The Oregon Psychologist

Bulletin of the Oregon Psychological Association

3rd Quarter 2015 Volume 34, Number 3

What's Inside

OPA President's Column

OPA Qualified, Capable of Healing, Building Trust

Wendy Bourg, PhD, OPA President

On July 1, 2015 I became President of Oregon Psychological Association. During the first 9 days of my term, I spent my time thinking about how to be a good steward of OPA's interests by helping the Board of Directors connect with members on a regular basis, by understanding the dreams that led our volunteer Board of Directors and committee members to give so generously of their time, and by viewing my role as a facilitator of communication and champion of translating those dreams into reality.

And then, on July 10, in the middle of our retreat, the first meeting of our year of service together, we learned that the Hoffman report, commisioned by APA, had been leaked to the *New York Times* and we were made aware of the devastating nature of its conclusions. One thought went through my mind, "Karma." I will tell you a brief personal story that I promise will weave back into this moment.

My journey on this path began in childhood, where I was able to sort my way out of a set of adverse childhood events that could have had a very different outcome. I learned to remain calm in a crisis and to think my way out of it. I became a psychologist because it makes me happy to share that gift of calmly considering options for survival, solution and healing, even in the roughest of times. I suspect many of us have become psychologists due to a similar gift. And like many psychologists, I embrace the yin and yang of crisis and truly believe that crises can be opportunities for growth, if support is available and resources are appropriately directed. And I chose to spend most of my time working in the area of high conflict divorce, wherein I firmly believe my clients are experiencing an attachment trauma, and remaining calm, empathic, and focused on solutions for the children helps me deal with some very difficult behavior.

Other than becoming a psychologist, the next chapter in that story involved a confluence of psychology and the other most important thread of my life, my children. I was doing exposure therapy with a man who lost his wife to a dry drowning. It was difficult and painful work to repeatedly hear the details of exactly how he watched her die. In the effort to help him feel some control to begin his healing, I looked up scientific information on the topic of dry drownings. Just as we wrapped up our work together, I chaperoned my son's class trip to Costa Rica. While we were there, one of the children on the trip suffered a dry drowning episode. The doctors were able to save his life, because of the bizarre coincidence that I happened to recognize the symptoms of this very rare phenomenon and was able to convince the doctors (in broken Spanish, mind you) to consider that hypothesis. And so my client's work to heal from his devastating loss helped prevent another family from experiencing that same devastating loss. And that

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OPA Helpful Contacts

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**Through OPA's relationship with Cooney, Cooney and Madigan, LLC 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 their services, you will receive their services at discounted rates. When calling, please identify yourself as an OPA member.*

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circled back into the client's healing when he heard that the boys' life had been saved due to his courage in confronting the pain and grief of the loss of his wife.

And now here we are, in this crisis together. I will share my viewpoints on what I think is happening to us and an outline of a path that I believe can lead us to healing. I include some thought-provoking references because I "grew up" in the Boulder model of scientist-practitioner and I firmly believe it is through the integration of art and science, empathy and reasoning, right and left brain that we achieve our highest ground. And, from the influence of spiritual traditions, I also believe that ultimately, though we walk this path together, we will each walk it in our own way. The ending of this story, for each one of us, will be ours alone. On the way, we can support and help each other. So here is my contribution to that journey, offered with the humbleness that it is merely one person's viewpoint and with the hope that it will stimulate you to share your thoughts on healing with others, too.

First, an article by one of Oregon's own, Dr. Jennifer Freyd, who has long written on betrayal trauma and recently penned an article for the *American Psychologist* on institutional betrayal (2014). I find her work applicable and helpful, and hope you will too. In essence the revelation of APA's role in supporting Bush administration policies on torture caused many of us to experience an institutional betrayal. The organization we trusted with our money, reputation, integrity and security let us down. Like children whose parents betray them with abusive acts, we were at first shocked and maybe overwhelmed or numb (or some of both) when we discovered we were unsafe where we thought we were safe. Like any adverse event, the impact varies from stressful to traumatic depending on our individual characters and histories. Like children responding to adverse events or like adults responding to betrayals in their intimate partnerships, we have three choices. We can turn a blind eye to the bad behavior in the hopes of maintaining the attachment. We can yield to our anger and cut off the relationship. Or we can do what we, as psychologists, are so uniquely positioned to do. We can begin walking the long road to re-building trust in this relationship. We know how to do this. We are the ones who studied the problem and created the evidence-based solutions that can renew trust in damaged relationships (c.f. the work of John Gottman and Janis Abrahms Spring). We created the tools and we know how to use them better than anyone. And we have many leaders in our own field to guide us.

And as we heal ourselves, we must ensure that our institution also grows stronger. If we don't learn from history, we are destined to repeat it. Our profession also offers many answers to these questions. I refer you to an article on groupthink by Dr. William McConochie in this issue. Groupthink is a phenomenon identified by and studied by psychologists and explains why and how dissenting voices are quashed in group processes, and how the process

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Diversity Resources on the Web

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. Check us out online!

- Go to www.opa.org and click on Committees and then Diversity Committee.

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

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of quashing those voices can have devastating consequences in decision-making. Embracing dissenting voices and attempting solutions that integrate their concerns is one path to avoiding disasters like this one. And on the core question of torture, we are already the leaders on better solutions in that area as well. Please see Herbert's (December 11, 2014) article on a better way to gather information from detainees.

Oddly, this connects to another thread of my experience, interviewing children about concerns of abuse. It turns out that many of the same techniques that are used to acquire reliable, accurate information from children are also the ones that yield high quality information from detainees. No torture or coercion needed. In fact, the use of coercive processes produces inaccurate information. The increased anxiety leads to problems with memory retrieval. And both children and adults will acquiesce to false information in order to terminate an aversive questioning process or please an authority figure. We are all human beings and we respond in some remarkably similar and predictable ways to how we are treated. High-quality information is derived from the use of empathy and narrative in conversations with people, including victims of crime, perpetrators of crime, prisoners of war, your clients, and even your friends and family. And there are hundreds of research studies establishing that fact, and guess who did that research? We did.

So I have shared my thoughts with you on the path to healing. We can stay calm and think and feel and research our way out of this. Whether you find my thoughts helpful, or you have some thoughts of your own that work much better for you (and if you do, please share them), I hope that we will all embrace the path of healing in our own unique ways. And I hope we will insist on transparency, accountability, and healing from the organization we trusted, and that they will equally engage in the hard work that it takes to earn our trust again.

And the same goes for OPA. We will be transparent, accountable and communicative with you throughout this year. We will be reaching out to you in many ways and we hope you reach out to us, too.

Thank you to Dr. Shahana Koslofsky and Dr. Daniel Reisberg for providing me with the citations that are included in this article.

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Preparing for ICD-10-CM

Freda Bax, PsyD, OPA Professional Affairs Committee

Get ready to leave the ICD-9-CM diagnostic classification system behind. As of October 1, 2015, health care professionals are required to use the ICD-10-CM code sets for diagnostic coding and billing purposes. Clinical services dated through September 30, 2015 require ICD-9-CM coding, while services beginning October 1, 2015 require ICD-10-CM coding.

The OPA Professional Affairs Committee (PAC) previously highlighted changes in the June, 2014 *Oregon Psychologist* article, "What's the 'Big Deal' with ICD-10?" In our ongoing effort to support OPA members through this transition, PAC is pleased to provide updated information. What follow are suggested best practices for adapting to these changes.

- **Understand the basic structure of ICD-10-CM and how it differs from ICD-9-CM.** Instead of the numeric codes that have been generally used by psychologists, all ICD-10-CM codes are alphanumeric. The letter corresponds to the relevant chapter where the code is found. Clinical psychologists are most likely to use Chapter 5, Mental, Behavioral, and Neurodevelopmental Disorders where codes begin with the letter F. For example, F10.2 is now used instead of 303.90. Health psychologists, neuropsychologists, and others might find additional chapters important, such as Chapter 6, Diseases of the Nervous System (Codes G00-G99). All psychologists will want to be familiar with Chapter 18, Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (Codes R00-R99). Within each chapter, disorders are clustered together so that similar disorders have similar codes.
- **Take advantage of resources to keep the ICD-10-CM codes handy and help you convert ICD-9-CM codes to ICD-10-CM by downloading the ICD-10-CM codes free of charge from the Centers for Disease Control and Prevention (CDC) website.** Go to the CDC website, http://www.cdc.gov/nchs/icd/icd10cm.htm, and scroll down to the **FY 2016 release of ICD-10-CM section.** The files are available in PDF and XML file formats.

