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Dr. Joseph French:

A Wise and Compassionate Leader

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Pennsylvania psychologists lost one of their most influential members with the passing of Dr. Joseph ("Joe") French in January 2018. Joe had a long list of contributions to professional psychology through his work as director of the school psychology program at the Pennsylvania State University, as published a author in the field of school psychology, as a leader within PPA, as a member of the Pennsylvania State Board of Psychology, and so much more. A generation of school psychologists in Pennsylvania trained in the school psychology program at Penn State and developed much of their professionalism through their contact with Joe French.

Dr. French was a past-President of the Pennsylvania Psychological Association and did much to move PPA into becoming a more member-responsive organization. He was also one of the founding members of PennPsyPAC, the PPA affiliated political action committee. He told me (Samuel Knapp) about the earliest days of Penn PsyPAC when he and his friends would stuff envelopes around his kitchen table to get PennPsyPAC its first donations. Joe received

numerous awards from PPA and other organizations for the work he did for PPA and for psychology in general.

Joe French, along with Samuel Knapp and Zita Levin, wrote a History of the Pennsylvania Psychological Association. Joe helped record the history of psychology in Pennsylvania as well as creating it. Throughout his tenure as a professor in the school psychology program at Penn State, he kept in close contact with the late Dr. Robert Bernreuter, the father of school psychology in Pennsylvania (who had worked to secure the first governmental recognition of psychologists in Pennsylvania in 1936 when the positions of school psychologists were created). He made certain that his students understood the role of the pioneers in creating a public role for psychology and urged them to continue to advocate for public access to psychological services.

I (Samuel Knapp) knew Joe French primarily as a member of the Pennsylvania State Board of Psychology where he served almost continuously from 1974 to 2016. In my contacts with him, he never had an ounce of pretense and only spoke with authenticity. He spoke up firmly in discussions on controversial issues and often disagreed with the majority. But he never alienated anyone in these discussions and never made them personal.

Joe developed an independent school psychology program after being recruited by Penn State in 1964. He ran that program until retiring as an emeritus professor of education in 1997. During his time at Penn State he served in the Faculty Senate, Graduate Council, College of Education Faculty Council, and more.

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Introduction to Articles on What Is New in Psychotherapy and Counseling in the Last 10 Years?: Part Three

Samuel Knapp, Ed.D., ABPP[1]
John Gavazzi, Psy.D., ABPP

This is the third and final part of our series on "What is New in Counseling and Psychotherapy in the last 10 years." As we stated in the introduction to the first set of articles, the field of psychology is changing rapidly. Neimeyer et al. (2012) estimated that the half-life for a professional psychologist is 9 years and will soon decline to 7, although the half-life varies across specialty. These articles will help psychologists keep up-to-date on the most significant changes in the field of psychotherapy and counseling in the last 10 years.

Psychologists who read these articles should remember that:

- Because of space limitations, we could not include references to many developments, and had to summarize complex issues into a few sentences.
- These articles are neither definitive nor final; they are the basis for more discussion.
- Psychologists will differ in what they believe are important developments, in part, because they work within specific subfields of psychotherapy, have different areas of interest, have different theoretical orientations, are exposed to different sources of information, or simply know more than we do.
- Finally, what is "new" is a subjective decision. Sometimes we reference older techniques, but list developments as new because of an increasing research base for their support.

These articles have been enriched by the feedback given to us from participants in workshops on "What is New in Psychotherapy and Counseling" which were held in King of Prussia, Erie, Bedford, and Lancaster in 2017.

We broke up the advances into several articles. In this issue, we look at developments in the prevention of suicide, supervision, ethics, and professional education. Previous articles published in the July/August and November editions of the Pennsylvania Psychologist Update looked at developments in the science of psychology; psychotherapy processes; outcomes with specific treatments; cultural diversity; how psychological science is being incorporated into psychotherapy; social and cultural changes that impact psychotherapy; changes in American families; and changes in the social determinants of health, Please feel free to contact us with your comments (sam@papsy.org; or johngavazzi@aol.com).

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1. Samuel Knapp is rated a perfect 5.0 by Uber drivers.

