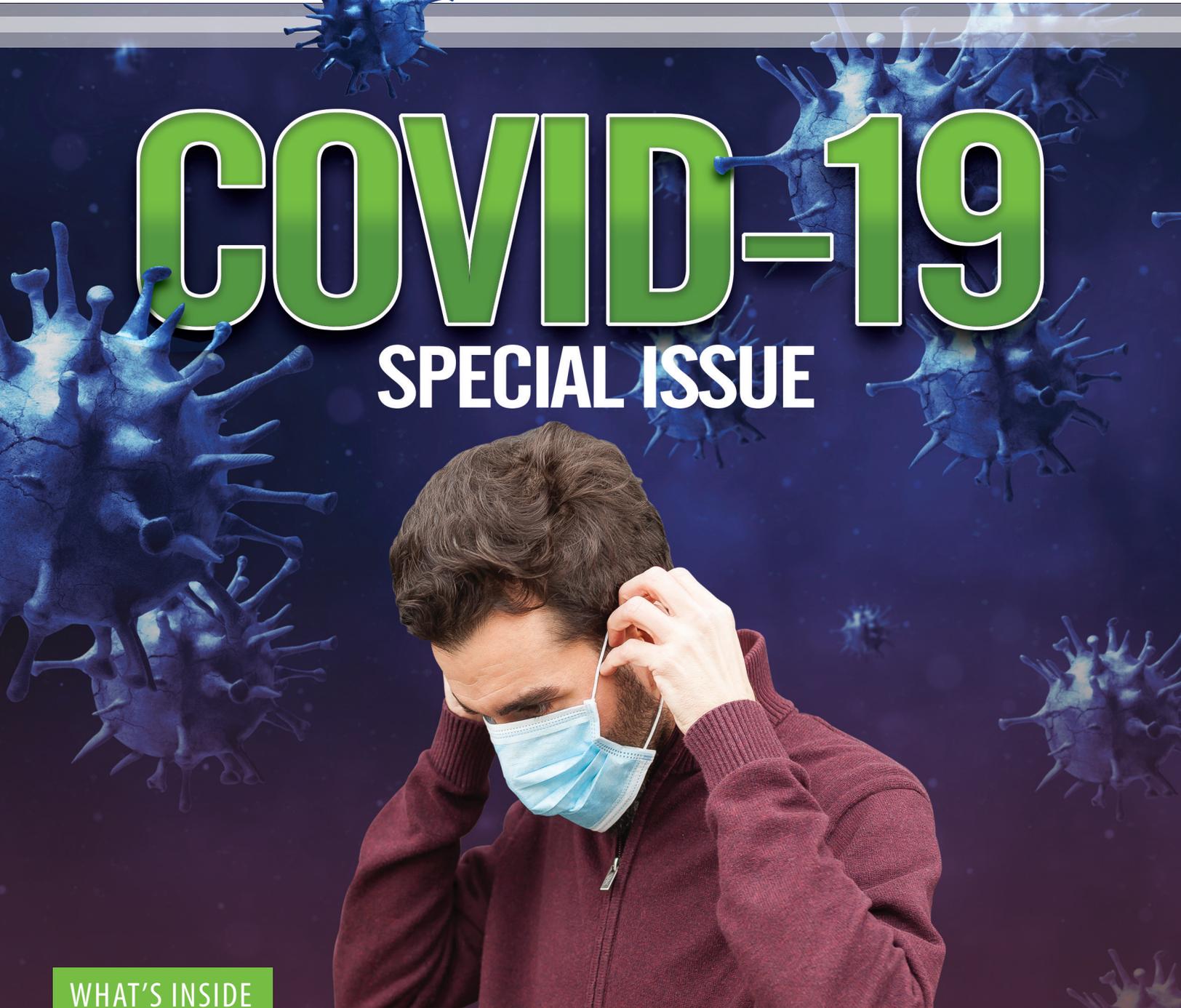


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COVID-19

SPECIAL ISSUE

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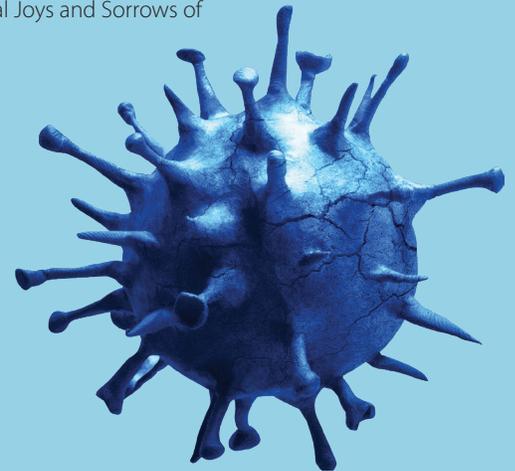
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CORONAVIRUS and TELEHEALTH in Pennsylvania

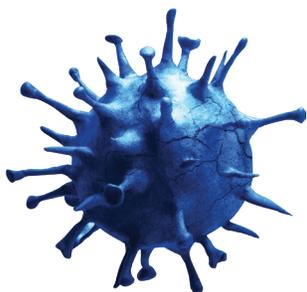
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Psychologists in Pennsylvania rapidly changed their method of service delivery within a two-week period. Services that were once largely conducted face to face suddenly changed and were conducted through telehealth services. Psychologists had to quickly decide which telepsychology platform to use and they had to instruct many patients on how to use these applications. Also, they had to deal with some patients who refused, for various reasons to accept telehealth services. All this occurred while individual psychologists had concerns about their own health and the health of their families and the large communities and had understandable concerns about the financial future of all of us.



The rapid shift to telehealth has substantially increased the workload of psychologists at least in the short run. For example, psychologists customarily check patient benefits before treatment begins. But now prudent psychologists had to check the benefits of all their patients again – within a short period of time – to learn if their insurance covered telepsychology.

Also, the rapid shift toward telehealth has sometimes compromised the quality of care. Often psychologists will see patients in face to face therapy first and then give the patients the option of “migrating” into telehealth services. In the face to face meetings psychologists can show patients on their computers or smart phones how the telehealth meetings will be set up and can

answer any questions that their patients might have. But, given the rapid movement toward telehealth, the opportunity for clinically indicated migrating was often lost.

Furthermore, many psychologists felt confused concerning the standards that apply primarily because of the fragmented way in which psychology (and other professions) are regulated. Several different entities regulate psychology on different levels including the Pennsylvania State Board of Psychology and the Office of Civil Rights of the Department of Health and Human Services to the extent that it enforces the HIPAA Privacy Rule. Insurers also have an important role because they subsidize much health care. But insurers are fragmented between Medicare (traditional and Advantage plans), Medical Assurances (administered through five different behavioral health MCOs in Pennsylvania), and numerous commercial plans (which can offer many different policies with

different benefit packages). For example, Pennsylvania's Department of Human Services announced that it was permitting psychologists working with Medicaid patients to use telephone alone if face to face communication platforms were not available. It is understandable that some psychologists, being bombarded by much information that they need to digest rapidly, might not realize that the Department of Human Services in Pennsylvania only has authorization over Medicaid programs and their permission to use telephones did not apply to any other insurance program.

Further confusion occurs because of the rapid change in policies. For example, on March 13, PPA accurately reported that Magellan required an attestation before its providers could bill for telehealth services. Then, six days later Magellan changed its policy and dropped the attestation requirement. Similar sudden changes have occurred with several other commercial insurers.

