

Rapport

Focus on:

The National Register of Health Service Psychologists

*By Karen Todd, PhD, R Psych
Guest Editor*



As a new guest editor, I want to first extend gratitude to longstanding Board member and former Rapport editor, Dr. Myles Genest. Dr. Genest provided years of dedication to this publication and in so doing ensured varied and relevant content with a clear commitment to the CRHSP membership.

I would also like to thank Dr. David Pilon, who served as guest editor for the last edition of Rapport.

In continuation of the last issue of Rapport, the current issue maintains the focus on health service psychology, notably via highlighting the U.S. National Register of Health Service Psychologists (herein referred to as the “National Register”). Approximately ten times per year, Dr. Morgan Sammons, ABPP, Executive Officer for the National Register, publishes an Executive Officer online column, and we are fortunate to have permission to reprint some of these columns in this issue of Rapport. In his columns, Dr. Sammons provides unique and often compelling perspective on timely and topical issues relevant for the discipline of psychology.

As Canada’s credentialing body for health service psychology, CRHSP has enjoyed a longstanding and collaborative relationship with the National Register. In highlighting Dr. Sammons’ columns, we hope to share knowledge and expertise and expand our members’

awareness of health service psychology nationally and across borders. We also hope to highlight the wide range of National Register **continuing education opportunities** available to CRHSP members at no or minimal cost. Directions on how to access these opportunities are available at the end of this issue and on the CRHSP website.

Information about the National Register including values, mission, credentialing criteria, publications and resources are available on their website: www.nationalregister.org.

Executive Officer columns, inclusive of those included in this issue of Rapport, are archived at:

<https://www.nationalregister.org/category/national-register-connect/executive-officers-desk/>

Two recent Executive Officer columns are included in this issue. These columns are reprinted verbatim and with permission, and with gratitude to Dr. Sammons and the U.S. National Register of Health Service Psychologists.

Note: The archived columns were chosen as potential topical areas of interest, with opinions therein those of Dr. Sammons and not necessarily of the CRHSP Board.

Please continue to submit your English or French papers for future publications in Rapport to: djpilon@dal.ca

MEASURING WONDER: THE PERTINENCE OF ROMANTIC SCIENCE TO MODERN PSYCHOTHERAPY

By Morgan T. Sammons, PhD, ABPP
Executive Officer of the National Register of Health Services Psychologists

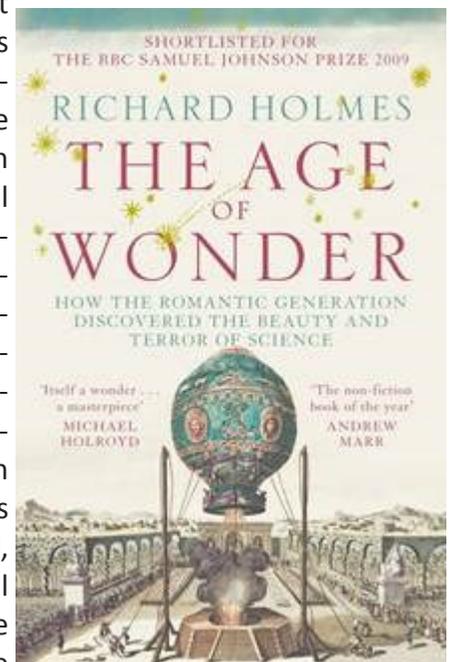


A recent article in the *New York Times* had the provocative title of “If you could add one book to the high school curriculum, what would it be?” The reporters (Concepcion de Leon, Lovia Gyarkye, and Tas Tobe) asked a number of well-known authors (whose works, I’m sad to say, I was largely unfamiliar with) to recommend a title. I was equally embarrassed to find that I had read only two of the books they recommended, even though one was by a psychologist: Stanley Milgram’s *Obedience to Authority*. I guess I have a lot of summer reading to do, and here it’s already September.