DR. JOSEPH FRENCH

Continued from page 1

Joe was highly respected and appreciated by all those who went through Penn State's school psychology program. He encouraged/instructed the members of each incoming class to support each other and to coalesce as a group. He was an advocate and practitioner of community, community building, and community service. One of his former students, Dr. Helena-Tuleya Payne, told me that he had a great impact on her and other students. He ensured that his students were competent and confident. She told us that, "you felt that he cared deeply about your success."

For many years Dr. French consulted for the Home of the Merciful Savior, a home for children with cerebral palsy in Philadelphia. For most of those years, he would cart a bunch of his graduate students to Philadelphia to perform psycho-educational evaluations on residents there in need of such as a means of contributing to and assuring these children's educational needs being met. He just could not help himself when it came to helping others.

Joe received much, well-deserved recognition throughout his career including:

1982 – Distinguished Service to the Pennsylvania Psychological Association

1992 – PPA School Psychology Award

1994 – Lifetime Achievement Award from the Association of School Psychologists of Pennsylvania (ASPP);

1996 – PPA Award for Distinguished Service to the Science and Practice of Psychology

1998 – Illinois State University (ISU) Distinguished Alumnae

1999 – National Association of School Psychologists Legends of School Psychology Award;

2006 – ISU College of Arts and Sciences Hall of Fame.

Dr. Joseph French had a rich and varied personal life that included camping, traveling, coaching Little League, playing softball, and being a Boy Scout Leader. He was also a devoted husband, father, grandfather, and great-grandfather. While Joe will certainly be deeply missed by his family, his passing will also be sorely felt by psychology and school psychology professionals across the Commonwealth and the nation.

What Is New in the Assessment and Treatment of Suicidal Patients?

Samuel Knapp, Ed. D., ABPP
John Gavazzi, Psy.D., ABPP

Suicide is the 10th leading cause of death in the United States and has increased by 20% in the last 15 years. Twice as many Americans die from suicide as die from homicides. World-wide the rate of suicide is about 15 persons per 100,000, compared to 12 per person in the United States. Despite the widespread public health costs of suicide, it receives only one twentieth the funding of kidney and lung diseases, which kill about the same number of Americans every year.

Some suicidologists claim that little has changed in the last 10 or even 15 years in suicide prevention. Some promising research has been conducted on the role of physiological inflammation and suicidal behavior, the possibility of improving predictions using machine based programs, and the potential for implicit association tests to improve suicidal predictions. However, these developments do not now easily translate into the day-to-day work of preventing suicides.

Nonetheless, we can identify three meaningful changes in in suicide prevention in the last 10 years. First, actual outcome studies show the effectiveness of certain interventions in preventing suicide attempts. Second, evidence is now conclusive that no-suicide contracts lack effectiveness in preventing suicides. Finally, we believe that methodological advances in tracking the affective states leading to suicidal behavior have the promise to prevent suicide attempts.

Outcome Studies Targeting Suicidal Behavior

Few pharmacological or psychological treatment outcome studies have looked directly at which treatments are most effective at reducing suicidal behavior. In part, this occurs because attempted or completed suicides tend to be rare. In addition, most outcome studies, including pharmacological studies, will exclude suicidal patients from the program. However, three recent studies have looked directly at the impact of psychological interventions on suicide attempts and all have been found effective in reducing suicide attempts: cognitive behavior therapy for depression (Rudd et al., 2015); dialectical behavior therapy for borderline personality disorder (Linehan et al., 2015); and Collaborative Assessment and Management of Suicide (CAMS, Jobes, 2016).

One of the greatest challenges is to predict suicidal attempt within days, hours, or even minutes. The distal factors of suicide are well understood (being male, older, having access to firearms, etc.), but the challenge is to predict suicide in the short-term.

No-Suicide Contracts

Many suicidologists had cautioned against the use of no-suicide contracts, but the review by Edwards and Sachman (2011) appeared to represent a substantial shift away for their use. Edwards and Sachman found that no-suicide contracts do not improve patient safety or reduce the likelihood of a patient suicide. Some clinicians argue that they use the contracts as part of an assessment. The rationale is that if the patient does not sign the contract, then the person is at a higher risk for attempting suicide. Again, no research supports this assumption. Patients may refuse to sign such a contract for many reasons; none of which could be related to the likelihood of the patient will attempt suicide.