  Psychologists may also want to use one of the ICD code conversion sites available at no charge such as ICD10Data.com to convert familiar ICD-9-CM codes to ICD-10-CM codes. Users may initially want to double-check the result by looking up the codes in the downloaded ICD-10-CM. Note that an overreliance on code conversion or crosswalk tools may result in choosing incorrect codes, given the far more numerous ICD-10-CM codes available compared to ICD-9-CM. Users should get in the habit of checking the results of conversion tools against the complete list of ICD-10-CM codes to ensure an appropriate degree of specificity in their choice of code.
- **Identify the ICD-9-CM codes you most commonly use in your practice and explore corresponding ICD-10-CM codes.** The transition from the ICD-9-CM to the ICD-10-CM is significantly more complicated for medical professionals than for mental health providers because the number of codes/diagnoses is changing from thousands to hundreds of thousands and most of these changes/additions fall within medical parameters. The ICD-10-CM system allows for greater specificity in coding compared with its predecessor. In particular, the substance use disorder codes listed in Chapter 5 are more extensive than in ICD-9-CM. For example, F10.2 is Alcohol Dependence, F10.23 is Alcohol Dependence with Withdrawal and F10.231 is Alcohol Dependence with Withdrawal Delirium. Luckily for us, the majority (if not all) of the diagnoses used by psychologists/mental health professionals are listed in the DSM-5. Additionally, the DSM-5 planned ahead for the ICD transition and already includes both ICD-9-CM and ICD-10-CM codes.
- **Promptly submit all claims for services provided on or shortly before September 30, 2015 using ICD-9-CM codes.** Avoid any backlog in claims filing as the October 1 transition date approaches in order to help safeguard your practice finances.
- **Make sure that all paper and electronic forms you use in filing claims for outpatient services on or after October 1, 2015 contain the ICD-10-CM codes.** Medicare and other payers will reject claims with dates of service on or after October 1 that contain ICD-9-CM codes.
- **Check with any billing service, clearinghouse or electronic health record (EHR)/practice management system vendor you use to ensure their readiness for ICD-10-CM.** Among the many resources available from the Centers for Medicare and Medicaid Services (CMS) website (www.cms.gov/ICD10) is the *Road to 10: the Small Physician Practice's Route to ICD-10,* available at www.roadto10.org. This CMS resource has helpful guidance and information from other health and mental health professionals, including practicing psychologists, even though it

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is tailored to small physician practices. It includes FAQs and videos, as well as templates to use when reviewing ICD-10 readiness with your billing service, clearinghouses, and other outside vendors. *Road to 10* also contains questions to ask payers with which you work.

- **Take advantage of training and system testing offered by any of the vendors and third-party payers with which you are affiliated.** Check vendor and payer websites for relevant information.
- **Ensure that any staff who handle billing and claims processing receive adequate training.** Available sources include online courses, webinars and even onsite training. Take advantage of training and educational resources offered by Medicare Administrative Contractors (MACs) and other applicable payers. For example, some MACs are offering webinars to interested Medicare Part B providers. Check their websites for details.
- **Have extra cash reserves on hand as October 1 approaches, or make other suitable financial accommodation in case you experience short-term disruption in cash flow during the transition to ICD-10-CM.** Taking this step is especially important if you rely heavily on third-party reimbursement.
- **Learn more from APA and the APA Practice Organization.**

For further information, please refer to the following:

- APA Members can find information about diagnostic codes through a web-based application free of charge. Log into my.apa.org and look under *Practice Tools*.
- More information about the transition to ICD-10-CM is available in the Billing and Coding section of the APA Practice Organization's Practice Central website at http://apapracticecentral.org/reimbursement/billing/index.aspx.
- *A Primer for ICD-10-CM Users* by Carol Goodheart is a spiral-bound resource from APA Books; it provides a helpful overview of ICD-10-CM and contains all of Chapter 5 (the F codes related to mental, behavioral, and neurodevelopmental disorders) as an appendix.
- The APA Office of Continuing Education in Psychology offers online programs on ICD-10-CM. Visit www.apa.org/education/ce/index.aspx and find available content at the link to *Professional Resources for Practice*.

Other helpful resources include:

- Centers or Medicare & Medicaid Services, Official CMS Industry Resources for ICD-10 Transition: www.cms.gov/ICD10
- Mobile apps and web-based code conversion tools are also available (for example, www.icd10data.com/Convert). If interested, go to the app store and search for ICD-10-CM products.
- *The ICD-10 Classification of Mental and Behavioural Disorders,* Clinical descriptions and diagnostic guidelines, World Health Organization: http://www.who.int/classifications/icd/en/bluebook.pdf
- American Psychological Association. (January, 2014). Your diagnostic codes are changing: https://www.apa.org/monitor/2014/01/diagnostic-codes.aspx
- American Psychiatric Association, DSM-5 Implementation and Development: DSM-5: http://www.dsm5.org/Pages/Default.aspx
- APA Practice Organization. (2015). Are you ready for ICD-10-CM? *Practice Update:* http://www.apapracticecentral.org/update/2015/05-14/international-diseases.aspx
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APA Council Representative Report

Teri Strong, PhD, APA Council Representative for Oregon

Most OPA members have been following the dramatic unfolding of the investigation into the roles psychologists played in enhanced interrogations during the Post-9/11 Bush era and any involvement of APA in either facilitating or withholding information about these activities. Many have been involved in the intense debate that has ensued since the PENS (Psychological Ethics and National Security) task force made its controversial report in 2005. As has been widely reported, the APA Council of Representatives met in Toronto in early August and passed a resolution that explicitly prohibits psychologists from participating in these types of interrogations. Given the complexity of these issues, I have chosen to publish in this column the statement that was released to all APA members after the APA Council meeting by APA's Past President Nadine Kaslow and President-Elect Susan McDaniel, members of the Special Committee for the Independent Review, on August 14, 2015. This is the most comprehensive statement to date as to the specific actions that will be taken by APA to address the findings of the Independent Review and set the organization on a path toward healing and reconciliation.

Dear Colleagues,

We are writing to report on the results of the American Psychological Association's (APA) Council of Representatives' (Council) deliberations on policies to address the major findings of the Independent Review that was conducted by David Hoffman and his colleagues. The Hoffman Report was commissioned by APA's Board of Directors and found there was undisclosed coordination between some APA officials and Department of Defense psychologists that resulted in less restrictive ethical guidance for military psychologists in national security settings. The findings were extremely troubling and required action.

During our annual convention in Toronto last week, the Council voted overwhelmingly to prohibit psychologists from participating in national security interrogations. The measure passed by a vote of 157-1, with 6 abstentions and 1 recusal. The resolution:

- states that psychologists "shall not conduct, supervise, be in the presence of, or otherwise assist any national security interrogations for any military or intelligence entities, including private contractors working on their behalf, nor advise on conditions of confinement insofar as these might facilitate such an interrogation";
- redefines the term "cruel, inhuman or degrading treatment or punishment" (CIDTP) in the 2006 and 2013 Council resolutions in accordance with the UN Convention Against Torture (rather than with the 1994 U.S. Reservations to this treaty, which were co-opted by the Bush administration to justify harsh interrogation techniques) to ensure it provides protections to everyone, everywhere, including foreign detainees held outside of the United States;
- continues to offer APA as a supportive resource for the ethical practice of psychologists in organizational settings (including those in military and national security roles), while recognizing that they strive to achieve and are responsible to uphold the highest levels of competence and ethics in their professional work;
- urges the U.S. government to withdraw its understandings of and reservations to the UN Convention Against Torture in keeping with the recent recommendation of the UN Committee Against Torture;
- clarifies that the UN Committee Against Torture and the UN Special Rapporteur Against Torture would serve as the authorities for determining whether certain detention settings would fall under the purview of the 2008 petition resolution as operating in violation of international law; and
- ensures that federal officials will be informed of the expanded APA human rights policy, while stipulating prohibited detention settings and requesting that psychologists at these sites be offered deployment elsewhere.

The prohibition does not apply to domestic law enforcement interrogations or domestic detention settings where detainees are under the protection of the U.S. Constitution.

The policy adopted by the Council clarifies that psychologists can only provide mental health services to military personnel or work for an independent third party to protect human rights at national security detention facilities deemed by the United Nations to be in violation of international law, such as the U.N. Convention Against Torture and the Geneva Conventions.

