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What's Inside

OPA President's Column

OPA Boasts Talented Leaders for 2018

Ryan C. Dix, PsyD, President, OPA

I am so pleased to be able to share a few of the many exciting things going on at OPA. The first is that we have hired our Director of Professional Affairs (DPA). This position has been discussed for many years and with your support we were finally able to make it a reality. We are confident that your board's selection for this position will be a great asset to OPA. Please join me in welcoming Susan Rosenzweig, PsyD as your new Director of Professional Affairs. In the upcoming weeks, members of the board will be meeting with her to discuss our shared vision for this position and ensure we are able to maximize the investment you have all made in making this position a reality. Additionally, she will be working right alongside the Professional Affairs Committee, so if you have any interest in that committee please contact OPA. I also asked Dr. Rosenzweig to tell us a bit about herself and she stated:

> "I'm really excited to join OPA as the new Director of Professional Affairs. I've been in independent practice in Oregon for more than 20 years, most of it in Portland but also a decade practicing in the smaller community of Gresham/Troutdale. I previously served OPA as Insurance Committee Chair and was on the OPA Board of Directors before stepping aside to focus on building my practice and raise my family. My to-do list for this new position is already quite long. My first step is attending the Professional Leadership Conference in Washington, DC, where I will be meeting the DPAs from across the country and getting up to speed in early March. During the conference, I will also be introducing myself to our federal lawmakers and their healthcare staff liaisons. Over the next few months, I plan to be working hard on developing a Professional Practice CE program, hopefully being able to do some of that at chapter gatherings across the state, and developing a Professional Affairs resource page on the OPA members-only site with links and answers to many questions that come up often. In my free time, I enjoy reading, yoga, and camping with my family. My husband and I have a middle schooler at home."

Again, please help me in welcoming Dr. Rosenzweig.

The second piece of exciting news I would like to share has to do with some of the great early career talent we have here at OPA. Roseann Fish Getchell is currently the American Psychological Association of Graduate Students (APAGS) representative on our board. This last year she was elected as the new Chair Elect of APAGS and I asked her to tell me a bit about it. She stated:

> "This past year, I was elected as the new Chair Elect of the American Psychological

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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.*

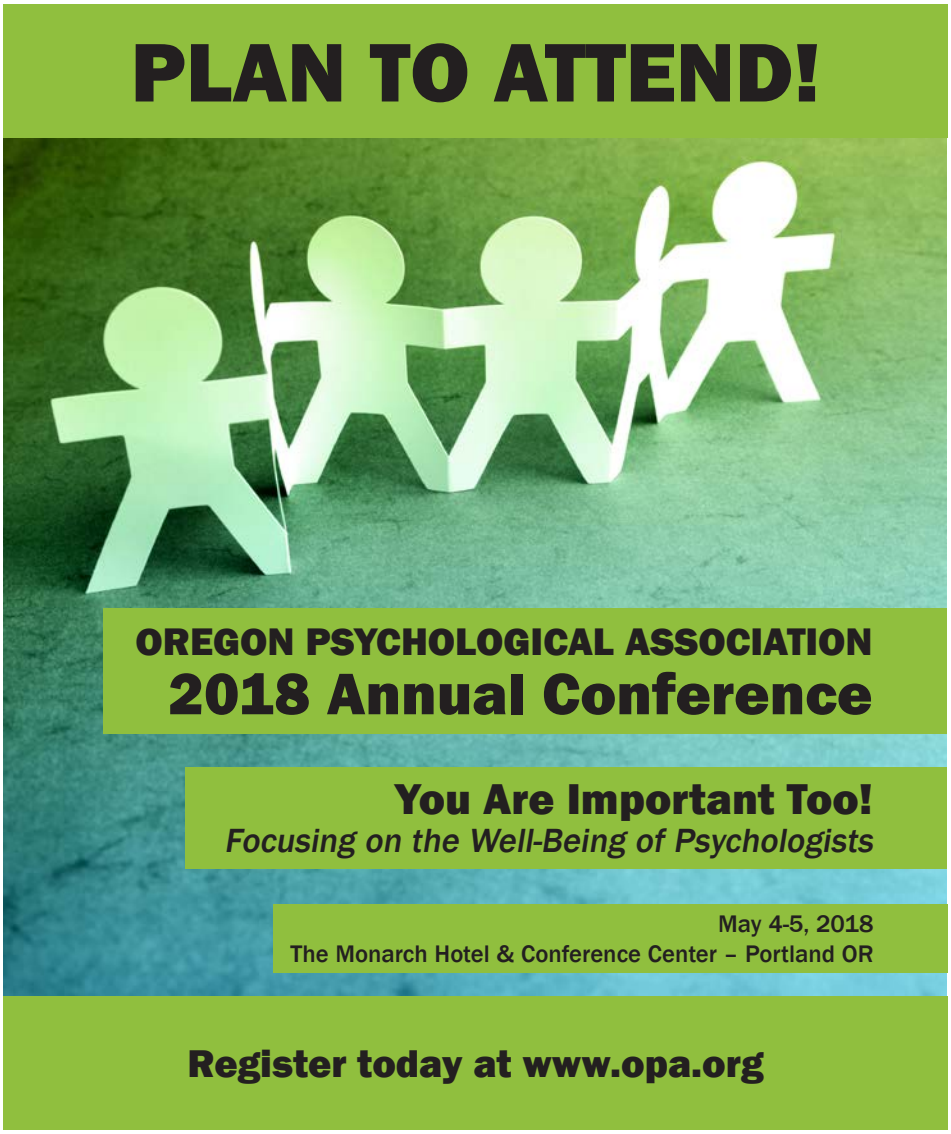
President's Message, continued from page 1

