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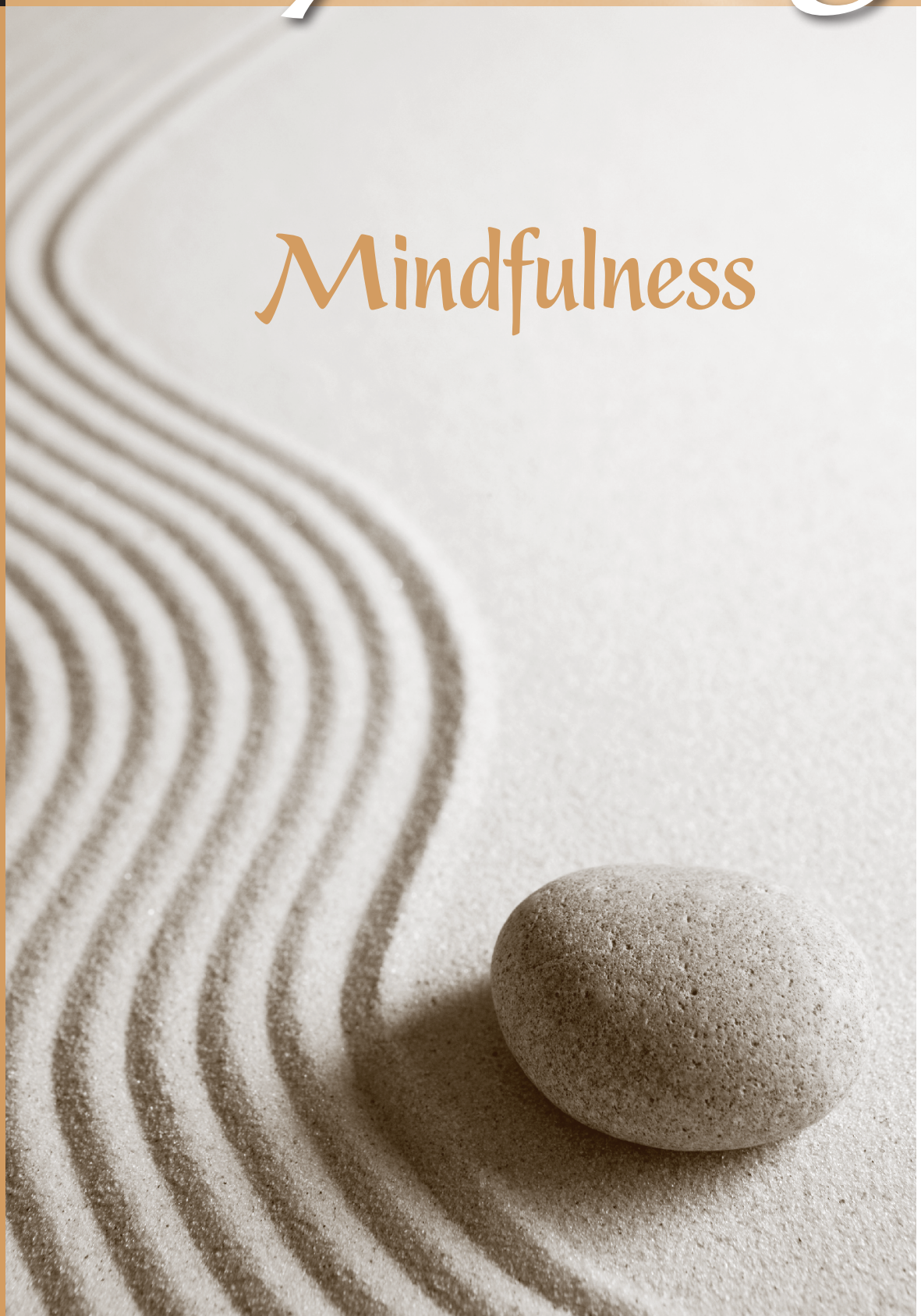
Mindfulness



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Winds of Change

Steven R. Cohen, Ph.D.

Dr. Steven R. Cohen

This will be my last message to you as president of PPA. I cannot list everyone who has served as board chairs, committee chairpersons, committee members and board members, but would like to thank all of you for making my tenure successful. Many of you have worked tirelessly for many years to support PPA and there are not enough thanks for your continued efforts and support. I know that we all benefit from the hard work of each committee. There are 300 PPA members who serve on committees to help the organization of approximately 3100 members. Many other states do not even have 300 members in their state psychological association.

I would like to especially thank Dr. David Palmiter for chairing the Cyber Technology Task Force. Dr. Palmiter was already deeply involved in committees for PPA as well as APA, when I pleaded with him to head this new committee. I appointed the task force to help keep PPA up to date in the newest technology and find ways to use these technologies to benefit our membership as well as the public. An edition of *The Pennsylvania Psychologist* in the fall will be devoted to exploring issues of cyber technology and its impact on us. The June Convention also includes many presentations on the impact of cyber technology. Under the guidance of the Electronic Media Coordination Committee we are currently updating the Web site to make it more user-friendly for you and the public. Many hours have been spent by this committee and the PPA staff to reach this goal. We were among the first state psychological organizations to have a Web presence, and with the upgrades, I believe we will have one of the best Web sites.

Other technological advances for PPA are in the works, including webinars and other electronic connections. While these technological advances are occurring, it is important to remember that human contact with our members will never go out of date. Relationships are the business of psychologists. Networking is so important to this profession. It is a way to break out of the isolation of clinical practice, a way to keep up to date on what is happening in our field, and a way to get and give support to each other.

> *While these technological advances are occurring, it is important to remember that human contact with our members will never go out of date.*

One of the ways to network with other members is to offer to serve on committees. Some of the membership serves on committees year after year with no complaint, but new members provide new perspective and invigoration. Your efforts are welcomed and needed.

My year as president has been filled with new experiences. I testified before the Pennsylvania Legislature on behalf of PPA, attended a black-tie dinner with U.S. Senator Olympia Snowe, a supporter of psychology. I traveled to Capitol Hill in Washington to support psychology in Medicare and parity in the coming health care changes. I was able to request changes in a Rule of the Pennsylvania Supreme Court that would have asked us to violate our Code of Ethics. My position as president gave weight to my request. One of the best parts of being president was the great pleasure in meeting so many of you in person.

PPA has the most competent staff. The board and the many volunteers set the direction for the organization, but the staff is there every day, making sure that PPA serves the needs of our members. Most of you know Marti Evans from conventions. She manages the conventions and conferences. I don't know how she keeps us all organized, including me, and makes it all work seamlessly. Iva Brimmer, our business and membership manager, has many jobs, which include finance, membership, and information technology. She is the master of the back office operations. Tom DeWall, our executive director, and Dr. Sam Knapp, our director of professional affairs, have been there right by my side through the entire year and are always available to members. Rachael Baturin, Esquire, our professional affairs associate, and I have collaborated on several projects, and her advice to PPA is priceless. Our administrative support from Katie Boyer and Peggie Price is invaluable. PPA staff is so special that they can function independently; however, their assistance to me in my new role as president was tremendous. I would like to thank them all for making me look good for the entire year.

I would also like to thank all of you for your support. It is clichéd to say this, but I really mean it; it has been a real honor to serve as your president. I know you will support your new president, as I pass the gavel to Dr. Mark Hogue at the convention.

I made several promises before taking office: to explore and find ways to keep PPA and our members up to date with the new technological challenges, to conduct shorter board meetings, and to tell good jokes at the meetings. You will have to ask a board member if I kept my goals. I hope you all enjoy the convention. I will still be around serving as past president. If you haven't met me, please stop me and let me get to know you, make a suggestion, ask to join a committee, or just say hello.

Dr. Judith Blau Wins Election for President of PPA

Dr. Judith Blau

Judith Blau, Ph.D., an independent practitioner from Doylestown, was elected to the position of president-elect of PPA. She will assume that position this month and will be president of the association from June 2011 to June 2012. Dr. Mark Hogue, who won last year's election, assumes the presidency at this month's convention for a 1-year term. Dr. Blau had received her doctorate in clinical psychology from Temple University in 1978. She has held many positions within PPA, including chair of the Communications Board, the Membership Benefits Committee and the Public Information and Marketing Committee. The latter committee was reconstituted as the Public Education Committee, which she has chaired for the past 2 years. She also served two terms as PPA's secretary and several terms on the PennPsyPAC Board of Directors.

Dr. Cheryll Rothery

Re-elected secretary of the association was **Cheryll Rothery, Psy.D.** She is director of clinical training and associate professor in the Chestnut Hill College Psy.D. program, while also maintaining an independent practice. She earned her Psy.D. in clinical psychology from Rutgers University in 1992. She also serves as secretary of the Delaware Valley Association of Black Psychologists and was a three-term member-at-large and student liaison in PSCP. She has served on the Executive Board of the National Council of Schools and Programs of Professional Psychology since 2006. She has also been a liaison to the APA Committee on Ethnic Minority Affairs.

Dr. John Abbruzzese III

Dr. John Abbruzzese III was elected chair of the Professional Psychology Board. He received his Ph.D. from the University of Pittsburgh in 1989. He is director of counseling and Psychological Services at East Stroudsburg University. He has been a member of PPA's Psychopharmacology Committee since 2002 and chaired it from 2002 to 2006. The Professional Psychology Board includes the committees on business, child custody, hospital practice, insurance, legislative and governmental affairs, and psychopharmacology, as well as the Practice-Research Network.

Dr. Beatrice Chakraborty

Elected to chair the Program and Education Board was **Dr. Beatrice Chakraborty**, who is a post-doctoral associate in psychiatry at the University of Pittsburgh School of Medicine. She is also the senior research fellow at the Biometrics Research Program. She earned her Psy.D. degree in clinical psychology from the Philadelphia College of Osteopathic Medicine in 2006. She has participated in PPA's mind-body workshops and is a member of the Convention Committee, which she will oversee, along with the CE Committee, in her new role on the Board of Directors.

Dr. Bruce Mapes

Dr. Bruce Mapes was re-elected chair of the Public Interest Board. For the past 2 years in this position he has overseen the committees on colleague assistance, disaster response, ethics, forensics, and multiculturalism. He is a member of the PennPsyPAC Board of Directors and is a member of the Pennsylvania Sexual Offender Assessment Board. He received his Ph.D. from the University of Pennsylvania in 1974. He maintains a private practice in clinical and forensic psychology. All of the board chair terms are for 2 years, beginning this month, and include membership on the PPA Board of Directors.

Looking ahead to her year as president, Dr. Blau stated, "Together, we have goals to achieve: to keep our profession strong and promote high standards of practice based on science; to be in the forefront of health care and to advocate for more access to our services through a carefully planned legislative agenda; and to serve the public through education about mental health and what psychologists have to offer."

We appreciate the participation of all members who ran for office in this election. The fact that we have contested elections of highly qualified candidates speaks to the health of PPA as an organization. This was the second year in which our election was conducted online, although those members for whom the office does not have an e-mail address were sent a paper ballot. A total of 707 ballots were received, which was about 23% of those eligible to vote.

PPA Members Press Legislation in Capitol

Thomas H. DeWall, CAE

Thomas H. DeWall

At our annual Advocacy Day in April about 50 PPA members and students met with their state legislators to urge action on three priority issues. The first of these was Senate Bill 383, introduced by Senators Jane C. Orie (R-Allegheny) and Daylin B. Leach (D-Montgomery). It would authorize the Pennsylvania Supreme Court to institute rules for the establishment of problem-solving courts and to appoint a statewide problem-solving courts coordinator and advisory committee. Such measures would allow local courts to apply for federal start-up grants. Courts may develop local rules as long as they are consistent with the legislation and Supreme Court rules. This bill was passed by the state Senate in June 2009, 49-0. It was amended and passed by the House of Representatives in March 2010, 196-0. At press time it was in the Senate Rules Committee; both chambers need to work out the differences.