While this new Council resolution invokes Ethical Principle A to "take care to do no harm," it does not amend the Ethics Code and is not enforceable as a result. However, Council's implementation plan for the new policy requests that

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the Ethics Committee consider a course of action to render the prohibition against national security interrogations enforceable under the Ethics Code.

The Council also voted to create a blue-ribbon panel of psychologists and non-psychologist experts to review APA's Ethics Office and ethics policies and procedures and issue recommendations to ensure our policies are clear and aligned with the very best practices in the field. In addition, we will institute clearer conflict-of-interest policies going forward.

These positive and momentous actions by APA's Council and Board of Directors are significant and concrete steps toward rectifying past organizational shortcomings. While we are pleased with and humbled by the steps we have taken, we must be deeply reflective about the ways in which we must continue to put front and center protecting human rights and ethically serving the public through our science, practice, education, and advocacy efforts.

We are moving forward in a spirit of reform and reconciliation. We have much work ahead to change the culture of APA to be more transparent and clearly focused on human rights and our core values as psychologists. The steps we are taking are aimed at resetting our moral compass and ensuring that APA regains the trust of its members and the public.

We hope you will be part of this change. We appreciated the opportunity to hear from the convention participants who were able to attend the town hall meeting about these matters. For those who could not attend or who were not able to speak, know that we greatly value your honest feedback and suggestions on next steps for APA as we move forward. Please send your ideas and recommendations to IRfeedback@apa.org or visit the Independent Review page on www.apa.org, where there is a section to provide feedback.

Together, we can foster change and build a stronger association.

Sincerely,
Susan McDaniel, PhD, APA President-Elect
Nadine Kaslow, PhD, ABPP, APA Past President
Members of the Special Committee for the Independent Review

In my next column for *The Oregon Psychologist,* I will provide an update on the many other accomplishments that resulted from Council actions in Toronto. Please feel free to contact me if you have any questions or need further information at drterilstrong@gmail.com.

Doing Our Homework: Ethical, Clinical, and Personal Considerations in the Context of Working within Gender and Sexual Communities

Del Rapier, MS, MA & Lisa A. Schimmel, PhD, OPA Ethics Committee

Small communities may be both geographically defined (e.g., small towns, rural areas) and/or culturally defined (e.g., disability, military, faith-based, professional, recovery, gender, sexual, and ethnic communities). Characteristics of small culturally defined communities include shared values, interests, or sets of experiences that connect its members. The challenges of working in small, culturally defined communities are numerous and include concerns and, at times, conundrums regarding healthy boundaries, issues of competence, and awareness of cultural/community expectations and mores (Schank, Helbok, Haldeman, & Gallardo, 2010).

A clinician may be a member of one or several small communities and may be faced with finding ways to navigate a professional role and simultaneous need for community support and connection. For example, a Buddhist lesbian psychologist may be faced with providing psychotherapy to lesbian clients who have recently joined and attend the only small Buddhist temple in the community. A psychologist may identify strongly with a small community but have little expertise in the form of clinical training to work with this group. For example, a transgender psychologist may have personal and cultural awareness of his, her, or their own process but may have received limited clinical experience, supervision, and training to work with a current trans-identified client. When engaging in the process of balancing these situations, it is essential to explore the ethical principles that guide our practices as psychologists.

In reviewing our *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) there are several ethical principles that are relevant in the context of working within the bounds of small cultural communities. These include standards reflecting multiple relationships, avoidance of harm, competence, confidentiality, and conflicts of interest. Ethical Standard 3.05: Multiple Relationships advises avoiding multiple relationships if "the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists." However, it also makes the following exception: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical." Standard 3.04: Avoiding Harm is inherent in our work, as we are to "take reasonable steps to avoid harming clients/patients…and to minimize harm where it is foreseeable and unavoidable…."

In considering these two standards, imagine you are a gay male psychologist who is an active, long-standing member of the gay men's chorus. Your new client, who recently relocated to your city, shares his readiness and desire to connect within other gay men in ways that he feels comfortable with, namely, joining the gay men's chorus, the one that has been so valuable to you. He reports he was an active member of the gay men's chorus in his city, and believes joining the chorus now will help him develop community here and help him feel less isolated. You have several issues to consider at this juncture as you review these standards. Do you relinquish your community connection so that your client can develop his community support in the chorus? Do you discuss and establish specific boundaries that allow you both to enjoy the community that the chorus provides? Will you obtain consultation to help you consider options before addressing this issue with your client? How do you discern what is exploitative in this situation? Can you successfully maintain confidentiality, and ensure that your client receives excellent care therapeutically? This scenario highlights the tensions and opportunities for growth that arise in navigating small communities and the importance of addressing and re-visiting these types of issues.

In addition to our enforceable, ethical standards, we are also guided by aspirational principles, including Principle E: Respect for People's Rights and Dignity, which states that "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." It states that we are to be conscious of and "respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status" in the work that we provide and asks us to "try to eliminate the effect on [our] work of biases based on those factors."

As a clinician interested in working with gender and sexually diverse communities, it is necessary to consider several clinical competency factors, namely, knowledge of group diversity, cohort variability, awareness of personal bias, and ongoing awareness of political/societal shifts that affect these

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communities. With regard to within-group diversity, sexual orientation includes, but is not limited to, gay men, lesbian, questioning, bisexual, queer, and pansexual identities. Similarly, gender identity encompasses a variety of diverse groups (e.g., binary transgender identities, genderqueer, gender non-conforming, non-gendered). Learning about each of these sexual and gender identities is essential and this learning needs to include information about the historical and social cohort from which each client originated and any disenfranchisement he, she, or they may have endured or continue to experience based on their sexual or gender identities. For example, a client who came out as trans at age 49 in 2015 may have a very different experience of community support, consciousness about gender identity diversity, familial/societal recognition, safety, and awareness of resources than a client who came out as their 15-year-old trans counterpart in the same year.

Membership in one of these gender or sexual identity communities does not inherently limit bias in our work or exempt us from ongoing clinical training and personal growth in the form of supervision, consultation, or psychotherapy in this area. Bias in the form of assumption or over-identification runs the risk of blinding us in ways that may exploit or do disservice to the client and impair the therapeutic relationship. Knowing the bounds of competency includes further recognizing that sexual orientation is not the same as gender identity, and having competence in working with sexual orientation diversity does not guarantee competence in working with gender identity diversity and vice versa.

When therapeutically engaging with these two diverse cultural communities, it is important to consider the requests you might receive from a client from these populations, your professional and cultural values regarding these requests, and whether you are competent to provide the kind of support needed. Possible requests include being a character witness in a same-sex adoption proceeding, providing a letter for transition surgery (a.k.a. gender affirming surgery), receiving an invitation to a small pre-LGBTQQ Pride gathering where your client was also invited, or being asked to attend the wedding of your long-term gay couple for whom you have been the only essential, confirming role model.

In doing your homework around developing competence in working with sexual and gender communities, you might consider the following questions: If I have an interest in working within a small community, why might I not follow through? Are my fears of offending someone getting in the way of my decision to work with gender and sexually diverse communities? Do I feel I might be incapable of working within this diverse community because I am not one of its members? Or, do I fear being dismissed as a valid provider of services to that community? Does my informed consent document imply a higher level of competency with gender and sexual identity communities than I actually possess? Does the way I present myself on my website accurately represent my level of knowledge in working with these groups? How do I appropriately yet humanely navigate shared social contexts with my clients? Is there something that is keeping me from doing my homework around developing competence in working with these small communities?

As clinicians we intentionally work to create compassionate, safe, healing, and productive therapeutic connections with our clients. Working with sexual and gender small communities affords an opportunity to continually stretch and develop ourselves ethically, clinically, and personally.

