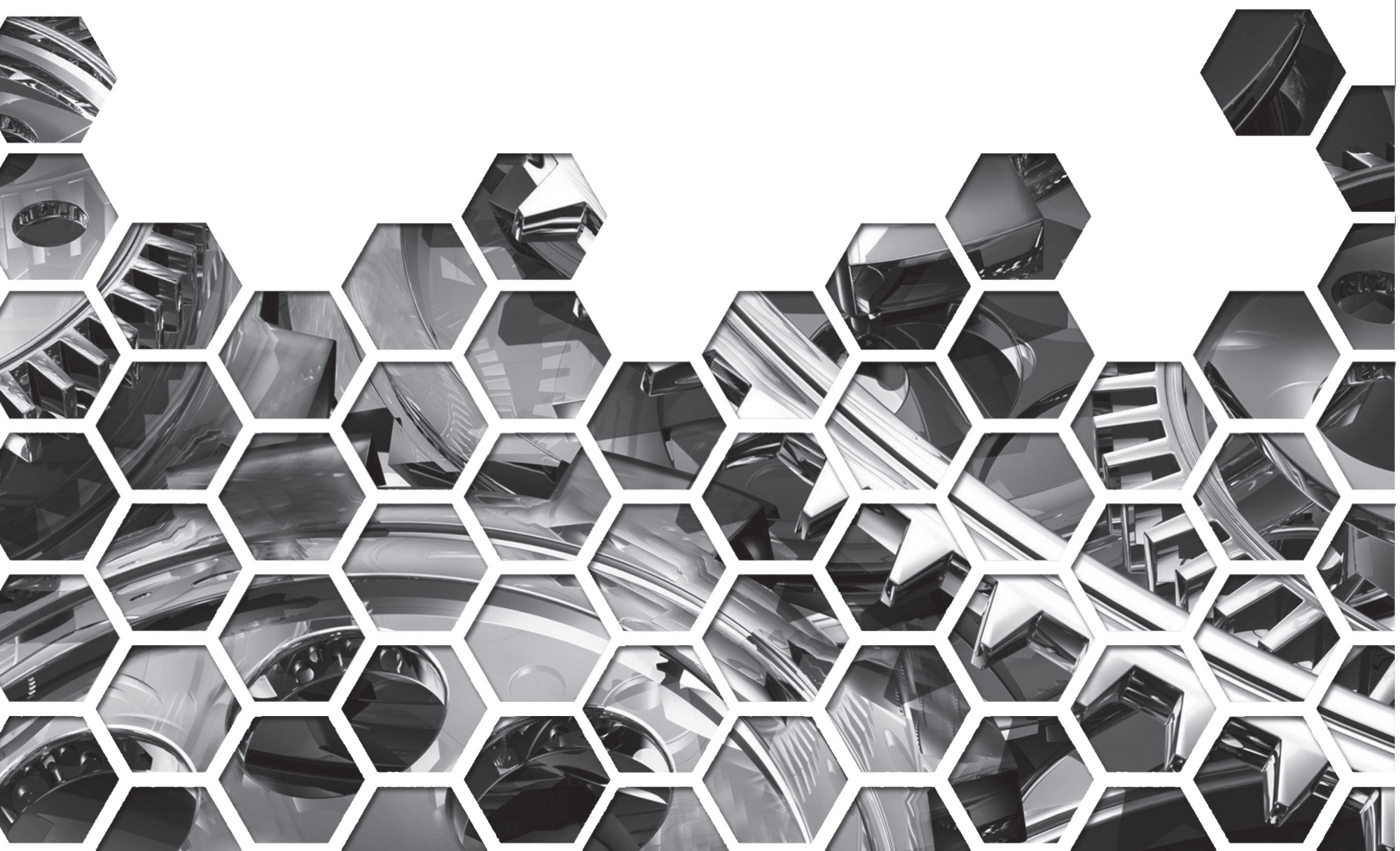


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### **These articles can be:**

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### **Instructions for authors:**

1. Articles are to be no longer than 1,600 words (not including APA abstract, references or biography). Articles should relate to the 2020 OPA convention theme, **“Today’s Psychology: Practice, Research and Emerging Trends”** and follow the guidelines set within the APA’s “Publication Manual.”
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3. Each article must contain a 100-150 APA Abstract.
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5. Please notify the managing editor, Karen Hardin ([khardin@ohpsych.org](mailto:khardin@ohpsych.org)), if you are planning to submit an article.
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# Staying in Your Lane: New Challenges With Integrated Healthcare and Multidisciplinary Teams

John Tilley, PsyD, MSCP, ABPP (Forensic)  
Bob Stinson, PsyD, JD, LICDC-CS, ABPP (Forensic)

## Abstract

Integrated health care is an approach characterized by a high degree of collaboration and communication among health professionals (e.g., physicians, nurses, psychologists, and other health professionals) (APA, 2019). Psychologists are increasingly moving into integrated health care settings. Without stunting the enthusiasm with which this movement is occurring, we endeavor to address an important issue that many psychologists find themselves struggling with when working within an integrated health care model: working collaboratively as a vital part of a multidisciplinary team while not stepping outside boundaries of competence. In other words, the importance of “staying in your lane,” not just as a psychologist but as a psychologist with limitations in the areas of competence and expertise. In this article, we discuss working with an interdisciplinary team, the potential perils that non-forensic psychologists face when asked to conduct work that falls within the scope of forensic psychology, and the importance of setting limits so as to maintain adherence to ethical guidelines. Similarly, we illustrate some of the ethical challenges that psychologists face when working in integrated healthcare and on multidisciplinary teams.

## INTRODUCTION

Psychologists who work on multidisciplinary teams and/or in integrated health care settings may find it difficult to resist the temptation, or even the pressure, to practice beyond one’s area of competence and expertise. It may be the perception of the psychologist, or others on the team, that because one is “the psychologist” that person should be able to address all things psychology. Most people appreciate that a physician who specializes in podiatry should not be expected to do an open-heart surgery. However, the specialties in psychology may not be as clearly distinguished to our colleagues from other professions. For instance, they may believe that if a forensic psychology matter arises, then any available psychologist—whether that psychologist is a forensic psychologist or not—can and should handle the matter. As such, we as psychologists have a responsibility to educate them and, when needed, insist on bringing in appropriate specialists or referring out.

## FORENSIC PSYCHOLOGY

Forensic psychology is a sub-specialty of psychology that broadly pertains to the interface between psychology and the law. Forensic psychologists specialize in the provision of psychological services to individuals and entities that involve the legal system or some adjudicative body to assist in addressing legal, contractual, or administrative matters (see *Specialty Guidelines for Forensic Psychology*; APA, 2013).

Forensic psychologists who conduct evaluations do so to address a specific psycholegal issue. Opinions offered pursuant to those evaluations tend to be relatively circumscribed, but

focused. The following are some of the psycholegal issues about which a forensic psychologist may be tasked with evaluating and offering opinions:

- Competence to stand trial
- Mental condition at the time of the alleged offense (Not Guilty by Reason of Insanity)
- Risk of violence
- Risk of recidivism / re-offending
- Capital sentencing
- Conditional release
- Civil commitment
- Diminished capacity and guardianship
- Testamentary capacity
- Disability
- Fitness for duty
- Personal injury and liability
- Parental fitness and child custody

## STAYING IN YOUR LANE

The *Ethical Principles of Psychologists and Code of Conduct* (EPPCC; APA, 2017) establish that psychologists must practice within the boundaries of their competence. Psychologists achieve competence by virtue of their education, training, supervised experience, consultation, study, or professional experience (Ethical Standard 2.01[a], EPPCC).

Ohio’s laws and rules also offer mandates on competencies for psychologists. Specifically addressed in Ohio Revised Code (ORC) § 4732.17 and Ohio Administrative Code (OAC) Chapter 4732-17-01, psychologists are obligated to limit their practice to those specialty areas in which competence has been gained through education, training, and experience



(OAC 4731-17-01[H][1]). Psychologists are obligated to maintain competency through continuing education, consultation, and/or other training in accordance with current standards of scientific and professional knowledge (OAC 4732-17-01[H][3]). If the issue in question falls outside of the psychologist's boundaries of competence, or when it is in the best interests of the client, the psychologist shall refer the client elsewhere to the appropriate professional resource (OAC 4732-17-01[H][1] and [6]).

Ohio psychologists must be careful in determining what constitutes their areas of competence insofar as psychologists who undertake practice in a specialty area will be held to the standard of care within that specialty (OAC 4731-17-01[H][2]). Thus, if a psychologist practices in the area of forensic psychology, then the psychologist will be held to the standard of practice associated with the specialty of forensic psychology.

Notably, though, a psychologist need not hold oneself out to be a forensic psychologist in order for the standards of the specialty of forensic psychology to apply to that psychologist. According to the *Specialty Guidelines for Forensic Psychology* (APA, 2013), a psychologist is practicing forensic psychology – and thus would be considered a “forensic practitioner” – when the psychologist conducts professional services that involve the application of the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, or administrative matters. More specifically, application of the *Specialty Guidelines for Forensic Psychology* “does not depend on the practitioner’s typical areas of practice or expertise, but rather, on the service provided in the case at hand” (APA, 2013, p. 7).

To illustrate this important point, consider the following examples:

- A treating psychologist works in a psychiatric hospital. A patient is admitted to the psychologist’s unit. The patient has pending criminal charges. The Court asks the unit psychologist to submit a letter that addresses any abnormalities in the patient’s mental status that might help the Court determine if the patient understands

the criminal proceedings and can assist in the patient’s defense. The psychologist writes the letter. By virtue of doing so, the psychologist is practicing forensic psychology, as this would be regarded as an evaluation for competence to stand trial.

- A patient is in psychotherapy with a psychologist. The patient’s attorney requests an opinion from the psychologist about the patient’s capacity to execute a will. After obtaining the patient’s consent, the psychologist writes a brief letter to the attorney offering an opinion. That psychologist is practicing forensic psychology, as this would be construed as an evaluation of testamentary capacity.
- A patient, who is a sophomore in college, has a panic disorder. The patient goes to the college’s counseling center for assistance. In addition to requesting therapy, the patient asks the counseling psychologist to fill out some paperwork that attests to the fact that the patient cannot work because of the panic disorder and is entitled to disability benefits. Upon completing that paperwork, the counseling psychologist has now engaged in the practice of forensic psychology. Disability determination is explicitly forensic in nature.
- A patient has a fear of flying and is comforted by her pet dog. She asks her treating psychologist to write a brief letter so that her dog can be qualified as an emotional support animal and can be in the cabin with her during flights. The psychologist honors the patient’s wishes and writes a brief letter. The psychologist has just practiced forensic psychology, insofar as the psychologist has offered an opinion that invokes the Air Carrier Access Act (ACAA).

In each of these instances, the psychologist would be held to standards of practice associated with the specialty of forensic psychology, including having the requisite education and training. The more specific and rigorous standards for the specialty of forensic psychology, the *Specialty Guidelines for Forensic Psychology* (APA, 2013), would apply. In accordance with those Specialty Guidelines, the psychologist would, among other things, be expected to:

- Possess a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern participation (Guideline 2.04);
- Use appropriate methods and procedures, maintain integrity by examining the issue at hand from all reasonable perspectives, and seek information that will differentially test plausible rival hypotheses (Guideline 9.01);
- Use multiple sources of information and refrain from relying solely on one source of data when possible (Guideline 9.02);
- Select and utilize assessment procedures that are appropriate in light of the research on or evidence of their usefulness and proper application (Guideline 10.02);
- Provide opinions that are sufficiently based upon adequate scientific foundation as well as reliable and valid principles and methods that have been applied appropriately to the facts of the case (Guideline 2.05);
- Disclose all sources of information obtained in the course of the professional services and identify the source of each piece of information that was considered and relied upon in formulating an opinion (Guideline 11.03); and
- Offer a complete statement of all relevant opinions that were formed within the scope of work on the case, the basis and reasoning underlying the opinions provided, and the relevant data that was considered (Guideline 11.04).