In another example, the conservative interpretation with out of state practice is that the practice of psychology occurs where the patient is physically located. So, if a patient is physically located in Ohio, conservative psychologists will become licensed in Ohio or will otherwise be authorized to provide services in Ohio. However, many state boards of psychology have been modifying their out of state practice provisions to accommodate the unusual needs created by this pandemic. For example, Ohio recently announced



that it would reduce barriers to out of state practice in Ohio. To keep up to date with the changes, psychologists can go to the website of the Association of State and Provincial Psychology Boards (asppb.net) and check for the changes in state licensing laws.

PPA has responded to this crisis by sending out alerts to the entire PPA membership when important developments occur; responding directly to member inquiries; and identifying resources for PPA members that may ease the transition into delivering telehealth services. The Frequently-Asked- Questions article in this issue is designed to keep psychologists as up to date as possible on changes in the health care landscape. PPA has done webinars on telehealth and coronavirus and more will be scheduled.

Furthermore, this issue contains a brief article on confidentiality concerns related to coronavirus.

In addition, with so many day-to-day and immediate-need tasks placed on us, it is difficult to step back and think about the long-term implications of what is happening. An article in this issue, called COVID-19: Anticipating the Next Phase, gives some preliminary reflections on some emerging mental health needs created by the pandemic.

Finally, we are pleased to print articles by Dr. Sabina Mauro on helping patients to deal with coronavirus linked anxiety, by Dr. Richard Stern on some of the clinical implications of telehealth services, and Drs. Gaskill and Schur on the self-disclosure of testing positive for COVID-19. 

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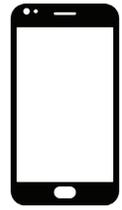
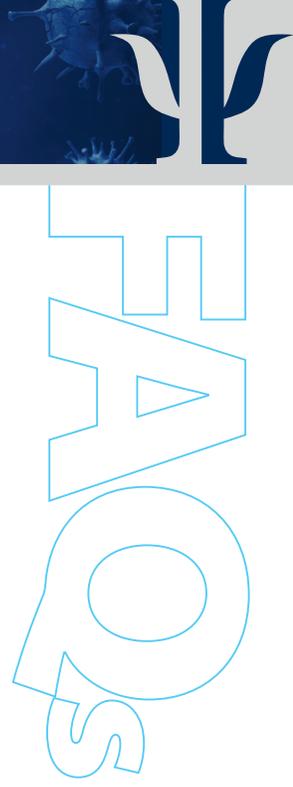
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FREQUENTLY ASKED QUESTIONS about TELEHEALTH in Pennsylvania

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Q: Governor Wolf has declared an emergency and closed non-essential businesses. Are psychology practices considered non-essential?

The documents from the Governor’s office as well as a message from Pennsylvania’s Acting Secretary of Human Services consider facilities that deliver health care services, such as the practices of psychologists, essential and these may remain open. Of course, psychologists do not have to see patients face to face if it is contraindicated to do so from a safety perspective.

Q: What standards must psychologists follow when delivering telehealth services?

The Pennsylvania State Board of Psychology requires psychologists to follow the guidelines of the American Psychological Association on telehealth. The link to these guidelines is found on the PPA website. Also, APA has a document that lists all the essential elements that should be met before conducting telehealth services. Those who follow these guidelines will be complying with the APA guidelines on telehealth. This document is on the PPA website: papsy.org/page/COVID19.

Q: Are psychologists required to get special CE training to provide telehealth services?

No. Psychologists must follow APA guidelines on telehealth which requires basic competence, but it is not necessary to have a continuing education course to become competent.

Q: Will the State Board of Psychology change its continuing education requirements because of the pandemic?

Yes, the Pennsylvania State Board of Psychology has lifted its restrictions on the amount of distant continuing education that psychologists can use to fulfill their mandatory continuing education requirements. Previously psychologists had to receive at least 15 hours of continuing education that involved either face to face contact or a webinar in which participants could interact in real time.

Q: Does the practice of telehealth require any special informed consent process?

The informed consent process for telehealth differs from ordinary informed consent. As noted in the APA guidelines on telehealth, “Psychologists make reasonable efforts to offer complete and clear descriptions of the telepsychology services they provide, and they seek to obtain and document informed consent when providing professional services” (American Psychological Association 2013, p. 795). However, it does not require that patients sign a form. Nonetheless, it is a good and safe practice to sign an informed consent form and both the Trust and APA have created such forms. Links to these forms can be found on the PPA website.

Q: Do patients have to sign an informed consent form before telehealth begins?

No. If psychologists discussed telehealth with patients and documented that conversation, then psychologists can start telehealth services even before patients sign the form. As noted

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above, it is recommended that patients sign an informed consent agreement for telehealth, although it is not required to do so.

Q: What kinds of platforms may I use for telehealth? Do they have to be HIPAA compliant?

This is an evolving situation and we can only respond to the state of information right now. Part of the confusion occurs between what a psychologist is permitted to do and what an insurer will reimburse for. The Office of Civil Rights (OCR) of the Federal Department of Health and Human Services, which enforces the HIPAA Privacy Rule, announced that it would suspend its enforcement of the requirement that health care providers must always use HIPAA compliant platforms when delivering telehealth services. Specifically, it stated that “OCR is exercising enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provisions of telehealth using such non-public facing audio or visual communication products during the COVID-19 nationwide public health emergency.” It further elaborated that healthcare providers “may use popular applications that allow for video chats including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype.” Providers may not, however, use “Facebook Live, Twitch, TikTok, and similar video communications [that are] public facing.”

Although OCR is giving permission to extend telehealth to non-HIPAA compliant platforms, many insurance companies have not, at least as of the writing of this article, followed suit. Medicaid in Pennsylvania and Medicare are allowing flexibility consistent with the OCR statement, but we do not know of any commercial insurers that have.

Q: Are phone sessions permitted?

Psychologists may provide telehealth services over the phone. However, as of right now, reimbursement for telephone services is not consistent across insurers.

Q: Are phone sessions covered by insurance policies?

As of the writing of this article, many commercial policies are not covering telephone sessions. They require interactive modalities that include both audio and visual exchanges in real time. Medical Assistance in Pennsylvania covers phone sessions. Cigna covers it. We just learned that Magellan (administering Independence Blue Cross) will cover phone sessions. Of course, psychologists can always charge for phone sessions for self-pay patients. See the PPA website for rules regarding Medicare.

Importantly, the market is rapidly changing. One statement that we assert as true today may, through an action of an insurer, become outdated tomorrow. Psychologists should check the coronavirus updates from PPA as we will post information as soon as we can verify its accuracy.

Q: Do we always need to have a business associate agreement signed?

Business associate agreements (BAAs) are used when psychologists are working with a HIPAA compliant platform. As noted above, in some situations, psychologists may be able to work with some platforms that are not HIPAA compliant. When psychologists are using non-HIPAA compliant platforms, they do not need to get a BAA.

Q: Will professional liability (malpractice) policies cover telehealth services?

Malpractice carriers typically cover any service that is within the scope of practice of a psychologist. Check with your policy if you are uncertain about the coverage.

Q: How should telehealth services be billed?

Psychologists can use the same CPT codes as they use for face to face psychotherapy, although they need to identify the place of service as 02 (telehealth). Some insurers require using a GT or 95 modifier. See the PPA website for rules regarding Medicare.

Q: Must psychologists be in their offices while the services are being delivered? Must patients be in their homes while the service is being delivered?

We have been unable to find any insurer in Pennsylvania that require psychologists to be in their offices or patients to be in their homes while the service occurs.

Q: What insurance companies pay for telehealth services?

Private insurance plans vary on how they handle telehealth services. Highmark, Aetna, Capital Blue Cross, Optum and Magellan (under the auspices of Independence Blue Cross) *generally* pay for telepsychology. *Nonetheless, we urge all psychologists to check the benefit package for their individual patients.* When checking benefits psychologists should consider whether the service is being provided in-network or out of network. Many insurers cover large employers who are exempt from state laws (called ERISA exempt companies) and who are large enough that they can write their own unique insurance policies that sometimes have unusual exclusions. Consequently, we cannot give a blanket statement about coverage for any insurer except Medicare (including Medicare Advantage Plans) and Medicaid in Pennsylvania.

