The Oregon Psychologist

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OPA President's Column

What is Addiction?

Alan Ledford, PhD, OPA President

What is addiction? The answer is tricky because addiction can mean different things to different people. The DSM-5 uses the term *substance-related and addictive disorders* to make clear that the behavior is actually abnormal and unhealthy.

The short definition of addiction adopted by the American Society of Addiction Medicine is:

> "Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
>
> "Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death" (ASAM, 2011).

Substance use disorders are diagnosed based on the presence of a subset of 11 characteristic features. If two or three of the characteristic features are present, then a mild addiction is diagnosed; if four or five features are present then a moderate addiction is diagnosed. And the presence of six or more features indicates a severe addiction.

The characteristic features can be divided into three groups: Those related to abuse, dependence, and craving. For behavior to be considered addiction, it has to lead to significant negative consequences for the addict. These consequences are often related to decreased productivity at work or school, physical deterioration or the onset of chronic medical conditions, social isolation, involvement in the legal system, and interpersonal conflict. Many addicts continue in the behaviors to the point that it alienates friends and family. Addicts often end up neglecting major responsibilities as a result of their addiction.

In addition to playing a central role in motivating normal behaviors like eating, the brain's reward circuit also plays a crucial role in the pathological behavior of addiction.

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What's Inside

Oregon Psychological Association

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

OPA Helpful Contacts

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

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

Oregon Board of Psychology (OBOP)
3218 Pringle Rd. SE, #130
Salem, OR 97302
503.378.4154
Website: www.oregon.gov/obpe

OPA's Director of Professional Affairs
Susan Rosenzweig, PsyD
Center for Psychology and Health
2476 NW Northrup, #2B
Portland, OR 97210
Email:
drsusan@centerforpsychologyandhealth.com
503.206.8337

OPA's Legal Counsel*
Paul A. Cooney, Attorney
Cooney, Cooney and Madigan LLC
19824 SW 72nd Ave., #201
Tualatin, Oregon 97062
503.607.2711
Email: pcooney@cooneyllc.com

**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.*

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

COVID-19 Update

OPA Members and Colleagues,

You have likely been inundated with frequent updates, recommendations and information regarding the novel coronavirus (COVID-19). OPA would like to take this opportunity to state that we stand with our state's efforts to reduce exposure through "flattening the curve" by limiting gatherings and encouraging social distancing. More can be found here on the Oregon Office of Emergency Management page: https://www.oregon.gov/OEM/Pages/default.aspx.

OPA stands with the American Psychological Association in promoting the use of our skills to alleviate fear and anxiety, combat bigotry, and provide much needed social support and processing during this distressing time: https://www.apa.org/news/apa/2020/03/psychologist-covid-19. Helpful link: A guide by APA on protecting your patients and practice through the COVID-19 pandemic: https://www.apaservices.org/practice/news/covid19-psychology-services-protection.pdf. OPA stands with our partnering state organizations in disseminating information and strongly encouraging methods of de-escalation of panic, reducing fear and its associated risks of bigotry, and harm to vulnerable populations: https://www.nyspa.org/news/493366/NYSPAs-Joint-Statement-on-Coronavirus-and-Xenophobia.htm and https://www.apa.org/news/apa/2020/02/coronavirus-threat.

Our Director of Professional Affairs, Dr. Susan Rosenzweig, has been actively tracking practice issues and reimbursement for telehealth and disseminating information, along with our members on the listserv. Roy Huggins of Person Centered Tech is offering quick and free telehealth webinar to aid with helping practices with rapid transition (register here: https://personcenteredtech.com/2020/03/14/emergency-telemental-health-implementation-moving-fast-while-maintaining-standard-of-care/). OPA stands with the Centers for Disease Control and Prevention (CDCP), the tireless efforts of our healthcare workers, and all emergency management workers who are treating the tide of this pandemic: https://www.cdc.gov/coronavirus/2019-ncov/index.html. We encourage and invite feedback, communication, and ongoing collaboration as a community to meet the needs of our patients and our practices, and thank every member and Oregon psychologist for the front line support you are offering as we face this challenging time.

Thank you,

The Board of Directors of the Oregon Psychological Association (OPA)

https://www.opa.org/leadership-and-staff

Additional Resources (please check frequently for updated information):

APA Resource Page

https://www.apa.org/practice/programs/dmhi/research-information/pandemics

National Register Coronavirus Resources

https://www.nationalregister.org/coronavirus-resources/

Telehealth mental health billing questions can be directed to (site is monitored daily):

dfr.insurancehelp@oregon.gov

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The reward system is part of the limbic system, which manages many of the basic operations of our brains that are below our level of awareness and control. These are deep structures that run the basic functions needed to keep us alive like hunger, thirst, and sleep as well as sex, motivation, and rewarding successful behaviors. All mammals have these structures in their brains. Non-mammals have similar structures as well. The reward system also regulates our emotions and attaches emotions to memories.