Psychologists must therefore be diligent in knowing the boundaries of their competence, what constitutes forensic psychology, and how they will be held to the standards associated with the practice of forensic psychology if they engage in professional services that constitute forensic psychology. Failing to do so could amount to negligence (see OAC 4731-17-01[B][1]).

### **AVOIDING ETHICALLY FORBIDDEN MULTIPLE RELATIONSHIPS**

As illustrated above, treating psychologists are many times asked to offer an opinion on psycholegal issues. In addition to being held to the standards of practice associated with the specialty of forensic psychology, a treating psychologist who takes on any one of the forensic evaluation roles described above commits a serious ethical violation, as it is well-established that the roles of a treating psychologist and forensic examining psychologist are irreconcilably conflictual (Greenberg & Shuman, 1997; see also APA, 2017, Standard 3.05 – Multiple Relationships). This position has been reinforced by state boards of psychology (State Board of Psychology of Ohio, 2003).

As an additional example, a psychologist who treats a child might be asked to offer an opinion as to which parent should have custody of the child based on what the psychologist knows about the child's psychological needs, the parents' styles of parenting, and so forth. A treating psychologist at a psychiatric hospital or prison might be asked to do a competency evaluation or risk assessment on one of the psychologist's patients. As noted above, situations like these constitute a role conflict and, consistent with standards of practice, should be avoided (see, for instance, Guideline 4.01.01 of the *Specialty Guidelines*). In fact, treating psychologists should avoid taking on forensic evaluations for any patients being treated by the psychologist (see Greenberg & Shuman, 1997 and State Board of Psychology of Ohio, 2003). Unfortunately, far too often treating psychologists fail to appreciate the inherent dangers and are lulled into providing a forensic opinion, which then opens them to a host of clinical and ethical pitfalls as the psychologist must either serve in irreconcilably conflictual multiple roles (i.e., treatment provider and forensic evaluator) or not do a forensic evaluation and, instead, offer an opinion without a sufficient basis for doing so—both of which can land the psychologist in trouble.

### **ESTABLISHING (NEW / FORENSIC) COMPETENCIES**

Under Ohio's laws and rules, psychologists who plan to practice in an area new to them must undertake or obtain relevant education, training, supervised experience, consultation, or study (Ethical Standard 2.01[c], EPPCC). If a psychologist is developing a new competency area, he or she must engage in ongoing consultation with other psychologists or appropriate professionals (OAC 4732-17-01[H][4]).

Forensic psychologists usually establish competence through a combination of education, training, supervised experience, consultation, study, and professional experience spanning several years and typically starting in graduate school. They may have earned a doctorate in forensic psychology or, while earning a degree in the more generalist area of clinical psychology, completed practicum placements and/or a predoctoral internship in the area of forensic psychology. Training, education, and experience typically continue at the post-doctorate level, and some forensic psychologists may have completed a fellowship or other formalized training in the area of forensic psychology. In the years that follow, forensic psychologists usually continue to develop and maintain competence through additional training, experience, specialized study, continuing education, consultation, and collaboration with knowledgeable colleagues and experts in the area. Traditionally, developing and maintaining competence in the area of forensic psychology spans multiple years and is a substantial investment in time and economic resources.

### SUMMARY

In summary, multidisciplinary teams and integrated healthcare provide great opportunities for psychologists to collaborate with other professions. However, like those other professions, there are specialties within the field of psychology. No one is an expert in everything. Non-forensic psychologists are encouraged to recognize when they are wading into forensic waters, step back, set limits, and stay in their lane. Alternatives to practicing outside your area of competence and/or engaging in ethically forbidden multiple relationships include bringing in a specialist, referring out to a specialist, or establishing a new competency, recognizing that the latter does not occur overnight and usually involves months or years of careful and continuous study.

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# Building Competency in Evaluating Individuals with Developmental Disabilities in Forensic Settings

A.J. McConnell, PsyD  
Forum Ohio

## Abstract

*The prevalence of individuals with a developmental disability (DD) becoming linked with the legal system has increased over the past two decades. Despite the increase of individuals with DD being referred for forensic psychological services, there has been minimal attention given to the best practices for properly assessing, treating, and managing the risk of this population. There are a limited number of psychologists in Ohio that specialize in both forensic psychology and working with individuals with DD; therefore, the purpose of this article is to provide a brief overview of the forensic profile of individuals with DD as well as strategies for completing forensic evaluations with this population.*

The prevalence of individuals with a developmental disability (DD) becoming linked with the legal system has increased over the past two decades with between 1.5% to 40% of individuals in forensic settings meeting criteria for a DD (Criminal Justice Advocacy Program [CJAP], 2014; Esan et al., 2015; Fazio, Pietz, & Denney, 2012; Lindsay et al., 2014). It has also been claimed that people with DD may be up to seven times more likely to interact with the police compared to the general population (Browning & Caulfield, 2011; Lindsay et al., 2014). Despite the increase of individuals with DD being referred for forensic services, there has been minimal attention given to the best practices for properly assessing, treating, and managing the risk of this population. Ethically, it is important for psychologists conducting a forensic psychological evaluation to have adequate experience working with individuals with a DD. Unfortunately, there are a limited number of psychologists in Ohio that specialize in both forensic psychology and working with individuals with DD. In order to begin building competency in this area, this article will provide a brief overview of the forensic profile of individuals with DD as well as strategies for completing an effective forensic psychological evaluation.

## WHAT IS A DEVELOPMENTAL DISABILITY?

According to the Ohio Revised Code § 5123.01 and § 5126.01, a DD is a “severe, chronic disability that is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness, that is manifested before the age of 22, is likely to continue indefinitely, and results in substantial functional limitations in at least three areas of major life activity” (e.g., self-care, language, and self-direction). A DD may include, but is not limited to, diagnoses such as an Intellectual Disability, Cerebral Palsy, Epilepsy, Autism Spectrum Disorder (ASD), or Down Syndrome. Thus, an individual with a DD may not always meet criteria for a DSM-5 diagnosis. For example, an individual with Epilepsy, which is a medical diagnosis, may not meet DSM-5 diagnostic criteria

for a psychiatric disorder. Also, cognitive testing alone does not always determine if an individual has a DD. Psychologists should use caution and not assume all individuals with a DD have a comorbid psychiatric diagnosis.

## A FORENSIC PROFILE OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Individuals with DD have a different forensic profile compared to the general population. Individuals with DD that have been linked within the legal system tend to be young, single males from a minority racial background who are likely to be homeless, unemployed, and/or have less education (McCarthy et al., 2016; Tsagaris et al., 2015). There is debate on whether individuals with DD are prone to committing certain criminal offenses. For example, Tsagaris et al. (2015) examined demographic characteristics of 315 adult offenders with DD in an urban environment in northern Ohio and found that the majority of charges against this population included drug possession, felonious and aggravated assault, and receiving stolen property. Other studies have found that individuals with DD, particularly individuals with ASD, have a high rate of committing arson and/or sexual offenses (Rutten, Vermeiren, & Nieuwenhuizen, 2017; Sondenaa et al., 2014; Steel, 2016). In comparison, King and Murphy (2014) concluded that there is little evidence that individuals with ASD are more prone to engage in certain crimes over others.

Individuals with DD in forensic settings often have comorbid psychiatric diagnoses. Common comorbid psychiatric diagnoses that have been diagnosed in the DD population within forensic settings have included substance use disorders, personality disorders, and mood disorders (Esan et al., 2015; Ruttan et al., 2017). Significant impulsivity, a history of engaging in self-injurious behaviors, and/or psychosis are also common (Esan et al., 2015; King & Murphy, 2014). It has also been found that severe mental health concerns are more prominent than delayed cognitive or adaptive behavior functioning in terms of treatment outcomes and risk

## Evaluating Individuals with DD in Forensic Settings

management for individuals with DD (Essan et al., 2015; Rutten et al., 2017; Sondenaa et al., 2014). However, characteristics of an individual's DD, such as their low IQ, behavioral rigidity, or lack of understanding of social norms may still be an underlying determinant for their involvement with the legal system (Tsargis et al., 2015).

Individuals with DD may experience a range of outcomes when they have been linked with the legal system. Tsargis et al. (2015) found that 21.4% of individuals received prison sentences, 43% were sentenced to up to 60 months of community control or probation, 16% were found incompetent to stand trial - unrestorable, and 16% had their cases dismissed. Unfortunately, individuals with DD that are incarcerated are at a high risk of being victimized.

Research has found that individuals with DD are at a high risk of being victims rather than perpetrators within prison settings. Thus, they are often targeted by other inmates and staff. Furthermore, individuals with DD often have difficulty understanding and following prison rules and schedules; therefore, they tend to spend more time in jail or prison due to disciplinary infractions (CJAP, 2014; Tsargis et al., 2015).

Murphy (2010) noted that forensic providers often struggle to make adequate recommendations for placement and treatment due to misdiagnosing individuals with DD and failing to understand the unique functioning and behavioral characteristics of the individual with DD. The lack of appropriate recommendations potentially places individuals with DD at further risk for being victimized. Fortunately, individuals with DD tend to have better outcomes in regards to prevention and services and supports when they are involved with professionals who are specifically trained in working with individuals with DD (Tsagaris et al., 2015).

### STRATEGIES FOR COMPLETING A FORENSIC PSYCHOLOGICAL EVALUATION

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Forensic psychologists may be asked to complete an evaluation on a variety of legal issues in relation to individuals with DD. Therefore, a forensic psychologist may need to assess an individual's decision-making abilities, the reliability of information that they provide, and assess specific legal situations, such as fitness to plead, mental state at the time of the offense, and various matters of competency. The selection of appropriate psychological tests needs to be considered when addressing specific forensic issues. At this time, there are limited forensic psychological tests specifically designed for individuals with DD. In general, Melton et al. (2018, pgs. 149-151) recommend that forensic assessments for individuals with DD consist of a structured interview and measures that focus on concrete concepts. In regards to risk assessment, Hounsome et al. (2018) found that both risk assessment tools for the DD population as well as risk assessment measures for the general population have been successful in predicting the risk of violence in individuals with DD (see Table 1 for examples on forensic assessment tools for individuals with DD).

Obviously, individuals with DD have differing presentations and no two individuals are alike. The Specialty Guidelines for Forensic Psychology (American Psychological Association (2013, p. 10) requires forensic psychologists to strive to understand how characteristics of an individual's disability and other relevant factors are associated with the individual's involvement with the legal system. Thus, an individual's unique qualities, such as their strengths and interests, as well as their adaptive and behavioral limitations associated with their disability should be adequately described in an evaluation.

### COMMON CHARACTERISTICS OF INDIVIDUALS WITH DD

This section will provide information on common characteristics of individuals with DD for psychologists that are not familiar in completing evaluations with this population. Individuals with DD may exhibit delays in verbal and nonverbal communication. This may include difficulty modulating the volume, rhythm, and pitch of their voice. It may also include avoiding eye contact, limited use of facial expressions, talking in the third person, use of neologisms, or stereotyped use of speech and language (e.g., echoing words, quoting phrases out of context). Individuals with DD may also experience social pragmatic language deficits. Common deficits might involve individuals having difficulty recognizing faces or engaging in the inappropriate use of facial expressions or behaviors, such as smiling or laughing when it is not socially appropriate. Difficulty engaging in a reciprocal conversation, not spontaneously providing information, or checking to ensure that others understand their perspective is also common.

