The Pennsylvania Psychologist

Vol. 76, No. 5 MAY 2016 • UPDATE

Can Mindfulness Help Make Us Better Psychologists?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

Effective psychotherapy requires self-awareness, meaning a general awareness of one's strengths, weaknesses, and overall skill level. In addition, during the actual process of therapy, it requires moment-to-moment awareness of how we feel during the session itself. Psychologists who have significant gaps in their self-knowledge risk making poor decisions about who to treat in therapy or their ability to implement certain interventions. And during therapy, those without adequate self-awareness may ignore, minimize, or confuse feelings or bodily sensations that should inform them about their relationships with their patients.

People in general have a rough, although not perfect, understanding of their personalities and strengths. Psychologists are not exempt from this general rule. For example, Walfish et al. (2012) found that 25% of mental health professionals placed themselves in the top 10% in terms of competence and no one placed themselves in the bottom 50%. Similar findings have been found for other professionals, including physicians. In addition, some of the worse performing physicians grossly overestimated their competence and believed themselves to be superior to others (Davis et al., 2006). Psychologists also vary in their ability to identify or understand their personal countertransference experiences with patients. Those who do better managing countertransference tend to have better patient outcomes (Hayes, Gelso, & Hummel, 2011).

Given the importance of self-awareness, it is no wonder that many psychologists are asking if mindfulness, which purports to improve self-awareness, can contribute to better self-awareness and patient outcomes.

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What Is Mindfulness?

Sometimes mindfulness meditation is practiced by itself, but variants of it are also incorporated in other forms of psychotherapy. Nonetheless, one good definition is that mindfulness is a family of interventions that emphasize the "nonevaluative, nonelaborative attention to and awareness of one's current experience" (Carlson, 2013, p. 125). It involves a pre-reflective and nonjudgmental acceptance of the stream of feelings or external stimuli as they occur. Because it is nonevaluative and uncensored, it allows individuals to accept more information about themselves including negative emotions, unpleasant thoughts, or ego-dystonic beliefs, without an attempt to dispute or discard them. Sometimes this is referred to as being "fully present" in the moment. Among other benefits, mindfulness helps disengage individuals from automatic thinking habits and unhealthy behaviors.

Can Mindfulness Improve the Performance of Psychologists?

Mindfulness meditation can reduce anxiety, depression, and stress at levels

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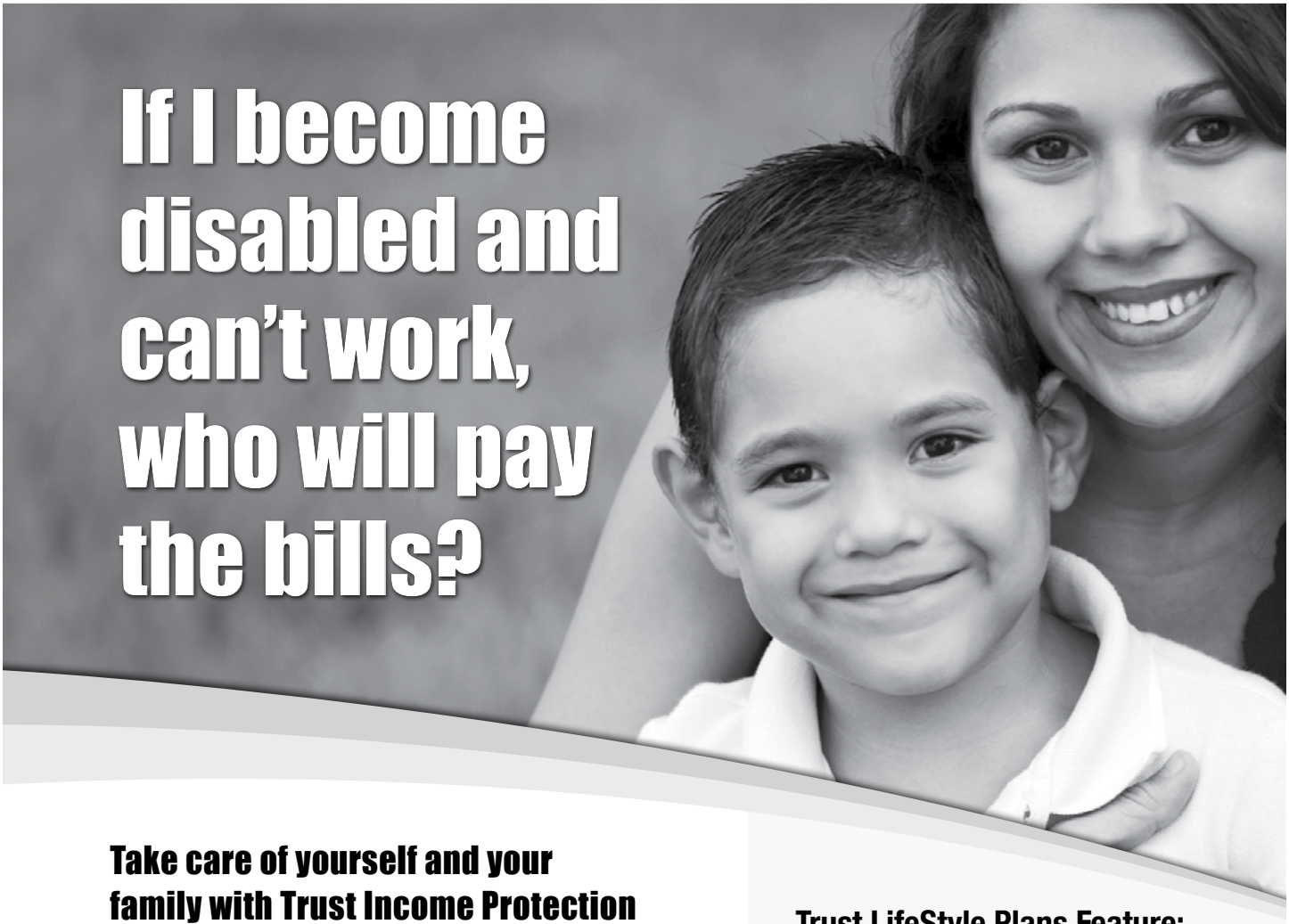
If I become disabled and can't work, who will pay the bills?