There are three main areas of the brain that are involved in processing reward: The nucleus accumbens, the prefrontal cortex, and the ventral tegmental area. These are also the three main areas involved with addiction. The nucleus accumbens is an important component of a major dopaminergic pathway in the brain called the mesolimbic pathway, which is stimulated during rewarding experiences. The most widely recognized function of the nucleus accumbens is its role in the reward circuit of the brain. This is one of the regions that both humans and rats repeatedly stimulate to the exclusion of everything else in self-stimulation studies.

The second major brain area involved in processing reward is the prefrontal cortex, which plays a central role in processing reward and controlling addictive behavior. It receives input from multiple regions of the brain to process information and adapts accordingly. The prefrontal cortex contributes to a wide variety of executive functions, including focusing one's attention, predicting the consequences of one's actions, anticipating events in the environment, impulse control, managing emotional reactions, planning for the future, and coordinating and adjusting complex behavior. It is often described as the CEO of the brain because it sets goals and makes sure that they are accomplished.

The third major brain region involved in processing reward is the ventral tegmental area (VTA), which is in the most primitive part of the brain. The VTA is located very near the middle of the head just slightly above the ears, a few inches behind and a little below the nucleus accumbens. Brain cells in the VTA project to both the nucleus accumbens and the prefrontal cortex and can influence both pleasure and self-control.

But what's most interesting about these cells is when they fire and when they don't. Wolfram Schultz

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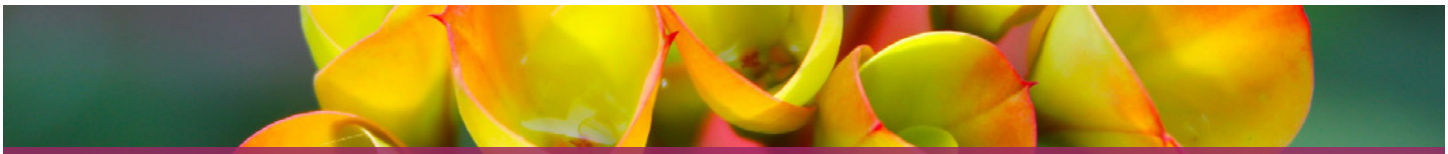

Professional Development for Mental Health Professionals

Center for Community Engagement at Lewis & Clark Graduate School of Education and Counseling

Friday, May 1, 9 a.m.-4:30 p.m. | 6.5 CEUs

Oppression, Patriarchy, and White Supremacy: Addressing Structural Inequality in Clinical Practice

Rebecca Hyman, LCSW

Clinicians receive training on how to ameliorate common sources of distress, but less addressed is the relationship between individual psychological pain and cultural violence—the larger structures and ideologies that marginalize and oppress individuals and communities. Learn how to introduce and work with structural violence in the therapy session, and examine the tension between the medical model, the current source of diagnosis and treatment, and other frameworks that account for the role of violence and oppression in the creation and maintenance of mental health suffering.

Saturday, May 2, 9 a.m.-4 p.m. | 6 CEUs

Unmasking the ACEs Campaign: The Hidden Agenda Behind the Trauma-Informed Movement - *Alex Winninghoff*

This workshop will evaluate the ACEs (adverse childhood experiences) study and trauma-informed movement; including it's foundation, uses in social policy, and application across fields of practice. A historical overview of the ACES campaign, including an analysis of the specific parallels it holds to the eugenics movement, will also be covered. Participants will develop the tools needed to build upon the strengths they see in current trauma-informed practices, and also the ability to critically analyze potentially dangerous practices that run counter to social justice goals.

Friday, May 29, 9 a.m.-4:30 p.m. | 6.5 CEUs

Starting a Nonprofit for Social Services with Special Focus on Mental Health and Addictions Counseling

Katelyn Bessette, LPC, CADC-III, NCC

Are you considering something other than private practice? Explore the step by step process of starting a nonprofit, helping participants brainstorm a concept for their organization, or find clarity around an existing idea. Participants will discuss how nonprofit work is an essential part of the greater community, explore equity, health gaps, and how nonprofit work can both help or hinder these disparities.

Saturday, May 30, 9 a.m.-4 p.m. | 6 CEUs

Becoming a More Inclusive Practitioner: Challenging Implicit Bias and Cultural Norms in Fat Phobia, Dieting and Eating Disorders - *Kyira Wackett, MS, LPC*

Implicit bias and unchallenged cultural norms perpetuate the many issues our society faces with diets, eating disorders, disordered eating, and body shaming. This workshop will provide attendees with a greater understanding of their cultural effect, how to treat them and what we need to do in order to shape new cultural ideals around appearance. Clinical presentations and concerns, working with integrated care teams, body image distress/shame, and models such as HAES and Body Trust will be covered. Multicultural inclusion and intersectionality (gender identity, sexual orientation, socioeconomic status, race and ethnicity, history of trauma).

More at go.lclark.edu/graduate/counselors/workshops

Billing Dos & Don'ts – Professional Affairs Corner

By Susan Rosenzweig, PsyD, OPA's Director of Professional Affairs

Let's talk about billing and questionable practices when billing.

