THE PSYCHOLOGICAL ASSOCIATION OF MANITOBA NEWSLETTER WINTER 2016-2017

P.A.M. is legally constituted by the Psychologists Registration Act (R.S.M. 1987) as the regulatory body for the practice of all branches of Psychology in Manitoba.

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Save the Date

AGM Annual General Meeting
Wednesday April 19th, 2017
Best Western Plus
1715 Wellington Avenue
Winnipeg, MB.
5:00 – 9:00 PM

From the Registrar

Registrar [ˌrɛdʒɪˈstrɑː ˈrɛdʒɪˌstrɑː] n

1. Chief administrative official responsible for maintaining legal registers of, and appropriate information about, P.A.M. Members
2. Person responsible for providing information as required by the Provincial Minister
3. First point of contact for members of the public seeking information about psychology in Manitoba, or who are concerned about the actions of a P.A.M. member

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I am pleased to take an opportunity to update you on the activities of PAM over the past several months. Your council and committees have been hard at work on a number of important initiatives and good progress has been made in several areas.

A fair bit of time has been spent over the past six months continuing our work on bringing psychology under the Regulated Health Professions Act. In order to move this process forward PAM has hired a consultant who was instrumental in assisting the speech language pathologists and audiologists to form their new college and be the first profession to come under the RHPA. To date we have had two meetings with this consultant and have also had a number of meetings with Manitoba Health to begin the process of regulation writing/development. We are actively working on rewriting our regulations, preparing practice standards and practice directions, and submitting requests for reserved acts. Once all of these regulations have been drafted, they will be circulated to the PAM membership for feedback. Thereafter broader consultations with other stakeholders will be undertaken, at which time they will have an opportunity to offer their thoughts on our proposals. We also continue to work with our colleagues in the Manitoba Association of School Psychologists towards implementing the agreement reached with them around the creation of a school psychology practice roster.

The past few months have also seen the introduction of a number of efficiencies in the way the PAM office is run. As many of you know, we have hired an administrative assistant (Ms. Virginia Campbell) who is in the office 3 half days per week. Having an assistant in the office has improved the response time to telephone messages and also enabled us to begin tackling some long overdue administrative tasks. In addition, the complaints committee has begun actively utilizing the services of Ms. Andrea Doyle, a lawyer with Thompson Dorfman Sweatman. Ms. Doyle has been hired on a salaried basis to provide services to the committee, and in so doing we have been able to significantly reduce the costs connected with the operation of this committee. Mr. Blair Graham, our long serving legal counsel to this committee, continues to provide consultation services however over time these will be gradually phased out as Ms. Doyle comes up to speed. We are quite grateful to Mr. Graham for his pro bono offer of these services in assisting Ms. Doyle to become better acquainted with our organization and its processes.

Finally, more and more, the day-to-day operations of PAM are becoming centralized to the new office. Oral examinations are now being held at the office, as are our Registration and Membership and Complaint committee meetings. Through the centralization of these meetings, we are reducing our costs and improving the security of our operations, by reducing the transportation of applicant and registration files.

In a few short weeks, registration renewal will begin, and we encourage you to keep an eye out for email notification of this. As before, April 30 will be the deadline for the submission of your renewals. Also, April 19 has been set aside for the annual PAM Annual General Meeting and we look forward to seeing everyone there.

Alan Slusky, Ph.D., C. Psych.
Registrar

R & M F.A.Q.

By: Hal Wallbridge, Ph.D., C.Psych.

1. Can I count post-doctoral supervision hours that I obtained out of province?
Post-doctoral supervision is typically carried out by psychologists registered in Manitoba and within a work setting based in Manitoba. An exception could be in the case where an applicant has obtained permission from PAM ahead of time. For example, if an applicant plans to move to Manitoba after a year of post-doctoral training in another jurisdiction, then the applicant could ask if this supervised experience would be eligible. The applicant would apply to become a candidate for registration with PAM prior to the start of the postdoctoral training. The work would need to be supervised by a psychologist or psychologists registered in the other jurisdiction and approved by PAM. Most importantly, this supervisor or supervisors must be aware that the applicant is using the post-doctoral supervised experience for the purpose of seeking registration in Manitoba and they must use PAM Work Appraisal and Supervision Record forms. It is also possible to request that post-doctoral hours be considered as eligible for registration in Manitoba when collected for the purpose of registering in another jurisdiction but where the applicant then moved to Manitoba. Such a request would be considered but each request would be evaluated on an individual basis and might not be approved. It is recommended that if the applicant is seeking to use out-of-province hours that permission be obtained ahead of time.

2. Can I count supervision hours that I accrued prior to my official registration with PAM?
Normally post-doctoral supervision starts to accrue when the candidate become registered with PAM as a candidate. If the supervision approved by PAM is with the same PAM registered psychologist and in the same work setting as hours collected prior to becoming registered as a candidate, then some supervision hours collected prior to official registration might be counted. This must be requested by the candidate in a letter of explanation. No more than three months of supervision can be counted in this way. This work under supervision must also be continuous and be ongoing at the time of official registration. Supervised experience that is not continuous will not be counted. Note that this is subject to approval by PAM and this request could be declined.

3. How much detail do I need to include in Supervision Logs?
There are several important types of information to include in supervision logs: (a) Individual versus group supervision hours must be reported separately as group supervision hours are divided in half, reflecting the fact the group supervision hours may involve the supervision of clinical work not conducted by the applicant. (b) The work supervised must be reported in a way that shows it was clearly clinical or applied in nature. In other words, the supervised experience must involve intervention, assessment or consultation with the recipients of a health service. Any other context where the applicant is meeting with a supervisor, such as a staff meeting, educational seminar, or any other non-applied context that does not involve delivering a service to a consumer of a health service, cannot be counted. (c) Record the number of minutes of the supervision at each meeting and total the number of these minutes (recorded as hours) on each log form. (d) Ensure that the supervision log is validated with the signatures of the applicant and of the supervisor.

4. What if my graduate degree is from outside of North America?
Degrees from outside of North America must be verified through an international education credentialing evaluation. It is the responsibility of the applicant to contact this service and to obtain a report about the equivalency of their academic training.