Cognitively, individuals with DD may have limitations in their ability to read, write, or comprehend common legal terms. Deficits in abstract thinking and a limited vocabulary are also common. Therefore, individuals with DD tend to think concretely and struggle with sarcasm, humor, or social idioms. Forensic psychologists are recommended to avoid using professional jargon and to use short sentences with concrete, simple terms when interviewing individuals with DD (CJAP, 2014). Also, it is encouraged that forensic psychologists frequently check-in with the individual in order to assess the individual's comprehension of topics that are being discussed. Having individuals with DD use terms that they are comfortable with as well as having them restate concepts in their own words is encouraged.

Individuals with DD are easily influenced by others and may also be eager to please and/or attempt to mask their disability or deficits (CAJP, 2014). An individual with DD's eagerness to please should be carefully assessed because it is common for individuals with DD to be overly accommodating to others, especially individuals in positions of authority (CAJP, 2014). Also, individuals with DD's attempts to mask their disabilities or deficits is a barrier to a forensic psychologist trying to inquire about an individual's strengths and weaknesses. Forensic psychologists should be sensitive to an individual with DD's nonverbal cues and tendency to become overly compliant or guarded with disclosing details. Obtaining information about the individual's adaptive strengths and

## Evaluating Individuals with DD in Forensic Settings

weaknesses from previous records, caregivers, treatment providers, and other collateral sources will help forensic psychologists obtain an accurate perspective of the relevant factors of the individual's DD that is relevant to the context and purpose of the evaluation.

There are also several other behavioral characteristics individuals with DD may exhibit that should be assessed. It is common for individuals with a DD to act impulsively, have a short attention span, experience memory deficits, or struggle with new situations or changes in routine. Individuals with DD may also have extreme or unusual responses to various sensory inputs. For example, an individual with DD may be sensitive to light, certain sounds, being touched, smells, and/or clothing. Repetitive body movements, such as body rocking, hand flapping, and making self-stimulating vocalizations are also common behaviors among individuals with DD. It is estimated that 7-10% of individuals with DD, even those not linked with forensic services, act aggressively at least once within a six month period (Cooper et al., 2009; Hounsom

et al., 2018). The function of any aggressive behavior should be assessed in order to determine its purpose. For example, individuals with low intellectual functioning may occasionally become aggressive because they lack understanding of a social situation or have deficits in expressing their needs. Overall, understanding the behavioral needs of the individual with DD is important because the forensic psychologist may need to educate others in the legal system (e.g., judges, lawyers) about certain characteristics of the individual that may limit the individual's ability to participate in court hearings, treatment, or other situations.

In conclusion, completing forensic evaluations for individuals with DD requires advanced knowledge of the unique skills and deficits of the individual as well as common experiences and outcomes in legal situations. This article serves as an introduction to some of the issues and concerns that are common in working with individuals with DD. Table 2 provides additional resources to further build competency in evaluating individuals with DD in forensic settings.

**TABLE 1: ADDITIONAL RESOURCES FOR WORKING WITH INDIVIDUALS WITH DD IN FORENSIC SETTINGS**

Agency	Website	Description
Ohio Department of Developmental Disabilities	<a href="http://dodd.ohio.gov/">http://dodd.ohio.gov/</a>	Information on services, programs, and initiatives for working with individuals with DD is provided. Furthermore, a Sex Offender Protocol is available that describes the best practices in completing risk assessments for the DD population in Ohio.
The Arc: National Center for Criminal Justice and Disability	<a href="https://www.thearc.org/nccjd">https://www.thearc.org/nccjd</a>	Online trainings, publications, videos, and other resources on forensic issues in the DD population is provided.
American Association on Intellectual & Developmental Disabilities	<a href="http://aaidd.org/">http://aaidd.org/</a>	Information on policies, research, effective practices, and additional educational resources work working with the DD population is provided.

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# Evaluations of Diminished Capacity for Guardianship

John Tilley, Psy.D., MSCP, ABPP (Forensic)

Forum Ohio, LLC | Behavioral Science Specialists, LLC | Columbus Springs

## Abstract

A guardianship is established for someone who is deemed incompetent by a Probate Court. In determining whether a person is incompetent, a Probate Court considers a “Statement of Expert Evaluation,” which is authored by a psychologist or other qualified mental health professional. This article explores the components of an evaluation of diminished capacity, which is conducted in conjunction with the “Statement of Expert Evaluation.” Emphasis is placed on the multifaceted nature of diminished capacity evaluations and importance of adherence to the best practices of clinical and forensic psychology.

A fundamental aspect of the law is protection for the members of society. When a person becomes so impaired that he or she poses a risk of harm to himself or herself, a risk of harm to others, or a risk of being unable to care for his or her property, the law is designed to intervene and offers protection.

By Ohio law, a person is *incompetent* if he or she is “so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person’s self or property or fails to provide for the person’s family or other persons for whom the person is charged by law to provide” (see Ohio Revised Code [ORC] § 2111.01). If a Probate Court determines that a person is incompetent, a guardian may be appointed. A guardian has legal responsibility for the incompetent individual (or “ward”) and is empowered to make various decisions concerning the individual’s healthcare and estate.

A Probate Court considers a variety of information in determining a person’s competence and need for a guardian. A key piece of information is the *Statement of Expert Evaluation*, which is a report completed by a clinician – such as a psychologist or a physician – that has evaluated the individual to offer opinions about various issues, including the individual’s current mental status and diagnosis as well as the individual’s capacity to manage his or her activities of daily living, decisions concerning medical treatments, finances, and property. A clinician who completes a *Statement of Expert Evaluation* is also tasked with offering an ultimate opinion as to whether a guardianship should or should not be established.

The *Statement of Expert Evaluation* appears to be a relatively simple document on the surface. It is only 4 pages long, there are only 14 areas that need to be addressed, and a lot of the questions can be answered by checking boxes. However, it can be fraught with peril for the unsuspecting or unknowledgeable clinician. Clinicians who complete the *Statement of Expert Evaluation* without a proper

understanding of the area in which they are practicing or the magnitude of the opinions they offer run the risk of finding themselves under the uncomfortable scrutiny of cross examination and judicial inquiry.

Evaluations involving the *Statement of Expert Evaluation* – and, hence, evaluations for diminished capacity and guardianship – address explicitly psycholegal issues for an adjudicative body (a Probate Court) and thus fall squarely within the purview of forensic psychology. Forensic psychology is, broadly, the interface between psychology and the law. More specifically, forensic psychology is the professional practice by any psychologist of any subdiscipline when applying specialized knowledge of psychology to the law to assist in addressing legal matters (see *Specialty Guidelines for Forensic Psychology*; APA, 2013). Thus, any psychologist who completes a *Statement of Expert Evaluation* is practicing forensic psychology regardless if that psychologist specializes in forensic psychology or holds him- or herself out to be a forensic psychologist. In such a case, all standards of practice pertaining to forensic psychology apply, such as adherence to the *Specialty Guidelines for Forensic Psychology*.

Therefore, as simple as the *Statement of Expert Evaluation* may appear, the evaluation surrounding it is often anything but simple. Instead, evaluations of diminished capacity are multifaceted, often complex, and require advanced knowledge in both clinical and forensic psychology.

Psychologists or other clinicians who endeavor to complete an evaluation of diminished capacity must address several questions at the outset. Some of those questions include the following:

- What’s the primary referral issue?
- Who is my client? Is it the person I am evaluating? An attorney? A family member? A Probate Court?
- What functional processes are in question?
- What data will I need to offer an expert opinion?
- Am I qualified to do this?

## Evaluations of Diminished Capacity for Guardianship

- Do I want to do this?
- Who is going to have access to my results?
- Is the Court already involved? Can I reasonably expect Court involvement?
- When are the results needed?
- In what form will I need to communicate the results?
- Will a report be needed to supplement the *Statement of Expert Evaluation*?

An evaluation of diminished capacity involves several components. At the outset, notification of purpose of the evaluation should be provided, which would also include a disclosure as to the limits of confidentiality of the information collected. When consent is not feasible, assent should be sought.

Relevant records should be collected and reviewed. In addition to the more traditional records, like those pertaining to medical or psychiatric history, the records may also include financial documents. Records are often vital for establishing or supporting a diagnosis. They are also important for identifying troubling trends in the person's functioning.

Collateral interviews are often an important component of an evaluation of diminished capacity. These interviews might include family members, neighbors, or friends. Care must be taken to not place too much weight on the report of a family member, neighbor, friend or other individual whose objectivity might be compromised or may otherwise have ulterior motives.

A thorough clinical interview is another staple of a good evaluation of diminished capacity. As part of the interview, relevant history is collected. Several areas are typically emphasized, such as the individual's educational and employment history (which are important for establishing a premorbid baseline), medical history, history of alcohol and other substance use, and the individual's history of mental health and psychiatric problems.

Additionally, during the clinical interview, specific functional domains are assessed. One functional domain is activities of daily living. This would include both basic activities of daily living – such as bathing, dressing, toileting, and feeding oneself – and instrumental activities of daily living – such

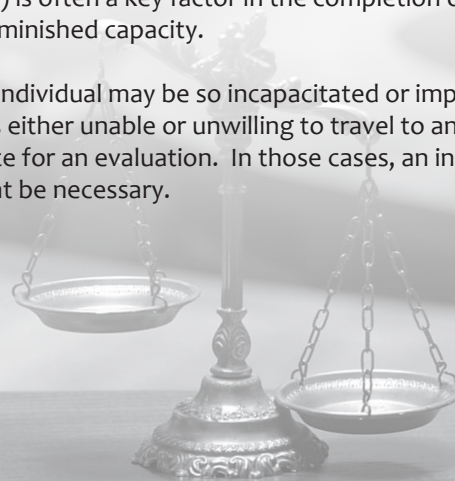
as shopping, doing housework, preparing meals, taking medicine, and paying bills. Another functional domain is the individual's rational understanding of his or her medical needs. This includes an understanding of the person's medical issues, medications, and medical appointments. A third functional domain is the individual's rational understanding of his or her property and finances. This would include his or her property, savings, income, monthly expenditures, and bills.

Consideration of the individual's values and preferences should be made in an evaluation of diminished capacity. A determination of incapacity should be based on dysfunction and not because of a mismatch in values. For instance, just because a person does not value money the way the evaluator values it does not mean the person is necessarily incompetent. Evaluators must be careful to not allow value judgments to skew the assessment and the appraisal of the individual's capacities.

Further, as part of a thorough evaluation of diminished capacity, a mental status examination is conducted. Similarly, when feasible, standardized psychological tests – some of which have been designed specifically to address particular functional domains related to diminished capacity – are administered to aid in collecting data and identifying strengths and weaknesses.

Collaboration is another component of a good evaluation of diminished capacity. Specifically, the evaluator should collaborate with other professionals who are involved with the individual. Sometimes, professionals from Adult Protective Services might be involved in the case, and they should be consulted. If the individual has a psychologist, psychiatrist, and/or other treating mental health professionals, they should be consulted, as they would be well-positioned to offer a wealth of information germane to the evaluation. Timely and open collaboration (which, of course, sometimes requires a properly executed authorization for release of information or a court order) is often a key factor in the completion of an evaluation of diminished capacity.

Sometimes, an individual may be so incapacitated or impaired that he or she is either unable or unwilling to travel to an evaluator's office for an evaluation. In those cases, an in-home evaluation might be necessary.



## Evaluations of Diminished Capacity for Guardianship

Opinions concerning a person's need for a guardian are frequently contested. If an evaluator opines that the person needs a guardian, the person may contest that opinion, as his or her freedom to make choices would obviously be at stake. If the evaluator opines that the person does not need a guardian, the party who raised the issue – such as a family member – may contest the opinion, as obviously that party perceives the person to be incapacitated. If a thorough evaluation has not been conducted, or if the evaluator fails to appreciate the complexities of the case, it becomes exceedingly more difficult to successfully defend the expert opinion under scrutiny. Contested hearings are not for the faint of heart or the ill prepared.