Also, the use of the term "contract" implies a legal element to the agreement. But nothing about this "contract" has legal standing. The use of a "no-suicide contract" is not a good risk management strategy and does not meet the standard of care. Finally, depending on how it is used, a no-suicide contract may interfere with the therapeutic alliance. A patient may interpret that the psychologist is more interested in avoiding a lawsuit than the promoting the patient's well-being.

However, alternatives such as commitment to life or commitment to treatment documents can be effective, if they include coping statements, reasons for living, warning signs, suggested responses, and crisis numbers and are conducted in a cooperative manner with the patients. A commitment to life or commitment to treatment document tells a patient what they can do if they experience suicidal thoughts; a no-suicide contract only tells them what they cannot do.

Nonetheless, all treatments of suicidal patients should include suicide management strategies, including explicit agreements on treatment, means restriction (removing or restricting access to the means of suicide), monitoring of patients, and referrals for medication (if indicated). However, psychotherapists are cautioned that the risk of suicide for patients referred for medication remains high until (or if) the medications begin to have a therapeutic effect.

Proximal Causes of Suicide

One of the greatest challenges is to predict suicidal attempt within days, hours, or even minutes. The distal factors of suicide are well understood (being male, older, having access to firearms, etc.), but the challenge is to predict suicide in the short-term. No single test definitively predicts who is likely to die from suicide, and even the distal factors have high rates of false positives; because suicide is a relatively rare event. Also, these distal risk factors interact with each other in idiosyncratic ways and are not necessarily additive.

Near term predictions have relied on warning signs, or the patient's immediate thoughts and behaviors that appear to predict short term suicide risk. One

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list of warning signs, developed by the American Association of Suicidology uses the mnemonic IS PATH WARM (Suicidal Ideation, Substance abuse, Purposelessness, Anger, Trapped, Hopelessness, Withdrawal, Anxiety, Recklessness, and Mood changes) to identify common warning signs. However, these warning signs are not strong or reliable predictors of suicide in the short-term. Also, other groups have created similar lists of warning signs, although so many warning signs have been added and their descriptors are so vague that they lose all meaning.

Nonetheless, we are encouraged by recent research on the affective states that appear linked to suicide attempts. Improvements have been made in the identification of proximal factors for suicide which should increase the ability to prevent suicides in the near term. Retrospective reports have long identified the intense emotional suffering that usually occurs immediately before an individual decides to kill themselves. The pioneer suicidologists Edwin Schneidman referred to this as a "psychache." Now studies with time sampling have added to our knowledge of what occurs in the mind of a suicidal person immediately before the attempt (Bagge et al., 2017; Kleinman et al., 2017).

Researchers have identified a condition called the acute suicidal affective disorder (ASAD) that includes a cluster of behaviors, thoughts and feelings that appear to co-occur with suicidal thoughts (Rogers et al., 2017; Tucker et al, 2016). This cluster of symptoms is derived from the interpersonal theory of suicide and includes:

1. A very rapid increase in suicidal intent that developed within days or hours (as opposed to weeks or months);
2. Either social-alienation (social withdrawal, perceived burdensomeness, or disgust with others) or self-alienation (self-disgust and perceived burdensomeness);
3. A belief and the states in item 2 cannot be reversed (hopelessness); and
4. Two or more of the following indices of hyperarousal such as agitation, irritability, nightmares, and insomnia.

The ASAD appears to define the state of mind that cognitive psychotherapists call the suicide mode, or a constellation of thoughts, feelings, behavioral reactions and behaviors that lead an individual to attempt suicide (Clemans, 2015).

The identification of the acute suicide affective disturbance, combined with David Rudd's fluid vulnerability therapy, allows a clearer framework for understanding and responding to suicidal states. The fluid vulnerability theory postulates that suicidal ideations have both chronic factors that are slow to change and form a baseline of risk, and acute factors that can appear suddenly and move an individual into an actively suicidal state (Clemans, 2015). The chronic factors that establish the baseline of risk could include a weak social support network or a history of abuse that habituates an individual to suffering, or factors that creates a high tolerance of pain, or psychological vulnerabilities, such as pervasive hopelessness. The acute factors could be the loss of a cherished interpersonal relationship, a sudden decline in physical health, or an emotional cascade wherein the cumulative effect of a series of smaller events leads to an acutely suicidal state. Patients with a high baseline can move into an acute suicidal state quickly and take longer to return to their baseline.