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Gender and Violence

Chris Huffine, PsyD

Nearly half of all people in the U.S. have brown hair. What if you were to read a report tomorrow that indicated that people with brown hair committed 85% of the violent crimes, 90% of the homicides, and were, in general, 7 times more likely than other hair colors to commit a violent act in the U.S.? Would you become concerned about hair color? Would you start to wonder if, perhaps, we should start to understand what about being a brunette contributes to crime and violence? How would you feel if the hair color of perpetrators was virtually never mentioned, even though they did a significant majority of the crime in this country? We know, of course, that there is no significant connection between hair color and crime perpetration, but there is another demographic that the above statistics apply to that is virtually never mentioned in day to day discussions of violence and crime—gender. We know that men do, indeed, commit 90% of the homicides (Cooper & Smith, 2011) and 98% of the mass killings (Melnick, 4/23/2013), are seven times more likely to commit a violent act (Cooper & Smith, 2011), and comprise more than 80% of those arrested for most crimes (with the exception of prostitution) (Anonymous, n.d.). Virtually every form of violence known—murder, robbery, sexual assault, simple assault, elder abuse, domestic violence, war crimes, terroristic acts, etc., are primarily committed by males and often overwhelmingly committed by males. The only forms of violence where women are more likely to be the perpetrators are elder neglect and child abuse. However, even those statistics may be misleading since women are more likely than men to be around the children or caring for the elderly (e.g., you can't abuse a child or an older adult whom you have no contact with). This is a key point that Jackson Katz makes in his video "Tough Guise" (1999) and in his follow-up book *The Macho Paradox* (2006).

Our "gender blindness" is pervasive and continues to be quite troubling. You can find examples virtually every day. In an online article written last year about the causes of violence (Hayes, 2014), psychologist Laura Hayes challenged the misconception that mental illness causes violence, instead stating that "anger" is the primary cause. Unfortunately she did not make a single mention that most of these "angry" individuals are males. More recently, in the book *Why "Good Kids" Turn into Deadly Terrorists: Deconstructing the Accused Boston Marathon bombers and Others Like Them* (LoCicero, 2014) reviewed in the last issue of *The Oregon Psychologist,* political recruiters and cultural context are focused on, again without a single mention of the even more dominant quality of gender. "Good kids" is an overly broad characterization since the vast majority of terrorists are males. We shouldn't be asking why "good kids" turn into terrorists, but why "good boys" do. We are continuing to wrestle with issues like race in this country (e.g., the "Black Lives Matter" campaign) and homophobia (e.g., the recent Supreme Court decision supporting same-sex marriage), but sexism continues to be mostly off of our radar. Just one recent example of this was the theater shooting in July in Louisiana in which a man with a "history of mental illness" shot and killed two theater goers before killing himself. The movie showing in that theater was Amy Schumer's *Trainwreck* (Apatow, 2015) and since then she has spoken out in favor of gun control (and the ability of the "mentally ill" to access guns), including with her second cousin, a New York senator. What is striking is the complete absence of any discussion of gender. Not only was the gunman a male, but both of the people he killed were women, as

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OPA Public Education Committee Facebook Page - Check it Out!

We are pleased to announce the OPA Public Education Committee 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.

Go to https://www.facebook.com/pages/Oregon-Psychological-Association-OPA-Public-Education-Committee/160039007469003 to visit our Facebook page.

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were a number of those wounded. In fact, it is apparent that this killer, who openly spoke of his hatred of women, intentionally selected a "women's" movie that would likely have primarily women in attendance. Yet virtually no media outlet (or the movie's star and writer, Amy Schumer) has named this for what it clearly is—a hate crime against women. The only article I could find mentioning this factor was an article in *Huffington Post* (Licorish, 2015).

As psychologists, we are often asked about the psychology of violence, in particular the role that mental illness plays. We know that mental illness plays a small, almost negligible role in violence (Mental Health Reporting, n.d.) and it is important that we make this clear. On the other hand, it is equally important that we also name a clear factor that does play a role in violence—that of gender and, I believe, gender socialization. A key aspect of stopping violence is addressing the underlying gender socialization which involves a simultaneous embracing of masculinity and rejection of femininity. It is central in the work I do on a daily basis with men who have done domestic violence. It is vital that we include a gender analysis in these crimes and acts of violence and understand that without addressing the role of gender socialization we won't be adequately naming, acknowledging, or addressing what is really going on.

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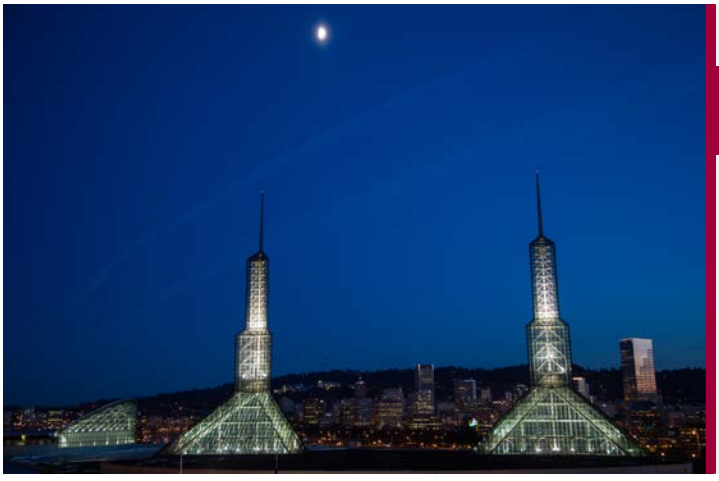
PAC Notes On the Web

The Professional Affairs Committee (PAC) would like to remind OPA Members of content available on the OPA website (www.opa.org). In the Professional Affairs Committee section, the PAC has a subsection with an assortment of resources for members. Included are articles related to practice by PAC members, guidelines, and a template for professional wills to help get us all compliant, information on APA Record Keeping Guidelines, links to CEUs related to practice, and more!



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Save the Date!

OPA Annual Conference

May 6-7, 2016

Oregon Convention Center

Portland, OR

APA/DOD Collusion: Physician Heal Thyself

William McConochie, PhD, OPA Board, Lane County Chapter Representative, Political Psychology Research, Inc.

The recent Hoffman report revealed that several top officials of the American Psychological Association colluded with the Department of Defense to enable psychologists working in military prisons to participate in interrogation of prisoners using procedures considered to be torture. The APA collusion was designed to keep APA ethics principles loosely defined to permit torture without violating professional ethics.

Apparently, there were two implicit underlying dynamics that facilitated this misbehavior. One was financial benefit. The Department of Defense is the largest employer of psychologists in the nation. Thus, to keep these psychologists happily employed and especially those involved in prison activities that were apparently very handsomely recompensed, collusion protected income of APA members. In addition, it was payback time to the Department of Defense, which had helped psychologists by developing programs to certify psychologists with prescription privileges. Participating in torture programs indirectly paid the Department of Defense back for initiating the prescription privilege program.

The other dynamic underlying the collusion appears to have been groupthink. Three of the 10 members of the PENS committee opposed the efforts to collude with the Department of Defense but were argued down by the other seven members, who were directly involved in the military activities themselves. Under testimony to the Hoffman investigation, the three psychologists suggested that they may have been intimidated by principles of groupthink to sign the original agreement, even though it conflicted with their underlying better judgment.

In my specialization of political psychology, I have in recent years done research that led to a couple of scales suggestive of groupthink. I followed these up with a more direct study to clarify psychological dimensions of groupthink and measure them with questionnaires, a technique that had previously not been applied to this area of study, as far as I could tell. In thinking about the Hoffman report and its implications, the admonitions to physicians to do no harm, and curing oneself came to mind. A related principle in clinical psychology is evidenced-based treatment programs.

It occurred to me that the dimensions of groupthink that came out of my studies could be used as a questionnaire that psychologists could use to assess their own groupthink-proneness. To this end, I created a 77-item questionnaire based on this research. The questionnaire measures nine facets of groupthink, six that measure classic groupthink as a counterproductive trait and three that measure facets of what I have imagined can be a constructive form of groupthink. I have designed a way to validate the instrument specifically for psychologists in terms of the issues of professional ethics raised by the Hoffman report. At the end of the questionnaire I provide scoring instructions so that people can compute their own scores to evaluate their level of the different facets.

My political psychology research has also yielded half a dozen questionnaire measures of economic attitudes that might be used as a measure of financial greed of sorts. This cluster of facets might enable psychologists to measure their "greed-proneness," so to speak.

The overall idea of this approach is to encourage psychologists to realize that some of us may be prone to the counterproductive influences of groupthink and financial benefit to fudge our ethics as professionals. On the principle of "heal thyself" and of evidenced-based treatment, I think it behooves us to explore these dimensions and be responsible for being aware of them and of our personal vulnerabilities to be seduced by them. I believe APA should add to its ethical code two items to obligate professional psychologists to be aware of and to guard against groupthink and financial greed as possible sources of temptation to fudge one's ethics.

