The Pennsylvania Psychologist

Vol. 74, No. 2

FEBRUARY 2014 • UPDATE

Record Keeping With Medical Assistance

Samuel J. Knapp, EdD, ABPP
Director of Professional Affairs

Rachael L. Baturin, MPH, JD
Professional Affairs Associate

This is the third of a series of articles on record keeping for psychologists in Pennsylvania (See also Knapp & Baturin, 2013; Knapp, Baturin, & Tepper, 2013). Of all insurers, Medical Assistance (MA) has the most burdensome requirements when it comes to record keeping. Many of the MA rules on record keeping were developed years ago and can be found in the MA Regulations (see 55 Pa. Code 1101.51).[1] As most readers know, regulations are promulgated by administrative agencies to expand upon statutes. They are considered law and citizens must obey them just as they must obey statutory law. The private Health Maintenance Organizations (HMOs) that administer MA in Pennsylvania must follow these regulations. These companies are under substantial pressure to identify fraud or abuse and have been instructed to conduct more audits of professionals and their records.

Continued on page 7

[1](*http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html*).

The Role of Outcome Measures in the Practice of Psychology

A conversation with Dr. Vincent Bellwoar, PPA President

DR. KNAPP: What is driving the increased discussions about the perceived need for psychologists (and other health care professionals) to use outcome measures?

DR. BELLWOAR: Many insurers report that they feel pressure from purchasers to demonstrate results. Also, it is likely that some Accountable Care Organizations (ACOs) will reimburse psychologists contingent on the measured outcomes that they can demonstrate. In addition, as patients pay more for their health care through higher premiums, copays, coinsurances and deductibles, they will question more intensely the benefit they get out of psychological treatment. Finally, it is important to note that quantifiable data can help behavioral health practitioners integrate better with primary care physicians, who don't understand nor have the time to read long narratives. Instead, showing the scores on a standardized tool, such as the SCL-90, may be a more productive way to communicate with them.

DR. KNAPP: Several large insurers already have outcome measurement systems in place. What lessons have been learned from these programs?

DR. BELLWOAR: One of the lessons learned is that there can be a large gap between the promise and the reality of outcome measures. Although on the surface it makes great sense to reward practitioners who get good results, the reality is that the measurement of good results is not always straightforward

Continued on page 8

The Pennsylvania Psychologist
416 Forster Street, Harrisburg, PA 17102-1748
www.PaPsy.org

If I become disabled and can't work, who will pay the bills?

Take care of yourself and your family with Trust Income Protection (disability income) Insurance.

Think about how many people you care for… in your business, in your community, and especially at home. How would your family continue to get by if you suddenly lost your earning power due to a debilitating illness or injury? The Trust Income Protection plans are the affordable answer.

Our plans* are designed to provide you with income in the event of total disability, and you can choose the benefits and features that best suit your personal needs.

Learn more about protecting your earning power at **www.apait.org** or simply call us at **1-800-477-1200** for a no-obligation consultation. We'll show you how protecting yourself today may save you and your family so much trouble and expense tomorrow.

Trust LifeStyle Plans Feature:

- ★ "Your own occupation" definition of disability
- ★ Monthly benefits up to $10,000
- ★ Choice of benefit payment periods (5-year or to Age 65)
- ★ Choice of benefit Waiting Period (28, 90, or 180-day)
- ★ Residual benefits to ease your return to work
- ★ Guaranteed Insurability Option
- ★ Benefit Booster, which prevents inflation from eroding the value of your benefit
- ★ Additional dollars to replace retirement plan contributions with Lifestyle 65-Plus plan

THE TRUST
www.apait.org

* Coverage is individually underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of Liberty Mutual Group. Plans have limitations and exclusions. For costs and complete details, call The Trust or visit www.apait.org.

Integrating Religion and Spirituality Into Psychotherapy

Raisa Manejwala, MA, La Salle University

Interest in the integration of psychology and religion has re-emerged as an increasing amount of Americans have embraced spirituality. Surveys have confirmed a remarkable rise in spirituality among Americans (Gallup & Jones, 2000). Various surveys of Americans indicate that between 71% and 90% of the population report a firm belief in God, whereas between 56% and 85% report that religion is important in their daily lives (Barnett & Johnson, 2011). For many Americans, religion or spirituality are essential aspects of their sense of self. Empirical studies have consistently shown that many people turn to spirituality for strength and support during stressful times (Pargament, 1997).

