# The Oregon Psychologist

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## What's Inside



*OPA President's Column*

## Communication at Our Core

*Ryan C. Dix, PsyD, President, OPA*

Warren Buffett once told the BBC that the only diploma he displays in his office is one from a Dale Carnegie public speaking course. He said, "I don't have my diploma from college or from graduate school, but I have my Dale Carnegie diploma there because it changed my life." He and many other highly successful CEOs cite communication as the lynchpin in their success. Communication is at the heart of what we all do and OPA continues to maintain and grow many open lines of communication to seek your input, and continues to use your input in directing your organization as we move into 2018. To that end, I wanted to highlight a few things your organization has been working on in response to direct feedback as well as items brought up on the listserv.

In response to requests from members regarding even more opportunities to communicate, we recently hosted our first Portland area town hall in many years. During this town hall, members were able to have a great discussion on local, statewide, and national issues. Topics discussed ranged from social justice in our communities on issues such as immigration and access to healthcare, to prescription privileges and limited access to prescribers. Members also discussed OPA's relationships with coordinated care organizations and ongoing representation of psychologists in influential roles in areas of healthcare policy and implementation. This town hall is in addition to regional town halls your board has presented at year after year and continues to be one way in which we try to keep everyone informed and be informed by members across the state. We hope you will attend a future town hall in your area and let your voice be heard.

Following past postings on the listserv, your board has approached issues around insurance through legislative bills as outlined in the most recent legislative update, and will continue to focus on this area as we move forward. As we all know, uncertainty continues to swirl about the direction of our healthcare system. We remain focused on continuing to advocate for our patients and our profession both at the insurance level and the legislative level. We are also hoping to improve our relationship with insurance companies through the creation of the Director of Professional Affairs (DPA) position that I mentioned in my last newsletter article. It is our hope that, once filled, this position will take on an active advocacy role for our patients as well as our profession. We continue to look for someone willing to take on this role and we welcome anyone interested to inquire further or apply through info@opa.org.

Lastly, committees of OPA continue to work on improving communication around who they are and what they do. Please check out the OPA website along with committee links and social media feeds to stay up to date on how your committees are working for you.

I continue to thank you for the opportunity to serve as your president and look forward to working with your board toward an ever-improving organization.

## OPA Helpful Contacts

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

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**Through OPA's relationship with Cooney, 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.*

# The Need to Increase Access to Peer Support

*David Gardiepy, BA, CADC II, Psychological Assessment, Consultation, and Education Services (PACES)*

Peer support is an effective way to significantly improve the outcomes of mental health treatment services. Peers can provide nonclinical support that improves the quality of treatment, improves engaging the individual receiving services in the recovery process, and improves the overall efficacy of clinical interventions. Peer support specialists should be used in conjunction with clinical services as a means of improving our current deteriorating and ineffective mental health treatment system.

Individuals who are receiving treatment for mental health illness will experience improved treatment results and adherence rates if a peer support specialist is a part of the treatment team. Peer support specialists are able to provide a unique perspective to individuals in treatment from their shared experiences, in addition to providing hope that recovery is possible by being a role model and an example. In addition, because of their lived experiences within mental health treatment systems, peers are able to provide unique and nonclinical services that promote the efficacy of treatment provided by clinicians. Furthermore, peers have the ability to develop more insight into the daily lives of the individual in treatment and can therefore discuss day-to-day needs with the treatment team.

Peer support specialists have an alternative perspective with regards to mental health treatment, compared to clinicians. For someone to be considered a peer support specialist, they must have either progressed through their own recovery or be a family member of an individual who has received treatment services and was actively involved in supporting their family member (SAMHSA, 2009). Because of these requirements, peers have a consumer perspective, a general perspective of what interventions may be utilized in treatment, as well as the areas in which treatment can be supported. Peers' own experiences in treatment allow them to understand the limitations of what clinicians can do, and provide the knowledge of where an individual may need additional support so that they can assist an individual progress through their recovery (SAMHSA, 2009; Convirs, 2014).

Peers also have the ability to explain the various caveats and nuances of clinical interventions in order to provide clarity to the individual receiving treatment. This allows the individual in treatment the opportunity to understand the need for certain activities and interventions, even if the individual is initially unable to understand the importance of the intervention and treatment service being provided. Peers are able to also listen to an individual's reluctance to activities or intervention types, allowing the individual to vent their frustrations while reframing the negative ideology into a productive paradigm (Kaplan, 2008; SAMHSA, 2009; Convirs, 2014). Peers are able to assist the individual in Kaplan linking what may seem like archaic or useless interventions back to the individual's self-identified goals (Eisen, Schultz, Mueller, Degenhart, Clark, Resnick, Christiansen, Armstrong, Bottonari, Rosenheck, & Sadow, 2012). By doing this, the peer is actively using their own experiences to promote the adherence to the treatment plan (Eisen et al., 2012; Kaplan, 2008). Furthermore, "studies . . . have found positive effects of peer support, including greater understanding, practical knowledge, empowerment, coping skills, social network, social support, functioning and quality of life" (Eisen et al, 2012, p. 1244).

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The services that peers provide are not clinical in nature; rather, they are nontraditional. They are nontraditional because they are services that mental health providers have not typically provided in a treatment setting. Furthermore, the services are typically provided within the individual's community, home or other non-clinical setting (Kaplan, 2008; SAMHSA, 2009; Convirs, 2014). Services can include role play, transportation, medication management, empowerment, advocacy, skill development and promoting the notion that recovery is possible (Eisen et al., 2012; Convirs, 2014). By far, one of the most important services that can be provided (as identified by providers) is resource acquisition, mutual social interaction, and skill development (Kaplan, 2008). These services are not typically provided by an individual's therapist, in part because of the time constraints that have been put on professionals by managed care organizations. Peers do not have the same constraints; thus, they are able to spend additional time with individuals to ensure that their needs are met, they understand treatment, and are able to effectively employ the skills necessary to progress through treatment. By working within different settings, peers are able to reinforce the skills learned in treatment as well as demonstrate their applicability to a wide array of settings, promoting self-efficacy and self-esteem in the people they are working with (Bracke, Christiaens, & Verhaeghe, 2008). With an improved sense of self-efficacy, an individual is significantly more likely to continue participating in treatment and is also more likely to be actively involved in designing their treatment plan (Bracke et al., 2008).