The goal of problem-solving courts is to respond more effectively to mental illness and other issues presented to courts. There is no one single problem-solving court model. Some are in large cities; others in small towns. Some deal with mental health, while others deal with drug addiction, drunk driving, juvenile mental health concerns, or other non-violent offenses. The unifying principles of problem-solving courts is that they involve judicial staff (judges, probation officers, prosecuting attorneys) who have specialized training; work collaboratively with local agencies; and require accountability and monitoring of offenders. It is not surprising that more local courts are looking at a problem-solving model. Not only are they more humane from the standpoint of helping people with serious mental illnesses. Data suggests that these programs are fiscally prudent. Studies have shown that diverting people away from prison and into treatment saves money after the initial start-up costs.

The second issue that was addressed was legislation that provides for management of head injuries among high school athletes and evaluation by psychologists or other providers. The legislation — HB 2060, introduced by Rep. Timothy B. Briggs (D-Montgomery), and SB 1241, introduced by Sen. Patrick M. Browne (R-Lehigh) — are in the Education Committees of the House and Senate, respectively. PPA's School Psychology Board was instrumental in bringing this issue to the attention of the Board of Directors, which adopted a position in favor of the legislation. These bills would require the Pennsylvania Interscholastic Athletic Association, in cooperation with the Pennsylvania Department of Health, to develop guidelines and other pertinent information to educate students, their parents, and their coaches about head injuries, "including the risks associated with continuing to play after a concussion or head injury." Student athletes suspected of sustaining a concussion or head injury would not be allowed to return to play until they are evaluated by a "licensed health care provider trained in the evaluation and management of concussion" and receive written clearance to return to play from that health care provider. See a fuller description of this issue in the school psychology section on page 23.

Studies have shown that diverting people away from prison and into treatment saves money....

This is an issue that has gained a great deal of awareness and visibility in the news media in recent years, with research that has shown significant negative consequences in later years among athletes, especially football players, who sustained multiple concussions. It is an issue that PPA is educating legislators about. They tend to think of psychologists as dealing only with mental health, whereas psychologists engage in a wide range of health-related and other activities.

The third issue was a bill to be introduced by Rep. Kathy Manderino (D-Philadelphia) that would authorize psychologists to testify on the initial determination of insanity in forensic cases. PPA members made the point that Pennsylvanians will benefit when the courts have the discretion of accepting testimony from a wider range of qualified professionals. Nothing in this bill would alter the standards for an insanity defense in Pennsylvania. Insanity determinations are rare and constitute less than 1% of all homicides, although attorneys will often seek private evaluations to determine if a reasonable basis exists for their clients to claim insanity. Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice of psychologists and the recognition of psychologists in a variety of forensic areas. Even the current Pennsylvania insanity statute permits defendants to summon an "other expert" (such as a psychologist) to testify on their behalf. It makes little sense for the court to allow a psychologist expert to testify for the defense, but not allow a psychologist expert to testify for the prosecution in the initial determination of insanity. This bill was introduced as HB 2496 on May 11. PPA members on Advocacy Day asked state House members to cosponsor it.

Building on the Work of Others: How to Properly Rely on a Previous Assessment

Samuel Knapp, Ed.D.; Director of Professional Affairs
Rachael L. Baturin, MPH, J.D.; Professional Affairs Associate

Dr. Samuel Knapp

Assessments have multiple purposes. They may, for example, describe a patient for purposes of treatment planning, or they may present a baseline of patient functioning that can be used to assess future progress. For example, a forensic report may attempt to describe how much damage an individual suffered as a result of an illness or trauma, or a BHRS report may focus on how much a child has improved since a previous report and recommend changes in the treatment.

Assessment represents a professional skill that requires professional knowledge and judgment in selecting, implementing, and interpreting the psychological test, and integrating the results with clinical information to address the referral questions. Often the information contained in previous reports can help to address the referral question because, among other reasons, it gives a base line of functioning. For example, the existence of scores from an earlier WAIS administration may help a current psychologist determine the functional impact of a recent brain trauma. However, the writer of the more recent report should clearly identify the sources of information as being from a previous report, and take full responsibility for all the conclusions and recommendations made in the current report.

If it is helpful to the reader of the report and accurately reflects the decision-making process of the report writer, it can be appropriate to quote from the original report, including several sentences or paragraphs, if properly attributed. However, the Ethics Code requires psychologists to substantiate their findings.

Rachael L. Baturin

Standard 9.03 (a) states that "psychologists base the opinions contained in their recommendations . . . on information and techniques sufficient to substantiate their findings" (APA, 2002). So a psychologist who relied, even in part, on the data in a previous report needs to identify the data obtained from that previous report and attribute its source accurately. The general rule is that the average reader should be able to identify which parts of the current report are borrowed, quoted, or paraphrased from a previous report. The report may say things such as "as noted in the 2003 report by Dr. Doe, the patient . . . ."

Another rule is that the average reader should be able to identify the opinions of the current report writer from the opinions of the previous report writer. The report may say things such as, "I agree with the conclusion of Dr. Doe that the patient . . . ." The existence of a previous report does not exonerate the current report writers from the obligation to draw their own professional conclusions.

Finally, it may be appropriate or even essential to use an earlier and otherwise outdated version of a test if it is used as a baseline from which to measure improvement or deterioration. For example, it may be clinically appropriate to administer a WAIS-II on a patient who received a WAIS-II years ago, if the degree of deterioration is a focus of the assessment.

Reference

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

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of May 11, 2010

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 251 HB 2186	Establishes involuntary commitment process for outpatient mental health treatment and expands mental health resources - Sen. Stewart J. Greenleaf (R-Montgomery) - Rep. Mario M. Scavello (R-Monroe)	For if amended	In Judiciary Committee	In Health & Human Services Committee
SB 306 HB 1879	Requires all health care providers to wear ID badge - Sen. Edwin B. Erickson (R-Delaware Co.) - Rep. Thomas H. Killion (R-Delaware Co.)	Against	In Public Health and Welfare Committee	In Professional Licensure Committee
SB 383	Promotes establishment of "problem solving courts," including for mental health and addictions - Sen. Jane C. Orie (R-Allegheny)	For	Passed, 6/3/09, 49-0. Removed House amendment & passed, 5/5/10, 49-0	Amended and passed, 3/23/10, 196-0
SB 515	Establishes involuntary commitment process for outpatient drug and alcohol treatment - Sen. Stewart J. Greenleaf (R-Montgomery)	For if amended	Passed by Judiciary Committee, 3/24/09; in Appropriations Committee	None
SB 1241 HB 2060	Provides for management of head injuries among high school athletes and evaluation by psychologist or other provider - Sen. Patrick M. Browne (R-Lehigh) - Rep. Tim Briggs (D-Montgomery)	For	In Education Committee	In Education Committee
HB 1	Expands state adultBasic program to cover more people and add prescription drugs and behavioral health - Rep. Todd A. Eachus (D-Luzerne)	For	In Banking and Insurance Committee	Passed 6/29/09, 104-96
HB 215 SB 1017	Restricts insurance companies' retroactive denial of reimbursement - Rep. Stephen E. Barrar (R-Delaware Co.) - Sen. David G. Argall (R-Schuylkill)	For	In Banking and Insurance Committee	Passed by Insurance Committee, 6/30/09; in Appropriations Committee
HB 1250	Establishes a "practice act" for social workers, marriage and family therapists, and professional counselors; provisions intruding on psychology practice amended out - Rep. Marc J. Gergely (D-Allegheny)	Neutral	In Consumer Protection & Professional Licensure Committee	Passed 3/9/10, 185-11
HB 1639	Comprehensively revises child custody laws; establishes 16 factors for courts to consider in custody cases - Rep. Kathy Manderino (D-Philadelphia)	For	None	Passed by Judiciary Committee, 5/4/10; in Appropriations Committee
HB 2496	Authorizes psychologists to testify in court on the determination of insanity - Rep. Kathy Manderino (D-Philadelphia)	For	None	In Judiciary Committee

Information on any bill can be obtained from http://www.legis.state.pa.us/WU01/LI/BI/billroom.htm

Mindfulness in Clinical Practice: An Overview

Theresa A. Kovacs, Psy.D.

Background and Applications

In classical Buddhist psychology, mindfulness is regarded as a mental state, one of the many functions of the mind that can arise in various combinations to assist in cognizing experiences in daily life (Olendzki, 2008). In today's society many of us rush through the day with ad nauseam thoughts imparting on our psyche. These thoughts are often automatic, and they can be intrusive or obsessive in nature; impacting our mood and detracting from the quality of our life (Freeman, Pretzer, Flemming, & Simon, 1990).

Jon Kabat-Zinn defines mindfulness as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment" (Kabat-Zinn, 2003, p. 145). Through systematic exercises, clients learn new ways of working attentively with their thoughts and feelings. The practice is rehearsed and learned through simple meditation exercises. Eventually through this process comes a rich awareness and presence into one's daily life. This practice can reduce intrusive thinking, help to prevent stress, anxiety, and relapses of depression (Kabat-Zinn, 2003).

Mindfulness has repeatedly been referred to as the "third wave" in cognitive-behavioral therapy (behavioral therapy is seen as the first wave, and cognitive therapy as the second) (Hayes, 2004; Segal, Teasdale, & Williams, 2004). Interest in the use of mindfulness has grown immensely in recent years, accomplishing validation by both the scientific literature and the clinical community. The applications of mindfulness in clinical work are receiving growing evidence-based support, particularly in the prevention and treatment of stress, anxiety, and depression. The use of mindfulness for clients dealing with stress and chronic pain was pioneered by Jon Kabat-Zinn, in a program known as Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 1990).

Subsequently, mindfulness has been incorporated into a variety of treatments, such as Mindfulness-Based Cognitive Therapy (MBCT) for prevention of depressive relapse (Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (DBT) for borderline personality disorder (Linehan, 1993), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), and Mindfulness-Based Relapse Prevention (MBRP) for addictions (Witkiewitz & Marlatt, 2007). These programs are now considered evidence-based practices (Didonna, 2009, Germer, 2005).

Dr. Theresa A. Kovacs

Mechanism

According to Orsillo, Lerner, & Tull, 2004, the acting mechanism of mindfulness is thought to be exposure, operating on the same brain mechanisms that are affected by behavioral interventions for anxiety. Worry can be seen as a cognitive strategy for attempting to reduce the anxious emotion. However, while thinking about all the possible things a person can or cannot change in the situation, the person is actually attempting to avoid experiencing the anxiety in the moment, and the ruminations are sustained through negative reinforcement. In mindfulness, acceptance of whatever is present is learned. Although a person may choose to change unfavorable circumstances, accepting the truth of the present situation is the first step. By allowing oneself to feel whatever physical sensations are present, whatever emotional reactions are occurring, and by observing what thoughts are in the mind, one can remove oneself from the habitual process of over-identification with them. This process is known as "decentering" (Segal, Teasdale, & Williams, 2004; Segal, Williams, & Teasdale, 2002, p. 38).

Decentering is thought by some to be a crucial mechanism for the success of traditional cognitive-behavioral therapy. In learning to recognize thoughts, and in challenging or reframing irrational thoughts, the individual becomes less identified with the thoughts and feelings themselves. On the other hand, in mindfulness training, this process of "moving the identified self back" to view one's own thoughts, feelings, and sensations is explicitly developed. Rather than fighting thoughts with thoughts, one recognizes that thoughts are not necessarily facts (even the ones that say they are) (Segal, Williams, & Teasdale, 2002).

Mindfulness for the Clinician

As a qualification for competently using mindfulness in clinical practice, the clinician must be able to effectively use the techniques personally (Segal, Williams, & Teasdale, 2002). Daily practice can enhance the clinician's awareness of how personal thoughts and feelings manifest and dissolve. Using the technique prior to and following a client can help keep the clinician focused on the client's issues while diminishing the distraction of extraneous or irrelevant feelings of countertransference.