The groupthink-proneness instrument is presented below for your consideration. If you are interested in helping with a validation study, I would be happy to hear from you. I am a new member of the Oregon Psychological Association Board of Directors, and will be sharing these ideas with the board for discussion at a future meeting. My e-mail address is bill@politicalpsychologyresearch.com.

Professional Perspectives Questionnaire

Please circle one number to indicate how strongly you agree or disagree with each of the items below, using this code:

Strongly disagree **1**

Disagree **2**

Neutral or between 2 & 4 ..... **3**

Agree **4**

Strongly agree **5**

1	2	3	4	5

1. I am totally devoted to my preferred government and religious leaders.

1	2	3	4	5

2. In general, the leaders of a group are more important than are the group members.

1	2	3	4	5

3. In conversations with others, I prefer the clear guidelines of rules and doctrine to the uncertainties of personal opinions.

1	2	3	4	5

4. We should not question persons in positions of authority but rather take them at their word.

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APA/DOD Collusion, continued from page 14

1 2 3 4 5

5. I prefer to be part of a group who all believe in the same things and worship the same way.

1 2 3 4 5

6. What my leaders tell me is the truth is the truth.

1 2 3 4 5

7. The more people there are who believe something, the truer that belief is.

1 2 3 4 5

8. I see little point in learning new ways of doing things as long as proven ways work.

1 2 3 4 5

9. If scientists come up with facts that are contrary to my religious beliefs, I expect my religious leaders to explain why the claims of the scientists are false.

1 2 3 4 5

10. Often the best leadership can be characterized as almost divine in inspiration.

1 2 3 4 5

11. In crisis, the best plans can come from intuition alone.

1 2 3 4 5

12. Good plans for handling a crisis can originate in dreams and even in horoscope advice.

1 2 3 4 5

13. Intuition is better than formal planning procedures.

1 2 3 4 5

14. Believing that your group's ethical foundation is unquestionable can expedite good decisions in crises.

1 2 3 4 5

15. My self-confidence is unflinching, even when others doubt me.

1 2 3 4 5

16. I usually have a sense of superiority when contemplating competition against another individual or group.

1 2 3 4 5

17. I would rather take a chance and make a guess about how to solve a difficult problem than be very cautious.

1 2 3 4 5

18. A group is almost certain to win in conflicts with other groups if its mission is noble and correct.

1 2 3 4 5

19. A group that is dedicated to doing what is right will have advantages over other groups that are not so dedicated.

1 2 3 4 5

20. The plans and strategies of a group are almost certain to succeed if its leaders are confident of the inferiority of their opponents.

1 2 3 4 5

21. Individuals or groups against which I have competed have usually seemed inferior.

1 2 3 4 5

22. Enemies of groups to which I have belonged have been by nature inferior to our group.

1 2 3 4 5

23. In competition it is wise to think your group is likely to defeat any opponent.

1 2 3 4 5

24. Consistent winning in competition requires one's group to see itself as superior to all opponents.

1 2 3 4 5

25. For group success one should believe that your leaders are superior to your opponents' leaders.

1 2 3 4 5

26. In times of great stress members of a group should be willing to follow bold leaders without hesitation.

1 2 3 4 5

27. For competition, the primary design of plans should come from a leader with strong opinions.

1 2 3 4 5

28. Religious inspiration should be a primary guide when making group decisions in critical situations.

1 2 3 4 5

29. With sufficient faith in God, a group is bound to succeed.

1 2 3 4 5

30. For group success one should believe that your leaders are superior to your opponents' leaders.

1 2 3 4 5

31. It is better to trust leaders' judgments in crisis situations than to risk their disapproval by offering contrary ideas.

1 2 3 4 5

32. In times of crisis, questioning or criticism of leaders should not be tolerated.

1 2 3 4 5

33. In times of great stress members of a group should be willing to follow bold leaders without hesitation.

1 2 3 4 5

34. I believe in deferring to my superiors' judgments in crisis situations.

1 2 3 4 5

35. My leaders' understanding is virtually always superior to my own.

Continued on page 16

APA/DOD Collusion, continued from page 15

1 2 3 4 5

36. It is important to follow without question those above you in the chain of command.

1 2 3 4 5

37. It is important to dominate those below you in the chain of command.

1 2 3 4 5

38. When making decisions under crisis it is important for everyone to agree on action plans without question.

1 2 3 4 5

39. Planning in crisis is best with minimal input from outside sources.

1 2 3 4 5

40. Decisions in competitive situations should be made from inside sources rather than from outside sources.

1 2 3 4 5

41. The best decisions in a crisis come from a top leader with firm initial ideas and plans.

1 2 3 4 5

42. The best plans originate virtually exclusively in the mind of a charismatic leader.

1 2 3 4 5

43. In crisis, the best plans can come from intuition alone.

1 2 3 4 5

44. A group is almost certain to win in conflicts with other groups if its mission is noble and correct.

1 2 3 4 5

45. When dealing with an enemy or competitor, it is more important to plan a good first move than to study what one's opponent is up to.

1 2 3 4 5

46. It is more important to assess one's own resources than to study one's opponent's resources.

1 2 3 4 5

47. Once a plan is taking shape, it makes little sense to consider changing it depending on opponent actions.

1 2 3 4 5

48. Studying one's opponent during the planning process is unwise, as the opponent may be trying to fool you with false moves.

1 2 3 4 5

49. If most people want things done a certain way, they are probably right.

1 2 3 4 5

50. I'd rather do what my close friends or associates want to do than go my own way.

1 2 3 4 5

51. I like the saying "If we don't hang together, we'll hang separately."

1 2 3 4 5

52. If our nation's access to natural resources, such as oil or uranium ore, is threatened, we must be willing to wage war immediately.

1 2 3 4 5

53. If terrorists or other nations attack us, we should retaliate immediately.

1 2 3 4 5

54. I am inclined to do what benefits me today, regardless of possible bad results later from what I do.

1 2 3 4 5

55. I would rather enjoy chocolate, ice cream or cake today than refrain to avoid being overweight in the future.

1 2 3 4 5

56. If I were a member of a union, I would expect the union to fight for high wages and benefits for me in the short run even if it destroyed my employer's company in the long run.

1 2 3 4 5

57. I expect my preferred politicians in national government to oppose competing party efforts so that my politicians will look better in the next election, even if it means impeding current government.

1 2 3 4 5

58. In times of peace, questioning or criticism of leaders should be tolerated.

1 2 3 4 5

59. An organization should expect leaders to be prudent and thoughtful in times of peace and calm.

1 2 3 4 5

60. In times of peace and calm, leader plans should be subject to modification from subordinates' ideas.

1 2 3 4 5

61. In peaceful situations it is wise to consider many alternatives to solving community problems.

1 2 3 4 5

62. It is important to be considerate and fair to those below you in the chain of command.

1 2 3 4 5

63. Believing that your group's ethical foundation is reasonable can expedite good decisions in times of calm.

1 2 3 4 5

64. A good leader will seek advice from others before taking great risks.

1 2 3 4 5

65. In times of calm, getting to good plans should allow time enough to consider relevant details.

1 2 3 4 5

66. In crisis situations it is better to offer helpful suggestions to leaders than just trust their judgments.

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APA/DOD Collusion, continued from page 16

1	2	3	4	5

67. In times of calm, the best plans come from openly discussing ideas.

1	2	3	4	5

68. The best plans originate in the minds of all interested community members.

1	2	3	4	5

69. The best leadership can be characterized as an expression of the good will of the community.

1	2	3	4	5

70. The best decisions in time of community calm come from leaders and community members working together.

1	2	3	4	5

71. Decisions in times of calm should be made with information from outside as well as inside sources.

1	2	3	4	5

72. Design of plans should be based in part on input from everyone who will be influenced by those plans.

1	2	3	4	5

73. In competition, it is important to study what one's opponent is up to.

1	2	3	4	5

74. In competition, it is important to assess the resources of one's opponent.

1	2	3	4	5

75. Studying one's opponent during the planning process is wise, as it may provide important information.

1	2	3	4	5

76. In competition it makes sense to consider changing plans depending on opponent actions.

1	2	3	4	5

77. I often have good advice to contribute to leaders when important plans are being made.

Scoring:

1-4 Four-item groupthink scale, 64 traits study. 4
Scoring: Add items 1-4, divide by 5.
Scores above 3.5 = Caution. High scores suggest tendency to endorse beliefs consistent with groupthink.