A basic concept identified by Maslow is that an individual is not going to progress through mental health treatment if their basic needs are not met (Sims, 2002; Huitt, 2007). Part of a peer's job description is to know what resources are available and how to access them, to meet the identified basic needs deficits (Convirs, 2014). By doing so, peers are assisting in preparing the individual in every way possible for treatment. If the individual has food, shelter and their other needs met, they are significantly more likely to be an active participant in their own recovery (Huitt, 2007), whereas if an individual is concerned with how they are going to meet their need for food, they are not necessarily fully engaged in their treatment plan, nor are they fully prepared to engage in psychological work that may be difficult, emotionally challenging, and physically demanding.

Role plays are an excellent way to develop skills; however, many clinicians do not have the necessary time to engage in role plays to perfect skills. This is another area where peers can be utilized effectively, because during the time that a peer can spend with an individual they are able to actively work on perfecting skills that are necessary to progress through recovery. These skills can include coping skills, social skills, basic living skills, relaxation skills, self-soothing skills, communication skills, time management skills, sobriety skills, and employment skills (Bracke et al., 2008; Kaplan, 2008; SAMHSA, 2009; Chinman, George, Doughertry, Daniels, Shoma Ghose, Swift, & Delphin-Rittmon 2014; Convirs, 2014). Part of treatment involves identifying areas where skills may be lacking, which is another way that peers can provide a unique perspective to the treatment team. Because of their ability to work in non-clinical settings, peers are able to identify skills that may need to be addressed by a clinician and report these back to the team. Likewise, peers are also able to identify skills that they may be able to strengthen without a clinician, and after consultation with their supervisor and the treatment team, peers are able to start working on these skills with the individual. Skill acquisition can also be promoted by providing education, another aspect that is usually briefly used by clinicians in a typical treatment setting. Peers can provide more information, both from an empirical perspective and from a personal perspective; thus, the information provided may be more comprehensive and useful for the individual receiving services (Lucsted et al., 2013).

It is imperative that treatment teams know what is occurring in the individual's life when they are not in a clinical setting so that they can alter or improve the treatment plan to appropriately meet the needs of the individual served. Peers can have a major role in this aspect of treatment plan monitoring, in part because they work with the individual in a variety of nontraditional settings. Peers are able to observe the progress that the individual is making outside of a clinical setting, and to make progress reports back to the treatment team. This allows the team a more complete perspective of the individual's life and needs. Furthermore, peers can also highlight what is working and what is not working for the individual (SAMHSA, 2009). This allows the treatment plan to be altered when necessary to promote the needs of the individual as well as work towards the self-identified goals for treatment.

There is a multitude of reasons why access to peer support should be a cornerstone to any person-centered mental health treatment approach. These reasons vary greatly, and as more empirical research is concluded, treatment teams will be able to point directly to quantitative evidence that supports the need for peer support. Whether the research is based on the unique perspective that peers have, the ability to work within various settings, a peer's ability to provide extensive non-traditional support services, or the mutuality between a peer and individual, there is ample evidence to support including peers in any treatment approach.

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*Access to Peer Support, continued from page 3*

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# Plan to Attend!

## *OPA Annual Conference*

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# Is Social Justice Advocacy Burning out Therapists? How Mindfulness May be a Healthier Approach to Helping Clients and Therapists

*Goali Saedi, PhD, OPA Diversity Committee*

It was New Year's last year when I made a resolution I finally intended to keep. After years of collecting clinical books that I'd recommend to my therapy clients off of hearsay, I intended to start cracking them open. Brene Brown, Michael Singer, Daniel Siegel, Susan Cain, and others; I devoured book after book on empowerment, the neuroscience of the teenage brain, introversion and other countless topics. While several key books still remain and the list is really somewhat endless, it felt wonderful actually reading and integrating all this knowledge. That is, until my last two recent reads.

Looking for some additional private practice books to learn more about the administrative side of things (no business background whatsoever for this psychologist!), I stumbled on the reviews of Casey Truffo's *Be a Wealthy Therapist: Finally, You Can Make a Living While Making a Difference* (2007). The title sounded like the perfect infomercial and the mixed reviews made it just intriguing enough to pick up. The one-star Amazon ratings accused the five-star ratings of being friends with the author. So naturally, I interspersed reading snippets of Truffo's title with the majestically written *Mindful Therapy* by Thomas Bien (2006). His work is truly poetic and masterful, and I'd easily say one of the best books written for therapists I've ever read. Granted, I'm also a huge proponent of the mindfulness school of thought.

As I read both books (naturally one read a lot quicker and the other lent itself to profound thought—I'll let you figure out which was which), I found myself stuck. I kept thinking about social justice. Advocacy has been a huge part of my training, not only as a psychologist but also as a multicultural researcher. How do we help the disenfranchised? How do we improve access to care? What is our role in this grand tapestry?

What I came to realize is that talk is cheap. It is easy from the ivory towers to send along messages of promoting equality and getting our hands dirty. But are we really doing it, and ultimately at what cost to the clinician? Although the title of Truffo's book really does no one any favors in taking it seriously, her points are actually very well received. She talks about the reality of therapist debt, burnout, and compassion fatigue. She discusses the headache of paperwork, bureaucracy and all the components that make social justice work just so taxing for the individuals involved in it daily.