I recently had a conversation with a professional regarding inflating one's fee when billing insurance. In this case, the professional routinely charged one rate for clients paying by cash or check, but when submitting bills to insurance companies (out of network), inflated the rate to 3.5x the routine rate. For illustration purposes, use these numbers: Cash rate for 90834 = $130, insurance rate = $450.

Yes, you read that right. And when asked about the insurance rate, the professional claimed that because she was out of network, she was not contractually bound to offer the same rate to insurers, and had been "assured" by others in the field that this was perfectly okay. Furthermore, she went on to state that she inflated her insurance fees "in order to make therapy more affordable to the people who need it." The rationale is that if insurance only pays 50%, then 50% of $450 will cover completely the fee for therapy, so the client won't be stuck with a $65 cost they cannot afford. Furthermore, for clients with large deductibles, the inflated billing "helps them reach their deductible faster" so insurance will start paying. Pressed even further, the professional claimed that by "hitting for the fence" (charging a very high fee), she was helping the entire field as it would drive insurance's calculation of "Usual and Customary" fees higher.

So – is this perfectly okay? Or not?

I propose to you that not only is it not okay, it is not okay on several different levels, including potential harm to patients.

First of all, let me state my opinion that while something might not be illegal, it can still be wrong. Secondly, this might involve illegal activity, perhaps even felony level insurance fraud, according to APA's Legal and Regulatory attorneys.

Does your view of whether it is okay change if the patient requests the arrangement? Would you feel comfortable if your patient asked you to change your billing amount on the bills submitted to the insurance? I invite you to sit with that hypothetical for a few moments, and consider whether you would agree or feel comfortable agreeing. For many of us, it might touch off feelings of discomfort, feeling recruited into a scheme. It might feel like a boundary-crossing.

So, if it were not okay when requested by a patient, why might it seem okay if initiated by the clinician? It's tempting to think that this price inflation is "victimless" or that the only party harmed would be the insurance companies, who we often view as profit-hungry or mean.

I would argue that first and foremost, the clinician's integrity is harmed by agreeing to or offering such an arrangement. As a patient, alarm bells go off in my head if my clinician bends the rules or shows questionable integrity. I find myself asking, where else are they crossing boundaries? Can I trust this professional?

Does this behavior (again, whether requested by the client or offered freely by the clinician) change the balance of power in the therapeutic relationship? Could a client feel that they now "owe" the clinician for this act of lowering their financial cost of therapy?

Consider another scenario – the patient did not request the fee inflation, and the patient is a healthcare provider, perhaps in another discipline. The patient worries that if the inflated fees are discovered, the patient's own contracts with the health insurer could be threatened, because they noticed the fee inflation but did not report it, thus making them feel complicit in fraudulent billing.

Professionally, I have spent much of my career in Oregon pushing back on a narrative that mental health costs are "out of control" and need to be "better managed" (which is usually borne on the backs of outpatient psychotherapy). Charging 3-4 times the going rate in town, even if presumably with the altruistic claim that it moves the needle on usual and customary rates (UCR), I believe, opens up a reason for insurers to push back against the mental health parity gains we fought so hard for in Oregon and on the federal level.

So, as OPA's Director of Professional Affairs, what do I recommend?

- Keep your billing consistent and clean.
- Set your usual and customary rate according to what you need in income and what you believe your patients can afford.
- **Always bill your same rate(s)** (different rates for different procedures, such as 90834, 90837 or intake is fine).
- You can offer a cash discount, but keep it reasonable. Document the discount as a write off/write down. Have a written policy about discounted fees.
- Read all your insurance contracts, if you take insurance. Make sure you know under what circumstances you may offer discounts to covered insured patients.
- You **can** offer a discount or write down for financial hardship. You **can't** routinely write off copays.

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and his colleagues (2000) performed some of the most influential studies of these cells at the University of Fribourg in Switzerland. They implanted electrodes in the VTA of monkeys so that they could record neural activity while a monkey was performing different tasks. Schultz proposed that activity in the VTA neurons reflects reward prediction error. When the neurons fire, it doesn't necessarily mean that a reward has arrived; rather, it means that there has been a reward prediction error. The fundamental biological importance of rewards has created an increasing interest in the neuronal processing of reward information. The suggestion that the mechanisms underlying drug addiction might involve natural reward systems has also stimulated interest. Neurophysiological studies in primates have revealed that neurons in a limited number of brain structures carry specific signals about past and future rewards. This research provides the first step towards an understanding of how rewards influence behavior before they are received and how the brain might use reward information to control learning and goal-directed behavior (Schultz, 2000).

Robert Heath (1963) conducted controversial experiments on psychiatric patients in the 1950s. He implanted electrodes part of the brain called the septal region, and the electrodes were connected to a box with buttons that would stimulate that particular regions of the patient's brain; the patients could actually stimulate their own brains by pressing a button. The patients reported feeling pleasure and even excitement whenever the electrode was stimulated. In fact, they would repeatedly press the button more than 1,000 times and even complained when the box was taken away, asking for just a few more button presses. People choose stimulating the septal region over sleep, taking care of children, and sex, which sounds a lot like addiction. The septal nuclei play a role in reward and reinforcement along with the nucleus accumbens.

