SOCIOCULTURAL: CULTURE/DIVERSITY

- Sue & Sue racial identity stages: features of a person in each stage
- JW Berry model of acculturation
- Culturally encapsulated vs culturally humble therapist stance
- Basic terms: implicit bias, privilege, stereotype, microaggression
- Culturally specific communication differences: high/low context, high/low structure, formal/informal
- Importance of acculturation assessment & culturally tailored treatment for appropriate groups
- Cultural mediation of child development: Vygotsky model of culture mediating language/cognitive development
- Differential risk of health conditions, including suicide in various ethnicities

Sue & Sue Racial Identity Stages

Conformity:	Accepting and preferring the dominant culture's values, potentially devaluing one's own racial identity (leave the old to conform to the new)
Dissonance & Appreciating:	Beginning to question dominant culture beliefs, recognizing racism, and developing a greater understanding of one's own culture (questioning the new, and appreciating the old)
Resistance & Immersion:	Embracing one's own racial heritage, rejecting dominant culture values, and potentially feeling anger towards the dominant group (resistance to the new and emersion to the old)
Internalization:	Also called Integrative Awareness. Integrating a positive sense of racial identity while recognizing and appreciating other cultures (internalize & value both)

Also known as the **Minority Identity Development Model**

JW Berry Model of Acculturation

Assimilation:	When individuals do not maintain their cultural identity and seek regular interaction with other cultures (e.g., changes in language preference; adoption of dominant attitudes and values)
Separation:	When individuals place value on their original culture and wish to avoid interaction with people from other cultures (e.g., not dating outside the race)
Integration	When people maintain their original cultural identity while also interacting with people from other cultures (e.g., speak english at work/ school and Spanish at home)
Marginalization:	When people do not maintain their cultural identity and do not seek interaction with people from other cultures

Those who remain the **marginalization** stage tend to not do as well (Social perspective)

Culturally Encapsulated vs Culturally Humble

therapist stance

Basic terms:

Implicit bias:	Subtle, often unconscious, prejudices influence individuals' judgements towards members of different social groups
Privilege:	An unearned advantage granted based on group membership
Stereotype	A stereotype is an oversimplified and often inaccurate belief or assumption about a group of people. Stereotypes can be harmful and lead to discrimination and prejudice

Basic terms: (cont)

Microaggression:	Everyday subtle interactions or behaviors that communicate bias toward historically marginalized groups. (e.g., a faculty member of color being mistaken for a service person or being forced to choose male or female when completing basic forms)

Culturally Specific Communication Differences

high/low context

high/low structure,

formal/informal

Cultural Assessment

Importance of acculturation assessment & culturally tailored treatment for appropriate groups

Cultural mediation of child development

Vygotsky's Sociocultural Theory

Believed cognitive development is influenced by cultural and social factors.

He emphasized the role of social interaction in the development of mental abilities (e.g., speech and reasoning in children).

Srongly believed that community plays a central role in the process of “making meaning.”

Risk in Ethnicities

Differential risk of health conditions, including suicide in various ethnicities

Cognitive/Affective Basis of Behavior

Learning: Classical/Respondent Conditioning

Conditioned Response (CR):	A learned response
Unconditioned Response (UR):	A unlearned response (e.g., **reacting** to loud noises, pain, cold, smells, food)
Conditioned Stimulus (CS):	A neural stimulus paired with the **US** that leads to a **CR**

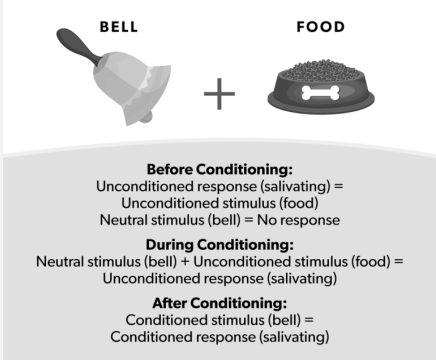
Learning: Classical/Respondent Conditioning (cont)

Unconditioned Stimulus (US):	A stimulus that automatically triggers a response **(UR)** without prior learning (e.g., loud noises, pain, cold, smells, food)
Neutral Stimulus(NS):	A stimulus before conditioning. Will become a **CS** after conditioning

Example: An **US** naturally triggers an **UR,** while a **CS**, after being paired with the **US,** elicits a **CR**

The smell of food (US) naturally makes you hungry (UR), but after pairing a bell with the food, the bell alone (CS) can make you hungry (CR).

Example



Habituation

The **unconditioned stimulus (US)** no longer elicits the **unconditioned response (UR)**

e.g., a person who moves to a home near a train track eventually becomes accustomed to the noise of passing trains *(unconditioned stimulus).* After a few weeks, they no longer startle or wake up *(unconditioned response)* when the trains pass by.

Habituation always involves the *unconditioned stimulus,* not the *conditioned stimulus*

Counterconditioning & Exposure to Fear

Counterconditioning:	Weakening the maladaptive conditioned response (e.g., fear) by strengthening an incapable or antagonistic response (e.g., relaxation)

Counterconditioning & Exposure to Fear (cont)

Example Afraid of Dogs:	**Old response:** "Fear when they see a dog." **Intervention:** Person it taught to pet a calm dog while simultaneously practicing relaxation techniques. **New Response:** Over time, they associate dogs' relaxation and calm rather than fear
reciprocal inhibition:	Based off this principle that two incompatible responses cannot be experienced at the same time, but rather, the stronger response will inhibit the weaker (e.g., fear will inhibit pleasure)
Interventions:	Systematic desensitization; Sensate focus; Assertiveness training; and Aversive counterconditioning

Systematic Desensitization & Exposure to Fear

Systematic Desensitization:	gradual hierarchy of graded exposure from easy to hard over time. Usually paired with relaxation/safety (hence a form of counterconditioning)
Used for:	Simple phobias
Research:	The research emphasized that prolonged and intense exposure treatments are more efficacious for specific phobias.
Scenario:	Imagine you're scared of something, like a big dog. Instead of just jumping right into it, you take tiny steps to get used to it without feeling scared.
First:	You learn how to calm down and feel relaxed, like taking deep breaths
Then:	You start with something small, like looking at a picture of a dog
Next:	You might watch a video of a dog

Systematic Desensitization & Exposure to Fear (cont)

After that:	You might stand near a dog, but not touch it yet
Finally:	You get brave enough to pet a dog, but only when you're feeling calm and relaxed

Classical Extinction & Exposure to Fear

Classical Extinction:	A behavioral process that occurs when a conditioned response to a stimulus gradually weakens or disappears
Example:	If a dog is conditioned to salivate at the sound of a bell, but the bell is rung repeatedly without food, the salivation response will eventually diminish
habituation:	A learning process where an organism gradually reduces their response to a repeated stimulus or situation that is not harmful or dangerous
Interventions:	In Vivo Exposure or Exposure with Response Prevention (ERP); Exposure in imagination

Exposure with Response Prevention (ERP)

ERP (in-vivo exposure):	Exposure to various feared stimuli, **gradual or intense**, with active prevention of client's usual anxiety mitigating behavior
Used for:	OCD (excessive hand washing), specific phobias, and PTSD
Gradual Exposure:	Start with less distressing situations and gradually progress to more challenging ones.