### About the Author



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# Speak to Me so I Can Understand: Language Usage in Decision Making

Amel Sweis-Haddad, PsyD

## Abstract

Language contributes to the development of social constructs. This paper examines how language impacts decision making processes. Behavioral psychology utilizes behavioral charts to reflect social constructs through the juxtaposition of ideas expressed in opposite terminology. Antonyms are useful for this purpose. It is understood that definitions overtly (and covertly) provide valuation and contribute to a child's understanding of their social milieu. It is also understood that meaning and understanding can be obscured or obfuscated. When things are ambiguous there is interference with the decision-making process as it is a "definition dependent" process and employs IF/THEN sequences that operate on perceived utility (value and purpose).

Behavioral charts contain social constructs that are predetermined by the juxtaposition of ideas that are presented in a contrasting manner. The utilization of behavioral charts by Cognitive Behavioral Psychologists fosters understanding and discernment in children through the use of clear definitions. These definitions of appropriate and inappropriate behavior contribute to the development of a child's social constructs.

The challenge for many parents and educators is establishing clear definitions and valuations of appropriate or inappropriate behaviors for children. Children need to understand what is expected of them. They must learn to discriminate between helpful and harmful behaviors in order to make meaningful choices and obtain desirable outcomes. Choices must be clear, not murky.

Behavioral Psychologists do understand that not all definitions are learned through verbal interactions; some are modeled while others are influenced (or limited) by innate biological factors such as intelligence, past experience or even conditioning. However, the focus of this paper, is the examination of how language impacts decision making and social constructs. We will move from the most elementary sensate experiences of the child to the examination of micro and macro social interactions.

## UNDERSTANDING IS CREATED THROUGH EXPERIENCES OF SENSATION AND PERCEPTION

Language is a binary system containing words that can be classified as antonyms and synonyms. These words possess enormous power to influence and shape social constructs as they express what we discern and perceive: Light and Darkness, Beauty and Vileness, Harmony and Cacophony. In their expression is peace and conflict, understanding and discord. We must examine their use.

Indeed, one of the first things we teach young children is how to sort and label things that are the same and different. One of their first developmental tasks is to contrast and name colors and shapes. We train children to pay attention to details as they interact with their environment. They utilize their senses and name what they experience.

Perception then interprets these sensations, but these perceptions are often based on past experiences and are understood within the context of time and space, as well as social milieu or culture (Sweis-Haddad, 2017). Factors, such as these, influence how children make interpretations. For example, if a child plays outside in the snow and then comes indoors to a room of 70 degrees, that child thinks it warm but if that child comes in from the beach where it is 95 degrees, the child would feel cool inside. Past experiences shape present perceptions. We understand sensate experiences when *change* is perceived.

In the poem, *The Blind Men and The Elephant*, by John Godfrey Saxe (1873), the six blind men of Indostan each interpret their present experience of the elephant based on their *limited* past and present experiences. Their sensory experiences and perceptions are clouded by the fact that none of them possess an experience with the *whole* elephant and as a result conflict ensues. Each man speaks from his own experience and perspective only. There is no unified and comprehensive experience or definition to name the elephant before them. Each man defines for himself a reality that is severely limited by personal experiences and perceptions.

## UNDERSTANDING IS CREATED THROUGH SHARED DEFINITIONS

Definitions are not always shared and this is historically the reason for micro and macro conflicts around the world. One man's definition of success or failure is not necessarily shared by another man. One group's definition of robustness or frailness is not necessarily appreciated by another. One country's definition of strength or weakness is not lauded by



another. The problem spins larger and larger for the individual within the smallest of these social constructs (the family) to the largest of constructs (political systems).

Families have their own microcosms. Cognitive behavioral psychologists assist parents and teachers in developing behavioral intervention plans. The problem-solution identification process is the *mechanism* that helps children discern whether a particular behavior is either positive or negative. This mechanism is a process that basically uses antonyms to anchor behavioral choices in a diametrically opposed (or orthogonal) manner.

An understanding of the effectiveness of antonyms and synonyms within behavioral intervention plans is crucial for behavioral psychologists. Interestingly, we know that antonyms can be more thoroughly understood by synonyms. For example, synonyms of the (Adjective) “clean” include: pure, understandable, comprehensible, intelligible, plain, direct, uncomplicated, explicit, lucid, perspicuous, distinct, simple, and straightforward. On the other hand, antonyms of the (Adjective) “clean” include: messy, dirty, cloudy, murky, indefinite, sketchy, vague, insensible, obscure, incomprehensible, unintelligible, nebulous, imprecise... This most basic observation is important for understanding how language helps create social constructs, for these constructs are value laden.

Parents create the earliest social constructs by identifying both problems and solutions. When they identify problems, they generally tend to describe a child’s problematic behavior in general terms using *adjectives* such as messy, impolite, or lazy. Later, with the help of a therapist, they learn to use *verbs* to describe specific positive and negative behaviors. For example, positive verb phrases describing the adjective “clean” may include: brushing your teeth, taking a bath, wearing clothes that have been washed while negative verb phrases describing the adjective “dirty” may include: not brushing your teeth, not taking a bath, or wearing unwashed clothes. Since antonyms describe opposite behaviors, we understand that the word “clean” is opposite to the word “dirty” and that brushing your teeth is the opposite of not brushing your teeth. Behavioral charts outline these actions and phrase them in a dichotomous manner using antonyms.

The point is opposite *actions* (verb phrases), as well as opposite *descriptions* (adjective phrases) are diametrically opposed distinctions that allow “sensing” or “sensible” people to understand differences and choose. Our senses help us discern differences such as hot or cold, sweet or sour, soft or hard, aromatic or pungent, loud or soft. It is through comparative juxtaposition, that we understand things.

#### **UNDERSTANDING CAN BE OBSCURED OR OBFUSCATED AT THE INDIVIDUAL LEVEL**

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Freedom requires an awareness of choices perceived through senses. However, things are not always as they appear. We can be deceived into thinking something is what it is not,



or that something is good when it is, in fact, harmful. For example, things can be “cloaked” to represent something they are not. Two errors can result. The first is an error *definition*: calling something what it is not. Indeed, things are not always what they appear to be. Children understand this concept when they play and engage in fantasy and “dress up.” The second error is one of *valuation*: valuing something as good and desirable when it really is not. For example, a child may open a bottle and think the contents are yummy candy when the contents are, indeed, a harmful cleaning agent. *The challenge is to know the truth, the true definition of things.*

#### **AN INDIVIDUAL’S UNDERSTANDING IS CREATED WITHIN SOCIAL CONSTRUCTS**

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At the individual level, sensations and perceptions are a very personal matter. Definitions may hold personal meaning but they are also social constructs. For example, a child’s first social/cultural interaction is usually within the family. Gradually the circle widens to include friends and acquaintances at school. Later, the circle widens again to include others based on geography, culture, interest, and work among other things. Within each social construct there is a shared understanding of basic definitions (and valuations) characterizing that particular milieu. Parents create these social constructs by using behavioral interventions that, first, clearly define appropriate and inappropriate behaviors so their children can choose a course of action and then, second, teach them how to obtain goals (Sweis-Haddad, 2016).

#### **UNDERSTANDING DEFINITIONS REQUIRES THE FREEDOM TO CHOOSE**

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There is no real freedom without acknowledging different choices. Freedom does not thrive on similarities but on the ability to discern distinct differences and accurately label those differences. *It is in discernment that one can be truly free to choose.* This is the reason why behavioral psychologists encourage parents and teachers to use behavioral charts

**TABLE 1: SOLUTION BEHAVIORS, CHARACTER QUALITIES, AND OUTCOMES**

IDENTIFIED PROBLEM BEHAVIOR	POSSIBLE NEGATIVE OUTCOMES	IDENTIFIED SOLUTION BEHAVIOR	POSSIBLE POSITIVE OUTCOMES
<b>Fights with siblings and peers</b>		<b>Gets along with siblings and peers</b>	
Screams, yells, uses unkind and mean words Hits, punches, kicks Does not share or take turns Does not play together	Stuck in Time-Out Does not have friends Not asked to play Avoided and not liked by peers	Talks nicely to other Keeps hands and feet to self Shares, take turns Agrees to play together	Can play, not in Time out Has friends Peers ask child to play Befriended and liked by peers
<b>Does not pick-up after self</b>		<b>Picks-up after self</b>	
Will not put things away or make the bed Leaves toys on the floor Needs frequent reminders	Disorderly room Friends cannot come over to play Does not enjoy privileges	Puts things away, makes the bed Picks-up messes left on the floor Remembers to do chores	Room is orderly Friends can come over to play Enjoys privileges
<b>Exhibits poor social skills</b>		<b>Exhibits good social skills</b>	
Does not look at person speaking Does not reply when spoken to Does not say hello or good bye Does not say please or thank you Does not tell the truth	Considered shy or anti-social Considered unfriendly Does not make new friends Considered ungrateful and impolite Not trusted	Looks at person who is speaking Replies when spoken to Says hello or good bye Says please or thank you Tells the truth	Considered engaging and attentive Considered friendly Makes new friends Considered grateful and polite Trusted to do something
<b>Displays poor table manners</b>		<b>Displays good table manners</b>	
Does not stay seated and fidgets excessively Does not eat with utensils	Considered to have poor self control Considered impolite and a “baby”	Stays seated and eats quietly Eats with utensils	Finishes food Polite and well mannered
<b>Performs poorly academically</b>		<b>Performs well academically</b>	
Does not write down assignments Does not bring home necessary books Does not do homework independently Does not return homework to school Gives up easily on challenging tasks	Fails tests Cannot do homework Cannot work independently Stays in for recess Does not learn material	Writes down assignments Brings home necessary books Works independently Returns homework to school Persists with challenging tasks	Passes tests Can do homework Can work alone Plays at recess Learns to try again and succeed

outlining appropriate and inappropriate behaviors, as well as their outcomes (Sweis-Haddad, 2018).

Yes, there are a diversity of choices, opinions, and beliefs and they must be examined. However, for diversity to really be diversity, it needs to focus on *both* similarities and differences. At times, it has focused heavily on similarities and neglected important differences. There are differences! And these differences help define life choices so children (and adults) can sort through and label the options before them in order to choose the pathways and outcomes truly desired.

Behaviors have an implied value, both, at the point of decision and at the point of outcome. These values may be overtly or covertly stated but, nonetheless, they are present and influence one’s ability to make choices. *The decision-making process is definition dependent and uses IF/THEN sequences that operate on perceived utility (value and purpose).*

Cognitive-Behavioral psychology cannot fully remove itself from value-based decisions. There is an implied value (whether positive or negative) assigned to the exhibition of certain behaviors, either by the individual or by the particular social construct of the child. These values may differ between the individual and the social milieu. Generally, there is *less* conflict when definitions and valuations are the same for the individuals engaged in discourse. And, generally, *more* conflict and confusion about choices or outcomes is observed when definitions are not clearly articulated or agreed upon.

**UNDERSTANDING DEFINITIONS IS ESSENTIAL FOR OBTAINING OUTCOMES**

We value diversity. However, diversity is only diversity when both similarities and differences are recognized. It thrives on discernment, the recognition of differences that help us all make meaningful choices. Indeed, a few synonyms for

## Speak to Me

discernment are: understanding, illumination, and wisdom. We must not sacrifice clarity of definition. How will young people be able to choose and obtain positive outcomes if definitions are unclear and muddled?