5-9 Gpt5 scale. Five-item groupthink scale. 5
Add items 5-9. Divide by 5. Scores above 3.5 = Caution. High scores suggest tendency to endorse beliefs consistent with groupthink.

10-26 In group superiority. 17
Add items 10-26, divide by 17. Scores above 3.5 = Caution. High scores suggest tendency to endorse membership in groups that feel superior to other groups.

27-37 Authoritarian leadership trust. 11
Add items 27-37, divide by 11. Scores above 3.5 = Caution. High scores suggest tendency to trust authoritarian leadership strongly.

38-48. Insular leadership planning. 11
Add items 38-48, divide by 11. Scores above 3.5 = Caution. High scores suggest tendency to be insular when involved in leadership planning.

49-57. GTN9Ex. Groupthink. 9
Add items 49-57, divide by 9. Scores above 3.5 = Caution. High scores suggest tendency to endorse groupthink in general.

58- 66. Open-minded democratic leadership. 9
Add items 58-66, divide by 9. Scores BELOW 3.0 = Caution. Low scores suggest tendency to disavow democratic leadership processes.

67-72. Community planning. 6
Add items 67-72, divide by 6. Scores BELOW 3.0 = Caution. Low scores suggest tendency to disregard common good of one's community.

73-77. Opponent assessment planning. 5
Add items 73-77, divide by 5. Scores BELOW 3.0 = Caution. Low scores suggest tendency to disrespect groups against which one is competing.

Seeking to Understand; Seeking to Help

Nathan W. Engle, MA, George Fox University, Graduate Department of Clinical Psychology

As soccer practice started one day back in high school, I remember my coach gathering us together to share an announcement—one of our teammates would not be with us for a couple weeks of practice and games because his father passed away from suicide. My eyes were wide as I stopped messing with a soccer ball between my feet and studied the faces of my friends. Some teammates already knew, judging by the bowing of their heads. Others just stood still with eyes glued to the now-silent coach. After the coach broke the stillness with an announcement of the first drill, I spoke softly to one of my teammates and said, "Why did he kill himself?"

In that moment, I did not realize the complexity of the situation or know what to do with the few pieces of information I gathered from uninformed peers. All I knew is that I was sad, confused, and very curious. I made countless speculations as to what may have happened. I wondered if there were arguments, threats, or division in their family. I wondered if he was sick, although I did not know what I meant by that. I remember struggling with how little I knew and how uneasy I felt.

Jumping forward to graduate school, I received training on evaluating risk factors of suicide and personally explored those conflicting feelings that arose in my soul way back in high school. At times, I desired to know as much as possible about human experience, pain, suffering, and living well. At other times, I felt overwhelmed by my overall powerlessness and inability to change my feelings of pain or confusion. It was an interesting set of feelings I discovered when I dove deeper into the confusing sadness only to find a broader, more powerful set of feelings reflecting my finiteness, my dependency on others, and my need for help just as much as anyone else—just like my friend's dad.

I once hoped to apply all I knew about life and living well to myself and live happily ever after. For a time I even openly pursued this idealism as a pseudo-spiritual practice. However, I always returned to the reality that even if I understood all aspects of human struggle, I would be left—at best—with a style of living that was obsessed with being good, strong, and safe enough.

Since the days of Freud and Wundt, psychology has evolved into a complex professional field. A playing field that presents a gauntlet of stressors that is not dissimilar from other vocations. Despite professional training and potential resource of personal psychotherapy, research continues to confirm that psychologists deal with stress of life the same as everyone else—a magnanimous journey of meaning-making notwithstanding anxiety, pain, and/or death.

Some of the research results I recently contributed echoed the reality of psychologists "being human." These results showed that nearly 36% of psychologists' professional life stress is accounted for by the emotional well-being of the psychologist. Stated succinctly, the emotional aches and pains of life explain over a third of stress that burdens psychologists and their work.

APA increasingly advocates for state psychological associations to address professional life stress of local psychologists. Yet, the impact of stress on a psychologists' professional career remains quite similar to the lives of other stress-impacted professions. Since it is clear that suicide is highly correlated with mood-related struggles, suicide prevalence is a realistic concern among psychologists. The APA's Advisory Committee on Colleague Assistance investigated the incidence of suicide for psychologists and found an increase in suicide attempts by practicing psychologists over the last two decades (Kleespies et al., 2011).

My recent research found that over 38% of effective coping strategies are individually-based coping strategies, such as mindfulness activities and friends. Surprisingly, personal psychotherapy did not make the cut—at all. Further research into why personal therapy is not a particularly effective way for psychologists to cope with professional stress may help us understand more about the importance of identifying an effective style of coping and continue investing in the strategies that work.

One of the greatest lessons I learned in graduate school was not how to conceptualize stress or develop sophisticated ways of coping but, rather, the realization that I, too, am an ordinary human in need of life skills and a supportive community.

I may never know the reasons why my friend's dad killed himself. I may never know if I could have predicted it. Perhaps the better questions are how did he struggle, how did he cope, and how did we help?

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Federal Advocacy Update

Eleanor Gil-Kashiwabara, PsyD, OPA Federal Advocacy Coordinator

Hello OPA!

I want to introduce myself to those of you who do not know me, and provide an update on my new role with OPA to those of you who do know me.

My name is Eleanor Gil-Kashiwabara. I am a Past President of OPA and have served in multiple roles on the OPA Board over the years, including Diversity Committee Chair, Secretary, and Treasurer. I have recently been appointed to the role of OPA Federal Advocacy Coordinator (FAC). It is an honor to serve in this role.

Many folks may wonder exactly what this "FAC" role entails. Well, each State Psychological and Territorial Association (SPTA) is appointed an FAC (due to their size, a few states have two). My job includes cultivating and strengthening relationships with members of Congress in Oregon, being identified as a key contact on mental health issues before Congress, and developing and maintaining an effective grassroots network of psychologists within our state.

Furthermore, the FAC is committed to strengthening the involvement of psychologists in their state in advocating for legislation that advances the profession of psychology. How? By organizing and supervising grassroots initiatives for federal issues in their state. I will work closely with our Legislative Committee members (who are working on our legislative issues at the state level) in order to coordinate efforts as applicable and communicate efficiently around legislative issues that impact our work and our clients' access to care.

From time to time you will receive an e-mail from me. These e-mails will be federal legislative and regulatory requests-for-action from the APA Practice Organization. They will be titled "ACTION ALERT," reflecting contact from APA Government Relations staff or from the regional field consultants. I will distribute these ACTION ALERTS to special assessment payers in Oregon. These e-mails from me will be inviting you (pretty please) to engage in some specific form of advocacy (such as a letter or call to Congress) in order to support an effort that will benefit our work as psychologists and ultimately the care/access to care of our clients. Please read the alerts when I send them and consider taking a moment to act. Sometimes it is just as simple as adding your signature. Sometimes my ask might be more involved and I will do my best to provide understandable explanations around the purpose and potential impact or goal of the requested action. Please keep in mind that I am making requests because your participation is necessary in order for change to happen. While I am happy to serve as FAC, we can best impact the needed changes if we respond collectively to the alerts and other requests that you receive.

Last, but definitely not least, I want to acknowledge all of the hard work of Cliff Johannsen, who served as OPA's FAC for the past 9 years. I have big shoes to fill so I appreciate in advance your patience with my learning curve! Thanks to Cliff for the years of service as FAC, and thank you for representing Oregon in your next role on the APA Council of Representatives.

Thanks for reading and please feel free to contact me at gilkashi@pdx.edu if there are ways I can be of support in this role.

Oregon Psychological Association

OPA 2015 Final Legislative Report

By Robin Henderson, PsyD, OPA Legislative Committee Chair and Lara Smith, OPA Lobbyist

The 2015 Legislative Session proved to be a fairly successful one for the OPA. OPA weighed in on many bills and played a major role in a few significant bills. Here are highlights of some of the key bills OPA had impact on this session.

SB 832 - This bill was brought by OPA's Legislative Chair, Dr. Robin Henderson. Despite many hurdles and tough negotiations with multiple parties the bill passedwith flying colors. This bill sets the path for the Oregon Health Authority to integrate behavioral health services and physical health services in patient centered primary homes and behavioral health homes. This means that psychologists for the first time will be able to work and have their services reimbursed by Medicaid in primary care homes. The bill is already in rule-making through the Person Centered Primary Care Home Standards Advisory Committee, and OPA has two members sitting on this committee.