5. How do I select which competencies and populations to indicate when I register?
The competency area selected at the time of registration is primarily based upon the name and nature of your graduate degree. PAM expects the majority of applicants to select only one area of competency, specifically the one most represented by the name of their highest degree. The addition of other competency areas would require the applicant to provide additional information to PAM outlining in specific detail the educational preparation (graduate courses, possibly research activity) and supervised clinical experience that could justify an additional area of competency. Additional competency areas should only be pursued if they are a major area of work with clear educational and supervised experience supporting the area. If the work associated with an additional competency area is more secondary in scope for the applicant, then they should consider whether the primary competency area is sufficient. Each competency area has a

sufficiently broad scope of practise to capture diverse types of work. Similarly with populations, those selected should be supported by significant educational preparation and supervised clinical experience. Extensive research experience with a certain population might also be used to justify adding this population, although supervised clinical experience will also always be required. Note that PAM may or may not approve a request for additional competencies and populations and each case is reviewed on an individual basis.

6. If I want to add a competency or population later, how do I do it?

When PAM members wish to add another competency area after working in independent practise for some time, they again must make a written request detailing their relevant educational preparation, research work, and supervised clinical experience. A strong letter of support from another psychologist or psychologists with the competency/population designation being requested may be helpful or might also be requested by PAM. Usually the person making the request will outline extensive work experience describing specialized work to justify the request. Each request is reviewed on an individual basis. Sometimes additional actions may be requested of the member making the request, such as additional education and/or supervised experience.

7. Why are individual and group supervision counted separately?

It is possible that the supervision of an individual's work might occur in a group setting (i.e., their work is being specifically supervised and other supervisees are observing) such that it is viewed as equivalent to individual supervision and the time involved could be counted as individual supervision. However, when the applicant is in group supervision and it is not their work that is being reviewed but another supervisee's, then this counts for half credit. This practise is intended to capture the fact that there is educational value in observing and participating in a situation where a supervisor is working with another supervisee.

8. What types of experiences can I count as supervision?

First, the supervisor must be registered with PAM to count for the post-doctoral supervised experience (although psychologists registered in other jurisdictions might be permitted with the prior consent of PAM; see question #1). The supervision must also be about clinical or applied work of a person or persons who are receiving some type of health service, such as intervention, assessment, consultation or supervision. Any other context where the applicant is meeting with a supervisor (e.g., staff meeting, educational seminar, or research supervision) does not qualify. The supervision must be related to applied work related to a health service.

9. How recent does my Criminal Record Check and child/adult abuse registry information have to be?

A current Criminal Record Check and Child/Adult Abuse Registry Checks need to be submitted at the time of Candidate registration. The original certificate is required or a copy that has been endorsed by an official from a recognized institution in Manitoba. Individuals may be asked to resubmit checks at the time of full registration, if it is considered that the original checks are out of date. PAM reserves the right to request that these checks be up-to date and might require an applicant to repeat these checks.

10. If I come from another province, where do I get my Criminal Record Check from?

When applicants have recently moved to Manitoba, then the Criminal Record Check that they submit should indicate that the record search was of national databases. The Manitoba Child Abuse Registry and Adult Abuse Registry must always be submitted, even for applicants who recently moved to Manitoba.

"I'd like to introduce our speaker, here to speak about the phenomenon of déja vu".

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PAM celebrated its 50th year in 2016!

To commemorate, The Manitoba Psychologist turns back the clock to take a look at ourselves a half-century ago:

From The Manitoba Psychologist, Bulletin of the Psychological Association of Manitoba (Volume 8, No. 1, October 1966): Publication: I Bilash, L .Shewchuk, C. Friend

Executive	1965-66	1966-67		Institute Committee	1965-66	1966-67
Past President	A. H. Shephard	K. R. Hughes			I. Bilash	L. A. Shewchuk
President	K. R. Hughes	I. Bilash			J. Caldwell	J. Caldwell
Vice President	I. Bilash	L.A. Shewchuk			R. Kristjanson	W. Nazeravich
Secretary	J. J. Cote	C. Friend				
Membership Secretary	L. Fry	L. Fry			W. Nazeravich	H. Shaw
Treasurer	D. D. Ellis	I. Crofts				

Psychologists' Bill passed: April 26, 1966
Membership: 74 (39 full members, 30 associate members, 5 student members)

PAM two-day Institute: Dr. Bruno Klopfer on the empathic use of the Rorschach

Financial Report of the 1965-66 Institute Committee:

REVENUES

Carried over from previous institutes:	$156.00
Registration Fees:	$760.00
Mental Health Grant:	$387.50
Total:	**$1,303.55**

EXPENDITURES

Speaker's Fee:	$321.37
Speaker's Air Fare:	$255.40
Speaker's Accommodations & meals:	$64.85
Stationary:	$48.93
Miscellaneous:	$24.50
Banquet:	$125.00
Total:	**$840.05**

Balance as of April 29th, 1966: $463.50

Look Ma – I'm Certified

Morgan Wright, Ph.D.

(October, 1966, Volume 8, No. 1)

In 1959 the first serious discussions were held about certification in Manitoba. Now seven years and a few hundred dollars later, it has become a reality. I think many of us rather regret its necessity, as being a fringe professional person had its advantages. No one really knew what we did or cared – both within and without the "profession." Alas our state of blessed ignorance is about to end. Soon we will be engaged in suing one another for malpractice, charging exorbitant fees, ecstatically looking up our names in the yellow pages and snubbing our non-registered ex-colleagues.

As a person who has been involved in certification from the beginning, there is a feeling of bereavement now that the battle is over. It was indeed tragic that Tony Norton was unable to lead the last heroic charge in the legislative chambers in March as we presented our bill to the Law Amendments (sic) Committee. Certainly, it was his spirit that carried the day in the face of strong opposition. The chief obstacle presented itself in the form of the Honorable Saul Cherniak who innocently asked us (Hughes, Shephard, Wright and Brock) whether we had made provisions in our bill for sociologists. It was given to me to reply, somewhat disdainfully, that this was quite unnecessary since sociologists and psychologists were two different breeds of animal. Not so, replied the redoubtable Saul, and presented us with a myriad (of) articles from the A. P. A. and A. S. A. indicating that sociologists should indeed be exempted from the restrictions of any such bill. Mortified and chastened we hurriedly contacted the Sociology Department at the U. of M. and they enthusiastically agreed. We then incorporated a clause exempting sociologists from our bill and represented it to the Law Amendments (sic) Committee. All was going well until the government lawyer screamed foul and said our bill was now unconstitutional since we were exempting sociologists and they were not, in Canada, a legal entity – i.e., anyone could call himself a sociologist and so evade the restriction of the bill. If only Tony had been there! As it was, we stammered, blushed, and retracted the clause, waiting for someone else to confound us with articles we should have read or things we should have done. Fortunately, nothing happened and the bill was waved through. In retrospect, I was much impressed by the calibre of our public officials, and believe that in having our bill sponsored by Mr. Cowan, a wise choice was made. Also, Reece Brock was an able tactician and advisor. Luckily, he was not raised to the Queen's Bench before our bill was presented – though his future elevation is now assured.