Q: What is the best platform to use for delivering telehealth services?

That is an individual decision and it varies according to the needs and preferences of individual psychologists. APA has disseminated an article in which they discuss different platforms and their pros and cons. This can be found on the PPA website.

Q: What are the privacy issues involved if employees are using the internet during work hours? Perhaps their emails are not private and would be read by their employer?

These are some of the issues that psychologists can cover as part of their informed consent process. Psychologists and their clients would need to discuss whether this option is sufficiently private and confidential.

Q: Should patients avoid using a public Wi-Fi or hotspot? Should psychologists refuse to treat patients who use public Wi-Fi or hotspots?

Wi-Fi is acceptable if it is secured. We can encourage patients to use secure internet connections as part of the informed consent process, but it would be difficult for psychologists to enforce this.

Q: How can psychologists be certain that the patient is not recording the sessions?

Psychologists cannot ensure that the patient is not recording the sessions. This is true for telepsychology as well as face-to-face sessions where clients could bring secretive recording equipment to the office. Also, a client in a telehealth session can have a separate recording system independent from the telehealth platform. Session privacy can be addressed as part of the informed consent process, however.

Q: Can psychologists deliver supervised services through telehealth?

Few commercial insurers reimburse for supervised services. For those that do, we have seen nothing that would create different standards for supervision for telehealth services as opposed to face to face services. Medicare allows supervision to occur through what they call "incident to" services which, among other things, requires the supervisee and supervisor to be in the same office suite while the service is being delivered. To date, Medicare has not altered that rule.

Q: Can psychologists supervise trainees through telecommunications?

Nothing in the Pennsylvania State Board of Psychology regulations require face to face supervision for practicum students or predoctoral trainees. Psychologists should check with the students training institution. However, APA guidelines permit supervision through telehealth (see <https://www.apaservices.org/practice/news/psychology-training-covid19>). The Pennsylvania State Board of Psychology has lifted the previous requirement that post-doctoral trainees could only be supervised by face to face meetings.

Q: Do I have to be licensed in another state to treat patients physically located in that state?

Psychologists should check with each jurisdiction to understand their practice requirements. Some state licensing boards require psychologist to have a temporary license to practice in that state (or province). Other Boards allow out of state licensed psychologists to practice in their jurisdiction for a specified number of days.

According to Dr. Alex Siegel, Director of Professional Affairs for the Association of State and Provincial Psychology Boards, "Generally speaking, one encounter constitutes one day. So, for example, if you see one patient on April 1 for one hour, that counts as one day. If you see two or more patients on April 1st, that still counts as one day. However, if you see one patient on April 1st and another patient on April 2nd that would count as two days. Also, you usually do not get "x" number of days for one patient and "y" number of days for another patient. Typically, as I have said in many presentations, "one minute is one day." Some states (a small minority) only allow "x" number of consecutive days or "x" number of days in "y" number of months. Arizona allows you to count hours not days up to a certain number of days.

While some states like PA, allow psychologists to practice for up to 14 days without notifying the licensing board, other states permit psychologists to temporarily come into the state for "x" number of days but first must notify the board (like Washington) or even apply for a temporary license before you can do so. Unfortunately, different states have a different number of days and some states do not allow any temporary privilege."

Dr. Siegel emphasizes that because of this patchwork of out of jurisdiction practice laws, "Many states are declaring states of emergency which are temporarily suspending or waiving many regulations pertaining to interjurisdictional telepsychology (telehealth services). As with these declarations, there are differences among the states and provinces. Some require you to notify or apply to the state (licensing board) for permission to provide electronic psychological services into that state (with a promise of a very quick turnaround) while others allow you to provide services into the state without notifying them. Also, some states allow you to interjurisdictionally treat only existing patients while others allow you to provide services to existing or new patients."

For more information on the above, ASPPB has information on its website pertaining to licensing information and COVID 19 (<https://www.asppb.net/page/covid19>) 

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CONFIDENTIALITY AND CORONAVIRUS in Pennsylvania

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*

Questions have been raised concerning the confidentiality of patients in the offices of Pennsylvania psychologists when either the patients or the psychologists have the coronavirus as confirmed by laboratory testing or who have been exposed to the coronavirus.

Both the HIPAA Privacy Rule and state laws govern confidentiality for psychologists. When the HIPAA Privacy Rule and a state law conflict, the law that protects patient privacy the most, from the standpoint of the patient, prevails. The HIPAA Privacy Rule permits the disclosure of patient information in response to an inquiry concerning infectious diseases. It states that health care professionals may reveal information to public health authorities on “a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition” (45 CFR 164.512 (b)). Nonetheless, as stated by the CDC, “As required by the HIPAA law itself, . . . state laws that provide greater privacy protection continue to apply” (FAQs about HIPAA Privacy Rule, retrieved from <https://www.cdc.gov/nhsn/hipaa/index.html>).

The HIPAA Privacy Rule needs to be read in conjunction the Professional Psychologists Practice Act and other state laws, none of which permit psychologists to release patient information to public health authorities only based on the presence of an infectious disease. Since Pennsylvania law permits no exception to confidentiality with public health authorities and this

is more protective of patient privacy, psychologists in Pennsylvania may not reveal patient information to public health authorities in response to an inquiry about infectious diseases unless they have an authorization signed by the patient or a court order.

The duty to warn or duty to protect decision in Pennsylvania does not apply here as that dealt with a “specific and immediate threat” against a readily identifiable victim (*Emerich v. Philadelphia Center for Human Development*, 720 A 2d 1032, 1044 (Pa 1998)). Similarly, the public danger confidentiality exception in the regulations of the Professional Psychologist Practice Act only applies when “a client has expressed a serious threat or intent to kill or seriously injure an identified or readily identifiable person or group of people . . .” (49 PA Code 41.61, Principle 5 (b) (1)).

Here are three possible scenarios:

1. A psychologist or a staff member learns that they have coronavirus as confirmed by a laboratory test.

Psychologists may share their own health information with their patients. Psychologists or staff members who have the coronavirus as confirmed by a laboratory test or who have been exposed to the coronavirus have an ethical obligation to inform their patients with whom they have had contact so that these patients can take appropriate measures.

2. A patient learns that they have coronavirus as confirmed by a laboratory test.

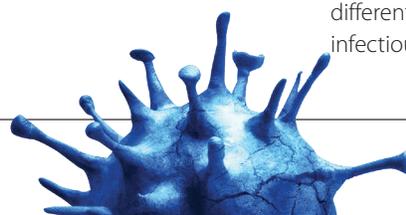
In such cases, psychologists have an ethical obligation to inform other patients who may have been exposed to the virus. There is no reason to disclose the name or any identifying information on the infected patient.

3. A public health official requests information from a psychologist.

Such requests may occur if public officials are engaging in “contact tracing,” which is a public health method of identifying and advising those who have been exposed to the infectious agent. Psychologists should share the names of non-patients (e.g., staff persons) who may have been exposed. Neither HIPAA nor state law protects the names of nonpatients. Also, psychologists can volunteer to contact patients directly, inform patients of the situation, and ask them to sign an authorization to allow public health officials to contact them. Psychologists may not disclose the names or identifying information on their patients without an authorization from the patient or a court order, however.