Addressing spirituality and religiosity of clients who prefer to discuss this area of their lives relates to several general principles of the American Psychological Association's Ethics Code which guide psychologists towards excelling in their professional roles. First, Principle A of the APA Ethics Code states that psychologists should strive to benefit those with whom they work and take care to do no harm (APA, 2002). Respecting a client's preference for addressing their spiritual and religious beliefs and practices benefits the client and strengthens the therapeutic alliance. In contrast, neglecting this area of concern may possibly lead to harming the client and premature termination. Additionally, Principle D refers to treating all clients with fairness and justice. Striving to treat all clients with justice helps ensure a more equal access to quality psychological services for all individuals with a variety of backgrounds and spiritual beliefs

The vast majority of Americans consider themselves to be spiritual and/or religious . . .

(Knapp, 2011). Furthermore, spirituality is considered an issue of diversity because of various beliefs and practices among individuals. It is important for psychologists to respect a client's spiritual beliefs in order to establish a relationship of trust. Principle E of the APA Ethics Code, Respect for People's Rights and Dignity, states that among the various elements of human diversity, psychologists "are aware and respect . . . religion . . . and consider these factors when working with members of such groups" (APA, 2002).

Taken together, the critical question is not *whether* but *how* spirituality should be addressed in psychological practice (Pargament & Saunders, 2007).

Since the vast majority of Americans consider themselves to be spiritual and/or religious, many have demanded for health as well as mental health professionals to respect, acknowledge, and integrate spirituality and religious principles into their professional work (Plante, 2007). Unfortunately, therapists often feel unprepared to talk about spiritual matters with their clients because of their lack of training in this area. Using spiritual and religious interventions with a lack of training in this area can result in harming a client. Competence in the services provided is a fundamental ethical requirement (APA, 2002).

To practice competently and ethically, psychologists must first be aware of and sensitive to the importance and

Continued on page 4

Dr. Randy Fingerhut, assistant professor of Psychology at La Salle University, presents the Patricia M. Bricklin student ethics award to Raisa Manejwala, MA.

INTEGRATING RELIGION AND SPIRITUALITY. . .

Continued from page 3

role of spirituality and religion in each client's life. They must also be knowledgeable of the role and potential impact of religion and spirituality on health, mental health, and emotional well-being (Miller & Thoresen, 2003; Pargament, 1997; Plante, 2009; Plante & Sherman, 2001). Psychology programs need to begin providing training in this area so that psychologists can feel competent when working with clients who need this kind of intervention and be able to provide the most appropriate and effective treatment possible. Training would include teaching students about various religious and spiritual beliefs, values, and practices; how to effectively integrate religious and spiritual treatments into clients' treatment plans; and how to integrate religious and spiritual resources into treatment when it is appropriate. Reading journals such as the *Psychology of Religion and Spirituality* and joining Division 36 of the American Psychological Association can aid psychologists in learning about the research on religion/spirituality and mental health and how to integrate this aspect into clinical practice.

It is crucial for psychologists to be aware that simply sharing a client's religious and spiritual beliefs does not make a professional competent in this area. Competence in this area should resemble competence in other areas of expertise: a combination of course work, supervised experience, continuing education, professional reading, and consultation (Gonsiorek, Richards, Pargament, & McMinn, 2009). Therefore, professional training is necessary for psychologists to be competent when integrating spirituality into therapy for clients who consider this area an important aspect of their identity.

Along with awareness of one's own expertise, psychologists should be aware of both their negative and positive biases toward spirituality and religion. Biases can impede one's ability to respectfully and competently address a client's concerns. As a result, it is important for professionals to self-examine their beliefs and consult with others to gain additional awareness of biases that can lead to destructive therapeutic outcomes.

Psychologists may also enhance their competence by becoming familiar with measures that address religious or spiritual dimensions of clients (Yarhouse & VanOrman, 1999). Several instruments, such as the Spiritual Well-Being Scale (Ellison, 1983) and the Religious Problem-Solving Scale (Pargament, Kennell, Hathaway, & Grevengoed, 1988), have been found to have strong reliability or provide clinically useful information. It is crucial for therapists to understand the importance of this area in their clients' lives so that they can respect their values, empathically understand them, and decide if spiritual interventions would be helpful.

. . . psychologists should be aware of both their negative and positive biases toward spirituality and religion.