According to Dr. Richard Sears, the director of the Center for Clinical Mindfulness & Meditation, mindfulness intuitively is an important component to therapists' self-care. "From early on in graduate school training, students and clinicians alike are given a double message: take care of oneself, but be a high achiever. Currently, too much is squeezed into a day, while facilitating the reduction of stress in others. As a simple introduction to mindfulness, therapists can learn to practice these techniques and extend their training through coursework and mentoring online." (March 14, 2010, http://www.psych-insights.com).

Conclusion

Mindfulness has been around for a while in many ways. However, the growing momentum of systematically teaching these skills and attitudes, supported by a growing research base with diverse populations, may lead to more effective interventions that draw out the best in clients and clinicians.

Continued on page 11

Mindfulness Training Changes the Brain and Builds Neuropsychological Resources

Christine Molnar, Ph.D.

Dr. Christine Molnar

Many psychologists are discovering how a secular form of Buddhist meditation called mindfulness training (MT) reduces negative emotion (Hofmann et al., 2010) and builds new brain cells in regions that play an important role in information and emotion processing (Greeson, 2008; Treadway & Lazar, 2009). Mindfulness is the awareness that is cultivated when one repeatedly attends to the direct experience of the present moment non-reactively and without elaborative and conceptual processing (Kabat-Zinn, 1990). MT changes brain activity in regions associated with awareness, attention, self- and emotion-regulation. With these increased cognitive and emotional resources, one can enhance his or her capacity for skillful responding in a way that is grounded in the present moment's possibilities rather than in the past or a feared future. Mindfulness can be cultivated through a range of formal meditation practices that ultimately support our clients in applying mindfulness in everyday life. In this article, research about how MT results in structural changes in the brain that enhance its functions and facilitate psychotherapy is summarized. With enhanced brain functions, people with emotional disorders have a greater capacity to actually learn what psychologists attempt to teach in psychotherapy and to reduce reactivity and unnecessary suffering. Just two months of MT can actually produce changes in brain activity that enhance attention and support new learning.

Recently, an entire issue of the American Psychological Association's journal *Emotion* was devoted to articles about how MT is changing the brain's structure and activities in ways associated with the prevention and reduction of symptoms of emotional disorders. For example, Jha and her colleagues (2010) described a study in which MT was delivered during a stressful pre-deployment period to Marines. Her results indicated that MT enhanced working memory capacity (WMC), increased positive emotion and decreased negative emotion in those who received MT compared to a control group. When the group who received MT was split into those with high and low levels of mindfulness practice, protective effects of MT on WMC and reduced negative emotion at the end of the pre-deployment period were only seen in those with higher levels of practice. Interestingly, WMC mediated the relationship between practice and reduction in negative emotion but not the increase in positive emotion associated with the MT in the high practice group. This suggests that pre-deployment training should strengthen both body and mind.

Also in *Emotion*, Goldin and his colleagues (2010) reported that after MT, people with social anxiety disorder (SAD), who practiced mindfulness upon exposure to words designed to activate negative self-referential beliefs, showed less reactivity in brain regions associated with fear and rated the words as producing less negative emotion. The amygdala, which is activated when one appraises a stimulus as threatening and which prompts the body to engage in the fight or flight reaction, activated more rapidly in response to threatening words after MT but then returned to baseline levels more rapidly than it had before the MT. This more rapid return to baseline levels of amygdala activity was not seen when the same people with SAD were instructed to avoid awareness of negative beliefs: Distraction resulted in greater ratings of negative emotion in response to the negative self-belief words. Finally, brain regions associated with the intentional deployment of attention also increased activity after MT. In summary, MT enhanced the capacity of people with SAD to experience fear efficiently in response to threatening words but then to flexibly return to baseline more rapidly than when they engaged in avoidance of threatening material. MT effectively reduced the toll on the body that the chronically activated amygdala can take in people who habitually turn away from fear rather than approach and cope with it.

While people with anxiety disorders attempt to avoid feeling fear by repeatedly anticipating threats that may occur in the future, people with depressive disorders deplete precious cognitive resources and maintain their depression while reviewing the regretted past or ruminating about its imagined implications. MT can reduce such rumination (Jain et al., 2007), and reduce relapse to depression in people with a history of three or more episodes (Segal et al., 2001). The same brain regions that are active during rumination are active when one experiences what researchers call the narrative or autobiographical self. The narrative self is activated when one defines the self in terms of past thoughts, actions, and feelings. In contrast to the narrative self is the experiential self, or the sense of self noticeable through interoception. Interoception relies on brain regions such as the insula and somatosensory cortex and is the felt sense of the body internally. Interestingly, MT supports people in activating brain regions associated with the experiential self, rather than the narrative self, during experimentally provoked sadness (Farb et al., 2010). Experientially this can be understood as noticing impermanent physical sensations evoked by sadness rather than getting lost in stories about the past during sadness. MT enhances one's ability to know the ever-changing experiential self in a way that makes change possible and that changes one's relationship with emotion. When one appreciates the impermanence of emotion and its ever-changing nature, one is less likely to fear and avoid it.

Another line of research is building to suggest that MT increases activity in brain regions associated with the experience of positive emotion. Davidson and his colleagues (2003) were the first

Continued on page 11

Training Options for Learning to Offer Mindfulness-Based Interventions

Christine Molnar, Ph.D.

Mindfulness is an element of many therapies and has been shown to reduce the suffering that occurs across a range of disorders (Hofmann et al., 2010). Many psychologists want to integrate mindfulness into their work and are confronted with questions about training options that range from brief workshops and symposia to intensive training programs. At the annual conference of the Center for Mindfulness (CFM) many important questions about competent training for teaching mindfulness arose. One important question was about who is qualified to teach mental health and other professionals how to teach mindfulness meditation as it is taught through the 8-week Mindfulness Based Stress Reduction (MBSR) curriculum and its many derivatives such as Mindfulness Based Cognitive Therapy (MBCT; Segal et al., 2001). Another question arose about what kind of training should be required for people to say they are qualified to teach clients MBSR and its derivatives. How can we remain flexible so that novel applications of mindfulness-based interventions can develop while the CFM's curriculum maintains integrity and meaningful standards? Although the answers are still evolving, there are some clear ways through which psychologists can develop competency in teaching mindfulness-based therapy interventions.

This article reviews a traditional path of training that psychologists can take to teach mindfulness competently, with a focus on the training offered through the CFM. It should be noted that mindfulness is a component of several interventions that do not require a psychologist to have a personal mindfulness practice. An area of great debate is about whether or not people can teach mindfulness practices with integrity if they lack a personal practice. To date, it remains an empirical research question whether or not a personal mindfulness practice is associated with superior therapeutic outcome when mindfulness-based therapies are offered by psychologists. The focus of this article is on training options that do require that the person teaching mindfulness have a personal mindfulness practice before offering mindfulness-based therapy interventions professionally.

Before traditional MBSR training is reviewed, a brief background about MBCT is offered because many psychologists first learn about mindfulness through hearing or reading about MBCT. MBCT is almost identical to MBSR with a few exceptions. In MBCT, didactic material covers the nature of depression and relapse prevention. In MBSR didactics are about stress reactivity, mind-body connections, and the full range of negative emotions (not just depression) along with application of mindfulness in everyday life. Many begin teaching MBCT after completing professional training programs not offered through the CFM. Many psychologists without a personal mindfulness practice read a book about MBCT and teach their clients about mindfulness.

The CFM is the internationally recognized program through which psychologists learn to teach MBSR and its derivatives. The minimum training required before one can teach MBSR is a 7-day residential training retreat that offers 59 continuing education credits about teaching mindfulness using the MBSR curriculum. This retreat is called "MBSR in mind-body medicine." At this training participants are led through the entire curriculum as participants for several days. This is followed by dialogue and education about curriculum elements, its theoretical, philosophical, and scientific basis, teaching strategies, and reading material. Many teach MBSR with this minimal training. Others also complete what the CFM calls the foundational practicum training program.

There are two versions of the practicum. First there is the "Practicum in MBSR: Living inside participant-practitioner perspectives." In this, a professional participates alongside people from the general public in an 8-week MBSR class that includes an all-day silent retreat. After each MBSR class, professionals learning to teach MBSR meet in a seminar where they learn about the curriculum and teaching strategies, discuss scientific readings, and practice giving and receiving feedback to each other about the teaching skills of practicum members. The second way to complete the practicum is to complete the "summer intensive practicum" over a period of 9 days with other professionals. To qualify for either practicum experience, one must have an ongoing personal meditation practice and complete at least one 5-day silent, teacher-led mindfulness retreat. Although the MBSR curriculum is based upon the Theravadan Buddhism tradition, the CFM accepts practicum students with a range of diverse meditation experiences including Hatha and other yoga traditions.

Until the last few years, the practicum officially recognized by the CFM was offered only at either the CFM or through an affiliate of the CFM in California. Recently, training programs with close ties to the CFM have arisen at two medical schools in Philadelphia. At both Thomas Jefferson University and the University of Pennsylvania a practicum for training mental health and other professionals to teach mindfulness is offered. Neither program is officially sanctioned by the CFM, as many other programs arising in Pennsylvania and nationally are not. Many who want to teach mindfulness may wonder if the CFM accepts training programs not officially sanctioned by the CFM as prerequisites for training programs. Although there is not a guarantee that such non-CFM programs will fulfill prerequisites for training, in many cases they do. It is important to note that both programs in Philadelphia are of high quality and are usually accepted as prerequisites to the CFM's training programs.

The most advanced structured training offered by the CFM to teach mindfulness is an 8-day training called the

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For Existential Questions, Stress, and Greed, Choose Mindfulness

Steven Pashko, M.A., Ph.D., FYM@earthlink.net

Dr. Steven Pashko

Here's a good, quick joke. A person walks into the pizza parlor of a Zen master and asks, "Can you make me one with everything?" The serious side of this joke is that it points to a vague feeling in many of us that there is more to life than one currently understands. I, as well as many of my friends, became psychologists because of this sensibility.

A recent definition of mindfulness is "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). The practice can be followed anytime and anywhere, even while just walking along. The instruction for practice is to notice the arising of all bodily sensations, not become involved in them and watch them arise and pass away. Some people accept more directed mindfulness practices like repeated counting from 1 to 10, with the occurrence of each outbreath. Mindfulness is the root practice of all meditations, including chanting and prayer, and it takes some practice to be mindful with any consistency. To this point, purposeful attention (i.e., mindfulness) means not being swept up in the lengthy digressions of our rambling thoughts. Without practice it's virtually impossible, but it's a constant comfort for the many who have practiced enough. Mindfulness, in essence, is a mental practice that enhances our ability to hold attention more strongly than we have interest in our distracting thoughts. I highly recommend it for everyone. Because some incorrectly assume the word "thought" covers one kind of mental phenomenon, I wrote (Pashko, 2005) about how to distinguish among types of thought (e.g., single, brief occurrences; logical thinking; and thought streams). Although it's helpful to know the difference, while actively engaged in mindfulness practice all thought-types are viewed as having the same value.

Intentional disinterest in rambling thought has many benefits. After mindfulness practice has strengthened the attention, attention becomes "owned" in the sense that one is able to purposefully direct it. Within the stress-reduction context, being able to direct attention away from chronic ruminations about the meaning of "cancer" to one's life and family decreases the penchant for negative fantasies. This appears to be one of the ways the "stress" of this life event is moderated (Baer, 2003). Everyone has periods or moments of mental clarity, a mind free of encumbering thought. For example, runners have it while running and movie-goers have it during show time. Mindfulness practice leads to retaining mental clarity at all times.

Mindfulness is the way to return to the unadulterated experience of your life.