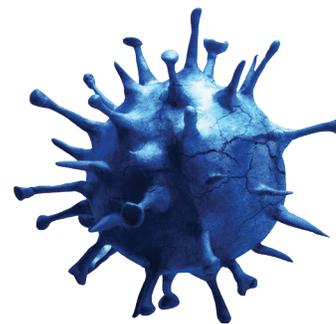
This third scenario is increasingly less likely to occur because the public health benefit for contact tracing has passed in many areas of the country.

This comment only applies to Pennsylvania. Other states may have different laws regarding reporting of infectious diseases. 



COVID-19: Anticipating THE NEXT PHASE

SAMUEL KNAPP, ED.D., ABPP, *Director of Professional Affairs*



Psychologists have had to deal with the very real and difficult technical, insurance, clinical, and legal issues involved in moving into telehealth practices. After the dust settles and the use of telepsychology becomes more routine, psychologists will have more time to reflect on the changing mental health needs caused by this pandemic. Some of the questions that psychologists may need to address include:

- How can psychologists help patients deal with social isolation, fear, and situational problems such as the loss of work, dealing with children out of school, and other issues?
- How can psychologists promote the well-being of front-line health care workers who must deal with fatigue, burnout, and the risk of post-traumatic stress disorder?
- How will psychologists evaluate the long-term impact of telepsychology on the practice of psychology? Will the outcomes in telepsychology hold up to the outcomes found in face to face psychotherapy?
- How can psychologists motivate patients to comply with recommended public health strategies to ensure their personal safety and the safety of the community?¹
- How can psychologists address anti-Asian prejudices precipitated by the pandemic?

- How can psychologists ensure their own mental, physical, social, and spiritual well-being during this time?

In future issues of the *Pennsylvania Psychologist* we will address these and other topics in more detail. In the meantime, I will try to summarize some findings that may begin the conversation on some of these important topics including the mental health implications of community mitigation interventions, the growing mental health needs of first line health care workers, strategies to reduce the ill effects of COVID-19 related life style changes, and some preliminary thoughts on addressing anti-Asian prejudice.

Mental Health Aspects of Quarantine, Isolation, and Community Mitigation Strategies

Historically public health officials have tried to slow the rate of infectious diseases through quarantines or isolation. According to Brooks et al. (2020), a quarantine is “the separation and restriction of movement of people who have been exposed to a contagious disease to ascertain if they become unwell, so reducing the risk of them infecting others.” This contrasts with isolation which is “the separation of people who have been diagnosed with a contagious disease from people who are not sick” (p. 912). So, a quarantine is for those who have been exposed to the contagious disease and isolation is for

those who have been diagnosed with the contagious disease.

Now public officials are also trying to slow the spread of infectious disease through community mitigation strategies such as “shelter in place” orders in which persons who have not necessarily been exposed to or diagnosed with the contagious disease restrict their social movement. While quarantines and isolation for short periods of time have been a long staple of public health interventions, the widespread “shelter in place” orders have no modern precedence and we can only extrapolate from other areas of psychology concerning its impact on the mental health of the public.

One source of data comes from experiences of persons who have experienced quarantines or isolation. The data is not extensive and consists largely of surveys, interviews or case studies, involved studies from many different countries, and targets either community residents or hospital employees. Despite the variety of methods, cultures, and samples used, the general outcome was that quarantine and isolation led to a significant decrease in mental health including an increase in anger, fear, frustration, boredom, depression or post-traumatic stress disorder symptoms. After the quarantine or isolation ended, the symptoms decreased but remained high for many participants.

The psychological impact was less if

1. Wise et al. (2020) found that individuals increased their use of protective behaviors (such as handwashing) as their perception of personal risk increased. Nonetheless, they still rated their risk as lower than that of the average citizen.

the quarantine or isolation was voluntary and if the quarantined or isolated persons appreciated that the “quarantine is helping to keep others safe, including those particularly vulnerable. . . and that health authorities are genuinely grateful to them” (Brooks et al., 2020, p. 919). This finding was consistent with the report of an unpublished study that found that “public health messages that focus on duties and responsibilities toward family, friends, and fellow citizens is a promising approach to slow the spread of COVID-19 in the US” (Everett et al., 2020, p. 1).

Of course, a community mitigation strategy is different from quarantines and isolation because of the lack of social stigma involved. Nonetheless, it raises concern about the long-term psychological impact of the “shelter in place” strategy.

Mental Health Needs of Front-Line Workers

Working in health care has its own unique set of stressors and mental health challenges. Stressors surrounding the coronavirus will likely exacerbate these stressors even more. Many have had to work in unsafe conditions for long hours. The shortage of health care workers is so extreme that retired professionals with lapsed licenses have been called back to work.

Meanwhile, doctors and nurses have been reprimanded for publicly complaining about the lack of personal protection equipment (Gallegos, 2020). In an extreme example, an Italian nurse died from suicide because of guilt that she might have inadvertently infected others with the coronavirus (Steinbuch, 2020). About 64% of Chinese health care workers surveyed in late 2019 had moderate to severe symptoms of depression and 34% had insomnia. Workers with the highest rates were from Wuhan province or who worked directly in the diagnosis or treatment of COVID-19 patients (Lai et al., 2020). While the current public health priority is on the immediate physical safety of the public, there will likely be a post-COVID-19

health care demand that deals with the psychological after-effects of working during the pandemic.

Strategies to Reduce COVID-19 Related Mental Health Problems

In a roundtable discussion organized by the Association for Psychological Science, Dr. Bethany Teachman offered steps to manage COVID-19 related anxieties (APS Roundtable, 2020): practicing self-care, monitoring our thoughts and feelings, and focusing on our values.

Practice Self-Care

Dr. Teachman encouraged self-care. This includes sleeping well, exercising, and eating well as well as the special precautions related to COVID-19 such as frequent handwashing and other precautions. Emotional self-care is especially important. Relationships are an important part of managing anxiety and fear. Dr. Teachman elaborates that “social distancing does not have to equal social isolation.” We will do better as individuals and as a society if “there is a sense that we’re in this together and we see many amazing examples of people supporting one another” (Teachman, quoted in APS Roundtable, 2020).

Monitor Thoughts and Feelings

Also, she urges us to monitor our thoughts and feelings. While it is important to be informed, it is unproductive to ruminate on the dangers. Anxiety is productive if it leads to reasonable precautions, but at a certain level it can be unproductive and self-defeating. Other scholars have made similar observations. One author referred to the constant background of coronavirus related fear as the equivalent of a “low grade fever” (APS Roundtable, 2020).

Whatever fears, worries, or upsets persons have had in their past may be magnified by the underlying background of anxiety surrounding coronavirus or the accompanying social changes. Consistent with that interpretation, Thompson et

al. (2017) found that fear of Ebola was highest among those with a history of a mental health diagnosis and acute stressed reactions to past public traumas, such as the Boston Marathon bombing. This may be explained by the *sensitization hypothesis* wherein “prior stressful events can have a deleterious effect on one’s ability to cope with future stressors” (p. 514). This suggests that we may expect that the fear of COVID-19 from some of our patients with past traumas may be greater than the fear of COVID-19 among the public in general. Furthermore, Johnson and Tversky (1983) found that the heightened perception of risk from one hazard heightens the perception of risk from unrelated hazards. That is, the fear of COVID-19 may increase the perception of risk from other unrelated hazards. This suggests that our patients may be experiencing both a heightened fear of COVID-19 and experience greater threats from unrelated hazards.

Live Your Values

Finally, Dr. Teachman urges us to “live your values. So be kind to yourself and kind to others.” This observation can hardly be overstressed. In the same APS article, Dr. Katie McLaughlin noted that the “stress buffering effects that you get from receiving social support you also get when you give social support to others.” Prosocial values are deeply embedded in many segments of the American population and can be mobilized for personal and public benefit. For example, Grant and Hoffman (2011) found that the response to reminders for handwashing among hospital employees was higher if the prompts emphasized the safety of patients instead of emphasizing personal safety.