Meanwhile, Bien's evocation of Thich Nhat Hanh's meditation whereby one imagines oneself as a mountain, flower, water, and space invites us to acknowledge the fragility of life. He reminds us that those who set out to heal the world must heal themselves first. And that much havoc is wreaked by those intending to set the world right. The pushing of agendas causes polarization, and no true voice is given to the agenda of equal rights. Further, he invites us to be in touch with the flower in each of us, so delicate and transient. He asks us to consider the circumstances that wilt the flower within each of us. He states, "If patients' difficulties are too much for you, if their interactions with you are too difficult for you despite your best effort to deal with them mindfully, you must recognize and acknowledge this, and then make an appropriate referral. No one is served by your going down with your patient" (2006, p. 37).

Interestingly, albeit in a very different manner, Truffo is ultimately advocating a similar agenda. Her bottom line is that therapists have worked hard for their education, and deserve to be adequately compensated. In the preface to one of her chapters, she uses a quote from Marianne Williamson that reads,"Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, Who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world" (Williamson, in Truffo, 2007, p. 29).

Both authors are in effect writing advocacy pieces about the therapist. Perhaps not intentionally, but when so much of the rhetoric is about doing all that you can to help the client, they offer a much-needed perspective on advocating for the rights of the therapist. At first blush, I, for one, feel guilt. After all, many of us were raised with a Mother Theresa complex. Give, give, give, and when there is little else left, still give more. But what good does that do other than burn out young professionals and keep them from helping those they can?

I recall many years ago hearing about the social workers who had gone into the trenches to help their clients, only to find themselves right there next to them. With student loan debt to get their MSW degrees and low-paying jobs, they were lining up for food stamps alongside their clients. How were they supposed to help their clients access services when now they

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*Social Justice Advocacy, continued from page 5*

were slipping under the poverty line themselves?

When I went to look up the aforementioned story online, all the search terms of social workers in poverty led to results of glorification of social workers helping, helping, helping, with no acknowledgement of the challenges they may face themselves. It is as though they are meant to be superheroes with nothing as their kryptonite. I did, however, find an article by Adrian D. Anderson, assistant professor at Savannah State University, discussing how social work was never meant to be a "poverty profession." He writes:

> We can promote social justice and honor our code of ethics in high salary positions or as owners of billion dollar enterprises. We can be millionaires and practice social work in the same spirit as some wealthy philanthropists who promote and enhance society. Furthermore, some of the early social work pioneers who established our profession emerged from very affluent families and used their personal wealth to improve society (2015).

Perhaps in the field of social work there is greater dialogue about what it means to help in a social justice context than there is in psychology. But what I do know well is the attitude that, as Truffo states, money is dirty. She discusses the idea of dirt poor and filthy rich. However, you look at it, there is certainly an unsavory nature to it. And therefore, we don't talk about it. Even if reimbursement rates for mental health practitioners decrease annually and lag behind those of other medical providers, because of our privilege we are resigned to guilt. And the cycle repeats itself. We are lucky to have jobs, roofs over our heads, and so forth. But there are also many ways of accomplishing this that do not equate to sitting with deep pain and suffering.

Further, much as Anderson states, wealth can do much good in advocating for strong social justice programs. Why not allow the therapists to be in this position? After all, wouldn't they be the least likely to fall into the trappings of corporate greed and be the most likely to give it all away anyhow? That is, if they can get past their guilt of having any excess to be in this position in the first place.

As I end this year's New Year's resolution readings with quite an eclectic array of topics, it has been interesting to end on this quandary. When all that I have been taught (or, more fairly, absorbed?) has been about social justice advocacy for the disenfranchised, at what point do I turn the lens onto myself and colleagues? Is this an expression of my privilege? Or is it exposing only half of the story?

As I continue to digest the wisdom in Bien's book, I wonder if the agenda should have been about mindfulness all along. Perhaps mindfulness would do more for our society today than social justice. Or maybe it is one mere expression of it. Maybe mindfulness would encourage more kindness, less fighting, more compassion, and less anger, and more would be accomplished at the end of the day. It is tough to say in these turbulent times when for so many the reflex has become to protect themselves and outcast others. However you look at it, though, we are all deserving of kindness and must always take care of ourselves even when we may not want to at the expense of others. But it is our duty to be able to serve only once we have honored the flower within us, protected it, and then used its beauty to illuminate the world.

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*This article was originally published in slightly different form at https://www.psychologytoday.com/blog/millennial-media/201612/is-social-justice-advocacy-burning-out-therapists and is used by permission of the author.*

## 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.

# Unique Ethical Challenges Facing Integrated Behavioral Health Providers

*Petra Zdenkova, PsyD and Christopher Watson, MA, OPA Ethics Committee*

With mounting evidence supporting the cost benefits and improved health outcomes of integrated healthcare treatment, it is no surprise that mental health treatment is increasingly being conducted in integrated primary care settings (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Hedrick et al., 2003; Woltmann et al., 2012). With these changes, mental healthcare providers are often faced with solving byzantine ethical and legal issues that are further complicated by a lack of consensus and collaboration between the professional organizations of the providers (i.e., American Psychological Association and the American Medical Associations; Williamson et al., 2017).

There are also notable differences between standards of care for behavioral health providers and specialty mental health providers (Runyan, Robinson, & Gould, 2013). For instance, the primary customer (patient vs. primary care physician), treatment goals, delivery of care, team structure, and healthcare services access all differ between settings (Runyan et al., 2013). Despite these distinctions, there are no specific guidelines for how to provide mental health services within an integrated setting. As a result, ethical breaches are likely to present for mental health providers within these settings. The purpose of this article is to outline some common ethical issues that may present within an integrated behavioral health setting.