Association of Graduate Students (APAGS). This has been an incredible honor to join other student leaders across the country as we work to support the next generation of psychologists, leaders, and innovators. Over the next three years, I will be working with the APAGS Committee as we find ways to bring more graduate students 'to the table.' Whether this is through serving on the APA Council of Representatives, or sitting as a voting member on the APA Board of Directors, the student voice has never been stronger.

The APAGS Committee is full of graduate students who have the creativity, energy, and grit to make a difference within our communities. Additionally, I have been blown away by the willingness of psychologists within the American Psychological Association, and specifically the Oregon Psychological Association to provide mentorship and support to graduate students who are interested in leadership within the profession. It brings me hope to see so many people who are invested in the future of psychology!"

Please join me in congratulating Roseann as she continues in this role.

As I have said before, I truly appreciate the privilege of serving as your president and look forward to what 2018 has in store for our organization.



Imagine There's No Google (with Apologies to John Lennon)

Carol A. Carver, PhD

Imagine there's no Google
It's easy if you try
No fax or listserv
No computers to buy
Imagine all your clients
With no DBT----Uh Oh, Uh Oh....

How did we ever practice without these things?

By the time this article sees print, I will have retired from the practice of psychology. Since I started graduate school in 1971, I have had the privilege of seeing the profession change dramatically, and myself along with it. What follows are my thoughts about what has changed and how to make some meaningful sense of what I have contributed to the world in my life's work.

So—what was it like back when dinosaurs roamed the earth and I started private practice as a psychologist? Well—there was no voicemail. Answering machines were the order of the day. There were Answering Services, but your pager wasn't digital. It beeped you and you called the service to discover who had called. All phones were landlines until years later when I acquired a "brick" cellphone. My office had a typewriter (and carbon paper!). Fax machines were extremely new and I didn't have one. Psychological testing routinely included a Rorschach and a Thematic Apperception Test. Therapy notes were kept on notebook paper (if at all) and there were no real standards for what was written. Insurance billing didn't require any special form—just a paper statement of service and charges—and they paid my full fee!