The therapeutic effectiveness of mindfulness, however, does not seem derived solely from its attention-strengthening capabilities. Good attention is just a prerequisite to being able to experience life unconstrained by the conceptual boxes inherent in thought. What is the meaning of the thought/concept "cancer?" Its meanings can range from fantasies about an agonizing death that ruins an entire family to ones involving only a brief interlude to one's normal activities. Remaining apart from the concept of cancer, and the rambling thoughts associated with it, is helpful since it allows one to be involved with the reality of the experience without delving into the melodrama.

Some people theoretically object to actively working with thought and attention, believing "free thinking" is creative and helpful. They may have forgotten or may simply have never known about the inherent restrictions, flaws, and downsides of intrusive thought. Life is a unique event about which nothing can actually be said. One can (only) say things about concepts and beliefs, but these are artificial in that they are one step removed from actual experience. Have the thought/concept and, regrettably, you miss or dampen the full experience. Mindfulness is the way to return to the unadulterated experience of your life.

Mindfulness practice is similar to the curve for learning to play tennis. It takes time to develop to a good skill level. With practice, disinterest in thought and conceptualization inevitably leaves the mind clear to examine our life and the world with less bias. This is when the results of mindfulness practice are most helpful to our lives. The bonds of conceptual living are altered such that we loosen identification with strict interpretations of our operational identities (e.g., as "a worker," as "the downtrodden," or as those who "need to be right"). The experience of who we are appropriately regains precedence over the conceptual boxes into which thought has packaged us. Ethical behaviors may have a higher probability of occurring since what our experiential nature knows to do is more authentic than what our role, thought, emotion, or other operational identity may guide us to do. Mindfulness practice is the only remedy I know against greed and the other deadly sins. What's required for all ethical behaviors is the sacrifice of a self-serving interest for a greater

good. My sense is that when one's strongest identification is with a role (e.g., financial profit-maker) behavior congruent with that role will tend to follow. However, when one's strongest identification is less with a role conceptualization and more with direct experience, behavior congruent with a lifetime of experience as a human being will follow.

Lastly, Petkova and Ehrsson (2008) recently published an interesting article showing that simply under conditions of conflicting visual cues, self-identity is not fixed in the body. As Armel and Ramachandran (2003, p. 1506) have written, "The mechanisms of perception are mainly involved in extracting statistical correlations from the world to create a model that is temporarily useful." Understanding the relationship between the body and the identity is the last and most important result of the practice of mindfulness. Clearly understanding that one's self-identity is not one's body is the hallmark of a mature mindfulness practitioner. The ramifications of that are as valuable as the relief of stress produced by mindfulness.

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MINDFULNESS IN CLINICAL PRACTICE

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Special thanks to Richard W. Sears, Psy.D., M.B.A., ABPP, FAACP, for his contributions to this article and interview. Dr. Sears is a core faculty member of the Psy.D Program and Director of the Center for Clinical Mindfulness & Meditation at the Union Institute & University in Cincinnati. He is a licensed psychologist in the state of Ohio, is board certified in clinical psychology, and a Fellow of the American Academy of Clinical Psychology (FAACP).

References

References available on the PPA Web site, www.PaPsy.org, or upon request from the author, tkovacspsyd@gmail.com

MINDFULNESS TRAINING CHANGES THE BRAIN ...

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to show this and recently Barnhofer and his colleagues (2010) reported that after MT people with a history of depression experienced this same shift toward activation that is associated with the experience of positive emotion. Positive emotion is associated with a broader field of attention and is considered a resource with which people can cope with stressors (Frederickson & Branigan, 2005).

In summary, we are in the beginning stages of understanding the mechanisms through which MT and practice change brain structure and function to reduce suffering. Many researchers are reporting evidence that MT does change the brain in ways that have great potential to facilitate the information and emotional processing necessary for learning to adaptively regulate the self. When one cannot land attention in the present, creative possibilities for problem solving and learning are missed. Although people's bodies are constantly changing at the cellular level, their minds often get stuck. There is hope, however, in the malleability of the body, in particular the brain cells, for people who are habitually missing the present moment.

References

References available on the PPA Web site, www.PaPsy.org, or upon request from the author, chris@molnarpsychology.com

TRAINING OPTIONS...MINDFULNESS-BASED INTERVENTIONS

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"Teacher Development Intensive" (TDI). To take it one must have a daily meditation practice, have completed the practicum and/or the mind-body residential training. In the TDI one learns the MBSR curriculum thoroughly. It involves many experiential opportunities through which one practices teaching curriculum elements and receives multiple forms of feedback from several people. After completing the TDI, one can become certified to teach MBSR with additional supervision. In order to teach professionals to teach MBSR, one must be certified by the CFM and engage in consultation with the CFM. Most who teach MBSR and many who teach professionals to teach MBSR are not certified. Only a few dozen people in the world are officially certified.

If you are a psychologist who wants to learn more about mindfulness, one way to begin is to participate in an MBSR class taught by a professional who trained to teach at the CFM. Such professionals can be identified by visiting http://www.umassmed.edu/cfm/mbsr/ where you can search by state and click on an instructor's name to see what training they have received. Information about professional training programs for teaching mindfulness is available at www.umassmed.edu/cfm/oasis. For links to the Philadelphia practicum training programs and to teachers who trained at the CFM click on "Other MBSR programs worldwide."

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Management of Overeating: Doing Our Own Homework Before We "Prescribe" It to Our Clients

Pavel Somov, Ph.D.

Dr. Pavel Somov

The focus on wellness, particularly on the management of overeating, in therapy can be a double-edged sword. While clients often readily embrace the vector of self-care, goal-specific treatment planning and clinical homework can trigger the games of avoidance. Suddenly, the validating therapist is thrown into the role of a wellness expert and becomes an accountability check. Before too long, mere inquiry into the client's progress runs a discordant parallel to punitive supervision. With this actual or perceived change of hats, the process of the therapy changes, the wellness goals are eventually abandoned and the closet of therapy fills up with the skeletons of failed objectives.

Such experiences have taught me that a non-directive, harm-reduction, humanistic angle of engagement works best in facilitating clients' wellness goal of weight management. In particular, I have enjoyed better "compliance luck" from the clinical position in which I frame success in overcoming overeating as more of a know-how issue than a motivational issue. With this in mind, as part of the role-induction to behavioral weight management, I let clients know that I am aware of a variety of behavioral exercises that can help them transition from mindless reactive eating to a more mindful and more conscious eating stance, and I then offer the client to look at their weight management "homework" as a kind of experiential journey of gradual acquisition of mindful eating skills, and not as a frantic blitzkrieg of change.

This gradual, exploratory behavioral goal-frame, in my experience, reduces the often arbitrary urgency of the need to change, e.g., "I need to lose weight to look good at my son's wedding." An open-ended stance on behavioral homework (e.g., "You have the rest of your life to gain control over this issue and I have several exercises for us to try, so let's just take time to see what works best for you") also pre-empts and obviates "compliance relapse." Furthermore, a humanistic-permissive therapeutic posture allows the clinician to accept the client's level of motivation for change such as it is.

The motivational process is not always linear, and sometimes homework can increase motivation. My work in the correctional substance use setting taught me that precedents of behavioral success can lead to a sense of self-efficacy, which leverages the motivation to change. Teach a mandated substance use client how to control his/her cravings and the extrinsic motivation for treatment gets an intrinsic boost. The skill-focused homework – even when embarked on prematurely (from the motivational stand-point) – can leverage self-efficacy, and the realization that one "can" change paves the way for "I want to change." The key here, however, is "to test," "to experiment," "to try and see what happens" – i.e. an exploratory verbal framing of the behavioral homework that makes it "optional" and, therefore, safe to fail.

The trick is to keep clients interested in clinical homework by diversifying it. Typically, folks in therapy give an exercise a week-long try and then forget about it. I used to "follow-up" on homework, explore what worked and what didn't and why the client stopped trying. In my experience, no amount of clinical tact prevented slight relational rifts when clients, projecting their transferential shame onto the provider, felt chastised or criticized. Many a client wanted to cancel a session to avoid the "homework check." I didn't want to do that kind of therapy. It occurred to me that if I only had more of the same kinds of exercises at my disposal, then each exercise could be presented as but one way to shed light on a particular issue. It would be then understood that the exercise would be tried on for a week or two and be replaced by yet another exercise. As such, each exercise would then offer a temporary self-help angle at the issue at hand and its expiration date meant that there was no performance pressure to turn the exercise into a life-long habit.

We as clinicians need to do our own homework before "prescribing" homework for our clients. Clinical homework can be a double-edged sword. While it can teach clients a specific skill, it can also do so at a cost of self-efficacy – that is, if the client is unable to translate a given skill-focused homework assignment into a new habit. With this in mind, I recommend that a clinician wanting to assign a specific skill-focused homework first identify multiple alternative ways of practicing the skill in question. Armed with a "menu of choices," the clinician can then offer

...I let clients know that I am aware of a variety of behavioral exercises that can help them transition from mindless reactive eating to a more mindful and more conscious eating stance....

the client, hopefully, half a dozen different ways to achieve the behavioral goal in question. This way, with each homework assignment being a kind of experiential appetizer that may hold the client's interest for a week at a time, we can help our clients log in a month or two worth of skill-practice on a particular point. With more practice-time under the belt and no immediate performance pressure, the client stands a better chance of internalizing the essence (rather than the form) of the homework that we "prescribe."

In developing one's homework repertoire it helps to divide the behavioral exercises into *awareness-building* and *habit-modifying* exercises, with the former raising the awareness and inadvertently leveraging motivation for change, and the latter turning the awareness into an actionable platform for habit modification. I find that it helps to be explicit

about whether a given homework exercise is awareness-building or habit-modifying. As suggested above, awareness-building homework is psychologically safer to fail. In regard to habit-modifying exercises, it helps to not exactly assign them as homework but to make clients aware of these exercises so that they can "try" them and decide if they want to officially commit to these changes. I also find it helpful to offer clients exercises that allow them to integrate the specific wellness goals into a broader existential framework (for example, in the case of weight management, a life-modifying exercise prompts the client to formulate his or her "philosophy of eating" in light of how much emphasis they place on health, hedonism, social justice).

In sum, approaching behavioral medicine objectives such as weight management from *a gradual, humanistic, creative, harm-reduction* homework stance helps avoid the classic behavioral therapy "do-or-die" head-on collision with homework non-compliance. Approaching weight management not as a phase of therapy or a treatment module but as an ongoing clinical theme allows us to calibrate our clinical attention to this objective as it understandably goes in and out of clients' focus, in proportion to their motivational ebb-and-flow. Given that the interplay of motivation and skill-efficacy appears to be in an intricate feedback-loop, an ample stock of problem-specific behavioral homework allows the clinician to match the client's non-linear motivation for change with ever-fresh homework options and ideas. But towards this end, of course, we have to do our own homework first.

Pavel Somov, Ph.D., private practice, Pittsburgh (www.eatingthemoment.com, www.drsomov.com), author of Eating the Moment *(New Harbinger, 2008),* Present Perfect: Letting Go of Perfectionism and the Need to Control *(New Harbinger, June 2010) and* The Lotus Effect: Shedding Suffering and Rediscovering Your Essential Self *(New Harbinger, November 2010)*

Letter to the Editor

Money, the Zeitgeist, and Musings of an Old Therapist

Dr. Bellwoar's nine points to a successful practice (*The Pennsylvania Psychologist,* September 2009, p. 9) left me with a feeling of discomfort. I have a solo practice and recognize that things may be different for a large operation. Still, since 1966, my practices have not changed.

1. Marketing never stops: Dr. Bellwoar states that we should be able to "describe to strangers what we do and that we do it well in the time it takes to ride an elevator. If not, [we should] practice it until it flows smoothly. Be ready, willing and able to talk about psychology in a non-threatening way at parties, soccer games, at weddings and funerals." What can be explained of psychology at a party or "a funeral" (did I read that right?) is common knowledge. To go beyond that point in such surroundings would be a disservice to psychology and in bad taste.