Additionally, it may be appropriate for psychologists to collaborate with religious leaders in order to provide the most effective treatment plan for their clients. Psychologists have a responsibility to be aware and thoughtful of how religion and spiritual matters impact certain individuals and the possibility of having to work with religious leaders when it seems to be beneficial towards the client's personal growth. Collaboration can help each of them to stay within their roles and to not engage in interventions that are more appropriately performed by the other (Gonsiorek et al., 2009).

As the practice of integrating religion and spirituality into psychotherapy increases, it is important for psychologists to receive professional training in this area. Proper training can help professionals to be aware of ethical issues, knowledgeable about various religious and spiritual beliefs, and able to appropriately consult with, refer to, or collaborate with other professionals or religious leaders. An ethical decision-making model proposed by Barnett & Johnson (2011) may be needed to decide which actions to take on as a professional. Increasing competency in this area will help the field of psychology to provide services to a variety of clients and meet the needs of the vast majority of individuals whose spirituality is a key aspect of their lives.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060 – 1073.

Barnett, J. E., & Johnson, W. (2011). Integrating spirituality and religion into psychotherapy:Persistent dilemmas, ethical issues, and a proposed decision-making process. *Ethics & Behavior, 21*(2), 147 – 164.

Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology, 11*(4), 330 – 340.

Gallup, G., Jr., & Jones, T. (2000). *The next American spirituality: Finding God in the twenty-first century.* Colorado Springs, CO: Cook Communications.

Gonsiorek, J. C., Richards, P., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40*(4), 385 – 395.

Knapp, S. (2011). Ethics, diversity, and multiculturalism. *The Pennsylvania Psychologist, 71*(9), 5 – 6.

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist, 58*(1), 24 – 35.

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice.* New York, NY: Guilford Press.

Pargament, K. I., Kennell, J., Hathaway, W., & Grevengoed, N. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion, 27*(1), 90 – 104.

Pargament, K. I., & Saunders, S. M. (2007). Introduction to the special issue on spirituality and psychotherapy. *Journal of Clinical Psychology, 63*(10), 903 – 907.

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology, 63*(9), 891 – 902.

Plante, T. G. (2009). *Spiritual practices in psychotherapy: Thirteen tools for enhancing psychological health*. Washington, DC: American Psychological Association.

Plante, T. G., & Sherman, A.S. (Eds.). (2001). *Faith and health: Psychological perspectives.* New York, NY: Guilford.

Yarhouse, M. A., & VanOrman, B. T. (1999). When psychologists work with religious clients: Applications of the general principles of ethical conduct. *Professional Psychology: Research and Practice, 30*(6), 557 – 562.

Morality, Disgust, and Countertransference in Psychotherapy

John D. Gavazzi, PsyD, ABPP, and Samuel Knapp, EdD, ABPP

At the most basic level, successful outcomes in psychotherapy require a strong therapeutic alliance between psychologist and patient. A strong therapeutic bond can be cultivated in many different ways including, but not limited to, similarities between psychologist and patient (such as age, socioeconomic status, gender, etc.), psychologist empathy and acceptance, and patient confidence in the psychologist's skills. A similarity in moral beliefs likely enhances the working relationship and correlates with positive outcomes in psychotherapy.

Just as shared values and moral similarities can strengthen the therapeutic relationship, negative moral judgments about a patient's behaviors and beliefs (both past and current) can erode or rupture the helping relationship. In clinical terms, moral judgments can lead to negative countertransference. When a psychologist experiences a negative, morally-driven emotion related to the patient, this dynamic may adversely affect the quality of the therapeutic relationship. Within the therapeutic discourse, there are many topics related to the patient's values, personal responsibility, and moral behaviors. Moral judgments and beliefs, like countertransference, are complex, intuitive, automatic, and emotional. In this article, we will focus on one theory of moral origins to understand how these complicated, instinctive, and gut-level reactions may promote negative countertransference.

Dr. John D. Gavazzi

Dr. Samuel Knapp

> *. . . this dynamic may adversely affect the quality of the therapeutic relationship.*

One theory of moral origins posits that the reaction of *disgust* is a fundamental experience that shapes our moral opinions about others' beliefs and behaviors (Inbar & Pizarro, 2009). Disgust is a basic, universal, emotional response that provides a rapid way of knowing that something is very wrong. Whether we imagine a person eating feces or a foul-smelling, maggot-infected rotting corpse, the experience of disgust is so profoundly automatic and instinctual that it leads us to recoil, exhibiting odd facial expressions, and feeling nauseous. These examples are intentionally stark in order to appreciate the gravity of disgust. Furthermore, the more disgust a person feels, the more strongly the person is convinced of what is right and wrong.