Exposure with Response Prevention (ERP) (cont)

Example:	A person with OCD who fears contamination might be exposed to something they believe is dirty (like touching a doorknob), but instead of immediately washing their hands (the compulsion), they are encouraged to wait and experience the anxiety without performing the ritual.
Response Prevention:	Prevent individuals from engaging in their usual compulsive behaviors or rituals while they are exposed to the feared situation.
Example:	Client with dirt/germ phobia must dip hands in mud and sit with dirty hands with therapist until nervous system calms down. Therapist usually actively reframes extreme thinking and overlooking of positive or mastery aspects to balance experience.
Habituation:	Allow anxiety to decrease over time through repeated exposure and response prevention.
Flooding:	**Intense** exposure to the worst aspect of fear. Goal is to take a *habituation effect*.
Used for:	Specific phobias. *Strong evidence for post-rape for clients who choose this*.
CBT:	Anxious thoughts are often extreme, black-and-white, and catastrophic. Therapists help reframe them, assess pros/cons, reality-test, or use experiments to challenge fears. This is especially useful for GAD, where varied triggers make desensitization impractical.

How & When to Apply Counter-Conditioning

Reciprocal Conditioning/ Reciprocal Inhibition-Based:	pairs a competing positive experience *(safety, mastery, pleasure)* with anxiety to offset anxiety's negative impact *(sensate focus, assertiveness training, systematic desensitization)*
Aversive Conditioning (Classical Extinction):	pairs an unpleasant experience *(mild-strong electric shock, gross imagery, nausea)* with a high reward, undesirable behavior, which is hard to stop

Examples of Aversive Conditioning

alcohol misuse/ Antabuse -> nausea

binge eating/ disgusting imagery of maggots on it -> icky food, loss of appetite

erection with images of children/ electric shock-> sexual focus on child less appealing & exciting

Extinction Paradigm for Classical Conditioning

Extinction paradigm:	Refers to the process of reducing or eliminating a learned behavior by **withholding the reinforcing consequences** that previously maintained it
Example- Think of Pavlov's dog:	If the *bell* **(CS)** is rung repeatedly, but *without food* **(US)** following, the dogs will eventually *stop salivating* **(CR)** to the bell

Schedules of Reinforcement

Fixed--Ratio (FR):	Reinforcement delivered after varying amounts of time
Examples:	A factory worker gets paid for every 10 items they manufacture; A child gets a sticker for every 5 pages read

Schedules of Reinforcement (cont)

Variable--Ratio (VR):	Reinforcement delivered after an unpredictable number of responses
Examples:	*Slot machines:* wins occur unpredictably after a varying number of spins; *Fishing:* catching a fish is unpredictable and depends on the number of attempts
Fixed-Interval (FI):	Reinforcement delivered after an unpredictable number of responses
Examples:	A student is rewarded for completing a task after a set amount of time (every 20 mins); Receiving a paycheck every two weeks
Variable--Interval (VI):	Reinforcement delivered after varying amounts of time
Examples:	Random social media notifications; Checking for email, as the times that new emails come are unpredictable
Rates of responding (highest to lowest) -> variable ratio (VR), fixed ratio (FR), variable interval (VI), then fixed interval (FI)	
Ratio Schedules:	Based on the **number of times** a behavior occurs. The more the behavior happens, the more reinforcement is possible. ***Higher rates in responding***
Interval Schedules:	Based on **time passing,** reinforcement only becomes available after a set period, and the behavior only needs to happen once after that time
Variable Reinforcement:	***Higher rates in responding*** because the reinforcement is unpredictable
Fixed Reinforcement:	Lower rate in responding because it's more predictable

Patterns of responding

Schedules of Reinforcement (cont)

Fixed Schedules	Result in pauses after reinforcement. result in more steady response rates. When graphed, this pattern is smooth. Fixed interval (FI) schedule results in the longest pauses after reinforcement
Variable Schedules	Result in more steady response rates. When graphed, this pattern is smooth.

Reinforcement: *Fixed* = Predictable; *Variable*= Unpredictable
Schedules: *Ratio* = number of times; *Interval* = passage of time

TIP: Schedules of Reinforcement

To help remember the order of the schedules, keep in mind first that linking reinforcement to the actual behavior (i.e., ratio) is stronger than linking it to the passage of time (i.e., interval). Next, remember unpredictability (variable) keeps the subject guessing and trying harder than predictability (fixed).

Primary vs Secondary Reinforcers

Primary Reinforcer:	Stimuli that are inherently reinforcing, meaning they satisfy a basic biological need without any prior learning or association *(e.g., food, water, sleep, shelter, safety, pleasure, sleep & sex)*
Secondary Reinforcers (also called Conditioned Reinforcers):	Stimuli that become reinforcing through association with primary reinforcers or other secondary reinforcers *(e.g., money, grades, tokens, praise)*
What is the difference?	A secondary reinforcer is a stimulus reinforcing after being paired with a primary reinforcer, such as praise, treats, or money. Responding to the secondary reinforcer is a learned behavior, not a born reflex

Positive/Negative Reinforcement/Punishment

Positive Reinforcement:	Involves **adding** something positive or desirable to increase the likelihood of a specific behavior occurring again
Example	Giving a dog a treat after they sit on command is positive reinforcement
Negative Reinforcement:	Involves **removing** something aversive or undesirable to increase the likelihood of a specific behavior occurring again
Example	Taking away chores for a child if they clean their room is negative reinforcement
Positive Punishment:	Involves **introducing** an unpleasant stimulus or consequence after an unwanted behavior occurs
Example	A parent gives a child extra chores as punishment for poor grades
Negative Punishment:	Involves **removing** something desirable after an undesirable behavior.
Example	A parent takes away a child's phone for not doing their homework

Positive = add stimulus
Negative = remove stimulus
Reinforcement = increase / maintains behavior
Punishment = decrease behavior

Differential Reinforcement of Other Behaviors

DRO:	Combines extinction of one behavior and reinforcement of another behavior to shift a habit
Example	Reinforce taking time to meditate or exercise to lower anxiety while extinguishing use of sedative medication
Withhold reinforcement for challenging behavior:	e.g., A hyperactive child is ignored *(withholding reinforcement)* when she speaks out of turn *(extinction)*

Differential Reinforcement of Other Behaviors (cont)

Providing reinforcement for an appropriate replacement behavior:	e.g., Reinforcing (providing reinforcement) when she waits for her turn to speak, is engaged in on-task behavior, raises her hand to ask questions, or remains seated

Also known as ***DRI*** *(differential reinforcement of incompatible responses)* or ***DRA*** *(differential reinforcement of alternative responses)*

Operant Extinction Paradigm

Operant Extinction Paradigm:	When reinforcement is first removed, there may be an intense upsurge in the problem behavior - it's necessary to hang in there and ignore that to avoid giving in with an **intermittent reinforcement**

Operant Extinction Paradigm: (Remove Reinforcement)

Extinction Burst

Extinction Burst:	An increase of behavior that occurs when a behavior that has been reinforced in the past is no longer reinforced
Example:	A child who typically cries to get attention may start crying more intensely or for longer periods when attention is no longer given
Example:	A person who has been reinforced for a particular behavior (like asking for something repeatedly) might increase their requests when the reinforcement is no longer provided

Latent Learning (Tolman)

Latent Learning: *(also known as incidental learning)*	The subconscious retention of information or skills without reinforcement or immediate behavioral change

Latent Learning (Tolman) (cont)

e.g., Tolman conducted experiments with rats in mazes. Rats that explored the maze without any rewards still formed cognitive maps of the maze. When a reward was later introduced, these rats navigated the maze more efficiently than those without prior exposure, demonstrating latent learning.