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Should the APA Ethics Code Ignore the Interests of Psychologists?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs[1]

The major purpose of the APA Ethics Code is to protect the public. That is, the enforceable standards should be written and enforced to promote the well-being of patients and the public in general. The best way to do that is to ensure that the standards are anchored on overarching ethical principles. But should the personal interests of psychologists be entirely absent from an ethics code? Here are some examples of places where the APA Ethics Code deliberately incorporates the interests of psychologists.

Terminating Patients Who Threaten Psychologists

Standard 10.10 of the APA Ethics Code states that psychologists may terminate patients when they or one of their family members threatens the life or safety of the psychologist. Consider this scenario:

A psychologist in a solo practice was treating an abused woman whose husband was very opposed to her seeking therapy. Later the psychologist received a text from the husband that conveyed a veiled threat, but included nothing that could warrant a criminal report. The next day the tires on her car were slashed and she received an anonymous letter that enclosed a picture of her children walking home from school. Because she was afraid for her safety and the safety of her children, she referred her patient to a large facility that had security guards, a large staff, and a legal department, under the assumption that this agency would have the resources necessary to protect the safety of their therapists.

Few of us would argue that she acted unethically for terminating a patient when her safety and the safety of her children were at stake.

Withholding Records for Nonpayment

Standard 6.03 allows psychologists to withhold records in nonemergency situations for nonpayment of services. Often this occurs when a client agrees to psychological testing, but then refuses to pay the cost of the service. However, this standard has been overturned for health care services by HIPAA which requires that psychologists make assessment reports or treatment summaries available to patients regardless of payment issues. Of course, the withholding standard still applies to nonmental health assessments, such as educational testing. Nonetheless, most of us do not think it is wrong for psychologists to be paid for the services that they and their patients had agreed upon.

Promoting, but not Mandating, Pro Bono Services

Should the Ethics Code require psychologists to provide some pro bono services? The Ethics Code does not require this, although Aspirational Principle D does state that "psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology." One of the problems with mandating pro bono services is in defining a pro bono service. Consider a psychologist who routinely charged $150 an hour, but decided to take one family for $100 an hour. The family could not afford her full fee but she wanted to fill a vacancy in her schedule. Is this a pro bono service, when most of the other psychologists in her geographical area accept insurance and never charge more than $100 anyway?