Although only a few studies have looked at the ASAD, it fits nicely into current theories of suicide and clarifies aspects of the suicidal mode that could be targeted during treatment. Psychologists can identify patients with high baselines and can then take precautions to circumvent or interrupt the thoughts and emotions that lead to the ASAD. That is, through interviewing, psychologists can identify the insomnia and nightmares, for example, and begin programs on sleep hygiene to address those issues. Or, they can address the hopelessness and self-disgust found in the acute suicidal state in therapy, and encourage social connections which would address the social isolation that is commonly found.

The ASAD also explains the importance of having means restriction plans in place since the move toward a suicidal state can occur very quickly—sometimes in less than an hour. The goal of means restriction is only to keep the patient safe until the suicidal crisis ends.

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What is New in Supervision?

Samuel Knapp, Ed. D., ABPP
John Gavazzi, Psy.D., ABPP

About 20 years ago, supervising standards were often vague or lacking, and training for supervisors was non-existent or very limited (Watkins, 2014). Now there is greater emphasis on accountability, in part, because of stricter licensing board regulations. Supervision differs from psychotherapy. Psychologists who are proficient in psychotherapy are not necessarily proficient in supervision.

Anecdotes and self-report surveys reveal that the quality of supervision is sometimes poor. Supervisees have reported harmful supervisor behaviors, such as having supervisors who do not showing up for supervision, act in a dismissive manner, show personal disrespect, or who are overly critical or overly directive (Goodyear & Rodolfa, 2012). Supervisees sometimes feel disappointed, let down, abandoned, or "thrown under the bus" by their supervisors. We do not know if the quality of supervision has improved over recent years, although we suspect that it has.

Supervision can be a complex process, depending on supervisor skill level, trainee skill level, clinical setting, supervision requirements, and each professional's ability to set goals and resolve conflicts, to name a few variables. Good supervisors understand supervisory models; help guide supervisees through ethical concerns and diversity issues; know how to assess their supervisees, can manage their supervisory relationship, and learn how to teach self-reflection and self-assessment (Watkins, 2014).

Good supervisors understand supervisory models; help guide supervisees through ethical concerns and diversity issues; know how to assess their supervisees, can manage their supervisory relationship, and learn how to teach self-reflection and self-assessment (Watkins, 2014).

Some evidence suggests that supervision can lead to better patient outcomes for psychotherapists, although the research in this area has been limited and far from conclusive (Bambling et al., 2006). Evidence also suggests that supervision can improve the outcomes for resident physicians (Farnan et al., 2012).

Research on supervision tends to be limited, and much of it is correlational or consists of reports of satisfaction as opposed to prospective, randomly assigned studies that look at supervision processes and patient outcomes. Nonetheless, existing research tends to focus on the importance of the psychologist/supervisee relationship and a stance that supports and encourages supervisee growth and self-reflection.

Some of the difficulties in the supervisory relationship are related to the power imbalance between supervisor and supervisee. Even the more conscientious supervisees may be reluctant to disclose mistakes, to admit to "forbidden" emotions such as anger or sexual attraction to patients, or to challenge the supervisor for fear of negative evaluations with potentially career-damaging consequences. Effective supervisors can establish conditions in the relationship that reduce nondisclosures by adopting a non-judgmental stance and normalizing mistakes by sharing their own shortcomings.

Fortunately, supervisors can access many new resources to help them enhance the quality of their services. APA has several high-quality books on supervision and an impressive DVD series on supervision edited by H. Levenson and A. Inman.

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What is New in Ethics?

Samuel Knapp, Ed. D., ABPP
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If one were to ask most psychologists about the changes in ethics in the last 10 years, we suspect that they might refer to the application of ethical standards and principles to new work environments, such as when services are delivered through telehealth or within integrated care settings or how to use electronic media in their practices. Some examples: psychologists will have to consider when or how they receive or send emails to patients. They may consider whether to google their patients, establish a social media policy for their patients, or to use an electronic health record system, or apps in their clinical practice. Although these are important issues, we believe that psychologists can make good decisions by exploring these issues from the standpoint of principle-based ethics or some other overarching ethical theory.

However, we think that the most important developments in ethics is the application of psychological science to inform ethical behavior. A corollary of that development is an increased awareness of the role of self-care in maintaining good ethical behavior.