There are three major changes within the brain that contribute to addiction: Repeated overstimulation of the brain's reward circuit numbs the response in the brain's pleasure center; strengthens associations with addiction-related cues, which increases cravings; and weakens inhibition from the prefrontal cortex, which undermines self-control.

Natural rewards stimulate the reward system of the brain. That system tells us what feels good or relieves a need and makes us want to repeat the same behavior when needed to relieve the need again (reinforcement). When things don't feel good, we don't usually repeat the behavior.

"Drug use messes up brain wiring, and the mess doesn't disappear when you quit." Neuroscientists studying addiction have been reporting that addiction co-opts the learning functions of the brain. The brain is hijacked by repeated behavioral patterns of drug seeking combined a strong "desire" for the high (Lewis, 2016). This is really important; *if we didn't have a reward system there could be no such thing as addiction* (Campbell, 2007).

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Billing Dos and Don'ts, continued from page 4

(see APA Good Practice article: APA Good Practice, 2009) You cannot make a blanket statement/plan to waive patients' coinsurance. If an insurer with whom you are contracted has a 20% coinsurance fee, if you were to waive the fee entirely, you are violating your contract (and the insurer might consider it fraud) because you are now accepting the 80% insurance payment as 100% of the fee. Don't do this.

- If you bill insurance on behalf of **public** insurance (Medicare, Medicaid, Workers' Compensation), you might be violating the laws of those programs.

As your OPA Director of Professional Affairs, I welcome emails or phone calls to discuss these kinds of issues. If I don't know the answer, I will research and reach out to APA colleagues.

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Clinical Considerations for the Therapeutic Relationship in Telepsychology: Personal Reflections from a Developing Practice

Nora Heins-Murray, PsyD, OPA Diversity Committee

The practice of telemedicine (specifically, synchronous services delivered via video) has grown rapidly. For mental health care, this has resulted in an increase in accessibility and a decrease in disparities related to availability (McCord, et al., 2015). These changes have meant greater access for historically underserved populations, including rural patients and those who have difficulty attending treatment in-person, for clinical, cultural or logistical reasons.

It is now possible for clinicians to provide services via this emerging modality with little or no additional training, nor awareness of the unique considerations and challenges presented by therapy via video. Telemedicine is only beginning to be studied methodically, and standards of care are still evolving.

Four years ago, I paused my career in order to stay home with my children during their early years. Last summer, I returned to work, albeit without having to stray too far from my kids, now 5 and 2. I now practice from home, working for a large telehealth company that provides medical and mental health services, provided by MDs and clinical psychologists, remotely to patients in the United States. I am licensed in both California and Oregon, so I see a wide variety of clients, dispersed across a broad geographical area.

Frequently, this means talking with people who live and work in places that I have never visited. In a traditional, in-person treatment, the client and clinician have, at the very least, both had to find their way to clinic and enter the same building. There is some shared experience and knowledge inherent in being in the same place. The subjective experience of place can be completely disparate, but comparing those perspectives is at least a place to start finding common ground.

Many of my patients work in technology and live in large cities in California. Telepsychology appeals to them primarily because they can attend therapy without leaving work, making the time commitment merely an hour instead of 2-3 hours when accounting for time commuting to and from treatment.

Working via video allows me unique access to information about my clients' lives that I wouldn't have the opportunity to observe in person. I see into their cars, living rooms, offices, and kitchens. I have additional means of evaluating patients' judgement and decision making, such as which physical spaces they deem private enough for a conversation with their therapist. (I always encourage them to speak with me in a space that supports confidentiality, but ultimately, I defer to their preferences.) I get serendipitous glimpses of interactions with partners, coworkers, and strangers. I get to observe my patients in their context (not mine), as I might if I were doing home visits, but somehow the medium of video makes these moments seem less formal and more spontaneous.

While telepsychology does provide new information, some important elements of assessment can be lost in video. For example, the physical appearance and presentation of clients can be easily obscured. After four months of working with a client, I recently discovered that he is 6'7" tall. In my work with this client, he is always seated, so I was completely unaware of his height. Does this detail matter? Is it relevant to the clinical work? Well, yes. As we consider our patients' experiences in the world (especially relationally), all data are relevant. What is it like for this individual to move through a world in which his body is larger than most of the people around him? How has his height impacted his sense of himself, and his sense of his gender?

Beyond literally seeing a patient, there are other ways we use ourselves and our senses to evaluate someone that are rendered moot by telehealth. Does a patient smell of alcohol? Body odor? Heavy perfume? These bits of information can be critical to our ability to conceptualize a client's presentation and make sense of how this person is perceived and responded to by others.

Similarly, the information about us that our patients have access to is limited by the medium. For example, I've configured my office so the wall behind me is blank, painted a soft and muted gray. This minimizes distractions from our clinical exchange, but also denies the patient the opportunity to observe how I've configured, decorated, and furnished the space that I choose to spend my time in. Also, I happen to be five months pregnant, which you might guess if you saw me on the street. But to my patients, who only see me from the neck up, this knowledge is only available when I choose to disclose it. What is the impact on the therapeutic relationship? What does this do to our ability to connect deeply and authentically?