Inclusive definitions must be used alongside Exclusive definitions to create a real understanding of organization and taxonomy. For example, teaching a child that poison ivy and aloe are both “plants” is an example of an inclusive definition. However, making the distinction that although both are “plants” (an inclusive definition), they each have a unique distinctive identifier, or name, that provides an exclusive definition since one is harmful and one can provide healing.

Specificity is illustrated in biological taxonomy where scientists make a distinction between a dog and a wolf, although both are canines. The more general and inclusive the definition, the less meaningful it becomes. The more specific and exclusive the definition, the more meaningful and useful it becomes for one to truly see choices, exercise freedom and pursue goals. By neglecting exclusive distinctions, we make choices less readily understandable and outcomes more difficult to attain in the process of making positive life choices.

Decision making flourishes with clarity. IF/THEN logic requires one the freedom to choose among distinct options. When choices along linear pathways are obscured or are nebulous, it becomes difficult to attain goals. Positive outcomes are less likely if one navigates in the dark. Definitions are Light. They illuminate pathways.

## WHO WILL CREATE THE DEFINITIONS NECESSARY FOR UNDERSTANDING?

We all need definitions. Cognitive Behavioral Psychology thrives on clear definitions. The observations made in this paper raise questions for us all. Definitions are how we create a culture of understanding; but what are the ramifications of everyone creating their own definitions and laws? How will this affect our society’s ability to effectively communicate?” And will this compromise its stability? Is anarchy inevitable? Or will a new social construct be imposed to put everyone on the same page?

The question is: “Who will determine the correct definitions?” A definition and value judgment will have to be made by someone. The question is: “Who will make the call?” Will it be the parent or the child, the student or the teacher, the employer or the employee, the government or the citizen? The question now becomes political, philosophical, and even theological. The Philosopher will say, “It depends, for it is hard to say;” while The Politician will say, “It rests with the Stronger;” and The Theologian will say, “God.” Again, “Who will make the call?”

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# When Minor Separation Becomes Major: Our Clinical and Ethical Border Crisis

Sheresa Wilson-DeVries, PA-C  
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## Abstract

Nearly 3,000 minors have reportedly been separated from their families upon their arrival and detainment at the US borders, in accordance with a spring 2018 zero-tolerance policy instituted officially by the Department of Justice and the Department of Health and Human Services. This article highlights the deleterious effects—both psychological and physiological—of traumatic separations in pediatric populations. As both empirical research and ocular observations demonstrate, these separations constitute a “major minor crisis.” As a profession, we do not support the unnecessary perpetration—or perpetuation—of human suffering (including and especially the most vulnerable amongst us).

Sergio arrived in the US with his father, but they were detained at the border. Their belongings were confiscated, the group was divided, and they were ushered into separate vehicles. Sergio was directed to a different vehicle than his father, with assurances that they would be together again shortly. At the time of his interview, it had been 45 days since Sergio last saw his father. Sergio was taken to a shelter for migrant children, and it was over a month before he was allowed to speak to his father on the phone. In his interview he stated (via translator), “I worry about him every day and every night. I can’t sleep well at all because I worry so much about my family. I have only spoken with my father a total of 20 minutes in these 45 days” (Silva, 2018).

Sergio has been informed this his father has been slated for deportation, and that is all he knows. He would like to go home with his father, but feels powerless and invisible in the process. In his interview with Danielle Silva, he reported, “I do not want to be here anymore, especially since I know how much my father is suffering... The way I have been treated makes me feel like I don’t matter, like I am trash” (Silva, 2018).

Nearly 3,000 such children have reportedly been separated from their families upon their arrival and detainment at the US borders, in accordance with a spring 2018 zero-tolerance policy instituted officially by the Department of Justice and the Department of Health and Human Services (DHS, 2018). However, the increase in documented cases of such separations dates back to 2017, even before the policy was legally implemented. The policy was subsequently reversed in June of 2018, and the families were ordered to be reunited. Hundreds of children have, in fact, reconnected with their families (DHS, 2018; OIG, 2019). However, this task has proven difficult due to challenges in identifying and tracking the children, and then locating the parents, some of whom have already been deported. Numerous children are still awaiting familial reunification, and there are reports of additional children being separated from their parents, even following the termination of Zero-Tolerance legislation (OIG, 2019).

## SEPARATION ANXIETY

Separation anxiety is a normal developmental phenomenon of infancy, wherein a child displays distress at the “loss” of a caregiver or attachment figure, as they disappear from direct view. This stage usually concludes at approximately age two, when the child comes to comprehend permanency, and the idea that the caregiver will eventually return (American Academy of Pediatrics, 2000).

However, separation anxiety is considered pathological when this reaction becomes disruptive, and when it occurs in a child who has developmentally exceeded the toddler stage. These children may experience insomnia, as exacerbated by nightmares; may be clingy and persistently worry about separation from the caregiver; and may be unable to spend time alone, or in settings away from the attachment figure. These children may also display a variety of physical symptoms (ranging from headaches and nausea to vomiting and palpitations) while experiencing difficulty in concentration, extreme homesickness, specific fears and phobias, or panic attacks (APA, 2013; Bernstein, 2018).

While it is not completely clear what causes pathological levels of separation anxiety, there seems to be increased susceptibility in individuals with a family history of anxious or depressive symptomatology. Furthermore, this phenomenon may be related to major stressors in the child’s life, including death, divorce, change in schools, or some devastating event that separates children from their family or loved ones. This is especially true when the child is young and the circumstances surrounding the separation are traumatic (Bernstein, 2018).

## TRAUMATIC SEPARATION

Based on these factors, it stands to reason that a traumatic separation will predispose a child to pathological levels of separation anxiety. Examples of traumatic separation include parental incarceration, immigration, deportation, military deployment, or termination of parental rights (NCTSN, 2016).



Parental incarceration alone has been independently linked to such outcomes as learning disabilities, speech and language impairment, inattentiveness / hyperactivity, behavioral or conduct problems, and developmental delays (Turney, 2014).

Children exposed to these events respond similarly to those who have experienced traumatic grief and/or Post-Traumatic Stress Disorder. However, the primary distinction between traumatic grief versus traumatic separation occurs when (in the latter case) the child seems to maintain hope for reunification (whether realistic or otherwise), since the parent has not ostensibly deceased. Unfortunately, this expectation for reconnection can complicate their adjustment to interim care, or inhibit healthy coping, since they are simply “in waiting” for their parent or caregiver to return—which may or may not transpire (NCTSN, 2016). More specifically, symptoms of traumatic separation include intrusive thoughts; nightmares; avoidance of triggers or reminders; re-enactment in play; negative or self-destructive beliefs, thoughts, or feelings related to the incident; self-blame; difficulty concentrating; or somatic symptoms such as head pain, stomach aches, and insomnia (NCTSN, 2016).

Additional complicating factors can occur when children have witnessed their parents being beaten, raped, arrested, detained, or otherwise mistreated throughout the circumstances of their separation. For example, these children are more likely to demonstrate persistent anxious ideation regarding their parents, and especially regarding the uncertainties of not knowing their present wellbeing, nor the duration of the ongoing separation (NCTSN, 2016).

Even on a post-reunification basis, some children and families have continued to struggle. Depending on their age, length of separation, and myriad other compounding or contextual factors, some children have remained emotionless, avoided their parents, or even failed to recognize them (Riley, 2018). In addition, chronic problems resulting from childhood traumas in general are well-established, with far-reaching implications ranging from mental, emotional, behavioral, and addictive

dysfunction to cancer, heart, lung, liver, and skeletal diseases (Felitti, et. al.)—and especially in women, autoimmune disorders (Dube, et.al.). In short, traumatic separation can undoubtedly cause both acute and chronic problems for the children and families involved.

#### **BACK AT THE BORDER**

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A representative from the Center for Human Rights and Constitutional Law Foundation acknowledged that the increasing numbers of children in their facilities have strained fundamental resources, including potable water, edible food, mats, blankets, and basic toiletries. The same representative reported that the children frequently show signs of trauma and emotional distress, such as anxiety, nightmares, difficulty sleeping, and depression (Silva, 2018). These ocular observations are consistent with the empirical research referenced throughout this article.

For centuries we have prided ourselves as a nation of law and order. Indeed, the primary reason for this long-standing deference to legality has been the protection of individual rights (and especially those of vulnerable populations). As psychologists, we aspire to an even higher mandate than our legal structures. In all decisions within our professional roles, we are compelled to pursue the highest ideals of beneficence—or at the very least, non-maleficence. Our ethical codes further mandate that we do not discriminate based on race, ethnicity, culture, language, or socioeconomic status. As a profession, we do not support the unnecessary perpetration—or perpetuation—of human suffering (including and especially the most vulnerable amongst us).

Do we have a crisis at the border? Yes. Is this crisis minor or major? Yes. We have a major ethical and clinical crisis of minors. And any sub-ethical, sub-clinical treatment of minors (irrespective of immigration status) will only ensure that the major crisis continues: Perhaps for decades, perhaps for life, and perhaps for generations.

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# A Model for Addressing Emotional Support Animal Requests: Who Should (And Shouldn't) Do It and How

Bob Stinson, PsyD, JD, LICDC-CS, ABPP (Forensic)

## Abstract

Recent years have seen an increase in the number of requests for Emotional Support Animals (ESAs). Research to date indicates that many treatment providers are certifying that their patients need an ESA, despite this running contrary to ethical practice, regulatory rules, and the prevailing standards in the field of psychology. The reasons treating psychologists should avoid taking on such a role is explained. Why that role should be left to third party forensic evaluators is clarified. Finally, an assessment process is offered, taking into consideration the ethical and legal issues, the necessary components of an appropriate ESA assessment, and the process of formulating and communicating opinions on such matters.

## INTRODUCTION

An Emotional Support Animal (ESA) is a companion animal that provides therapeutic benefit and is recognized as a “reasonable accommodation” for a person with a mental or psychiatric disability (Wisch, 2015). Unlike service animals, ESAs are not trained to perform specific tasks for the person with a disability (Wisch, 2015).

In recent years, there has been a significant increase in the number of ESAs. Airlines, in particular, have seen an influx in recent years. There has been a 150% increase in animals in flight between 2015 and 2018 and “animal incidents” increased 84% between 2016 and 2018 (Bachman, 2018). It has become a bit of a zoo in the air, as kangaroos, pigs, ducks, turtles, miniature horses—in addition to other animals and the expected cats and dogs—have flown under the guise of ESAs. Delta airlines has reported that customers have attempted to fly with comfort turkeys, gliding possums, snakes, spiders, and more (Bachman, 2018). A woman attempted to fly on United Airlines with a peacock (Silva, 2018).

## TREATMENT PROVIDERS SHOULD AVOID CERTIFYING ESAS

So who’s approving all these critters to fly? According to at least one study (Boness, Younggren, & Frumkin, 2017), it is a combination of clinical and forensic practitioners. In their study, 80% of clinicians believed it was appropriate for a treating mental health professional to offer an opinion on the need for an ESA, 62% of the clinicians believed they were qualified to make an ESA determination (even though there were no guidelines for such), and 50% had made an ESA recommendation for one or more individuals. This data demonstrated a lack of awareness of (1) the forensic nature of such an evaluation, and/or (2) the ethical problems with treating clinicians taking on a forensic evaluation role.



Stinson (2018) identified the complex legal, contractual, and administrative matters that make certifying ESAs a forensic matter. More than 20 years after Greenberg & Shuman (1997) published their seminal work on “Irreconcilable Conflicts Between Therapeutic and Forensic Roles,” many therapists continue to struggle to avoid the perils that come with simultaneously engaging in therapeutic and forensic roles. Younggren, Boisvert, & Boness (2016), Dingle (2016), and Younggren (2019) have examined the ethical problems that psychologists may face in their practices related to the evaluation and certification of ESAs, including role conflicts, issues about competence, risks to the therapeutic alliance, loss of objectivity, problems with thoroughness, and liability. Stinson (2018) offered the following as it relates to treatment providers evaluating and certifying ESAs:

1. These therapists are engaging in the practice of forensic psychology (see also the Specialty Guidelines for Forensic Psychology, Introduction section, APA, 2013).