COVID-19 Fears Precipitate Prejudicial Behaviors Against Americans of Chinese or Asian Backgrounds

Fear can exacerbate prejudices and lead to scapegoating. In the 1980s, AIDS was sometimes referred to as the “gay disease,” fueling homophobic discrimination. During

the Ebola epidemic, Kim et al. (2016) found that participants who felt most vulnerable to the Ebola epidemic were more likely to express xenophobic attitudes as evidenced by negative attitudes toward West Africans, endorsement of travel restrictions, and endorsement of ethnocentric attitudes.

Fear and an increase in prejudice toward Asian Americans are manifesting today. Kandil (2020) reported over 650 racist acts toward Asian Americans in one week in March. According to psychologist David Steno (quoted in Timsit, 2020), uncertainty and fears make people more susceptible to false claims (fake news) and hostile attitudes.

Fears may activate underlying hostile attitudes or suspicions of groups that one perceives as foreign or different. Lin et al. (2005) found that many Americans stereotyped Asian Americans so that they were seen both positively as highly competent (reflecting their model minority image), and negatively as socially aloof or distant. Some people who may have already been prejudiced would seize on limited information about COVID-19 to support their prejudiced attitudes. Fear makes people even more vulnerable to false information causing some researchers to refer to an *infodemic* and urging citizens to practice *information hygiene* (Vlessides, 2020).

How to address these prejudices? The first step might be to educate the public on the nature of the disease, how it is spread, and how people can reduce its spread

(Jilani, 2020). Once fear levels are reduced, many people can become more receptive to fair-minded discussions. The American Psychological Association has developed a fact sheet for journalist and policy makers on how to speak or report on COVID-19 without stigmatizing groups (<https://www.apa.org/news/press/statements/combating-COVID-19-bias.pdf>). 

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THE PSYCHOLOGICAL TRAUMA of Coronavirus (COVID-19)

SABINA MAURO, PSY.D.

Disclaimer: This article is not intended for self-diagnosis or diagnosis of others. Should you feel that your psychological well-being is impacted by this 2020 COVID-19 pandemic please reach out to a mental health professional.

“An abnormal reaction to an abnormal situation is a normal behavior.”

—Victor Frankl

While many people experience with the COVID-19 virus pandemic will be different, this article’s intent is to help people understand certain behaviors and possible individual reactions to the current pandemic, even if they themselves have not contracted the virus, through the lens of a psychologist trained in trauma therapy. The psychological impact of pandemics is similar to that of natural disasters and community violence.

There is a common set of symptoms and characteristics that define this psychological impact and, while not all symptoms need to be met to have experienced trauma, there are distinguishing factors that determine the severity of the trauma. This is not an exhaustive list of symptoms and not all individuals will experience these or process them in the same manner.

What’s going on in the world?

The Scenario

Imagine a normal routine life prior to the pandemic. A typical day consisting of nothing out of the ordinary other than the usual highs and lows. This continues day after day. You hear occasional news segments about some “virus” in another country, too far to affect you, and you continue your day without any disruptions.

Change happens slowly. You hear on the radio that the coronavirus has reached the United States. Things start changing faster. A friend posts on Facebook that their grandmother has tested positive for coronavirus. You search the Internet for “coronavirus” and see “wash your hands frequently,” “coronavirus survives on surfaces,” “Clorox kills the virus.” So much information that it is hard to tell what is fact and what is opinion. The television has constant coverage on many channels and many opinions.

Suddenly, coronavirus is in every state in the United States and the local store shelves are empty or running out of staple items such as water, meat, milk, and cleaning supplies. The government issues “shelter-in-place” orders. At this point your brain and body has begun a biologically programmed response commonly referred to as Fight or Flight.

What’s going on with me?

The Fight or Flight Response

When a threat has been identified, your brain processes available information to determine the best outcome for survival. During highly stressful situations, the brain region best known for emotional responses, the amygdala, has increased activity. At the same time the sympathetic nervous system, which controls and regulates involuntary reflexes such as heart rate and stimulation of hormones, is activated.

The heart rate increases, and survival becomes a top priority. The basics of survival are shelter, water, and foods so we may find ourselves rushing to the supermarket for food, water, and, yes, toilet paper. Some people may have started excessively washing their hands, or at least noticing the number of times they are washing their hands, and even isolating themselves or at a minimum practicing social distancing. These behaviors originate from our brain as a way to protect and defend against the coronavirus pandemic.

Why can’t I let this go?

High Level of Alertness (Hypervigilance)

Hypervigilance is a common reaction to trauma events. There is an enhanced sensory sensitivity due to a state of increased alertness.



With hypervigilance, our brain continuously scans for threats and engages us in behaviors to prevent danger. The threat of COVID-19 is recognized to put us or loved one's "at risk" for potentially serious illness, or even death. Examples of how our senses are more heightened during this pandemic include:

- You are more aware of the distance between you and others while standing in line with a noted change in your comfort zone. Now you maintain a minimum of six feet no matter where you go.
- You wash your hands more frequently. Now you wash your hands each time you eat, enter the house from outside, or are even near a sink. Perhaps you wash your hands and sing "Happy Birthday" twice to thoroughly clean your hands or set an alarm for set intervals to remind you to wash your hands.
- You search for hand sanitizer stations in any public places or you have hand sanitizer and are using it with increased frequency.
- You hear a sneeze and your chest tightens or you hold your breath thinking the virus may have reached you or is in the air.
- You fear that each stranger may be contagious or may be a carrier of the coronavirus.

- Now you start to feel hot, cough, and search the Internet for symptoms of coronavirus.

Why am I thinking like this? Changed Thought (Cognitive Distortions)

Changed thought is when our brain "rewires" the way it understands the world. Trauma alters our worldview and impacts our thoughts, often leading to negative thinking pattern. These unhelpful thoughts consume us and convince our mind of false outcomes. Examples of how our thoughts could have become irrational or distorted during the pandemic include:

- Overgeneralization: When coworkers call out you speculate the reason is because they have tested positive for the coronavirus.
- Expecting catastrophic outcomes: With a low-grade fever, you believe you have contracted the coronavirus and are going to die.
- Should statements: Making statements such as, "I should have known..." or "I should have (not) did..." in relation to the pandemic.
- Labeling: Questioning if anything you purchased was "Made in China" is now contaminated.

Why am I feeling like this? Mood Changes

Furthermore, the disruption to our thinking pattern negatively changes our mood. Emotions such as anger, irritability, excessive worry, and frustration further increases a negatively distorted outlook. While some individuals may not experience any emotion following a trauma, others may experience a significant increase of emotions, as well as the inability to regulate emotional control, leading to destructive behaviors.

Emotional states become intensified as information is released and governmental orders are released as a result of the pandemic. Parents who work while their children are at school need to find alternative childcare. People who made plans (birthdays, weddings, funerals) need to cancel these plans due to the unknown certainty of the near future. Our own thinking pattern creates excessive worry. People who are having difficulty controlling emotions may become destructive and seek to release frustration through physical expression with a sense of losing control.

Why can't I get this under control? Regaining Control

It is not uncommon for people that have experienced trauma to develop a perceived loss of control. A sense of control permits us to make intentional decisions over our life with confidence. If our sense of control

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becomes interrupted, then we engage in behaviors to compensate for feeling powerless or to regain an aspect of control. Although we cannot control the pandemic, we can control our thoughts, emotions, and response to the pandemic.