2. Always get back to referral services: This is a marvelous suggestion.

3. Surround yourself with good people: A very good suggestion, but it should be implemented with fairness. As an employer/psychologist, I use my interpersonal and assessment skills to hire competent people. If my skills fail me and the less-than-competent employee tries his or her best, I will then do my best to help him or her grow, develop and become better at the job.

4. Don't be afraid of money: I love money, and I "value the product that I sell," but not to the point of putting a price on every minute of my time. I dread the thought that a distressed patient may hesitate to call me because he or she cannot afford to pay for the call. I know that, as Dr. Bellwoar states, "lawyers and accountants charge for everything they do," but something in me rebels at being lumped together with "lawyers and accountants." Maybe it is being snobbish. Maybe it is a deep belief that there is more to my cherished profession than making money.

5. Collect aggressively: Dr. Bellwoar writes, "Remember, it is business, not personal." I could not disagree more. For me, it is much more personal than business. When I run into a former patient who comes over to me and says, "Thank you for saving my marriage" or "Thank you for saving my life," the feeling that I experience is hard to describe. What I do know is that my insurance agent and car salesman have never experienced such feelings toward me nor I toward them.

6. Invest in IT

7. Work with insurance companies

8. Do what you do best

On the above points, I fully agree with Dr. Bellwoar.

9. Establish disciplined and well developed practices: Dr. Bellwoar states, "Establish consistent policies for no-shows, overdue balances, fees for records, emergency procedures, employee benefits, disciplinary action, etc." I believe that "no-shows or unpaid balances" cannot be dealt with by "policies in place," but should be discussed with each patient separately as such issues are integral parts of treatment. I realize that I sound, at times, snobbish and elitist. Yet, I would not change a single word of what I wrote. Partly because I believe that my practices serve best my patients' interests, but also because I believe that, in addition to ethics, our profession should adhere to a certain dignity and grace. Maybe I am wrong, maybe times change and the Zeitgeist has left me behind. If such is the case, I would feel very sad but still hold to my convictions.

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An Orientation Into the New Age of Awareness: Mindfulness

Lavanya Devdas, MSW

Lavanya Devdas

A special section dedicated to mindfulness exemplifies the growing interest in this approach. The integration of mindfulness into mainstream clinical practice and research in psychology has increased manifold and yet, its multi-dimensional nature eludes a consensual, precise definition. The roots of mindfulness meditation is linked to a fifth-century B.C. Indian prince, Siddhartha Gautama, later known as the renowned Buddha. Bhikku Bodhi, the Theravadan (a school of thought in Buddhism) scholar and monk, incorporated multiple dimensions to sum up mindfulness as paying attention to occurrences in one's immediate experience with care and discernment (as cited in Shapiro & Carlson, 2009). A similar definition holds mindfulness as the awareness that arises because of intentionally attending in an open and discerning manner to whatever arises in the present moment (Shapiro, 2009). Mindfulness is about feeling the flow of your experiences and being aware of the accompanying bodily sensations in the present moment. Other definitions focus on a different aspect of mindfulness. For example, mindfulness is viewed as a trait (Way, Creswell, Eisenberger, & Lieberman, 2010) where individuals differ in their dispositional quality of mindfulness. Individual differences are attributable to a complex interaction of genetic predisposition, circumstances, and training one receives in mindfulness (Davidson, 2010).

Jon Kabat-Zinn and his colleagues (1979) went on to adapt the practice of mindfulness meditation to extend its applicability to modern medical settings, culminating in their program of mindfulness-based stress reduction (www.mindfullivingprograms.com/whatMBSR.php, n.d.). Mindfulness training aims to create an alternate mode of being through meditation that pays open attention to objects in the internal and external world as they unfold, moment by moment (Williams, 2010). Mindfulness intends to regulate affect without altering the momentary subjective experience of emotion. Mindfulness training may reduce chronic reactivity by re-directing attention away from subjective evaluations of affect, toward more sensory-based representations of emotions (Farb et al., 2010). The art and practice of mindfulness is no easy task. A misconception of mindfulness is that it has the ability to stop our thought processes and unpleasant affective states. In fact, the aforementioned constitutes a common complaint of beginners in the mindfulness practice. Mindfulness does not take away any thoughts and does not involve avoiding or negating emotions, pleasant or unpleasant. Mindfulness brings acceptance and compassion to emotions as they arise while noticing and observing emotions as they are (Erisman & Roemer, 2010). The key in mindfulness is to be aware of the thoughts and emotions, including body sensations that accompany them, experience them and then gently re-direct one's attention to the focus of mindfulness meditation. Through repeated practice, one can gain more control over the mind and increase one's concentration (http://www.contemplativemind.org/practices/subnav/meditation.htm, n.d.).

Mindfulness-based training and therapy have been increasingly used to deal with issues such as stress reduction, affect regulation, attention, anxiety, and dealing with crisis. For instance, mindfulness based cognitive therapy (Segal, Williams & Teasdale, 2002) aims at helping individuals who experience repeated bouts of depression and chronic unhappiness (www.mbct.com, 2007). The practice of mindfulness meditation coupled with cognitive therapy enables individuals to pay close attention to one's thoughts, feelings, and body sensations with a quality of acceptance, sans judgment (www.mbct.com, 2007; Hepburn et al., 2009). The mindfulness-based stress reduction program uses mindfulness practices coupled with yoga and martial arts. The benefits of yoga and mindfulness are experienced simultaneously while martial arts is used to deal with disuse atrophy that stems from a largely sedentary lifestyle, particularly for those with pain and chronic illnesses (http://www.mindfullivingprograms.com/whatMBSR.php, n.d.).

Attention training in mindfulness programs eventually enables individuals to hold their experiences (both sensory and conceptual) at a wider level of awareness that is neither sensory nor conceptual (Williams, 2010). Mindfulness skills may enhance psychological processes related to affect regulation, such as clarity of emotional experiences by navigating and managing complicated emotions (Erisman & Roemer, 2010). Mindfulness eating, another form of mindfulness practice, has its source in Buddhist teachings; however, similar traditions are practiced across the globe. Mindfulness eating provides individuals with the unique experience of eating and the food. The process involves pausing before the intake of food and experiencing the food with one's senses, including the aroma, the color, the texture, the smell, and the taste of food. When all the senses are in the active mode of experiencing the food in its wholeness, the process of tasting, chewing, swallowing, and digesting slow down, allowing one to experience the process of eating at a different dimension, with increased awareness (http://www.contemplativemind.org/practices/subnav/eating.htm, n.d.).

Several mindfulness studies have reported a significant relationship between self-reported trait mindfulness and various aspects of well-being (Baer, Smith, Hopkins, Krietmeyer, & Toney, 2006; Brown & Ryan, 2003; McCracken & Yang, 2008). Studies examining state

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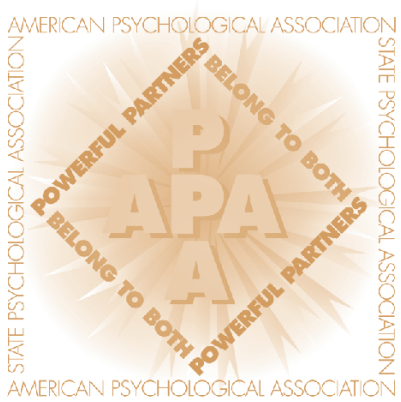
Welcome New Members

We offer a hearty welcome to the following new members who joined the association between February 1 and April 30, 2010.



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Prescribing Practices Within the BHRS System:
An Examination of Independent vs. In-House Prescriber Models

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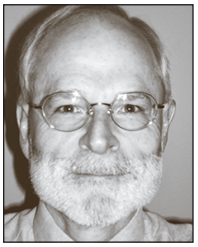
Dr. Robert A. Reed

Can psychologists diagnose with impartiality if they also provide services for those they are evaluating for services? Some say they cannot. There are those who claim that both diagnosing and treating the same client presents an inherent conflict for the psychologist in the Behavioral Health Rehabilitation Services (BHRS) system. Complaints have been raised that psychologists who evaluate and then treat their clients are more likely to inflate the recommended levels of services because it becomes financially desirable to do so.

Because of this perceived conflict, some counties within the state have chosen to mandate an independent prescriber model, where the psychologist or psychiatrist who diagnoses and prescribes the treatment, is "independent" from those who provide the services. This study compared Independent BHRS evaluation with in-house evaluation to assess the perceived conflict.

Methods

A sample of convenience was used (N=235) looking at the BHRS treatment prescriptions in 2008 at one provider agency. Data were collected from the reports of six psychologists who completed evaluations using both the independent prescriber (IP) and the in-house (IH) prescriber models. Data were collected from the following domains: prescribed number of hours of therapeutic staff support (TSS) services per week, prescribed number of behavior specialist consultation (BSC) hours per week, prescribed number of mobile therapy (MT) hours per week, the reported GAF score, input from the BSC measured by word count, and prescriber treatment recommendations measured by word count.

Results

This study examined the treatment prescriptions for clientele receiving independent prescriber (IP) and in-house prescriber (IH) evaluations. Specifically, three treatment prescriptions were measured across those two groups: TSS service prescriptions, BSC service prescriptions, and MT service prescriptions. Table 1 highlights the findings for TSS, BSC and MT services provided for IP and IH services.

Table 1. *TSS, BSC and MT prescriptions for both IP and IH services*

		Mean	Std. Dev.	N
TSS Hours Per Week	Independent	7.40	9.52	142
	In-House	6.57	7.39	93
BSC Hours Per Week	Independent	2.08	2.40	142
	In-House	2.50	1.82	93
MT Hours Per Week	Independent	0.41	1.05	142
	In-House	0.65	1.36	93

A one-way MANOVA applied to this data yielded no significant differences between independent and in-house methods for prescribing TSS, BSC and MT services. This suggests that psychologists did not vary their prescriptions significantly based on their work within the independent or in-house formats.

We also compared the GAF scores, the length of the BSC's report to the psychologist, and the length of the psychologists' recommendations for the IP and IH models. Table 2 highlights those findings:

Table 2. *GAF, along with length of BSC and psychologist reports*

		Mean	Std. Dev.	N
GAF Scores	Independent	51.59	7.61	142
	In-House	55.32	6.43	93
BSC Report Word Count	Independent	51.06	81.87	142
	In-House	348.87	346.11	93
Word Count of Psych. Recommendations	Independent	445.88	361.99	142
	In-House	502.86	290.12	93

A one-way MANOVA applied to the data listed in Table 2 yielded no significant difference between independent and in-house models for the psychologist recommendations. A significant difference was noted for GAF scores with the IP GAF ratings being significantly lower than the IH GAF ratings.

A significant difference was observed for the length of the BSC reports. BSC reports to the psychologist using the IH model were significantly longer than BSC reports within the IP model. This would suggest that BSCs provide more detailed information to the IH psychologist than the IP. Additionally, the IP psychologist attended eight percent of the ISPT meetings where treatment planning occurs, while the IH psychologist attended 63 percent of the ISPT meetings.

Discussion

No statistically significant differences were found in service prescriptions provided by the independent prescribers as compared to the in-house prescribers. These results suggest that in-house and independent prescriber models did not influence the levels of services that were recommended.

While there were no differences in the *quantity* of service prescriptions, this study revealed that there may be differences in the *quality* of service collaboration. BSCs provided significantly more information to the in-house psychologists. Additionally, the psychologists working within the IH model were much more likely to attend ISPT meetings where the multidisciplinary team consults with the client, the client's family and each other regarding the client's treatment. Thus, the IH model produces a more collaborative team approach in service prescription and treatment planning.