## Emotional Support Animal Requests

2. They are reminded that their therapeutic roles and such forensic evaluation roles are irreconcilably conflictual (Greenberg & Shuman, 1997) and, therefore, should be avoided.
3. They are arguably violating APA's Ethical Principles for Psychologists and Code of Conduct (APA, 2017), potentially inviting ethics complaints and state board sanctions (see especially standard 3.05 on Multiple Relationships).
4. Their certifications can result in danger to others, potentially leaving the psychologist vulnerable to civil liability claims.
5. Finally, certifications based on inadequate procedures and information, in the end, can result in a disservice to all those who legitimately need ESAs.

In short, the literature to date establishes that certifying ESAs is a forensic evaluation matter but it is being undertaken by a number of treatment providers. These treatment providers are putting themselves, their patients, and others at risk as this practice by treatment providers is contrary to ethics codes, specialty guidelines, state boards of psychology rules and regulations, and the prevailing standards in the field of psychology.

### ESA EVALUATIONS

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It is concerning that 50% of clinicians from one survey (Boness et al., 2017) acknowledged they had made an ESA recommendation for one or more individuals. It should be equally concerning that 62% of treatment providers (and 65% of forensic psychologists) felt qualified to make an ESA determination, even though there are no established guidelines for such a determination. To address that concern, standard assessment recommendations for those who do undertake this type of evaluation are offered here, giving attention to the ethical and legal concerns, the actual assessment, and the documentation and reporting of such an assessment.

1. The psychologist should assess whether it is appropriate to agree to undertake the requested evaluation.

At a minimum this should include an assessment of competence to take on the role, such competency being based on education, training, supervised experience, consultation, study, or professional experience (APA, 2017, 2.01). The psychologist should assure the psychologist's work is based on established scientific and professional knowledge (APA, 2017, 2.04) and, assuming it is, the psychologist should be able to show what efforts were undertaken to develop and maintain that competence (APA, 2017, 2.03). The psychologist must have adequate knowledge in the field of psychology but also a fundamental and reasonable knowledge of the laws, rules, and precedents that govern their participation in these types of assessments (e.g., the difference between an ESA and a service animal, the Americans with Disabilities Act (ADA, 2011), the Fair Housing Act (FHA, 1968), the Rehabilitation Act of 1973, and the Air Carrier Access Act (ACAA, 2003)) (APA, 2013, 2.02 and 2.04).

In addition to addressing matters of competence, the psychologist must take care to avoid entering a multiple relationship that could reasonably impair the psychologist's objectivity, competence, or effectiveness, or otherwise risk exploitation or harm to the person being served (APA, 2017, 3.05). This means treatment providers should avoid providing this service for their patients (Greenberg & Shuman, 1997; Younggren Boisvert, & Boness, 2016; Stinson, 2018). Relatedly, psychologists should determine if the proposed service goes beyond the role for which the psychologist has obtained informed consent (APA, 2017, 3.10, 9.03, and 10.01).

If the service is not within the psychologist's area of competence and expertise, if it would create a forbidden multiple relationship, and/or if it goes beyond the scope of service for which the psychologist has obtained informed consent, then the psychologist should not take on the role and should, instead, refer the matter to a third party. For treatment providers, this is always going to be the preferred option when the request comes from the treatment provider's patient.

2. The psychologist must undertake a forensic disability evaluation of the person requesting certification for an ESA to determine, as a threshold issue, if the person has a psychological disorder consistent with the applicable statutes, rules, and regulations.

The psychologist must be sure to apply the appropriate legal definition of "disability." If one is not sure of the statutory definition of "disability" as it applies to a particular request for certification of an ESA, that may be an indication that the appropriate competence has not been achieved. The psychologist must understand, among other things, that he or she is offering a psycholegal





## Emotional Support Animal Requests

opinion on the presence of a disability, there are specific standards for undertaking such an evaluation, and there may be long term (even if unintended) consequences of being identified as a person with a disability.

3. The psychologist must assess whether the person making the request has a disability-related need for an assistance animal.

The psychologist must assess functional limitations that are a consequence of the identified disorder; that is, in doing a forensic disability assessment, the psychologist must assess whether the disability substantially interferes with the person's ability to perform one or more major life activities. In this regard, it is important to understand that terms like "disability," "substantial," and "major life activities" are legal terms and the psychologist is ethically required to have "knowledge of the laws, rules, and precedents" that apply (APA, 2013, 2.02 and 2.04, p. 9)

4. The psychologist must determine if the animal will ameliorate the problems and limitations associated with the disability.

Any opinions should be based upon adequate scientific foundation and reliable and valid principles and methods that have been applied appropriately to the facts of the case (APA, 2013, 2.05). Younggren (2019) has suggested that a proper evaluation consist of an evaluation of the interaction of the animal with the owner to support the claim of amelioration.

Additionally, throughout, it will be important to remember that a psychologist involved in this role ordinarily avoids relying on one source of data and when relying upon data that have not been corroborated, the psychologist should seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data. (APA, 2013, 9.02). In fact, psychologists engaging in these services should be prepared "to disclose all sources of information obtained in the course of their professional services, and to identify the source of each piece of information that was considered and relied upon in formulating a particular conclusion, opinion, or other professional product" (APA, 2013, 11.03, p. 17).

5. The psychologists should consider context.

It may be that in one setting (e.g., in a controlled home setting) a particular animal does provide support that ameliorates one or more of the identified symptoms or effects of a person's disability. However, this cannot be assumed to be the case in all contexts. A simple Google search provides a number of examples of innocent others, including young children, being attacked and mauled by ESAs. Not taking the context into consideration has the potential to cause significant harm to others and to expose the psychologist to liability.

6. Every ESA evaluation should consider and assess the possibility that the person is being deceptive in symptom report and/or claims of alleviation of symptoms as a result of the ESA.

According to the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5; APA, 2013), malingering should be strongly suspected in a medicolegal (or psycholegal) context. In ESA evaluations, external gain can include not having to pay to transport an animal, not having to pay to board an animal, being permitted to have an animal in places where pets otherwise are not permitted, etc.

7. Finally, the psychologist will document his or her findings, usually in the form of a letter or a report.

Psychologists should "recognize the importance of documenting all data they consider with enough detail and quality to allow for reasonable judicial scrutiny... This documentation includes, but is not limited to, letters and consultations; notes, recordings, and transcriptions; assessment and test data, scoring reports and interpretations; and all other records in any form or medium that were created or exchanged in connection with [the] matter" (APA, 2013, 10.06, p. 16). Moreover, psychologists in this role must strive to "distinguish observations, inferences, and conclusions [and] are encouraged to explain the relationship between their expert opinions and the legal issues and facts of the case at hand" (APA, 2013, 11.02, p. 16).

## CONCLUSIONS

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There has been a significant increase in the number of individuals requesting and being granted certification of ESAs. The literature suggests many of the ESA certifications are being granted by treatment providers. Treatment providers, however, should avoid taking on such roles for their patients as the practice runs afoul of ethics standards, specialty guidelines, state boards of psychology rules and regulations, and the prevailing standards in the field of psychology. Perhaps more involved and more complicated than may be obvious at first, requests for ESA certifications are complicated forensic evaluations intertwined with complex state and federal laws. By following the seven-step process proposed here, treatment providers will avoid taking on such referrals and forensic evaluators will have much needed guidance on how to approach such evaluations from the time of referral, through the actual assessment process, and to the point of formulating opinions and writing reports.

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## A Developmental Perspective of the Neuropsychological Impacts of Lead Exposure

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### Abstract

The Centers for Disease Control define an elevated blood lead level (EBLL) as  $\geq 5 \mu\text{g/dL}$ . While the drinking water crisis in Flint, Michigan in 2014 renewed national attention for the health risks posed by lead exposure, water-based lead exposure remains an area of concern in many communities across the United States. The neurological, cognitive, and behavioral implications of lead exposure present an opportunity for psychologists to support impacted communities. A literature review was conducted to illustrate the neurological, cognitive, and behavioral impacts of lead exposure at varying stages of development.

### INTRODUCTION

Despite engagement from the Centers of Disease Control (CDC) classifying an elevated blood lead level as low as  $5 \mu\text{g/dL}$ , lead exposure at toxic level remains a common source of environmental poisoning. As of 2017, blood lead levels in the toxic range continued to impact 6% of children between the ages of one and two years of age (American Academy of Child and Adolescent Psychiatry, 2017). Young children are particularly vulnerable to lead exposure as many of their early exploratory behaviors include putting objects in their mouths. When legislation in 1977 reduced the acceptable amount of lead in paint to .6%, the risk of lead exposure due to house dust and yard soil decreased (Phelps, 1998). However, failing infrastructure, particularly in communities associated with low socio-economic status, presents a renewed risk for lead exposure. As the drinking water crisis in Flint, Michigan in 2014 illustrated, plumbing and ineffective water treatment present another potential source of lead exposure. Lead exposure through water may be a more salient risk for those for whom dehydration is also a serious concern – the young and the elderly. Furthermore, as lead is considered a neurotoxin (Bellinger, 2010), it is important to understand the potential neurological, cognitive, and behavioral implications for child and adolescent development.

### METHOD

A comprehensive literature review was conducted using Google Scholar, Medline, and PsychInfo databases and search terms including: “lead exposure,” “child development,” “adolescent development,” “neuro\* impact,” “cognitive impact,” and “behavioral impact.” Articles were included if they were peer-reviewed. For each article, the type of impact (i.e., neurological, cognitive, behavioral) was noted as well as the age of exposure to lead, amount of exposure, and method of measurement (e.g., blood lead levels, tooth lead levels, bone lead levels).

The resulting information was organized in table format (e.g., Figure 1) by developmental age group (i.e., intrauterine, infant-toddler, early childhood, middle childhood, adolescence), degree of exposure, and type of impact (i.e., behavioral or cognitive). Neurological impacts were discussed separately as neurological change mechanisms were not described at varying ages in the articles reviewed. The measurements of lead exposure in the literature was sorted categorically into degrees of exposure (i.e., low, moderate, high, and severe) in order to aid organization and visualization of the information.

While the intention was to organize the impact of lead exposure based on the cognitive and behavioral impacts at varying degrees of exposure across child and adolescent development, the literature often did not distinguish whether the age of exposure and age of measurement were the same. For the purposes of this study, it was presumed that this was the case, and the data was organized accordingly with the exception of intrauterine exposure. In this section, while the levels of exposure occurred during intrauterine development, cognitive and behavioral impact was measured at different stages of development. This was acknowledged by repeating the information verbatim in the appropriate cells of the table.