HB 2044 - This was a bill that was once again brought by Walden University and would weaken the licensing standards for psychologists in Oregon. The OPA strongly opposed this bill as well as the bills brought by this organization in the past. We met early in the Session with members of the House Higher Education Committee where the bill was assigned and explained our concerns. The bill was never scheduled for a hearing. However, the proponents tried to amend SB 418 with their language on the Senate side. The amendment had a brief hearing but was not adopted. OPA has worked with the APA to provide language that would allow Walden University graduates to be licensed in Oregon, but Walden has not been interested in pursuing these options at this time.

HB 2307 – This bill prohibits mental health providers from practicing conversion therapy on minors. Basic Rights Oregon introduced this bill and consulted with the OPA many months before the Session started. Dr. Brad Larsen-Sanchez, an OPA Diversity Committee member, took the lead on this subject and spent many hours on background work, and testified in support on behalf of the OPA. The bill passed and received national attention.

HB 3427 – Originally this bill would have prohibited insurers from reducing reimbursement rates by more than 5% in 2 years and specified the amount of reimbursement to be paid to mental health providers that pegged to the reimbursement of psychiatrists. This bill was introduced by the Oregon Independent Mental Health Practitioners. The OPA Legislative Committee had many conversations regarding this and ultimately found it to be very problematic as written. Instead of opposing we suggested to the proponents that the bill be amended to create a task force on mental health care reimbursement. All of the mental health provider associations agreed to this approach. The bill was amended with this language and sent to Ways & Means for funding. Despite heavy lobbying efforts on behalf of all of the associations the bill failed due to lack of funding. The OPA legislative committee will continue to work with the other associations on this difficult issue.

SB 696 – This bill modifies the statutes relating to the Behavior Analysis Regulatory Board within the Health Licensing Office of the Oregon Health Authority. The bill defines applied behavior analysis, includes criteria for licensing, and increases the membership of the Board from seven members to nine. The bill also grandfathers in those individuals that were already practicing behavior analysis in 2013, and does not require a license of those individuals until July 1, 2018. OPA's Dr. Carol Markovics spent much time and efforts ensuring that licensed psychologists did not have to obtain the additional certificate to practice this therapy.

You can obtain a full list of the bills OPA followed in this session at www.opa.org. You must be logged in as a member to access the report. The report can be found under the Committee menu, then Legislative Committee, then the blue button that says Legislative Session Reports.

OPA 2016 Conference
Request for Presentations

Now is the time to set aside May 6-7, 2016 for the OPA Conference at the Oregon Convention Center in Portland, OR. This is also the official call for presentations.

- Our conference theme is ***"Staying Relevant and Adapting to a Changing World."*** We are particularly interested in presentations on topics related to the delivery of psychology in the current and evolving psychology landscape. This may include presentations on neuroscience, working with diverse populations, telespsychology, integrated healthcare, and innovative practice models. All presentations are to run 1.5 hours.
- If you would like to suggest a specific presenter and topic, please e-mail OPA at info@opa.org with that information.
- Psychology students are encouraged to submit their work as well.
- Due to the limited number of sessions available during the conference, not all submissions can be accepted. The OPA conference committee will make the selections based on the foundation in evidence, clarity of the proposal, probable interest to participants, feasibility, and space and time constraints.

If you would like to submit a proposed presentation, please fill out the following information and send it to the OPA office preferably via email at info@opa.org or fax it to 503.253.9172. You can also use the on-line application form at www.opa.org. All applications must be received by 5:00 p.m. on October 30, 2015. Any proposals received after that time will not be considered by the committee. Please note that if your presentation is selected, OPA will *not* be able to give an honorarium, a complimentary conference registration, or pay for lodging or travel to the conference. A conference registration discount will be offered to presenters that are selected. Questions? Call the OPA office at 503.253.9155 or 800.541.9798, or email us at info@opa.org.

➢ **COMPLETE ONE FORM FOR EACH PRESENTATION TOPIC YOU WISH TO SUBMIT**⮜

OPA 2016 Conference Call for Presentations Application

Presenter's name(s):		
Phone:	Email:	
Address:		
City:	State:	Zip:

Title of Presentation:

Quick Speaker Bio (*3-4 sentences*):

Are you a psychologist? Yes ☐ No ☐ If no, please state your profession here:

Date Preference Friday ☐ Saturday ☐ Doesn't matter ☐

How many presentations have you made in the last five years? _____

Summary of Presentation:

Return to the OPA office by 5:00 p.m., October 30, 2015 to info@opa.org or FAX to 503.253.9172

Welcome New and Returning OPA Members

Julie Adams, PsyD
Portland OR

Glena Andrews, PhD
Newberg OR

Sasha Bailey, MS
Vancouver WA

Nicole Byers, Med Educational Psychology
Portland OR

Heather Casady
Wilsonville OR

Timothy Catlow, PsyD
Corvallis OR

Lane DeWan, PsyD
Newberg OR

Scott Elmore, PsyD
Salem OR

Jenny Evans, PhD
Cleveland OH

Glenna Giesick, PhD
Oregon City OR

Zachary Hackbarth
Portland OR

Elizabeth Hamilton, PhD
Newberg OR

Christina Irvine, PsyD
Portland OR

Koreana Mangan, PsyD
Portland OR

Daniel Moshofsky, MA
Portland OR

Daniel Munoz, PhD
Portland OR

Carolyn Narcavage, PsyD
Clackamas OR

Edwin Pearson, PhD
Medford OR

Alison Shannon
Portland OR

Rosanna Shoup
Newberg OR

Nadezhda Vladagina
Bronx NY

Sara Walker, PhD
Portland OR

Bonnie Witkin-Stuart, PhD
Eugene OR

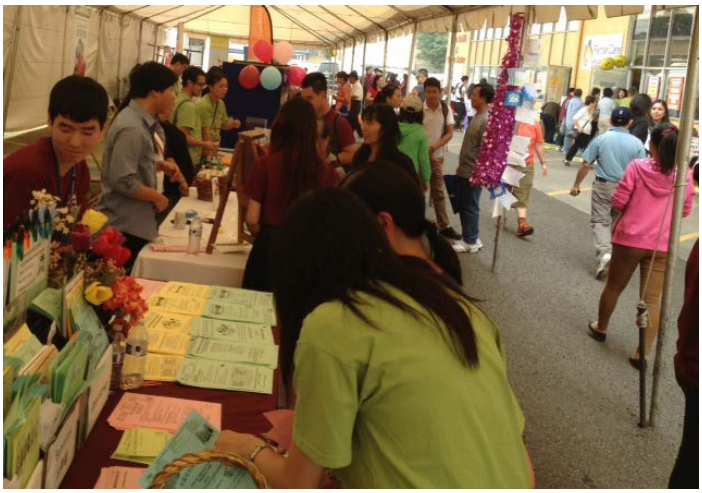
Petra Zdenkova
Hillsboro OR

James Lindemann, PhD, 1927-2015

OPA Past President James Lindemann passed away May 10, 2015. In 1963 he became an associate professor of medical psychology at Oregon Health Sciences University, retiring as professor emeritus in 1992. Dr. Lindemann was active in psychology organizations throughout his career. He was president of the Psychology Club at Penn State, secretary of the Maryland Psychological Association, trustee of the North Carolina Psychology Association and president of the Oregon Psychological Association in 1968-1969. At the national level, Dr. Lindemann served as Oregon Representative to the Council of Representatives of the American Psychological Association for 12 years, president of the Division of State Psychological Associations, and APA's representative to the Accreditation Council. He was one of the founders of the Portland Suicide Prevention Service and served as 24/7 consultant to the crisis workers for 17 years. He also served as chair of the Multnomah County Mental Health Advisory Committee, president of Gutman Rehabilitation Programs, and president of the Board of Directors of the Morrison Center for Youth and Family Services. As a faculty member of OHSU, Dr. Lindemann served as consultant to the Child Development and Rehabilitation Center Hemophilia Program beginning in 1980. In response to the discovery that AIDS was transmitted by the blood supply and had already infected 85% of the hemophilia population, he developed a social/psychological program for AIDS risk-reduction. He was principal investigator/project director for an HIV/AIDS curriculum for individuals with mental retardation/developmental disabilities. Dr. Lindemann created and packaged a program for training in interviewing skills. He was author/editor of *Psychological and Behavior Aspects of Physical Disabilities,* published by Plenum in 1981. With his wife, Sally, as co-author, his book *Growing Up Proud: A Parent's Guide to the Psychological Care of Children with Disabilities* was published by Warner Books in 1988. He was author of several dozen journal articles and special publications.