And is offering pro bono services necessarily the most ethical decision? Consider this other scenario: Psychologist One works one day a week for a much reduced rate at an agency that serves indigent patients. Psychologist Two works at the same agency two days a week. One would assume that Psychologist Two is more ethical than Psychologist One. But is that necessarily true? What if Psychologist One was the sole breadwinner in her family, had two young children, and substantial educational debts; Psychologist Two was married to a successful physician, had no student debts, and his children had a trust fund that ensured that he had no financial worries about putting them through college? Certainly we applaud the contributions of Psychologist Two, but few would argue that Psychologist One is less ethical because financial circumstances allow her less discretion in donating her time?[2]

In the event of conflicts of interests, we try to resolve them with primary consideration for the welfare of the patient. But psychologists do have legitimate rights that any ethics code should respect.

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[1]The Author thanks members of the PPA Ethics Committee for their comments on a previous version of this article.

[2]Some ethicists could claim that extraordinary sacrifices become immoral if they detract us from our primary obligations.

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Accuracy in Billing

Standard 1.26 of the 1992 Ethics Code stated that "in their reports to payor for services . . . psychologists accurately state the nature of the . . . service provided, the fees or charges . . ." The 2010 Ethics Code no longer requires complete accuracy in billing, only that psychologists make "reasonable steps to ensure the accuracy of reporting" (Standard 6.06). I know of a psychologist who had his records audited, apparently the result of some random selection process on the part of the insurance company for quality assurance purposes. The request for records was quite extensive and, out of several hundred records, the company did find two discrepancies in the date of service found in the treatment notes and the date found in the billing invoices. The company could have claimed the money back, but it allowed the psychologist to resubmit a bill using the dates found in the treatment record. Should the company instead have referred the psychologist to the licensing board for disciplinary action?

A large agency in Philadelphia expended much effort to ensure complete compliance with Medicaid's onerous documentation requirements. They billed Medicaid for almost $1 million a year. Yet, one year they were penalized $6,000. Repayment rules were based on billing accuracy, even if the errors were in the favor or Medicaid. This year it was determined that the agency had under-billed Medicaid for several procedures. According to a literal interpretation of the Ethics Code of 1992, the psychologist in charge of the agency should have been charged for violating the ethical standard.

Conclusion

As professionals we have an obligation to promote the well-being of patients. In the event of conflicts of interests, we try to resolve them with primary consideration for the welfare of the patient. But psychologists do have legitimate rights that any ethics code should respect.

In each of these examples, we see that the Ethics Code made accommodations for the well-being of the psychologist. In two of these cases a strong argument could be raised that the "pro-psychologist" provisions do not harm patients. For example, would it be reasonable to expect a patient to get high quality service from a professional who has a realistic fear of assault from that very patient? Or, is it fair for patients to have their psychologists spend an ordinate amount of time double or triple checking billing records, knowing that one error, no matter how slight (or even one that benefits the patient or insurer), could result in a disciplinary action?

In other cases the perceived benefits to the patients are less obvious or nonexistent. Nonetheless, the provisions do seem consistent with fundamental notions of fairness. The value of the Ethics Code depends, in part, on its perceived fairness to psychologists and an Ethics Code that appears unnecessarily harsh or unfair risks losing its legitimacy.

I Am More Ethical Than You Are

Enhancing Your Ethics Reputation in Three Simple Phrases

Samuel Knapp, EdD, ABPP; Director of Professional Affairs[1]

Reputation is important in all kinds of businesses. After all, you want to take your car to the shop with the best ratings you can find. Reputation is important for professional psychologists as well, and it is especially important to have a reputation for being ethical. When you walk into a room, you want people to say, "She is the most ethical person in the room." Whether you are ethical or not could be the topic of another essay. But even Machiavelli (1532) noted that it is important for a prince to appear virtuous and whether or not he really is just isn't that important[2].

In this article we have distilled the process of being perceived as ethical into three basic steps, each characterized by an easy to remember catch phrase.

First, adopt the most stringent position that you can on any issue. When it comes to a standard in the ethics code, advocate for the one that is the most restrictive, comprehensive, and detailed. It is best if it includes the words "always," or "never." The failure to use such words may increase the likelihood that psychologists would use their discretion based on the unique circumstances they face. Also, advocate for the harshest penalties against those who are disciplined. After all, modern psychology has conclusively proven that pain and fear are the major motivators of virtue (see for example, Hobbes, 1640)[3]. The phrase to use is: "Nothing less than losing your license!"