So, richer in legal status and poorer in pocketbook, we face our destiny as legal entities. Fortunately, we will have plenty to keep us busy and so are not likely to become depersonalized by our new power and titles. After we define what the psychologist is (and this should be good for a year or two) we must then provide facilities for his training. Then what about fee schedules? Codes of ethics? Professional post doctoral training? Registrar? These and many other concerns will challenge a new and vigorously developing profession; while the old sweats, like myself, will be content to watch and bask in its reflected glory.

Per ardua ad astra.

A Room in the House of Psychology

L. A. Shewchuk, Ph.D.

(October, 1966, Volume 8, No. 1)

During the past years, Clinical Psychology has pressed vigorously for some room in the house of psychology, but after many, many discussions at the conference tables and in just about every beer parlor (sic) and liquor lounge in Winnipeg (and points West and North), we seem to be no closer to a training program than we were when Manitoba's first Clinical Psychologist sat in his office in a Winnipeg hospital a few decades ago. I must admit, however, that since the advent of the mixed drinking parlor (sic) and lounge, the amount of discussion has increased ten-fold. In fact, I have the most uncomfortable feeling that we are becoming content with mere talk…

Rather than summarize the events that have taken place to date I will attempt to itemize the major points of discussion, but not necessarily in order of importance, nor in order of the amount of discussion.

One point that has been discussed at some length is that of staff. It has been expressed that there are an insufficient number of qualified staff both in and outside the university to provide the level of instruction which is required for a good training program. Certainly, within the Fort Garry Department of Psychology this is the case as far as Clinical Psychology is concerned, however, if we were to count the number of qualified staff within the total university setting (and not only those within the Department of Psychology at Fort Garry) the numbers would be appreciatable (sic). Just off hand, I could think of four people who could make a very significant contribution to our cause. Outside of the university settings there are at least three Ph.D.'s trained in clinical methods and any number of M. A.'s with a vast amount of experience and knowledge in particular areas who could contribute a great deal towards the training of young clinicians. Whether or not these people could, or would be willing to, devote time and energy in molding (sic) future clinical psychologists is something which has never been explored.

There is a growing unrest amongst some clinical and applied people that this whole problem is being handled in reverse. In other words, it should not be up to the clinician in practise to present a program to the University and hope that they may accept it, but rather it should be up to the university to present a program to the clinician and hope that he will support it by opening up training facilities for practicum experience. In a sense this is what is being done now, although the clinician is not being approached for his support. While the Department of Psychology does not claim to be preparing students for applied work, their program of courses is such that potential students may construe that they are in fact being prepared to take on clinical positions upon graduation. A look at the catalogue (sic) of courses offered would indicate that 13 of the 32 half-courses are clinical in nature. Whether the content of these courses bring the students any closer to understanding human behaviour, or whether some sort of theoretical approach to understanding behaviour in general is presented is a moot point. In my associations with the students, all I have heard so far concerns only the irrelevance of their courses of instruction as far as the human being is concerned.

Of late, faint rumblings have been heard that the Department of Psychology at Fort Garry cannot be ready to institute any sort of clinical program because they are still fighting desperately for the survival of an experimental program. Such a state is certainly reflected by the huge change over in staff each year. Furthermore, there appears to be (at least to the outside observer) a vast change over in student population as well, with many students going to other universities before they have completed their course of studies here. Until some stability is reached in this respect, no program – clinical or experimental – can survive. Perhaps the membership of the P. A. M. should become more concerned about the training of experimentalists and forget the clinical program for the moment.

We could keep on struggling for some room in the house of psychology, but let us be sure that the house has a good foundation.

MENTAL HEALTH APPS: INNOVATIONS, RISKS AND ETHICAL CONSIDERATIONS

http://file.scirp.org/pdf/ETSN_2014090415142681.pdf

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Abstract
The purpose of this article is to briefly review some of the innovations that mobile mental health apps present to consumers and mental health practitioners. Particular attention was given to understanding some of the important risks and the potential ethical dilemmas which may arise for counselors and psychologists who embrace them in their practice. Key considerations of issues pertinent to regulations, privacy concerns, and research are being discussed.

Keywords - Mental health, Apps, Counseling, Risks, Ethics

1. Introduction

Mobile technologies and networks are increasingly expanding in their sophistication and capacity, and new applications (software programs) are enhancing the ways in which individuals interact. Given the widespread use of smartphones and the increasing uptake of tablet devices, mHealth (the use of mobile and wireless technologies for health objectives) is believed to have the potential to improve the cost and quality of health care received, as well as reduce stigma and increase treatment accessibility globally [1]. Since the creation of *Apple*'s *iTunes App Store* and *Google*'s *Android Market* that allowed users to download mobile application software (apps) in 2008 [2], more and more sophisticated mobile apps are being developed in the field of mental health, and are being adopted almost as quickly as they can be developed [3]. The purpose of this paper is to review a number of innovations in the thriving department of mental health apps, as well as discuss important risks and potential ethical dilemmas which may arise for counselors and psychologists who would be willing to embrace them in their practice.

K. G. Giota, G. Kleftaras 20

2. The Power of Mobile Technologies: Innovations in Mental Health

Research shows that the majority of people and particularly young adults with mental health problems often do not seek professional help, despite the existence of effective psychological and pharmacological treatments [4]. The most common reasons include the lack of available services, especially in rural and remote areas, problems recognising symptoms, cost of treatment, time constraints and concerns about confidentiality and stigma [5]. However, mobile technologies, social networks and online media present an exciting, untapped opportunity for engaging younger populations in health and wellness activities, as well as promoting universal prevention and intervention [4] [6].