Much of the clinical encounter remains consistent with in-person

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Confidential Peer Support Committee

The Confidential Peer Support Committee (CPSC) works to provide support and avert impairment to members. We provide members with consultation on a range of issues including conflicts with colleagues, clinical concerns, potential complaints or lawsuits, venting, concern about impairment, client suicide, colleague behavior, family conflicts, problems in the business of psychology and any distress affecting the capacity or enjoyment for work. Members may reach the Confidential Peer Support Committee (CPSC) by contacting one of the members listed below, or via e-mail at opa.cpsc@gmail.com. All responses will be encrypted and are kept strictly confidential.

CPSC offers the following programs to OPA members:

- Confidential consultations with members of the CPSC. Our names and contact information are listed below. You may call anyone on the committee.
- A panel of providers for therapy referrals, who are well versed in privacy and confidentiality concerns.

Questions and referral requests to the Confidential Peer Support Committee are confidential under ORS 41.675 and are not shared with OPA or OBOP. No demographic information is kept on callers.

Confidential Peer Support Committee Members

Marcia Wood, PhD - Chair
503.248.4511
Allan Cordova, PhD
503.452.8002
Jennifer Huwe, PsyD, LLC
503.538.6045
Rebecca Martin-Gerhards, EdD
503.243.2900
Colleen Parker, PhD
503.466.2846
Maura Sullivan, PsyD
503.432.8470

OPA Public Education Committee Facebook Page — Check it Out!

Please take a moment to check out 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/OPAPEC/ to visit our Facebook page.

Personal Reflections, continued from page 7

care—we discuss the same issues, and I use the same interventions—but my clients and I face technical interruptions and challenges specific to telehealth, such as flaky wifi, crashed web browsers, and audio hiccups. Occasionally, a client will be back-lit and their facial expression completely obscured, or the audio will continue while the video is frozen, leaving me to guess what might have been communicated nonverbally that I have missed.

As telepsychology gains in popularity, it is imperative that clinicians reflect on how video influences the ways in which we present ourselves and observe our patients. This medium can bring us closer together, but also creates new potential pitfalls in our clinical work.

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Resources

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Caring for Our Communities In and Out of the Office

OPA Public Education Committee

There is a strong connection to be made when looking at services and support provided inside and outside the office. As mental health providers, we have experience and training helpful to those we serve in our professions as well as in our local communities. Consider what sort of change you hope to influence in our society. Now, ask yourself, how are you connected with local communities? What resources help you communicate and serve local communities? Does your work involve interprofessional collaboration, volunteerism, advocacy? As members of the OPA Public Education Committee, we will speak from our experiences inside and outside the office with the intention of capturing this opportunity to reach and support local communities through education.

Let us recall a moment in October 2019 in Portland, Oregon. Many people visited the tables of sponsors and advocates at Out of the Darkness, which is a community walk hosted by the American Foundation for Suicide Prevention (2020). Out of the Darkness walks occur yearly in cities throughout Oregon, including Salem, Bend, Coos Bay, Pendleton, and Medford. It is one of many events that have engaged difficult mental health issues in camaraderie with our neighbors. At the Portland event, there has always been much energy and presence, despite this event facing arguably the most complex and distressing layers of being a human. People have presented impassioned stories, connected with one another, and motivated others to heal. As community members approached the OPA Public Education Committee's table, conversations unfolded quickly. Questions and topics included, "What is a psychologist?," if there are ways "to catch depression from those who are suicidal?," and that their "[Primary Care Provider] got nervous when I told them that someone in every generation of my family has committed suicide; but I know I'm fine." These brief moments provide a small glimpse of the broad array of needs folks have when managing mental health issues as well as areas for community growth regarding mental health education and resource support.

Now, let us branch out more broadly from community health events and focus on "office" experiences like those at Primary Care Clinics (PCC), which can be the most common setting for health conversations. Similar to local community events, community members seek support from professionals and seek healing. A PCC is generally equipped with multiple disciplines, each responsible for their own treasure-trove of life-changing information, making it as accessible as possible for the greater good of our communities. Individuals may present with an array of questions and concerns in addition to fear of stigma and limited knowledge on mental health topics. The American Academy of Family Physicians (AAFP) released a position paper advocating for advances in healthcare and a plea for interprofessional collaboration titled, *Integration of Primary Care and Public Health* (2014). The authors highlighted the role of education between professions and between professionals and patients. Figure 1 from the AAFP position paper gives a visual aid in conceptualizing interprofessional collaboration, identifying where community involvement intersects with areas of primary care and public health.