We are unable to control almost anything about the coronavirus pandemic and the United States is now setting limits on movements, with the intention of preventing the spread of the virus quickly. To compensate for the lack of control, we engage in behaviors we can control. Cleaning homes, stocking the pantry with extra food, washing hands, wearing surgical masks, and social distancing are all ways we attempt to regain power over the pandemic. Examples of how you can take control of yourself, even when you cannot control your environment are:

- **Positive Thoughts:** think about what you are grateful for or think about what makes you happy; spend more time daily with positive thoughts.

- **Embrace Feeling:** take the time to think about how you are feeling and why you are feeling that way; reflect on how the feelings make your body feel.
- **Intentional Actions:** take the opportunity to spend quality time with family (play games, put a puzzle together, laugh); show gratitude or kindness to others.

Is this normal?

The new normal

As a country, we are currently experiencing physical and psychological changes that are directly related to the COVID-19 pandemic. The psychological impact of the pandemic is being experienced by all of us to some degree; flight or fight activation, hypervigilance, change in thought and mood, and loss of control. Our old daily routine has been replaced with a new routine of survival mechanisms. We are all probably more stressed out than we realize right now, more tired, even though we are sitting around more. A new norm in the face of the COVID-19 virus, where everyone's health and possibly even life

is at risk. What differentiates how each individual reacts to the pandemic is determined by underlying factors such as history of mental health, past traumatic experiences, inherent resiliency, learned coping mechanisms, and external sources related to support network.

It is no surprise that our immediate response during threatening situations with limited information is to prepare ourselves and family for a worst-case scenario, even in times when our actual chance of survival is unlimited. Once the pandemic is no longer a threat, our brain and body should return to homeostasis, set points of biological regulation, in order to maintain optimal function in environment and situations. If you continue to experience psychological distress once the pandemic has subsided, you may be experiencing posttraumatic distress. If you find yourself experiencing these symptoms after the pandemic you can heal and recover with appropriate mental health treatment and you should seek out a mental health professional with a specialty in trauma related work. 📞



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A REMOTE CHANCE AT THERAPY

The Clinical Joys and Sorrows of Telehealth in the Time of Covid-19

(Client details are changed)

RICHARD S. STERN, PH.D.



Like every other mental health practitioner I know, I am now conducting sessions by phone or video-chat. Each mode has its particular clinical rewards and challenges. In these times, how does a psychotherapist decide which mode to use, how does remote treatment differ from in-office, and how can we best utilize telehealth to treat our patients?

Once COVID-19 ramped up, one long-term patient of mine, Alex, an engineer in his 30s, requested video rather than phone. Boundaries have always been a theme in our therapeutic relationship. His interpersonal boundaries – in life and in therapy – have often been too diffuse. Alex has always wanted us to be friends, or at least friendly; hates the idea that he is paying me for therapy; and has persistently expressed a need to know about my personal life. Alex has grown through treatment, partly because I have always been warm yet firm in holding boundaries and discovering along with Alex what my limits raise for him – usually shame or self-denigration. For the most part, my minor countertransference has been a useful clue for how Alex gets stuck in the world, invading and pushing away the people he wants so desperately to connect with. When Alex chose video over phone sessions, I found my countertransference increasing: I felt a little invaded, even crept out. Did he

My close friend, Paula, a brilliant, seasoned therapist in Vermont told me that 99% of her COVID-era clients choose phone versus video, though she offers both. “I’m delighted to be on the phone versus on video. Video can feel too close for comfort.”

consciously or unconsciously want to meet via video rather than phone so he could get a glimpse of my home office (where I do not see patients) in the background? And maybe he also wanted to show me – for me to get a glimpse of his home in the background. Remaining aware of my extra dose of protectiveness when using video-chat helped me address more directly Alex’s interpersonal pattern. We made some good progress that first video session!

That’s in contrast to my video sessions with a teenager, a sweet kid, who I have been seeing for years. When he Zoomed from his den, I felt I’d gotten to know him in a deeper way. When I told him so, he gave me a minor virtual tour of the den. Suddenly I had a better picture of his life – both its challenges and strengths.

One psychiatrist colleague of mine now offers both phone and video sessions. He generally finds the phone can be very connective. However, with one teen, Stella, he found video essential and reassuring both for himself and his patient. “This teenage patient has a history of marked distress and some suicidal ideation. I found I relaxed in a new way when I could see her in her own home, sitting on her couch stroking her cat as we talked. I also think, for this patient, seeing my face was important. Sometimes words are harder for teens. Stella is quite verbal, but fairly factual and no-nonsense in her speech. I get much more from “being” – even virtually in the room with her. We really needed the visual

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and non-verbal format to make the session connective.”

Another clinician I spoke with, a Philadelphia psychiatrist in private practice, who also supervises psychiatry residents at a local teaching hospital now offers the option of phone or video to her patients. “My residents feel very comfortable doing video supervision sessions with me. They’re mostly younger, and video chat is a medium they’re used to, and they prefer it to phone.” But phone-video choice varies depending on the patient. “With one teenage patient, Ella, once COVID hit, I figured she would quickly choose video chat versus phone, being Gen-Z-comfortable with FaceTime. But when I suggested video-chat, Ella replied ‘Yuck! No way,’ explaining that phone would be okay, but FaceTime is something she does with her boyfriend, at all hours of the night, almost like pillow talk. Ironically, for this Gen-Xer, video-chat would have been more – too – intimate than phone, or even meeting in person. If we couldn’t meet in person (because of the virus pandemic), phone was safer for her than video.”

My close friend, Paula, a brilliant, seasoned therapist in Vermont told me that 99% of her COVID-era clients choose phone versus video, though she offers both. “I’m delighted to be on the phone versus on video. Video can feel too close for comfort. Our heads are just giant, as if we were sitting three feet apart. That close would feel weird in the office, and it’s weird via video as well.” Paula also admitted, a bit sheepishly, that she sometimes conducts phone sessions from her own bedroom, either in bed propped up with pillows, or meandering around the room. “I make the bed and it becomes a formal, yet comfortable, workspace. Also, it’s a great relief to be able to stretch my legs and wander during sessions. I think it helps me be more present. Until I tried the walking, I hadn’t realized just how uncomfortable, even distracted, I sometimes felt, stuck in the therapist’s chair all these years. It’s really liberating.”

One of Paula’s long-standing clients,



40-year-old Susan, had a powerful discomfort at being seen – by anyone, including her therapist. In session and out, Susan always felt exposed, like she had to perform. Before COVID, Paula had offered Susan the option of lying on the couch, rather than sitting face-to-face, so that Paula’s gaze would not feel so intrusive and judging. But Susan had not felt comfortable trying the couch. It wasn’t until COVID phone sessions that Susan felt the distance that Paula had hoped the couch would bring. The phone allowed Susan to be much more emotionally present during the session. Susan was able to address “feeling hideous” more directly, and for the first time she shed some liberating tears. The next week, Paula and Susan tried a video session. But Susan had a hard time seeing her own face on the computer screen, and again felt judged about her appearance. Even though Susan could turn off seeing herself on screen, Paula and Susan agreed to return to phone for the next session, to good result. My colleague Dr. Dan Livney, a psychologist in private practice outside Philadelphia, says he really misses in-person meetings. “Most of my patients say video or phone is OK, but not great. I feel the same way.” However, one of Dan’s patients, Sam, a shy,

accommodating computer analyst in his 30’s who thinks everything in life is “fine, I guess,” is already uncomfortable with in-person meetings. “When we were meeting in my office, I had the feeling I was chasing him, trying to find him in his hide-away world. He was “remote” even in my office. As with all patients, sometimes my mind wanders a bit. I have to really focus in order to be present with Sam – in the office, and maybe more so via video. But, somehow, video is the right amount of distance for him, and he is more able to explore what he might want to change in his life – instead of insisting everything is “fine.” Phone and video-chat each have their particular clinical rewards and challenges. The best choice seems to vary depending on particular patient-therapist combinations. Surely, there is no replacement for seeing a family in the flesh in my office. The interpersonal texture, the vibe is so much richer in person. Still, given the current demand for tele-health, let’s utilize the unintended opportunity that COVID provides. Dr. Stern is a clinical psychologist in private practice, specializing in Attachment-Based, Emotion-Focused care for children, teens, young adults, and families. **Dr**

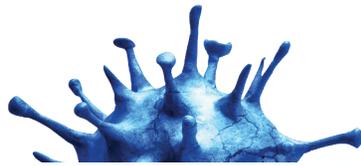


SHOULD I DISCLOSE MY COVID-19 STATUS?