Even though I didn’t know anything about most of the books recommended, it was interesting to read these eminent authors’ rationales for recommending a book. Pretty much everything you’d want to see was on the list—a desire to teach enduring precepts (the Bible, the Epic of Gilgamesh), or to present a framework for understanding social problems (Milgram, Albert Murray’s *The Omni-Americans*, Nicola Yoon’s *The Sun is also a Star*, Heilbroner’s *The Worldly Philosophers*). All of the important authors who were surveyed sought to provide a frame for conceptualizing and maybe even solving major social problems. After all, who doesn’t at heart view themselves as a pedagogue, able to impart only the best lessons to the young, transmitting whatever small wisdom life has taught us to another generation, in the hopes that they will both be spared the hardship and pain of our unpleasant lessons and be inspired to do better than we have been able to? Needless to say, the *Times* reporters somehow overlooked me on their lists of go-to authors to find what classic volume I would recommend. At least this leaves me free to opine, for whatever it’s worth.

Hands down, the book I’d like to see high school students read is Richard Holmes’ *The Age of Wonder*, a brilliant history of the “second” scientific revolution in the early 19th century, the so-called era of Romantic Science. As Holmes noted in his introduction to this remarkable book, this was an era where the scientific

revolution of the 17th century became democratized, where techniques of rigorous analysis, measurement, and experimentation became coupled with a metaphysical sense of the infinite, when scientists expressed themselves via poetry and poets expounded scientific precepts. Unlike in modern society, where walls between the “hard” sciences, social sciences, and literature and arts are increasingly rigid, Coleridge, Keats, Byron and Blake shared an intellectual curiosity regarding science, and often expressed this curiosity in verse, as did the scientists, though they were probably more successful at writing equations than iambic pentameter. Historically, the modern emphasis on the key experimental criterion of reproducibility can arguably be traced to experiments with nitrous oxide and other gases by Humphrey Davies, Joseph Priestley and others during this period, and the chemical revolution of the 19th century was the



foundation, and remains a core pillar, of much of modern psychopharmacology. Although Holmes doesn’t make this particular link, it is not too much of a stretch to see that many of the foundations of modern clinical psychology were rooted in the Romantic Scientific revolution. Romantic scientists, for example, carried out systematic studies of the mind-altering properties of nitrous oxide. Although its role in anesthesia was observed, for a number of reasons it did not become a component of surgical practice for many decades. But the notion of repeated experimentation (even at great risk to the experimenter, as Davies inhaled many of the gases he manufactured, including carbon monoxide), careful observation of inner responses and reproducible results stuck, and became a part of the modern scientific method.

Around this time, we also began to explore the psyche systematically, rather in the narrative descriptions that had predominated before then. Modern concepts of psychosis, depression, and mania were carefully and systematically based on close observation and the reporting of case series. One rainy day several decades ago in a medical library I came across what I think is the first published description of postpartum depression in America, written at the height of Romantic Science in 1828. Leaving aside the joy of opening a book 150 years old and how *sensing* that book enriched the experience—the typeface, the archaic language, the heft and the smell of that old volume lending immediacy to my learning—it was clear that the author had on the basis of a careful case series deduced that puerperal mania, as it was then known, was a recognizable clinical phenomenon that had both physiological and psychological components. In a wonderful juxtaposition for me, Paul Meehl’s classic 1973 article “*Why I no longer attend case conferences,*” was a current reading assignment in the internship program where I was on faculty. Meehl’s dismissal of case conferences is eloquent and powerfully reasoned, in spite of its somewhat cranky title. His analysis stood in contrast to the rich, clinically based descriptions of the 19th century article I had just read. Now to be fair, Meehl wasn’t dismissing the power of clinical observation, and he certainly had a few choice words for misapplied standardized tests. His contempt was reserved for the way that observational data was construed, and the fallacious reasoning often employed to explain a patient’s behavior or shove her or him into a specific diagnostic box.

We are a profession of clinician scientists. We are schooled in science, our best therapeutic techniques are rooted in science, and we impart science to our students and, more importantly—even more so if we do it right—our patients. We teach our patients to be curious about themselves, not overwhelmed by their flaws or misperceptions. But most of us, I suspect, are like the Romantic scientists of the 19th century. The structured, logical processes we employ are charged with a sense of curiosity and wonder regarding the infinite and often unexpected variety of human experience. Although CBT is the therapeutic coin of the realm in most current empirical research, I imagine that whatever our avowed theoretical orientation, we all use a combination of humanistic techniques that tap into that sense of wonder (unconditional positive

regard, accurate empathy, and reflective listening) to help our patients gain the courage to undertake a dispassionate analysis of their strengths and weaknesses and to identify areas for therapeutic change.