Second, display moral outrage openly and loudly. In order to do this effectively it is important to avoid any discussion of the facts (in case you were in error), alternative interpretations, or mitigating circumstances. Every once in a while, some individuals may plead that "they did the best they could under the circumstances," or "there are features here that you are not considering." Do not be dissuaded by these pleas, simply dismiss them as rationalizations. This strategy is most effective if you combine it with raising your voice or making facial expressions of disgust. Your reputation enhancing phrase could be "I am shocked that . . . !" or "I am appalled that . . . !"

Third, be certain to mention the shortcomings of others in as many public venues as possible. Whispering in public places is especially effective because you can convey the information and, at the same time, give the impression that you care about the reputation of the individual being talked about. If you start talking about the blemishes of

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[1]**The author thanks his French instructor, the late Dr. George Clemons, for introducing him to the satires of Molière, including *Tartuffe* (the *Hypocrite*). He also thanks members of the PPA Ethics Committee for their review of a previous draft of this manuscript and for telling him to tone it down.**

[2]**"A prince may be perceived to be merciful, faithful, humane, frank, and religious, but it is important only to seem to have these qualities" (Chapter 15).**

[3]**E.g., "Man pays his debt only for fear of imprisonment." (Chapter 21)**

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others, you may find third parties who would be willing to share even more information with you. As the amount of information you have on a third party increases, the likelihood that some of it may actually be true will also increase. Besides, you probably never really liked them in the first place. Of course this step is only effective if you combine it with the harshness and moral indignation of the first two steps. The phrase to use is, "You would not believe what I just learned about . . . !" It is important to use the word *learned*. Do not say, "you would not believe what I just *heard*," because that could convey an impression that the origin of the information is second hand or less than reliable.

Avoid any introspection; people want moral certitude and you are doing them a favor by displaying it. Whenever you encounter a conversation or an article dealing with ethical issues or stories of individuals who failed to live up to ethical ideals, remember that those criticisms apply to others and not to you. Ethics is a weapon and it is about time we start using it as intended. It can be both a sword to attack others and a shield to protect us against criticism.

If you speak loudly enough with sufficient conviction, you should be able to keep others from daring to offer an alternative position. Do not worry about the off chance that they manage to squeeze in effective counterarguments or raise facts that weigh against your position. If this happens, you have two options. First you can simply beg their forgiveness (thus demonstrating your virtue of humility), but explain that you only acted this way because of your deep conviction and great sensitivity to ethical issues. That way you can turn the fact of your being wrong into even more evidence of your superior virtue. The second option is to quickly turn any criticism back on the other person. If they say, "you are being self-righteous," then immediately accuse them of the same flaw. Sometimes you can use both tactics in the same conversation.

A More Serious Conclusion

I hoped you have enjoyed this little satire, but now it is time to adopt a more serious tone.

In Molière's play *Tartuffe*, the king of France unexpectedly arrives towards the end of the play, prevents a grave injustice, and lectures the audience on the difference between true virtue and hypocrisy. Alas, no king of France will arrive to protect us from our own follies; we have to rely on ourselves and our friends (if we have managed not to alienate them).

Like all satires, this essay included elements of truth. Concern about our reputation is legitimate and all of us will, at some time, feel appropriate moral outrage motivated by compassion or a sense of justice. However, the persona of the author lacked the self-reflection, humility, and compassion that needs to drive our decisions. Without these qualities we risk acting like the self-satisfied and harmful persona of this article. Ethics should not be seen as a weapon, but as a handshake (or even a hug!).

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2016–2017 PPA Election Results

Every year, the Pennsylvania Psychological Association (PPA) holds elections for leadership positions which rotate based upon the election cycle. PPA congratulates the following organizational leaders for their continued commitment to serve in these governance roles on behalf of the membership at large.

President-Elect: David Zehrung, PhD

Dr. David Zehrung prevailed in the race for PPA president during the recent election. He will serve as president-elect during 2016-2017 and assume the presidency the following year. Dr. Zehrung has been a member of PPA since 1997 and has held various positions including treasurer, and has served as chair of the Bulletin, EMC, CTI committees, as well as the Innovation Task Force. He currently works at the Lebanon VA Medical Center and earned his PhD in Clinical Psychology from George Mason University.

