# The Oregon Psychologist

**Bulletin of the Oregon Psychological Association**

March/April 2013 Volume 32, Number 1


## What's Inside



*OPA President's Column*

## Use Your Brain to Make Diversity a Habit

*Julie Nelligan, PhD*

Over the past few years I have found myself having several different conversations with psychologists about diversity. While some colleagues expressed frustration that diversity-related factors were not considered in various situations, others questioned the need for a focus on diversity. These latter colleagues might say, "We all learned about the importance of taking diversity into account in grad school and we have all had experiences where diversity played an important role. So, what's the big deal in focusing on diversity?" To them, diversity seemed like a "no-brainer."

As I mulled this issue over, I realized that diversity is a "no-brainer" the same way ethical decision-making is a "no-brainer." They AREN'T!! It takes mental effort to ask the right questions in order to determine how diversity-related factors are playing a role, just as it takes thoughtfulness and (often) consultation to sort through ethical dilemmas.

Last year a book was released in the popular press titled *The Power of Habits*. In the book, Charles Duhigg explored what habits are, how they are formed, and why they are important. One of the take-home points from the book is that our brains are designed to make shortcuts out of everything because our brains don't like to expend effort. Consider something that took you a long time to learn, like driving a car. At first you put a lot of effort into it. But over time it became easier and easier until eventually, you reach a point where you don't need to think as much about it at all.

Learning and thinking about diversity started out the same way. We spent a lot of effort learning the values and cultures of various groups. Then we learned that groups have subgroups, and within those subgroups we consider an individual's family culture. In practice, we realized that groups intermingle and suddenly the issues of diversity become extremely complex. Learning all this took a lot of effort, but we did it.

Unfortunately, diversity is not like learning to drive. We don't really get to a place where it is an easy "no-brainer." If we treat issues of diversity as "no-brainers" or habitual, we invariably start to make assumptions that trip us up.

Diversity is complex and requires ongoing learning and openness to new or different ways of thinking and behaving. We need to stay vigilant about diversity concerns in much the same way that we need to stay vigilant about our ethics. Just as OPA's Ethics Committee provides education and consultation to OPA members about ethics-related topics, OPA's Diversity Committee works hard to bring diversity-related continuing education speakers and (best of all) provides consultation to OPA members about diversity-related topics. At the conference in Eugene this May, Melba Vasquez, PhD will be talking about Ethical Considerations in a Multicultural World.

*Continued on page 5*

# Farewell from Editor Chyrelle Martin, PsyD

This issue marks Shoshana Kerewsky's debut as the editor of *The Oregon Psychologist*. Shoshana is a past president of the Oregon Psychological Association and previously served on and chaired OPA's Ethics Committee as well as serving as the Director from Lane County Psychologists' Association. She is a perfect example of the kind of dedication to psychology and Oregon psychologists so many on the Board possess. She is also a warm and engaging human being and a wonderful and interesting writer, so I know I am leaving the publication in very capable hands, though I do so with regret.

I have very much enjoyed being editor over the past four years. It has allowed me to meet and work with some amazing psychologists, learn about new ways to practice, and to have a front row seat to the kinds of endeavors the Board undertakes. I still experience a pang (or six) when I realize that time is over, but being a relatively new-career psychologist, I have found it difficult to balance work and home life. I finally realized I need to figure that balance out before I jump back into volunteering with OPA. And I plan to do that in the hopefully not-too-distant future. I worry about the future of psychology and psychologists. Working with OPA helped me to feel I was doing some small part in furthering our profession.

I want to encourage all Oregon psychologists to jump in and volunteer with the Board. You will meet amazing people, have fun, and make a difference. There aren't too many avenues that offer so much opportunity. Hopefully I'll see you in some committee soon!

# Editor's Note

*Shoshana D. Kerewsky, PsyD, HS-BCP, Past President, Editor*

It is my great pleasure to assume the editorship of *The Oregon Psychologist*. I'd like to extend my great appreciation to Chyrelle Martin, PsyD, for her four years as editor. We hope to see her again as an active OPA volunteer in the future. Chyrelle, thank you for your service to OPA.

I'd like to introduce myself as well. As I finish my term as past president of OPA, I wanted to take on a different role in the organization. I am a licensed psychologist and work at University of Oregon as a Senior Lecturer in a career non-tenure line that includes teaching in the Counseling Psychology and Human Services Department and as the academic lead in the Substance Abuse Prevention Program. My professional interests include narrative and solution-focused therapy, professional ethics, diversity, international services and learning, HIV and other health issues, and undergraduate education in the helping professions.

In addition to my work as a psychologist, I am a member and former co-chair of the National Organization for Human Services Ethics Committee and outgoing Board President of Friendship with Cambodia, a Eugene-based non-profit that raises funds for underserved people in Cambodia.

In this issue of *The Oregon Psychologist,* you'll find articles by OPA's board and committee members, OPA members, and our community partners. Several focus on ethics, diversity, or both, which was not deliberate but serendipitous. I hope that you will consider submitting articles as well. Short articles about a variety of psychology topics are welcome. In addition, I'd like to solicit your brief reports on these topics for upcoming issues:

1. This year's Western Psychological Association, APA, or other psychology-related conferences.
2. Your 1-3 paragraph review of DSM-5 (currently scheduled for release on May 22), with a note about the context in which you are reviewing it—as a private practitioner, as an agency or hospital psychotherapist/evaluator/administrator, as a forensic or other specialist, as a student, or in some other role. All I ask is that you actually read DSM-5 before writing your review! If the upcoming release of DSM-5 strikes terror into your heart, OPA is holding a workshop on the DSM-5 on September 27, 2013 featuring Vikki Vandiver, DRPH, MSW. Registration information will be available mid-summer.
3. Brief reviews (with citation) of books, whether professional, for bibliotherapy, or memoirs relevant to psychology. I'll be reviewing *Brain on Fire: My Month of Madness* by Susannah Cahalan in an upcoming issue. Please don't review your own book; contact me if you've published a book and I'll try to find a reviewer.
4. Brief reviews (with citation) of films, as for books.
5. Reports on being a psychologist or psychologist associate in your region. What's happening professionally in your part of the state? What issues do therapists, researchers, evaluators, and clients face in your part of Oregon?

Along with Chyrelle, I want to encourage you to get involved with OPA. There's always something meaningful and satisfying to do.

## OPA Helpful Contacts

The following is contact information for resources commonly used by OPA members.

***OPA Office***
Sandra Fisher, CAE - Executive Director
147 SE 102nd
Portland, OR 97216
503.253.9155 or 800.541.9798
Fax: 503.253.9172
Email: info@opa.org
Website: www.opa.org

***OPA Lobbyist***
Lara Smith - Lobbyist
Smith Government Relations
PO Box 86425
Portland, Oregon 97286
503.477.7230
lsmith@smithgovernmentrelations.com

***Oregon Board of Psychologist Examiners (OBPE)***
3218 Pringle Rd. SE, #130
Salem, OR 97302
503.378.4154
Website: www.obpe.state.or.us

OPA's Legal Counsel*
Paul Cooney - Attorney
4949 Meadow Rd., #460
Lake Oswego, OR 97035
503.607.2700
Fax: 503.607.2702
Email: pcooney@cooneyllc.com

**Through OPA's relationship with Cooney & Crew as general counsel for OPA, members are entitled to one free 30-minute consultation per year, per member. If further consultation or work is needed and you wish to proceed with Cooney & Crew, you will receive their services at discounted rates. When calling, please identify yourself as an OPA member.*

# Dear EC: To Specialize or Not to Specialize—That Is the Question

*OPA Ethics Committee*

***Dear EC:***

*I am a relatively new psychologist and am wondering about the ethical need or appropriateness of becoming board certified versus just practicing under the general state license. What are the important things I should consider?*

*Sincerely,*
*New to the Practice*

***Dear New to the Practice:***

Few people would argue that one needs to be a good psychologist before they are a good forensic psychologist, police psychologist, or industrial/organizational psychologist. There are several core competencies that cut across specialties and represent foundational competencies in psychology (e.g., professionalism and ethical/legal knowledge). Thus, broad-based training and education would seem best suited for the recently licensed/early career psychologist: One modeled after the concept of generalist. However, many areas in psychology are rapidly evolving as a function of accelerated advances in science, technology and the law. This requires that the practitioner remain abreast of the advancing field to practice competently. Bob Dylan once said, "He not busy being born is busy dying." Just like tests that become obsolete or require revision because they rely on outdated technology or language, competence is not static. But competence is an ethical standard (APA, 2002). Standard 2 (Competence) states that "psychologists have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services. . . ." Standard 2 also states that if a psychologist does not possess such competence, they shall gain competence or refer to a psychologist who can provide competent services. This all relates to the general principles of responsibility and nonmaleficence.

Licensure in psychology grew out of efforts to regulate the profession and provide consumer protection. In most jurisdictions, licensure is generic and is obtained through the establishment of one's general psychological education, training and knowledge. Licensure provides assurance that a psychologist is sufficiently knowledgeable to practice psychology in general. This is in contrast to specialty practice, which requires specific knowledge and competence. According to APA and the Council of Specialties (CoS), a specialty is defined as a distinct area of professional practice with a unique combination of competencies aimed to solve specific problems in particular populations. Such practice requires advanced knowledge and skills obtained through an organized training mechanism beyond an accredited broad-based education focusing on general science and practice. The fundamental difference between licensure and board certification relates to the difference between general knowledge and training in psychology, specific knowledge of a specialty, and competence in the practice of that specialty. Some authors have noted that the consuming public and health care organizations are demanding specialized health care information and services as well as accountability (e.g., Drum & Blom, 2001; Rozensky, 2011). This has led to some organizations expecting their doctors to be board certified (Rozensky, 2006). Specialization is considered a means of assuring quality care in the increasingly complex world of health sciences.

Recent research on the half-life of professional knowledge in psychology (i.e., the time it takes, in the absence of new learning, for someone to become roughly half as knowledgeable or competent to practice as a function of the generation of new knowledge in a given field [Neimeyer, Taylor, & Rozensky, 2012)] suggests that the durability of knowledge in

*Continued on page 4*

*Dear EC, continued from page 3*

professional psychology is diminishing. Although the half-life in professional psychology is estimated to be about 9 years (Neimeyer, Taylor, & Rozensky, 2012), the research suggests significant variability in the half-life of knowledge as a function of specialty practice and proficiencies. Generally speaking, a psychologist's competence would be obsolete in less than a decade following graduation or licensure. Importantly, the half-life of knowledge decreases as a function of new knowledge production in a given field. Because of the growing complexity of health science information, and the inability for one to keep up with the growing knowledge across fields to be sufficiently knowledgeable to practice more generally, competence in select areas may be the only alternative.

The American Board of Professional Psychology (ABPP) is the only non-profit professional unitary organization recognized by the profession as certifying specialty practitioners in psychology. ABPP can be differentiated from other certifying boards by their verification of qualifying criteria, examinations of work product, and oral examinations by a panel of peer specialists. ABPP offers a number of reasons to become board certified. Among these are designation as an expert, marketing, and monthly specialty bonuses for psychologists working at the Department of Defense or Public Health Service. Some other health care providers consider board certification a minimum standard for quality patient care and many hospitals asked about board certification when applying for privileges. Some medical facilities require board certification, some academic and medical settings require board certification for promotion and tenure, health insurance companies routinely ask about board certification during application to join their network, and consumers increasingly ask about board certification and can identify board certified psychologists online.