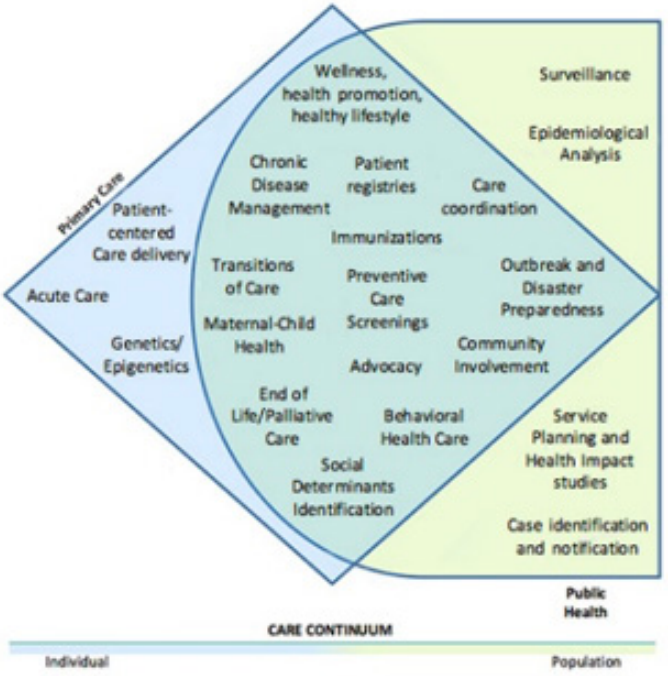

Figure 1

Image source: https://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html

Our hope is to reduce community members' experience of frustration, suffering, and isolation through education. This giant, healthcare-sized problem is workable. A lot has been done already across disciplines to collaborate with one another and to disseminate the knowledge and resources we have into our communities, schools, clinics, and beyond. Maybe you have been a part of that movement already. Maybe you share the beliefs of interprofessional collaboration and public health. Or, perhaps you have been an example of the countless people who have fervently sought to improve you or your loved one's health but could not find a solution.

In all settings, remember the power of collaboration and the power of sharing what you know. Where do you see yourself supporting community education on mental health topics? Where in your professional experience might you strengthen interprofessional collaboration and education for those you serve?

Thank you,
OPA Public Education Committee
Oregon Psychological Bulletin @OPAPEC (Facebook)

References:

AAFP Integration of Primary Care and Public Health Work Group (2014). *Integration of primary care and public health.* Retrieved from https://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html

America Foundation for Suicide Prevention. (2020). [Home page]. Retrieved from https://afsp.donordrive.com/index.cfm?fuseaction=cms.page&id=1370

OPA Membership Survey 2020 Results

Dr. Jenjee Sengkhammee, OPA Secretary

In February 2020, OPA conducted a membership survey to better understand membership experiences, concerns, and needs. According to our OPA membership data reported in January 2020, there were 727 members:

- 508 professional licensed members
- 87 life members
- 61 student members
- 28 professional non-licensed members
- 18 allied professionals
- 11 associate members
- 13 out of state members
- 1 corporate affiliate member

The survey received 152 responses, a 20% response rate.

Respondents Profile

- Gender: Sixty percent of the respondents identified as female, 34% as male, 2% nonbinary, 2% gender fluid, 1% transgender, and 1% preferred not to say.
- Age: Ten percent were between the ages of 25-34, 13% aged 35-44, 16% aged 45-54, 28% aged 55-64, and 33% aged 65 plus.
- Race/Ethnicity: Eighty-six percent of respondents identified as being White or Caucasian, 4% Latinx/Hispanic/Latino(a), 7% preferred not to say, and less than 1% for each of the following racial identities: Asian/Asian American, American Indian or Alaska Native, Hawaiian or Pacific Islander, and African American/Black.
- LGBTQ+ Community: Approximately 17% of respondents identified themselves as being a part of the LGBTQ+ community, 4% described their membership (e.g., ally) and 2% preferred not to say.
- Career Stage as Psychologist/Clinician: Twenty-seven percent of the respondents were in the senior stage of their career (21-30 years in the field), 24% mid-career (11-20 years), 24% late senior (31+ years), 19% early career (0-10 years), 6% retired (5%) and less than 1% identified as a student.
- Practice Setting: Sixty-eight percent of respondents worked in a private or group practice,

Continued on page 12

Membership Survey, continued from page 11

followed by 7% hospital setting, 6% other setting (such as primary care, family practice), 5% university setting, 2% K-12 schools, 2% human service and community mental health, 2% community/2-year college, less than 1% in remaining settings (such as business, medical school, and government) and 5% indicated none of the settings.

- Professional Identification: A majority of respondents (77%) identified as being a psychologist/clinician/ practitioner, followed by 9% other (responses included administrator, assessment/ testing, integrated behavioral health), 8% applied psychologist (forensic, consulting, I/O), 2% as college/university educator, and less than 1% in remaining settings (such as, K-12 educator, student, researcher).
- Practice Location: Approximately 67% of respondents indicated that they practiced primarily in the Portland and Portland Metro area. The remaining respondents identified locations such as Eugene, Corvallis, Sherwood, Medford, Newberg, Salem, The Dalles, Washington or Multnomah counties, and Central Oregon.