In graduate school we learned psychoanalytic psychotherapy, Rogerian and Gestalt therapy, and Rational Emotive Therapy. Couples therapy referenced Virginia Satir. Gottman hadn't done his work yet. CBT was not created yet, and neither were DBT, Solution-focused Therapy, and a host of other approaches. The DSM still listed Homosexuality as a mental disorder (although my graduate program disagreed). I learned to give the Thematic Apperception Test and the Rorschach test (but the Exner method of interpretation had yet to be developed and I learned it later). I gave the Stanford-Binet individual intelligence test and the WAIS and WISC and WPPSI (older versions, obviously). Dissertation data meant computer punch cards taken to the university computing center—or in my case, I'm doing a 2 x 2 x 2 x 2 Analysis of Variance on my (new and exciting) hand-held Texas Instruments calculator! Libraries only used card catalogues. Journals were huge bound volumes in the university library, and we graduate students could check them out for weeks at a time.

I've often been asked: Why did you become a psychologist? In 1967, when I went off to college, I didn't plan to become a psychologist. However, as my interests changed, I looked at what professions women could enter and be welcomed (it was not illegal to discriminate based on gender in hiring back then!). So I chose psychology. I had randomly stumbled across a book in the U of O library: *The Fifty Minute Hour* by Robert M. Lindner, MD—several case studies from a psychoanalyst. I couldn't put it down. I sat in the library reading as much as I could until library hours ended. The inner workings of the psyche fascinated me. People were amazing puzzling kaleidoscopes of difficult life experiences and reactions. I audited the course in Abnormal Psychology after already taking it once because each individual seemed like a mystery novel to me. I had women professors, so I knew women could have careers as psychologists. I was hooked.

And then I was forced to take a course called "Careers in Psychology." The sole purpose of the class seemed to be to convince us that no one really ever got into graduate school. But it was too late for me. I was already a junior and couldn't choose a different major. Fortunately I was admitted to several APA-approved PhD programs in spite of the dire warnings of how unlikely that would be. And I was relieved and excited to start the journey towards a PhD in Clinical Psychology (which they told me would take about 4 years—but really took 7).

Many (most?) people become psychologists because they "want to help people." I became a psychologist because I wanted to figure people out and find ways to intervene with them so that they solved their problems and developed better ways to cope.

In the 47 years since I entered graduate school, I have learned and used Psychoanalytic psychotherapy, Gestalt psychotherapy, Rogerian psychotherapy, Rational Emotive Therapy, Cognitive Behavioral Therapy, Solution-Focused Therapy, 12-Step- based Chemical Dependency Treatment, Mindfulness Meditation, DBT, ACT, various personality and intelligence tests, hypnosis, supportive psychotherapy, and likely some other things that don't come to mind. Most of those approaches have been learned in CE courses, since they didn't exist when I was in graduate school. I have learned about psychopharmacology (starting before the SSRIs were invented!). I learned about Thorazine and Stelazine and amitriptyline—and a hundred more since then.

But what about "helping people"? The research takes us in many different directions as we try to figure out what we do that is helpful, or whether we are better than a placebo. When Managed Care and capitated healthcare plans swept through the landscape in the mid-90's, we saw our work monitored and measured by insurance companies. Suddenly, we had to submit treatment plans to faceless others (not even psychologists in most cases) who decided whether or not our work

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Imagine There's No Google, continued from page 3

would be reimbursed going forward. The philosophy seemed to be that most clients should finish therapy in 12-20 sessions. Manualized therapy approaches yielded results in research, so we were supposed to apply them liberally with clients who never would have been admitted to the clinical trials because their problems were more complex!

Facing retirement, I wonder: Has anything I have done made a difference? What can I look back on with pride and satisfaction? Does the answer lie in the outcome measures I use? Or is there something happening that isn't well-measured in a questionnaire? And how have my experiences as a psychologist changed me?

I have seen a few thousand clients in my career. Client beliefs about therapy have changed over time, as the models in the media have shaped what clients expect will happen when they enter my office (think: *The Sopranos, Nuts, The Dr. Phil Show, Bob Newhart,* or Judd Hirsch in *Ordinary People*). Diagnostic choices have changed, too. Health insurers have inserted expectations into our practices. Standards for what a chart should look like have changed—from no notes at all or random notes, to a more organized and categorized framework likely done electronically. APA guidelines have emerged for treatment of LGBT community members, elderly clients, multicultural clientele, etc.