Zeigarnik Effect

Tendency to remember unfinished or interrupted tasks better than completed ones

This phenomenon occurs because incomplete tasks create a state of mental tension, which keeps them active in our memory until they are completed

e.g., Students who interrupt their study sessions to perform unrelated activities may remember the material better than those who finish study sessions without breaks.

Impact of Sleep on Learning & Memory

Sleep is the time where we consolidate the things we learned

Development Across the Lifespan

Genetic Disorders

Genetic Disorder	Cause	Impact
Down's Syndrome	Extra Chromosome 21 (3 vs 2)	Intellectual disability, physical defects, hearing loss, immune & cardiac systems weak
Tay Sachs Disease	Can't metabolize fats due to missing enzyme, hexosamin-idase-A	To avoid neural damage, must avoid foods with high fat
Phenyl-ketonuria (PKU)	Can't metabolize phenyl-alanine due to enzyme deficiency	Intellectual disability, other neurological problems. Must avoid hi protein foods with PA
Sickle Cell Disease	Red blood cells sickle shaped, get stuck in capillaries	No oxygen to tissue, resulting pain hard to handle
Cystic Fibrosis	Recessive - 25% chance when 2 carriers conceive: Aa+Bb-> ab, gene shows symptoms	Thick, sticky mucous clogging lungs/gut, infections destroy lung tissue, shortens life
Klinef-elter's Syndrome	Males with an extra X chromosome (XXY)	physical, psychological, and develo-pmental symptoms, including infertility, reduced muscle mass, increased height, and learning difficulties. Abnormal development of secondary sex characteristics (breast develo-pment, small testicles, high-pitched voice.)

Genetic Disorders (cont)

Turner Syndrome	Females with the absence or partial absence of one X chromosome	physical and developmental issues, such as short stature, underdeveloped sex organs, infertility, heart and kidney problems, and learning difficulties. Girls with Turner Syndrome may also have a distinct physical appearance, such as a webbed neck, low hairline at the back of the neck, and drooping eyelids.
Fetal Alcohol Syndrome	Teratogen agents in alcohol	delayed growth, physical deformities, delayed motor development, decreased intelligence, learning disabilities, short attention span, restlessness, irritability, hyperactivity
Intersex Conditions	A group of disorders where sexual development is different than the normal binary of male or female development	

Critical vs Sensitive Periods

Critical Periods	***Limited*** time periods when certain experiences are necessary for the proper development
Impact:	*if the experience is missed, the ability or trait may never develop*
Sensitive Periods	Important and ***flexible*** periods when the brain is more receptive to experiences

Critical vs Sensitive Periods (cont)

Impact:	*can still have a significant impact on development, however catch up is possible*

Object Permanence vs Object Constancy

Object perman-ence:	Birth - 2 y/o	The understanding that an object continues to exist even when it is not seen (10 mos), in **sensorimotor stage**
Object constancy:	2 - 3 y/o	The ability to maintain the image of the mother when she is not present, as well as to unify the good and bad into a whole representation

object permanence: Piaget's stages in cognitive and intellectual development

object constancy: Mahler stages of development

Ainsworth Attachment types

Secure	Are warm responsive. When exposed to the stranger, these infants seek closeness and contact with the mother, may show moderate distress upon separation, and greet the mother with enthusiasm when she returns. It is hypothesized that a parenting style of sensitive and responsive caregiving is associated with secure attachment
Avoidant	Do not seek closeness and contact with the mother, treat the mother like strangers rarely cry when she leaves the room, and ignore her on her return. They may even prefer the stranger over the mother. It is believed that a caregiving style an aloofness and distance, or intrusive-ness, and overstimulation is associated with avoidant attachment

Ainsworth Attachment types (cont)

Ambivalent	Are clingy and become upset when the mother leaves the room. When the mother returns, the babies are happy and reestablish contact, but they show their ambivalence by then resisting the mother's comforting behaviors. They may cry, kick, or squirm to get away. Ambivalent babies do little exploration and appear angry toward both the mother and the stranger
Disorganized:	No clear strategy in dealing with the mother. They may be unresponsive when the mother returns. At times, they may avoid and resist the mother. At other times, they may freeze and stop moving when their mother comes near

Effect of Extreme Neglect

Medical Work Up

Role medical work up to rule out medical/medication issues

Pseudo-dementia vs dementia

Dementia (NCDs)	
symptoms:	Progressive cognitive decline; often **deny** memory issues
	testing:
treatment:	Irreversible deterioration
Pseudo-dementia	Cognitive impairment in older adults due to **depression,** mimicking a neurocognitive disorder (NCD).
symptoms:	Slower processing speed, difficulty with concen¬tration and attention, psychomotor retardation; Patients **acknowledge** memory loss;
	testing:
treatment:	Cognitive function **improves** once depression is treated

Fluid vs Crystallized Intelligence

Crystallized	Semantic memory (facts, vocabulary). **Preserved** with age.
Fluid	Processing speed, problem-solving. **Declines** with age (slower reaction time, fine motor speed, hand-eye coordination).
Healthy Aging	Mental capacity remains intact, but processing slows

Sleep Changes Over the Lifespan

Functions of REM Sleep:	Psychological restoration; **Memory consolidation** & emotional processing; Brain development; Dreaming (often bizarre and illogical)
Newborns:	50%
5-year-olds:	50-25%
Older adults:	18%

REM sleep decreases with age

Freud's Psychosexual Developmental Stages

Age Period	Psychosexual	Main Features
Birth - 1.5 year	Oral	Sucking, chewing, & biting
1.5 - 3 year	Anal	Anus, bladder control
3 - 6 year	Phallic	Genitals, masturbation
6 - Puberty	Latency	Sexual feelings
Puberty - Adult	Genital	Sexual interest

Freud vs. Erikson

	Freud	*Erikson*	
Age	**Psychosexual Stage**	**Psychosocial Crisis**	**Strength**
1st year	Oral	trust vs. mistrust	Hope
1-3	Anal	autonomy vs. guilt	Will
3-5/6	Phallic	industry vs. inferiority	Purpose
5/6-12	Latency	identity vs. role confusion	Competence
12-18	Genital	intimacy vs. isolation	Fidelity
18-35		generatively vs. stagnation	Love
35-60		integrity vs. despair	Care
60+			Wisdom