Member Benefits

Overall, 64% of the respondents rated the value and benefits of OPA membership as "excellent" or "above average," 28% "average," 6% "below average," and 2% "poor." In general, respondents were aware of all the OPA benefits offered, though not all benefits were used by respondents, in some cases a majority of respondents had not used a benefit. Of those benefits used, respondents rated having good experiences (noted by ratings in "above average" and "extremely good") with:

- Legal consultation
- Ethics consultation
- Confidential peer support consultation
- Diversity consultation
- Consultation/information provided by OPA Director of Professional Affairs
- Use of OPA listserv for information and networking
- Reading OPA newsletter
- Discounts on OPA workshops

Eighty percent of respondents indicated that they were "likely" or "very likely" to recommend OPA membership to a friend, while 17% responded "neither likely nor unlikely," and about 3% indicated they were "unlikely" or "very unlikely" to recommend membership.

Respondents ranked their top three reasons for OPA membership:

1. Advocacy for the field and profession of psychology
2. Networking with colleagues
3. Professional identity/sense of belonging

Top three considerations for membership renewal:

1. Sense of belonging to a community of professionals
2. Benefits of membership
3. Role of OPA in advocating on issues related to licensure and psychologist practice in Oregon

Greatest professional challenges:

1. Self-care (work-life balance)
2. Managing insurance/ reimbursement issues
3. Managing time

It is worth noting that keeping current on new and research in psychology and managing day-to-day business operations were closely followed.

When asked about what benefits members would like to see OPA offer, a range of comments were suggested, however two common themes emerged such as: CE Workshops with greater flexibility (2-4 hours, more affordable, Saturdays) and group health insurance.

OPA Involvement and Communication

- Just more than half of the respondents preferred the OPA newsletter in email pdf file only, with just under 20% preferring a mobile-friendly version. About 62% of respondents rated the OPA website as "very" and "somewhat appealing." Additionally, 31% of respondents indicated the website was "very" or "extremely easy" to obtain information. A majority (88%) of respondents preferred that OPA continue to communicate via email.
- About 52% of respondents indicated that they were "likely" or "very likely" to attend an OPA continuing education workshop that was offered via live webcast.
- When asked about respondents' participation on an OPA Committee or Board position, most respondents had not participated in all categories (these were committees such as Ethics, Diversity, Legislative, etc.). Forty-four percent of respondents reported no interest, while 20% expressed interested in serving, and 36% indicated being uncertain.
- Thirty-six percent of respondents felt OPA had been "extremely" or "very responsive" to a concern they brought up with OPA, while 16% felt that OPA had been "less than somewhat" or "not at all" responsive.
- Forty percent of respondents have donated to POPAC (Psychologists of Oregon Political Action Committee) in the last two years, and 53% are "likely" or "very likely" to donate in the future.
- Eighty-six percent of respondents indicated that OPA values and support issues related to diversity and social justice.

Continued on page 13

Welcome New and Returning OPA Members

Hailey Albin
Hillsboro, OR

Kathryn Biesiada
Hillsboro, OR

Cynthia Boyd, PhD
La Jolla, CA

Stephanie Burkhard
Newberg, OR

Lorie DeCarvalho, PhD
Roseburg, OR

Nikki Frederick, PhD
Beaverton, OR

Nathan Goins, PsyD
Portland, OR

Halie Kellett
Portland, OR

Linda Luther-Starbird
Bend, OR

Wendi Major, PhD
Happy Valley, OR

Caitlin McCann
Portland, OR

Joseph Miloschm, B.A.
Hillsboro, OR

Jeff Mudrick, MD
Portland, OR

Chandra Mundon, PsyD
Portland, OR

Preeti Pental
Hillsboro, OR

JoHanna Sendejo
Beaverton, OR

Hannah Smith
Portland, OR

Heather Tollander, PsyD
Portland, OR

Membership Survey, continued from page 12

Summary of Findings

Results of the membership survey suggest that OPA is meeting many of our membership needs. In general, respondents reported overall satisfaction with the current value and benefits of membership, though not all benefits were used. Respondents indicated that use of benefits such as the OPA listserv, consultation (legal and committees), and the quarterly newsletter were beneficial. Responses suggest changes and/or exploration in the area of CE offerings. Respondents experience challenges balancing their professional lives and responsibilities, value their OPA membership and community, and care about the profession. Respondents represented a range of professionals of varying ages and career stages. While a majority of respondents were White, and about 20% described themselves as having an LGBTQ+ affiliation. Many of the respondents practiced in the Portland Metro area and were practitioners in a private practice/group setting.

Final Thoughts

Thank you to the respondents who took the time to complete the survey. I thank you for your membership and appreciate hearing your concerns, needs, and experiences as OPA members. I invite any respondents who a) want follow-up on any of their responses or b) expressed interest in serving on a committee or Board position to get in touch with me directly. I can be reached at drsengkhammee@gmail.com or by phone (503) 922-3316. Lastly, thank you to members of the Board who assisted in the survey.

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.

The Oregon Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists.

The Oregon Psychological Association maintains responsibility for the program and its content.

OPA Current Education Offerings

Locations for workshops subject to change, based on COVID-19 recommendations from the CDC. Please continue to check our website for updated information. In order to register for OPA workshops online, you will need a credit card for workshop payment to complete your order. Registration fees for workshops will not be refunded for cancellations as of one week prior to the scheduled event or for no-shows at the event. Prior to that, a $25 cancellation fee will be assessed. For other events, check their specific cancellation/refund policy.

