involve school and community support. At all tiers, data are systematically collected and analyzed to decide adequacy of support and decisions are made whether to maintain the current level or move to another tier. Movement occurs bi-directionally; students in Tier 1 may move to Tier 2 and vice versa.

School psychologists are trained in skills that support each level of MTSS. Although we are often associated with identification of those who show chronic deficits to determine if there is a disability or a need for individualized instruction, our skills are critical at each level of MTSS. We know of school-wide and classroom interventions that promote appropriate learning and behavioral outcomes and the more targeted and intensive interventions needed at Tier 2 and Tier 3. Importantly, we are skilled in data collection and analysis that are key in making decisions about moving students across the tiers. School psychologists are encouraged to seek membership on decision-making teams.

Outside of the MTSS framework, school psychologists have a position perhaps unique in a student's trajectory. Unlike a teacher who may engage with a student for a single grade, school psychologists often follow a student as they transition across grades and levels. It is important that school psychologists know the trajectory of chronic conditions and how they manifest at different developmental levels. For example, a student with ADHD may show hyperactivity at earlier grade levels but in high school the primary symptoms may be inattentiveness and lack of focus.

Early intervention may keep problem academic and social behaviors from becoming a chronic condition. Screening at the kindergarten level can alert educators when a child is at risk for developing specific reading disability. A child displaying antisocial behaviors in kindergarten is at risk for developing a conduct disorder. School psychologists have a role in advocating for those screenings and aiding in the data collection and interpretations.

A final note about school psychologists and chronic conditions: They may be one of the first individuals to diagnose a condition such as intellectual disabilities or ADHD. Sharing the disability and its impact on the child can be difficult as such news may have an emotional impact for caregivers. Presenting accurate information in a thoughtful manner while stressing programming that will maximize the functioning of a child is a skill that school psychologists are prepared to deliver.

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WRITING A LETTER FOR A CLIENT? JUST SAY NO!

JEANNE M. SLATTERY, PhD; LINDA K. KNAUSS, PhD; AND MELISSA HUNT, 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 include Ashley Greenwell, Sam Knapp, Deb Kossmann, Brett Schur, and Ed Zuckerman. Rather than immediately reading our responses, consider carefully working through the vignette first.

Dr. Kindness recently had a client ask if she would write a letter of recommendation for a graduate school application. She had only seen this client briefly and not for several years. She would like to write a letter but isn't sure she should.

DON'T WRITE

Although some of us felt more strongly about this than others, our consensus was that therapists should not write letters of recommendation for graduate school, as it seems that there are far too many possibilities for unexpected and unwanted consequences stemming from multiple relationships, confidentiality concerns, conflicts of interest, boundaries of competence, and failures to avoid harm. Could psychologists write a strong letter if they had only seen the client briefly several years ago? Would they have relevant knowledge even for current clients? What if the client didn't get into the program? Would the client be willing to give up confidentiality and allow disclosure of the therapy relationship in the letter? Would the program look favorably on applicants who submitted such letters? Would such a letter constitute a clinically contraindicated multiple relationship?

Section 2.01 of the Ethics Code (American Psychological Association [APA], 2017) states that psychologists provide services only within the boundaries of their competence. It is unclear whether the therapist would have sufficient knowledge of the patient's skill set with respect to graduate school to comment appropriately on their candidacy. Section 3.04 requires psychologists to take reasonable steps to avoid harm to their clients. Agreeing to write the letter could cause harm by breaching client privacy by revealing that they are in therapy, if the letter was viewed as inappropriate by a graduate program and harmed the patient's chances of admission, and if the therapeutic relationship was damaged if the client did not gain admission to a desired program. Section 3.05 defines multiple relationships as occurring when a psychologist is in a professional role with a person (therapist in this case) and at the same time in another role with the same person (letter of recommendation writer). Psychologists must refrain from entering these roles if it could reasonably be expected to impair their objectivity of efficacy. Can one write a truly objective letter of recommendation for a patient? Almost certainly not. Finally, Sections 4.01, 4.02, 4.04, and 4.05 note that psychologists have a primary obligation to protect confidential information, to discuss the limits of confidentiality, to minimize intrusions on privacy, and to disclose confidential information only with consent or as mandated by law. Letters of recommendation typically begin by explaining the relationship of the recommender to the person being recommended. It would be impossible to do this without disclosing the therapy. Even if the patient were comfortable with this disclosure, and agreed to it, it is the responsibility of the therapist to minimize breach of confidentiality. There is no way to

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write the letter honestly while still protecting the patient's privacy.