OPA Committees Reaching Out in Our Communities!

OPA Public Education Committee (PEC) members staffed a booth at the NAMI walk this spring.



OPA PEC members participated in the Pan Asian Community Health Fair this August.

OPA PEC members staffed a booth at the "Sundae in the Park" event this summer.

OPA Diversity Committee Members and other OPA Members participated in the Annual Pride Parade in Portland this June.

OPA Continuing Education Workshops

The Oregon Psychological Association sponsors many continuing education programs that have been developed to meet the needs of psychologists and other mental health professionals. The Continuing Education Committee works diligently to provide programs that are of interest to the wide variety of specialties in mental health. Below is a list of the upcoming education offerings. All workshops are held in Portland, Oregon unless otherwise noted. Full information and registration for the fall workshops will be available in early summer at www.opa.org.

The Oregon Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. OPA maintains responsibility for this program and its content. Letters of completion will be awarded to participants who attend the entire workshop. No partial credits are given. OPA workshops should be satisfactory for Oregon Licensed Social Workers' and LPCs' continuing education requirements. Approval for any other licensing or regulatory bodies must be completed by individual attendees.

If you are interested in diversity CE offerings, cultural competence home study courses are offered by the New Mexico Psychological Association (NMPA) to OPA members for a fee. Courses include: Cultural Competency Assessment (1 CE), Multicultural Counseling Competencies/Research (2 CEs), Awareness-based articles (3 CE), Knowledge based articles (3 CE), Skills-based articles on counseling (3 CE) and Skills-based articles on assessment (3 CE). Go to www.nmpsychology.org for more information.

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

2015-2016 Schedule

September 25, 2015

The Peaceful Parenting Approach to Working with Children & Parents

By Laura Markham, PhD

October 15, 2015

CFHA Pre-Conference Workshop co-sponsored by OPA

Practice Modification to Embrace Multiculturalism: Integrated Primary Care for the Person AND the Population

By Samantha Pelican Monson, PsyD and KC Lomonaco, PsyD

December 4, 2015

What's Food Got to do With It? The Relationship between Nutrition and Mood

By Erin Enzweiler, LPC, RD

January 29, 2016

The Ever Changing Landscape of Diagnosing and Treating Autism Spectrum Disorder

By Darryn Sikora, PhD and Erin Moran, PsyD

May 6-7, 2016

OPA Annual Conference

Oregon Convention Center - Portland, OR

To register go to www.opa.org

OPA Ethics Committee

Do you have an ethics question or concern? The OPA Ethics Committee is here to support you in processing your ethical dilemmas in a privileged and confidential setting. We're only a phone call away.

Here's what the OPA Ethics Committee offers:

- **Free** consultation of your ethical dilemma.
- **Confidential** communication: We are a peer review committee under Oregon law (ORS 41.675). All communications are privileged and confidential, except when disclosure is compelled by law.
- **Full consultation**: The committee will discuss your dilemma in detail, while respecting your confidentiality, and report back our group's conclusions and advice.

All current OPA Ethics Committee members are available for contact by phone. For more information and phone numbers, visit the Ethics Committee section of the OPA website in the Members Only section, and page 27 of this newsletter.

OPA Attorney Member Benefits

Through OPA's relationship with Cooney, Cooney and Madigan, LLC 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 their services, you will receive their services at the discounted OPA member rate. Please call for rate information. They 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 them at 503.607.2711, ask for Paul Cooney, and identify yourself as an OPA member.

Join OPA's Listserv Community

Through APA's resources, OPA provides members with an opportunity to interact with their colleagues discussing psychological issues via the OPA listserv. The listserv is an email-based program that allows members to send out messages to all other members on the listserv with one email message. Members then correspond on the listserv about that subject and others. It is a great way to stay connected to the psychological community and to access resources and expertise. Joining is easy if you follow the steps below. Once you have submitted your request, you will receive an email that tells you how to use the listserv and the rules and policies that govern it.

How to subscribe:

1. Log onto your email program.
2. Address an email to listserv@lists.apapractice.org and leave the subject line blank.
3. In the message section type in the following: subscribe OPAGENL
4. Hit the send button, and that is it! You will receive a confirmation via email with instructions, rules, and etiquette for using the listserv. Please allow some time to receive your confirmation after subscribing as the listserv administrator will need to verify your OPA membership before you can be added.

Questions? Contact the OPA office at info@opa.org.

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.

OPA Classifieds

JOB OPPORTUNITY

Psychologist, Cascade Health Solutions Behavioral Health & EAP. Part-time position; Pay Range: $35.18-52.78, plus benefits. Duties: Wide range of psychological services for clients and client companies, including assessment, diagnoses and short & long-term treatment; conduct educational presentations; provide conflict resolution and critical incident response, rotating on-call crisis coverage. Pain management and familiarity working with health care providers preferred. Flexible hours. Requires doctorate in clinical or counseling psychology and Oregon psychologist licensure. Contact Laurel Anderson, LCSW, Manager, CHS Behavioral Health & EAP. 2650 Suzanne Way, Eugene, OR 97408 or 541.345.2800.

OFFICE SPACE

Office Rental: Professional office space, 160 sq ft, furnished or unfurnished, with waiting room in charming English Tudor near Good Samaritan Hospital, NW Portland. Bus/streetcar/freeway access. Full or part-time. 503.225.0498.

Attractive solo practice office available part-time in downtown Lake Oswego, nicely furnished, large waiting room with ample parking. Rent by the hour or day email info@drritamaynard.com or call 503.692.4092.

Office space, Salem: Part-time nicely furnished professional office and waiting room in downtown Salem in professional building. Share with psychologist. Available 2 days and 2 mornings/week. $200/mo. 503.585.3644.

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

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.

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.

SERVICES

Medical Transcription: 35 years' exp in Psychiatry, Forensic Psychiatry, and Psychology • 140 wpm, 180 wpm real time • Accurate, dependable • Verification of content integrity • HIPPA compliant encryption used to send and receive data. Excellent references available • Laura Arntz, 503.260.6506, oregonbranch@gmail.com.

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.

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.

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.

Beautiful Manzanita Beach Getaway. Sleeps 6 (2 bedrooms and comfortable fold-out couch), & is available year-round. Wood stove & skylights, decks in the front & back of the house. Clean & comfortable. Centrally located; a few short blocks to beach, main street, & park. Golf & tennis nearby. No smoking/pets. Call 503.368.6959, or email at karen@manzanitaville.com or, go to www.manzanitaville.com.

OPA Colleague Assistance Committee Mentor Program Is Available

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.

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.

Colleague Assistance Committee

Kate Leonard, PhD, 503.292.9873
Rebecca Martin-Gerhards, EdD, 503.243.2900
Lori Queen, PhD, Chair, 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

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 September 2013:

1/4 page display ad is $100

1/2 page display ad is $175

Full page display ad is $325

Classifieds are $25 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 emailed to the OPA office in camera-ready form. 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 four times a year. The deadline for ads is listed below. 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**

2015

4th Quarter Issue - deadline is November 2 (target date for issue to be sent out is mid-December)

2016

1st Quarter Issue - deadline is February 1 (target date for issue to be sent out is mid-March)

2nd Quarter Issue - deadline is May 2 (target date for issue to be sent out is mid-June)

3rd Quarter Issue - deadline is August 1 (target date for issue to be sent out is mid-September)

4th Quarter Issue - deadline is November 7 (target date for issue to be sent out is mid-December)

*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:

Jill Davidson, PsyD
503.313.0028

Alex Duncan, PsyD, ABPP
503.807.7180

Jenne Henderson, PhD, Chair
503.452.8002

Cathy Miller, PhD
503.352.7324

Nnenna Nwankwo
Student Member

Karen Paez, PhD, Chair
971.722.4191

Del Rapier
Student Member

Lisa Schimmel, PhD
503.381.9524

Sharon Smith, PhD
541.343.3114

Casey Stewart, PhD, ABPP
503.317.4453

Jane Ward, PhD
503.292.1885

The Oregon Psychologist

Wendy Bourg, PhD, President • Shoshana D. Kerewsky, PsyD, Editor

The Oregon Psychologist is a newsletter published four times a year by the Oregon Psychological Association.
The deadline for contributions and advertising is listed elsewhere in this issue. Although OPA and The Oregon Psychologist 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