Secretary: Jeanne M. Slattery, PhD

The new PPA secretary will be Dr. Jeanne M. Slattery. Dr. Slattery has been active with PPA on the Executive Council of the Pennsylvania Psychological Foundation and most recently served as chair of the Public Interest Board. She earned her PhD from Indiana University of Pennsylvania and is currently employed as a professor at Clarion University.

Professional Psychology Board Chair: Nicole Quinlan, PhD

Dr. Nicole Quinlan will once again serve as chair of the Professional Psychology Board. A PPA member since 2010, Dr. Quinlan has been extraordinarily active with PPA in her prior roles as chair of the Professional Psychology Board and chair of the Public Education Committee. Dr. Quinlan is employed as a pediatric psychologist at Geisinger Health System and earned her PhD in Clinical Psychology from Duke University.

Program & Education Board Chair: Dea Silbertrust, PhD, JD

Dr. Dea Silbertrust has been elected to a second term as chair of the Program & Education Board. Her previous service to PPA includes roles as chair of the Bulletin Committee and PennPsyPAC. Dr. Silbertrust has been a member of the Ethics, CE, Public Education and Budget & Finance committees as well. She currently works in private practice with Bala Psychological Resources. Dr. Silbertrust earned a JD from Villanova University School of Law and her PhD in Clinical Psychology from Hahnemann University.

Public Interest Board Chair: Tim Barksdale, PsyD

The new Public Interest Board chair is Dr. Tim Barksdale. Dr. Barksdale has served in a variety of capacities with PPA in his 11 years as a member including chair of the Committee on Multiculturalism and APA Diversity delegate. He has also been honored as PPA's ECP of the Year and with the PPA Foundation Award. Dr. Barksdale serves as director of Clinical & Behavioral Services for Horizon House, Inc. and is a professor at Lancaster Bible College. Dr. Barksdale earned his PsyD in Clinical Psychology from the Philadelphia College of Osteopathic Medicine.

When Is It Marital Therapy?

Samuel Knapp, EdD, ABPP[1], Director of Professional Affairs

Consider this situation:

> *A woman asks to be seen for depression and it becomes clear that the depressed mood is related to marital stress and the optimal intervention is to improve the quality of the marriage. Upon discussion with the client, the psychologist then invites her husband in for all future sessions. Twelve weeks later the depression has lifted and therapy ends.*

On the surface this may appear to be a rather routine intervention, but several years later the psychologist received a letter from the federal government asking the psychologist to comment on the mental fitness of "your former patient" (the husband) who claims that he was once your patient and is now seeking high level security clearance. How should the psychologist respond given that the wife (not the husband) was the real patient? Certainly the psychologist might have developed some informal impressions of the husband. But the psychologist never did (nor should she be expected to do) a mental status examination of the husband or a formal assessment of his mental health. Nonetheless, the husband may perceive that he was a patient and believe that his chance at clearance is jeopardized if the psychologist does not respond.

Or consider this other possibility: two years later the husband objects when the psychologist released the records of the wife after he received a release of information form signed by her. The husband, who believes that he was also the patient of the psychologist, alleges that "I was your patient too, and you should have secured my consent as well."

These incidents point to the importance of clarifying the nature of the treatment relationship when two or more parties are involved in therapy. The goal is to have unity or consistency in how the psychologist explains the nature of the sessions to all partners, and how the psychologist bills and documents the sessions. Problems can occur if these factors are incongruent. In these situations, the psychologist has obligations to the parties receiving the intervention and to the insurer (if any). Everyone needs to be on the same page as to how the psychologist will conceptualize and document the intervention. This has implications for the payment of services and the authority to control the release of information.

Psychologists have options, based on their therapeutic discretion, on how to handle these situations. Some psychologists believe that the "relationship" is the patient, consider both parties as equal participants in the treatment process, and document accordingly. This is entirely legitimate from a clinical perspective and can be done without any unusual problems if the patients are paying out of pocket.

These incidents point to the importance of clarifying the nature of the treatment relationship when two or more parties are involved in therapy.

The psychologist needs to ensure that the patients understand that their relationship is the focus of treatment, and document accordingly, reminding the patients that insurance will not pay for these sessions (since no one has a mental illness) and that both parties will collectively have control of the release of information (See the chart below that compares relationship-conceptualized and individual-conceptualized treatments).

However, psychologists who bill third parties need to ensure that the

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[1]The author thanks members of the PPA Insurance Committee who contributed perspectives on this topic.