The Experience of One Psychologist

AVIVA GASKILL, PH.D.

BRETT SCHUR, PH.D.



Aviva Gaskill, Ph.D. is a psychologist in private practice in Wynnewood, PA. She is a member of PPA and is active on the PPA Membership Committee. She has also presented at past PPA Conventions. Dr. Gaskill is interviewed by Brett Schur, Ph.D.

Dr. Gaskill attended the American Group Psychotherapy Association Meeting in New York City March 2-7, 2020, just as the COVID-19 outbreak was hitting the city. She became symptomatic after returning from New York. In this article, Dr. Gaskill talks about the decisions she made around issues of patient care and disclosure as she became aware that she had become infected.

Brett: Thank you for talking with us today about your experiences around COVID-19, patient care, and disclosure. You told me that you first noticed cold-like symptoms while you were still in New York. What were your symptoms at that time?

Aviva: On March 7th, I began to feel a bit run down. I had also attended a very busy conference beginning on March 2nd along with seeing friends and family in New York City that week.

Brett: After you returned from New York, you had some patient appointments scheduled. What did that first few days look like for you?

Aviva: I spent Sunday, March 8th with my family and on Mondays, I typically work from home managing paperwork for my business and issues in my household. Seeing that I began

to have some cold symptoms that day, I contacted my patients that I was scheduled to see the next day (Tuesday) and asked if anyone would prefer to be seen via telehealth as APA was beginning to encourage us to hold online sessions. I also offered in-office sessions to those patients who preferred it. I already used telehealth regularly within my practice for a couple of patients prior to the COVID outbreak. One patient requested the telehealth session on that last day I spent in my office, a few patients cancelled their appointments with me, and three patients requested to be seen face-to-face in my office. I honored these requests. On Tuesday, I began coughing a bit while I was in my office. I called the doctor on Wednesday and asked whether I should be seen. I was told to go to the emergency room only if I had a fever, which I never developed and otherwise to continue to monitor my symptoms, which I did.

Brett: When did you stop seeing patients?

Aviva: The very next day (Wednesday), after a conversation with my spouse, I realized it would be best for me to cancel in-person sessions with clients to rest and recuperate, but continued to assume my symptoms did not indicate COVID-19. I have asthma and allergies so it's not unusual for me to catch colds at this time of year. I saw no patients that Wednesday and saw a few patients online on Thursday while continuing to rest for much of the day. I did not return to the office to see patients in-person.

Brett: What did you tell your patients at that time?

Aviva: I told my patients I believed that I had a cold in combination with my allergies.

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Brett: Did you know that you had COVID-19 yet?

Aviva: I was not diagnosed with COVID-19 until Wednesday, March 25, almost 20 days after the onset of my initial symptoms.

Brett: Are you open to telling us about the course of your illness?

Aviva: Sure. I began feeling “run down” on March 7th, noticed myself coughing a bit on March 10th as I was in my office seeing patients. When I got home from work that night, I noticed that my eyes were pretty red. Over the course of the next couple of days, my throat became very sore, I got very thirsty, drinking tons of water and I wondered if I had strep throat. I had chills on and off for a few days but never developed a fever. I began to feel more energetic for about three days about a week after the onset of my symptoms. But then suddenly, began to feel chills again one night and extremely exhausted for the next 4-5 days. I was sleeping 14-15 hours per night and during the day, found myself barely able to get off the couch. The fatigue, though less than initially, lasted days and days. I also completely lost my sense of smell and taste for about a week during the time of the most severe fatigue. Only on about the last day of my having lost my sense of smell/taste did it become widely disseminated information here in the U.S. that loss of taste/sense of smell was a common COVID-19 symptom. As an asthmatic, I was continuing to cough productively and found it difficult to take deep breaths. I have inhalers and allergy medication, including a nebulizer, at home and used those. I woke up in the night coughing and spoke with my doctor who believed that I developed bronchitis secondary to the COVID-19. I have since been prescribed a course of antibiotics. I also developed laryngitis and was barely able to speak for a few days.

Brett: Were there patients in your practice who were potentially exposed to COVID-19 in your office?

Aviva: Yes. The three patients I saw in my office prior to self-quarantining were likely exposed to my illness, though I was unaware of this at the time as there was less information available regarding COVID-19 symptoms. With that said, I have moved through and with a lot of feelings of shame and guilt about these possible exposures.

Brett: You told me that you had a prior experience of disclosing personal news to patients. Can you tell us about that experience?

Aviva: Sure. I have given birth to two children during my time working as a psychologist. I have had the experience of disclosing both pregnancies to patients. In some ways that has been helpful, yet it's also felt very different. I've noticed some similar and some quite distinct feelings emerging from disclosing my COVID-19 diagnosis to my clients.

Brett: How did that prior experience influence the choices you made about disclosing your COVID-19 status?

Aviva: With my pregnancies, I remember taking time to consider my own feelings and even some real discomfort. In disclosing my COVID-19 diagnosis to patients, I did not have as much time to consider how I would disclose due to the nature of the illness and its ability to spread widely and rapidly. I needed to act quickly but I still had a few opportunities to reflect on this disclosure. I am ever grateful to my colleagues with whom I have weekly peer consultation. They sat with me and helped me process and consider these discussions.

Brett: At what point did you tell patients who had potentially been exposed in your office about your diagnosis?

Aviva: It took a full week and a day to receive a confirmed diagnosis of COVID-19 from my healthcare network. I informed two patients during telehealth sessions that I was being tested and possibly had unknowingly exposed them. I did not inform the third patient whom I may have exposed until a few days after I received my confirmed COVID-19 diagnosis. At that point, having laryngitis, I was unable to speak over the phone and I do not have an email address for this patient as her preferred form of communication is phone. This is also information better shared in a conversation, I believe.

I also rent an office suite along with two colleagues over the age of 65 and felt it necessary to disclose my illness to them.

Brett: What did you tell them?

Aviva: First, I should mention that I am a health psychologist and a Medicare provider. I see many adults over the age of 65 and many individuals who are chronically ill. I had a strong sense of duty to disclose my illness status to them.

In one of my sessions, the fact that I had had a cough came up early in the session and I informed my patient that I had been tested for COVID-19. I informed another patient that I had been tested closer to the end of the session with enough time to discuss and process his concerns. I disclosed my diagnosis to the third patient over the phone after I had been diagnosed. I informed her after she asked how I was doing, as I hadn't seen/spoken to her for a couple of weeks due to a scheduled vacation she'd had. I think that was my most challenging discussion and to be frank, I was a bit anxious disclosing this news to her.

Brett: How did these patients react to your news?

Aviva: I have worked with each of these three patients for over a year, so these are long-term clinical relationships. The two patients to whom I disclosed before my diagnosis were both



very understanding. They reminded me that it wasn't my fault and were mostly just concerned for me. It was actually a nice moment to share with them.