Mobile devices can become an ideal platform for self-monitoring symptoms and behaviours and providing personalized feedback, motivational support, and psychotherapeutic advice [1]. They can also be used for educational and training purposes (e.g. the APA Concise Dictionary [7]) or for administering standardized assessments and calculating scores (e.g. the PAR Assessment Toolkit [8]). Previous research suggests that mental health interventions delivered through mobile apps can have positive effects on a range of mental health problems, such as depression, stress, anxiety, and smoking cessation [9] [10]. These apps can be used as stand-alone self-help programs or in conjunction with guided programs offered via a website or through direct contact with a mental health professional. They can act as a bridge between therapy sessions and have the potential to improve adherence to treatment [11].

There is a growing amount of mental health apps for mobile devices that are youth-friendly, easily accessible and flexible to use. For example, Mobile

Therapy [12] is an app where users can indicate their current mood at random times throughout the day, as well as record their energy levels, sleep patterns, activities, eating habits… The app offers therapeutic exercises ranging from breathing visualizations, to progressive muscle relaxation, to useful ways to disengage from a stressful situation. The information can later be charted and printed out so that users can evaluate the connection between their mood and other factors in their lives. In the same sense, the CBT-based My Compass [13] is a self-guided psychological treatment delivered via mobile phone and computer, designed to reduce mild-to-moderate depression, anxiety and stress, and improve work and social functioning. It encourages real-time self-monitoring of moods, mood triggers, and lifestyle behaviours using SMS text messaging and email prompts. Other apps include Relief Link [14], a mood-tracking tool that tweets users regular affirmations, helps them make a safety plan and puts them it touch with nearby resources if they're contemplating suicide, and the Live Happy app [15] that is based on positive psychology and provides a set of daily activities scientifically proven to boost both short and long term happiness.

Even though the use of technology in mental health is relatively new, the idea of using games to help people with mental health problems is not novel. There are hundreds of mental health apps already on the market, and many incorporate elements of gamification (the use of video game techniques for more than entertainment purposes). Researchers have often focused on using these techniques with children, however, now it is common for adults to play games on their phones. For example Personal Zen [16] is an app based on a cognitive treatment for anxiety called attention-bias modification training. With the help of a game, people can learn to ignore threatening stimuli and focus on the good, feeling that way less anxious in stressful situations.

3. Risks and Ethical Considerations

However, mental health professionals should be aware of the risks, as well as potential ethical dilemmas when using mobile devices and applications for mental health problems. One of the most common issues revolve around the constraints of technology itself as a medium, for example problematic device and telecommunication technologies, battery failures, as well as unreliable or unstable internet connection [17]. Additionally, there is always the possibility of theft, loss, or malfunction of the mobile device that could have serious consequences when important data (e.g. electronic folders with history intakes, therapy session and billing notes, contact numbers and addresses of clients) are not stored in an easily accessible secondary location [3].

Many health and fitness applications often collect a large number of demographic and medical information by urging users to enter a lot of personally identifiable data, for example name, phone number, email address, age, gender, and photos [18]. They may also catalogue lifestyle information such as food consumption and exercise habits, or information related to their diagnoses, treatments and insurance (e.g. chronic health/mental health problems, screening results, medication dosages). Additionally, while using the app, people usually create a record of their daily routine and practices (e.g. diet, exercise, pregnancy and menstrual cycle, appointments and medication refills). Even if there is a privacy policy issued by the developer, there are, usually, no regulations that protect the privacy and security of personal health information, as once sensitive information is public via social media, users have little to no control over it [18].

Mental health professionals must take under consideration that free apps depend on advertising for funding and any information people provide to an app may be distributed to the developer, to third-party sites the developer may use for functionality reasons, and to unidentified third-party marketers and advertisers [19]. In the same sense, there is a strong possibility that they lack in reliable security, as they might transmit unencrypted personal data over insecure network connections, or allow ad networks to track users, that way raising serious concerns on their ability to protect the privacy and confidentiality of user information [19] [20].

Personal health information is of great value for cyber-criminals and can be used in order to obtain medical services and devices, or bill insurance companies for phantom services in the victim’s name. As there are few legal protections, victims are forced to pay them or risk losing their insurance and/or ruining their credit ratings [21]. Fraudulent healthcare events can leave inaccurate data in medical records about tests, diagnoses and procedures that could greatly affect future healthcare and insurance coverage [22]. Furthermore, erroneous mental health information could potentially influence a person’s social circle, school life or work opportunities [23].

Mental health professionals should carefully screen any apps that they are recommending and inform clients on whether their use could compromise their privacy [3] [4]. It is important to avoid applications that embed advertising or that seem to be primarily about selling products. User reviews, looking at the privacy policy in the developer’s website, or learning about the app or the developer in the media, are ways to assess the quality and content of information of the app and validate the

credibility of the app developer [18]. Some apps give users the option of trying out their features without entering personal information. Furthermore, deleting the app after no longer using it is an easy way to free up some memory, retain battery, as well as prevent the continuous broadcast of personal stored data. There are also apps that allow users to erase data in case the handheld device is lost or stolen. Another matter to consider is not to share confidential and personal health information through texts, as texting is not secure [18] [20]. Users should also be aware of the fact that smartphones and tablets can become ideal tracking tools, as people carry them almost everywhere they go, use them continuously, and rarely turn them off. An app might utilize various tracking technologies, such as collecting precise, real time location data or using geo-targeting (*i.e.*, targeting by city and zip code) [24].

However, the most important issue that should be addressed is the lack of research evidence on the potential efficacy or effectiveness of mobile healthcare apps [1]. Research reviews show that the number of tested evidence-based mental health apps is small, and their studies usually have samples that are small, non-controlled, and non-randomised. Furthermore, few studies report findings of sustainable results for a period of more than three months, try to replicate these results or test the effects of these mobile interventions on everyday life, work and social functions in general [25] [26].