Piaget Stages of Cognitive Development

Sensorimotor Stage:	Infants experience the world through senses and actions. **Object permanence**, the understanding that an object continues to exist even when it is not seen

Piaget Stages of Cognitive Development (cont)

Preoperational Stage:	Children begin to **use symbols and language** to represent objects and ideas, but their thinking is still primarily **egocentric and concrete.** They struggle with concepts such as **conservation**, which is the idea that the amount of substance remains the same even when its appearance changes
Concrete Operational Stage:	Children begin to think **logically about concrete events** and objects. They can understand **conservation** and begin to grasp concepts such as **reversibility, classification** and **cause-and-effect** relationships
Formal operational	Adolescents and adults are able to **think abstractly** and reason **hypothetically.** They can engage in **complex problem-solving** and can **understand multiple perspectives**

Stage	Age	Goal
Sensorimotor	Birth to 18-24 months	Object permanence
Preoperational	2 to 7 years old	Symbolic thought
Concrete operational	7 to 11 years	Logical thought

Piaget Stages of Cognitive Development (cont)

Formal operational	Adolescence to adulthood	Scientific reasoning

(attention to pre operations vs concert operations as per (conservation/irreversibility; centration, intuitive thinking, accommodation vs assimilation)

Assimilation vs. Accommodation (Piaget)

Schemas:	A way of organizing distinct pieces of knowledge within the human mind. They help us make sense of the past and plan for the future *(e.g., Objects, Abstractions, Concepts, Actions)*
Centration:	The tendency to focus on one aspect of a problem at a time *(e.g., example, a young child will have difficulty seeing his mother in both a mother role and sister role to his aunt. The child cannot process her having two roles.)*
Assimilation:	The process of taking in a new experience and incorporating it into existing cognitive structures or schemas *(e.g., a child may label a horse as a dog because it fits their schema of four-legged animals.)*
Accommodation:	The adjustment of existing schemas to make sense of new information. This process occurs when existing schemas cannot explain new experiences *(e.g., when a child sees a cat for the first time, they may need to create a new schema for cats that is distinct from their existing schema for dogs)*

Assimilation vs. Accommodation (Piaget) (cont)

Assimilation & Accommodation:	Two Processes constantly work together in development of new schemas and the refinement of existing ones. It is essential for cognitive development, as it enables individuals to continuously learn and adapt to their environment

Kohlberg stages of moral development

Stages	Age	Description
Pre-Conventional Stage	4-10	Obedience & punishment orientation *(How can I avoid punishment?)*; Self-interest orientation *(What's in it for me? aiming at a reward)*
Conventional Stage	After 10	Interpersonal accord and conformity *(Social norms, good boy-good girl attitude)*; Authority and social-order maintaining orientation *(Law and order morality)*
Post-Conventional Stage	After 13	Social contract orientation *(Justice and the spirit of the law)*; Universal ethical principles *(Principled conscience)*

Erickson's Stages

Age	Conflict	Resolution	Culmination in Old Age
Infancy (0-1 year)	Basic trust vs. mistrust	Hope	Appreciation of interdependence and relatedness
Early childhood (1-3 years)	Autonomy vs. shame	Will	Acceptance of the cycle of life, from integration to disintegration
Play age (3-6 years)	Initiative vs. guilt	Purpose	Humor; empathy; resilience

Erickson's Stages (cont)

School age (6-12 years)	Industry vs. Inferiority	Competence	Humility; acceptance of the course of one's life and unfulfilled hopes
Adolescence (12-19 years)	Identity vs. Confusion	Fidelity	Sense of complexity of life; merging of sensory, ogical and aesthetic perception
Early adulthood (20-25 years)	Intimacy vs. Isolation	Love	Sense of the complexity of relationships; value of tenderness and loving freely
Adulthood (26-64 years)	Generativity vs. stagnation	Care	Caritas, caring for others, and agape, empathy and concern
Old age (65-death)	Integrity vs. Despair	Wisdom	Existential identity; a sense of integrity strong enough to withstand physical disintegration

Gilligan's Theory of Moral Development

Self-In-Relation Model:	Woman's sense of self is primarily developed and understood through her relationships with others
The relational paradox:	Seeking connection while at the same time keeping important parts of oneself out of connection

Gilligan's Stages of Ethic of Care

Stage	Goal
Pre-conventional	Goal is individual survival
*Transition is from **selfishness** to **responsibility to others***	
Conventional	Self sacrifice is goodness
*Transition is from **goodness** to **truth that she is a person too***	
Post-conventional	Principle of nonviolence: do not hurt others or self

Biological Basis of Behavior

Functions of the Brain Areas

Cerebral Cortex	Involved in many high-level functions, such as reasoning, emotion, thought, memory, language and consciousness
Frontal Lobe:	the largest portion of the brain (about ⅓ of the entire brain) divided into ***prefrontal cortex,*** *premotor area,* and *motor area*
Parietal Lobe:	Primary sensory areas that process somatosensory information, sensations of touch, pain, heat, and propri-oception.
Temporal Lobe:	Auditory processing, memory information retrieval, and involved in emotional behavior. Connected to limbic system (hippocampus, amygdala, etc).
Occipital Lobe:	Visual perception, visual interpretation, and reading
Prefrontal Cortex (PFC)	Integration center for all sensory information and executive functions (decision making, planning, working memory, personality expression, social behavior, speech and language). **Personality center**
Broca's area	Controls the muscles that produce speech and language comprehension
Wernicke's Area	Language compre¬hension = receives auditory signals from the ear and processes them to understand the meaning of spoken words

Functions of the Brain Areas (cont)

Limbic System (Primitive brain)	Regulates emotions (basic survival instincts), influences memories/ learning, and motivation (basic drives)

lobes, main structures/impairments if they get damaged

Divisions of the Brain

Forebrain:	Processes sensory information, helps with reasoning and problem-solving, and regulate autonomic, endocrine, and motor functions
Midbrain:	Helps to regulate movement and process auditory and visual information
Hindbrain:	Helps regulate automatic functions, relay sensory information, and maintain balance and equilibrium

Types of scans used for the brain/purpose of each scan

Circadian Rhythms

Circadian Rhythm:	Natural, internal processes that regulate the timing of physiological functions, such as sleep-wake cycles, hormone release, and body temperature
Suprac-hia-smatic Nucleus (SCN)	A small brain region in the hypothalamus that acts as the body's master biological clock, regulating circadian rhythms like sleep-wake cycles, hormone release, and other physiological functions
Pineal gland	Helps control the circadian cycle of sleep and wakefu-lness by secreting melatonin
How do they interact?	The **SCN** sends messages to the **pineal gland**, which triggers the *release of melatonin at night* and triggers the *release of cortisol* and other hormones to help you *wake up in the morning*