It seems that it would be wiser for the psychologist to have a frank conversation with the client about letters of recommendation. Even if the therapist might have seen attributes during treatment that would make this client a good candidate, most strong applicants should have other options available—former supervisors, faculty, bosses—who could assess skills desired by a program. Having someone else write the letter would allow the client to maintain the therapeutic relationship without it potentially being damaged by an undesirable outcome that might be blamed on the writer. Even if the client was accepted into their top school, writing for clients might create problems if they later felt unable to be angry with someone who had written for them.

ANY EXCEPTIONS?

Dr. Knapp asked whether writing such a letter might be appropriate in some situations. He suggested a scenario where the client might have dropped out of the graduate program after being sexually assaulted and, after a successful round of treatment, requested a letter to return. If this is a program requirement, Dr. Schur and others asserted that this wasn't a letter of recommendation but a medical clearance, even if the client requested the letter.

Dr. Greenwell asked about a situation where a former client and psychologist both live in a small town, where they now have a different relationship (e.g., both are serving on the same board). We believed it might be possible to write the letter from the perspective of that new relationship, although many of the same pitfalls would still be present and, in a small town, the person would be more likely to return as a client than in an urban setting where there are more options. Dr. Hunt observed that in this case, we should "talk about it and work it out. That's what we do."

Dr. Greenwell worried about whether we were usurping the client's autonomy by refusing to deal with the potential messiness of writing a letter. As she notes, there is a conflict of values here—at least client self-determination with integrity and nonmaleficence. As Principle A of the Ethics Code asserts, "When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm" (APA, 2017, p. 3). We all agreed, however, that patients frequently make requests for things that the therapist would be unwise to comply with. It is the therapist's responsibility to set limits with patients in these cases and to explain why complying with the request might well not be in the client's best interest.

WHY CONSIDER WRITING?

Although all of us agreed that therapists should not write letters of recommendation for graduate school—there are too many things that could go wrong—this issue comes up frequently on our listserv and other listservs to which we belong. Boundary crossings such as this one can damage the client, therapist, and our field.

Some applied programs might consider a letter from a therapist if it addressed skills valued in that program (e.g., critical thinking skills, insight, understanding of diversity issues, persistence). It might be relevant and appropriate for a student applying to a psychoanalytically oriented program to request a letter from their analyst. This type of program might even require such a letter. Presumably both the analyst and the analysand would know that such a letter would be requested well before the analysand requested the letter, and a goal of analysis may have been to prepare the analysand for future work as an analyst.

CONFLICT AVOIDANCE AND OTHER FACTORS

Many of us enter this field because we want to help others and may, as a result, have difficulties setting firm boundaries or saying no. Refusing a request can be an important skill, one that may not be taught well in graduate school (or life).

A client may make a request that goes against a psychologist's better judgment; nonetheless, our professional judgment and integrity are on the line. As with many of our vignettes, we urge psychologists to learn to integrate their professional and personal ethics (Handelsman et al., 2005). How can we establish positive limit setting, where we recognize the good motives and legitimate needs of our patients, yet prioritize the limits necessary to ensure a productive psychotherapeutic relationship (Koocher & Keith-Spiegel, 2008)?

Several of us offered reframes of Dr. Kindness' desired actions. Dr. Schur noted that doing good is different from making someone happy. Dr. Knapp suggested that these "helpful" actions are really misplaced beneficence or runaway altruism, thereby making these previously benign actions distasteful and exposing our excuses and hidden goals (Sommers-Flanagan & Sommers-Flanagan, 2018). Real beneficence might be to talk about the recommendation process with clients, help them understand why the therapist is the wrong person to write, and help them identify a more appropriate person to ask.