**Informed Consent**

In specialty mental health settings, informed consent is a formal process where the mental health provider instructs the patient about the "nature and course of therapy," the cost of services, and the involvement of third parties and limits to confidentiality (10.01 Informed Consent to Therapy; American Psychological Association, 2017). The informed consent process for behavioral health providers in an integrated setting generally follows a brief oral script (Kanzler, Goodie, Hunter, Glotfelter, & Bodart, 2013). Furthermore, providing a formal informed consent within an integrated setting is often not recommended (Hodgson, Mendenhall, & Lamson, 2013). A formal informed consent may be too cumbersome or time-consuming for each patient to complete due to the briefness of the appointments for mental health services in integrated settings. Indeed, warm handoffs, which are brief initial meetings usually lasting only a few minutes, are usually the time most appropriate for a behavioral health provider to instruct the patient about the context of their role and what services they are providing.

However, this is not to say informed consent is not adequately provided. Actually, most integrated settings choose to provide patients with a consent form outlining the collaborative care model at the outset of services (Hodgson et al., 2013; Hudgins, Rose, Fifield, & Arnault, 2013). It is then expected that behavioral health providers will be responsible for verbally reviewing their role and limits of confidentiality within the first meeting with the patient.

**The Warm Handoff**

As previously noted, the warm handoff is an essential aspect of the collaborative care model. According to Hudgins et al. (2013), the best practice is to initiate the informed consent during the warm handoff process (or sooner; i.e., at first establishment of medical care). The authors detailed that in crisis situations, they recommend simply introducing oneself but not providing treatment until basic consent can be obtained.

Furthermore, Hudgins et al. (2013) stressed the importance of the primary care physician's introducing the behavioral health provider to patients. This may be the patient's first introduction to behavioral health and thus it is important that the PCP outlines accurate expectations regarding the role of the behavioral health provider, how collaboration will be conducted, and what treatment and goals will look like (Hudgins et al., 2013).

**Confidentiality**

Confidentiality is a considerable dilemma within an integrated care setting. Hallway consults, shared medical records, patients presenting with support persons, and poorly built clinics can all contribute to confidentiality breaches (Hodgson et al., 2013). Documentation for behavioral health notes is generally briefer since they are part of patients' medical records and not protected as they would be in specialty mental health. Kanzler and colleagues (2013) suggested that maintaining a balance between thorough record-keeping and protecting patient confidentiality must be met in an integrated care setting. One suggestion on how to address this issue is to focus notes on long-range planning rather than the immediate session contents (Hodgson et al., 2013). Clinical interpretation, transference, countertransference, or specific memories patients recall should be left for psychotherapy mental health notes (Hudgins et al., 2013; Steinfeld & Keyes, 2011). Also, Hodgson et al. (2013) suggested that

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an auditing mechanism should be in place for the medical record system in order to track appropriate access to records.

Regarding support persons accompanying patients to appointments, confidentiality should be reviewed promptly before any information is shared (Hodgson et al., 2013). Indeed, boundaries are recommended for consultations in the workplace, ensuring that confidential conversations are kept behind closed doors (Hodgson et al., 2013). However, Hudgins et al. (2013) emphasized that because the exchange of information is central to the success of collaborative care, understanding the legal and ethical guidelines is paramount to successful care. HIPAA provides that health information can be shared between a provider and the patient's primary care provider without authorization, as long as the information communicated is provided for the purpose of treatment and the patient is notified of the exchange and how the exchange will benefit their care (United States, 2004). To act in accordance with our higher ethical standard, psychologists should make this notification as soon as is feasible.

### Multiple Relationships

Multiple relationships are more common within integrated care settings and patient expectations are more likely to reflect their experiences with medical providers who follow the American Medical Association (AMA) guidelines and have more flexibility in their roles (e.g., a physician can treat an entire family, while behavioral health providers typically would not individually treat relatives; Runyan et al., 2013). Multiple relationships also may present in the workplace among providers. For instance, a co-worker may ask to be seen by the behavioral health provider or ask for mental health advice. These situations can become even more complex when working in small, rural communities or in areas where personnel serve in multiple roles (Hodgson et al., 2013). It can also be a problem when behavioral health providers seek their own medical care within the collaborative care settings in which they work, and as a result may interact with patients who are employees of other specialty clinics within those settings.

### Conclusion

The areas of ethical concern detailed in this article should not be viewed as an all-inclusive list of ethical challenges faced within integrated settings, nor should our review of the literature be viewed as a suggestion of a singular path

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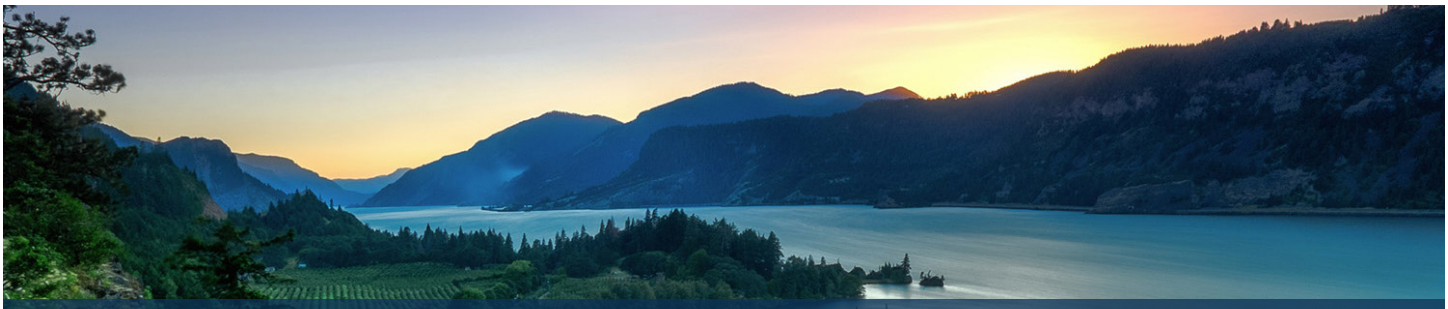