In the IP model, the prescriber may serve more of a gatekeeper role than a collaborative professional. A question arises: Are the client and the family better served by someone who is less involved in treatment planning and has less information about the client? BHRS services are guided by the **Child and Adolescent Service System Program** (CASSP) principles. One of the core CASSP principles refers to services being offered in a multisystem approach. "Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress" (http://www.parecovery.org/principles_cassp.shtml). The current data suggests that the IP model may restrict the psychologists' role as a collaborative member of the ISPT team.

There were obvious limitations to this study. First, this current study was limited to data from one provider agency. One must be very cautious in generalizing this information to the BHRS service system. In addition, there is no way of knowing if the psychologists or the BSCs were representative of the broader service delivery system. The sample was also limited to an agency that provides services primarily to children with ASD.

These findings raise concerns for those who aspire to live up to the CASSP Core Principles, but a more extensive examination of BHRS using multiple agencies across a variety of clientele is needed to verify these current findings.

A more detailed account of this study can be found on the PPA Web site, www.PaPsy.org.

Reference

Guiding Principles: CASSP (n.d.). Retrieved March 28, 2010, from www.parecovery.org/documents/CASSP_Introduction.pdf

Student Section

AN ORIENTATION INTO...

Continued from page 14

mindfulness after mindfulness training reported lower levels of self-reported negative affect such as sadness when exposed to emotional stimuli, indicating a relationship between mindfulness and emotion regulation (Farb, et al., 2010; Erisman & Roemer, 2010). It is imperative to bear in mind the differences in conceptual definitions of mindfulness, sample size, type of sample and duration of mindfulness training in the course of mindfulness studies. Additionally, there is dissonance among therapists as to the type of clientele that can reap its benefits. Some propose applicability for individuals with moderate emotional problems while others such as Dr. Linehan vouch for mindfulness effectiveness with clients experiencing severe emotional distress (Carey, 2008). Most of the measures assessing the impact of mindfulness are self-report measures, which brings into play the extent of accuracy of the aforementioned. Since mindfulness meditation varies in its impact on different mental struggles, further research delving into when mindfulness can be most efficacious is called for, to fortify its place in psychology.

References

References available on the PPA Web site, www.PaPsy.org, or upon request from the author, devdas001@gannon.edu

Memorial Hospital of York Wins PPA's Psychologically Healthy Workplace Award

Memorial Hospital of York (MHY), a winner of PPA's Psychologically Healthy Workplace Award, was recognized at the APA State Leadership Conference in Washington, DC, as a "Best Practices Honoree." Pictured above, left to right, are Barbara Seward of MHY, Marti Evans, Dr. Mark Hogue, Dr. Sam Knapp, Susan Luchka of MHY, Tom DeWall, Dr. Steve Cohen, and Linda Knittle of MHY.

Photo: Tracey Brown

Thanks to Our Members Who Help to Make *Psychology* a Household Word

Marti Evans
APA Public Education Campaign Coordinator for Pennsylvania

The vision of APA's current Public Education Campaign focus, *For a Healthy Mind and Body...Talk to a Psychologist,* is to help the public recognize the health benefits of caring for both mind and body and take proactive steps to promote whole-body health.

More and more PPA members have become active in our Public Education Campaign and have let us know about their outreach activities to the public (November 1, 2009, to April 30, 2010). We thank them for helping to "make psychology a household word" in Pennsylvania.

The members of the E-Newsletter Committee continue to publish PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." PPA is the only state psychological association with an e-newsletter for the public. **Dorothy Ashman** and **Drs. Jack Williams, Dana Fry** and **Joseph Wieliczko** contributed to the December 2009 issue, and **Christine Duprey** and **Drs. Lillian Meyers, Marolyn Morford** and **Terri Erbacher** contributed to the March 2010 issue. The e-newsletter editor is **Dorothy Ashman**.

On January 27 **Dr. Hue-Sun Ahn** spoke to 14 educators on "The Perfect Body: Myths and Realities" and to 20 members of the College of New Jersey coaching staff on "Mental Health among College Athletes."

Dr. Judith Blau discussed "Is This Relationship Good for Me?" on April 15 to 55 people at the Delaware Valley College in Doylestown.

Dr. Lori Cangilla and **Daniel Gittins** presented "Passive, Aggressive, or Assertive?" at the Sewickley Public Library on March 2.

Dr. Helen Coons participated in the American Psychological Association's 2009 Stress in America Survey results to 18 media writers in New York in November. She was also interviewed on November 6 by *Newsweek.com* for "Woman vs. Cookie" and on November 4 by *WallStreetJournal.com* for "Are We Too Stressed Out to Reduce Our Stress?"

Dr. Tom Fink was a panelist in an hour-long radio program on chronic pain on December 16 on *WITF Smart Talk* in Harrisburg.

Dr. Paul Friday has been interviewed many times by the news media in Pittsburgh (KDKA radio, WTAE-TV, KDKA-TV, and the *Pittsburgh Tribune Review*) on topics such as snow stress, infidelity, sexual addictions, sports icons, and New Year's resolutions.

In November **Dr. Christine Ganis** presented "Is It a Diet or an Eating Disorder" to 30 faculty at Harrisburg Area Community College and "Biopsychosocial Risk Factors for Eating Disorders, Treatment and Recovery" to 15 student nurses at Penn State Hershey Medical Center. For the past 25 years, she has run a support group for eating disorders at the Polyclinic Campus of WomanCare Resource Center in Harrisburg.

Dr. Dennis Given discussed "Couples Coping with Cancer" during a 4-week program in October and November at the Chester County Hospital.

Robert Griffin was featured in an article in Wilkes-Barre's *PAHomePage.com* on April 22 on child porn addictions.

Scranton psychologist, **Dr. Lauren Hazzouri**, was the keynote speaker on March 2 for the Scranton Chamber of Commerce's Women in the Workforce Conference. Her topic was "Self Esteem in the Workplace."

Dr. Mark Hogue was a panelist in an hour-long radio program on concussions on February 1 on *WITF Smart Talk* in Harrisburg.

We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and services psychologists offer.

Dr. Sharon H. Katz was interviewed by WNWR-AM Philadelphia's "Let's Talk Health" program on November 24 about stress management, and by WHAT-AM 1340 Philadelphia for programs on New Year's resolutions, caring for aging parents, and parenting gay children.

Dr. Peter Langman, KidsPeace Director of Psychology, has been interviewed more than 100 times by newspapers and radio and television stations on numerous child and adolescent issues, including violence in children.

"Managing Serious and Chronic Illness" was presented by **Dr. John Lobb** on November 24 to the Multiple Myeloma Support Group in DuBois.

Dr. Don McAleer spoke about "Behaviors Exhibited in Alzheimer's and Other Dementias" to 15 family members of the residents in the Alzheimer's Unit of Saint Mary's Home of Erie on April 20.

Alexandra Milspaw presented "Holistic Approaches to Empowering Survivors of Sexual Assault" to 75 people on November 14 at the National Conference on Sexual Assault in Schools in Orlando, Florida.

"Thinking vs. Emotions in Family Conversations" was presented by **Dr. William Montgomery** to 80 people at the Lutheran Church in Doylestown on December 6.

Dr. Marolyn Morford wrote an article for the March issue of *Smart Start – Centre County Monthly News* on "How to Help a Child with Obsessive Compulsive Disorder."

Dr. Michele Novotni, the recipient of PPA's Psychology in the Media Award for 2009, has had several articles printed in *ADDitude* magazine, including "5 Ways to Fight Fair with Your Spouse." She also presented "Making and Keeping Friends Who Are Good for You" to 40 people at the Chester County CHADD on April 13.

Dr. David Palmiter, chair of PPA's Communications Board, has been interviewed by *Market Watch* on April 10 on "Recession Lessons That Will Last Kids a Lifetime" and by *Parenting.com* on December 3 on "How to Keep Your New Year's Resolutions." He and his students, **Megan Flack, Kim Regan** and **Matt Eisenhard**, presented a workshop at the Greater Scranton YMCA on "Childhood Obesity: Prevention, Implications and Treatment" on March 31. Dr. Palmiter also presented "Preventing and Coping with Burnout" to 18 legislative staff members at the State Capitol Building on January 22.

Dr. Steven Pashko presented a four-part series on "What Happens During Meditation" in March at the Philadelphia Meditation Center in Havertown.

On March 4, **Stacey Rivenburg** presented "Beating the Blues after a Stroke" to 35 people at the Stroke Survivor's Club on Lancaster.

Dr. Elaine Rodino and life coach **Dr. John Bellanti** presented "Workplace Stress: Coping Strategies for Handling Stress More Effectively and Efficiently" to 12 people at the Central Pennsylvania Regional Business & Industry Expo on November 17 in State College.

Dr. David Rogers of Hershey Psychological Services has presented numerous workshops, including "Compassion Fatigue" on November 19 to the Pennsylvania State Police, FBI and other law enforcement agencies. On January 15, he presented a workshop for legislative staff at the State Capitol Building entitled, "Dealing with Difficult People." He was also interviewed for an article, "Am I Doing Enough?" about family caregivers by the *Central Pennsylvania Magazine* in February.

Dr. Susan Ryan wrote an article for the *Bucks County Courier Times* on March 18 on the stigma of mental illness.

Dr. Jacqueline Sallade of Lewisburg was featured by Harrisburg's *Patriot-News* in a 4-part series about childhood obesity on April 18 and April 25.

Dr. George Schmidt was a panelist in an hour-long radio program on ADD/ADHD on January 25 on *WITF Smart Talk* in Harrisburg.

Adam Sedlock appeared on the Arts and Entertainment Channel's *Paranormal State Program* on December 15.

Dr. Pauline Wallin writes a column, "On Your Mind...with Pauline Wallin" for the *Body & Mind* magazine published by the *Patriot-News* in Harrisburg six times each year. Recent topics have included, "Pets Can Be Therapeutic," "Yelling Too Much? Reconsider Angry Feelings," and "Squeezing Seconds." A recipient of PPA's Psychology in the Media Award in 2002 and 2005, Dr. Wallin continues to actively reach out to the media nationally and internationally to help make psychology ***and*** psychologists a household word. In March she did a 6-minute podcast on anger management with the *Wall Street Journal*, and she was quoted in an *Associated Press* article about Tiger Woods, which was featured in *The New York Times* and several other newspapers on February 19.

Dr. Norman Weisberg wrote an article for the *Bucks County Courier Times* on December 1 on "Myths and Misinformation about Suicide and How to Help."

Submissions

If you have done a presentation about psychology and mind-body health to a community or business group, please let us know about it so your activities can be recognized in our next "Thanks to Our Members" article for the December issue of *The Pennsylvania Psychologist*. Kindly send the following information about your presentation(s) to Marti Evans at mevans@PaPsy.org:

- Your name
- Title of your presentation
- Name of the group
- Date of presentation
- Location of presentation (city/state)
- Number of people present

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details!

And, we hope to see ***your*** name in our next article.

Practicing Mindfulness with Children and Adolescents

Patricia C. Broderick, Ph.D.
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Dr. Patricia C. Broderick

A rapidly growing research literature supports the usefulness of mindfulness practice as a way of training the mind, reducing distress, promoting emotion regulation, and fostering well-being. The benefits observed in studies with adults have sparked an interest in bringing mindfulness to children and adolescents, primarily with a focus on promoting the development of emotion regulation and executive functioning. For children and youth, these skills have been identified as critical components of academic achievement, emotional well-being, and social competence. Developing the executive functions that support behavioral and emotional regulation is an important developmental goal. Although the precise nature of interrelationships is not yet fully understood, current research suggests a dynamic interaction between emotion regulation and processes of attention, working memory, response inhibition, planning, and decision-making.