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CE QUESTIONS FOR THIS ISSUE

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

Family Management for Caregivers of Young Adults With Chronic Conditions: Implications for Practice

1. Condition-focused family management leads to better psychosocial outcomes because caregivers typically revolve family activities and routines around managing their child's condition.

TRUE
FALSE

2. Problem-solving interventions may encourage condition-focused caregivers to approach family management challenges in new, more effective ways that shift family management patterns.

TRUE
FALSE

Reframing Chronic Pain as Systemic Impacts

3. According to research cited in "Reframing Chronic Pain as Systemic Impact", chronic pain:

a. Is a direct cause of cognitive impairment
b. Is correlated with poor performance on tests measuring executive functioning
c. Is known to be exacerbated by "pain catastrophizing"
d. Both B and C

4. According to the article, chronic pain may result in:

a. Recognition and use of unrecognized resources
b. Intentional or unintentional disbelief and invalidation of the patient's pain
c. Adverse impacts on the children of patients with chronic pain
d. All the above

Women With Chronic Pain: Implications for Psychotherapy

5. When mothers with chronic pain neglect their own personal needs to take care of their children, they perceive themselves as:

a. Responsible and reliable
b. Sacrificial and family-centered
c. Damaging and unreliable
d. Self-harming and punishing

6. Which of the following is NOT true?

a. History of abuse and post-traumatic stress disorder are significant predictors of pain and depression in women with chronic pain.
b. Psychotherapists should teach passive coping strategies as they can strengthen mental health.
c. Women with chronic pain may struggle with their identities as a woman, a partner, and a mother.
d. Psychotherapists should provide assessment and treatment services to the population based on the cultural model of disability.

Psychology's Greatest Opportunity: Treating Substance Use and Addiction as a Chronic Illness

7. Psychologists are particularly well grounded for substance use work by their training in:

a. Physiology
b. Pharmacology
c. Neurology
d. Intergenerational vulnerability
e. All the above

8. Flaherty and Marion suggest:

a. Substance use is best conceived as a potentially chronic illness
b. Psychologists are the predominant profession treating substance use disorders
c. Other professions are growing more in their treatment of substance use
d. A and C
e. A and B

The Effects of Stroke on Family System

9. Strokes not only affect a person's cognitive, physical, and emotional functioning, but can also negatively impact interpersonal relationships.

TRUE
FALSE

10. When working with a family that has experienced role change due to stroke, the therapist should try to help the family to get back to their original roles.

TRUE
FALSE

Psychological Effects of COVID-19 and Preliminary Treatment Recommendations

11. The literature suggests that invasive ventilation can result in post-traumatic stress symptoms.

TRUE
FALSE

12. There has been an increase in alcohol use, domestic violence, and suicide in the past year.

TRUE
FALSE

School Psychologists and Their Role in Treating Chronic Conditions

13. Chronic educational conditions can be avoided given proper, timely intervention.

TRUE
FALSE

14. The MTSS framework can be used by schools to prevent educational problems.

TRUE
FALSE

Ethics in Action: Writing a Letter for a Client? Just Say No!

15. What possible problems might cause a therapist to refuse to write a letter for a client?

a. Undesirable outcome
b. Multiple relationships
c. Lack of information
d. All the above

16. The APA Ethics Code asserts that when conflicts occur among psychologists' obligations or concerns, psychologists attempt to resolve these conflicts by:

a. Contacting the State Licensing Board
b. Finding a solution that avoids or minimizes harm
c. Consulting an ethical colleague
d. Consulting Google Scholar for research and guidelines

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, June 2023

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

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

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

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

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Calendar

Friday, September 15, 2023
Teaching Suicide Prevention: A Format for Educators, Supervisors, and Self-Directed Learners
Live Webinar
12:00 – 1:00 p.m.

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

November 30, 2023
License Renewal Deadline for Psychologists in Pennsylvania

Wednesday, June 12 - Saturday, June 15, 2024
PPA2024 Convention
Lancaster Marriott at Penn Square
Lancaster, PA

Home Study CE Courses

Act 74 CE programs

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

Act 31 CE Programs

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

General

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

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

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

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

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