Using Psychological Science to Enrich Ethical Conduct

Empirical research cannot prescribe ethical behavior.[1] That is, it cannot tell people how to behave; but it can describe how people act, think or reason about ethical issues, or identify way that moral agents can become better at reaching their ethical goals. All moral agents display a discrepancy between how they act and how they believe they should act (a gap between ethical behavior and ethical ideals). Although this gap will always exist to some extent, it is certainly worthwhile to reduce it as much as possible.

Psychological science can help psychologists to reach their ethical ideals. For example, Ayal et al. (2015) presented

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the REVISE acronym to help moral agents remember the influence of reminders, visibility, and self-engagement in promoting ethical behavior. Drawing upon laboratory studies, the authors noted that ethical behavior will increase (or unethical behavior will decrease), when participants are exposed to signs, pictures, or reminders of ethical behavior, have their behavior more open to outside scrutiny (or peer monitoring), or make public commitments to ethical conduct.

Psychological science can also help psychologists think through ethical and clinical decisions. All people are vulnerable to using heuristics or biases that can lead to irrational or unproductive solutions to problems. Rogerson et al. (2012) showed how health care professionals and psychologists could be influenced by these psychological processes. For example, psychotherapists may hold unfair biases against persons based on racial stereotypes, yet these biases may be implicit (outside of their immediate awareness). Uncomfortable egalitarians may articulate egalitarian principles and strive to treat others fairly, but the lack of awareness of their own biases may impede their ability to live out their goals fully (Banaji & Greenwald, 2012). Fortunately, psychologists who are aware of these biases can monitor and compensate for them.

Psychologists can also rely on psychological science to help patients make better ethical decisions. For example, a considerable body of research has looked at *motivated moral reasoning* which occurs when a moral agent is motivated to reach a specific moral conclusion (Ditto et al., 209). Most patients believe that they base their moral judgments on well justified moral principles that they apply impartially and consistently over time and across situations. However, both psychologists and their patients will typically make a judgment based on reflexive, automatic, and intuitive reactions to situations. They tend to make moral judgments first, and answer the question of why later (and only if asked). Thus, the moral reasoning is often backward. We establish a position first and then look for reasons to justify it.

Psychologists who understand the role of motivated moral reasoning might be better able to help their patients think through the ethical implications of their decisions. They can ask patients to slow down their thinking, identify the relevant moral principles and the consequences of their decisions on others (Gavazzi & Knapp, 2014).

Self-Care and Ethics

During the last 10 years, commentators have emphasized the relationship between self-care and ethical behavior. Engaging in self-care practices is not just an aspirational goal; it is a professional responsibility. Psychotherapists use their cognitive resources as well as their emotional responses (both positive and negative) as part of the psychotherapy experience. Psychologists do not perform at their highest levels when their cognitive and emotional resources are taxed.

[1] A minority of scholars, such as Harris (2010) disagree and believe that values can be logically derived from science.

Quite simply, it is harder to implement goals when suffering from fatigue or while being distracted by unpleasant emotions or intrusive thoughts. For example, Danziger et al. (2010) looked at the outcome of parole decisions according to the proximity of the judges' food breaks. The number and percentage of decisions granting parole was highest after a food break, but gradually decreased to as the time away from the food break increased. Despite the efforts of conscientious judges to adhere to the law and the merits of each case, feelings of hunger and fatigue perhaps due to lower glucose levels appeared to influence their decisions. In another study, Barnes et al. (2011) found that sleep deprived workers engaged in more unethical behavior, as rated by their supervisors, and the frequency of their unethical behavior varied according to the quality of their sleep.

These findings apply to psychotherapists. While we think that it is unlikely that psychotherapists will suddenly breach confidentiality or engage in serious boundary violations simply because they are hungry or tired, it does suggest that hungry or tired psychotherapists might engage in subtle boundary violations or make less than optimal treatment decisions.

Dr. Jeff Sternlieb (2014) has noted that self-care is a 50/50 proposition and has two dimensions: work/life balance and managing job stress. Psychologists can build resilience by taking better physical care of themselves, such as eating well, exercising on a regular basis, participating in meditation, limiting alcohol intake, and developing a healthy sleep cycle. They can take vacations, nurture their family life, and seek hobbies and activities outside of their profession.