Though some theoreticians claim that intellectual roots of CBT lie in operationalizing the Stoic philosophies of two millennia ago, the functional basis of CBT is dispassionate structured inquiry into the self. That is, we teach the scientific method to our patients: We work with our patients to elucidate the schemae that underlie their sadness, guilt, and anxiety. We teach them to test assumptions, and, if we do our job right, we teach them another key of the scientific method—reproducibility. We teach them to apply the same technique to each problem they uncover. We teach them to be impartial and to recognize enduring schemae that allow them to correct inaccurate assumptions about themselves or others. Most patients, in my experience, are reluctant to expose themselves to a frank examination because of the fear that they will come up wanting, that they will validate yet another deficit or incorrigible flaw. Sometimes we talk about the courage to heal. In my mind, “healing,” or resolution, is the part of the process that involves the least amount of courage. What requires most courage is the initial decision to look dispassionately on one’s shortcomings and errors of omission and commission and set a path toward remedying them. This is a lesson that all of us who act as psychotherapists have learned. The techniques of CBT and other therapies can be scientifically developed, reproducibly assessed, and efficiently imparted to patients. But courage cannot be taught, nor can the exercise of will be easily manipulated. So when all is said and done, I suspect that it is our acknowledgement and encouragement of those inner resources, rather than any specific therapeutic technique, that leads to the lasting change we hope our patients will remember us for.

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<https://www.nationalregister.org/eo-desk-sept-2018/>

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On the Ethics of Clinical Data Collection: Are Data Informative or Transformative?

By Morgan T. Sammons, PhD, ABPP
Executive Officer of the National Register of Health Services Psychologists

All psychologists who do third party billing, and particularly those who work with electronic health records, provide, whether they know it or not, a steady stream of patient related data to an unseen army of analysts. Every coded encounter gets swept up and tossed into an analytic mill, where insurers, actuaries, and others chart healthcare engagement, costs, outcomes, and a myriad other factors. Psychologists who work in most healthcare delivery settings, and even independent practitioners, are increasingly bound to the Promethean rock by two adamantine chains: electronic health records and outcomes data. Viewed separately, it is easy to characterize these chains as real fetters that constrain our practices and limit our independence.

But there is the possibility that combining the chains will be transformative, and potentially even turn into a benefit that will assist patients and providers alike.

Insurers and regulators are increasingly concerned about the ability of clinicians to demonstrate positive outcomes. Patients must get better, and preferably quickly, in order for providers to be reimbursed. Unfortunately, despite years of trying, we don't have very robust standardized outcomes measures. One of the most common outcomes measures, and one that is increasingly relied on by planners, is the Patient Health Questionnaire -9, or PHQ-9. Variants of this form exist (there is a PHQ-2, which some say produces outcomes data that are as informative as those from the longer version). Whichever version you choose, it's not very good. It may or may not surprise you to know that the PHQ-9 is based on an earlier assessment tool called the PRIME-MD, which was developed in the 1990s essentially as a helpmeet to pharmaceutical companies to aid the sale of antidepressants in primary care. The copyright on the PHQ-9 is still owned by Pfizer, Inc.

While not all outcomes measures have copyrights by pharmaceutical firms, most are problematic. First, they are not terribly descriptive, and it has long been argued that there is scant incremental validity of a standardized form over the classic "How ya doin'?". Second, some of the better outcomes measures, like the OQ-45, take significant amounts of time to complete and are therefore not widely used clinically,

although they may be robust research tools. Third, few if any of these were devised specifically for psychology.