Although CBT interventions are successful in a number of mental health problems in face-to-face therapy [27], the evidence on the impact of CBT-based mHealth apps is still limited [28]. Few apps provide credible sources (e.g. systematic reviews, peer-reviewed articles) that allow users to locate information on the quality, accuracy and reliability of the content and outcomes [3] [25] [28]. Furthermore, there are apps that are criticized on their lack of effectiveness for the specific diagnostic and therapeutic recommendations that they claim to possess [29] [30]. It seems that the technology is advancing so fast that research is unable to keep up with every new development [31].

Only a small number of mHealth applications is designed by healthcare professionals and based on strong research, whereas a significant number of others are developed by institutions and individuals that are not mental health researchers or professionals [28]. It is of utmost importance to emphasize the fact that people download and use mobile apps at their own risk, as there currently are still no clear measures and certifications (from federal or other third-party institutions) in place to guarantee that the app a mental health professional is recommending to clients or downloading for personal use delivers credible content, contains safeguards for user data, and functions as described [2]. As apps become rapidly integrated into routine healthcare (e.g. logging data, checking and updating patient status), time seems be of the essence in creating strong guidelines for such technology, as well as certification programs for mHealth apps worldwide [32] [33].

4. Conclusion

Healthcare professionals have very little experience on how to best evaluate apps and older healthcare practitioners may be less inclined to use them or even be intimidated by these new technologies. Similarly, old clients may find it difficult to use and interpret the information provided to them by their smartphones [1]. We must take into consideration the fact that embracing new technologies cannot possibly replace the therapist-to-client relationship, but technology has the potential to provide better tools in making this more productive therapeutic alliance and enhancing the quality of care and support [28]. Future research should focus on certificating the quality and accuracy of mHealth apps, as well as creating courses that will train mental health professionals in using mobile technologies that could revolutionize approaches to patient care. Furthermore, psychologists, counsellors and therapists should contribute to the constantly growing body of evidence on the impact of mobile technology on mental health by reporting their experiences, publishing their findings, and improving their current practices [34].

Acknowledgements

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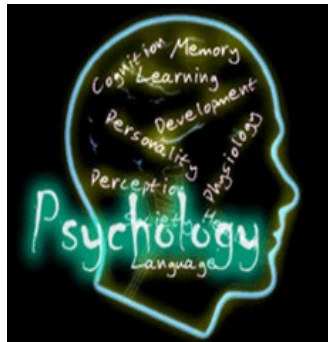

Assessing Wellness in Psychology: Examples from Medicine

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Abstract

Wellness is increasingly becoming an area of research and clinical focus among health care professionals. At the same time, it is not entirely clear what constitutes attainable wellness goals, particularly among individuals in demanding professions. The focus of this paper is to review recent research on physician wellness and draw comparisons to psychologists. We discuss our research findings that physician wellness encompasses three factors, Career Purpose, (lack of) Distress, and Cognitive Flexibility. The hope is that psychologists, who are increasingly moving into medical practice settings, will be able to benefit from this different perspective.

Assessing Wellness in Psychology: Examples from Medicine

The practice of psychology can be stressful (Hannigan, Edwards, & Burnard, 2004). Commonly reported stressors include excessive work, concerns about poor management, excessive, competing responsibilities, a lack of resources, self-doubt (Hannigan, Edwards, & Burnard, 2004), long hours, compassion fatigue, and secondary traumatization around working with patients who have chronic problems and in difficult life circumstances

(Barnett, Baker, Elman & Schoener, 2007; Lawson, 2007). To complicate matters, the last 10 years in health care have ushered in vast changes in documentation, reimbursement, and organizational structure. These changes have been associated with a "do more with less" philosophy that has left health care professionals at all levels feeling strained. Perhaps not coincidentally, there has been an increase in research that examines burnout and stress among health care providers. We now know a great deal about factors that contribute to burnout and impairment. On the other hand, we know much less about factors that contribute to wellness and resilience among health care providers. The focus of this article is to highlight the importance of wellness promotion as a method of thriving in health care practice as opposed to merely ameliorating stress.

We focus on our research findings related to physicians and draw comparisons with psychologists who may benefit from this different perspective.

Historically, literature in both psychology and medicine has focused on awareness and treatment of burnout and impairment so that clinical practice is not compromised. Both fields share the common feature that much initial attention was paid to distress, burnout and impairment, while attention to wellness came later. Barnett, Baker, Elman, & Schoener (2007) argued that psychologists have an ethical mandate to engage in self-care in order to allow them to practice psychology competently. There seems to be general acknowledgment that impaired psychologists are more likely to harm clients, and well psychologists are more likely to help their clients improve (Lawson, Venart, Hazler & Kottler, 2007; Smith & Moss, 2009.) We agree that self-care is extremely important in order to provide quality patient care, but we also believe that an equally important goal of wellness promotion is more aspirational – to assist the psychologist in optimal overall functioning. Arguably only by working toward becoming our fullest selves can we achieve high levels of performance, connection, and authenticity in our work as psychologists. We espouse the position of Keyes (2002) who argues that in order to achieve mental health, we should focus on flourishing or being filled with positive emotion. Survival alone (akin to, perhaps, amelioration of burnout) gives undue emphasis to a “good enough” philosophy (Wise, Hersh, & Gibson, 2012). Even the most vigilant psychologists will find themselves in circumstances where wellness is challenged due to the very nature of the work. Compounding this is the observation that, mental health professionals don’t do well at self-care (Dattilio, 2015). Psychologists are not alone in this regard; physicians work in very similar circumstances. Psychologists and physicians are well-trained in wellness strategies for patients, and they teach these to patients in daily work. At the same time, both professionals are noted to be low utilizers of self-care in their personal lives. Does a health care professional have to exercise, eat well, and meditate to be well? In addition, what does it mean to be well?

Physician Wellness

Our research has focused on wellness for physicians. Although these ideas are untested among psychologists, we think there may be some important parallels that extend to psychology as a profession. We began by considering what wellness may be for a physician. Historically, wellness has been conceptualized as finding life balance (Eckleberry-Hunt et al., 2009), but Federico (2015) suggested that the general goal of balance isn't often reasonable for physicians (and perhaps psychologists). Depending on the demand experienced at any particular time, either work or home may be more heavily weighted, making the concept of “balance” illusory. While this is true, it is important to acknowledge that physicians and psychologists cannot be all things to all people and remain well. There is a tradition in medicine of long work hours and self-denial of needs in order to meet the needs of patients – just as the demands of clinical training and practice place similar demands on psychologists. Younger generations (e.g., the Millennial Generation) are more vocal about stronger expectations of having home-life balance, but the culture of medicine is slow to change.