Links for more information and registration are available at www.opa.org.

2020 Schedule

June 19, 2020

Cultural Responsiveness and Cultural Responsibility in Our Work as Psychologists

Presented by Eleanor Gil-Kashiwabara, PsyD

Watch for more details to come

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

Oregon Psychological Association

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.
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

PROFESSIONAL SERVICES/EQUIPMENT

The Fully Equipped Therapist: 3 session training on effective strategies for empowering & equipping clients. 12 hrs CEU plus FREE copy of new book, Handouts for Psychotherapy (avail. Amazon). Meets Fridays 2/14/10, 2/28/20, & 3/13/20 from 9am - 1pm. $375 (discounts avail. online). Information and registration at elsb-ethmartindale.com (trainings tab).

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

OPA Mentorship Program

Dear Colleagues,

We are happy to announce that the OPA Mentorship program is up and running. We have two forms for the Mentorship program on the OPA website. The first form is for interested parties to give some details of their practice setting, training, interest and location. The second form is for Informed Consent, limits of confidentiality, etc. Please join your colleagues and offer to serve as a Mentor and to learn or ask questions as a Mentee. Monthly phone or in person meetings are set up by the Mentor and Mentee once a match is made. Enjoy a bit of colleague support, new information and conversation regardless of age, orientation or years of experience.

www.opa.org

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 with questions of an ethical nature. Our hope is to be proactive and preventative in helping OPA members think through ethical issues. The committee is provided as a member benefit only to members of OPA 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.

If you have an ethical question or concern, please contact Dr. Jill Davidson at dr.jilldavidson@gmail.com. Include a description of your concerns, your phone number, and good times for her to call you back. She will make contact with you within two business days. She may ask for more information in order to route your call to the appropriate person on the Ethics Committee, or she may let you know at that time which committee member will be calling you to discuss your concerns. You can then expect to hear from a committee member within a week following Dr. Davidson's phone call. The actual consultation will take place over the phone, so that we can truly have a discussion with you about your concerns.

Following the consultation call, you can expect the committee member to present your concern at the next meeting of the committee. Any additional comments or feedback will be relayed back to you via a phone call.

Ethics Committee:

Allison Brandt, PhD

Jill Davidson, PsyD, Chair

Irina Gelman, PsyD, Secretary

Leonard Kaufman, PhD

Nicole Sage, PsyD

Jenna Sheftel, PsyD

Jamie Young, PsyD

Petra Zdenkova, PsyD

Stephanie Garcia, Student Member

Claire Metzner, Doctoral Student

Maria Lytle, Doctoral Student

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.

Let's Get Digital! Incorporating Telecommunication Technologies in the Provision of Psychological Services

Jill Davidson, PsyD and Petra Zdenkova, PsyD, OPA Ethics Committee

With the advancement of technology, telepsychology has a growing role in psychological practice today. Telepsychology presents unique opportunities and consideration in patient care, and can be used as a way to increase access to psychological services. Telecommunication technologies provides both opportunities and challenges for psychologists and patients. The America Psychological Association (APA, 2017) introduced 8 professional practice guidelines for psychologists to assist in their use of telepsychology.

According to APA, telepsychology is defined as "the provision of psychological services using telecommunication technologies" (2017). Surprisingly, telepsychology doesn't just include providing psychological services using interactive video conferencing, but can also include email correspondence, telephone, chat, and text. The information can be in writing, sound, or images. Some examples of this communication include emailing psychoeducational materials after an in-person session, forwarding information, and online bulletin boards.

Telepsychology practice guidelines (APA, 2017) include:

Guideline 1: Competence of the Psychologist

Psychologists who provide telepsychology services strive to take responsible steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals.

Guideline 2: Standards of Care in Delivery of Telepsychology Services

Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

Guideline 3: Informed Consent

Psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide. When doing so, psychologists are cognizant of the application of laws and regulations, as well as organizational requirements that govern informed consent in this area.

Guideline 4: Confidentiality of Data and Information

Psychologists who provide telepsychology services make reasonable effort to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks to loss of confidentiality inherent in the use of the telecommunication technologies, if any.

Guideline 5: Security and Transmission of Data and Information

Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.

Guideline 6: Disposal of Data and Information Technologies

Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for usage and appropriate disposal.

Guideline 7: Testing and Assessment

Psychologists are encouraged to consider the unique issues that may arise with the test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.

Guideline 8: Interjurisdictional Practice

Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional international borders.

References

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct. Washington, DC: American Psychological Association. Retrieved from https://www.apa.org/ethics/code/

Knapp, S. J., & VandeCreek, L. D. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

The Oregon Psychologist Advertising Rates, Policies, & Publication Schedule

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

Advertising Rates & Sizes

Advertising Rates & Policies Effective January 2017:

- 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 Oregon Psychologist is published four times a year. The deadline for the 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

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

2nd Quarter Issue - deadline is June 1 (target date for issue to be sent out is mid-July)

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

4th Quarter Issue - deadline is December 1 (target date for issue to be sent out is mid-January)

The Oregon Psychologist

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.

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