Extrapolating from this data, when a psychologist experiences disgust during psychotherapy, the psychologist is likely to produce instinctive and unanticipated facial expressions and gestures that are likely witnessed by the patient. Additionally, the psychologist likely will have already formed a moral judgment about the patient based on the emotional reaction. The stronger the psychologist feels disgust, the greater likelihood of harsher moral judgments. During training, supervision, and self-reflection, psychologists need to know how disgusted or repulsed they are about certain beliefs

Continued on page 6

MORALITY . . . IN PSYCHOTHERAPY

Continued from page 5

and behaviors in order to treat patients fairly and humanely. Additionally, it is important for psychologists to be aware of moral biases and prejudices in our culture that may also be motivated by disgust.

In terms of negative countertransference based on morality, many psychologists already know what triggers disgust, outrage, and emotional turmoil. Given our politically divisive culture, certain political opinions expressed by a patient may trigger moral outrage within the psychologist. Most psychologists likely know their reactions to obvious current moral issues, such as abortion, same-sex couples, polygamous relationships, assisted suicide, pedophilia, sexual paraphilias, and promiscuous behavior of married adults. While psychologists may find it easy to screen for some of these issues prior to treatment, we cannot assess for all of these moral issues prior to the onset of psychotherapy.

Consider this example:

Twenty sessions into treatment, a psychologist finds that the patient engages in pedophilic activities, such as collecting digital pornographic pictures of children. He describes these activities in great detail. Depending on the level of disgust, can the psychologist treat the patient fairly and effectively given this new information? Can the psychologist work through his/her countertransference to continue to treat the patient effectively or is a referral necessary? And, if a referral is needed, how does the psychologist make the referral without shaming the patient?

In the example above, the feeling of disgust of pedophilic acts aligns closely with common notions of morality and protection of vulnerable persons in our society. At other times, however, feelings of disgust may represent moral shortcomings on the part of the psychologist.

For example, Puhl and Brownell (2001) found that individuals who have excess weight face discrimination in the workplace, educational settings, health-care offices, and in the insurance market. As psychologists who are part of society, we may not be immune from these forms of unfair discrimination. Disgust for groups can be culturally reinforced. Simultaneously, cultural attitudes and beliefs toward that group may change. As one example, LGBTQ individuals and couples have been the targets of scorn and marginalization for a long stretch of time in American culture. In the past decade, American attitudes and beliefs about the LGBTQ community have shifted from disgust and homophobia toward acceptance, respect, and equality. Depending on a variety of factors, including religious beliefs, some psychologists may not have moved past their disapproval of LGBTQ individuals and cannot work effectively with this population due to negative countertransference.

Psychologists need to be aware of their negative emotional reactions toward clients to provide high quality care. Within the ongoing process of ongoing professional development, psychologists may want to explore moral values, emotional responses, and cultural biases in order to avoid negative countertransference. Self-reflection can focus on the primal reactions of disgust, which have shaped moral codes. However, given a more comprehensive understanding of morality, do we need to rely on disgust or revulsion to inform us of our moral opinions? Or, can we reflect on our instinctual, emotional reactions to determine if a more reasoned opinion can help us define what is right and wrong?

References

Inbar, Y., & Pizarro, D. A. (2009). Grime and Punishment: How disgust influences moral, social, and legal judgments. *The Jury Expert, 21*, 11 – 23

Puhl, R., & Brownell, K. D. (2001). Bias, Discrimination, and obesity. *Obesity Research, 9* (12), 788 – 805.

RECORD KEEPING WITH MEDICAL ASSISTANCE

Continued from page 1

Among other things, MA regulations require a diagnosis, documentation of medical necessity, and a treatment plan. Some HMOs that administer Medicaid contracts have specific information that they want included in those treatment plans. Also, the Medical Assistance regulations require that each page of the documentation include the location of service, name of the patient, date of service (the clock hours in which it was delivered and whether it was AM or PM), type of intervention, any change in diagnosis, the relationship of the services to the treatment plan, the extent of progress, any consultations, and a disposition note at the end of treatment. Each note must be signed and dated. Because HMOs may have additional record keeping requirements, psychologists should double check with their carriers to ensure that they are up-to-date with these record keeping requirements.