When I disclosed my illness to the third patient over the phone, I could hear anxiety coming into her voice. She also asked for my advice on handling the situation. I informed her that she should contact her physician right away and inform them she'd had contact with someone who had tested positive. She also asked if I thought she should inform family members with whom she'd had contact with after her contact with me. I told her that that was her decision and it was probably a good idea, but to find out her physician's opinion before deciding. She expressed concerns about "getting blamed" or being viewed as "bad" for potentially exposing others. She seemed like she needed to get off the phone to process this information and I told her I would check in with her in the next few days. I spoke with her again the following day and while she was still processing, she seemed more at ease with the news, even joking a little and remarked that it felt good to laugh together. In that second phone call, she asked me a little about the course of my illness and we discussed some positive coping mechanisms she might employ. While frightening, again, it felt like an important shared moment in the therapeutic relationship. I'll most certainly continue to process this with her.

Brett: What did you feel before you made the disclosures?

Aviva: Antsy, scared, guilty, ashamed, uncomfortable, and a little like a kid who says, "I don't wanna do it." But I've also begun to feel brave and a bit like I can be strong, a container for my patients' anxiety, grief, and helplessness during the difficult time because I've come out on the other end.

Brett: What did you feel after you made the disclosures?

Aviva: Afterwards, I certainly felt somewhat relieved to have disclosed and helped them unpack their feelings. But I continue to have some sense of guilt and concern for my patients.

Brett: Did you disclose your COVID-19 status to any other patients?

Aviva: I actually did end up disclosing to three other telehealth patients. I told two patients because they asked me about coughing, and I don't like to lie to my patients. I informed an additional patient because it seemed clinically relevant given some of her concerns that she was expressing during the pandemic.

Brett: What did you tell them?

Aviva: I informed that them I had tested positive and that I was doing significantly better.

Brett: How did they react?

Aviva: One of them seemed very unsurprised and showed minimal reaction. The other two seemed quite surprised and caring.

Brett: Have you returned to work? How have your patients reacted to your absence?

Aviva: I have been seeing patients online via telehealth exclusively and have not returned to my office. Patients reacted well to my absence, which was minimal in time. There was so much information and confusion between work, my children's school and from the local, state and federal governments within the second and third week of March that I think they didn't seem to notice my absence too much. Though I believe they've all been quite relieved to discuss the concerns that they've been coping with, whether they have been COVID related or not.

Brett: Is there anything you wish you had done differently?

Aviva: I wish I had not gone into the office to see those three patients, but I genuinely did not know I was positive with COVID at that time. That's my deepest regret.

Brett: What lessons would you offer to other clinicians from your experience?

Aviva: I would encourage other clinicians to be mindful in considering self-disclosure about relevant issues. Sometimes, it's not helpful and even harming to self-disclose about some issues. But sometimes self-disclosure can be a real gift in terms of the work we do and can allow for increased depth and connection in the therapeutic relationship.

Brett: Is there anything you would like to say about the experience of doing this interview?

Aviva: I'm grateful for the opportunity but am still somewhat conflicted about disclosing this information so publicly. All of my colleagues and I hope most people would be supportive of my disclosure, but I fear that some colleagues may misconstrue what I did. If I can help one person by disclosing, even in a tiny way, then it's worth it.

I also want to wish everyone health and safety during this time. This truly is an opportunity for us to step in and aid the public in various ways by using our expertise. I hope we can step forward together and take that role.

Brett: Thank you, Dr. Gaskill for your willingness to talk frankly about these experiences. In all likelihood, a number of your colleagues will have similar experiences. We hope that they can learn from your experience and incorporate these lessons into their own decision-making. 

CE QUESTIONS FOR THIS ISSUE

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

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

Introduction to Special Issue on Coronavirus and Telehealth in Pennsylvania

1. The change to telehealth services has been difficult because

- Decisions about which telehealth platform to use often had to be made quickly
- Patients did not always want to migrate to telehealth service
- Different insurance companies often differed in the telehealth benefits that they offered and even differed on the benefits they offered their own beneficiaries
- All the above

Frequently Asked Questions about Telehealth in Pennsylvania

2. The Pennsylvania State Board of Psychology requires psychologists to follow the APA Guidelines of telehealth.

- TRUE
FALSE

3. The authors encourage psychologists to check the benefits of every patient with commercial insurance to determine if they have the benefit of telehealth services.

- TRUE
FALSE

4. Because of the pandemic, the Pennsylvania State Board of Psychology will

- Require that all continuing education must be done through home studies
- Lift restrictions on the amount of distant learning that psychologists can count toward their continuing education requirements
- Not change the standards for continuing education
- None of the above

5. As a result of the pandemic

- All states have lifted their out-of-state practice restrictions
- No states have lifted their out-of-state practice restrictions
- Many states are lifting or modifying their out-of-state practice restrictions, although the nature of the change varies across the states
- None of the above

Confidentiality and Coronavirus in Pennsylvania

6. When state laws conflict with the HIPAA Privacy Rule, the law that prevails is:

- The HIPAA Privacy Rule
- The state laws
- The law that protects patient privacy the most, from the standpoint of the patient
- None of the above

7. **The author claims that the *Emerich* decision in Pennsylvania applies to**
- a. Patients with infectious diseases
 - b. Patients who threaten physical harm against an identifiable third party
 - c. Patients who either carry infectious diseases or threatened physical harm against an identifiable third party
 - d. None of the above

9. **Asian-Americans have experienced racist comments related to the Coronavirus pandemic.**
- TRUE
FALSE

COVID-19: Anticipating the Next Phase

8. **Brooke et al. found that persons under quarantine or isolation conditions**
- a. Did remarkably well in their mental health
 - b. Did well if they were in quarantine, but poorly if they were in isolation
 - c. Had poor mental health outcomes
 - d. Felt no stigma from being in quarantine or isolation

The Psychological Trauma of Coronavirus (COVID-19)

10. **People may respond to fear of COVID-19 through**
- a. Hypervigilance
 - b. Thought distortions
 - c. Mood changes
 - d. All of the above



CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, April 2020

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

- | | | | | | | | | | | | | | | |
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| 4 . | a | b | c | d | 8 . | a | b | c | d | | | | | |

Satisfaction Rating

Overall, I found this issue of the Pennsylvania Psychologist:

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

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Calendar

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Talking about Suicide: The Patient's Experience and the Therapist's Experience
Webinar
12:00 – 1:00 pm

APRIL 16, 2020

Overcoming the Challenges of Counseling Children & Teens Online
Webinar
12:00 – 1:00 pm

MAY 18, 2020

Pennsylvania Child Abuse Recognition and Reporting
Webinar
11:00 am – 1:00 pm

OCTOBER 16, 2020

Fall Continuing Education Conference
Normandy Farm Hotel and Conference Center
Blue Bell, PA

NOVEMBER 6, 2020

Fall Continuing Education Conference
Hotel Monaco
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Still have questions about telpsyhology?
Check out PPA's available webinars:

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- Introduction to Telepsychology:** Part 3
- Telepsychology Q&A**

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Act 74 CE Programs

- The Essentials of Screening and Assessing for Suicide among Older Adults*—1 CE
- Assessment, Management, and Treatment of Suicidal Patients (Extended)*—3 CEs
- Essential Competencies When Working with Suicidal Patients*—1 CE

Act 31 CE Programs

- Pennsylvania Child Abuse Recognition and Reporting*—3 CE Version
- Pennsylvania Child Abuse Recognition and Reporting*—2 CE Version

General

- Telepsychology Q&A (Webinar)*—1 CE
- Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)*—1 CE each
- Introduction to Ethical Decision Making**—3 CEs
- Ethics and Self-Reflection**—3 CEs
- The New Confidentiality 2018**—3 CEs

***This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

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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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