In addition, psychologists can address the other 50% of self-care by acknowledging an addressing the stressors of being a psychologist. Research shows that psychologists have rates of emotional disturbances that approximately mirror those of the population in general. Although the mental health baseline for psychologists may be routine, vicarious trauma, compassion fatigue, complex patients, and other issues that psychologists face are far from routine.

Sternlieb notes psychologists who are best at managing the emotional stressors of their work are sensitive to their emotional reactions ("You have to be it to see it") are able to reflect and identify their reactions ("You have to name it to tame it"); and can share their reflections with trusted colleagues ("You have to share it to bear it:" Sternlieb, 2013, p. 21).

Psychologists who understand the role of motivated moral reasoning might be better able to help their patients think through the ethical implications of their decisions.

Sharing our emotional concerns illustrates the importance of being embedded into a protective social community. One of the important aspects of self-care is to embed ourselves into a protective social community. Johnson et al. (2012) used the term ***competent community*** to refer to a such a network of contacts, friends, or associates who offer such support. This is "a consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence" (p. 566). These social contacts can provide us with information (e.g., "did you see that recent article in the American Psychologist?"), give us emotional support when we encounter a particularly difficult patient, or offer instrument support (e.g., "Here let me show you how to fill out this HCFA 1500."). When we have close connections with colleagues, they can also give us an opportunity to self-reflect or can act as an informal monitor if they see our behavior going downhill.

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What Is New in Professional Education?

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Professional education is changing at both the doctoral and post-doctoral level. In our opinion, most of the interesting changes are occurring at the post-doctoral level, although doctoral level education is changing as well.

Changes in Doctoral Education

Doctoral programs are focusing more on objectively described and measured competencies. It is no longer acceptable for a graduate to simply take and pass a course. The emphasis is now on demonstrating the necessary competencies as measured by specific benchmarks. Although the movement for competence-based education started more than 10 years ago, it has now become firmly embedded in the ethos of doctoral programs.

Programs are also emphasizing professionalism among doctoral students. The term professionalism has many different definitions, although self-awareness and self-reflection tend to run through these definitions. Professionals, including psychotherapists tend to overestimate their competence. For example, Walfish et al. (2012) found that all the psychotherapists in their sample rated themselves as above average. While a certain amount of self-enhancement may be innocuous enough, a serious overestimation of one's ability could result in patients receiving incompetent care.

Some findings from medical education may have relevance here. For example, Davis et al. (2006) found that, although many physicians overestimated their skill level on a series of standardized tasks measuring professional competence, a subset who performed well below average, consistently overestimated their skill level. Also, Lipsett, Harris, and Downing (2011) found that medical residents who were poor performers tended to overestimate their skill level. In other words, those who needed the most improvement, were least likely to recognize this fact.

Programs are also emphasizing professionalism among doctoral students. The term professionalism has many different definitions, although self-awareness and self-reflection tend to run through these definitions.

To ensure that recent graduates have acquired the professional skills needed for effective practice as a psychologist, the Association of State and Provincial Psychology Boards (ASPPB) has proposed an EPPP-2 or an addition on the EPPP that would be required as a condition of receiving a psychology license. This part of the EPPP would test the applicant's ability to apply knowledge to real life problems. Whether the EPPP-2 is an appropriate way to promote professionalism is a matter of considerable debate, however.

Finally, inter-professional education is growing largely in response to the need for greater team work in the delivery of integrated health care. The movement is not without its problems because members of other professions often do not know enough about each other, or understand the differences in terminology, codes of ethics, and implicit guild norms. Nonetheless, when done properly, students tend to appreciate inter-professional education and believe that it helps prepare them to work cooperatively with other professionals in real-life practice. A phrase that is sometimes used is to move from interdisciplinary care (where different professionals offer services with only basic communication between each other) to inter-professional care (where different professionals offer services together based a shared process of decision making; Thistlethwaite, 2013).

Changes in Post-Doctoral Education

Post-doctoral education is changing as well. On the surface, one would think that most of the education of licensed psychologists come from formal sources such as from professional journals or continuing education programs. Nonetheless, informal sources appear to be especially important. Psychologists, like most other Americans, are increasingly relying upon less formal sources, such as Twitter or other social media to acquire information. Contacts with peers continues to be a major source of information. Neimeyer et al. (2012) found that 75% of psychologists reported that self-directed learning contributed to their professional competence; compared to 71% for peer consultation and 79% for formal CE programs did. It appears that formal continuing education programs are only one venue for on-going professional development. In the meantime, new methods of delivery continuing education have occurred through Massive, on-line, open, courses (MOOCs), podcasts, or webinars.