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**An Evidence-Based Sociocultural Approach to Eating Disorders Prevention in the Age of Neurobiology: 10 Principles for a Bolder Model**

Michael P. Levine, PhD, Emeritus Professor of Psychology, Kenyon College

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**Beyond the Basics: Medical Topics Important for Special Populations with Eating Disorders**

Jennifer L. Gaudiani, MD, CEDS, FAED, Founder,Medical Director, Gaudiani Clinic

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This conference is co-sponsored by the Columbia River Eating Disorder Network (CREDN), and Lewis & Clark Graduate School of Education and Counseling's Professional Mental Health Counseling –Addictions Program and the Center for Community Engagement.

COLUMBIA RIVER EATING DISORDER NETWORK

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toward resolution. Our hope is to illuminate some of the complexities that may present within an integrated care setting regarding informed consent, patient engagement, confidentiality, and multiple relationships. We hope that by reviewing these issues and relevant literature, we will support Oregon's psychological community in better understanding our increasingly complex and evolving role within integrated healthcare settings.

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## Why I Hate Self-Care

*Charity Benham, PsyD, OPA Colleague Assistance Committee*

"So... what do you do for self-care?"

I smile and manage to refrain from the nearly automatic and barely perceptible eye role as Dr. Whoever asks the dreaded question on my fifth straight internship interview in five days. I quickly scan my sleep-deprived brain for the mental file with information on which state I am in and what site I am interviewing for at the moment.

*"I have many varied hobbies including running marathons, painting, fiber arts, hiking, travel, writing, and performance art."* Spoken with a smile and a sincere voice almost devoid of sarcasm. My fatigue, however, makes the eye-rolling suppression difficult.

*"I chose to apply in rural Wyoming because I have a strong desire to expand my horseback riding skills."*

*"This environment is an ideal place to feed my love for nature, much needed after the intensity of graduate school. It's a wonderful community in which to raise a child."*

*"I love the energy of the city, and NYC will provide endless opportunities to indulge my passion for the arts."*

*"I love spending quiet and low-key weekends with my family, so the rural setting is ideal for me."*

*"Because of my love for running and my lifelong connection to the sea, the coastal environment is a perfect match for my particular ways of caring for myself."*

It was covered in class after class. I have been asked the question countless times by mentors, supervisors, teachers, colleagues, and students. The wording varies, but the question is the same.

*"What do you do for self-care?"*
*"How do you fill your tank?"*
*"What restores you?"*
*"What are your hobbies?"*

*Continued on page 12*

## 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 information about running the business of psychology, articles related to practice by PAC members, guidelines, and a template for professional wills, information on APA Record Keeping Guidelines, links to CEUs related to practice, and more!

*Why I Hate Self-Care, continued from page 11*

*"How do you nurture the life of the mind?"*
*"How do you maintain work-life balance?"*

I have graduated, finished my residency, passed the EPPP, and obtained my license. I left that first job that I took to pay the bills, and built the private practice that I always wanted. I no longer have supervisors, professors, bosses, and mentors. Now, I am the supervisor, teacher, mentor, and, of course, therapist. I am a member of the Colleague Assistance Committee (CAC) and pay my dues to OPA and APA. Now I am the one posing some form of that ubiquitous question about self-care. I have discussed it with trainees, clients, and in at least four OPA conference presentations offered by the CAC. And now… I am writing an article on self-care. I have been on the receiving end of the same polite nod and barely perceptible eye-roll, and heard the same cringe-worthy canned answers that I once gave when on the other end of the power differential.

My cringe has nothing to do with the validity of the premise. We do, indeed, feel better when we engage in classic self-care activities. A cursory review of the APA Colleague Assistance Committee web-page regarding self-care reveals a set of activities that are repeated on nearly every resource page for mental health professionals. *How do we avoid burnout?* Self-care. *How to leave work at work?* Self-care. *How to deal with overwork?* Self-care. *How to cope with a patient suicide?* Self-care. *How to navigate (divorce/financial strain/grief/life transitions/ medical problems/etc.)?* Self-care.

The "lists" usually include some versions of the following:

- Take physical care of yourself by exercise, eating right, and addressing medical needs.
- Get a hobby.
- Go to therapy.
- Interact with colleagues (consultation groups, state associations, etc.).
- Self-reflect.
- Read about self-care.
- Reduce your work load.
- Take vacation.
- Nurture your spirituality.
- Nurture your relationships.
- Spend time in nature.
- Do an art project.
- Etc.

No arguments here! When people do these things, they feel better. When I am doing these things, I feel better. It is no coincidence that when someone is not doing so well, inquiry reveals that they are not "taking care of themselves." And they already know it. Most people seeking my support as a therapist, mentor, or supervisor already know exactly what they need to do to feel better.

What they often do not know is why they are not doing the things that will make them feel better. The negative impact of poor self-care is rarely a newsflash.

I hate self-care because of the word "self." In reviewing the lists on how to do good self-care, the overwhelming majority of suggestions are things done in isolation. While most "lists" include one or two references to friends or community, the relational elements of "self-care" are generally side-notes.

I hate *self-care* because of the implication that a person is suffering because of things they aren't doing.

I hate *self-care* because it is a convenient way to avoid joining with a person who is suffering.

I hate *self-care* because it edges into victim-blaming.

I hate *self-care* because it supports the pathological notion that we can do it alone.

I hate *self-care* because it drips with privilege.