Despite the number of ostensible benefits, there may be some drawbacks. One drawback is the time and energy required to submit to such a rigorous peer review process—time and energy that takes away from family and social life as well as practice and practice development. There are also fees associated with application, examination, and renewal. Finally, it is clear that some of the benefits listed by ABPP do not apply to many of the psychologists in Oregon who practice privately.

Importantly, diminishing competence happens in the absence of new learning and no one is immune to that standard. According to clinical lore, the best predictor of continued competency is continuing education. It appears that to address the shrinkage of knowledge over time and corollary reduction in professional competence, we must look to the current strategies and qualities of our continuing professional education and development. Beyond the 50 hours of general continuing education (including ethics and pain management), Oregon has no requirement for a certain number of continued education units in the psychologist's specific area of practice. The only specialized training required is in areas that are not recognized specialties of practice, but rather foundational to psychology. This does not address the issue of rapidly growing knowledge in the various specialty fields of psychology.

Another source of organized and specialized education is through the various Academies of ABPP, such as the American Academy of Police & Public Safety Psychology (AAPPSP) and American Academy of Forensic Psychology. These entities function as the educational arm of the various specialty boards of ABPP. The mission of the AAPPSP is to contribute to the development and maintenance of Police & Public Safety Psychology as a specialized field of study, research, and practice, and to serve the members, consumers of services, and the public by promoting high standards of professional practice in the field. This mission is achieved through, among other things, comprehensive continuing education programs and forums to disseminate and exchange scientific and scholarly specialty-specific information.

Psychologists can also read journal articles, create study groups to review authoritative texts, and join peer-consultation groups, all in the service of maintaining competence and developing as a professional. The ongoing maintenance of competence is the central issue, especially in the face of rapidly growing information within specialty areas.

*Continued on page 5*

*Dear EC, continued from page 4*

From the beginning, continuing education was designed for the purposes of countering obsolescence of knowledge in the field over time (see Neimeyer & Taylor, 2010 for a review). The rapidly changing practices of professional psychology represent a major challenge to the generation and support of education, training, and continued professional development in our field. Again in the words of Bob Dylan, "The times they are a-changin'" and these changes telegraph a need to redouble efforts in the area of evidence- and competency-based training and continuing education. This requires an enhanced educational infrastructure to ensure adequate continuing development and competence. Beyond graduate training and organized postdoctoral programs and fellowships, the Academies of ABPP appear to be the kind of organizations we can rely on for specialized continuing education.

The most important question may not be whether or not one should specialize, but rather how to establish and maintain competence in your specialty area of practice. Maintaining competence is an ethical standard and relates to the general principles of responsibility and nonmaleficence. The benefits of affiliation (i.e., certification) with an ABPP specialty board in your area of practice probably outweigh the costs. Although the process undoubtedly is time-consuming, the advanced educational model and mechanisms for disseminating information offered through ABPP appear to be a benefit that outweighs the initial drawbacks.



We should all strive to improve the quality of services in our areas of practice. It appears that seeking out focused training from expert psychologists through established organizations providing evidence- and competency-based training and development is the best way to achieve that goal. This does not require board certification, but it will cost more money if you are not affiliated with the specialty board that houses the Academies that provide this level of specialized continuing education. The alternative is to find opportunities that approximate this high level of training (e.g., American Psychology-Law Society conferences, APA Annual Conventions, or the OPA Annual Conference). You can also enroll in selective workshops, locally and nationally. However, the further you get away from the specialty boards, the more varied and generic the training can be. Given the rapidly advancing allied health sciences, and the demands for specialization, we know that without high-quality, specialized continued education, our relevant knowledge and competence dwindles quickly.

## *References*

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

Drum, D. J., & Blom, B. E. (2001). The dynamics of specialization in professional psychology. *Professional Psychology: Research and Practice, 32,* 513–521.

Neimeyer, G. J., & Taylor, J. M. (2010). Continuing education in psychology. In J. C. Norcross, G. R. VandenBos, & D. K. Freedheim (Eds.), *History of Psychotherapy*. Washington, DC: American Psychological Association.

Neimeyer, G. J., Taylor, J. M., & Rozensky, R. H. (2012). The diminishing durability of knowledge in professional psychology: A Delphi poll of specialties and proficiencies. *Professional Psychology: Research and Practice, 43,* 364-371.

Rozensky, R. H. (2011). The institution of the institutional practice of psychology: Health care reform and psychology's future workforce. *American Psychologist, 66,* 797–808.

Rozensky, R. H. (2006). An introduction to psychologists treating medically ill patients: Competent practice and seeking credentials in organized health care settings for routine or incidental practice. *Professional Psychology: Research and Practice, 37,* 260–263.

*President's Column, continued from page 1*

I encourage you to continue thinking about diversity as you practice. Attend workshops and trainings, even if you think they don't apply to you. You never know when it might apply to you and your patients. Consult the Diversity Committee when you have questions. You'll be glad you did.

Until next time,
*Julie*

# OPA Colleague Assistance Committee Mentor Program Is Now Available

On March 8th, OPA's Colleague Assistance Committee (CAC) held their first Mentor Training with guests Paul Cooney, JD, OPA's counsel, and Karen Berry, JD, the investigator for the Oregon Board of Psychologist Examiners. The CAC now has a subcommittee of nine mentors who can provide support to OPA members in the throes of a licensing board complaint. The goals of the Mentor Program are to assist Oregon psychologists in understanding the OBPE complaint process, reduce the stress-related risk factors and stigmatization that often accompany the complaint process, and provide referrals and support to members without advising or taking specific action within the actual complaint. The subcommittee falls under peer review committee rules, which exempt these mentor activities from the health professional reporting law. Members interested in being matched with a mentor should contact any member of the Colleague Assistance Committee. CAC members are listed at the end of this article.

In addition to the Mentor Program, members of the Colleague Assistance Committee are available for consultation and support, as well as to offer referral resources for psychologists around maintaining wellness, managing personal or professional stress, and avoiding burnout or professional impairment. The CAC is a peer review committee as well, and is exempt from the health care professional reporting law. The CAC maintains a Provider Panel of psychologists, nominated in writing by their peers as psychologists who are qualified to treat other psychologists, and then screened by the OPA Colleague Assistance Committee as psychologists with both interest and specializations related to working with other psychologists. Contact information for members of the CAC and the Provider Panel are always listed on the Colleague Assistance Program section of the OPA website.

**Colleague Assistance Committee**
Nancy Taylor Kemp, PhD, Chair
541.349.1167
Jonathan Lurie, PhD
503.261.1850
Kate Leonard, PhD
503.292.9873
Rebecca Martin-Gerhards, EdD
503.243.2900
Lori Queen, PhD
503.639.6843
Marcia Wood, PhD
503.248.4511
Chris Wilson, PsyD
503.887.9663

**CAC Provider Panel**
Barbara K. Campbell, PhD, 503.221.7074
Michaele Dunlap, PsyD, 503.227.2027 ext. 10
Debra L. Jackson, PhD, 541.465.1885
Kate Leonard, PhD, 503.292.9873
Doug McClure, PsyD, 503.697.1800
Lori Queen, PhD, 503.639.6843
Ed Versteeg, PsyD, 503.684.6205
Beth Westbrook, PsyD, 503.222.4031
Marcia Wood, PhD, 503.248.4511

# Welcome New and Returning Members

**Roberta Ballard, PhD**
Beaverton, OR

**Marion David, PhD**
Beaverton, OR

**Carolyn Ferreira, MS**
Orem, UT

**Jaelithe Formway-Nelson**
Wilsonville, OR

**Sandra Gonzalez, PsyD**
Portland, OR

**Shirley Johnson, LCSW**
Medford, OR

**Paul Knackstedt, MS**
Portland, OR

**Eugene Kranz, PhD**
Bend, OR

**Koreana Mangan, PsyD**
Portland, OR

**Kristen McClard, PsyD**
Portland, OR

**Brittany Neighbours, BA**
Portland, OR

**Jeffrey Schloemer, PsyD**
Newberg, OR

**Ryan Scott, PhD**
Eugene, OR

**Tara Sharifan**
Portland, OR

**Stuart Silberman, PsyD**
Springfield, OR

**Marc Stuckey, PsyD**
Hillsboro, OR

**Kimberly Swanson, PhD**
Redmond, OR

**Jessica Tolleson, BS**
Portland, OR

**Brittany Ward, PhD**
Medford, OR

**Justine Williams, PsyD**
Salem, OR

Oregon Psychological Association

# The HIPAA "Mega Rule"

*Professional Affairs Committee*

Further modifications and updates to the Health Information Portability and Accountability Act (HIPAA) Privacy, Security, and Enforcement rules have been implemented and are effective as of March 26, 2013. This final HIPAA rule has been referred to as the "Mega Rule" at times.

Based on information from the Office of the Federal Register,

> [T]he final rule is needed to strengthen and expand the privacy and security protections for individuals' health information and privacy rights established under the HIPAA, as mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act and Genetic Information Nondiscrimination Act (GINA). These enhancements are necessary to ensure continued adequate protections for health information, as well as trust in the health care system, particularly as the adoption and use of electronic health records increases.

Importantly, among other changes, the rule makes business associates of covered entities directly liable for federal penalties for failures to comply with certain provisions of the rule.

> The final rule also lays out standards for when individuals and the Secretary must be informed that a breach of protected health information has occurred so that individuals may take measures to protect themselves from risks associated with the breach.

The government expects that clarifying the requirements for notifying individuals of breaches of PHI and making business associates directly liable for compliance with certain provisions of HIPAA will cause the number of breaches of PHI to decline over time.

According to the Office of the Federal Register,

> this final rule also makes changes to the HIPAA rules, such as those that streamline the research authorization process, that are designed to increase flexibility for, and decrease the burden on, the regulated entities, as well as to harmonize certain requirements with those under the Human Subjects Protections regulations.

The modifications in this final HIPAA rule may impact you as a psychologist, depending on the type of services you provide. Many of the amendments do not significantly alter the previous HIPAA Privacy and Security rules, with which psychologists are expected to be in compliance. However, if you are directly responsible for drafting contracts with business associates who have access to your clients' PHI, then the change in responsibility of and liability for business associates may impact your contracts with such associates. If you are involved in conducting research that uses PHI, then the change in the authorization process may streamline your consent procedures and forms. Additionally, the changes implemented by this final rule may also require a revision of your Notice of Privacy Practices (NPP), including the addition of a statement that "most uses and disclosures of psychotherapy notes require an authorization."

The full text of the HIPAA revisions can be found at www.federalregister.gov/articles/2013/01/25 under the Health and Human Services Department category. This summary information is not a legal interpretation of the revised HIPAA rule or the implications for your practice as a psychologist. Consult your attorney for further legal implications as needed.

# Cultural Competence and Oregon's Health Care Providers

*Fabiana Wallis, PhD, OPA Diversity Committee Member and Past Chair, OHA Cultural Competence Continuing Education Committee Co-Chair*

I was excited when Tricia Tillman, MPH, Director Office of Equity and Inclusion, Oregon Health Authority (OHA), first announced in 2010 that legislation was going to be introduced requiring cultural competence CEUs for all health care professionals in the state. I immediately went to speak to her: If there is going to be a requirement, I wanted to get involved to support the availability of quality trainings.

The bill originally proposed that 18 health care licensing boards require cultural and linguistic competency training as part of providers' continuing education. After substantial amendments, the bill was passed in the House in 2011 but failed in the Senate. The amended bill provided a definition for cultural and linguistic competence and in section 2, it also directed to adopt these definitions, to develop standards for cultural competency trainings, to develop and/or identify existing trainings that meet the standards, and explore implementation issues with multiple licensing boards. OHA convened the Cultural Competency Continuing Education Committee (CCCEC) in order to work on the above-mentioned items in section 2 of the bill. I was elected co-chair of that committee and the complete report the committee produced is available at www.oregon.gov/oha/oei/pages/cultural-competency-education-committee.aspx. The current bill (HB 2611 or SB 530) reflects many of the committee's recommendations below. This report is intended as an evolving document, so your input is welcome! A summary of the recommendations from the committee is transcribed below.

**Recommendations to the Oregon Health Authority**

1. Adopt and apply standards for cultural competency continuing education
2. Require cultural competence training for agency staff and contractors
3. Support curriculum development
4. Develop centralized website with training registry
5. Provide funding to support implementation of cultural competency continuing education for re-licensure
6. Staff standing Cultural Competence Continuing Education Committee

**Recommendations to Oregon's Health Professional Licensing Boards**

1. Adopt and apply standards for cultural competency continuing education
2. Include cultural competency in ethics requirements
3. Encourage licensees to pursue cultural competence continuing education opportunities and, if interested, a mandate for all licensees, and monitor engagement
4. Make infrastructure changes to monitor licensee engagement in cultural competence
5. Encourage entities to leverage funds to support licensing boards in implementing cultural competence continuing education and the development of trainings

**Recommendations to Coordinated Care Organizations**

1. Adopt and apply standards for cultural competency continuing education
2. Require cultural competence training
3. Encourage funding to develop continuing education options

**Recommendations for Trainers and Developers of Continuing Education for Health Care Professionals**

1. Apply the recommended standards for cultural competency continuing education when developing trainings and embed into currently available trainings.

*Continued on page 10*

## CCCEC'S CULTURAL COMPETENCE TRAINING STANDARDS

| | | |
|---|---|---|
| Awareness | Essential | 1. Provider is mindful of cultural factors that may influence own and patient's behaviors<br>2. Foster a non-judgmental and respectful environment during the health encounter<br>3. Provider understands relationship between cultural competence and ethics |
| | Advanced | 4. Explore concepts of power, privilege and oppression across personal identities<br>5. Provider is proactive in eliminating barriers<br>6. Provider has opportunity to articulate the commitment to equal quality of care |
| Knowledge (Provider) | Essential | 1. Understanding of cultural competence as a developmental process and not an endpoint and includes lifespan perspective from pre-natal to end of life across diverse experiences<br>2. Knowledge of legal, regulatory and accreditation issues of diversity and linguistic issues and your own professional standards regarding cultural competence<br>3. Knowledge of health disparities and social determinants of health |
| | Advanced | 4. Knowledge of meaning of culture, and culture of health care<br>5. Knowledge of a wellness model of health<br>6. Knowledge of ethnocentrism, micro-aggressions, identity, privilege, power, oppression, assumptions and bias as it applies to vulnerable populations<br>7. Knowledge of the limits of cross-language communication and cross-cultural variation in verbal and non-verbal communication<br>8. Knowledge of medical pluralism or integration of traditional and biomedical<br>9. Knowledge of local and national demographics, including local and state history of minority communities<br>10. Knowledge of trauma-informed care principles<br>11. Knowledge of epidemiology and within-group variance, including population specific diseases<br>12. Knowledge of genome research and ethnopharmacology |
| Knowledge (Trainer) | Essential | 1. Trainings include facilitated learning processes<br>2. Trainer skills are not degree dependent, but attitude, knowledge and skill dependent<br>3. Trainings create a spirit of collaboration and inclusion<br>4. Trainings must provide a broad and inclusive definition of diversity, even if it will focus on a specific population<br>5. Trainings are evaluated to assess impact on participants and efficacy of trainers |
| | Advanced | 6. Trainers elicit information from target audience to assess provider's existing knowledge and strengths and tailor trainings to meet provider needs<br>7. Trainers obtain informed consent from participants (e.g., strong emotions that may be elicited, plan to respond to adverse outcomes, offer follow-up)<br>8. Trainings should be offered in a wide range of options utilizing multiple education modalities, including case studies<br>9. Trainings are best accomplished by an interdisciplinary, multi-cultural team<br>10. Training style and methodology reflect the principles of privilege, power, oppression and bias and the guiding principles of cultural competency outlined in this document<br>11. Trainings offer follow-up through coaching, supervision, mentorship and/or consultation |
| Skills | Essential | 1. How to collaborate with patients in making health care decisions<br>2. How to develop and/or utilize communication tools and assessment strategies, e.g., patient- and family-centered communication<br>3. How to collect and utilize data to inform clinical practice related to health equity<br>4. How to collaborate effectively with community, providers and other types of healers<br>5. How to access self-assessment tools<br>6. How to access multiple formats of education (including translated, audio, and visual materials) in order to effectively communicate with patients |
| | Advanced | 7. How to adequately use interpreter services, when needed<br>8. How to assess own biases or preconceptions<br>9. How to assess receptivity to knowledge and literacy level of patients<br>10. How to assess own empathic attunement<br>11. How to effectively advocate for cultural competence within own professional setting<br>12. How to adequately intervene if witnessing culturally-insensitive or oppressive behavior<br>13. How to access and interact with diverse local communities<br>14. How to assess own language skills and proficiency |

*Cultural Competence continued from page 8*

In addition, the committee recommends the development of a definition and standards for ***organizational* cultural competence** given that the literature contains many existing standards that are applicable to the systems in which individual providers work.

The standards were organized into 3 domains: Awareness, knowledge, and skills, according to the most widely used model for understanding, training, and researching cultural competence (Sue et al., 1992). For the purposes of training standards, the knowledge domain was divided in two: knowledge for providers and for trainers, thus creating a total of four sets of standards. Please see the table on page 9.

Standards marked **essential** indicate the standards that trainings must meet to receive approval. The criteria for selecting essential standards included (1) topics that apply across all health disciplines and (2) topics that can be reasonably included in brief trainings (e.g., 1- or 2-hour continuing education credits). Standards marked **advanced** serve to provide additional guidance for the development of cultural competence continuing education options. The criteria for selecting advanced standards included (1) more specialized topics (e.g., profession-specific or population-specific, such as the use of interpreters) and (2) topics that while also considered essential cannot be adequately covered during brief trainings (e.g., self-awareness regarding power and privilege). The standards reflect both linguistic and cultural competencies.

**Please stay tuned** for the next installment on interpersonal neurobiology and evidence-based treatments that support cultural competence.

### *References*

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64-88.

## OPA Attorney Member Benefits

Through OPA's relationship with Cooney & Crew as general counsel for OPA, members are entitled to one free 30-minute consultation per year. If further consultation or work is needed and you wish to proceed with Cooney & Crew, you will receive their services at the discounted OPA member rate. Please call for rate information. Cooney & Crew are available to advise on OBPE complaints, malpractice lawsuits, practice management issues (subpoenas, testimony, informed consent documents, etc.), business formation and office sharing, and general legal advice. To access this valuable member benefit, call Cooney & Crew at 503.607.2700, ask for Paul Cooney and identify yourself as an OPA member.

OPA members can also benefit from Cooney's legal wisdom by visiting the Members Only section of the OPA website, www.opa.org. Under the legal program button on the member's only page of the site, you can access various email listserve postings from Cooney through "Cooney's Corner." Most of this information comes from the OPA general membership email listserve program and has not been edited. Topics covered include subpoenas, patient access to records, abuse reporting, record keeping and retention, liability insurance, etc.

# Ethical Webs: Multiple Relationships and Practicum Training Sites

*Nathan W. Engle, Jeffrey A. Schloemer, and Bethany Webb, OPA Student Committee Members*

University campuses overflow with complex stories of individuals navigating the next chapter of life. My graduate practicum site involves a psychological treatment center and career counseling center providing multiple ways to engage the college population. While these multiple ways are helpful for my training and offer many resources to the students, ethical boundaries can be quickly tested as relationships are confounded by out-of-office encounters. It's not just university campuses that have the risk of multiple relationships and out-of-office encounters. Psychologists run the risk of running into clients regardless of their setting or community. Multiple relationships always challenge the appropriate boundaries but may also provide opportunities for modeling relationship formation.

Recently, I experienced the multiple relationship dynamics our ethics courses routinely warn against when I encountered a therapy client in a way I had not anticipated. I frequently see clients as I trek across campus from the counseling center to the library, or jog near the campus. However, it seemed that with these experiences I had been able to quickly acquire a sleek shroud of "normal person's camouflage" to blend in with the public. Since I have a practicum placement in both the University Health and Counseling Center as well as Career Services, I suppose it may have been expectable to experience confusing relationships boundaries.

As I browsed my calendar of appointments in the Career Services office, I was startled when I recognized a name on the list of students scheduled to meet with me. A client who had received therapy from me several weeks prior now wanted me to assist her in developing a networking plan to find an internship. Dozens of ethical quandaries streamed through my now-hypervigilant conscience. *Can I tell my Career Services supervisor? That would be breaching confidentiality, right? Should I email the student and suggest the option to see a different Career Counselor? Maybe, but that might communicate that I don't care to see her? Should I conveniently be "out-for-lunch"? Well, at 9 a.m. that may be suspicious and unethical in a whole other sense. Maybe she won't recognize me.*

Multiple relationships like these can occur in almost any profession but can be nearly overwhelming at clinical training sites such as college career or counseling centers. Direct from the APA Code (American Psychological Association, 2012), psychologists are charged with maintaining ideal objectivity, competence, and effectiveness when challenged by multiple relationships, not to mention refraining from risking the exploitation or harm to the client in any way and holding in highest regard the professional care of the client's well-being.

Very few dare argue with such admirable goals but, for graduate students who assume complex roles for the sake of training, avoiding multiple relationships may seem a bit daunting if not virtually impossible. Graduate students may be an instructor, counselor, advisor, researcher, or may simply live in close proximity with the served population. While multiple relationships may be unavoidable, several key concepts can help guide graduate trainees through the web of multiple relationships.

A recent article in *Ethics & Behavior* (Dallesasse, 2010) offers these key concepts specifically for graduate students who find themselves in ethical dilemmas:

1. *Is entering into a relationship in addition to the professional one necessary, or should it be avoided?* Basically, is the relationship unavoidable or could small changes help reduce the unnecessary risks? Never overlook the awareness that can be found in supervisor consultation.

*Continued on page 12*

*Ethical Webs, continued from page 11*

2. *Can the multiple relationship potentially cause harm to the undergraduate student?* Consider the therapeutic progress or underlying life scenarios of the client that may make a multiple relationship confusing or harmful to the client.

3. *If harm seems unlikely or avoidable, would the additional relationship prove beneficial?* This may seem like an unethical suggestion yet it can be a valuable approach. Consulting a supervisor to help shape the direction and assess risks of multiple relationships will guard against creating risky scenarios with multiple relationships.

4. *Is there a risk that the multiple relationship could disrupt the therapeutic relationship?* Again, would an additional relationship with a client disturb the treatment or therapeutic collaboration?

5. *Can the graduate [student] evaluate the matter objectively?* This guidance aligns directly with the APA Ethics Code and points out the importance of maintaining professional objectivity as multiple relationships are conceptualized.

If a conclusion can be drawn about how to navigate through inevitably confusing relationships, it is to keep in mind some of the core values graduate students are taught to implement in all training areas: Consult supervisors, maintain ethical standards, hold the client in high regard, avoiding harm. Not all multiple relationships can be avoided and, perhaps, should not be avoided, but the responsibility to avoid exploitative or harmful relationships remains a pervasive theme. As graduate students and other professionals risk journeying through ethical webs, it is valuable to model ethics in any professional relationship and think twice before wandering through the potential web of a multiple relationship.

### *References*

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

Dallesasse, S. L. (2010). Managing nonsexual multiple relationships in university counseling centers: Recommendations for graduate assistants and practicum students. *Ethics & Behavior, 20*(6), 419-428. doi: 10.1080/10508422.2010.521440

# APA Council of Representatives Report

*Teri Strong, PhD, APA Council Representative*

At the February 2013 meeting of the APA Council of Representatives, held in Washington, D.C., a number of actions were taken that will have an impact on Oregon psychologists. Highlights include the role of psychology in the new healthcare system, expanded pre-doctoral internship opportunities, and proposed changes in the governance structure of APA.

Norman Anderson, CEO, provided an overview of the newly formed APA Center for Psychology and Health. The stated mission of the Center is to oversee and facilitate the organization-wide effort to support APA's strategic goal to "Expand Psychology's Role in Advancing Health." The four areas of focus for the Center are education and training, advocacy, public education and outreach, and member communications. You can find more information on the Center on APA's website at www.apa.org/news/press/releases/2013/01/psychology-health.aspx.

An update was provided on the first phase of the internship stimulus program funded by the APA. The goal of the program is to increase the number of accredited internships and support the overall quality of graduate training. During the first phase of the program in 2012, 82 applicants sought funding and $593,000 was distributed to 32 programs.

Council continued work on the Good Governance Project, which was initiated in January 2011 as part of APA's Strategic Plan. The goal of the project is to "[assure] APA's governance practices, processes and structures are optimized and aligned with what is needed to thrive in a rapidly changing and increasingly complex environment." More information on the Good Governance Project can be found at www.apa.org/about/governance/good-governance/index.aspx.

The following additional actions were taken by Council:

- Approved the Guidelines for Prevention in Psychology as APA policy. The guidelines will be submitted for consideration for publication in *The American Psychologist* and will be posted on the APA website.
- Approved continued funding for the APA/ASPPB/APAIT Joint Task Force for the Development of Telepsychology.
- Approved APA's endorsement of the document *Structure and Function of an Interdisciplinary Team for Persons with Acquired Brain Injury*. The document was authored by a joint committee on interprofessional relations drawn from the American Speech-Language-Hearing Association and APA Division 40 (Clinical Neuropsychology). A draft of the document can be access via the earlier call for comments at www.apa.org/pubs/newsletters/access/2012/06-26/call-for-comments.aspx.
- Approved APA endorsement of the report *Core Competencies for Interprofessional Collaborative Practice*. This report was written by the Interprofessional Education Collaborative (IPEC) consisting of the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools of Public Health. IPEC was created by the Federation of Association of Schools of the Health Professions, of which APA is now a liaison member. The report can be accessed through the earlier call for comment at www.apa.org/pubs/newsletters/access/2012/09-25/core-competencies.aspx.
- Approved inviting each of the seven regional psychological associations to send an observer to future Council meetings. Funding for travel to council meetings would be the responsibility of the regional associations.

As your representative to the APA Council, I welcome your input on these or any other issues. Please feel free to contact me at tstrong@cascadehealth.org or call 541.343.6496.

## Check Us Out!

Now you can find diversity information and resources on the OPA website! The OPA Diversity Committee has been working hard to make this happen. You can also learn more about the OPA Diversity Committee and our mission on this site. So go ahead and check us out online.

- Go to the OPA members only page and click on ***"Diversity"*** at www.opa.org.

We hope the Diversity Committee's webpage is helpful to OPA members and community members in our mission to serve Oregon's diverse communities.

Oregon Psychological Association

# Oregon Psychological Association

Register Today

# 2013 Annual Conference

**May 10 – 11, 2013**

*OREGON CONVENTION CENTER — PORTLAND, OR*

## *FRIDAY, MAY 10*

| | |
|---|---|
| 8:00 – 8:45 am | Continental Breakfast with Tabletop Exhibits |
| 8:45 – 9:00 am | Welcome & Opening Remarks by Conference Chair Eleanor Gil-Kashiwabara, PsyD |
| 9:00 am – Noon | General Session – Ethical Considerations in a Multicultural World |
| Noon – 1:30 pm | Lunch & Awards Presentations |
| 1:30 – 3:00 pm | Breakout Sessions A (Please choose one)<br>A1. OBPE Town Hall<br>A2. Oregon Healthcare Reform 2013 Updates<br>A3. Rewards & Challenges: Psychologists' Work with Traumatic Brain Injury Survivors |
| 3:00 – 3:15 pm | Break with Tabletop Exhibits |
| 3:15 – 4:45 pm | Breakout Sessions B (Please choose one)<br>B1. Living Under the Shadow of Reproach: Bursting the Myth<br>B2. The Relationship Between Internalized Homophobia and Gender Roles in Gay Men<br>B3. Biofeedback in the Treatment of Chronic Pain: Clinical Applications and Case Studies |
| 5:00 – 7:00 pm | OPA Reception |

## *SATURDAY, MAY 11*

**– Student Saturday! –**

**OPA gives a special welcome to students to conference participation this day!**

| | |
|---|---|
| 8:00 – 8:30 am | Continental Breakfast with Tabletop Exhibits |
| 8:30 – 10:00 am | General Session - Redesigning Primary Care: The Mental Health Clinic of the Future |
| 10:00 – 10:30 am | Break with Tabletop Exhibits |
| 10:30 am – Noon | Breakout Sessions C (Please choose one)<br>C1. What Makes Us Unique: Poster Session and Discussion of the Scope of Practice of Psychologists in Oregon<br>C2. Emotion-Focused Therapy for Depression<br>C3. Anticipating and Preventing Licensing Board Complaints: Ethical, Legal, and Risk Management Consideration |
| Noon – 1:30 pm | Lunch & Awards Presentations |
| 1:30 – 3:00 pm | Breakout Sessions D (Please choose one)<br>D1. Using Ethical Decision-Making Models in Addressing Ethical Dilemmas: A Process Approach<br>D2. Detecting Deception in Psychological Evaluations<br>D3. Recommendations from the Oregon Commission on Autism Spectrum Disorder and Implications for Psychologists |
| 3:00 – 3:30 pm | Break with Tabletop Exhibits |
| 3:30 – 5:00 pm | Breakout Sessions E (Please choose one)<br>E1. Recognizing Tiny Tigers: Therapy for Reactive Attachment Disorder<br>E2. Working with Transgender and Gender Non-Conforming Children, Adolescents, and Their Families<br>E3. Video Games and Internet Use: Where is the Balance? |
| 5:00 pm | Conference Concludes |

**Conference schedule, topics and speakers subject to change*

*Register today at www.opa.org or call OPA for a conference brochure at 503.253.9155 or 800.541.9798*

# OPA 2013 Annual Conference Pop Quiz

*Eleanor Gil-Kashiwabara, PsyD, OPA President-Elect*

When asked recently about the favorite part of her day at school, my 7-year-old daughter replied that she loves spelling because they sometimes have "pop quizzes." That got me thinking, "Why not a pop quiz in the newsletter for folks to test their knowledge about the upcoming 2013 OPA Conference?" It has been ages since most of us have had a pop quiz.... The best part is that there is no penalty on this one for not knowing some of the answers. But hopefully taking this quiz will make you want to register if you haven't already done so! See you in May at the Conference!

**1. Our Keynote Speaker on Friday, May 10th is:**
- a. a former APA President
- b. the first Latina and woman of color to serve as APA President
- c. a Fellow of ten Divisions of APA
- d. awesome
- e. all of the above

The answer is **e,** all of the above. Our Friday keynote, Dr. Melba Vasquez, is indeed an accomplished professional. Over the many successful years of her distinguished career, she has been a strong leader in feminism, multiculturalism, and social justice. Her presentation is titled *Ethical Considerations in a Multicultural World* and will include the ethical imperatives that underlie the importance of multicultural competence in psychotherapy with members of racial/ethnic minority groups, including immigrant and international groups. Her presentation is highly relevant for Oregon psychologists—and you will also get ethics CEs as well.

**2. Our keynote speakers on Saturday morning, March 11th are a dynamo pair. Who are they?**
- a. Brangelina
- b. Drs. Shahana Koslofsky and Shoshana Kerewsky
- c. Drs. Robin Henderson and Benjamin Miller
- d. Ben & Jerry
- e. Mary Church Terrell and Medgar Evers

The answer is **c.** Our super-knowledgeable speakers, Drs. Henderson and Miller, will discuss the problem of healthcare fragmentation, and how models of integrating behavioral health services into primary care settings can combat fragmentation. Their presentation will tackle the clinical, operational, financial, and training aspects of integrated care and propose real-time ways psychologists can become more involved. Incidentally, Dr. Henderson has worked tirelessly on many legislative efforts impacting professional psychology. In fact, she was an invited speaker at this year's APA State Leadership Conference! A local rock star indeed!

**3. Which OPA Committee is providing a special presentation as part of a breakout session?**
- a. the Ethics Committee
- b. the Colleague Assistance Committee
- c. the Conference Committee
- d. a and b
- e. none of the above

The answer is **d.** The Ethics and Colleague Assistance committees are conducting relevant presentations on ethical decision-making models and self-care respectively. There is also a presentation by two members of the Diversity Committee focused on the relationship between internalized homophobia and gender roles in gay men. OPA's committees work hard to bring excellent programming to OPA members and conference attendees during the annual conference. Come check out these excellent contributions.

**4. Recommendations will be shared from which Oregon Commission as part of a Saturday afternoon breakout session?**
- a. Oregon Health Services Commission
- b. Oregon Commission on Autism Spectrum Disorders
- c. Oregon Criminal Justice Commission
- d. Public Commission on the Oregon Legislature
- e. none of the above

The answer is **b.** We are fortunate to be hearing from two experts in the field of autism, Dr. Darryn Sikora and Jean Rystrom. Their presentation will summarize the work of the Oregon Commission on Autism Spectrum Disorder (OCASD) with emphasis on recommendations regarding screening and identification (diagnosis). You will not want to miss this informative presentation, or their article in this edition of the newsletter.

**5. What other topic will be addressed in the OPA 2013 Conference?**
- a. biofeedback in the treatment of chronic pain
- b. detecting deception in psychological evaluations
- c. therapy for reactive attachment disorder
- d. emotion-focused therapy for depression
- e. all of the above

You guessed it, Smarty. The answer is **e**, all of the above. These interesting and timely topics will be covered as well as much more, including a session on video games and Internet use as well as anticipating and preventing licensing board complaints, presented by our own Paul Cooney, JD and Eric M. Johnson, PhD. What more can we say?

**6. What fun event will you not want to miss at the 2013 OPA Conference?**
- a. the Friday lunch and awards presentation
- b. the Friday evening reception
- c. the Saturday student poster session
- d. the Saturday lunch and awards presentation
- e. all of the above

The answer is **e.** So much fun to be had!

Thank you for taking this pop quiz! I hope I have successfully convinced you to register for the conference, or at least to strongly consider it. In addition to all that has been covered in this pop quiz, our conference is a time to network with fellow psychologists and learn about all of the things that OPA is doing on behalf of Oregon psychology and psychologists. See you in Eugene!

# Ethical Considerations for Psychologists in Community College Settings

*Karen N. Paez, PhD, OPA Director*

The community college system is founded on the tenets of open and equitable access to remedial and higher education. As such, community colleges attract a population of learners who reflect the general community in regard to age, ethnicity, gender, sexual orientation, socioeconomic status, disability, indigenous heritage, and national origin. This diversity, complemented by an emphasis on developmental learning, comprehensive and accessible support services for students, and smaller class sizes makes the community college an attractive setting for psychologists seeking full- or part-time work as instructors, counselors, academic advisors, career support professionals, administrators, and much more.

The community college's emphasis on a holistic approach to education results in value for college personnel to work collaboratively and take on multiple roles so that students can develop ongoing supportive relationships with faculty and staff. Given the incredible barriers that many community college students face, these substantive relationships with college personnel serve as protective factors that encourage successful completion of the student's academic goals. While this holistic framework is a nice complement to the psychologist's training, it also beckons for a review of a number of ethical considerations.

### *Clarify Your Role*

When a student enters a community college, s/he has most likely developed expectations of the role of the psychologist with whom s/he comes in contact. The way psychologists' roles are defined within the community college setting may or may not resemble those expectations. For example, a student unfamiliar with the boundaries of the psychotherapeutic relationship may be unaware that her psychology instructor, who is in an evaluative role, cannot also serve as her therapist. It is imperative for psychologists to define their roles up front to clarify the boundaries, limits, and opportunities that exist within the relationship. Failure to clarify the relationship can result in breaches of trust, boundary crossings, or missed opportunities to best support the student.

### *Be Clear about What Is and Is Not Confidential*

Clarifying the relationship also serves an important role when it comes to confidentiality. If roles are not clarified and limits to confidentiality explicitly defined before the relationship begins, the student may assume confidentiality when the institution may not.

Unless a psychologist is operating in the primary role of mental health provider, Federal privacy laws governing higher education (i.e., Family Educational Rights and Privacy Act [FERPA]) include a "need to know" clause that allows college personnel to communicate about students in order to serve the needs of the student and campus community. Many students enter a relationship with a psychologist (operating outside of the role of mental health professional) assuming privacy exists within the relationship. However, this may not be the case given the policies of the college and the local, state, and federal law (e.g., mandated reporting or college policies requiring faculty to report concerning student behavior).

### *Conflicts between Ethics, Law, and College Policy*

Psychologists are faced with operating under the legal and ethical guidelines for the practice of psychology in addition to college policy/guidelines. There may be instances where college policy conflicts with professional legal and ethical guidelines. In these instances, the psychologist must address the conflict head on, gathering information on best practices, educating colleagues and administrators on applicable ethics and laws, and working conjointly to address the conflict. In order to address potential conflicts, the psychologist must first identify: (1) the role of the psychologist and nature of the relationship (as clarified with the student at the outset and as informed by the psychologist's job description and departmental policies/practices), (2) the student's understanding of the limits to confidentiality (also clarified with the student at the outset), (3) the applicable laws and ethics, and (4) the college policies or interventions designed to support the student and community. Often this conflict is a result of misinformation or misunderstanding. It may be prevented by having a dialogue with college personnel that mirrors the steps listed above.

Psychologists within the community college system have a great opportunity to serve the needs of the community and can provide a type of service that honors each individual student's diverse needs and strengths. With that opportunity exists the responsibility of integrating legal and ethical practices into work within this educational system. There are many payoffs to being informed of the professional ethics and dilemmas for psychologists working within the community college setting, and addressing any conflicts in a proactive and communicative manner.

# Improving the Autism Identification Process

*Dr. Darryn Sikora and Jean Rystrom, Oregon Commission on Autism Spectrum Disorder*

According to local, regional, and even national media outlets, not to mention support and advocacy groups, Oregon has one of the highest rates of autism spectrum disorder (ASD) in the country. Based on special education census data, approximately 1 in 70 students receiving a public education in Oregon have an ASD. More and more families are seeking services from psychologists and other mental health professionals after being told by the school that their child has ASD. Often, after working with these children for weeks or even months, concerns for the accuracy of the presumed diagnosis arise. Psychologists may complete their own evaluations or make referrals to hospital-based autism diagnostic clinics in an attempt to clarify the diagnosis. All too frequently, a special education eligibility of ASD does not equal a diagnosis of ASD.

How does this happen? In all 50 states, ASD is both a mental health diagnosis and a special educational eligibility category. However, in most states a mental health diagnosis is needed in order to receive a special educational eligibility. Not so in Oregon. Children in Oregon can receive a special education eligibility of ASD without ever having a diagnostic evaluation. The disconnect starts with eligibility criteria in education that do not match DSM criteria, and continues with processes of identification that differ across settings. Parents generally do not have sufficient knowledge to understand these differences, and can be caught in the middle when they are told "autism" in one setting and "not autism" in the other. Standardizing the identification process based on a single set of criteria is the key to providing these families with the most accurate information possible.

Even within health care there can be considerable variation in the diagnostic process. ASD can be legally diagnosed in Oregon by both physicians and psychologists in hospitals, clinics, and private practice offices; sometimes by a team and sometimes by an individual clinician; sometimes by clinician(s) who are highly specialized; and sometimes by those who may only see a handful of patients with ASD each year. Such variability can also lead to inaccuracies in the diagnostic process where parents and children are again caught in the middle. The American Academy of Pediatrics and the American Association for Child Neurology have published guidelines and parameters for diagnosis ASD. Both institutions recommend interdisciplinary team evaluation that includes members with appropriate knowledge and skills.

At present, this "gold standard" interdisciplinary evaluation at a center of excellence is not accessible to everyone in Oregon due to geography, transportation issues, cost and wait times. Children and their families can wait up to 2 years for such an evaluation. There is broad agreement that early diagnosis is important for best possible outcomes. Therefore, establishing an identification process, based on best practice, that can be enacted in communities across the state, blending available resources, is of utmost importance.

The Oregon Commission on Autism Spectrum Disorders (OCASD) was appointed by the Governor to represent a wide variety of interests regarding services provided to individuals with autism in education, health care and the community.

One area of particular interest to OCASD is the determination of which individuals in Oregon have an ASD, either as a health care diagnosis or a special educational eligibility. In order to make best use of available resources, prevent bottlenecks, and ensure consistent and reliable results, the OCASD has recommended certain requirements as the minimum necessary for accurate identification, without specifying

*Continued on page 26*

# Fast Trauma/Phobia Cure: A Neuro-Linguistic Programming Technique

*Ron Lechnyr, PhD, DSW*

### *Introduction*

Psychologists are frequently confronted with patients who present with anxiety, tension, fears, phobic behaviors, and/or PTSD trauma/injury responses that have not been fully resolved in the traditional verbal therapy modes. The present need for short-term therapy using brief and effective change techniques requires that practitioners employ adjunctive techniques that can help patients in quickly resolving problem areas and blocks.

Techniques utilized by practitioners trained in Neuro-Linguistic Programming (NLP) provide interesting intervention models and approaches that offer the potential of treating a variety of difficult emotional conflicts. NLP techniques were developed by Richard Bandler and John Grinder from their observations of master practitioners such as Fritz Perls, PhD, Virginia Satir, MSW, Milton Erickson, MD, Carl Rogers, PhD, the communication theories of Gregory Bateson, PhD, the linguistics theories of Noam Chomsky, PhD, and others. Bandler and Grinder wanted to understand which common psychotherapeutic techniques and language used by these leading practitioners in the field of behavioral change provided for effective therapeutic change strategies. They developed a number of rapid new behavioral change techniques and coined simple and practical terms for each of them, including the one they called the "Fast Trauma-Phobia Cure."

As a result of these observations, a number of techniques have been developed to help understand how people psychologically code, and change, problem and traumatic events in their lives. Virginia Satir reportedly stated that she observes the words used by people because the words we use trigger images in our minds. Additionally, these images create feelings which guide how we function in life (Bandler, 1985; Andreas & Andreas, 1989). Issues of mental coding, responses, and communication theory are the basis of NLP theory and therapeutic change techniques.

### *Emotions and Images*

Emotions are our greatest friends and, at times, our worst enemies (Greenberg, 2012). We know that there is an interaction between emotions and our cognitive processing as they influence issues of personal meaning, our physical health, our well-being, memory, thoughts, decision-making and our future behaviors and functioning in life. They are automatic and adaptive. The more conscious emotions can be dealt with in cognitive behavioral therapy as part of changing faulty thinking patterns. Pre-conscious feelings can activate fear responses mediated by the brain's amygdala, creating anxiety, tensions, and avoidance responses.

*Continued on page 19*

Professional Affairs News

## Sample Authorization Forms for Members' Use on OPA Website

The OPA Professional Affairs Committee has developed two sample Authorization Forms for disclosure of protected health information (PHI). There is an adult form and a child form. These Authorizations were designed to contain the core elements required by the Federal Privacy Rule, as well as content considered most useful to Oregon psychologists. They have been reviewed by OPA's attorney, Paul Cooney, JD, and are compliant with federal and state law as of March 2011. The sample forms, and advice on using them, are now available to OPA members on the OPA Members only section of the website at www.opa.org.

To find them:

- Log in to **Members Only***
- Click on **Professional Affairs Section** in the right hand side sidebar
- Click on **Practice Management Info** in the sidebar
- Click on **OPA Release of Information Sample Forms and Information**
- Click next on **Comments and Information Regarding Use of the Forms**
- Select **Adult Release of Information Form** or **Child Release of Information Form** in Word or PDF format

*Please read the comments and information sheet before downloading and modifying these forms for your practice. Please note that if you are a regular user of the OPA website, or applied online as a new member, you have probably set your own username and password; please use those when logging in. If it is your first time logging in to the website you will need to follow the instructions on the log in page. If you cannot remember your username or password, please click on the links to the right of the log in box to recover those items.

*Fast Trauma/Phobia Cure, continued from page 18*

These feelings can become stuck in a repetitive mental loop that seems to give the emotions experienced by the patient even more power.

Patients need the guidance of a psychologist/mental health provider to feel and experience emotions that are experienced as overwhelming. This can be done by the process of learning to regulate these emotions by soothing and distracting techniques (Linehan, 1993). They can also be facilitated by the use of guided imagery and related techniques that help to change the neurological-cognitive imprinting of the events in the patient's mind. "[I] magery technique(s) [can be used] as a vehicle to transport the rational information from the head to the heart. . . . Images are much more powerful to change emotions than verbal information" (Jung & Steil, 2012; see also Rodriguez, 2012).

The goal of psychotherapy is to achieve a therapeutic outcome related to these pre-conscious repetitive "stuck" emotions. Dealing with, and activating, the arousal of these emotions is a critical factor in real therapeutic success. To do this, these stuck emotions require the guided activation of the traumatic emotions as a part of psychotherapy if the repetitive emotional responding is to be replaced with new, more functional emotions and responding patterns for the patient (Greenberg, 2012; Gurgevich, 2010).

### *NLP and PTSD Disorders*

Therapy for patients with Post-Traumatic Stress Disorders (PTSD) is traditionally conceptualized as requiring long-term treatment. NLP suggests that there may well be a way to change such traumatic experiences in a relatively short period of time. In fact, NLP techniques are based on the fact that one-trial learning does indeed take place. Traumatic events can be "laid down" or imprinted in the brain neurologically because of the overwhelming and uncontrolled nature of the trauma experience. These patterns are neurologically/psychologically imprinted in linguistic visual, auditory, and/or kinesthetic forms. In order to change this programming, certain neurological/psychological change-states need to take place in the individual.

Intense anxiety and tension can create an escape-avoidance that reinforces the trauma. In fact, the individual may have flashbacks to the events that lead up to the traumatic event. These assist the patient in avoiding the actual traumatic event that is perceived as being potentially psychologically overwhelming.

The individual has a block to overcoming the situation/trauma and is caught in "T+1" ways, is stuck in the past, unable to move forward emotionally, or get beyond the time just before the event because they are "blocked" by the trauma. As a result, they are unable to develop their full personality and social/interpersonal style in relation to living a full life free of the blocking experience of the trauma.

An additional important factor is that people who have experienced a traumatic experience are many times too associated with the emotional experience. By being associated, the person feels like they are seeing, experiencing and hearing the event in the immediate present, i.e., as though they are in the middle of it—seeing it through their eyes. They are unable to step back in a manner that allows them to step away from the emotionally overwhelming experience. To do this, they must be assisted to disassociate themselves from the experience in order to distance themselves so that they do not feel overwhelmed by the emotions of the experience. Sometimes it is helpful to assist the patient in being able to dissociate even further to a state where they do not feel the emotions as intensely.

### *NLP Techniques*

In order to make NLP successful, the therapist starts by educating patients about how traumatic events become imprinted in the mind with one-trial learning experiences. To change these imprinting patterns, the patient is told that it helps to use a series of NLP guided imagery techniques.

### *Changing Sub-modalities Technique*

Patients are asked to picture the traumatic event in their minds. When they are able to do this, they are asked if the picture is dark or bright. Normally patients will picture the event as dark. They are then asked to change it and make the picture brighter by letting in more light, turning on lights, having the sun shine in, or adding artificial light to it in any manner. When they are able to do this, they are asked about any changes in feelings they have about the picture. Sometimes the picture is very bright and the opposite is done, i.e., asking the patient to darken the picture. The patient is then asked if there is a frame around the picture. If there is no frame, the patient is asked to put one on (or take one off). This helps to contain the traumatic image to lessen the perceived power of the attached emotions.

Again, patients are asked how these changes felt. They are then asked to hang the picture on the wall, step back, and look at it. Once again, they are asked how this felt. Patients then open their eyes to discuss the experience more fully. They are told that by just changing the sub-modalities, or sub-parts (such as color, size, shape, framing) of the events, this can help reduce the trauma. They are told that they can do the same at home when faced with any upsetting event.

### *The Swish Technique*

Patients are now asked if they have any comfortable and relaxing pictures from their experiences that they can think about—a lake, mountain, being out camping, hiking, etc. Once they are able to identify this positive picture, they are told that in a minute you will want them to see the traumatic, or problem situation, as a large

*Continued on page 20*

*Fast Trauma/Phobia Cure, continued from page 19*

picture that is right in front of them. However, down in the corner of that picture will be the peaceful, comfortable, and relaxing picture that they told you about. As they start, you are going to take them through several steps related to those pictures. Patients close their eyes and are told to visualize the large negative picture right in front of them with the small, comfortable picture in the bottom portion of that picture. As they are able to visualize this, they are told that in a second the picture will be sucked up into the middle as if a vacuum cleaner is behind it. As this happens, the small, peaceful picture will swish up and take its place. They are then told that this is happening, with the large negative picture being sucked up and the peaceful picture taking its place. When patients indicate that this is done, they are told to do this five more times, ending with the peaceful picture. Once this happens, they are to reach out and "hug in" the picture into themselves, making it a part of them. They are asked to see themselves walking off into the future with this new picture inside of themselves as they walk off into the sunshine feeling more comfortable and relaxed. This last statement is referred to as future pacing, a technique that helps the patient move on from the present into a more comfortable future.

This experience is also explained to the patient as one part of helping to rid the self of negative images. Often, this has to be done several times, with each experience being replaced by a more positive swish image.

### *The Fast Phobia/Trauma Cure*

The Fast Phobia/Trauma Cure is a simple and easy technique to employ for a variety of anxiety, tension, and traumatic and phobic experiences. It can be utilized well with victims of sexual or physical abuse, as well as serve as an adjunctive technique in other parts of therapy. This technique allows the patient to resolve some of the overwhelming experiences and emotions so that they can get beyond the intensity of feelings associated with the problem situation. This can allow patients to utilize other aspects of therapy more appropriately. Resistance in therapy is at times related to the fear of facing overwhelming emotions that may not be fully understood by the patient. By changing the neuro-linguistic memories "programmed" into the mind, the patient is freed to act and behave differently and in a more relaxed manner. What this requires is flexibility on the part of the therapist to see that a number of anxiety and tension symptoms may be open to intervention with this technique. It requires understanding that the patient is phobic in dealing with these fears and tensions.

Reframing the concept of anxieties as phobic responses to past traumatic events and experiences in one's social environment can help patients to accept the use of this technique. The technique, which is a form of guided imagery, is presented to the patient as follows:

### *The Guided Imagery of the Fast Phobia/Trauma Cure.*

1. I would like you to close your eyes and see yourself sitting in the middle of an empty movie theater. Let me know when you see yourself there.
2. As you are sitting in the middle of the theater, you will see a black and white slide picture of the problem or traumatic situation on the movie screen. Let me know when you see it.
3. As you are sitting in the middle of the theater, I now want you to magically transport yourself up into the projection booth. Let me know when you are there. Now that you are in the projection booth, you will be able to look down into the theater, seeing yourself sitting in the middle of the theater looking at the picture on the screen.
4. Now I want you to turn the projector on so that the slide turns into a movie of the entire event. You will see it unfolding on the movie screen starting from beginning to end in about 40 seconds. Let me know when you get to the end of the movie.
5. Now I want you to magically transport yourself up to a third position, in other words, on to the movie screen and into the movie, but this time, at the END of the movie. As you get into the movie it will turn into vivid living color. Let me know when you are up in the movie at the end of it.
6. Now I want you to run this movie in REVERSE from the END to the BEGINNING in 30 seconds so that everything goes backwards, talks backwards and happens backwards. Let me know when you get to the beginning of the movie again.
7. Now I want you to run this movie again in REVERSE from the END to the BEGINNING, but this time in 20 seconds. Let me know when you get to the beginning.
8. Now I want you to run this movie again from the END to the BEGINNING, but this time in 10 seconds. Let me know when you get to the beginning.
9. Now I want you to run it again from the END to the BEGINNING in 5 seconds. Let me know when you get to the beginning.
10. Now I want you to run it from the END to the BEGINNING in 2 seconds and let me know when you get to the beginning.
11. Now you will see yourself walking off the stage and out of the movie theater into the bright sunlight of the future. As you walk out of the theater, you notice how you are handling things differently, more flexibility, and feeling more at ease, as you move into the future in a new and different way.

*Continued on page 21*

*Fast Trauma/Phobia Cure, continued from page 20*

This latter step is known as "future pacing" and is important in helping the patient view their functioning in the future in a different manner, no longer held back by the trauma or problem.

### *Discussion of the Technique.*

This technique offers a number of helpful ideas to the patient in dealing with the situation. First, the patient is able to disassociate themselves and step back to look at the problem from a distance. In this manner they are not so closely associated, or overwhelmed, with the feelings related to the event. Several steps are taken to disassociate further from the feelings of the event.

The second factor is that the patient is able to observe the events happening separately from being directly involved in the trauma incident. This disassociated viewing of the event is also a new experience for patients. It allows them to obtain a perspective at a distance from what they have been experiencing in a more overwhelming close-up perspective.

Third, the patient is able to reassociate with the experience, but this time at the T+1 phase, i.e., past the traumatic event. They have actually grown, or seen, beyond the trauma. This in itself is a new experience that can be seen as allowing patients to desensitize themselves to the experience. It allows them to see that there is a way to get beyond the anxiety that has blocked them up to this point.

Fourth, the patient is able to undo the entire event. Because the event is traumatic, it must be undone several times fast, and faster. Most patients report almost laughing at it all when it is reversed at half a second. They state that it does not seem to be that important any more. It is as though they are clearing their mind of the trauma that was previously programmed and "stuck" there.

Fifth, the technique is explained to patients at the end. They can be told that it comes from Neuro-Linguistic Programming techniques. It is based on the fact of one-trial learning where events are laid down neurologically in the form of visual images and language in the brain. This programming can be undone by the use of disassociation, which allows patients to step back from and later undo it. This gives patients a technique that they can use on their own later to assist in helping with other situations, or other aspects of the trauma, that upset them or cause them problems. This involves the patient as an active participant in the treatment process because the psychologist is "giving away" the technique that provides for the patient's empowerment.

### *Metaphors as Communication*

Traumas can happen around interpersonal events, job injuries, motor vehicle accidents, deaths, unresolved childhood experiences and fears, abuse, along with war experiences, being a victim, or just having experienced general anxiety states for long periods of time. Many individuals have hidden their past traumas from their conscious mind. This results in the psychological issues being converted to metaphors of bodily experiences and sensations that are not well understood by the individual. Such metaphors may be experienced in consciousness as tightness in the chest, a "ball" in the stomach or chest, or other physical sensations. Understanding that these metaphors may reflect hidden unresolved traumas assists the psychologist in guiding the patient to reframe the need to look at the traumatic experience in a different manner.

### *Conclusion*

Using NLP techniques to facilitate other aspects of therapy can help to shorten the therapeutic process. NLP techniques are not meant to replace other types of psychological intervention. These techniques can be used as part of the psychotherapy process, allowing blocks to be removed so that the patient can proceed more quickly through treatment.

**It is important to note that some patients are not ready for this technique in their first efforts to change their mental coding of the traumatic/phobic events.** They need time to vent, relive, explain, learn relaxation techniques, and deal with the immediate crisis. Others find it very useful with acute traumas, allowing them to process the traumatic event more quickly. A crisis often brings up memories of past unresolved problems that also need to be dealt with in therapy. It is necessary to listen for other issues that have come up at this time of trauma and crisis. Each therapeutic situation requires an appropriate diagnostic assessment and history in order to focus the specifics of interventions in treatment. Sometimes other NLP techniques are useful for the individual to gain full mastery of the traumatic event. All treatment techniques need to be individualized for the specific person and situation. The NLP Fast Trauma/Phobia technique can be a helpful adjunct in short-term treatment and in dealing with PTSD trauma events.

The best way to understand how to use these techniques is to move beyond just reading about them to trying them out, with attention to training and competence. This will help you to understand how they work in a sequential way that can be well-integrated with traditional forms of psychotherapy.

### *References*

Andreas, C., & Andreas, S. (1989). *Heart of the mind: Engaging your inner power to change with Neuro-Linguistic Programming*. Moab, Utah: Real People Press.

Bandler, R., Andreas, C. (Ed.), & Andreas, S. (Ed.). (1985). *Using your brain—for a change: Neuro-Linguistic Programming*. Real People Press, Moab, Utah.

*Continued on page 22*

*Fast Trauma/Phobia Cure, continued from page 21*

Greenberg, L. S. (2012). Emotions, the great captains of our lives: Their role in the process of change in psychotherapy. *American Psychologist, 67,* 697-707.

Gurgevich, S. (2010). *Hypnotic house call: A complete course in mind-body healing*. New York, NY: Sterling Publishing.

Jung, K., & Steil, R. (2012). The feeling of being contaminated in adult survivors of childhood sexual abuse and its treatment via a two-session program of cognitive restructuring and imagery modification—A case study. *Behavior Modification, 36,* 67-86.

Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Rodriguez, T. (2012). Mental cleansing. *Scientific American Mind*, *23*(2), 6.

### *Related Resources*

Andreas, S. (1991). *Virginia Satir: The patterns of her magic*. Moab, Utah: Real People Press.

Bandler, R., & MacDonald, W. (1988). *An insider's guide to sub-modalities*. Cupertino, CA: Meta Publications.

Densky, A., & Reese, M. (1986). *Programmer's pocket summary*. Available: P.O. Box 533, Indian Rocks Beach, Florida, 33535.

Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15,* 248-260.

Greenberg, L.S., Auszra, L., & Herrmann, I. R. (2007). The relationship among emotional productivity, emotional arousal, and outcome in experiential therapy for depression. *Psychotherapy Research, 17,* 482-493.

Lechnyr, T. A., & Lechnyr, R. J. (2010). Psychological wounds of trauma and motor vehicle accidents. *Practical Pain Management Journal, 10,* 24-28.

# OPA is on the Web!

**Check out OPA's website at www.opa.org to see information about OPA and its activities and online registration for workshops!**

## Psychologists of Oregon Political Action Committee (POPAC)

***About POPAC...*** The Psychologists of Oregon Political Action Committee (POPAC) is the political action committee (PAC) of the Oregon Psychological Association (OPA). The purpose of POPAC is to elect legislators who will help further the interests of the profession of psychology. POPAC does this by providing financial support to political campaigns.

The Oregon Psychological Association actively lobbies on behalf of psychologists statewide. Contributions from POPAC to political candidates are based on a wide range of criteria including elect-ability, leadership potential and commitment to issues of importance to psychologists. Your contribution helps to insure that your voice, and the voice of psychology, is heard in Salem.

Contributions are separate from association dues and are collected on a voluntary basis, and are not a condition of membership in OPA.

**Take Advantage of Oregon's Political Tax Credit!**

**Your contribution to POPAC is eligible for an Oregon tax credit of up to $50 per individual and up to $100 per couples filing jointly**

To make a contribution, please fill out the form below, detach, and mail to POPAC at PO Box 86425, Portland, OR 97286

### - POPAC Contribution -

*We are required by law to report contributor name, mailing address, occupation and name of employer, so please fill out this form entirely.*

Name:_____ Phone: _____

Address _____

City:_____State:_____ Zip:_____

Employer:_____ Occupation:_____

Senate District (If known):_____House District (If known): _____

Amount of Contribution: $_____

*Notice: Contributions are not deductible as charitable contributions for state or federal income tax purposes. Contributions from foreign nationals are prohibited. Corporate contributions are permitted under Oregon state law.*

# Physician Quality Reporting System (PQRS) Information for Psychologists

Formerly known as the Physician Quality Reporting Initiative (PQRI), the Physician Quality Reporting System (PQRS) is a voluntary reporting program that provides a financial incentive for certain health care professionals, including psychologists, who participate in Medicare to submit data on specified quality measures to the Centers for Medicare and Medicaid Services (CMS). In 2015, the reporting program will shift from voluntary program to a mandatory one in which penalties will be assessed for failure to participate. The PQRS, which was formerly an incentive-based program, is set to switch to one in which penalties will be assessed for failure to report. Practitioners who don't yet participate in PQRS must begin, and must begin doing so in 2013 or they will face payment penalties starting in 2015.

Health care professionals who successfully report on 50 percent of the applicable cases for any given measure will be eligible for a bonus payment equal to 0.5 percent of their total allowed Medicare charges for the 2013 reporting period. That's 0.5 percent extra for all of the claims Medicare pays you for, not just the ones you report on. The bonus payment will be 0.5 percent again in 2014. All claims have to be filed before CMS calculates the bonus payments. The deadline for submitting prior year claims is two months from the end of the calendar year, so bonus payments are issued in the middle of the next year. You will also receive confidential feedback reports from CMS.

To participate, you must be enrolled as a Medicare provider under the clinical psychologist designation and have a national provider identifier (NPI) number. As of January 1, 2011, you must also be enrolled in the Medicare PECOS system. You do not need to apply for the PQRS in order to participate. You can simply begin reporting on services provided on or after January 1 of the current year. You do not need to start immediately in January of each year, but because you must report on 50 percent of the applicable cases during the 12-month reporting period, failure to start early could prevent you from reaching this threshold and make you ineligible for the bonus payment. CMS has eliminated the 6-month reporting period for individual measures reported through claims or a registry. For 2013, individual claims should be submitted for a 12-month reporting period.

For 2013, psychologists have 13 measures available for reporting in PQRS:

- Major depressive disorder: antidepressant medication during acute phase for patients with MDD (#9)
- Major depressive disorder: diagnostic evaluation (#106)
- Major depressive disorder: suicide risk assessment (#107)
- Preventive care and screening: Body mass index screening and follow-up (#128)
- Documentation and verification of current medications in the medical record (#130)
- Pain assessment prior to initiation of patient therapy and follow-up (#131)
- Screening for clinical depression and follow-up plan (#134)
- Preventive care and screening: Unhealthy alcohol use—screening (#173)
- Elder maltreatment screen and follow-up plan (new measure effective in 2009)
- Preventive care and screening: Tobacco use assessment and tobacco cessation intervention (#226)
- Substance use disorders – counseling (#247)
- Substance use disorders – Screening for depression (#248)
- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions (#325)

In addition, a new measures group for dementia has been created that can only be reported through a registry due to the way in which the measures must be analyzed. The CMS website contains detailed specification worksheets for each measure. Worksheets for the measures with numbers listed above can be found on the CMS website under the link for Measures/ Codes. The 2013 Physician Quality Reporting System Measure Specification Manual is also available on the CMS website.

If you have further questions, the best place to start is with your local Medicare contractor. You can also find a wealth of information on the APA Practice Organization website at www.apapractice.org. Questions can also be directed to the APA Practice Organization government relations staff by phone at 202.336.5889 or by email. In addition, there are two documents on PQRS available on the OPA website in the Members Only section from the Pennsylvania Psychological Association and the Tennessee Psychological Association. Once logged into the Members Only section, click on the Professional Affairs Section, then Practice Management Information.

OPA would like to thank the American Psychological Association Practice Organization, the Tennessee Psychological Association, and the Pennsylvania Psychological Association for their information for this article.

# Oregon Psychological Association

## Continuing Education Workshops • Winter 2012-2013

## June 7, 2013

## *PRACTICAL APPLICATIONS OF MINDFULNESS IN TRAUMA TREATMENT: COGNITIVE, AFFECT REGULATION, AND EXPOSURE-BASED TECHNIQUES*

*Presented by John Briere, PhD*

**Crowne Plaza Portland Lake Oswego**
**14811 Kruse Oaks Drive • Lake Oswego, OR 97035**

**Registration 8:30 - 9:00 am • Workshop: 9:00 am - 4:00 pm**
**With one hour for lunch • 6 CE hours • CE credit level 2**

## About the Presenter

John Briere, PhD, is an Associate Professor of Psychiatry and Psychology, and Director of the Psychological Trauma Program at the Keck School of Medicine, University of Southern California. He is also Center Director of the USC Adolescent Trauma Training Center of the National Child Traumatic Stress Network. A past president of the International Society for Traumatic Stress Studies (ISTSS), he is recipient of the Award for Outstanding Contributions to the Science of Trauma Psychology from the American Psychological Association and the Robert S. Laufer Memorial Award for Scientific Achievement from ISTSS. He is author or co-author of well over 100 articles and chapters, 11 books, and eight trauma-related psychological tests. He teaches on trauma, therapy, and mindfulness practices internationally. For more information visit his website at www.johnbriere.com.

## Workshop Description

This workshop builds on Dr. Briere's prior presentations and publications on mindfulness-based trauma therapy, incorporating new information and techniques. New topics include clinical implications of the "pain paradox," using mindfulness to facilitate exposure and other aspects of emotional processing, teaching metacognitive awareness, "trigger work," contraindications for mindfulness, and Dr. Briere's new "hybrid" approach to balancing classical trauma treatment with mindfulness training.

## Workshop Objective

Attendees will be able to:

- Describe the pain paradox as it relates to avoidance and symptom chronicity.
- Define metacognitive awareness and its benefits.
- List three contraindications of mindfulness training for trauma survivors.
- Outline the major principles of Briere's hybrid model of mindfulness-based trauma therapy.

## OPA Workshop Calendar*

**April 19, 2013**
*Adventures on the Electronic Frontier: Ethics and Risk Management in the Digital Era*
by Jeff Younggren, PhD

**May 10-11, 2013**
*Conference*
Eugene, OR

**June 7, 2013**
*Practical Applications of Mindfulness in Trauma Treatment*
by John Briere, PhD

**September 27, 2013**
*DSM-5: An Overview of Changes and Challenges*
by Vikki Vandiver, DrPH, MSW

**November 15, 2013**
*The Creativity and Structure of Functional Family Therapy: An Evidence-Based, Family-focused Treatment for Youth and Their Families*
by Thomas Sexton, PhD, ABPP

**January 17, 2014**
*Ethics and Clinical Supervision*
by Carol Falender, PhD

*Calendar items are subject to change
To register go to www.opa.org

**Register at www.opa.org**

*Autism, continued from page 17*

particular disciplines or professionals. The intent is to allow maximum flexibility in meeting those requirements within each community using health care and/or educational resources.

The specific recommendations center on these key topics:

- Use of DSM as the diagnostic or identification criteria
- Use of an interdisciplinary team process
- A list of knowledge elements that must be present within the team
- A list of evaluation areas that must be included in the evaluation process

The OCASD believes that following these recommendations results in a reliable "identification" (in health care, diagnosis) of an ASD (or rule-out of same) which should be portable between health care and education. Additional assessments for education services and/or additional workups for health care issues are likely to be appropriate, but the identification process for an ASD itself should not need to be repeated between systems.

The recommendations outlined above will be discussed in greater detail in a presentation on May 11th at OPA's 2013 Annual Conference. Topics will include the knowledge elements and specific competencies for each element, as well as the evaluation areas necessary for an identification team. We also plan to discuss the role that psychologists will play in the identification process and the implications of the recommendations for psychologists in private practice and group settings. We hope that you will join us!

Oregon Psychological Association

## OPA Public Education Committee Facebook Page - Check it Out!

We are pleased to announce that after a year of research and preparation, the OPA Public Education Committee has launched its own Facebook page. The purpose of the OPA-PEC Facebook page is to serve as a tool for OPA-PEC members and to provide the public access to information related to psychology, research, and current events. The social media page also allows members of the Public Education Committee to inform the public about upcoming events that PEC members will attend. Please visit and "like" our page if you are so inclined and feel free to share it with your friends!

You will find the OPA Public Education Committee's social media policy in the About section on our page. If you do "like" us on Facebook, please familiarize yourself with this social media policy. We would like to encourage use of the page in a way that is in line with the mission and ethical standards of the Association.

Click here to visit our Facebook page.

# OPA Classifieds

## OFFICE SPACE

Westside Office Space. Ready to open a new office or branching out? Come see our Westside office in Raleigh Hills: affordable, quiet, comfortably furnished office in a suite of three offices with friendly colleagues, waiting room, kitchenette, utilities (except telephone), fax, copy machine, wireless cable. The building on Beaverton-Hillsdale Hwy is handicapped accessible, has free parking, and is easily reached from Westside highways (I-5, 26, 217). It is currently available two days a week. Some pictures available at: www.katemleonard.com. Call Kate Leonard, 503.292.9873.

Beautiful SW John's Landing office (290 sq. ft.) with large reception room, parking, and receptionist available for $884 per month, or $180 per day per month, optional secretarial services and billing. Some referrals. Steve Waksman, Or Johna, 503.222.4046. drwaksmanphd@gmail.com

Office space for an early career or established psychologist to rent or lease. Well-maintained professional building, with ample parking, located at the Sylvan exit off of Hwy. 26, close in Portland, and near Beaverton. Share a suite with experienced psychologists, opportunities for collegial interactions and practice-building. Large interior space with a nicely-appointed waiting room, and near a deli, with internet and copier/fax available. If interested, please contact Michael Fulop at 503.539.4932, or michael@forsterfulop.com.

Office available in office suite across from St. Vincent Hospital. Part time receptionist and ample parking available. Office close to MAX line. Practice associated with medical psychology. Call 503.292.9183 for information or email akotsphd@qwestoffice.net.

## PATIENT TREATMENT GROUPS

Women's Recovery Group. Allies in Change's Women's Recovery Group provides support to women who have been or are in an abusive romantic relationship. Women learn about the dynamics of abuse, common beliefs, and how to best manage the relationship and their own healing process from the abuse. Health insurance accepted. Sliding scale fee. Phone: 503.297.7979 - web: www.alliesinchange.org.

Pacific Psychology Clinic in downtown Portland and Hillsboro offers both psychoeducational and psychotherapy groups. Sliding fee. Group information web page www.pscpacific.org. Phone: 503.352.2400, Portland, or 503.352.7333, Hillsboro.

## PROFESSIONAL SERVICES/EQUIPMENT

Confidential psychotherapy for health professionals. Contact Dr. Beth Kaplan Westbrook, 503.222.4031, helping professionals since 1991.

Go to Testmasterinc.com for a variety of good online clinical tests for children and adults, plus manuals. Violence-proneness, PTSD, ADHD, Depression, Anxiety, Big Five Personality, etc. Bill McConochie, PhD, OPA member.

Pet Behavior an issue for your clients? I specialize in solutions for pet behavior problems, counseling owner-trained assistance/service dog teams, pet selection for families, and pet behavior management consulting (including biting and fighting). Mary Lee Nitschke, PhD, CPDT, 503.248.9689. mnitschk@linfield.edu.

Does the business part of your practice ever feel like too much? Do you wish you could take home more $$ with less effort? Would you like to work smarter, not harder? I provide practice management consultation exclusively to mental health professionals. I know your business. For a free consultation to see how I can help you, call Margaret Sears, 503.528.8404.

## VACATION RENTALS

Sunriver Home 2 Bd, 2 ba, sleeps 5, minutes to the river and Benham Falls Trailhead. Treed, private back deck, hot tub, well maintained. $150-$225/night Call Jamie Edwards 503.816.5086, To see photos go to vrbo.com/13598.

Sunriver: Close to Village Mall. Sleeps 8: 3 bedroom, 2 bath, 1 king, 2 queen, hide-a-bed. Large and private deck with hot tub, gas bbq. 4 TVs/3 DVDs, stereo, AC, small pets welcome. Rates $125-225 per night with $115 cleaning fee. Call 503.327.4706 or email methel_king@hotmail.com.

Alpenglow Chalet - Mount Hood. Only one hour east of Portland, this condo has sleeping for six adults and three children. It includes a gas fireplace, deck with gas BBQ, and tandem garage. The lodge has WiFi, a heated outdoor pool/hot tub/sauna, and large hot tub in the woods. Short distance to Skibowl or Timberline. $200 per night/$50 cleaning fee. Call 503.761.1405.

Beach Haven - 3 br condo at Cascade Head Ranch (5 mi N. of Lincoln City). Spectacular view of Salmon River Estuary and ocean. Hiking, fishing, and swimming in protected pool. Golf nearby. $85 per night; 2 night minimum. Call 503.245.5946 for information.

Two adjacent Beautiful Manzanita Beach Getaways. Rent separately or together. One sleeps 6 (available year-round; $110.00/night, plus tax and $50 cleaning fee); the other sleeps 9 (available July and August; $165/night, plus tax and $75 cleaning fee). Clean and comfortable homes, centrally located. A few short blocks to beach and downtown. Golf and tennis nearby. Woodstoves, skylights and decks. No smoking/pets. Call 503.245.8610 or, for more info, go to www.manzanitaville.com.

Beautiful Sunriver home with spectacular view of Mt. Bachelor. Sleeps 10. 3 bedrooms, 3 bathrooms. King, Queen, 1 set of bunks & 2 hide-a-beds. 2 master suites, 1 with jacuzzi tub. 3 TVs, 3 VCRs. Hot tub with a large deck. Bikes & garage. No smoking/pets. Rental price from $185 - $266, 20% reduction off regular rate given to OPA members. Call 503.390.2776.

Manzanita, 4 blks from beach, 2 blks from downtown. Master Bdrm/bath w/Qn, rm with dble/sngle bunk & dble futon couch, extra lrg fam rm w/Qn Murphy-Bed & Qn futon couch, living rm w/Qn sleeper. Well eqpd kitch, cable. No smoking. $140 summers, $125 winters. http://home.comcast.net/~windmill221/SeaClusion.html Wendy 503.236.4909, Larry 503.235.6171.

Ocean front beach house. 3 bedroom, 2 bath on longest white sand beach on coast. Golf, fishing, kids activities nearby and dogs (well behaved, of course) are welcome. Just north of Long Beach, WA, 2 1/2 hour drive from Portland. $150 per night, two night minimum. Week rental with one night free. Contact Linda Grounds at 503.242.9833 or DrLGrounds@comcast.net.

## *The Oregon Psychologist* Advertising Rates, Policies & Publication Schedule

If you have any questions regarding advertising in the newsletter, please contact Sandra Fisher at the OPA office at 503.253.9155 or 800.541.9798.

### *Advertising Rates & Sizes*

Advertising Rates & Policies Effective January 1, 2001:

1/4 page display ad is $75

1/2 page display ad is $150

Full page display ad is $300

Classifieds are $20 for the first three lines (approximately 50 character space line, including spacing and punctuation), and $5 for each additional line.

Please note that as a member benefit, classified ads are complimentary to OPA members. Members will receive one complimentary classified ad per newsletter with a maximum of 8 lines (50 character space line, including spacing and punctuation). Any lines over the allotted complimentary 8 will be billed at $5 per additional line.

All display ads must be sent to the OPA office in camera-ready form (faxes are not accepted for display ads). Display ads must be the required dimensions for the size of ad purchased when submitted to OPA. All ads must include the issue the ad should run in and the payment or billing address and phone numbers.

The OPA newsletter is published five times a year. The deadline for ads is listed below. Each issue is typically mailed during the final week of the later month listed for that issue. OPA reserves the right to refuse any ad and does not accept political ads. While OPA and the *The Oregon Psychologist* strive to include all advertisements in the most current issue, we can offer no guarantee as to the timeliness of mailing the publication nor of the accuracy of the advertising. OPA reserves the right not to publish advertisements or articles.

### *Newsletter Schedule**

**2013**

May/June Issue – deadline is May 10

July/August Issue – deadline is July 5

September/October Issue – deadline is September 6

*Subject to change

## OPA Ethics Committee

The primary function of the OPA Ethics Committee is to "advise, educate, and consult" on concerns of the OPA membership about professional ethics. As such, we invite you to call or contact us for a confidential consultation on questions of an ethical nature. At times, ethical and legal questions may overlap. In these cases, we will encourage you to consult the OPA attorney (or one of your choosing) as well.

When calling someone on the Ethics Committee you can expect their initial response to your inquiry over the phone. That Ethics Committee member will then present your concern at the next meeting of the Ethics Committee. Any additional comments or feedback will be relayed back to you by the original contact person. Our hope is to be proactive and preventative in helping OPA members think through ethical dilemmas and ethical issues. Please feel free to contact any of the following Ethics Committee members:

Alex Duncan, PsyD, ABPP
Chair Elect
503.807.7180

Sally Grosscup, PhD
541.343.2663

Jenne Henderson, PhD
503.452.8002

Mike Leland, PsyD, Chair
503.684.7246

Elsbeth Martindale, PsyD
503.236.0855

Karen Paez, PhD
971.722.4119

Lisa Schimmel, PhD
503.381.9524

Jeffrey Schloemer
Student Member

Sharon Smith, PhD
503.343.3114

Casey Stewart, PhD, ABPP
503.620.8050

Elizabeth "Buffy" Trent
Student Member

***The Oregon Psychologist***

Julie Nelligan, PhD • Shoshana Kerewsky, PsyD, Editor

The OPA Bulletin is a newsletter published five times a year by the Oregon Psychological Association. The deadline for contributions and advertising is listed elsewhere in this issue. Each issue typically is sent out during the final week of the month. Although OPA and the Bulletin strive to include all advertisements in the most current issue, we can offer no guarantees as to the timeliness or accuracy of these ads, and OPA reserves the right not to publish advertisements or articles.

147 SE 102nd • Portland, OR 97216 • 503.253.9155 • 800.541.9798 • FAX 503.253.9172 • e-mail info@opa.org • www.opa.org