Scans Used for the Brain

Type	Purpose	Uses
MRI	More expensive, detailed images possible with enhanced soft-tissue resolution to pick up more subtle structural issues. **Uses magnetic resonance**	tumors, strokes, dementia, epilepsy, Alzheimers, Parkinson's
CT Scan	Quick, cost-effective images of basic structures, very useful as first-line assessment in emergencies to identify brain issues that need emergent care (brain bleeds, etc). **Uses radio**	blood clots or internal brain injuries
PET Scan	Detailed metabolic picture of brain function. Can give info about low (Alzheimer's, stroke/ blood vessel damaging affecting function) or high (brain tumor or other inflammatory or cancer) related process. **Uses radioactive dye**	Alzheimer's, stroke, tumors, or cancer

Post-Concussion Syndrome/Symptoms

Aftereffects of **Head Trauma**	Can cause memory impairments (post-traumatic **amnesia,** persistent memory deficits), **executive functioning** disturbances, and **personality changes**
Phineas Gage Case (1848):	The most well-known case of frontal lobe dysfunction. His injury led to drastic personality changes, later associated with **"frontotemporal dementia."**

Post-Concussion Syndrome/Symptoms (cont)

Aftereffects of **Concussions**	May result in a short-term loss of consciousness, **anterograde amnesia** (difficulty forming new memories), and **retrograde amnesia** (loss of past memories)
Common symptoms:	Dizziness, headache, fatigue; Difficulty concentrating, memory deficits; Irritability, anxiety, insomnia; Heightened sensitivity to noise and light; Hypochondriacal concerns

Etiology/treatment of Movement Disorders

Definition:	Abnormal repetitive movements
Basal Ganglia:	The reservoir of our over-learned motor patterns, like riding a bike, automatic daily habits, backing out of the driveway, etc.
Hypokinetic:	Slow or reduced movements **(e.g., parkinson's disease, dementia with lewy bodies)**
Hyperkinetic:	Excess or involuntary movements **(e.g., huntington's disease/chorea, tremors, tics/ tourette's syndrome)**
Tourette's Syndrome:	A neurological disorder characterized by repetitive, sudden, and involuntary movements or sounds (tics)
Brain Area:	basal ganglia, frontal lobes and cortex
Comorbidities:	OCD; ADHD; Anxiety, Autism
Parkinson's Disease:	Damage to the **Substantia Nigra, caudate nucleus, and putamen,** the dopamine rich brain areas of the mid -brain where it's essential for movement and mood regulation. Some people can progress to severe depression, difficulty moving with a cue, and progress to psychosis

Etiology/treatment of Movement Disorders (cont)	
Possible Cause:	Bacterial infections (e.g., from foodborne pathogens) may travel via the **Vagus nerve,** leading to inflammation and degeneration
Symptoms:	**Movement difficulties** (tremors, rigidity, slowed initiation); **Depression, psychosis** in severe cases
Prevalence:	Increasing significantly (e.g., Michael J. Fox as a well-known case)
Treatment:	Taking **L Dopa** (a dopamine precursor) to build up missing dopamine can replace some of the lost dopamine, at least temporarily, to slow down progression and ameliorate symptoms. **Music Therapy** may aid *movement* and *mood regulation*; Deep Brain Stimulation (DBS) surgical tx for severe cases; Other psychopharmacology **(Carbidopa; dopamine agonists, enzyme inhibitors; amantadine; Anticholinergics)**
Huntington Chorea:	Degeneration of **basal ganglia** neurons, resulting in uncontrollable, jerky movements (chorieform movements) and speech outbursts, and progressive cognitive decline
Cause:	Genetic disorder causing degeneration of **basal ganglia** neurons
Symptoms:	Choreiform (jerky, **involuntary movements)**; **Speech** outbursts; Progressive **cognitive decline**
Onset:	Typically **40–50 years;** often passed down before symptoms appear
Treatment:	No cure available
(Parkinson's, tics, OCD)	

Delirium	
Delirium:	A disturbance in **attention** and **awareness** (e.g., reduced orientation to the environment). **Cognitive disturbance** (e.g., memory problems, disorientation, language difficulties, visuospatial abilities, or perceptual disturbance)
Features:	Rapid onset and fluctuates (typically worse at night). May involve hallucinations or belligerence requiring meds like Haldol (antipsychotic)
Causes:	Infections (e.g., UTI in elderly), medication reactions, intoxication/ withdrawal, brain chemistry disruption, or toxic exposures
Course:	Only diagnosed when there is evidence that the symptoms have a physiological cause
Treatment:	If the cause is found and removed, it is usually reversible

Aphasias	
Aphasia:	Loss of Speech or Language Comprehension
*Receptive Aphasia **(Wernicke's Aphasia):***	Damage to the **left temporal lobe** *(Wernicke's area)* impairs *language comprehension.* The person may speak in *gibberish* but remain unaware of their incoherence. Temporal lobe damage can also affect *semantic* and *long-term memory*
*Expressive Aphasia **(Broca's Aphasia):***	Damage to the posterior **frontal lobe** *(Broca's area)* affects *speech production.* The person understands language and knows what they want to say but *struggles to verbalize it*, causing frustration

Aphasias (cont)

Conduction Aphasia:	Damage to the neural pathways between the 2 ares. The message does not get through from **Wernicke's area** *(what you want to say)* to **Broca's area** *(actually physically saying it)*
Global Aphasia:	Widespread damage affecting both *comprehension and speech production,* severely impairing *communication*

Damage in all areas interferes with the **ability to repeat verbal phrases**, but for different reasons

Wernicke's Encephalopathy (WE)

Cause:	By thiamine (vitamin B1) deficiency; most commonly associated with **chronic AUD**; Malnutrition; Eating disorders; Hyperemesis gravidarum; Prolonged IV therapy; Gastrointestinal disorders
Symptoms:	Confusion *(mental status changes, disorientation, difficulty concentrating);* Ataxia *(impaired coordination, difficulty walking)*; Ophthalmoplegia *(eye movement abnormalities, nystagmus, double vision)*
Treatment:	Immediate Thiamine Replacement; Address Underlying Cause (e.g., AUD)
When Is It Reversible?	If treated **early** WE is potentially reversible, with improvement in symptoms within *days to weeks.* If **untreated** or chronic, it can progress to **Korsakoff's Syndrome (KS)**, a severe and often irreversible condition characterized by *profound memory loss and confabulation* (fabricated memories)

Wernicke's Encephalopathy (WE) (cont)

Korsakoff's Syndrome:	If WE progresses to Korsakoff's syndrome, the memory and learning deficits may be more persistent and less likely to fully reverse

AUD = alcohol use disorder
Early Treatment is Key

Neurotransmitters Functions & Effect

Neurotransmitter	Behavior or Disease Related
Acetylcholine (ACh)	Learning and memory; **Alzheimer's Disease's** muscle movement in the peripheral nervous system *(+ ACh = spasms. - ACh = paralysis)*
Dopamine (DA)	Motivation; Reward circuits; Motor circuits involved in **Parkinson's disease; Schizophrenia** Dysregulation is involved in **bipolar disorder** (manic episodes) and **depression.**
Norepinephrine (NE)	Arousal; Depression
Serotonin (5HT)	**Depression,** Aggression; **Schizophrenia** behavior
GABA	**Anxiety** disorders, **Epilepsy;** Major **inhibitory neurotransmitter** in the brain
Glutamate	Learning; Major **excitatory neurotransmitter** in the brain
Endogenous Opioids	Pain; Analgesia (inability to feel pain); Reward