### RESULTS

Ultimately, the review included 31 studies published between 1979 and 2018 and three books and/or chapters. Due to the method of organization of the materials, investigators were able to visually depict gaps in the literature. There was no literature available for the behavioral impact of lead exposure birth-2-years-old at a degree of exposure less than  $15 \mu\text{g/dl}$  and greater than  $15.5 \mu\text{g/dl}$ . Additionally, the behavioral impact of lead exposure in early childhood (3-5-years-old) was noted above  $40 \mu\text{g/dl}$  in general, but there was no specific research comparable to the  $70\text{-}100 \mu\text{g/dl}$  range as there was for cognitive impairment in that age-range. Similarly, there

FIGURE 1: NEUROPSYCHOLOGICAL IMPACTS OF LEAD EXPOSURE

		Degree of Exposure			
		Low	Moderate	High	Severe
Early Childhood (3-5 y/o)	Cognitive	Level: 5 µg/dL blood lead level  Mild cognitive impairment in facial recognition and visual processing deficits (Jedrychowski et al., 2009)	Level: 15 µg/dL blood lead level  General cognitive decline by 3 points, especially visual-spatial & visual-motor skills (Bellinger et al., 1994)	Level: >30 µg/dL blood lead level  Mild to profound intellectual impairments, impaired facial recognition, and verbal memory (Canfield et al., 2005; Tayloy et al., 2010)	Level: 70-100 µg/dL blood lead level  Readily observable symptoms including significant cognitive delays, convulsions and even death (Canfield et al., 2005; Tong & Lu, 2001)
	Behavioral	Level: >15 µg/dL blood lead level significantly higher TBPS and Externalizing scored on the CBCL as compared to lower levels of exposer. Aggression and hyperactivity at clinically significant levels seen more often in boys (Sciarillo, Alexander, & Farell, 1992)	Level: 10-20 µg/dL blood lead level  Increased concentration within the range associated with increases in Destruction and Withdraw subscale behaviors (Wasserman et al., 1998)	Level: >40 µg/dL blood lead level  Increased aggression, distractibility, organizational problems, hyperactivity and impulsivity (Banks, 1997; Rummo et al., 1979)	No literature available
		Level: ≥ 2.66 µg/dL bone lead  Associated with increased ODD behavior (Lin et al., 2019)	Level: 10-24.90 µg/dL blood lead level  Increased hyperactivity, distractibility, and low frustration tolerance; a trend toward a similar association with increased fearfulness, social withdraw, and disinterest in surroundings (Mendelsohn et al., 1998)		

was no behavioral information in middle childhood (6-11-years-old) and adolescence (12-18-years-old) to correspond with the cognitive impact associated with the range of 80-100 µg/dl.

**CONCLUSION**

**Neurological Impacts of Lead Exposure**

The environmental quality of living has an important influence on the development of a child’s temperament and mood. Children are especially vulnerable to the harmful effects of lead exposure during the early stages of development, as it can have wide range of effects on the development of behavioral patterns. Intrauterine lead exposure has been shown to negatively impact synaptogenesis, the blood-brain barrier, and metabolism (Silbergold, 1992; Sundstrom & Karlsson, 1987; Goldstein, 1992). Lead interferes with

the typical synaptic pruning period which occurs from early childhood through puberty. Lead exposure negatively impacts the blood-brain barrier by making it less permeable (Goldstein, 1992). Finally, lead interferes with the metabolism of neurons by deregulating calcium and protein kinase C (Goldstein, 1992). As a result of lead’s interference in synaptogenesis, the blood-brain barrier, and metabolism, lead accumulates in several regions of the brain, notably the hippocampus, amygdala, and cholinergic systems that regulate the neurotransmitter acetylcholine which is implicated in learning and memory (Lockitch, 1993). Research indicates a wide degree of variability in the impact of lead exposure; however, while a precise profile is unclear, even mild levels of lead exposure have been associated with cognitive and behavioral difficulties (Phelps, 1998).

## Neuropsychological Impacts of Lead Exposure

### Behavioral Impacts of Lead Exposure

Exposure to small amounts of lead levels can cause children to appear inattentive, antisocial, hyperactive, and irritable (American Academy of Child & Adolescent Psychiatry, 2017). The somatic symptoms associated with lead exposure, such as fatigue and lack of appetite, play a role in the development of this irritable behavior. These temperament patterns can put a child at risk for the development of ADHD and other behavioral disorders (Liu et al., 2010). Early childhood exposure to lead is associated with a wide range of behavior difficulties including distractibility, impulsivity, and aggressiveness. Even lower levels (2 µg/dL) of exposure is associated with later psychological disorders such as Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD; Needleman et al., 1990; Bellinger, 2010).

### Cognitive Impacts of Lead Exposure

In addition to behavioral difficulties, research suggests that levels well below the currently accepted blood lead guidelines of 10 µg/dL can result in executive functioning deficits, short-term memory deficits, and a decrease in IQ scores (Banks et al., 1997; Canfield, 2005; Taylor et al., 2010). Blood concentration at age two was predictive of later IQ performance. In middle childhood, IQ points decreased 1-3 points after lead exposure (Canfield, 2005). This evidence indicates that there should be a heightened cause for concern regarding the neuropsychological, cognitive, and behavioral development of children who are exposed. While early identification of lead exposure is an important step in receiving appropriate medical treatment to mitigate the effects of lead-exposure, longitudinal studies suggest that difficulties may persist. Appropriate interventions should be implemented with an awareness of the level and timing of lead exposure relative to the individual's developmental process.

## DISCUSSION

In addition to investigating the developmental neurological, cognitive and behavioral functioning impacts at varying degrees of lead exposure across child and adolescent development, this study also illustrated current gaps in the literature. These gaps primarily existed in behavioral impacts at high and low degrees of lead exposure. It is possible that these gaps exist because the cognitive studies may have conceptualized behavioral problems through their cognitive etiology (e.g., executive functioning deficits). Additionally, Because the centers for disease control determined that there is no safe level of lead exposure, there is currently no classification system of degree of exposure such as the one represented in this presentation. This classification strategy was utilized as a way to organize information and should not be considered a guiding spectrum of exposure and impact without further investigation and analysis.

One limitation highlighted in this area of research was variation in measurement methodology (e.g., age of exposure vs age of measurement, blood lead levels, bone lead levels, tooth lead levels). Future studies should aim to improve

consistency of methodology (Marcus, Fulton, & Clarke, 2010). Additionally, the literature reviewed for this study was published between 1979 and 2018. Literature on lead exposure tended to be published in concentrated waves, with most studies published before 2000. There is a need for updated literature in the impact of lead exposure on neurological, cognitive, behavioral development. Future studies may also investigate gender differences (Jedrychowski et al., 2009) and explore moderating factors such as poverty and low socio-economic status. Finally, future studies should examine whether treatment of lead exposure with micronutrients mitigated negative impacts on cognitive functioning (Canfield et al., 2015).

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## Cyberbullying and an Unlimited Audience: The Bystander Effect on the Web

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### Abstract

*The bystander effect theory was tested in a cyberbullying situation on a social media platform. Participants were asked to rate the likelihood that they would defend the victim (male or female) on a post with few or many views. It was hypothesized that the amount of bystanders (views) will increase the participant's feeling of responsibility. It was also predicted that participants will be more willing to intervene when the victim is a female, rather than a male. Results supported hypothesis two, but showed opposite results than expected for hypothesis 1, suggesting that the bystander effect does not manifest itself on social media.*

When contemplating how one might react to witnessing an emergency situation in public, most predict that they would offer their assistance in the situation. Whereas the majority of people hold this prediction, research shows that it is very unlikely that an individual will offer assistance if there are multiple witnesses to a particular emergency event. A study by Darley and Latane (1968) examined helping behaviors and bystander apathy as the number of witnesses to an event increased. The results showed that the number of perceived bystanders to an emergency situation significantly affected the report rate. When it was believed that only the participant knew about the emergency, 85% of participants reported it, whereas when there were four other perceived bystanders, only 31% of participants reported it. The bystander effect indicates that most people would not show helping behavior, but rather a reluctance to offer assistance. A follow up analysis found that bystander apathy is facilitated by diffusion of responsibility, evaluation apprehension, and pluralistic ignorance (Latane & Darley 1970). Finally, it was concluded that bystanders are most likely to intervene when they feel responsible for the crisis.

The bystander effect does not require a life or death situation in order to be observed. Later studies on bystander apathy reported this effect to occur in instances of bullying among youth (Salmivalli, 2014). When youths engage in bullying publicly, bystanders generally do not intervene to support the victim. Salmivalli (2014) suggests that the mechanism responsible for this lack of intervention is pluralistic ignorance, or the perception that because nobody is intervening, it is not a harmful behavior. Pluralistic ignorance allows for the youth to indirectly participate in bullying through a belief that it is not harmful to the victim, and to continue to observe the bullying. In addition to traditional bullying, the internet has provided a new platform for bullying that is equally

threatening to youth. Cyberbullying is distinct from traditional bullying in that the victim is always available. This unique genre of bullying has the potential to cause serious troubles such as academic struggles, and affective problems (Tokunga, 2010). This new platform for bullying brings into question whether the bystander effect presents itself online, as it does in face-to-face interaction, or if bystanders are more likely to help when physical interaction is no longer required.

To test if the bystander effect presented itself online as it does in physical interaction, Markey (2000) studied the manifestation of the bystander effect in computer-mediated communications (CMC) by observing an online chatroom in which a message was sent to the chat room asking for assistance. The results demonstrated that the bystander effect through CMC was observed as occurring in the same manner as it would in human interaction when participants were asked to offer assistance to another individual. Other studies presented similar results when tests were completed in CMC chatrooms. However, when related methods (e.g. a message is sent to either a large or small group chat requesting help) were employed to study the bystander effect in social media messaging, the bystander effect results as seen in Markey's (2000) study were not replicated. In a study by Fatkin and Lansdown (2015), a Facebook message was sent to a group of either one, three, six or nine individuals asking for participants to complete a survey for a research project. The results showed that helping behavior was not affected by the group size. A recent study also presented conflicting results to that of Markey (2000) when testing social support on Facebook (Liu & Wei, 2018). The results obtained by Lui and Wei did not demonstrate the bystander effect when participants were presented with a stimuli of a public post with varying severity levels. The conflicting results do not support whether the bystander effect is manifest in online interaction, and



furthermore, all of the above results were obtained when the stimulus was not threatening or emotional, meaning they do not properly address if the effect will manifest when a crisis, such as cyberbullying, is viewed online.

A direct bystander effect, meaning decreased helping behavior with a larger perceived audience, has not been observed in cyberbullying studies. However, a recent study found an indirect bystander effect, meaning helping behavior was not affected by the size of the audience, but another factor, such as participant's feeling of responsibility for viewing the bullying was affected. Results showed that there was an increased feeling of responsibility for witnessing a cyberbullying attack on Facebook when there were very few bystanders, 2, compared to a very large amount, 5025 (Obermair, Fawzi, & Koch, 2016). Participants intent to intervene were not directly affected by the number of bystanders. However, when participants witnessed the attack with few bystanders, they reported an increased feeling of responsibility to intervene. Though the results do not replicate a direct bystander effect, they are consistent with another Latane and Darley (1970) finding that a smaller number of bystanders increases the feeling of responsibility, whereas a large number of bystanders leads to a diffusion of responsibility.

The above studies presented some limitations that may account for the conflicting results. First, all of the above studies were conducted in social media messages, or social media groups, which are not public contexts, as only those within the group or message are involved. Secondly, participant empathy was not tested prior to testing helping behavior, which has been demonstrated to be a significant participant variable when observing helping behavior (Hortensius & Gelder, 2018). Finally, gender of the stimuli was not tested as a variable for response rate (Walker & Jeske, 2016). To examine the bystander effect, with consideration of these variables, the present study will examine if the bystander effect will occur when a participant views an instance of cyberbullying on a public social media platform, Instagram, that is targeted at either a male, or a female victim. While a direct bystander effect is not expected, it is hypothesized that the amount of bystanders (views) will increase the participant's feeling of responsibility. It is also predicted that participants will be more willing to intervene when the victim is a female, rather than a male.

## METHOD

### Participants and design

Participants (N = 79; 40 males; 39 females) were students at John Carroll University who participated in an online experiment through Qualtrics Survey system. This study is a 2 (Gender: male, female) x 2 (Views: few, many) between subjects design. Researcher recruited participants through the SONA sign-up system and participants consented to the experiment electronically. Participants received credit towards a psychology class requirement.