Many of the MA record keeping requirements were established for large agencies or hospitals, with multiple locations and providers. Unfortunately, not all of the rules make sense for a psychologist with a single outpatient location. For example, the rules that every page must include the name of the provider and the location of the service may make sense for record keeping in a large agency, but it makes little sense for the records of an independently practicing psychologist. Fortunately, many of these issues can be addressed easily by creating a standard treatment record format that includes all pertinent information.

A sample treatment note that complies with the record keeping standards of Medical Assistance (we also note where the requirements of the State Board of Psychology are simultaneously met) is shown in Figure 1. Of course, treatment notes can best be understood in the context of the initial evaluation, treatment plan (if one is required) and other psychotherapy notes. Depending on the nature of the service, it is possible that a treatment note should include more information, such as life endangering features, use of adjunctive treatments (such as psychopharmacology), emergency interventions, assessment data, results of consultations, etc.

References

Knapp, S., & Baturin, R. (2013, September). Record keeping for psychologists. *The Pennsylvania Psychologist*, 4 – 5.

Knapp, S., Baturin, R., & Tepper, A. (2013, November). Record keeping practices in high risk situations. *The Pennsylvania Psychologist*, 3.

Figure 1: Example of a Treatment Note

Juanita Ponce de Leon, Ph.D.
Discovery Psychological Services
1513 Fountain of Youth Street
Melbourne Beach, FL[1]

Patient: *Isabella de Castile*[2]

Time: *Monday, January 5, 1492 (Gregorian calendar); 9 AM to 10 AM*[3]

Bella reported that she was doing well in the last week. We reviewed her "Exposure to Anxiety Provoking Events" chart and found that she has two situations in the last week in which she began to experience panic, but she was able to stop the panic attacks both times using cognitive control and muscle relaxation.[4] *She is still bothered by the problems of driving out the Moors and discovering the New World. She wonders if she had made a mistake in using her jewelry to fund the expedition of Columbus. We reviewed the cognitive behavioral strategies that she has learned.*[5] *She has shown a willingness to learn these techniques thoroughly which has greatly facilitated her recovery. She has had no suicidal ideation in the last month. And believe that it is unlikely to reoccur.*[6] *She reports that her husband, Ferdinand of Aragon, is pleased with her progress.*

We will continue to evaluate her skills at controlling panic attacks and may consider phasing out sessions if she continues to improve. We will continue to meet weekly. The next appointment is scheduled next Monday, January 12 at 9 AM.

Juanita Ponce de Leon[7][8], *1/5/92*
Juanita Ponce de Leon

[1] MA: location of service

[2] MA: name of patient on each page

[3] MA: date of service, including clock hours or treatment: State Board of Psychology

[4] MA: requires objective and measurable goals

[5] MA: type of intervention used; State Board of Psychology

[6] MA: progress at each visit; State Board of Psychology, "formal or informal assessment of client status"

[7] MA: schedule for service delivery

[8] MA: entries must be dated and signed

THE ROLE OF OUTCOME MEASURES . . .

Continued from page 1

and, if implemented poorly, any measurement system could actually degrade the quality of care.

DR. KNAPP: Is there any empirical evidence that outcome measures can actually improve patient care?

DR. BELLWOAR: Under some circumstances, patient outcomes can be improved through the use of outcome measures. For example, Lambert (2007) reported that clinicians who used the OQ 45 (and received constructive feedback on patient progress and options), were able to double the improvement rate for "at risk" patients from 22% to 45%. These and other studies, led the Division 29 Task Force on evidence-based relationship factors to conclude that feedback is empirically validated to be a factor that can improve treatment outcomes (Norcross & Wampold, 2011). The goal is to figure out how to integrate these positive findings about outcomes into a system that actually helps psychologists get better outcomes, rather than creating another mechanism that imposes bureaucratic requirements on psychologists (and patients) with no tangible benefit.

DR. KNAPP: What are some of the reasons that some psychologists resist outcome measures?

DR. BELLWOAR: Many of the early outcomes programs were implemented poorly. All assessment instruments come at a cost in terms of patient and therapist time. Psychologists usually spend time between sessions writing notes, previewing the notes for the next patient, taking phone calls, or doing other clinical tasks. It takes a high level of justification to add anything more to the workday of the average psychologist.