KEY TERMS:
Mania: arousal, aggression
ADHD: learning, memory
Addiction: reward

Disorders & Neurotransmitters

Mood Disorders (Depression, Bipolar Disorder, Anxiety)	
Serotonin (5-HT):	Regulates mood, anxiety, and emotional stability. **Low levels** are linked to **depression, anxiety disorders,** and **mania**
Dopamine (DA):	Associated with motivation, reward, and pleasure. Dysregulation is involved in **bipolar disorder** *(manic episodes)* and **depression**
Norepinephrine (NE):	Plays a role in alertness, energy, and stress response. **Low levels** contribute to **depression** and *fatigue,* while **high levels** are linked to **anxiety**

Disorders & Neurotransmitters (cont)

Glutamate (Glu):	The brain's main excitatory neurotransmitter. Imbalances are associated with **bipolar disorder, depression,** and **schizophrenia**
GABA:	The primary inhibitory neurotransmitter, promoting relaxation and reducing excitability. **Low GABA** levels are linked to **anxiety disorders** and **mood instability**
Psychotic Disorders (Schizophrenia)	
Dopamine (DA):	**Excessive dopamine** activity is associated with **positive symptoms** *(hallucinations, delusions)*. **Low dopamine** is linked to **negative symptoms** *(apathy, cognitive deficits)*
Glutamate (Glu):	Dysfunction in glutamate signaling, particularly at *NMDA receptors*, may contribute to **schizophrenia symptoms**
GABA:	Impaired function can contribute to cognitive and sensory processing deficits in **schizophrenia**
Memory and Cognitive Function	
Acetylcholine (ACh):	Essential for learning and memory. Low levels are associated with **Alzheimer's disease** and other **dementias**
Glutamate (Glu):	Crucial for synaptic plasticity and memory formation. Dysregulation is linked to *neurodegenerative disorders* **(Alzheimer's, Parkinson's, ALS, Huntington's, Frontotemporal dementia, ataxias)**
Dopamine (DA):	Supports working memory and executive function. Impairments are observed in **Parkinson's disease** and **schizophrenia**
Sleep Regulation	
Serotonin (5-HT):	Plays a role in sleep onset and regulation of *REM sleep*

Disorders & Neurotransmitters (cont)

GABA:	Promotes relaxation and inhibits wakefulness, essential for deep sleep
Melatonin:	A hormone influenced by serotonin, regulating the sleep-wake cycle
Orexin (Hypocretin):	Promotes wakefulness; deficiencies are linked to **narcolepsy**

Uses & side effects of major psychotropic drugs

(anti-psychotics, anti-depressants, mood stabilizers, stimulants, sedatives)
Examples: Tardive dyskinesia, akathisia, anti-cholinergic effects
Withdrawal effects of drugs & substances
Including substances especially dangerous to withdraw from

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Assessment & Diagnosis

Fluid & Crystallized Intelligence on WAIS

Senior Scores in the WAIS:	Scores on the processing speed index (PSI) **decline** more significantly; Scores on the verbal comprehension index (VCI) *stay the same**
Crystallized Intelligence-	Older adults find vocabulary, information, and comprehension the easiest of the subtest and scores on the subtests may only begin to show a decline in the 70's
Fluid Intelligence-	The performance subtests are therefore experienced as the most difficult, with subtest scores beginning to decline in the 30's or 40's

Releasing Test Results

The Ethics Code defines test data as: "raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists notes and recordings concerning client/patient statements and behavior during an examination"

Psychologists should release test data to the client or to whomever is designated on a client's release of information form.

From an ethical perspective, psychologists may refuse to release the data if they believe doing so would cause **"substantial harm, or the misuse or misinterpretation of test data."**

If a client has not signed a release of information, psychologists may only release data if mandated by law or a court order.

Releasing test results: when ok to release raw data, honor client's choice to receive data/note obsolescence if tests are old when test results are released

Purpose of Projective Tests

Purpose of Projective Tests	The premise underlying projective testing is the *projective hypothesis*

Purpose of Projective Tests (cont)

Projective Hypothesis	When persons are presented with unstructured stimuli to interpret or elaborate upon, it is believed that they project material from their unconscious onto the stimuli. Thus their interpretations and elaborations will reveal unconscious material from their psyche, such as repressed wishes, conflicts, and preoccupations

Differential diagnosis of Pediatric disorders

Differential of psychotic disorders

Schizo-affective vs Schizophrenia vs (Bipolar) Mood disorder vs Delusional Disorder

Differential Diagnosis of Anxiety Disorders

Social Anxiety Disorder vs Generalized Anxiety Disorder vs OCD vs OC personality disorder

Treatment, Intervention

Domestic Violence

Safety Issues

Depression Treatment

Anxiety Disorders Treatment

Bipolar Disorder:

genetic etiology/treatment, including psychopharmacology.

Psychodynamic

Basic psychodynamic defense mechanisms. Freud vs Adler

Group Therapy

Group Stages	Yalom has proposed that process groups evolve through three stages
Initial Stage:	Participation is hesitant. The group discusses topics of little personal significance and searches for commonalities. Members give and seek advice. In this stage, group members typically talk to the therapists, rather than with one another
Second Stage:	Conflict among group members. Rebellion toward group leaders. Attempts at dominance.
Third Stage:	If the second stage is successfully negotiated, the gThe development of closeness, intimacy and cohesion. Group members talk freely with one another
Yalom's 12 Therapeutic Factors:	
Instillation of Hope:	Members recognize other member's improvement and develop optimism for their own improvement
Universality:	Members realize that they are not alone in their feelings, impulses, thoughts, and problems
Imparting information:	Education and advice provided by the group members and therapist
Altruism:	Members boost their self-esteem and sense of value and significance by helping other group members

Group Therapy (cont)

Family dynamics re-enacted:	The opportunity to re-enact family dynamics within the safety and corrective manner of a group setting
Development of socializing techniques:	Provides an environment for group members to have social development, tolerance, empathy, and other interpersonal skills
Imitative behavior:	Group members expand their own knowledge and skills by observing other member's self-exploration, working through, and personal development
Interpersonal learning:	**Input:** members gain personal insight about their interpersonal impact through feedback provided by other members. **Output:** members provide an environment that allows members to interact in a more adaptive manner and practice new skills
Cohesiveness:	Gives members a sense of trust, acceptance, belonging, and security
Catharsis:	Members release strong feelings or suppressed emotions about past or present experiences
Existential factors:	Members accept responsibility for their life decisions – by living 'existentially', members learn how to accept responsibility without escaping from them

Group Therapy (cont)

Self-understanding:	Members gain insight into psychological motivation underlying behavior and emotional reactions
Fostering cohesion in groups	**Cohesiveness** is the most important. Encourages acceptance, intimacy and understanding, and honest expression *(even conflict towards member and leaders)*
Group Norms	**Therapist's Role:** Shape the group into a therapeutic social system. Establish group norms (rules/guidelines) through direct and indirect influence