It is incredibly uncomfortable to observe a healthy, strong, stable individual losing hold of the frame that makes life manageable. It is a reminder that we are all vulnerable, and will face times in life when we simply don't know what to do. It is hard to see someone we respect and admire lose their shit—and it is a compelling reminder that each and every one of us may lose our shit at some point. The last thing any person needs in that place is an inquiry about how much they are exercising or if they have been on vacation.

*Continued on page 13*

*Why I Hate Self-Care, continued from page 12*

Attachment literature suggests that we co-create our reality. We are social animals, and working together is an evolutionary necessity. While research on mirror neurons is rudimentary and not clearly understood, there is sufficient evidence in the literature exploring the neurobiology of attachment to suggest that we regulate ourselves through interpersonal feedback loops. Our brains are hard-wired to regulate one another in times of distress.

Oxytocin is good for us. In popular psychology, there has been a dramatic increase in writing, both research-based and anecdotal, touting the importance of touch to our physical, emotional, and relational well-being. A basic Google search of "Oxytocin t-shirt" yielded over 300,000 hits, offering buyers a myriad of merchandise depicting everyone's favorite "cuddle hormone." Oxytocin is hot.

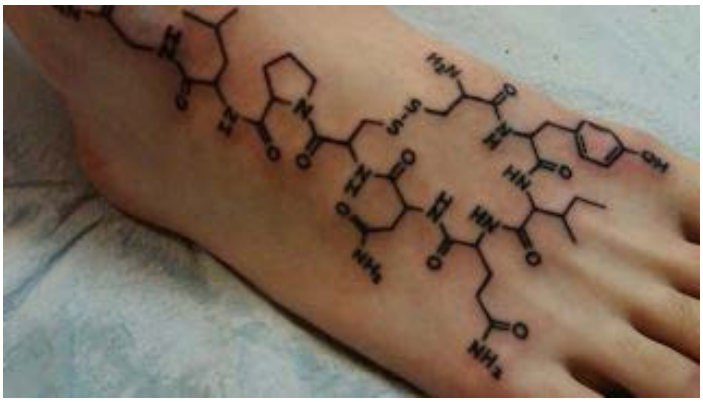

***Image retrieved from https://i.pinimg.com/236x/0d/d5/58/0dd5587b8b3a781f046a444d7e3aec82--chemical-structure-chemistry-tattoo.jpg***

In 2015, Portland hosted its first annual CuddleCon, a convention devoted to education and practice of consensual platonic cuddling, complete with a Consent 101 class, emphasizing both the need for touch, as well as the need to hear and say "no."

**When Connection Enhances Self-Care**

Self-care does not thrive in a vacuum. We do not need to teach one another self-care. We need to support each other in overcoming the obstacles to self-care by giving and receiving connection. The "self" becomes "selves," all doing the best we can, better together than apart.

I no longer ask, *"How is your self-care?"*

I now ask:

*"How can I support you?"*

*"Where are you receiving nurture?"*

*"How good are you at asking for help?"*

*"Who shares common goals in your life?"*

*"Where do you find community?"*

*"How often do you give and receive touch?"*

*"Who do you have in your life that always has your back?"*

*"Do you feel seen?"*

And I ask these questions of myself. When I reach out for support, this is what I want to be asked.

While the idea of connection as the core of self-care is cuddly and nice, it is not much better than suggestions to walk more, eat better, and take a vacation. The building of community is something that entails several challenges, particularly for psychologists. Since the Duty to Report law was enacted, we live in fear that a colleague might see our humanity as "unprofessional."

I will not offer an easy answer, because it doesn't exist. I want to ask the question, in hopes of starting a dialogue among ourselves about the question. Asking questions can be the first step to community. So I ask the following:

*How can I be a safe person for my colleagues?*

*What will increase my sense of safety when around my colleagues?*

*Who is one person I can reach out to that I know is safe? (Hint—CAC is here.)*

*Am I open to receiving care and nurturing from others?*

*Am I getting enough touch?*

*Am I being honest with myself about my level of connection?*

Colleagues and friends, let us put effort into seeing one another's humanity. In our current political climate, feeling safe may be too much to ask. Perhaps this isn't about telling one another our deepest and darkest secrets. Perhaps it's a game of Scrabble during the lunch hour. Being intentional about connection time. Being honest about the need. Being open and willing to receive.

# The Bookshelf: Memoirs and Book-length Accounts for Ethics Exploration

*Shoshana D. Kerewsky, PsyD, HS-BCP, Editor, The Oregon Psychologist*

I love reading about professional ethics, but it can also be nerve-wracking to read about psychologists who have intentionally or unintentionally crossed a line. The anxiety that comes with professional identification sometimes makes it hard to concentrate on the ethical standards and decision-making processes that led to the reported outcomes. Like me, my graduate students seem to find it easier, and perhaps more comfortable, to read about ethical dilemmas and issues experienced by our peers in related professions and roles.

This month's Bookshelf presents situations that do not focus on psychologists. Whether you choose to apply our ethical standards to these subjects as if they were psychologists engaged in similar behavior, or use these stories as a springboard for learning related ethics codes, I hope this list provides you with an expansive assortment of examples from the practices of professionals in the fields of medicine, research, education, and psychiatry. Ancillary materials and differing opinions are easily found online.

As with any media, review items yourself before making recommendations to clients or students.



Dully, H., & Fleming, C. (2008). *My lobotomy: A memoir*. New York, NY: Three Rivers.

You may be familiar with Howard Dully's story from his 2005 NPR report (available at http://www.npr.org/2005/11/16/5014080/my-lobotomy-howard-dullys-journey; the NPR page includes a photo that may be disturbing to some). Dully was lobotomized by Walter Freedman when he was 12 years old. In the audio report and book, Dully raises many ethical concerns related to Freedman's actions, some of which are supported by other interviewees. For more on Freedman, see also Jack El-Hai's 2005 *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness* (Hoboken, NJ: Wiley).