MOOCs

Even the nature of formal educational programs has changed with the development of MOOCs such as those offered by Coursera or other providers. Most allow participants to take the course for free. However, participants typically must to pay for the course, and pass some type of examination or provide a work product to receive a formal certificate. In addition, some companies offer free access to class lectures on college courses on a wide

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range of topics, including basic psychology courses. To date, we are unaware of MOOCs being applied to continuing education for psychologists, although theoretically, this could happen in the future.

Podcasts and Webinars

Podcasts represent a contrast to MOOCs. Whereas MOOCs attempt to have a wide audience, podcasting is a form of "narrowcasting" meaning that they are geared to niche audiences or to specific topics. A podcast is a digital file, usually audio, that psychologists can easily download to a portable device. John Gavazzi offers podcasts related to ethics and psychology. They are also free to listen for self-education; however, continuing education credits will cost money. Podcasts are "sit and get" and offer convenience of 24/7 access.

Webinars (live or recorded) are now more common for continuing education. Many psychologists and continuing education companies are moving toward this format because of cost and convenience. As with podcasts, webinars are mainly "sit and get" services, offering little opportunity for collaborative learning or discussions among participants.

Continuing Education Appears to Work, But We Don't Always Know Why or When

Although the format for learning may be changing, the question remains as to whether continuing education leads to improved patient outcomes. We know that certain types of continuing education for physicians can lead to improvement in patient outcomes (Forsetlund et al., 2012). Those effective programs tend to be more time-intensive, involve smaller groups, and include interactive learning. These findings and other findings from adult education are leading some educators to rethink the traditional lecture-based method of continuing education. This is not to say that lectures have no place in continuing education; only that they should be one element of a total experience that includes participant interaction and active involvement.

Other evidence suggests benefits of continuing education. Physicians who had the most continuing education had fewer patient complaints (Wengerhofer et al., 2015). Psychologists who reported more formal and informal professional learning activities also reported a higher sense of professional competence (Taylor & Neimeyer, 2015). However, on a state level, the number of mandates was not associated with lower rates of disciplinary actions against psychologists (Neimeyer et al., 2013).

In summary, it appears that continuing education leads to an improvement in patient outcomes. However, at the present it is not clear which CE program, delivered in which format, produces what kind of outcome improvement for which psychologist.

The Maintenance of Certification Movement is Stalled

A few physician specialties have required maintenance of certification (MOC) which involves retaking the board examinations. But there is no evidence that retaking the examinations has improved patient outcomes. As applied to psychology, there would be substantial resources devoted to developing assessments for all the many subspecialties involved. The American Board of Professional Psychology is moving toward MOC. Although the search for ways to improve the quality of services among licensed professionals continues, no definitive research supports MOC as improving the quality of a psychologist's work.

To ensure that recent graduates have acquired the professional skills needed for effective practice as a psychologist, the Association of State and Provincial Psychology Boards (ASPPB) has proposed an EPPP-2 or an addition on the EPPP that would be required as a condition of receiving a psychology license.

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2018 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

April 19, 2018
PPA's Day of Self-Reflection
Sheraton Station Square
Pittsburgh, PA

April 19, 2018
Regional Advocacy Day & Reception
Sheraton Station Square
Pittsburgh, PA

April 20, 2018
PPA Spring Continuing Education Conference
Sheraton Station Square
Pittsburgh, PA

May 11, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar Harrisburg, PA

June 13–16, 2018
PPA2018—PPA's Annual Convention
Doubletree Valley Forge
King of Prussia, PA

Home Study CE Courses

Act 74 CE Programs

Assessment, Management, and Treatment of Suicidal Patients—1 CE

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

Assessment, Management, and Treatment of Suicidal Patients (Podcast)—1 CE

Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Competence, Advertising, Informed Consent, and Other Professional Issues**—3 CEs

*The New Confidentiality 2018**—3 CEs

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

For all Home Study CE courses above, contact: Judy Huntley, 717-232-3817, judy@papsy.org.

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Register before March 30 to receive the early bird rate.

Additional information can be found here: https://papsy.site-ym.com/page/SpringFall

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

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