Structural vs Strategic Family Therapy

	Structural Therapy
Theory of Change:	Change occurs through restructuring the family's organization
Role of the Therapist:	Therapist is active and involved. Helps the family understand how family structure *(relationships and hierarchies)* can be changed, the impact of rituals and rules, and how new patterns of interaction can be integrated into the family
Treatment Goals:	Restructure family system to allow for symptom relief and constructive problem-solving; Change dysfunctional transactional patterns and create new ways of relating; and Help create flexible boundaries
Phases of Therapy:	

Structural vs Strategic Family Therapy (cont)

Beginning:	Join with family; both accommodate to and challenge rules of family system; assessment/mapping of hierarchy, alignments, and boundaries; reframing of problem to include whole system
Middle:	Highlight and modify interactions; utilize enactments of issues to challenge participants and unbalance system
End:	Review progress made; reinforce structural change; provide tools for future
	Strategic Therapy
Theory of Change:	Change occurs through action-oriented directives and paradoxical interventions
Role of the Therapist:	Therapist delivers directives that facilitate change, particularly around patterns of communication. Focuses on solving problem/eliminating symptoms. Designs a specific approach for each person's presenting problem
Treatment Goals:	Solve the presenting problems & Change dysfunctional patterns of interaction
Phases of Therapy:	
Beginning:	Define the problem; determine how the client understands the problem; assess family's destructive patterns of relating and communicating the continued problem; state goals – what behaviors need to change and what would be the signs of change
Middle:	Review attempted solutions; assign ordeals; prescribe the problem; relabel behavior; instruct client to respond to the problem in a new way

Structural vs Strategic Family Therapy (cont)

End:	Plan for maintenance of new behavior; plan for future challenges; emphasize positive changes made

Rational Emotive Behavioral Therapy (REBT)

Major components:	*Direct instruction, persuasion* and *logical disputation*
Emotional disturbances:	Thought to result from irrational beliefs. Ellis believed that one's beliefs about the event result in the consequences
ABC Model (intervention):	Helps clarify the role of cognition in behavior:
A =	the activating event
B =	the belief
C =	the consequence or emotional/behavioral outcome
DEF (treatment):	The DEF component is the result of therapy
D =	the disputing intervention
E =	the adoption of a more effective philosophy
F =	the new feelings

CBT vs. ACT

CBT:	Focuses on identifying and changing negative thought patterns and behaviors, providing structured solutions to current problems
ACT:	Focuses on identifying and changing negative thought patterns and behaviors, providing structured solutions to current problems

Trauma

post-trauma interventions recommended vs contraindicated

Intervention Levels

Primary Prevention	Prevents the problem or disorder from occurring altogether (e.g., mammograms, hotlines, aggressively treating children with conduct disorder to prevent the development of antisocial personality disorder)

Intervention Levels (cont)

Secondary Prevention	Involves early identification of and aggressive treatment for a disorder or problem that already exists *(e.g., mammograms, hotlines, aggressively treating children with conduct disorder to prevent the development of antisocial personality disorder)*
Tertiary Prevention	Targeted at minimizing the long-term consequences of a chronic condition *(e.g., vocational rehabilitation and day treatment centers for clients with schizophrenia, and 12-step programs for alcoholics or addicts)*
Community Psychology	bringing mental health care into the community instead of just relying on hospitals and clinics
Prevention →	Stopping mental health problems before they start
Treatment →	Helping people who are struggling
Rehabilitation →	Supporting people in recovery

Etiology/treatment of movement disorders

(Parkinson's, tics, OCD)

Ethical, Legal, & Professional Issues

First Response to Observed Unethical Behavior

What should be the first action?

> Attempt to resolve the issue by bringing it to the attention of that individual if an *informal resolution* appears appropriate and confidentiality will not be violated

What is not appropriate for informal resolution?

> When it can violate any confidentiality rights that may be involved

What if it's unsuccessful or not appropriate?

> Psychologists take further action *(e.g., referral to ethics committees or licensing board)* unless such action conflicts with confidentiality rights in ways that cannot be resolved

Multiple Relationships

When do multiple relationship occur?

> A multiple relationship exists when a therapist enters into a non-professional relationship with a current client, or with someone close to the client (e.g., the client's boyfriend or sister)

When should a psychologist not enter into a multiple relationship?

> If it might impair the psychologist's objectivity, competence, or effectiveness, or if it might harm or exploit the other party.

Is a multiple relationship unethical?

> The Ethics Code explicitly states that a multiple relationship is not in and of itself unethical

When is a multiple relationship unethical?

> "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical"

Conflict of Interest

3.06 Conflict of Interest : Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to: *(1) impair their* ***objectivity, competence, or effectiveness*** *in performing their functions as psychologists* or *(2) expose the person or organization with whom the professional relationship* ***exists to harm or exploitation.***

Informed Consent

When is informed consent required?

> When psychologists engage in research, assessment, therapy, counseling, or consultation

What kind of language should they consider?

> The language used must be reasonably understandable to the clients

What is an exception to this requirement?

> When laws or governmental regulations mandate conducting these activities without consent *(e.g., in a court-ordered evaluation, consent is not obtained. The client is, however, informed of the purpose of the evaluation and limits of confidentiality)*

Who signs informed consent for a minor?

> Psychologists must obtain permission from a legally authorized person (e.g., legal guardian). Psychologists have a responsibility to protect the client's rights and well-being, even if the law does not require them to get consent from a legally authorized person.

Informed Consent (cont)

Do you need informed consent from a client who is mandated by court?

> When someone is required by a court to receive psychological services (like therapy or an evaluation), the psychologist must: Explain the services; Clarify that it's mandatory; and Discuss confidentiality limits

Do you need a written informed consent for mandated services?

> Psychologists must record that informed consent (or assent) was given—whether it was written or spoken. At minimum, a psychologist should note in the client's records that they explained the information and the client understood it.

Treating Minors (Record Release/ Informed Consent)

Who consents to treatment?

> Legal guardian/parent or 12+ if mature and potential harm to client if the guardian is aware

Who holds privilege?