### Procedure

At the start of the experiment, participants were asked to indicate their gender, political ideology, and age and were then asked to complete the Empathic Responsiveness Scale (derived from Olweus & Endransen, 1998). Following the scale, participants were randomly assigned into one of four possible conditions in which they viewed one of the following Instagram posts: (a) female with few views; (b) female with many views (Appendix A); (c) male with few views; (d) male with many views (Appendix B). The Instagram post had either 41 views (few), or 401 views (many) and all had 6 comments. One comment on the post showed an instance of cyberbullying and was kept constant in all four conditions. After viewing the post for 20 seconds, participants answered questions about the nature of the post. The first question asked participants to indicate if they believed there was an instance of cyberbullying (0 = *strongly disagree*; 100 = *strongly agree*). The remaining questions asked participants to rate on a scale (0 = *strongly disagree*; 100 = *strongly agree*) the following: (a) inappropriateness of comment, (b) severity of comment, (c) humor of comment, (d) participant feeling of responsibility, and (e) intention to intervene on behalf of the victim. Finally, participants were asked to indicate the number of views that were on the post as a manipulation check. Participants were presented with a debriefing statement following the study and were given credit for a psychology class at the university as compensation.

## RESULTS

### Intention to intervene

Likelihood of response (intention to intervene) was analyzed with a 2 X 2 (Gender: male, female X Views: many, few) between-subjects ANOVA. There was a main effect for gender,  $F(1, 75) = 4.14, p = .045, \eta^2 = .05$  and a main effect for views,  $F(1, 75) = 4.47, p < .05, \eta^2 = .06$ . There was a significant interaction between gender and views,  $F(1, 75) = 5.26, p = .025, \eta^2 = .07$ . These results showed that participants were more likely to support a female victim ( $M = 68.94$ ) than a male ( $M = 57.07$ ). These results also show the opposite effect than was expected for views. When there were more views on a post, participants were more likely to respond ( $M = 69.21$ ) than when there were fewer views on the post ( $M = 56.82$ ). Finally, participants were most likely to support the victim when it was a female with many views. Table 1 shows the means and standard deviations of likelihood of response.

### Responsibility

Responsibility was analyzed with a 2 X 2 (Gender: male, female X Views: many, few) between-subjects ANOVA. There was no main effect for gender,  $F(1,75) < 1, ns$ . There was no main effect for views,  $F(1,75) < 1, ns$ . There was not a significant interaction,  $F(1,75) < 1, ns$ . Therefore, the manipulation of gender and views did not have a significant effect on the participant's feeling of responsibility.

### DISCUSSION

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Participant's feeling of responsibility did not increase significantly from the few views condition to the many views condition. These results did not support the hypothesis that responsibility would increase in the few views condition, as expected in the bystander effect theory. Though the results did not support hypothesis one, they are consistent with recent studies that have failed to produce the bystander effect in social media (Liu & Wei, 2018; Obermair et al., 2016; Fatkin & Lansdown, 2015). Although the aforementioned studies follow similar methodology as employed in 2000 by Markey, the bystander effect has yet to be replicated on social media. However, though previous aforementioned studies failed to produce a bystander effect, they did not report finding the opposing effect that my second statistical analysis reported. These results demonstrated that participants were more likely to respond in favor of the victim when there were many views rather than few views, which is the opposite of the bystander effect. These findings suggest that the bystander effect does not manifest in cyberbullying situations, but instead presents a differing effect. Rather than holding a greater degree of responsibility when there were fewer views, participants instead seemed to hold great empathy for the female when her cyberbullying was viewed by many bystanders. Hypothesis 2 was supported in that participants were more likely to support the female victim rather than the male victim.

The bystander effect may not have been supported in this study because of the platform that was utilized for the cyberbullying. The cyberbullying was presented on a social media page, a very popular place for bullying to occur, which is why it was selected. Because of the popularity of social media and the expertise teens hold in navigating social media, participants in the study were very familiar with social media and may have responded in an unpredicted way due to his familiarity. For example, social media is becoming increasingly popular for employers to check potential candidates during the hiring process. It is possible that because the participants were college students, and college students are often told to keep social media professional, that the participants felt more empathetic for the conditions in which there were many views because it could be more detrimental to the victim's career if more people have viewed it and liked the post. It could be more detrimental because it may signal to the employer that many people agree with the cyberbullying comment that was made.

The social media platform also could have influenced the results due to perceived popularity of the victim. Today on social media, more likes on a post is a signal for more popularity or more friends. This could have been a factor in the way participants responded to the cyberbullying comment. Perhaps because the victim had more likes on the photo, they are a more well liked person and led to participants reporting higher levels of empathy and support for that victim. Whereas in the few views condition, participants may have viewed this

victim as less popular or likable and their responses would not have elicited feelings of empathy if this were the case. A final suggestion for the bystander effect not being supported could be that the bystander effect is simply different in today's times. The bystander effect was first observed in 1968 (Darely & Latane, 1968), since this time technology and society have drastically changed. Future research should examine if the bystander effect still occurs and is facilitated by the same criteria that was originally found. While it is important to examine this effect in computer and social media communication, it is still necessary to study this effect in interpersonal communication and interaction.

### Limitations

This study did present limitations which could have influenced results. The limitation that could have been the most influential was the attractiveness of the victims. During a presentation of the study, many viewers commented that the photo of the female victim was more attractive and likable than that of the male victim. Because she may have been viewed as more attractive, participants may have had more empathy towards her, leading to the female getting more support. If this study is replicated, photos of victims should be pre-screened for attractiveness to ensure that this is not a confounding variable to the study. Another possible limitation could be that the participants did not have the opportunity to actually respond to the comment, but only self-reported what they believed they would do. Participants may not have been honest in their answers, or may not have actually reacted this way had the participants needed to respond to the comment rather than self-report. Finally, because participants were in a testing room and this experiment occurred on a computer, participants may have been influenced to answer the questions in a particular way rather than how they would truly respond had the experiment been in a more natural environment.

### Future research

Future research should continue to study this phenomenon in contemporary time in the context of social media to examine whether the bystander effect occurs in the same ways it did when it was first observed. Future research should also examine if popularity or employment affects the ways in which people respond to and perceive cyberbullying. Perhaps having three levels of views conditions and examining the ways in which participants respond to the bullying as the views increase could lead one to understanding this. It also is crucial to understand why one is responding to the cyberbullying, rather than just how they respond. Gathering data post manipulation to ask the participants why they responded in such a way would give better insight on how cyberbullying is being perceived and how it can be combated.

## Bystander Effect on the Web

TABLE 1: MEANS (AND STANDARD DEVIATIONS) OF LIKELIHOOD OF RESPONSE

	Gender of photo					
	Male		Female		Overall	
Views	n	Mean(SD)	n	Mean(SD)	n	Mean(SD)
Few	21	57.62(29.3)	20	56.00(28.91)	41	56.83(28.76)
Many	20	56.50(32.00)	18	83.33(15.72)	38	69.21(28.70)
Overall	41	57.07(30.27)	38	68.94(27.09)		

Note: N=79

### APPENDIX A

J\_Doe.19



Liked by John.D19 and 40 others

2 h

J\_Doe.19 Falling into the swing of things...

5 comments

Jane\_13 Oh look, another photo of you alone. All of your photos are by yourself because you have no friends. Literally nobody likes you. Nobody would miss you if you're gone.

1 h 20 likes Reply

Te

J\_Doe.19



Liked by John.D19 and 400 others

2 h

J\_Doe.19 Falling into the swing of things...

5 comments

Jane\_13 Oh look, another photo of you alone. All of your photos are by yourself because you have no friends. Literally nobody likes you. Nobody would miss you if you're gone.

1 h 200 likes Reply

### APPENDIX B

John.D19



Liked by J\_Doe.19 and 40 others

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John.D19 Falling into the swing of things...

5 comments

Josh\_13 Oh look, another photo of you alone. All of your photos are by yourself because you have no friends. Literally nobody likes you. Nobody would miss you if you're gone.

1 h 20 likes Reply

John.D19



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John.D19 Falling into the swing of things...

5 comments

Josh\_13 Oh look, another photo of you alone. All of your photos are by yourself because you have no friends. Literally nobody likes you. Nobody would miss you if you're gone.

1 h 200 likes Reply

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**REBEKAH ALTONEN** is a rising senior at John Carroll University (JCU), in University Heights, Ohio. She is pursuing a BS in Psychology with a minor in Philosophy. She hopes to continue her education in Psychology upon graduation. Rebekah, originally from Ashtabula, Ohio, is involved in many campus activities as well. She is a member of Kappa Delta sorority and serves as the chapter president for Eta Gamma chapter at JCU. She is also involved in JCU's chapter of Psi Chi International Honor society, as well as Order of Omega honor society. Additionally, Rebekah is involved in the Wind Ensemble at JCU, in which she plays both Flute and Piccolo. Outside of this ensemble, she also plays both Piano and organ. While Rebekah is very involved on campus, her passion remains in the psychology department where she is a dedicated student.

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### Article: Staying in Your Lane... (pg.3)

- Evaluations of the following would likely constitute the practice of forensic psychology:
  - Competence to stand trial
  - Fitness for duty
  - Parental fitness and child custody
  - All of the above
- According to the Ohio Administrative Code, psychologists are obligated to maintain competency through all the following EXCEPT:
  - Consultation
  - Feedback from clients
  - Training
  - Education

### Article: Evaluating Developmental Disabilities... (pg.7)

- The CAST\*MR is a forensic assessment that assesses an individual's ...:
  - Competency to stand trial.
  - Risk for sexual recidivism.
  - Risk for violence.
  - Intellectual/cognitive functioning.
- If completing a forensic evaluation on an individual with DD, a forensic psychologist should recognize that:
  - Individuals with DD are easily influenced by others and may attempt to mask their disability.
  - Individuals with DD may have a combination of verbal and nonverbal communication delays.
  - Deficits in abstract thinking is common in DD individuals.
  - All of the above.

### Article: Evaluations of Diminished Capacity... (pg.11)

- Pursuant to Ohio law, which of these conditions could be the basis for incompetence?
  - Mental illness
  - Chronic substance use
  - Intellectual disability (mental retardation)
  - All of the above
- A Statement of Expert Evaluation is most often associated with which of the following?
  - Competence to stand trial
  - Guardianship
  - Mental condition at the time of the offense
  - Risk assessment

### Article: Speak to Me... (pg.14)

- Decision Making involves:
  - IF/THEN sequences
  - Problem/Solution Identification
  - Goal/Outcome Identification
  - Clear expectations
  - All of the above

### Article: When Minor Separation Becomes Major... (pg.18)

- Separation anxiety is a normal developmental phenomenon of infancy?
  - True
  - False
- Traumatic separation can undoubtedly cause both acute and chronic problems for the children and families involved.
  - True
  - False

### Article: Emotional Support Animal Requests... (pg.21)

- Therapists who undertake ESA evaluations of their patients expose themselves to the following risks:
  - Board complaints
  - Ethics complaints
  - Lawsuits by patients and third parties
  - All of the above
- To competently perform an ESA evaluation, a \_\_\_-step process has been proposed:
  - 5
  - 7
  - 9
  - None of the above

### Article: Neuropsychological Impacts of Lead Exposure... (pg.25)

- Children are less vulnerable to the harmful effects of lead exposure during the early stages of development.
  - True
  - False
- Evidence indicates that there should be a heightened cause for concern regarding the neuropsychological, cognitive, and behavioral development of children who are exposed to lead.
  - True
  - False

### Article: Bystander Effect on the Web... (pg.30)

- According to Latane and Darley (1970), the Bystander Effect is facilitated by \_\_\_\_\_.
  - Evaluation
  - Diffusion of responsibility
  - Pluralistic ignorance
  - All of the above
  - None of the above



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