In our research, we avoided the concept of “balance”, because we worried that if wellness were defined as balance, physicians would appear perpetually deficient. “Balance” infers that it is possible to achieve a state of total satisfaction in work and home at the same time, and this may be a damaging inference. The culture of psychology has historically been more focused on the need for balance in order to remain effective in our work (at least compared to the medical culture), but it appears that psychologists, too, are facing increasing work demands (particularly administrative tasks) in workplaces that emphasize doing more with less.

It may be that all health care providers are finding it difficult to lead balanced lives. Just as physicians are being asked to become schedulers, coders, and billers, so to do psychologists face these increased burdens. As psychologists increasingly work in settings where they are aligned more with physicians versus other mid-level providers, we, too, may experience the impossibility of fully balanced work-home life ratios. Although some evidence exists to posit that “satisfied” psychologists are better able to maintain a sense of balance between work and home lives, this is hardly the only factor driving career satisfaction (Rupert & Kent, 2007) nor does it imply that such balance is readily attainable.

As previously noted, our research was performed with physicians. While they will serve as the primary reference point in discussing our work, we believe that these concepts can easily be extended to the profession of psychology. In an attempt to move beyond a discussion of balance, we sought to conceptualize physician wellness by specifically addressing their complex job demands. Previous attempts to measure wellness among physicians focused on distress and burnout, for example as measured by instruments like the Maslach Burnout Inventory or the Physician Well-Being Index. Our work, however, was predicated on the belief that wellness is more than just the absence of distress and burnout, just as health is more than the lack of active disease. We strongly felt that by identifying an evidenced-based definition of physician wellness that incorporated job stress we could more accurately define the concept of physician wellness. When "wellness" is expressed in measurable terms, it can be accurately assessed and tracked to determine what strategies may improve it within the physician population. Of course, even the act of measurement of wellness can be an intervention itself.

Team-based care decreases the burden associated with complex and chronic patient situations so that one person does not feel solely responsible. As team based care increases in primary care via the integrated primary care movement, psychologists and physicians may benefit.

We reviewed the literature, conducted physician interviews, and utilized expert opinion to develop a broad range of characteristics that might be associated with physician wellness. We conducted a pilot study and developed an instrument to test further among practicing physicians. We distributed the Physician Wellness Inventory to a random sample of full members of the American Academy of Family Physicians and performed a factor analysis to determine the best conceptual structure from the responses. We utilized the Maslach Burnout Inventory and the Subjective Happiness Scale to serve as validity comparisons. The final instrument, The Physician Wellness Inventory (See Appendix A) has three scales: Career Purpose, Distress, and Cognitive Flexibility. Interestingly, items on social support, exercise, and nutrition did not significantly load onto a scale. We cannot say that these factors are not valuable, but they were not salient to our study sample of family physicians. While it is possible that exercise, nutrition, and social support are necessary factors for wellness, it seems our sample of physicians did not perceive them as critical in predicting burnout or happiness. It is possible that our sample was over-identifying with aspects of work, or perhaps as medical professionals, there was little variance in reported exercise, nutrition, and social patterns. For the general population, Keyes (2002) argues that total wellness encompasses emotional and psychological wellness and social and relational wellness, including warm interpersonal relationships. These elements, too, were not factors related to wellness identified by our sample. This supports our initial idea that wellness may look differently for different professionals depending on the demands of their career. We describe our findings below, but more technical data are published elsewhere (Eckleberry-Hunt, Kirkpatrick, Taku, Hunt, & Vasappa, in press)

Career Purpose

The first and most robust scale, Career Purpose, involves getting satisfaction out of working with patients, having work-related joy, and having a good balance of positive vs. negative patient relationships. This finding is consistent with a literature review on resilience and wellness by McCann et al. (2013) who found that positive patient interactions were the most strongly associated with wellness among physicians in qualitative studies. Given the strong relational work necessary for assessment and treatment of clients, psychologists' wellness may even more strongly value or require positive patient interactions—or at least a greater proportion of positive vs. negative patient reactions. Among physicians, ways to increase Career Purpose include reflection groups where physicians can discuss the joys of practice and remind themselves and each other why they chose medicine. Psychologists have long engaged in consultative groups with colleagues; if appropriately directed, such groups might provide a similar opportunity. There is support within the psychology literature that work satisfaction is related in part to maintaining professional identity/values and participating in continuing education programs (Rupert & Kent, 2007). This is a good reminder to continue this practice in a work environment that is full of time constraints and limited resources. Ways to remain attached to one's original calling are likely powerful strategies to maintain wellness in physicians and psychologists.

Some authors (Hannigan, Edwards, & Burnard, 2004; Leiter, 2015) suggested that workplace engagement and finding work that aligns with personal/professional values will increase wellness and Career Purpose. Psychologists are taught to self-reflect in order to connect empathically with clients, and the very nature of empathic connection with others can provide a meaningful experience. By attending to one's ability to connect on a daily basis, one may develop a shared set of meaning with one's patients. By contrast, physicians have been taught objectivity without attention to connection, to "cure" rather than "heal" or "care" and to view themselves, their knowledge, or their procedural skills as

the curative agent. This is slowly changing, particularly within primary care specialties.

Traditionally, wellness work among psychologists has focused on internal factors related to wellness and how those internal factors relate to the external environment (Stevanovic & Rupert, 2004). It is also important to recognize that external factors can also influence the degree of meaningful work one perceives. Within the literature on physician wellness, a trend is emerging that highlights how the work environment affects wellness. McCann et al. (2013) supports that we need to begin looking at resilient environments, particularly work environments, as they relate to wellness. Workplace environments that allow physicians or psychologists the ability to focus more on meaningful work may improve wellness. Thompson, Ametea, and Thompson (2014) found that workplace factors had a major role in the development of counselor burnout and compassion fatigue, and Lawson and Myers (2011) noted that the most meaningful contribution to wellness was the work setting. As such, increasing Career Purpose may involve environmental shifts within the health care environment. For example, physicians who work in team-based environments are more well (Sinsky et al., 2013). Team-based care decreases the burden associated with complex and chronic patient situations so that one person does not feel solely responsible. As team based care increases in primary care via the integrated primary care movement, psychologists and physicians may benefit. Another example of a workplace factor associated with Career Purpose is that physicians are increasingly dissatisfied with paperwork and administrative demands that take away from the joy of patient care. Physicians complain that doing paperwork or billing isn't what they planned or what they are trained to do. It may be that work redistribution is another environmental way to increase Career Purpose.

Distress

The second scale, Distress, involves symptoms of depression and anxiety, distress from competitive administrative and clinical demands, distress from patient encounters, and difficulty controlling the distress. It is important to note that this scale of distress reflects situations specific to patient care, as well as competing demands upon one's role, versus generalized psychological distress. When the work that a physician is doing is perceived to be pointless or is related to difficult patient situations, distress results. Although we don't have solid data on how well interventions work to prevent distress among physicians or psychologists, internal strategies such as gratitude expression, prayer, self-reflective journaling, mindfulness, relaxation and challenging negative self-talk are thought to be important (Dattilio, 2015; Wise, Hersh, & Gibson, 2012). The challenge may be finding ways to increase practitioners' use of these strategies. Meditation, for example, can work but only for those who are willing to commit to a regular practice of meditation. More research needs to be completed regarding brief interventions that can be delivered in more settings. One thought is that health care organizations should offer workplace based interventions to encourage utilization and underscore self-care as a core value. The location would be convenient to practice and may increase support amongst colleagues. The possibility for professional organizations to offer virtual interventions is another area ripe with possibility (c.f., "Virtual Hope Box" app created to address distress in brain-injured military personnel, National Center for Telehealth & Technology, 2015).

One potential solution may be for health care organizations to provide on-site, confidential counseling for physicians and psychologists.

Elevated scores on the Distress scale indicate that physicians may need assistance in dealing with secondary traumatization associated with bad outcomes and negative patient encounters. Again, professional support and reflection groups may be good forums to process traumatic encounters. Physicians remain reluctant to seek personal counseling, and a top barrier is fear of compromised confidentiality and fear of negative consequences for licensure and practice. While fear of negative consequences for practice or licensure may be less of a barrier for psychologists, practical barriers to psychologists seeking personal counseling may be present. Dual-role relationships may be one barrier, particularly in smaller, more rural settings. Perceived lack of time may be another. One potential solution may be for health care organizations to provide on-site, confidential counseling for physicians and psychologists. These encounters would not be billed to insurance companies, limiting any paper trail. This approach is be consistent with the internal management of police occupational stress and trauma where debriefing and support is provided on the job. Indeed, if the distress that physicians experience is related to work, as our scale suggests, on-the-job supportive counseling would be a logical tool. Other studies show that there is a role for workplace interventions that decrease chaos, unnecessary administrative tasks, and improve flow (Sinsky et al., 2013).

Cognitive Flexibility

The Cognitive Flexibility scale assesses openness to new ideas, being self-reflective, seeing multiple perspectives, and feeling compassion for others. This finding is new to

the physician wellness literature but fits with the idea that being able to shift set and let go is important to being well. Dattilio (2015) suggested that to flourish, one needs to demonstrate flexibility and ability to shrug off unrealistic expectations. Cognitive Flexibility interventions might include reflective/mindfulness and/or cognitive-behavioral therapy type interventions to improve wellness. Wise, Hersh, & Gibson (2012) suggested that mindfulness based approaches can increase cognitive flexibility, as well as improve quality of life and joy. Sirgy and Jackson (2015) suggest that differential mindfulness strategies may be beneficial for therapists and possibly physicians. Other research has demonstrated that mindfulness has benefits, including enhanced attention, expanded affect tolerance and acceptance, greater self-awareness and empathy and greater wellbeing (Cashwell et al, 2007; Goodman & Schorling, 2012).

Finally, we examined the relationship of hours worked per week and perceptions of workload manageability. Among physicians, the number of hours worked per week is significantly related to Cognitive Flexibility, while the ability to manage workload is significantly related to Career Purpose and Distress. It appears that physicians need to consider both how much they work and how able they feel to manage the volume of work that they have. The implication of these findings is that for physicians (and perhaps psychologists), wellness involves more than self-care of breaks, exercise, and stress management.

Wellness on a Budget

One of the approaches we recommend for work with physicians "wellness on a budget." Commonly, physicians insist that there is no time for self-care, but this may be a cognitive distortion. We routinely work with physicians to improve wellness by employing creativity and negotiating discrete bits of time to demonstrate that even five minutes can boost feelings of wellness. We can tailor our wellness strategies to the time available. Please see Table 1 for suggestions regarding wellness activities.

Table 1. Wellness Strategies.

Time required Activity

- Communicate to trainees that wellness is important, even if it can't be ultimately achieved right now
- Set quarterly wellness goals for oneself with a supervisor or colleague
- Put wellness on the agenda for faculty meetings and staff meetings
- Schedule fun outings or events after hours
- Set up sports teams or spectator outings
- Create a fun work environment – playfulness
- Send out a weekly email reflection

Minimal

- Demonstrate appreciation
- Develop a list of PCPs in the area who are known to be good and who accept the insurance provided by the institution
- Develop a list of psychologists, psychiatrists, social workers, and counselors who know how to work with physicians or psychologists and who accept insurance provided by the institution
- Emphasize this upon orientation and post it where openly accessible
- Send "Piece of My Mind" from JAMA

30-60 minutes

- Conduct a meditation, guided imagery, or visualization
- Have a mini-consultation or reflection group
- Watch a TED talk together and discuss how it is relevant to your work
- Journaling with specific prompts relevant to your work setting
- Gratitude is renewing to our souls. Provide cards, stamps, and 15 minutes. Have psychologists write a thank you letter to someone. Mail the letters for them.
- Watch a powerful video: Struggling in Silence: Physician Depression and Suicide (American Foundation for Suicide Prevention)
- Do a values auction (Create a long list of values, particularly career related ones such as "autonomy", "flexible work hours", and "high salary." Write values one at a time on index cards. Give each participant a set amount of money. Auction off the values one at a time. People will not know what values are for sale ahead of time, and there is no additional money. Discuss the results at the end.)
- Create a list of positive comments about a group of people and give it to them

- Do something fun (jokes)
- Have the program director or faculty member take trainees out to lunch, and discuss stresses specific to your specialty, as well as "lessons learned" for coping with stresses
- Conduct the gratitude reframing exercise with a tennis ball (ask a participant to identify a stressful situation, then throw the tennis ball to another participant who must reframe the situation. Example: "flat tire = maybe missed an accident on the way." Continue until no other reframes are identified, then start a new stressful situation).
- Ask a nutritionist to come and speak about healthy ways to eat on the run. Specifically ask for nutrition information about energy drinks.
- Provide trainees with their personal statement from their application. Ask them to read it with reverence. Some portion of that self is still with them.
- Have a monthly support group
- Administer a measurement tool (Physicians Wellness Inventory; Maslach Burnout Inventory), give feedback, monitor in a safe way
- Engage in a group goal—Biggest Loser, or training for a marathon, or fundraising for something specific
- Have exercise breaks
- Go off site if possible; arrange coverage by offering to hold pagers for another program's wellness day if they will hold yours

A half or whole day

- Wellness conference with breakout sessions
- Team building with ropes course
- Reflective writing
- Service Learning project: clean up a river, serve at homeless shelter, contact organizations marketing department to see about possibilities

Back to Psychology

We believe that psychologists have something to learn from how physicians have addressed various aspects of occupational distress and work satisfaction. Psychologists should aspire to flourish and not just survive. In order to achieve this goal, both internal and workplace factors should be considered. Psychologists may consider working in team-based care and in organizations whose values align and that minimize unnecessary administrative tasks. Health care organizations may do well to provide in-house stress management and mindfulness skills, as well as confidential, free counseling. One area that we consistently draw attention to is the need to incorporate strategies for wellness within training settings. New physicians and psychologists are inheriting our flawed work environments and should be coached on realistic strategies to work toward wellness. Barnett and Cooper (2009) argued that the profession of psychology needs to do a better job of educating graduate students about self-care and burnout. We would add that graduate programs also need to educate students on wellness and resilience. Bamonti et al. (2014) reported that only a minority of graduate school handbooks have any sort of statement on self-care. These statements do not address wellness promotion or flourishing. We agree that education regarding burnout is necessary and important, but graduate programs in psychology need to help future professionals to reflect and find purpose in work as a long-term aspirational strategy for fulfillment. Programs should assist students to consider work with organizations with similar values. As well, students need to learn more about research on positive work environments that will perhaps decrease distress. Opportunities to learn advocacy skills would be helpful to empower future psychologists to ask for workplace interventions that decrease distress.

In conclusion, we believe that psychologists can learn from our conceptualization of physician wellness. Career Meaning, Lack of Distress, and Cognitive Flexibility are facets that resonate with psychologists given our educational and experiential backgrounds. As psychologists continue to move into medical practice settings, there is a risk of over-identifying with some of the negative aspects of the culture of medicine, particularly its history of self-denial in service of others. Further research into realistic strategies that enhance wellness of both physicians and psychologists is needed. We suggest that the Physician's Wellness Inventory might provide one avenue of research illuminating how changes

in workplace demands for psychologists affect various aspects of functioning and psychological health.

The Scale

We recently completed development of the Physician Wellness Inventory, but we have not yet had the opportunity to explore the application of the scales among physicians other than family doctors. We are beginning to examine the usefulness of the PWI among physician trainees of all specialties but are in the data collection phase. From an intervention perspective, we have routinely used it as a way to begin the conversation with individual physicians about one's wellness. Having a conceptual definition of wellness specific to physicians (high Career Purpose, low Distress, and high Cognitive Flexibility) has led to fruitful discussion of wellness strategies for individuals and training programs. This work can be more supported in the future with research to examine what strategies lead to improvements in which subscales as well as improvement overall. We have also not examined the applicability among other health care professionals. On the face, the PWI appears relevant to other providers, such as psychologists. At the same time, we suspect that different health care professionals may have differing values. As we mentioned previously, although we asked physicians about diet and exercise, these factors did not significantly load onto a PWI scale. These may be stronger factors among psychologists. The PWI is available in the public domain for others to use. We encourage researchers to examine its validity and utility among psychologists, and we give permission to alter the items to better fit psychologists' unique workplace demands. Our findings emphasize that physicians and should begin to consider how the work that they do relates to wellness. Given the similarities in the professional roles, psychologists may wish to do the same.

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Appendix 1. The Physician Wellness Inventory .

Circle the number in the appropriate column

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Working with patients brings me satisfaction.	1	2	3	4	5
2. I often see more than one side to an issue.	1	2	3	4	5
3. Over the last month, I have been bothered by feeling nervous, anxious or on edge.	1	2	3	4	5
4. During the last month, I have been bothered by little interest or pleasure in doing things.	1	2	3	4	5
5. I feel a spiritual purpose or connection in my life's work.	1	2	3	4	5
6. I am open to new ideas and ways of doing things in the workplace.	1	2	3	4	5
7. During the past month, my inability to control my distress has negatively affected the care I give patients.	1	2	3	4	5
8. I spend time reflecting on things I can improve about myself, my life, and my professional role.	1	2	3	4	5
9. Over the past month, there has been a patient encounter that distresses me.	1	2	3	4	5
10. My work brings joy to my life.	1	2	3	4	5
11. I am generally satisfied with my career choice.	1	2	3	4	5
12. During the past month, I have often been distressed by administrative demands that compete with clinical duties.	1	2	3	4	5
13. Positive patient relationships outweigh negative patient relationships.	1	2	3	4	5
14. Feeling compassion for others is a regular part of how I work.	1	2	3	4	5

CP: Career Purpose assesses the meaning of your work.
Total items 1, 5, 10, 11, and 13 and divide total by 5.
Mean: 4.12 SD: 0.66

Your score __________________/5=_____________

D: Distress assesses emotional distress and stress specific to physician responsibilities.
Total items 3, 4, 7, 9, and 12 and divide total by 5.
Mean: 2.85 SD: 0.83
Your score __________________/5=_____________

CF: Cognitive Flexibility assesses open minded-ness and the ability to see different perspectives.
Total items 2, 6, 8, 14 and divide total by 4.
Mean: 4.25 SD: 0.46
Your score __________________/4=____________

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