> If 12 y/o signs consent and is the holder of privilege (psychologist and client assert privilege together)

Informed Consent in Human Studies

Code 8.02 Informed Consent to Research	Ensures participants understand what they're signing up for and can make an informed decision
Purpose & Process	Explain what the study is about, how long it will take, and what participants will do
Voluntary Participation	Participants can choose to join or leave at any time
Consequences of Leaving	Any potential impact of withdrawing should be explained
Risks & Confidentiality	Inform participants of any risks, discomfort, or limits to privacy
Potential Benefits	Explain what, if anything, participants might gain from the research
Confidentiality	Clarify what information will be kept private and what won't

Informed Consent in Human Studies (cont)

Incentives	If participants are paid or rewarded, they should know upfront
Contact for Questions	Provide a person they can reach out to with concerns
Deception	Researchers still need to get consent

Experimental Treatments

Additional details must be included:	: Clearly state that the treatment is experimental; Explain whether the control group gets a treatment or not; Describe how participants are assigned to groups; Provide alternative treatment options if participants withdraw; and Clarify any costs or compensation, including insurance coverage

The goal of these requirements is to protect participants and ensure ethical research practices

Confidentiality Complications in Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the **roles and responsibilities** of all parties and the **limits of confidentiality**

Confidentiality Complications in Family Therapy

Code 10.02 Therapy Involving Couples or Families	*Includes spouses, significant others, or parents and children*
First Step:	When psychologists take reasonable steps to clarify at the outset: (1) Which of the individuals are clients/patients, and; (2) The relationship the psychologist will have with each person *(e.g., services provided, info obtained, limits of confidentiality)*

Confidentiality Complications in Family Therapy (cont)

Multiple Relationships:	If it becomes apparent that psychologists may be called on to perform potentially conflicting roles *(such as family therapist and then witness for one party in divorce proceedings)*, psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately

Protocol for Release of Records

Family Therapy:	All members of the family must sign the release of records.
Divorce Cases:	Whoever has legal custody has to sign, ask to see the custody agreement form to verify. Also consider medical custody
Treatment of Minors:	Legal guardian consents, 12+ mature and paying own fees, don't have to disclose to the family if **disclosing harms the minor.** *Document/history of why 12+ client could consent and reason why not disclosing to family due to potential harm (e.g., pregnant, transgender, etc.)*

Mandated Reporting for Psychologists

Danger to Others:	*"Tarasoff" Duty to Protect:* Applies when a client communicates a serious threat of physical violence against a reasonably identifiable victim to their therapist
Danger to Self:	Client is in imminent risk of harming themselves (e.g., has a plan, means, and intent)
Child Abuse:	Includes suspicion of physical, sexual, emotional abuse, and neglect
Child/-Elder Abuse:	Includes suspicion of physical, emotional, financial, sexual, or neglect

Mandated Reporting for Psychologists (cont)

Tarasoff Law	Can be collateral information from a family member

Proper Response to Subpoenas

Who usually issues a subpoena?

> Subpoenas are usually issued by attorneys and may be a subpoena alone (requiring the therapist to appear for questioning) or a subpoena duces tecum (requiring the therapist to appear with the client records).

Can subpoenas be ignored?

> Subpoenas cannot be ignored.

What are the first actions when receiving a subpoena?

> A psychologist should first contact the client, inform the client of the subpoena, and seek the client's permission to release information. If the client grants permission, the psychologist may release the records.

What happens if the client grants permission to release the records?

> The psychologist may release the records.

What happens if the client does not grant permission?

> The psychologist may first contact the attorney who issued the subpoena, requesting that the subpoena be quashed (nullified or voided).

What happens if the subpoena is not quashed?

> The psychologist must appear at the designated location (courthouse or attorney's office) and bring any requested records.

What should the psychologist do in court?

> The psychologist should then **assert patient-therapist privilege**, and neither testify nor turn over the records, unless ordered to do so by the court.

Court Ordered Eval vs. Court Ordered Treatment

Court-Appointed Eval:	The psychologist is retained by the court
Who is the client?	The court is the client
Privilege:	An exception to privilege; in a court-appointed evals, **privilege does not exist**
Informed Consent:	There is **no requirement** that the psychologist get the defendant's consent to participate.

Court Ordered Eval vs. Court Ordered Treatment (cont)

Confidentiality:	The defendant has **no confidentiality rights** however, the psychologist must explain the nature of the evaluation and the limits of confidentiality to the defendant prior to beginning the evaluation.
ROI:	The results of the eval are to be shared with the court, **no signed RIO is needed**
Court--Ordered Therapy:	The client hires the psychologist
Who is the client?	The client is the client
Privilege:	The client **may invoke or assert privilege** (or have the psychologist do so on the client's behalf)
Informed Consent:	The psychologist who agrees to treat this client must make sure to clarify the nature of the treatment that has been ordered by the court, as well as the information that the court needs. They must then discuss this information with the client and **obtain informed consent.**
Confidentiality:	The client has confidentiality rights and there is a need for a release
ROI:	The psychologist must generally **obtain a signed ROI** from the client in order to be able to communicate with the court. At the end of treatment, or periodically throughout treatment, the court requests information from the treating therapist

Privilege is the client's right to keep confidential communications from being disclosed in a legal proceeding

Internet Searches of Clients by Therapist

It's unethical and you shouldn't do it. - Dr. Forman

Sex with Clients

Code 10.05- Sexual Intimacies with Current Therapy Patients

Current Clients:	**Never** engage in sex

Code 10.08 Sexual Intimacies with Former Therapy Clients/ Patients

Former Clients:	**May never** have sex with a former client unless at least **two years have passed** since treatment ended
After Two Years:	Still, should not enter into sexual relationships with former clients unless the *"most unusual circumstances"* exist
Things to Consider:	The burden remains on the psychologists to prove that there has been **no exploitation,** especially in light of seven factors: time passed since termination; the nature, intensity, and duration of treatment; circumstances of termination; personal history of the client; the client's current mental status; the likelihood of adverse impact; and sexual statements made during treatment

Treating Former Sexual Partners

Code 10.07 Therapy with Former Sexual Partners

Psychologists may **never** treat previous sexual partners

Finances

Waiving co-pays:	We **can waive co pay if** it's okay with insurance company or if we reach out to them and ask to waive the co pay *(means we are willing to work for less money)*

Finances (cont)

Using collection agencies:	Must be indicated in the **initial consent forms/practice** parameters. Psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment.
Changing diagnosis:	We **can't change diagnosis** for insurance benefit

Client Abandonment

Client Abandonment:	Should never abandon a client
Code 3.12 Interruption of Psychological Services	
Includes:	Make plans for *continuation of care* in the event of their relocation, illness, death, relocation, or financial limitations
"A Professional Will"	Refers to the plans made. The Ethics Code qualifies this requirement with the statement "-unless otherwise covered by contract"
Code 10.09 Interruption of Therapy	
Includes:	Psychologists should make sure to provide appropriate resolution to their clients continue to receive proper care. The client's well-being should always come first, and efforts should be made for a smooth transition
Terminating a Client:	Consider safety of client and psychologist
Code 10.10 Terminating Therapy	

Client Abandonment (cont)

When to Terminate:	When it is reasonably clear that the client no longer needs, is not benefiting from, or is being harmed by treatment; if the client, or someone in a relationship with the client, is threatening or endangering the psychologist
Includes:	Should usually be preceded by pretermination counseling (e.g., suggesting alternative treatment providers)
Exceptions for Pretermination Counseling:	Actions of clients make it impossible (e.g., sudden refusal to attend therapy sessions) or when it is prohibited by third-party payors (e.g., managed care companies)

Goals of Supervision

-Growth and development through teaching

-Gatekeeping

-Promoting supervisee growth and development through teaching.

-Protecting the welfare of the client.

-Monitoring supervisee performance and gatekeeping for the profession.

-Empowering the supervisee to self-supervise and carry out the above goals as an independent professional.

Treating Minors (Record Release/ Informed Consent)

Culturally Encapsulated vs. Culturally Humble

Cultural Encapsulation:

Cultural Humility:

Cultural Competence: