The Oregon Psychologist

Bulletin of the Oregon Psychological Association

December 2012 / January 2013 Volume 31, Number 6

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OPA President's Column

Debates on Shootings Risk Stigmatizing Mental Health

Julie Nelligan, PhD

I was working on an article about communication with Coordinated Care Organizations when I became focused on the mass shootings at Clackamas Town Center and Newtown, CT. Suddenly, it seemed insensitive to be talking about marketing when families and communities are grieving. Suddenly, psychology was acutely relevant to current events.

OPA issued a press release in response to the Clackamas Town Center shooting. (This press release is available on the Facebook page of the OPA Public Education Committee. To find it, login to Facebook and search for Oregon Psychological Association Public Education Committee.) Several OPA members were interviewed about the shootings; they included Tony Farrenkopf, Ann Clarkson, Sandy Ramirez, and Frank Colistro. Thank you to everyone who stepped up to respond to this tragedy as a professional psychologist. I also want to thank Lori Queen for pointing out on the OPA listserv that many mall employees who were at work at the time of the shooting also needed support.

A few days after the Clackamas Town Center shooting, another tragedy occurred. A gunman walked into an elementary school in Newtown, CT and killed 26 people--20 of them were children.

These two shootings, as well as others from recent years, have brought national attention to concerns about treatment of mental illness. Normally, I applaud any discussion of improving access to mental health treatment. Instead, I feel dismayed.

The focus of the current discussion is on providing treatment to mentally ill persons so they will not commit mass shootings. It is focused on a very small group of mentally ill, violent and dangerous individuals. While discussion of mental illness generally serves to increase public understanding and reduce stigma, the current debate will not have this effect. Instead I fear that it will increase the stigma of mental illness.

In response to the recent violence, our country may make a variety of changes to gun laws and may fund additional treatment options for mental illness. The public may support both types of actions because they will be seen as doing something good to prevent further tragedies. However, I believe that neither will be very effective, and I fear that efforts to identify and treat individuals who are violent and mentally ill will be harmful to the majority of mentally ill individuals who are not violent.

Many of the solutions I have heard discussed in the media are focused on increasing the power of public agencies and health professionals to commit mentally ill patients before they act out violently. Given the difficulty of predicting a low base-rate phenomenon, like a mass shooting, there is the likelihood of a high number of false positives: Many people will be committed

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OPA Helpful Contacts

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

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**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.*

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unjustly based on suspicions of dangerousness. Furthermore, these solutions make mental illness seem scarier to the public. They can easily be misused and can reinforce stigma and prejudice: If someone seems scary, we can commit him or her.

The recent tragedies are very disturbing and frightening. While this can motivate our country to act, we must be guided by science and act with reason and, carefully weigh the options. This is not the first time our profession and our country have had to weigh the need for a safe society against the freedoms of individuals within that society. The stakes are high for so many people: people with mental illness, families and friends, gun owners, the general public.

Unfortunately, many of the arguments I've seen are reactionary and emotionally laden, even on our own listserv. Let us all strive for thoughtful discussions about treatment of mental illness, predicting dangerousness, gun rights and gun control. Let's talk about improving our gun control laws and mental health treatment, not default to banning guns and banishing the mentally ill.

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.

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!

Native American Mental Health Issues

By Susan Gelberg, PhD

The mental health issues of Native Americans and individuals with mixed heritage that includes Native lineage often reflect factors that reach beyond the individual. These factors can include the current health of friends, the immediate family, adopted family members, clans, tribes, ancestors, tribal histories, and the impact of 500 years of colonization by Euro Americans.

Oregon psychologists who are from the dominant culture or from non-Native minority cultures may be unfamiliar with local and national Native American traditional ceremonies, cultural beliefs, current events, interactional patterns, help-seeking behaviors, healing principles, natural laws, worldviews, and value systems. It is important to learn about these factors through reading, observing, studying, consulting, and interacting with Indigenous Peoples and Native resources. If we provide psychotherapy without this knowledge, we are likely to be seen by Native clients and providers as professionals who lack credibility or relevance, promote colonizing healing models, and/or reflect culturally inappropriate, irrelevant, biased, or otherwise hurtful psychotherapy. Native Americans are often likely to instead seek help from family members or traditional healing professionals who offer an Indigenous perspective.

In 2011, members of the American Psychological Association Ethics Committee attended the Annual Conference of the Society of Indian Psychologists (SIP) in order to learn more about Indigenous clinical and ethical issues. The conference participants, most of whom were Native, welcomed their visitors and expressed appreciation at seeing that the APA, which is a dominant-culture organization, was taking steps to understand the unique ethical and treatment issues in counseling Native American clients. With APA's encouragement, the Society of Indian Psychologists is now discussing ways to formally document those ethical issues, and in the future, we can all look forward to additional assistance from SIP to help us learn to develop more culturally informed psychotherapy for Native clients.

Evidence based practices are sometimes seen as inappropriate or irrelevant when viewed by Native clients. Because Native Americans are often omitted from research that focuses on diversity (due to the lower numbers of Native participants), it is difficult to empirically test the relevance of Evidence Based Practices for Native American clients. DHS has compiled a list of Tribal Best Practices, which lists treatment approaches that are seen by Native Americans as being culturally informed for Native clients. Psychologists need to become familiar with Tribal Best Practices and Native views of who qualifies as an "expert" in providing assistance to Native Americans for mental health issues.

Oregon is a wonderful place to immerse oneself in Native cultures. Powwows throughout the year are open to the public. Many colleges and universities offer specific programming in Native American cultural issues. More Native psychologists are beginning to write about Native psychology in books, articles, and the social media. Organizations like the Native American Rehabilitation Center (NARA) and the Native American Youth Association (NAYA) sponsor annual conferences. National nonprofit training centers such as White Bison and the Gathering of Native Americans (GONA) offer valuable educational resources. Tribes such as the Confederated Tribes of Grand Ronde and the Confederated Tribes of Siletz Indians of Oregon have staff members whose jobs it is to offer training and educational programs to the public. Local newsletters such as *Smoke Signals* and national magazines such as *Indian Country* focus on current events, legal battles, philosophical topics, political issues, and ongoing Native cultural celebrations. Within the Oregon Psychological Association, the diversity committee includes Native American mental health issues as a priority equal to other forms of diversity. Through utilizing the above resources, psychologists can begin to replace unconscious, outdated stereotypes with current information about the vibrant Indian Country communities in Oregon and their specific mental health needs.

In March, there is an event that focuses specifically on these issues as they relate to one crucial mental health issue: intergenerational trauma. Dr. Eduardo Duran, a psychologist from Montana who is licensed in four states, is an international consultant. He is highly respected in both Indian Country and mainstream diversity psychology. He will be offering a workshop to be sponsored by Portland Community College, Chemawa Indian School, the Oregon Psychological Association, and Cross Cultural Counseling and Consulting, Inc. Due to these sponsors, this workshop, which will offer 6 hours of CE for psychologists, will be free. (In the Native tradition of giving back, donations of nonperishable food items for the Oregon Food Bank would be greatly appreciated.) This workshop will offer an opportunity to learn about a treatment model that incorporates Native American beliefs and contemporary Western psychological worldviews. Dr. Duran is seen by the dominant culture and by Indian Country as being both an expert traditional healer as well as an outstanding psychologist. Dr. Duran is a warm, engaging speaker and enjoys interactions with his audience.

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Individuals with a wide array of clinical expertises will be at the conference, providing professional and clinical diversity.

Through opening up a dialogue about Euro American psychological treatment models and Indigenous models, we can strengthen both approaches, combine the best of both, and gain credibility with Indian Country as psychologists who value and celebrate Native cultures as factors crucial to healing. A Native prophecy tells us that healing in the world will only begin to happen when we all come together (the Four Directions and the Four Races – White, Red, Yellow, and Black) to offer the gifts of each of our cultures. This workshop seeks to reflect the value that people from all backgrounds, professional orientations, and cultures can strengthen the healing process for people who have been hurt by intergenerational trauma. You can find more information and how to register at www.4cdiversity.com.

Please join us!

Mitakuye Oyasin ("All my relations," or "We are all related")

Selected Resources

Addictions and Mental Health Division, Department of Human Services (2007).

Position Paper on Native American Treatment Programs and Evidence-Based Practices

Alaska Native/American Indian/ Indigenous Women
- *Section 6 of APA Division 35 (Society for the Psychology of Women)*

American Indian Higher Education Consortium Virtual Library
- *A virtual library of links to Native electronic resources throughout North American*
- *www.aihec.org*

APA Division 18: Psychologists in Public Service
- *New section: Psychologists in Indian Country*

APA Division 45: Society for the Psychological Study of Ethnic Minority Services

Chemawa Indian School
- *www.chemawa.bie.edu*
- *Contact: Mathew Ata'lunti'ski Poteet (mathew@4Cdiversity.com)*

Confederated Tribes of Grand Ronde
- *www.grandronde.org*

Confederated Tribes of Siletz
- *www.ctsi.nsn.us*

Duran, E. (2000). *Buddha in redface*. Lincoln, NE: IUniverse.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native peoples*. Columbia University: Teachers College Press.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany, NY: State University of New York.

Gathering of Native Americans (GONA) Train the Trainer
- *At Native American Center for Excellence website: http://nace.samhsa.gov*

Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists – American Psychological Association

Indian Country
- *Online and printed news sources*
- *www.indiancountrytoday.com*

Indian Health Services (IHS)
- *An agency within the Department of Health and Human Services*
- *http://www.ihs.gov*

Journal of American Indian Education

Native American Rehabilitation Center (NARA) – in Portland
- *An Indian-owned, Indian-operated, non-profit agency*
- *Provides substance abuse treatment, family treatment, family resource program, transitional housing, a primary healthcare clinic, and a mental health resource location*
- *www.naranorthwest.org*

Native American Youth and Family Center (NAYA) – in Portland
www.nayapdx.org

Native American Rights Fund
- *A non-profit organization that provides legal representation and technical assistance to Indian tribes, organizations, and individuals nationwide*
- *http://www.narf.org*

One Sky Center – in Portland
- *National resource center for American Indians and Alaska Natives*
- *www.oneskycenter.org*

OPA Diversity Committee

Smoke Signals
- *A free publication of the Confederated Tribes of Grand Ronde*
- *www.grandronde.org/news*

Society of Indian Psychologists
- *www.aiansip.org*
- *The only free-standing professional association for American Indians and Alaska Natives who are psychologists, psychologists-in-training, or from other disciplines*
- *Welcomes non-Native psychologists*

White Bison
- *Treatment and prevention programs for substance, intergenerational trauma, and wellness resources for the Native American Community*
- *Professional training programs*
- *www.whitebison.org*

Note: Dr. Gelberg is President of Cross Cultural Counseling and Consulting, Inc.
- *www.4Cdiversity.com*

Dear EC: Should I Accept Gifts from Clients?

Dear EC:

A relatively new client gave me a fruitcake in our last therapy session. I don't like fruitcake, but I was caught off guard and accepted it. I believe I now have an ethical dilemma: Was it wrong for me to take the cake? In the hypothetical case that I actually liked fruitcake, would it be ethically permissible for me to eat it? What if I shared it with office staff and didn't eat any myself? I'd appreciate any guidance you can offer.

Sincerely,
Reluctant Fruitcake Recipient

Dear Reluctant:

Particularly around the holidays, therapists may grapple with how to respond to receiving gifts from clients. Your angst regarding the fruitcake suggests you are aware that ethical considerations may become activated by the process of receiving a gift. A careful reading of the *Ethical Principles of Psychologists and Code of Conduct (2002)* will reveal that neither gifts in general, nor fruitcakes specifically, are mentioned even once. Members of the APA Ethics taskforce also chose not to take on the issue of fruitcake in the 2010 ethics code Amendments. In fact, psychologist-ethicist Ofer Zur notes that "there are no code of ethics or guidelines of major organizations that specifically ban gifts in therapy."[1]

The issue of receiving (and giving) gifts may raise potentially important issues regarding boundaries. At the very least, it can leave practitioners feeling uneasy or uncertain. Psychologists are generally aware of the need to be mindful of "dual relationships," and may therefore worry that they are making a mistake if they accept something offered by a client. Even so, being offered – and accepting – client gifts appears to be quite common. In a survey of psychologists, psychiatrists, and social workers, a majority of the 1,021 participants had accepted a gift worth less than $10 (85.2%; n = 870).[2]

"Multiple relationships" are covered under section 3.05 of our ethics code. A multiple role exists when we are in a professional role with our client and are simultaneously in another (nonprofessional) role with that client. In the context of accepting a client's gift, a psychologist might be in the role of therapist or evaluator as well as "gift recipient" – a role that we are more typically in with friends and other intimates. So, it would be accurate to characterize accepting gifts as raising issues about the boundaries we maintain with our clients.

However, keep in mind the final sentence of part (a) in section 3.05: "Multiple relationships that would not reasonably be expected to cause impairment [of the psychologist's objectivity] or risk exploitation or harm are not unethical." Thus, it is neither helpful nor accurate to make a blanket injunction regarding gifts. In this instance, as in many things, it depends.

Psychologist and ethics expert Ken Pope discusses gifts and myriad other ethics and psychology topics on his excellent website (www.kspope.com). He cites Knapp and Slattery's 2004 paper[3] in which the distinction is made between whether behaviors are "boundary crossings" or "boundary violations." A boundary is crossed when we step out of our strictest professional roles, and these crossings can be helpful, harmful, or innocuous. In this sense, accepting a gift would be a boundary crossing – but the impact of that crossing might depend on many circumstances, including the type of gift, the timing of the gift, the nature of the clinical relationship, and the client's condition, state of mind, and diagnosis.

Much has been written on the topic of gifts in therapy. Zur even has an entire CE course regarding this issue (http://www.zurinstitute.com/giftsintherapycourse.html). A general theme in the literature is that accepting gifts is not necessarily harmful, and that rejecting gifts – or over-analyzing the meaning of a client's gifts – might be harmful to the therapeutic alliance. From Zur's perspective, having a human response to a client's gift is not only reasonable but often the best clinical course to take. He writes, "Many if not most authors seem to agree that a gift in psychotherapy requires the therapist to express genuine appreciation and gratitude and, when appropriate, to also explore the meaning and conscious or unconscious intent of the gift with the client… The exploration of the meaning of a gift must be carried out only when relevant, potentially helpful and is not likely to shame or cause the client to feel rejected."[1] On the other hand, Zur also points out that even small gifts could be inappropriate and should not be accepted without being processed and discussed, if at all – e.g., if the gift is of a romantic/sexual or violent nature.

Of course, your clinical and theoretical orientation may guide your approach and policy regarding gifts. For instance, a psychodynamic therapist may conclude that accepting gifts is likely to interfere with the transference process. Regardless of orientation, a key consideration is to remain aware of our own motives in accepting a client's gifts, so as to ensure that accepting a gift represents a boundary crossing as opposed to a boundary violation – which by definition is exploitive and harmful to our clients.

Another consideration, in the spirit of "document, document, document," is to actually document the acceptance of a gift, the process through which this took place, and if possible, to include the gift in the clinical record. In some instances (e.g., fruitcake), including the gift in the clinical record would be ill-advised or impractical.

Finally, practitioners should be cognizant of cultural considerations when thinking about and responding

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to gifts. Gifts may have different cultural meanings, and as with all of our work, it is crucial that we approach this aspect of our practice from a position of cultural competency. Before we accept or reject a gift, it would be wise to assess whether we have a reasonable understanding of the gift's significance, not only within the context of therapy, but within the broader socio-cultural context of the client.

Best wishes to you, and good luck navigating the challenging but potentially fruitful road ahead.

Yours truly,
OPA Ethics Committee

1 Zur, O. (2011). *Gifts in Psychotherapy*. Retrieved 11/07/2011 from http://www.zurinstitute.com/giftsintherapy.html.

2 Borys, D.S. & Pope, K.S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice,* 20 (5), 283-293.

3 Knapp, S., & Slattery, J. (2004). Professional boundaries in nontraditional settings. *Professional Psychology: Research & Practice,* 35 (5), 553-558.

OPA Colleague Assistance Panel

Purpose and Structure of OPA Colleague Assistance Panel: This provider panel consists of psychologists who have been identified by their peers in writing as psychologists who are qualified to treat other psychologists. They are then screened by the OPA Colleague Assistance Committee as psychologists with both interest and specializations related to working with other psychologists. The psychologists on this panel are a small subset of qualified psychologists, and psychologists seeking treatment are encouraged to find the provider of their choice from this panel or from among the many well-qualified Oregon psychologists. Psychologists on this panel are current in their understanding of confidentiality concepts relevant to working with other psychologists and strive to create fully confidential environments for psychologist-clients within the limits of Oregon law.

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Steps to Ensure Your Emotional Competence

By Eric M. Johnson, PhD, ABPP

Although often overlooked, all of the mental health disciplines stress the need for emotional competence. Although mental health professionals understandably stress technical competence, emotional competence is unappreciated and seldom receives the attention it deserves. The need for emotional competence is embedded in the codes of conduct espoused by all of the mental health disciplines.

Emotional competence is as essential to mental health practice as technical competence. Technical skill alone doesn't allow us to practice competently. Mental health practice is demanding and stressful, and it requires technical and emotional competence. Emotional competence refers to a practitioner's emotional health and an ability to proactively address the conditions and circumstances that can compromise emotional health.

Like technical competence, emotional competence has to be cultivated and maintained throughout one's life. Achieving and maintaining emotional competence doesn't occur by chance. Emotional competence has to be actively cultivated throughout one's life and can be maintained through a variety of personal and professional activities.

Failure to address emotional competence can result in the provision of substandard care. To the extent that one's emotional competence suffers, one's technical competence will suffer, too, with the net result that client care suffers.

Failure to address emotional competence can lead to a shortened career. In a worst-case scenario, to the extent that a mental health professional does not attend to emotional competence issues, his/her career may be prematurely shortened. For example, stress and burnout can lead to or exacerbate preexisting anxiety, depression, or trauma disorders that contribute to a decision to leave the field. On the other hand, to the extent that a failure to attend to emotional competence leads to the provision of substandard care, a client complaint can result in licensing board action of a civil suit that will drive a professional from the field.

Begin by taking a "fearless personal inventory." Like our colleagues in the chemical dependency field say, "take a fearless personal inventory." The foundation for emotional competence is self-awareness, and every professional must engage in self-assessment. Practice mindfulness, learn to gauge your emotional health, and recognize the conditions and circumstances that jeopardize your emotional health. The need for self-assessment is noted in several Codes of Ethics. For example, the American Counseling Associations Code of Ethics (2005) notes the following:

> **C.2.g. Impairment**
> Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. *(See A.11.b., F.8.b.)*

Get a life! As an old friend used to say to me, the best way to promote emotional competence is to "Get a life!" To the extent that you are pursuing a life worth living and value yourself enough to take care of your personal and interpersonal needs, you will be well on your way to emotional competence.

Attend to your health needs. Physical health is the foundation of emotional health. Activities that promote physical health increase your ability to combat stress, depression, and anxiety. Don't overlook or minimize

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Welcome New and Returning Members

Ozge Akcali, PhD
Corvallis, OR

Heather Ambroson, MS, MA
Tigard, OR

Tina Amorok, PsyD
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Peggy Andersen, EdS
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Susannah Castle, PsyD
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Malgosia Cegielski, PhD
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Amy Crockford, BS
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William Davies
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Timofey Galuza, BA
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Daniel Gibson, MSW, MA
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Susan Glinka, BA
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Stephen Going, BS
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Jennifer Gomez, MS
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Lauren Gorog, MA
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Tera Hoffman, MS
Portland, OR

Tina Kang, MS
Beaverton, OR

Matia Kelly, BS
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Heather Kolodziej, MA
Lake Oswego, OR

Jenna Krueger, BA
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Allisen Landry, MA
Portland, OR

Alan Ledford, PhD
Grants Pass, OR

Daisy Lembke, PsyD
Portland, OR

Cindy Marino, BS
Portland, OR

Jennifer Moore
Hillsboro, OR

James Mours, PsyD
New Orleans, LA

Melinda Murray, BA
Portland, OR

Carolyn Narcavage, PsyD
Clackamas, OR

Timothy Neary, MA, MS
Pocatello, ID

Cynthia Parker, PhD
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Minal Patel, PsyD
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Brian Sandoval, PsyD
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Rochelle Schwartz, BA
Portland, OR

Alan Silver
Portland, OR

Ryan Skelton, PsyD
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Ann Sola, PsyD, MPH
Portland, OR

Clarissa Steffen, EdD
Springfield, OR

Kari Sulenes
Portland, OR

Lisa Thompson, MA
Gresham, OR

Wanda Tucker, MA, LPC
Beaverton, OR

Bethany Webb, BA
Newberg, OR

Emily Webster, BA
Hillsboro, OR

William Weiss, PhD
Vancouver, WA

Jennifer Wersland, MS
Portland, OR

Michelle Zietz-Zimmer, BS
Aloha, OR

Oregon Psychological Association

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your health care needs, and carefully examine any self-defeating behavior you engage in (e.g., working when sick, not asking for help when you are sick, and not letting others know you are sick or in pain).

Attend to your emotional needs. Mental health professionals are typically very sensitive to the emotional needs of others, but may not be as attuned to their own emotional needs. Increasing your "emotional IQ" is essential to maintaining emotional competence. Whether because of predisposing factors or practice-related stress, mental health professionals are at risk for stress, anxiety, depression, and vicarious traumatization. To the extent that a mental health professional is experiencing emotional problems, s/he will be less able to deal with the emotional problems of clients.

Attend to your social and sexual needs. Satisfying personal relationships and a healthy sex life help to promote a sense of well being and are antidotes to loneliness and poor interpersonal boundaries. To the extent that a mental health professional's needs for friendship and sexual intimacy are not met, s/he is at greater risk of meeting these needs through the exploitation of clients. It is worth considering that a significant percentage of therapists who become sexually involved with a client are sad, lonely, and without companionship. As a result, it becomes easy for such a therapist to form a romantic attachment to a client and fail to see how the budding romance is driven by unmet needs.

Be honest about the impact of any obsessions or compulsions: alcohol, drugs, sex, pornography, gambling.... Mental health professional are not immune from obsessions and compulsions and are at heightened risk of addictive behavior to the extent that emotional needs are not directly addressed. Addiction is a sure sign of a life out of balance and usually signals an inability to experience pleasure in life without external stimulation.

Seek out support for personal problems. Mental health professionals have an ethical responsibility to address personal problems that interfere with client care. This can be accomplished through family and friendship networks, spiritual guidance, professional coaches, professional support programs, or professional treatment. Considering that some mental health professionals are reluctant to pursue individual treatment, be sure to address any personal beliefs that discourage you from using professional treatment services. For example, do you attach any stigma to the prospect of seeking out personal therapy? Like other codes of conduct, the Code of Ethics of the National Association of Social Workers (2008) social workers to promptly address personal problems.

> **4.05 Impairment**
> (b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

Take time off from work - especially during periods of grief, loss, or significant disruption. No one is spared from the effects of major life losses. Diminished professional efficiency is a natural outcome of such losses. Take time off from work - practice self-care.

Notice when you are feeling trapped, victimized, or burnt out by your work. Buddhists say that pain is inevitable, but suffering is optional. To the extent that you are suffering at work, take charge of your life and recognize that your life is out of balance. Although some work settings (and client populations) are very stressful, even under the best of circumstances, feeling trapped, victimized and burnt out requires you to look at personal factors that contribute to your suffering.

Be mindful of compassion fatigue and vicarious traumatization. Although related to burn out, compassion fatigue is a special hazard for health and mental health care professionals. It is possible to give so much to others that you become emotionally depleted.

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Irreplaceable Miracle

By Lori Queen, PhD, OPA Colleague Assistance Committee

"Irreplaceable miracle." That's what one of my clients recently called me. This was the day before Thanksgiving, and many people were expressing their gratitude. I received a card from a client's wife telling me that I was at the top of her list of things for which she is thankful. Other clients brought me holiday goodies to munch on. And to be sure, I appreciated this... intellectually. Emotionally, it just sort of rolled off the surface. Now I understand part of that is appropriate. After all, it's not up to our clients to be the ones giving us our emotional gratification. But it was chilly to feel so disconnected from all that positiveness.

Yes, I know why this occurred, and it's not my intent to unload all that here. What I would like to do is talk a little about how we take care of ourselves, or don't. The Colleague Assistance Committee's ongoing goal is to figure out how to reach people. What we've realized is that often the people listening to us are the ones that don't need us. The ones that do need us, or might at least benefit somewhat from our services, are perhaps feeling as I was: disconnected and impervious to our outreach of support and assurance.

This is where I suggest one remember two things: 1) It is okay for life to suck; and 2) Don't forget to be your own best friend. The first reminder may sound either obvious or a bit contradictory, depending on your philosophy, but we all know that life does have a habit of being pretty rough sometimes. And not only are we, as psychologists, not immune to it, we often have a front row seat, be it for our own history of suffering or that of our clients. And spending time helping others can be particularly depleting if there isn't necessarily anyone there in turn to help you. This is when it's helpful to take the acceptance approach that "Yes, right now life sucks." Emphasis on "right now." And that, while it hurts, it is just a message that something is not right, something needs help or healing. That's all. It's not a judgment or condemnation. We just seem to take it that way.

And that's when being your own best friend comes in. Yes, best friends are supportive and loving. But they're also the ones that aren't afraid to call you out on your issues. They're more likely to be bluntly honest. And they're always there. Unfortunately, unlike T.V. shows, many people don't have those kind of best friends. If you don't have an attentive, loving partner at home, it can be a long time before anyone shows up to be that loving support

Continued on page 11

Irreplaceable Miracle continued from page 10

that will kick you in the pants to get you moving out of the dumps, as only someone who lives with you and has to put up with the gloom can do. You may actually need to be the one to do that for yourself.

So this is when you need those two reminders: "Yes, life sucks right now, and I do need some help even though I don't want it." Push past the urge to isolate. Get (lovingly) frustrated with the negative self-talk and versions of self-destructive behaviors (too much wine, Ben & Jerry's, sleep, work, etc). Let that internal "best friend" push you to make a call; to the CAC, a therapist, a friend, anyone that can help. And no, it won't be a quick and easy fix. As a psychologist you already know that. But as a person, let yourself trust it.

As people, we do better when we realize it's okay to need help. And as psychologists we particularly do better when we can lean into the things that make us suffer. That's when we learn, when we grow, and we become better people and better therapists. But yeah, it hurts like hell in the meantime. That's okay, as the Persian Sufi poet said way back when, and it's still true: "This too shall pass." Just like a rainstorm. And I know here in Oregon our rainstorms can seem to last forever, but they don't. And whether it's sooner or later, it's up to us if we are open to looking for the rainbow. Tacky and trite? Perhaps, but true nonetheless.

So stay mindful of your own process and your emotional resilience around life when it is getting rough. There is no need to struggle alone, and the Colleague Assistance Committee is a confidential group of peers who can help you to sort through resources and options to help clear away the storm. And remember, therapy is always confidential in Oregon.

OPA Workshop Calendar*

February 22, 2013
The Intersection of Neuroscience and Psychology
by Robert Hitzemann, PhD

March 15, 2013
Healing the Soul Wound: Treating Intergenerational Trauma
by Eduardo Duran, PhD
Information and registration available through www.4Cdiversity.com

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

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

Emotional Competence, continued from page 9

The net result is that you can become emotionally numb and client care can suffer. Relatedly, repeated exposure to client trauma traumatizes the treatment provider and creates all of the problems associated with a trauma disorder.

Shift, limit, or suspend your practice during periods of prolonged stress or professional impairment. Good client care is intimately related to good self-care. If you are impaired or experience prolonged stress, whenever possible, shift, limit, or suspend your practice. The American Psychological Association's Ethical Principles and Code of Conduct (2002) addresses similar concerns:

> **2.06 Personal Problems and Conflicts**
> (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend or terminate their work-related duties.

Make a lifetime commitment to consultation and supervision. Seek out support for professional issues that you find challenging or that could compromise your ability to provide good client care. Senior clinicians can provide needed perspective and can often offer time-tested strategies to cope with the challenges of mental health practice.

Create choice in your life: redefine or switch careers. Serving as a mental health professional has to be a choice, not a forced choice or a "default position." If your emotional competence has suffered due to personal or work-related problems, revision your career. Your distress may be a signal that you need to shift gears and redefine your career. For example, if possible, de-emphasize work with difficult, high-risk clients, spend more time teaching, or assume more supervision and administrative tasks. At times, it can be liberating to simply recognize that you can change careers. This doesn't mean that you can bring about a career change over night, but it does mean that you can set change in motion that will allow you to make such a change over a several year period.

Eric M. Johnson, PhD, is a board-certified clinical psychologist (ABPP) in full-time forensic practice in Portland, Oregon. A past president and Federal Advocacy Coordinator of the Oregon Psychological Association (OPA), Eric is a regular contributor to the OPA Bulletin. Eric is also institute director of Oregon Forensic Institute and Chair of the Juvenile Psychiatric Security Review Board. Eric provides trainings throughout the Northwest on ethical, legal, and forensic topics. He can be reached at EMJPDX@aol.com.

Clinical Internet Research Anyone?

By Bill McConochie, PhD

I enjoyed my guest dinner of tender, tasty scallops, courtesy of OPA, at the November meeting of the Lane County Psychological Association. Then we were treated to a detailed talk about the treatment of PTSD in military veterans by Julie Nelligan, PhD, followed by invitations to make innovative contributions to OPA activities, including copy for the newsletter. I asked Shoshana Kerewsky, our OPA rep, if such contributions could include Internet research of psychological issues. Cleverly, she said a perfect way to pose this question was via an article for the newsletter.

So, here goes. I have been doing research for years by loading questionnaires on my non-profit web site, Politicalpsychologyresearch.com. Students then typically complete the questionnaires for extra credit in their psychology classes in psychology at Lane Community College. They also immediately receive their scores on the traits and dispositions measured. Before the end of the term, they receive a one-page summary of the study findings.

Political psychology is a somewhat esoteric subject, and often not of central interest to clinical psychologists. But perhaps clinicians would be interested in a united effort to study a clinical topic, such as the I am currently studying via a 418-item questionnaire that measures about 40 psychological traits that might be related to spinal surgery outcomes. I was asked by a local surgery clinic this summer to do pre-surgery evaluations of patients.

Review of the literature of decades of prior research yielded mixed findings; some sources said there was sparse evidence of such traits. Another source, a book I suggested by Scott Pengelly of Eugene *(The Psychology of Spine Surgery by Andrew Block, et al)*, said there were scores of relevant traits. Having expertise in creating questionnaire measures, I decided to do a study to answer the question by measuring many traits, gathering data on surgery patients, and running correlations with patient expectations of outcomes. I also gathered and separate outcome ratings by spine surgeons.

By early November I had data on a handful of adults, most of whom had spine surgery histories. Though the sample was small, I ran some correlations. Twenty-five of the trait measures had substantial correlations (above .50) in the predicted directions between trait measures and two measures of patient outcome expectations: Diffuse Pain (.81**), Hypochondriasis (.79*), Poor social support (.74*), Financial worries (.80*), Depression (.69*), Psychotic symptoms (.80**), and "Afterlife doom" (.65). Thus, I am encouraged. I'll seek more data via collaboration with spine surgery clinics.

Perhaps OPA clinicians would be interested in joining in the study. I could load the questionnaire on a web site to which we could all refer subjects, including spine surgery patients and college and university students interested in how psychological research of this sort can be done.

If the results are promising, the questionnaire could be made available via the Internet for psychologist use in performing pre-surgery evaluations for surgery clinics. Questions about financing the project and services are open-ended, but the first step seems to be just vetting the project idea.

Other topics can be similarly explored as joint efforts. For example, I've toyed with the idea of a study to identify traits, communication habits, and opinions that differentiate successfully partnered adults from others. I suspect that there may be about twenty such traits and that having higher scores on more of them will characterize successfully married or otherwise intimately partnered adults. We could all contribute to the design of a questionnaire, as by suggesting traits for the study. We could then craft a questionnaire that measures, say, 30 or 40 traits with 15 items that assess each, including measures of marital/partnered status. We could load it on a web site, have 2,000 adults complete it, and run correlations. If it proves to be a fruitful instrument, it could be loaded on a site for anyone in the world to visit to take it for a modest fee.

We might create an affiliate for-profit organization that could thus generate income for OPA and fund the development of additional such instruments. I have measures of ADHD, depression, anxiety, PTSD, and verbal intelligence on my Testmasterinc web site, for example. They aren't big sellers, but that may be because I don't market the site well enough; the tests have good reliability and validity properties.

With half the marriages in our country ending in divorce, there's much room for improving our understanding of that institution. With PTSD and suicide constituting prominent problems for war veterans, there's room in that field, too, for new efforts.

Where to go from here? I suppose I can offer to form an ad hoc OPA committee to gather input and discuss possibilities. To this end, feel free to contact me at Bill@testmasterinc.com.

New CPT Codes for Psychotherapy

Dear Colleague:

The American Psychological Association Practice Organization (APAPO) has been communicating with members about new CPT® codes for psychotherapy that take effect on January 1, 2013. This removable publication provides an additional resource for your use as a handy reference guide.

Stay up-to-date with the latest information on the new codes by visiting our Practice Central website. The "2013 Psychotherapy Codes for Psychologists" section is found at **apapracticecentral.org/codes**. Also check for updates in our biweekly *PracticeUpdate* e-newsletter for APAPO members.

Thanks to our APAPO members for their continuing membership. You help others. We help you.

Sincerely,

Katherine C. Nordal

Katherine C. Nordal, PhD
Executive Director, APA Practice Organization

Beginning Jan. 1, 2013, all mental health professionals must use new CPT® code numbers for psychotherapy when billing clients and filing health insurance claims with third-party payers, including Medicare, Medicaid and private health insurance carriers.

The coding changes in store for 2013 involve only the psychotherapy family of codes – the codes found in the Psychiatry section of the 2013 CPT manual. There are no changes to other codes that psychologists use, such as testing or health and behavior codes.

Basic changes

As of Jan. 1, 2013, many diagnostic and therapeutic services will have new code numbers, and most of the codes now used for these services will be eliminated.

Yet the fundamental services underlying the codes will not change. All mental health professionals including psychologists, psychiatrists, nurses and social workers delivering psychotherapy services will use the same applicable codes for psychotherapy, though psychiatry will change how they bill for medical services.

Descriptions of the three new psychotherapy codes in the 2013 CPT manual are associated with specific times rather than the current time ranges that apply to these services (noted below in parentheses):

- **New Code 90832:** Psychotherapy, 30 minutes with patient and/or family member (not 20-30 minutes)
- **New Code 90834:** Psychotherapy, 45 minutes with patient and/or family member (not 45-50 minutes)
- **New Code 90837:** Psychotherapy, 60 minutes with patient and/or family member (not 75-80 minutes)

A couple of additional highlights related to psychotherapy codes for 2013 include:

Continued on the next page

- Outpatient and inpatient psychotherapy codes will be replaced by a single set of codes to be used for both settings.
- The code numbers and descriptions for psychoanalysis, family psychotherapy (with and without the patient), multi-family group psychotherapy and group psychotherapy will not change in 2013.

Add-on codes

There will be new "add-on" codes for specific services that can be provided only in combination with other diagnostic evaluation, psychotherapy and group psychotherapy services. Add-on codes identify an additional part of the treatment above and beyond the principal service. Both the principal service code and add-on code should be listed on the billing form.

The codes for interactive psychotherapy are being eliminated and replaced with an add-on code to capture "interactive complexity."

Interactive complexity, new add-on code 90785, refers to factors that complicate the delivery of a mental health procedure. Complicating factors include, for example, difficult communication with acrimonious family members and engagement of verbally undeveloped children. These factors are typically found with patients who:

- Have others legally responsible for their care, such as minors or adults with guardians,
- Request others such as family members or interpreters to be involved during the visit, or
- Require the involvement of third parties such as schools or probation officers.

Code 90785 may be reported with codes for diagnostic evaluation, psychotherapy and group psychotherapy. At least one of several circumstances identified in the CPT® manual that complicate the delivery of care must pertain in order for providers to bill the interactive complexity code as an add-on to the principal mental health procedure.

Pharmacologic management

Of particular interest to prescribing psychologists, a new add-on code 90863 will be used for pharmacologic management, including prescription and review of medication, when performed with psychotherapy services. A psychologist providing a psychotherapy service with medication management would report the 90863 add-on code along with the applicable new psychotherapy code.

Prescribing health care professionals who provide evaluation and management (E/M) services as well as psychotherapy will also have the following options, depending on the type of service delivered: Report an E/M code along with a psychotherapy add-on code if both E/M and psychotherapy are provided, or simply report an E/M code if only E/M is provided.

New crisis codes

There is a new principal code for a crisis psychotherapy session requiring urgent assessment and history of the crisis state, mental status exam and disposition. A new add-on code applies to crisis psychotherapy sessions lasting longer than 60 minutes.

In order for the new crisis codes to apply, the presenting problem must typically be life threatening or complex and require immediate attention to a patient in high distress.

Code 90839 will be billed for the first 60 minutes of psychotherapy for a patient in crisis, and add-on code 90840 will be billed for each additional 30 minutes of psychotherapy for crisis.

For more information related to billing the crisis and other codes, consult the 2013 CPT manual. Copies of the manual can be ordered from the American Medical Association online at https://catalog.ama-assn.org/Catalog/home.jsp or by calling toll-free, 800-621-8335.

Crosswalk of 2012 Psychotherapy CPT® Codes to 2013 Codes

Effective January 1, 2013

2012 Codes	2013 Codes
Diagnostic interview procedures	
90801, Psychiatric diagnostic interview examination	**90791,** Psychiatric diagnostic evaluation
Psychotherapy	
90804, Outpatient psychotherapy, 20-30 min **90816,** Inpatient psychotherapy , 20-30 min	**90832,** Psychotherapy, 30 minutes with patient and/or family member
90806, Outpatient psychotherapy, 45-50 min **90818,** Inpatient psychotherapy, 45-50 min	**90834,** Psychotherapy, 45 minutes with patient and/or family member
90808, Outpatient psychotherapy, 75-80 min **90821,** Inpatient psychotherapy, 75-80 min	**90837,** Psychotherapy, 60 minutes with patient and/or family member
90845,* Psychoanalysis	**90845,** Psychoanalysis
90846,* Family psychotherapy without the patient present	**90846,** Family psychotherapy without the patient present
90847,* Family psychotherapy, conjoint psychotherapy with the patient present	**90847,** Family psychotherapy, conjoint psychotherapy with the patient present
90849,* Multiple-family group psychotherapy	**90849,** Multiple-family group psychotherapy
90853,* Group psychotherapy (other than of a multiple-family group)	**90853,** Group psychotherapy (other than of a multiple-family group)
Codes for interactive services	
90802, Interactive psychiatric diagnostic evaluation	**90791,** plus interactive add-on code (90785)
All current interactive psychotherapy services (**90810 – 90815**, **90823 – 90829**)	**90785,** Add-on code to be used in conjunction with appropriate psychotherapy code based on length of the session
90857, Interactive group psychotherapy	**90853,** plus interactive add-on code (90785)
Psychotherapy for crisis	
None	**90839,** Psychotherapy for crisis, first 60 minutes
None	**90840,** Add-on for each additional 30 minutes of psychotherapy for crisis, used in conjunction with code 90839
Pharmacologic management add-on code	
90862, Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy	**90863,** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services; used only as add-on to principal psychotherapy code (90832, 90834, 90837)

* These codes are the same for 2012 and 2013.

The CPT® manual is available for purchase from the American Medical Association at https://catalog.ama-assn.org/Catalog/home.jsp, or by calling toll-free, 800-621-8335.

American Psychological Association Practice Organization
Practitioner Helpline: 800-374-2723 TDD/TTY: 202-336-6123
For additional questions, email us at praccodes@apa.org.

Q&A Answers to Psychologists' Questions about the 2013 Psychotherapy Codes

When do I use the new psychotherapy codes?

You will use the 2013 psychotherapy codes for billing clients and filing health insurance claims with third-party payers, including Medicare, Medicaid and private health insurance carriers, for psychotherapy services provided on or after Jan. 1, 2013.

What if a psychotherapy session is shorter or longer than the time specified in the code description?

All individual psychotherapy will be captured through one of three new codes. (See page 1.) Unlike the codes in existence through 2012, the new code descriptions in the 2013 CPT® manual list specific times (for example, 45 minutes) rather than a range (45-50 minutes).

Although the time for each code is specific, the manual allows for some flexibility. When reporting a psychotherapy service, the provider may choose the code closest to the actual time of the session. The examples provided in the manual are 16-37 minutes for code 90832, 38-52 minutes for 90834 and 53 minutes or more for 90837.

What happens if I bill using the old psychotherapy codes for services provided on Jan. 1, 2013, or later?

Effective Jan. 1, psychologists should assume that their Medicare carrier will reject any claims containing codes that have been deleted from CPT and that these claims will require refiling. We expect that private managed care and other insurance companies are also likely to reject claims filed using the 2012 psychotherapy codes.

What was psychology's role in the psychotherapy codes review process?

Revisions to the family of psychotherapy codes for 2013 resulted from the Five Year Review, the process by which the Centers for Medicare and Medicaid Services (CMS) periodically reviews all codes.

National associations representing psychology, psychiatry, child and adolescent psychiatry, social work and nursing participated in a confidential CPT coding workgroup process overseen by the American Medical Association (AMA). The multi-specialty workgroup evaluated the definitions of services under the existing psychotherapy family of codes and recommended work relative value units (RVUs) for the new psychotherapy codes. Along with other associations involved in the workgroup, the APA Practice Organization conducted a member survey during the spring of 2012 as part of the process of determining recommended work RVUs. The RVUs ultimately adopted by CMS are applied to the formula used by the federal agency in determining Medicare reimbursement rates.

Visit **apapracticecentral.org/codes** for additional answers to frequently asked questions and more information about the 2013 psychotherapy codes.

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*APA members who are licensed by a state board of psychology can renew their membership in the APA Practice Organization for 2013 online at **my.apa.org**. Log in using your APA user ID and password, click on "Renew Your Membership for 2013" and pay your 2013 Practice Assessment. You can also call APA Membership Services at 1-800-374-2721.*

**Printed with permission from Katherine Nordal, PhD, APA Practice Organization*

Hank Robb Receives Inaugural SMART Recovery Champion of the Year Award

Hank Robb, PhD received the inaugural SMART Recovery Champion of the Year award at the organization's annual meeting held in Chicago, Illinois September 19-21. Robb was a founding board member of SMART, Self-Management and Recovery Training, in 1994 and has continued his work locally and nationally. For a dozen years he has partnered with Portland area graduate psychology students looking to expand their skills in addressing addictive behavior and, in doing so, expanded the number of face-to-face meetings available in the four county region. For the last decade Robb has written a quarterly column for the organization's *News & Views* as well as presented and published nationally on SMART Recovery and addictive behavior. SMART, a four-point program for individuals choosing to abstain from addictive behavior, is based on empirically supported tools. It does not involve prayer, the removal of "character defects" or turning one's life over to a "Higher Power." It is recognized as an addiction resource by the American Academy of Family Physicians, the Center for Health Care Evaluation, The National Institute on Drug Abuse (NIDA), US Department of Health and Human Services, and the American Society of Addiction Medicine. Online meetings are available to English speakers around the world and, while the majority of face-to-face meeting still occur in North America, they also can be found many other countries including China, India and Uzbekistan. In addition to holding a certificate in the treatment of substance use disorders, Robb is certified in Behavioral & Cognitive Therapy by the American Board of Professional Psychology and previously served as President of the American Board of Counseling Psychology, President of the Idaho Psychological Association and Chair of the Idaho Board of Psychologist Examiners.

Oregon Psychological Association

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.

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, 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 to log 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.

Oregon Psychological Association

2013 Annual Conference

May 10 – 11, 2013

HILTON EUGENE CONFERENCE CENTER — EUGENE, OR

Mark your calendars to attend the OPA 2013 Conference in Eugene, Oregon. Information and registration will be available in late January, 2013.

www.opa.org

Giving Psychology Away

Nancy Williams, PhD, Public Education Committee

More than ever before, we need to educate the public about the value of psychotherapy. As discussed in the last issue of the OPA *Bulletin* in the article about depression, there is an increasing tendency for those suffering from depression to ask for drugs rather than to explore the possible causes of the depression with a therapist. To quote the article, "Research shows that psychology works. It is an effective way to help people make positive changes in their lives."

The New York Times on November 25th had a very interesting article by Lori Gottlieb in which she states that "psychotherapy is losing its customers," based upon her own experience starting a practice and her struggle to attract patients. She goes on to describe suggestions given to her for increasing her caseload. She explored a new specialized industry-branding consultants for therapists – these people focused on helping therapists develop a "brand" – what we might think of as a niche – so they could be matched with "today's consumer looking for quick solutions rather than long-term insight." In conclusion, she says that she "hates to think that therapy is an outdated idea, too slow and too private to satisfy a population that has come to expect immediate responses and constant gratification."

One solution to the "quick fix" trend is education. We all need to join in the effort to educate the public on the value of psychotherapy. The research supports our work and we need to advocate for our profession and the welfare of the public who can benefit from our expertise.

The Public Education Committee (PEC) is in the process of selecting a member of OPA who has made a significant contribution to public education in Oregon. This person will be given an award at the annual conference in May. The committee encourages members to submit names of members who have been engaged in public activities, anyone who has been "giving psychology away, " advancing our outreach in educating the public about the value and availability of psychotherapy.

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 on-line.

- 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.

Call for Nominations

OPA Public Education Award 2013

The OPA Public Education Committee is now accepting nominations for the OPA Public Education Award. Each day, psychologists in Oregon provide the public with information and education about psychology, healthcare, and the many roles psychologists fill. If you know a licensed psychologist and OPA member who exhibits excellence in public education please take a moment to nominate her or him.

Eligibility: Licensed psychologists in Oregon who are active OPA members and have participated in at least one public education activity in the preceding year are eligible for the Public Education Award. Examples of public education activities include being interviewed by the media on a psychology-related topic, speaking at a community event, or creating a public education initiative. Self-nominations are accepted. Members of the OPA Public Education Committee are not eligible.

Purpose of the award: The OPA Public Education Committee's mission is to educate the public about the functions and roles of psychologists and "make psychology a household word." We have developed the Public Education Award as a way to recognize and encourage public education activities by OPA members.

Award criteria: Nominees will be evaluated based on a number of criteria including career contributions to public education in Oregon, the number of public education activities, the uniqueness of the activities, and the reach and impact of their activities.

When the award will be given: The Public Education Award is given at the OPA Annual Conference in May.

Deadline for nominations: Nominations will be accepted until February 15, 2013. Submit nominations to info@opa.org or fax to 503.253.9172. Please see the nomination form on page 21.

Nominees may be contacted to obtain more information about their activities and the award winner will be notified before the May OPA conference. For questions please contact Sandy Ramirez at sandylou29@yahoo.com or 503.730.3702.

Oregon Psychological Association

OPA Public Education Award 2013
Nomination Form

Award Nominee

FIRST: _____ **LAST:** _____ **CREDENTIAL:** _____

PHONE: _____ FAX: _____ E-MAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Nominator

FIRST: _____ **LAST:** _____ **CREDENTIAL:** _____

PHONE: _____ FAX: _____ E-MAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Award criteria include: career contributions to public education in Oregon, the number of public education activities, the uniqueness of the activities, and the reach and impact of their activities.

Reason for nomination (Please be specific and reference the criteria above. Add additional pages as necessary):

Return to info@opa.org or fax to 503.253.9172 by 5 p.m., February 15, 2013

OPA Elections and Annual Meeting Notice

The following is information on OPA's upcoming board of directors election and annual meeting. Voting members of OPA will be mailed a ballot in late March on these issues and returned ballots are to be postmarked by May 3, 2013 in order to be tabulated. The OPA annual meeting will take place during our Annual Conference on May 10-11, 2013 at the Hilton Eugene Conference Center in Eugene, Oregon.

2013-2014 Elections Slate of Candidates

The following is a slate of candidates that the nominating committee presented to the board of directors. The board of directors has approved the following candidates for election:

Officer Positions

- Mary Peterson, PhD - President Elect
- Wendy Bourg, PhD - Treasurer
- Chris Wilson, PsyD – Secretary (second Term)

Director Positions

Please note that you will be asked to vote for 2 candidates for the director position

- Spencer Griffith, PsyD - two year position (second term)
- Maria Sophia Aguirre, PhD – two year position

Remaining board members will include (with the title that will go into effect on July 1, 2013): Eleanor Gil-Kashiwabara, PsyD, President; Julie Nelligan, PhD, Past President; Teri Strong, PhD, Director/APA Council Representative; Freda Bax, PsyD, Director; Karen Paez, PhD, Director; Alex Duncan, PsyD, Director/Ethics Committee Chair; Shahana Koslofsky, PhD, Director/ Diversity Committee Chair; Legislative Chair/Director TBA; Nancy Taylor Kemp, PhD, OBPE Liaison/Director; Carilyn Ellis, Student Representative; and the Lane County Chapter Representative; Eastern Oregon Chapter Representative; Southern Oregon Chapter Representative and a Central Oregon Chapter Representative are all to be announced.

Additional nominations may be made by written petition containing the signatures of no fewer than ten OPA voting members. Such nominating petitions must be received by the nominating committee chairman no later than two weeks after this newsletter announcement is sent out via email. Such nominations can be sent to OPA at info@opa.org.

If you have any questions, please contact Sandra Fisher at the OPA office at 503.253.9155 or 800.541.9798, or via email at info@opa.org.

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.

Oregon Psychological Association

Continuing Education Workshops • Winter 2012-2013

February 22, 2013

THE INTERSECTION OF NEUROSCIENCE AND PSYCHOLOGY

Presented by Robert Hitzemann, 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

Robert Hitzemann studied Chemistry as an undergraduate at Albion College in Albion, Michigan, obtaining a Bachelors of Science degree in 1967. He obtained an MS in Pharmacology from Wayne State University in Detroit, Michigan in 1970 and a PhD in Pharmacology from the University of California at San Francisco (UCSF) in 1975. He was an acting Assistant Professor from 1975-1976 and an Adjunct Assistant Professor from 1976-1979 in the UCSF Department of Pharmacology. In 1979, he moved to the Department of Psychiatry at the University of Cincinnati where he rose to the rank of Associate Professor. In 1985, he moved to the Department of Psychiatry at State University New York (SUNY) at Stony Brook, becoming a Full Professor in 1992. Since 2000 he has been Professor and Chairman of the Department of Behavioral Neuroscience at Oregon Health & Science University (OHSU) in Portland, Oregon. Over the past 20 years, his research has focused on using neuroimaging to assess the neuropathology associated with alcohol and drug abuse and the use of mouse models of psychiatric disease to understand the underlying genetic mechanisms. This work is funded by grants from the National Institutes of Health and the Department of Veterans Affairs. He is also Co-Director of the OHSU Brain Institute.

Workshop Description

Although it may seem obvious that neuroscience and psychology would often intersect, in reality this intersection probably occurs more frequently in the laboratory and the classroom than in the everyday practice of clinical psychologists. The goal of this workshop is to show that advances in neuroscience have the potential to inform clinical practice. Four topics will be discussed: a) Neuropsychopharmacology – Past, Present and Future; b) What have we learned from neuroimaging about the diagnosis and treatment of psychiatric disorders?; c) Genes, Genomes and Behavior – How the environment affects our genes; and d) What has neuroscience taught us about the diagnosis and treatment of depression? It may seem that these topics are unconnected but in reality that is not the case. For example, it is impossible to talk about new concepts of depression without considering genes, neuroimaging and neuropharmacology. The general format will be 90 minutes spent on each topic – 45 minutes of lecture followed by a discussion period.

A brief synopsis of each topic and some of the associated learning objectives follow.

A) Neuropsychopharmacology – Past, Present and Future

The practice of psychopharmacology is hardly new. Drugs like morphine, atropine, reserpine, ephedrine, cocaine, a wide variety of hallucinogenic drugs and of course, alcohol have been used for thousands of years. The beginning of modern psychopharmacology is a matter of debate but one safe argument is that it began somewhere between the synthesis of LSD in the 1940s and in the introduction of chlorpromazine to treat psychosis in the 1950s. This lecture will cover some basic principles of pharmacology but will emphasize how new drugs were discovered, the complexity of clinical trials for new drugs, drug effectiveness (or lack of effectiveness) and the future of new drug development. Particular attention will be paid to the interaction of cognitive and drug based therapies. The treatment of depression will be emphasized.

Neuropsychopharmacology Learning Objectives

- To apply some basic pharmacological principles that are practice relevant e.g. why is it safe to give a child methylphenidate (Ritalin) and not worry about drug abuse?
- To explain why the discovery of new neurotransmitters changed our thinking about drug discovery.
- To examine why some psychiatric disorders are seemingly drug resistant e.g. schizophrenia.
- To articulate the importance of the placebo effect.

Continued on the next page

B) What have we learned from neuroimaging about the diagnosis and treatment of psychiatric disorders?

In addition to the EEG, the use of techniques like MRI, PET, SPECT and some new optical imaging techniques have revolutionized our understanding of psychiatric diseases/ syndromes. We can now asses in real time how the waxing and waning of symptoms affects brain function. Structural abnormalities in the brain, e.g. enlarged ventricles, can be easily measured. From the functional side it is now possible to detect those brain regions which are associated with many abnormal behaviors e.g. the orbital frontal cortex and OCD. Equally important, neuroimaging has been used to detect the effects of cognitive therapy.

Neuroimaging Learning Objectives

- Analyze some basic principles of neuroimaging techniques, including their strengths and weaknesses.
- Examine and discuss when, if ever, neuroimaging will become an essential part of clinical practice.
- Predict how imaging techniques can detect subtle but persistent abnormalities in brain function.

C) Genes, Genomes and Behavior: How the environment affects our genes

We all recognize that within the next 10 to 20 years (and perhaps sooner) there is the strong possibility that we will keep in our wallets the sequence of our DNA on something about the size of a credit card. The costs of sequencing an individual genome to good accuracy is now less than $5,000 and the trajectory is clear that this cost will soon (< 5 years) be in the range of $100. How this information will be used in delivering medical and psychological care is an issue of concern to all. The potential for good and the potential for misuse are both great. What is generally somewhat less well recognized is that environmental influences can affect our DNA in ways that are passed on to subsequent generations. The evidence that this is true and that it can be easily measured is overwhelming from animal studies. There is the strong possibility that we will be able to detect (in probably less than the next 10-20 years) how the environment has affected an individual's DNA and how the consequences of these changes will affect the next generation; the data would need to be collected over time but if the cost is low, this may well be part of normal care. This phenomenon of gene-environment interactions is generally described as epigenetic interactions.

Genes, Genomes and Behavior Learning Objectives

Describe some basic principles of modern genomics, including how the data are measured and analyzed.

To assess that the environment can produce substantial and permanent changes in one's DNA – this is obvious from the perspective of cancer, less so to most from the perspective of behavior.

List the unique features of the brain which make it vulnerable to the effects of environmental by gene interactions.

D) What has neuroscience taught us about the diagnosis and treatment of depression?

This topic will attempt to not only provide new information about depression but also to integrate the information learned in the first three sessions. Depression is frequently encountered in clinical practice, even when the primary diagnosis is something else, e.g. drug abuse. Treating the depression is often one solution to dealing with the primary problem. Fortunately, there are a number of animal models of depression which have allowed scientists to investigate the underlying neurobiology. Neuroimaging which has pinpointed the brain regions associated with depression has led to clinical trials of deep brain stimulation to reverse symptoms. These trials, albeit small in number, have, in general, been successful. While we are not going to implant electrodes in all severely depressed individuals, the data obtained have led to a greater understanding of how to proceed with the next generation of depression treatments. The discussion of this topic will be followed by an open forum.

Diagnosis and Treatment of Depression Learning Objectives

- Explain, from the neurobiological perspective, current theories of depression.
- Discuss the concept that the brain is plastic and synaptic connections can be modified in a therapeutically beneficial manner by both antidepressants and cognitive behavioral therapy.
- To apply depression as a model for understanding the integration of neuroscience and clinical practice.

To register go to www.opa.org

OPA Classifieds

JOB OPPORTUNITY

Psychologist with skills in assessment and therapy for children and families wanted to join a multi-disciplinary private practice in Longview. NW Psychological Resources is a consortium of independent clinicians with a strong referral base, and is an NHSC approved site. Visit www.nwpsych.net for more information.

OFFICE SPACE

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

Allies in Change Relationship Groups for men are designed to help men learn how to be more successful and effective in their personal relationships by addressing anger, emotional abuse, and controlling behaviors. Groups are available for women as well. Health insurance accepted. Sliding scale fee. Phone: 503.297.7979 www.AlliesinChange.org.

Social Skills Groups: For teens and adults (ages 12-35) who are socially awkward, have Asperger's Disorder, or who have a non-verbal learning disability. These are 10 week groups that help participants fit in with peers, make friends, and avoid being bullied. Groups run quarterly in Portland, OR. Contact Michael Brooke, PsyD at 503.481.0020 or go to http://brookepsychologists.com/social_skills_groups.

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

Proactive billing company specializing in mental health wants to help you build your practice. 503.544.5735 | ActionBillingMgmt.com.

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.

OPA Bulletin 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 Bulletin 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 to not publish advertisements or articles.

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:

Allan Cordova, PhD
503.452.8002

Alex Duncan, PsyD, ABPP, Chair Elect
503.807.7180

Mary Gerrie, Student Member

Sally Grosscup, PhD
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*Newsletter Schedule**

2013

March/April Issue – deadline is March 1

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 Bulletin

Julie Nelligan, PhD • Chyrelle Martin, PsyD, Editor and 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.

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