Fadiman, A. (1997/2012). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures.* New York, NY: Farrar, Straus and Giroux.

In addition to its Oregon connections, Fadiman's account of Lia Lee's family describes both triumphs and tragedies as they intersect with a variety of professionals in relation to Lia's epilepsy. This is a useful book for teaching because it is engaging and emotional, and it can be difficult to generate options that are not tried by the family or the professionals. It raises important questions about ethics and cross-cultural interventions.

Jones, J. H. (1993). *Bad blood: the Tuskegee syphilis experiment* (new and expanded edition). New York, NY: The Free Press.

The "Tuskegee Study of Untreated Syphilis in the Negro Male" did not provide adequate informed consent, included deception, and caused harm by failing to provide treatment when it became available. It raises significant concerns about a lower standard of protection and care for non-majority research participants, and might be paired with *The Immortal Life of Henrietta Lacks* (Skloot, 2010), below.

McNamara, E. (1994). *Sex, suicide, and the Harvard psychiatrist*. New York, NY: Simon & Schuster.

Presents the relationship between Dr. Margaret Bean-Bayog and her patient Paul Lozano, who committed suicide and with whom she was charged with having a sexual relationship. She relinquished her license. Bean-Bayog also utilized poorly-supported interventions with Lozano, such as regression therapy.

*Continued on page 15*

*The Bookshelf, continued from page 14*

Noel, B., & Watterson, K. (1992). *You must be dreaming*. New York, NY: Simon & Schuster.

Similar to Bean-Bayog, Jules Masserman was accused of sexual misconduct and inappropriate interventions with his patients, such as the use of IV sodium amytal. These charges were settled out of court. Masserman was a past president of the American Psychiatric Association, the American Society for Group Therapy, the American Association for Social Psychiatry, the American Society for Biological Psychiatry and the American Academy of Psychoanalysis.

Olsen, G. (2012). *If loving you is wrong: The teacher and student sex case that shocked the world*. No city: CreateSpace.

This is a poorly-written potboiler, but remains the most highly rated book about middle school teacher Mary Letourneau's sexual relationship with her minor student Vili Fualaau, which resulted in two daughters. Letourneau told Barbara Walters that she did not know it was illegal to have sex with her student. After her prison term, Letourneau and Fualaau married; they are recently separated (according to some sources, so that Fualaau can obtain a license to distribute a marijuana product). A good text for genogram practice as well as discussion about how gender contributes to popular and legal opinions about the severity of adult-child sexual abuse.

Skloot, R. (2010). *The immortal life of Henrietta Lacks*. New York, NY: Random House.

Though she died of cervical cancer in 1951, Lacks's HeLa tumor cell line lives on. Her story raises issues of informed consent, who benefits financially from medical research on human cells, and ensuring that family members understand medical and research processes and have the opportunity to raise objections.

You will find many related books by entering these titles on Goodreads, Library Thing, Powell's, Amazon, or other online book review and sales sites.

*What's on your bookshelf? You're welcome to submit your own annotated list with APA-style references for main entries to kerewskyopa@gmail.com. Single book reviews of interest to psychologists are also welcome. If you've published a book, you're welcome to write an article describing it (please identify yourself as the author in your write-up).*

## OPA Awards Program

The OPA Board of Directors and Diversity and Public Education Committees are beginning the process of selecting awards candidates for the 2018 awards program.

The following is a listing of the awards, what they represent, and recent recipients. If you know of someone whom you would like to nominate, please submit a brief summary of the candidate and why you feel they should receive the award. Summaries can be submitted to the OPA office and will be forwarded on to the committee or board. Nominations need to be received by January 5, 2018. Please email your nomination to OPA at info@opa.org.

**Labby Award:** Presented to an OPA member for outstanding contributions to the development of the advancement of psychology in Oregon.

***2017 recipient was Lynnea Lindsey, PhD, MSCP***

**Outstanding Service Award:** Presented to a person or group within Oregon outside the formal field of psychology which has, by its actions, theory, or research, promoted or contributed to the emotional and psychological well-being of others through the positive use of psychological principles.

***2017 recipient was Children's Health Alliance and Children's Health Foundation***

**Public Education Award:** Any licensed psychologist in Oregon and active OPA member who has participated in at least one public education activity in the preceding year is eligible for the award. Examples of public education activities include being interviewed by the media on a psychology-related topic or presenting at a conference or event for community members (not just other psychologists). Self-nominations are accepted. Members of the Public Education Committee are not eligible.

***2017 recipient was Elsbeth Martindale, PsyD***

**Diversity Award:** This award recognizes a licensed psychologist with a record of a strong and consistent commitment to diversity through their clinical work, research, teaching, advocacy, organizational policy, leadership, mentorship and/or community service. Diversity is defined in its broadest sense and includes work with a wide range of minority populations and efforts related to social justice, inclusion, equity as well as cultural awareness and competence. The awardee must be licensed in Oregon and be in good standing with OBPE.

***2017 recipients were Sandra Gonzalez, PsyD and Eleanor Gil-Kashiwabara, PsyD***

# 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**

All workshops are held in Portland, Oregon unless otherwise noted. In order to register for OPA workshops on-line 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.