DR. KNAPP: What challenges are faced by those who promote outcome measures for outpatient psychotherapy?

DR. BELLWOAR: First, a good outcome measurement program will not penalize psychologists for treating very sick patients. Although the dynamics of any individual patient can vary considerably, on the whole, psychologists are more likely to have better outcomes by limiting their practices to patients with favorable demographics (college educated, high incomes, etc.) and diagnoses. However, health care costs are driven primarily by that small percentage of patients who utilize services of greater intensity and frequency. Any incentive plan that discourages the treatment of difficult patients will inadvertently increase health care costs in the long run.

"It takes a high level of justification to add anything more to the workday of the average psychologist."

Second, any instrument must balance brevity with usefulness. Brief instruments have the benefit in that they take little time for the patient to complete, thus increasing the willingness of patients to complete the surveys. The disadvantage is that they may not capture a sufficient range of symptoms for a patient. So patients in substantial distress could score rather well on the screening instrument because it is not sensitive to their type of distress (Goodheart, 2011).

Also, practitioners should not be penalized on the basis of a small sample size. The issue of small sample size becomes more obvious if the practice is split between many different insurers. The average psychologist doing psychotherapy full time may see approximately 120 different patients a year (and perhaps 100 patients covered by insurance). If that psychologist has his or her practice split among three or four major insurers, then it is very possible that he or she will only have one (or perhaps two) insurers who receive a sample of 30 or more patient outcome measures in a year. This could be addressed by having insurers agree on a common outcome measure (or a common set of acceptable outcome measures).

Finally, it needs to be accepted that any measurement system will be imprecise. For example, O'Brien and Monahan (2012) found that their sample of patients did worse than the national average on one outcome measure (the TOPS), but better than the national average on another outcome measure (the Polaris MH).

DR. KNAPP: What do you see as the future for outcomes measurement for psychologists?

DR. BELLWOAR: If they are implemented effectively, they can improve patient outcomes and reward the many psychologists who are doing excellent work. PPA and other professional associations will be working to ensure that any outcome system actually helps improve patient outcomes.

References

Goodheart, C. (2011). Psychology practice: Design for tomorrow. *American Psychologist, 66*, 339 – 347.

Kraus, D., & Castonguay, L. (2006). The outcomes assistant: A kinder philosophy to the management of outcomes. *Psychotherapy Bulletin,* 23 – 24, 29 – 31.

Lambert, M. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17*, 1 – 14.

Norcross, J., & Wampold, B. (2011). Evidence-based relationships: research conclusions and clinical practices, *Psychotherapy, 48*, 989 – 102.

O'Brien, J. M., & Monahan, L. (2012). Uses of psychotherapy outcomes in private practice: An exploratory study. *Psychotherapy Bulletin, 47 (2),* 23 – 38, 35 – 39.

Classifieds

POSITION AVAILABLE

SEEKING CHILD PSYCHOLOGIST FULL TIME position at Kreinbrook Psychological Services in Greensburg PA License required work hours are flexible large practice new facility with multi-discipline practitioners fax inquiry to 724-836-2876

OTHER

AVAILABLE PSYCHOTHERAPY OFFICE: BALA CYNWYD, PA – Very nice psychotherapy office space available for full- or part-time sublet in newly renovated light-filled suite with other psychotherapists. Internet access, attractive building with good security, many amenities, free parking, location convenient to public transportation. Contact Linda Guerra PhD at 215-545-7009 or email: guerra@netmcs.com.

OFFICE SPACE AVAILABLE: BALA CYNWYD – Attractive, furnished, window office, includes Wi-Fi, fax/copier, café, free parking, flexible hours week days and weekends. Perfect for therapy and evaluations. 610-664-3442.

2014 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

April 11, 2014
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

June 18–21, 2014
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@PaPsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.PaPsy.org/index.php/collaboration-communication/.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

EXTEND YOUR PRACTICE with Floortime™ and DIR® training. Learn a model and skill set to enhance your work with children and parents. Especially effective for children and adults with autism, developmental delays, or medical histories leading to behavioral challenges. Charlotte M. Collier, Ph.D. is a nationally certified trainer. Consultation also available. 215-208-4347. cmcollierphd@verizon.net.