Table One

Relation-Conceptualized and Patient-Conceptualized Marital Therapy

	Payment	Documentation	Release of Information
Relationship focused	No insurance as it does not meet medical necessity requirements	One chart in the name of the patients collectively that includes presenting problem and content of therapy, among other elements	Controlled by both parties
Patient-focused	May involve insurance if it meets medical necessity requirements (one patient has a covered illness and the treatment is focused on reducing the symptoms)	One chart in the name of the identified patient that notes the diagnosis, treatment focused on alleviating the diagnosis, among other elements	Controlled by the identified patient

WHEN IS IT MARITAL THERAPY?

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treatment meets the standards of medical necessity which requires the psychologist to identify one individual as the patient who has a mental disorder, develop a treatment reasonably likely to alleviate that disorder, and document accordingly. Furthermore, the psychologist needs to inform the partners that the identified patient will have control over any future release of records.

As a practical matter, people seeking marital or couples counseling are usually experiencing great distress and it is not difficult to give a diagnosis to one or both of the parties.

When providing couples counseling it is often true that both spouses may benefit from therapy and that the actual intervention will show concern and sensitivity to the well-being of both partners including the one who is not identified as the patient. From the standpoint of therapy, the well-being of the partner is important for the outcome of treatment, although from the standpoint of the insurer, the well-being of the nonpatient is only incidental. The concern, respect, and consideration that the psychologist shows to the nonpatients may cause them to consider themselves as equally patients as the ones identified to the insurance company as the patients, although from the standpoint of the insurer that is not the case.

Nothing requires psychologists to get patients to sign an informed consent document explaining the nature of the treatment relationship. However, signing such as document may be helpful if it reduces the risk of misunderstanding or misinterpreting the nature of treatment.

Medicare Facts & Figures

Medicare enrolls 57 million persons, including 9.1 million who have serious disabilities, and 15 million in Medicare Advantage plans.

Total Medicare costs in 2014 were $613.3 billion. Administrative costs under Medicare are about 1.5% of total expenditures.

Mental disorders are the sixth most common reason for an outpatient visit under Medicare, following hypertension, osteoarthritic conditions, physical trauma-related disorders, COPD, and upper respiratory infections. However, they are the fourth most common reason for a prescription, following hypertension, hyperlipidemia (too many lipids in the blood), and COPD.

Government spending (including Medicare, Medicaid, CHIP, Department of Defense, and the VA System) accounted for 43% of total health care expenditures in 2013. Private insurance accounted for about 40% and the rest was paid by consumers out of pocket.

Facility costs (hospitals, skilled nursing care, home health agencies, and hospice care) accounted for one half of the expenditures under Medicare.

The average Medicare beneficiary costs $9,436 a year. Those who have six or more chronic conditions cost an average of $31,543 a year. About 14% of Medicare beneficiaries had six or more chronic conditions.

Medicare receives an average of 46 million claims per day and rejects about 2% of them.

About 13% of the American population is 65 years old or older. By 2050, this will increase to 20%.

Pennsylvania ranks second in the highest percentage of older adults in the state, behind Florida (West Virginia is third). Three counties in Pennsylvania (Adams, Potter, and Sullivan) have more than 23% of their population over the age of 65.

Classifieds

PHILADELPHIA Center City, Fitler Square. — Four beautiful designer-decorated offices, three waiting rooms. fireplaces, decks, garden, a/c, cathedral ceiling, skylight, kitchen, Wi-Fi, fax, buzzer for each office. Over bridge from U/Penn. Psychiatrists and learning disabilities specialist on premises. Parking option. Flexible arrangements: Full time, day, hour. Reasonable rent. 215-546-2379, marlabisaacs@gmail.com

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PSYCHOLOGIST as an independent contractor wanted for established Hermitage, PA practice. Great work environment. Experience with psychological evaluations for children and adolescents, and psychotherapy with various ages needed. There is an opportunity for eventually taking over the practice. Send resume to: pccstc@roadrunner.com.

Continued from page 1

of effectiveness comparable to pharmacological, behavioral, or cognitive behavioral treatments (Khoury et al., 2013). It makes sense that psychologists, like any other professionals, would improve their performance if their overall health and sense of well-being improved. In addition, because of the emotionally-charged nature of our work and the importance of self-awareness, it would make sense that any intervention that increases emotional awareness, such as mindfulness meditation, may be especially helpful for health care professionals. After all, Buddhists developed mindfulness as an effort to improve their empathy and sensitivity to others. If this works as intended, then it would seem that the practice of mindfulness would improve a mind set (sensitivity and capacity for empathy) that is essential for effective psychotherapy.