## *2017-2018 Schedule*

### December 1, 2017

**Risk Assessment**

*By Rebecca Bolante, PhD, CRC, CTM*
*Wendy Bourg, PhD*
*Chris Huffine, PsyD*
*Casey Stewart, PsyD, ABPP*

### June 1, 2018

**Addiction as Attachment Disorder**

*By Philip Flores, PhD, ABPP, FAGPA*

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***

## Welcome New and Returning OPA Members

**Sarah Afromowitz**
Hillsboro, OR

**Greg Baron, PsyD**
Beaverton, OR

**Ross Bartlett, PsyD**
Salem, OR

**Stephen Boyd, PhD**
Portland, OR

**Grace Cantor, LPC**
Portland, OR

**James Carson, PhD**
Portland, OR

**Samantha Domingo, PsyD**
Corvallis, OR

**Katherine Eichner, PhD**
Portland, OR

**Bridget Fanning-Ono, PsyD**
Portland, OR

**Colby Hampton**
Newberg, OR

**John Hancock, EdD**
Portland, OR

**David Hayden**
Portland, OR

**Hannah Hoeflich, PsyD**
Portland, OR

**Leah Koski**
Vancouver, WA

**Patrick Moran, PhD**
Portland, OR

**Kristin Nick, PsyD**
Portland, OR

**Alyssa Nolde, PsyD**
Portland, OR

**Roshni Patel**
Beaverton, OR

**Luke Patrick, PhD**
Beaverton, OR

**Lianne Richland, PsyD**
Tigard, OR

**Gretchen Scheidel, PhD**
Eugene, OR

**Alexandra Schmidt**
Beaverton, OR

**Alison Shannon, PsyD**
Portland, OR

**Heather Sheafer**
Portland, OR

**Marc Taylor, PhD**
Newport, OR

**Chelsea Thomas, PsyD**
Beaverton, OR

**Fabiana Wallis, PhD**
Portland, OR

**Kurt Webb, PsyD**
Salem, OR

**Amy Williams, PhD**
Corvallis, OR

# *Income Protection Insurance*

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| 40 | $70.50 |
| 45 | $103.00 |
| 50 | $121.25 |
| 55 | $141.00 |

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## 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

## OPA Ethics Committee Benefits

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.

OPA Ethics Committee members are available for contact. For more information visit the Ethics Committee section of the OPA website and page 21 of this newsletter.

## 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/pages/Oregon-Psychological-Association-OPA-Public-Education-Committee/160039007469003 to visit our Facebook page.

**www.opa.org**

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

# Psychologists of Oregon Political Action Committee **(POPAC)**

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

The Oregon Psychological Association actively lobbies on behalf of psychologists statewide. Contributions from POPAC to political candidates are based on a wide range of criteria including electability, 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 -

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*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

### FOR SALE

Office Furniture Set, Ashley "Cross Island" Mission style, available as a set or individually. Google "Ashley H319-18" to see bookcase and style. Also included: 60" monitor stand, desk, desk chair, end table, under-desk file cabinet, and large recliner chair. 2 large cushy Stanton therapy chairs solid taupe. Call or email David for options and pricing. 503.972.8957. doctor@davidwindstrom.com.

### OFFICE SPACE

Office space to share for Mental Health Providers. Days: Mon, Fri, Sat, Sun. Rent $300/month. Great location in NW Portland. Easy Acess to NW 23rd street. 503.531.9355 to schedule a tour.

Office available soon in established practice in Gresham. 2-3 days a week initially, then FT as current Psychologist transitions to retirement. Shared expenses, incl. office manager, billing, reception. Converted Craftsman in historic Old Town at 502 N. Main Ave, 1 block from MAX. Contact Karen Swift or Greg Morse at 503.492.7470.

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.

Beautiful large office in 2 office suite to rent. Large windows, trees, close to route 26 and 217 intersection, west side, close to Max with lots of parking. Share suite with health medical Psychologist referrals possible. Call 503.292.9183 for details.

### 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.

### 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.

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.

### WORKSHOP

Restorative Self-Care Workshop for therapists, 1/18/17, 9am-4pm, $129, 6 hr CEU. Don't just teach self-care, practice it! Explore professional dangers of self-neglect, assess your skills at caring for your self, & learn strategies for teaching self-care to your clients. Leave with tangible tools to ground & embody your learning. www.elsbethmartindale.com/trainings-workshops.

## 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**

Charity Benham, PsyD, 503.550.7139
Allan Cordova, PhD, 503.546.2089
Jennifer Huwe, PsyD, 503.538.6045
Kate Leonard, PhD, 503.292.9873
Rebecca Martin-Gerhards, EdD, 503.243.2900
Colleen Parker, PhD, 503.466.2846
Marcia Wood, PhD, Chair 503.248.4511

**CAC Provider Panel**

Charity Benham, PsyD, 503.550.7139
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

# 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 2 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 Members**

**Morgan Bolen**
*Student Member*

**Jill Davidson, PsyD**

**Irina Gelman, PsyD**

**Steffanie La Torre**
Student Member

**Catherine Miller, PhD,** *Chair*

**Nicole Sage, PsyD,** *Chair-Elect*

**Christopher Watson, MA**
*Student Member*

**Jaimie Young, PsyD**

**Petra Zdenkova, PsyD**



## OPA Elections - Nominations Sought

The OPA Nominating Committee is working on developing the slate of candidates for the 2018-2019 board of directors. If you would like to serve on the board as a director, or would like to recommend someone for the board, please contact the chair or the OPA executive director by January 5, 2018. The board will be reviewing and approving the slate of candidates at their January board meeting to send to the membership for approval.

All board members attend six board meetings per year and volunteer for other OPA activities. If you would like to know more about the responsibilities of a board member, please contact either of the people listed below.

Nominating Committee Chair
**Shahana Koslofsky, PhD**
503.621.2313
drkoslofsky@gmail.com

Or

OPA Executive Director
**Sandra Fisher, CAE** at 503.253.9155 or 800.541.9798 or via email at info@opa.org

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

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

***Advertising Rates & Sizes***

Advertising Rates & Policies Effective January 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 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****

***2018***

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

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

## 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.

Oregon Psychological Association

***The Oregon Psychologist***

Ryan Dix, PsyD • Shoshana D. Kerewsky, PsyD, Editor

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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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