But the biggest issue with most outcomes questionnaires is that they simply do not capture patient progress in any meaningful way. Scores on instruments may move in a desired direction, but this does not truly describe a patient's trajectory through an episode of care. What is statistically significant is not, often, clinically significant. At some level, clinicians understand this, which creates resistance to compliance with payor mandated submission of standardized outcomes data. An alternative exists, and one that when fully utilized may provide us with a system that better predicts patient wellness but also alleviates the burden on patients and providers of completion of outcomes measures.

Let us, for argument's sake, posit that data are informative, and they are never transformative. The best data answer a question or set of questions with precision and brevity. Utilizing the scientific method, discrete data points accumulate to provide us with new understanding of a problem. "Aha" moments exist, but they occur rarely. In general, the process of discovery is slow, painstaking, and truth be told, rather tedious. Discrete data (information) points accrete gradually. Taken together, such data can be used to transform our understanding of a particular problem, but it is the synthesis, not the individual datum, that creates new understanding, i.e., is transformative.

But now I will argue that an exception to this exists. An *individual* datum will always be informative and not transformative, but *big* data can be transformative. "Big data" in health care refers to data sets that are collected on the basis of interactions with many hundreds of thousands of patients treated by many thousands of clinicians. One of the biggest health data sets that exists is collected by the U.S. military, which tracks the aggregate health care provided to approximately 9 million beneficiaries. Every patient encounter is recorded in this system, every prescription, every procedure, every diagnosis, every test, and every recorded outcome. The VA, large civilian HMOs, and others



also utilize parallel data sets. Electronic health records, like EPIC, that are used by small groups and other healthcare systems, also collect data on many thousands of encounters: data provided by all of us, wittingly or not. These data, in aggregate, can be used to identify factors predictive of positive outcome—factors generally not included in current clinical outcomes measures.

We know that standardized questionnaires do not adequately capture patient progress. We also know that, however effective our interventions are, the amount of time we spend with patients represents to them a vanishingly small part of their lives. The modal number of psychotherapy visits remains stubbornly stuck at 1. The average length of psychotherapy sessions remains at around 8 sessions—not a significant portion of any patient’s life. Our estimates of our abilities to transform patients’ lives are very likely highly inflated. So how do we ultimately measure the outcome of our interventions?



The key is utilization of condition management schemes that rely on the existence of big data sets. Such mechanisms allow us not only to track the progress of a patient through an episode of care but to detect if other factors, perhaps not directly related to that episode of care, have affected a positive or negative outcome. Here is where big data become transformative, because what they reveal as curative factors are often counterintuitive or unexpected. Incorporation of these unexpected factors can lead to algorithms that guide more effective care.

It follows, then, that to use these data sets we have to rethink how we measure progress, not as responses on standardized questionnaires but as separate factors that are predictive of a return to wellness or optimum functionality. Such factors are difficult, if not impossible, to identify without reliance on big data sets, as they may be both theoretically and temporally removed from an evidence-based intervention. Using large data sets to compare the status of

two groups of depressed patients, one that has returned to full functionality and one that remains impaired might, to use a far-fetched example, reveal that the prescription of a multivitamin, rather than any antidepressant or course of psychotherapy, made the difference between stasis and recovery—a serendipitous finding that emerges from the analysis of very large data sets.

Scary? Possibly. These data repositories can be hacked, and while there are significant protections that guard against individual patient data being divulged, breaches and misuses do occur. As a recent, horrible example, the insurer Aetna sent thousands of letters via U.S. mail that identified patients’ HIV status on a see-through envelope window. Other large hospital systems have recently had patient information held hostage by hackers, permanently compromising data in those systems (even the payment of electronic ransoms cannot guarantee that individual patient data might not be divulged in the future).

Psychologists and other healthcare providers have an ethical obligation to ensure that health delivery systems protect privacy. Because of the sensitivity of our work we are held to a higher standard to ensure that patient data are safeguarded from disclosure. We also have an ethical obligation to ensure that large healthcare organizations do not misuse such data, for example, by imposing treatment regimens that do not account for the needs or wishes of individual patients. Rather than focus on these ethical concerns, however, many psychologists have adopted the view that the very existence of these data sets is unethical. But these data sets are a reality, and have been for many years. In this electronic era, it is as pointless to argue against amassing large data sets as it was for King Canute to try and stop the incoming waves a millennium ago. Rather, the better questions are a) how do we protect the confidentiality of these data on both an individual and systems level, and b) what surprises do they hold that might allow us to materially advance the efficacy of our treatments for patients with mental disorders?