What Does Evidence Suggests about Mindfulness and Professional Competence?

Some preliminary evidence suggested that teaching mindfulness meditation to physicians improved their self-reported mood, empathy, conscientiousness, and emotional stability (Krasner et al., 2009). Also, Brady et al. (2012) found that mindfulness improved the well-being of the staff at an inpatient psychiatric unit, led to improvements in self-reported patient satisfaction, and reduced the number of safety events (patient falls, patient aggression, and medication errors).

Although these results are positive, they are hard to interpret. Did the patient care improve because the stress and anxiety of the health care professionals decreased? If so, then mindfulness, like other psychotherapeutic techniques, would be effective to the extent that it reduces dysphoric symptoms. However, it could also be possible that mindfulness involves the nurturing of attitudes or skills, such as empathy or perspective taking, that are especially important for good patient care. Sibinga and Wu (2010) further claimed that the cognitive states required for effective mindfulness could counteract common thinking errors among physicians. Although a subsequent review by Chiesa, Calati, and Serretti (2011) found preliminary evidence supporting the ability of mindfulness to enhance cognitive capabilities, they noted methodological issues and urged that "available evidence should be considered with caution" (p. 449).

Some preliminary evidence suggested that teaching mindfulness meditation to physicians improved their self-reported mood, empathy, conscientiousness, and emotional stability.

The available evidence, although sparse, suggests that mindful practice can target specific skills or attitudes related to improved health care outcomes. Beach et al. (2013) found that physicians who scored higher on a mindfulness awareness scale showed better relationships and created a more positive emotional atmosphere with patients, as evidenced by patient reports and observations of direct physician-patient behavior. The mindful physicians listened more carefully and their patients had a greater sense of being heard. Also, Schomaker and Ricard (2015) found that counselors who had mindfulness training showed levels of attunement (sense of perceiving the client's experience) with patients that was 1.58 times higher than controls.

In summary, mindfulness appears to help psychologists and other health care professionals do better work. It is unclear whether this is because it improved the overall well-being of the participants or because it helped facilitate the development of relationship enhancing skills, such as an increased ability to feel and express empathy. Furthermore, the term mindfulness encompasses such a wide range of specific techniques and theoretical rationales that it is not currently possible to determine which components or variations of mindfulness are directly related to the apparent positive outcomes (Lutz et al., 2015). We are a long way from endorsing mindfulness as an essential component for training as a psychologist. Nonetheless, many individual psychologists have found it helpful, and some preliminary studies suggest that mindfulness can specifically target skills essential for being an effective psychologist.