Emotion regulation may be fostered by becoming aware of emotions and by learning how to manage them without pushing them away or getting tangled up in them. Therefore, to train in the skills of emotion awareness, identification, and management, it is useful to practice noticing them "on the spot." Mindfulness is the practice of purposeful attention without judgment. It's simply the practice of being aware of present-moment experience without trying to push it away or over-engage and then letting it go. Mindfulness helps train the mind to pay attention and notice, so that action can be taken with greater reflection.

Often emotions can feel out of control when children and adolescents experience acute or long-term stress. One way to cope is to avoid or suppress difficult emotions, such as anger or fear. Behaviors that reinforce emotional avoidance, like substance abuse or aggression, can become preferred coping tendencies because they temporarily reduce the intensity of difficult feelings. An opposing tendency is to become preoccupied with emotions, for example, by constantly worrying or ruminating about problems. This coping style can lead to heightened anxiety and depression. Over-reliance on either extreme, or cycling between both, can prevent young people from developing the balance and flexibility that are the hallmark of healthy emotion regulation. Mindfulness practice offers the opportunity to develop hardiness in the face of life's uncomfortable feelings.

We are just beginning to see mindfulness-based programs for children and adolescents that are suited to their developmental needs. Several studies in clinical and school-based settings have shown promising results. Improvements in executive functions in second- and third-grade students were observed following a school-based trial of the MAPs (Mindful Awareness Practices) program, particularly for students who were less well regulated at outset (Flook et al., 2010). Mindfulness-based treatments reduced symptoms of anxiety and depression in clinical samples (Biegel et al., 2009; Semple et al., 2010). Mindfulness-based treatment also improved attention for adults and adolescents with ADHD (Zylowska et al., 2007).

Another program developed for middle and secondary students, Learning to BREATHE® is a mindfulness-based universal prevention curriculum designed to strengthen emotion regulation and attention skills, enhance capacity to manage stress, and promote resilience. Adolescence is an active period for laying down neural pathways related to emotion management that can shape the course of adulthood. Interventions during adolescence may capitalize on the neurological changes that occur during this period in brain areas implicated in metacognitive and social/emotional skill development (Blakemore & Choudhury, 2006).

Learning to BREATHE tailors mindfulness approaches to the developmental needs of adolescents to help them understand their thoughts and feelings and manage distressing emotions. The program provides opportunities to practice these skills with peers in a group or classroom setting. Six themes are built around the BREATHE acronym, and each theme has a core message. Two versions of the program allow for themes to be delivered in 6 longer or 18 shorter sessions, depending upon time and needs of participants. Lessons include a short introduction to the topic, student activities, and an opportunity for in-class mindfulness awareness practice. Workbooks and CDs for home mindfulness practice are given to participants as part of this program. The program is also designed to link to performance standards so that it can be used as part of standards-based health, school counseling, or other relevant curricula.

This program has been piloted in a secondary school setting and used in programs with clinically referred students. Results from the pilot study (Broderick & Metz, 2009) demonstrated reductions in negative affect and increases in feelings of calmness and self-acceptance. Other benefits for participants were seen in improved emotion regulation and decreased tiredness and aches and pains. Roughly two-thirds of the participants reported practicing mindfulness techniques outside of class during the length of the program. Approximately half of all participants reported that the most important skill they learned from the program was how to better deal with stressful thoughts and feelings. Qualitative results from another study of 14- to 17-year-old students in an after-school program in New York City indicated positive effects for participants in anger management and ability to concentrate.

Many highly beneficial interventions now exist that teach the "whats" and the "whys" of social and emotional learning. Programs that include a mindfulness component can help teach the "how" in real time. While clearly each is important, there is a difference between knowing about emotions and knowing one's own emotions as they are experienced. Learning to attend to one's present moment experience offers children and adolescents a tool to manage emotions as they are perceived and potentially increase in magnitude. Thus, addressing emotion regulation through the teaching of mindfulness may offer a distinct advantage. We not only teach about emotions. In the context of mindfulness training, attention itself is viewed as a skill that can be trained. It is a capacity that can be refined with practice so that it can be directed and maintained, intentionally and with greater stability, on objects of our choosing. Attending to, identifying, and letting go of emotions can mitigate habitual and harmful emotional responses and increase emotional balance and clarity.

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Meditate, Don't Medicate: A Solution for Some

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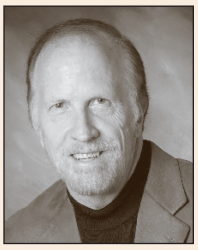

Dr. Timothy L. King

I was first introduced to the practice of mindfulness meditation approximately 3 years ago at a psychotherapy conference presentation by Daniel Siegel, MD. Dr. Siegel is a child, adolescent, and adult psychiatrist who is also a practicing psychotherapist and co-director of the Mindfulness Awareness Research Center at UCLA. During his presentation, Dr. Siegel introduced participants to one of the simplest forms of mindfulness meditation – closing your eyes, placing your hands on your knees, feet flat on the floor and focusing on your breathing for 10 to 15 minutes, while letting your thoughts just pass without focusing through your conscious mind. As simplistic as the practice sounds, it has actually been a very powerful and important tool for many of my clients who struggle with issues of anxiety, depression and ADHD.

While there are some who have responded with the observation, "I can't do it," and others who experience limited benefit, the intervention has been a useful tool for many to gain temporary experiences of thought control which, with daily practice, can reduce or even eliminate the need for medication. Its strength and principal benefit seems to derive from providing children, adolescents, and adults with an experience that helps them combat feelings of powerlessness in the face of obsessive thoughts that interrupt their concentration, intensify feelings of anxiety and depression, interrupt their feelings of interpersonal connectedness/being in the moment, and impair their ability to relax, "turn off their minds," and get to sleep at night. Educating clients to the notion that guiding one's mind to focus on a neutral stimulus (i.e., breathing slowly) can break up destructive thought patterns, has been well worth the effort in my psychotherapy practice. You may want to try it in yours!

Act 48 Reminder

June 30, 2010, is the last day for most school psychologists to fulfill their requirement.

PPA offers a free member benefit to school psychologists to submit Act 48 credits for them! Check your records by going to https://www.perms.ed.state.pa.us/Screens/wfPublicAccess.aspx and entering your Professional Personnel ID number in the box to see how many you need!

Questions? Contact Katie Boyer at 717-232-3817 or you can e-mail her at secretary@papsy.org

Update on the Model Act for State Licensure of Psychologists (MLA): More to Come

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Dr. Tammy Hughes

The American Psychological Association's (APA) Model Act for State Licensure of Psychologists (MLA) passed the Council of Representatives (CoR) in February 2010. School psychologists everywhere collectively breathed a sign of relief when they were notified that the changes in the MLA document would not substantially change individuals' ability to call themselves school psychologists. Yet what is less well understood is that the changes to the MLA regarding school psychology were substantial.

Previously APA's MLA explicitly provided an exemption for non-doctoral school practitioners to use the title "school psychologist." Today, this endorsement is no longer present in the act. Rather, the Division of School Psychology (16) was able to negotiate a compromise that ultimately could result in the same outcome (e.g., retaining title) but with the change that psychology *and* education would no longer share in the titling and credentialing of school psychologists. Rather, we would agree that there is a bright line between the entity that titles, credentials and regulates school-based practice (e.g., State Board of Education [SBE]) and the one that titles, credentials and regulates independent practice (e.g., State Boards of Psychology). Furthermore, since the MLA is designed for adoption by state psychology licensing boards and it pertains to independent practice, it does not need to endorse an exemption for a jurisdiction that they do not oversee (e.g., school-based practice). Indeed, this compromise was determined to be reasonable by the APA policymaking body Council of Representatives and was passed on February 20, 2010. The changes to Section J 3 of the MLA now read:

> *Nothing in this Act shall be construed to prevent (cite relevant state education authority or statutory provisions) from credentialing individuals to provide school psychological services in those settings that are under the purview of the state education agency. Such individuals shall be restricted in their practice and the use of the title so conferred, which must include the word "school," to employment within those settings.*
>
> *This provision is not intended to restrict the activities of licensed psychologists.*

And so we celebrated as we took our first step in separating and protecting school-based and independent practice. The second act of separation and protection of our newly minted agreement was in the amendments to National Association of School Psychologists (NASP) Standards; a document that serves as their model act to SBEs. Division 16 had already been working with NASP on their Standards to ensure that their model limits their recommendations to the school setting – an outcome that was passed two weeks after the CoR meeting on March 5, 2010.

Taken together, what we have today is a historic agreement that is far different from what was codified at the Thayer conference in 1954 and has been present in every MLA up to now. As such, there is more work to be done. This year the Association of State and Provincial Psychology Boards (ASPPB) is due to vote on their model act. Division 16 and NASP have worked to ensure that a similar exemption is in place for separating out school-based practice – you may want to track their recommendations at www.asppb.net/ASPPBModelAct regarding section XI. D. School Psychologists.

As the only state that allows for independent practice with the SBE credential, Pennsylvania has more to consider. Our documents are not in line with the bright-line separation of school and independent practice that, at present, are the foundation for the APA MLA, NASP Standards and soon-to-be ASPPB documents. In the interest of dealing with such a complex issue, a two-part article reviewing the history of the MLA and issues related to Pennsylvania will be forthcoming in the next edition of *The Pennsylvania Psychologist Quarterly*. I encourage each of you to ask questions, get involved at your local level and tend to the national conversation around school psychology practice; it is important for you to be a participant in shaping our future.

Dr. Tammy Hughes is the immediate Past-President of the Division of School Psychology (16) of the American Psychological Association, Past-President of Trainers of School Psychologists (TSP), and was active as a liaison to the MLA Task Force. She serves on the APA Presidential Task Force on the Future of Psychology Practice. *Dr. Hughes is the Chair of the Department of Counseling, Psychology and Special Education at Duquesne University in Pittsburgh, PA. She is a licensed psychologist and a certified school psychologist.*

Traumatic Brain Injury Among School Athletes

PPA Supports Legislation to Protect Pennsylvania Schoolchildren

PPA has endorsed state House Bill 2060 and Senate Bill 1241, which are designed to protect school athletes from undertreated or unrecognized traumatic brain injury (TBI). These bills would require the Pennsylvania Interscholastic Athletic Association and the Pennsylvania Department of Health to develop guidelines and educate athletes, their parents, and coaches about concussions including the risks associated with continuing to play after a head injury. Students suspected of sustaining a head injury would not be able to return to play until a licensed health professional trained in the evaluation and management of head injuries and concussions evaluates them.

A TBI is caused when a blow or assault to the head disrupts normal brain functioning. Not all blows to the head cause TBIs. Some severe TBIs cause loss of consciousness or amnesia for events prior to the assault. Milder TBIs result in temporary dizziness, nausea, disorientation, or other symptoms, although the symptoms might not appear for days or weeks after the injury. Athletes who have had one concussion are at an increased risk to have subsequent concussions. Repeated mild TBIs within a short period of time can cause permanent neurological or cognitive deficits and increase lifetime risks of epilepsy, Alzheimer's or Parkinson's disease, or other brain disorders. Children need more time than adults to recover from a mild TBI. The harm created by a mild TBI can be very greatly reduced if the athlete receives proper medical attention and has time to recover fully from the injury.

Most injuries in high school athletics involve minor sprains that result in the loss of less than one week of practice. Although the rate of sports injuries has decreased in the last decade, concussions account for about 9% of all high school injuries, involving about 1 in 50 high school athletes every year. Concussions were especially common in boys' soccer and girls' basketball, although they could happen in any sport (Reichel, Yard, & Comstock, 2008). School athletes with TBIs should not return to competitive sports until a health care professional has cleared them, and they are symptom-free both at rest and after physical exertion with gradually increased intensity and under controlled training conditions (Collins et al., 2003). Sport psychologist Dr. Mark Hogue notes that "Guidelines developed at the world Vienna Conference on Concussions in 2001 stated that neuropsychological assessment is considered as concussion management." He also stated, "neuropsychological testing is especially important with those athletes who may minimize the extent of their injuries."