November 2017

This article is available at: <https://www.nationalregister.org/from-the-executive-officers-desk-on-the-ethics-of-clinical-data-collection-are-data-informative-or-transformative/>

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Focus On: Continuing Education

The Canadian Register of Health Service Psychologists (CRHSP) has a well-established tradition of offering innovative Continuing Education through workshops offered across Canada. Among the topics have been Evidence-based Practice and Workplace Health as well as Accounting and Taxation Issues in Psychological Service. While CRHSP expects to continue to offer periodic traditional workshops, it is also developing CE products for online delivery.

The following highlights continuing education opportunities with the U.S. National Register of Health Service Psychologists.

The U.S. National Register of Health Service Psychologists

CRHSP's former and long-time editor, Dr. Myles Genest, regularly reported that CRHSP had negotiated an excellent opportunity to participate without charge in the online Continuing Education offered by our U.S. counterpart, the National Register of Health Service Providers in Psychology. As Dr. Genest did then and over many years, CRHSP will continue to highlight some of these offerings in the current and future newsletters.

CRHSP is proud of its ongoing partnership with the U.S. National Register in delivering online continuing education to Canadian Registrants.

Go to the National Register's continuing education website: ce.nationalregister.org/ and log in with your CRHSP Registrant ID and password. From there, you can select from a number of article- and video-based continuing education courses. Once you've passed an exam or watched a video, you can print your certificate of credit for your records.

Watch for upcoming live webinars (see next page)!

Recent webinars included:

Complying with Court Orders and Subpoenas While Minimizing Your Risk (June 2018).

Resilience After Trauma: Evidence-Based Assessment & Intervention (October 2018).

Psychotherapy Relationships that Work; Evidence-Based Therapist Contributions (March 2019)

If you aren't able to make it, webinars are archived.

For more information, please contact CRHSP at info@crhsp.ca or 819-771-1441.



Canadian Register of Health Service Psychologists Partnership with the TeleMental Health Institute

Member Benefit: 30% Discount on TeleMental Health Institute Certificate Program

Telehealth is an increasingly important component of healthcare delivery, and we know from our recent member survey that many of you are interested in this area. We are also aware that the practical concepts, technical aspects, and privacy concerns are significant barriers to psychologists utilizing telehealth to expand their practices.

To promote access to high-quality training, we negotiated a partnership with the TeleMental Health Institute (TMHI) to provide our members with a 30% discount on TMHI's Telepsychology Certificate Program. This partnership is a joint collaboration with our American colleagues at the National Register of Health Service Psychologists.

TMHI is widely recognized as an industry leader in telehealth training. Their internet-based certificate program includes 40 continuing education units* delivered through written, audio, and video coursework to give you:

- A practical overview of successful telepractice models.
- An introduction to evidence-based concepts in theory and practice.
- Reimbursement information.
- Legal and ethical risk management issues that include the basics of licensure across provincial/territorial downstream, intake, assessment, informed consent, documentation and emergency planning to help you comply with the American Psychological Association's 2013 Guidelines for The Practice of Telepsychology.
- Individual and group consultation to help you tailor your professional training to your specific needs.
- Access to a community of more than 2,000 behavioral health professionals worldwide who share your interests.

Access our partner portal at: telehealth.org/canadian-register/ to sign up for the Telepsychology Certificate Program and take advantage of the 30% discount. Visit www.telehealth.org to learn more about TMHI.

We hope you enjoy this new benefit!

PLEASE NOTE: The Canadian Register of Health Service Psychologists is not compensated by the TeleMental Health Institute for our role in this collaboration. As with all of our partnerships, the purpose is to provide Registrants with access to high-quality training opportunities and services, and pass along 100% of the savings.

*TMHI is approved by the American Psychological Association to sponsor continuing education for psychologists. TMHI maintains responsibility for this program and its content.



CRHSP
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