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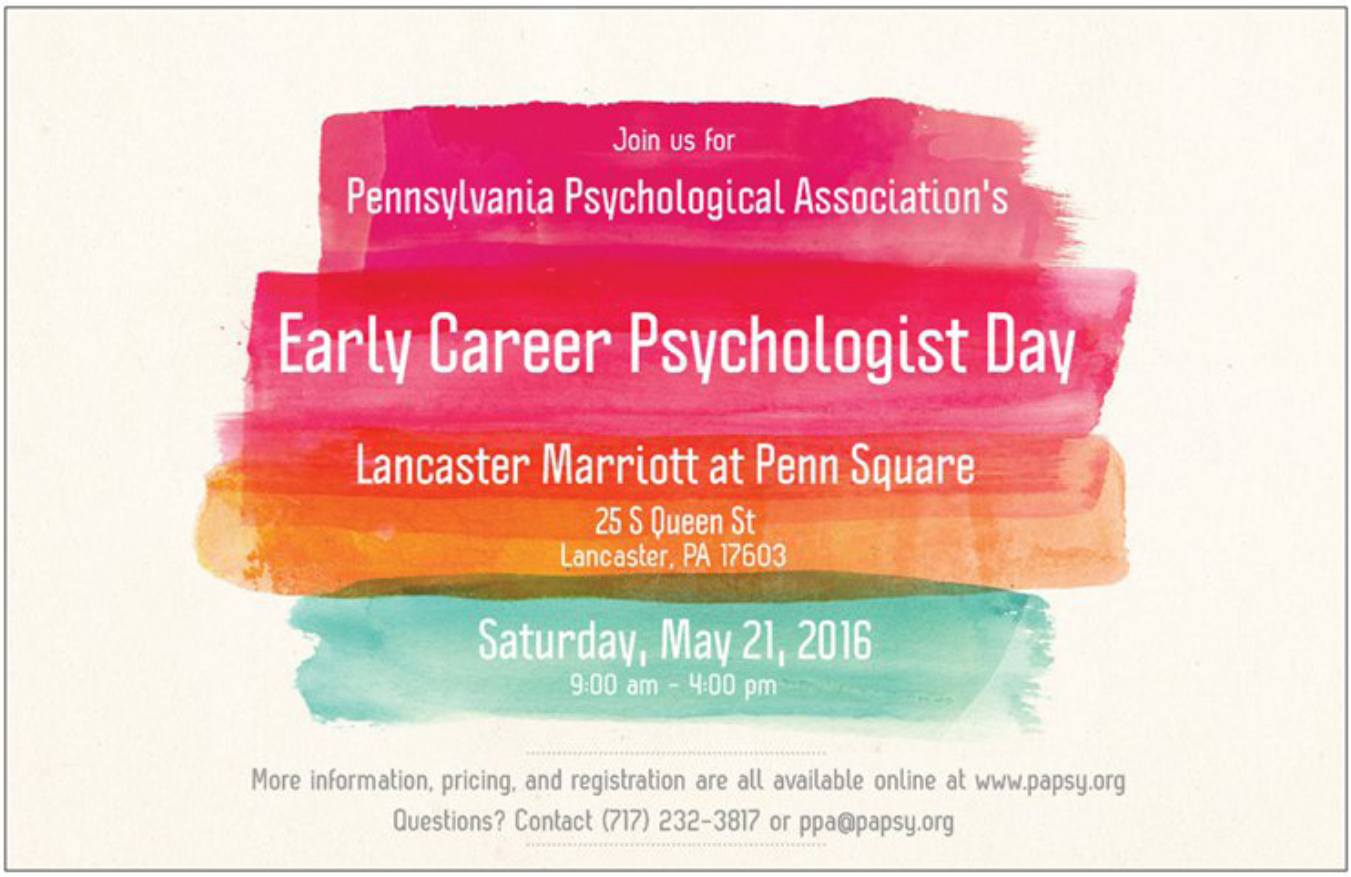

Agenda

8:30 - 9:00 am- Registration

9:00 - 11:30 am- Identify Your Niche: How to Find the Clients and Setting That's Right for You

11:45 am - 12:45 pm- Reach for the Stars: How to Become an Effective Leader While Promoting the Practice of Psychology (lunch is included!)

1:00 - 3:00 pm- How to Improve Your Networking Skills While Taking Care of Yourself at the Same Time

3:15 pm - 4:00 pm- Networking Reception

Full workshop descriptions and registration are available at www.papsy.org

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

2016 PPA Continuing Education

PPA is looking to continue its long-standing tradition of offering high-quality CE programs to psychologists. In 2016 we are looking to expand these options – we hope you'll join us for one of these programs!

Calendar

PPA on the Road: Scranton/Wilkes-Barre
May 13, 2016
9:00 a.m.–3:30 p.m.
John Heinz Institute, 150 Mundy Street, Wilkes-Barre

Live Webinar: PQRS Updates for 2016
Diane M. Pedulla, JD
American Psychological Association
May 17, 2016
12:00 p.m–1:30 p.m

PPA ECP Day
May 21, 2016
9:00 a.m.–4:00 p.m.
Lancaster Marriott at Penn Square

PPA2016 – PPA's Annual Convention
June 15-18, 2016
Hilton Harrisburg, Harrisburg

2016 Fall Continuing Education and Ethics Conference
November 4, 2016
9:00 a.m.–4:30 p.m.

Webinars and Home Studies
Available year-round!

Podcasts
Podcasts for CE credit by Dr. John Gavazzi are available on www.papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org.

Registration materials and further conference information are available at www.papsy.org.

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

Excess Weight and Weight Loss
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer, and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent, and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations, and Ethics**
6 CE Credits

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

For all Home Study CE Courses above contact:
Judy Smith, (717) 510-6343, judy@papsy.org.