Many coaches, parents, and athletes have inherited a tradition of "toughing it out," "playing through injuries," or otherwise minimizing the impact of sports injury. Often they assume that "getting dinged" or "having your bell rung" is an inevitable and harmless part of playing sports. However, in recent years, sports professionals are gradually recognizing the need to protect students from the impact of mild TBIs. In 2007, the Centers for Disease Control (CDC) introduced the "Heads Up: Concussion in Youth Sports" initiative, which included a toolkit and promotional materials, and has worked with the National Football League, *Sports Illustrated* magazine, *USA Football* magazine, the YMCA, and other groups to promote awareness of concussions in youth sports. HB 2060 and SB 1241 should further this awareness and provide greater protection for school athletes.

References

Collins, M., Iveson, G., Lowell, M., McKeag, D., Norwig, J., & Maroon, J. (2003). On-field predictors of neuropsychological and symptom deficit following sports-related concussion. *Clinical Journal of Sports Medicine, 13,* 222-229.

Reichel, J., Yard, E., & Comstock, R. D. (2008). An epidemiological comparison of high school sports injuries sustained in practice and competition. *Journal of Athletic Training, 4,* 197-204.

Start Accepting Credit Cards in Your Clinical Practice

Ed Zuckerman, Ph.D.

Dr. Ed Zuckerman

Congratulations, you are in independent practice! More congratulations that you require immediate payment for your services. Accepting credit card payments could make your clients happier and may lower your overhead costs. However, this raises legal and financial issues and ethical and clinical concerns which must be understood and addressed.

HIPAA and privacy and security issues

Protected Health Information (PHI)

The information needed to charge someone's credit card for typical services is not PHI and so credit card issuers (MasterCard, VISA, American Express, Discover, etc.) do not have to comply with HIPAA's privacy and security regulations. Clinicians can legally disclose the names of clients, charges, who provided the services, dates of service, and that what was offered was "for professional services" even if the clinician's business name includes "counseling" or "psychotherapy."

Security

When a card is swiped or its numbers typed into a "terminal," the machine encrypts this information before sending it out by phone line or Internet connection. The card's information is not saved on the machine nor sent back to the clinician's office when the sale is authorized by the credit card company and the client's bank. The clinician receives only a newly created and unique "authorization number" as a record of the sale. As you can see, there is little risk of a security breach.

Therapeutic concerns

Paying for therapy has been a traditional source of issues for therapists and accepting credit cards modifies this process in ways which bear examination. Credit cards do not create a dual relationship because the clinician is not a creditor when payment is immediate and in full. Payment is inherent in the therapy relationship and should have been clarified during intake and orientation.

Using a credit card to pay for services at the close of the session may seem more impersonal and mechanical than even using a check. It is up to the clinician to give meaning to this process so that it is interpreted in the best interest of the client. Would it be better for the client to do this with an office staff member or even a different clinician? Could the process be a beneficial ritual for the transition to life outside the office? Some systems allow the client to pay online which may suit some situations.

Because the client is not actually transferring personal assets to the clinician (as with payment by check) but is instead using credit some have argued that this process encourages thoughtless and irresponsible purchasing. Certainly some people have run up debts well beyond their incomes. Clinicians could inquire about such abuses and resources. When there is a reasonably foreseeable risk of abuse the clinician may decide to accept only debit cards from those with a history of gambling, bankruptcy, or similar stressors.

Advantages over the usual methods of payment

Those offering the package of services and hardware and software to process credit cards are called resellers and are happy to list numerous advantages of their programs. Here are a few that clinicians should consider.

- Although they will typically cost about 4% of the billed amount, your current practices are likely to have higher costs and certainly take more time.
- The client can "pre-authorize" payments to the clinician for the copays, missed sessions, etc., so these do not have to be billed and collected later.
- Payment to you is in full, certain, and immediate. By contrast, billing is burdensome and expensive, and payment is uncertain and delayed.
- Accepting cards is the current standard business practice. Few carry checks, no one carries cash, and almost all expect you to accept their cards.

What you will need

First you must open a "merchant account" which simply certifies that you are a legitimate business, with a bank account, in the eyes of the credit card companies. You also need a "gateway" agreement to transfer information and monies between the client's card and your account. These are usually bought from the same reseller, some of whom are listed below.

Second, you also need a "terminal" in your office to enter the card's data. There are three[1] simple options:

1. The familiar little machine with a keypad (numbers) and a card reader (slot to swipe card through) with a landline phone connection and (optionally) a separate or integrated receipt printer machine just like most stores use. These range from $75 to $350 or so.
2. Use your computer with a "virtual terminal" program and a wired/cable Internet connection (not unsecured Wi-Fi). You type in the card's information and can print a receipt from your computer's printer. Such programs are often included

[1]This article does not address the older credit card method using paper receipts and the hand-operated swiping machine. While still available, the procedures cannot guarantee payment and involve delays.

with the merchant account. Because the data is typed in (the card is not swiped) fees are higher for a virtual terminal but a simple card swiper can connect to your computer through its USB port or serial port. You would buy (for $30-$75) or rent the swiper and use the virtual terminal program to enter only the sale's amount.

3. Use your smartphone (iPhone, Blackberry, etc.) with a virtual terminal program. You can send the client a receipt by e-mail or buy a little receipt printer. Example programs are VTSwipe from jsorm.com for PCs and iSwipe for Macs. Smart phones with touch-sensitive screens allow "signature capture" just like the familiar desktop terminals.

Costs

There are three components to be understood and weighed in choosing a reseller. Resellers have to make a profit and may charge separately for these pieces or give them at no charge (but make money elsewhere in the process).

First are costs of getting started. Set up fees are typically $50-$150. Contract length and cancellation fees are important if the reseller proves unreliable or incompetent and you want to change. Add the costs of a terminal machine and perhaps a printer which can be bought (new or used) or included in your monthly fees.

Second are the per-transaction costs in two parts. The "discount rate" is a percentage of the sale (from about 1.6% to 3.9% depending on the card's issuer, swiped vs. typed-in data, card type such as debit, reward, or corporate, etc.). There is also a transaction fee (from about 10¢ to 35¢).

The percentage is a more important consideration than transaction fees because clinicians' typical sales are large dollar amounts. The reseller will quote you these charges in terms of "qualified," "mid-qualified," and "non-qualified" cards, "Card Present Transactions," etc. American Express and Discover often charge more and may require a separate agreement. Don't let these choices slow down your decision making; they are competitive and don't matter much because they can't be avoided or modified by you – they are your clients' choices.

Third are the monthly fees, which vary a lot. Here are the major ones:

- Monthly account fee ($15-$30) may include the gateway's cost.
- Monthly "statement" fee and others ($5-$20).
- Minimum transactions fee. Even if you do not run up this amount in transactions (percentage and transaction fee) you pay this minimum, usually about $20. Note that this is not total charges (e.g. client payments) but is the equivalent of perhaps $1,500 per month of billing.

Finally some other considerations:

- Compute the costs of accepting cards vs. your present system's costs over 2 years.
- Some resellers offer a 30- to 90-day trial period without termination fees.
- Does the reseller answer their phone and provide good support and availability when you need it?
- Can you view your account online whenever you choose?

From whom?

There are hundreds of options so here are a few (with whom I have no financial or other relationship which would affect my judgment). A Google search under "merchant accounts" or "accept credit cards" will find many more.

- PPA has made arrangements with Affiniscape for a competitive rate for members. PPA also receives a small commission from this arrangement, so the association benefits as well; see our Web site at www.PaPsy.org.
- Your bank may offer you such services at a reasonable cost and with local servicing.
- If you use a billing program or organization they may offer this option.
- TherapyMatch.com and ProfessionalCharges.com specialize for mental health professionals and are run by them.
- PayPal.com if the client has an account with a balance.
- Business membership in Costco.com or Samsclub.com offer credit card acceptance services.
- National resellers include: www.NationalBankcard.com, www.MerchantWarehouse.com, www.1NBcard.com, and www.MerchantCafe.com.

CE Questions for This Issue

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Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before June 30, 2012.

Return the completed form with your CE registration fee (made payable to PPA) for $20 for members ($35 for nonmembers) and mail to:

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Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

DeWall

1. PPA members on Advocacy Day met with legislators to discuss all of the following EXCEPT:
   a. problem-solving courts
   b. management of concussions among high school athletes
   c. insanity determinations
   d. authorizations for outpatient services

Kovacs

2. What is Mindfulness?
   a. paying attention to your current thoughts
   b. the awareness that emerges through paying attention in the present moment, and nonjudgmentally to the experience of moment to moment
   c. practicing feedback responses
   d. learning to meditate in silence
3. What is the decentering process?
   a. a cognitive strategy for reducing anxiety
   b. allowing all physical, mental, and emotional sensations to occur and by removing oneself from over-identification with them
   c. using diaphragmatic breathing to reduce stress
   d. Mindfulness-Based Relapse Prevention

Molnar, Training Changes the Brain

4. Goldin and colleagues (2010) reported that:
   a. MT did NOT change brain activity in people with social anxiety disorder (SAD)
   b. distraction was an adaptive way to regulate emotion in people with SAD
   c. there was no difference in brain activity when people with SAD engaged in distraction from threatening words compared to when they practiced mindfulness in response to threatening words
   d. MT resulted in a quicker recovery to baseline of activity in the amygdala in people with SAD who were exposed to threatening words

Molnar, Training Options

5. What is true about Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT)?
   a. They are largely the same with a few exceptions.
   b. They have nothing in common.
   c. There is no evidence of their effectiveness.
   d. They are superior to medications.

6. The minimum training required by the Center for Mindfulness before a person can teach MBSR is:
   a. a 1 year-long intensive practicum
   b. a 7-day residential training retreat called MBSR in mind-body medicine
   c. the Teacher Development Intensive (TDI) training program
   d. a 2-hour long workshop taught by a psychologist

Pashko

7. In the book, *Free Your Mind: It's Not What You Think*, which type of thought is specifically characterized in Pashko's schema?
   a. emotionally-laden thought
   b. logical thinking
   c. thought about thought
   d. self-directed thinking

Devdas

8. The Mindfulness Based Stress Reduction program:
   a. combines yoga, mindfulness, and martial arts
   b. stands by mindfulness alone
   c. implements yoga and mindfulness
   d. provides attention training
   e. uses mindful eating as its main stress-reducing strategy

School Psychology – Broderick

9. Which of the following is true with regard to emotion regulation and executive functions?
   a. Emotion regulation skills should be fully developed by the time a child enters kindergarten.
   b. Emotion regulation and executive function skills are interrelated.
   c. Emotion regulation skills are relatively unimportant for academic success in school.
   d. Executive functions need to be improved only for those who have diagnoses of ADHD.

School Psychology – Hughes

10. The APA Model Act for State Licensure of Psychologists (MLA) is a recommended document for State Boards of Education.
    T
    F

Psych Tech – Zuckerman

11. The routine costs of accepting credit card payments include all of the following EXCEPT:
    a. per-transaction fees
    b. charge backs
    c. percentage of the sale
    d. monthly account fees including gateway costs
    e. minimum transactions fee

Continuing Education Answer Sheet
The Pennsylvania Psychologist, June 2010

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d		**7.**	a	b	c	d	
2.	a	b	c	d		**8.**	a	b	c	d	e
3.	a	b	c	d		**9.**	a	b	c	d	
4.	a	b	c	d		**10.**	T	F			
5.	a	b	c	d		**11.**	a	b	c	d	e
6.	a	b	c	d							

Satisfaction Rating

Overall, I found this issue of *The Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

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Marti Evans (717) 232-3817

September 24, 2010
APA Insurance Trust Risk Management Workshop
Harrisburg, PA
Marti Evans (717) 232-3817

November 4–5, 2010
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

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.

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