When I began working as a psychologist, long-term psychotherapy was the norm. Along came SSRIs. The newest thing since sliced bread and the solution to whatever emotional troubles a person had. The wave of Managed Care pushed us to find quick fixes, to push people to change rapidly, and to program our therapeutic encounters in 12 sessions or less. The latest changes press us to focus more and more on how we can create changes in brains.

One thing has remained fairly constant: The troubles that bring clients into my office are depression, anxiety, grief, stresses in life, parenting, divorce, childhood abuse, obsessions and compulsions, substance abuse, trauma, confusion, aging, and work-life distress. It has been rewarding to hear that I have made a significant difference in someone's life. That feedback over the years has been a useful reminder that I have been more than a placebo. Many clients tell me they carry me around in their heads (frightening as that may be for me!) and they are comforted by that. As I have gone through session after session of terminations prior to my retirement, clients have been emotional about finishing their work with me, with lots of tears and hugs goodbye.

I've had countless experiences that changed my perspective on being a human in this world. One of my professors said you're not a "real" psychologist until one of your clients kills themselves. I decided I didn't need to be a "real" psychologist if that's what it meant—but it happened anyway. And it's humbling and frightening to feel so helpless, when you're supposed to be the one helping. I've worked with men serving time for murder, and clients who did awful things in alcoholic blackouts (including vehicular homicide). I've helped people come out as gay/lesbian, bi, and trans, and worked with women struggling with decisions to have secret abortions, divorces, and to leave their religions. I've heard stories of horrific abuse experiences—worse than I've encountered in any texts on the subject. We hear so much in our offices, and we hold it all in confidence. But it can skew our view of humanity if we aren't careful.

I have come to believe that every painful personal experience in my life has turned out be exceptionally useful to me in my practice as a psychologist: Coming out as lesbian with no legal protections; being disowned by my parents; being left by a partner who was having an affair; watching my income plummet and finding a new twist in my career by providing CE seminars; surgery for cervical neck fusion; death of both of my parents; finding love again in a polyamorous relationship—all of these increased my capacity for empathy with clients and helped me to anticipate potential difficulties for them.

One thing that has helped me the most came not from psychology, but from Buddhism. A 12-year practice of Mindfulness Meditation, including numerous meditation retreats at a Buddhist retreat center have (hopefully) deepened my compassion for myself and others, as well as increasing my appreciation for loving kindness, patience and equanimity. And that path continues.

When I wonder if I have made a difference, I focus on the things I did for colleagues, and not the things I did to earn a living. In 39 years I've given over 65 trainings and professional presentations to help colleagues work with the LGBT community, and to establish successful private practices. I've had the honor of testifying numerous times to the Oregon Legislature, as well as giving public presentations to combat misinformation and share what psychology knows. I've had the privilege of serving as President of OPA and participating on the Board of Directors for 7 years. It's in these activities where I hope I have created a legacy I can look back on with satisfaction.

So I ask: Why would someone want to become a psychologist now? The answer may not be so different than my own, but perhaps more complex. Private practice is changing—but also much of it may stay the same. The more we learn about the brain, the more psychologists collaborate with psychiatry and primary care physicians. But ultimately, psychologists will still find themselves sitting face to face with another human being, trying to help them unravel a set of problems and find solutions, using the best research findings to guide us and the best of our humanity to help us with the task. As I head toward retirement,

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Cliff's Notes

Cliff Johannsen, PhD, Oregon Representative to APA Council

Hello, colleagues.

As the Oregon representative to APA Council, I represent those of you who are both OPA and APA members. To your credit, a substantial portion of you already hold dual membership and hooray for you! If you don't yet hold dual membership, I offer you the most sincere encouragement to start a new era in your career. Those holding dual membership are my constituency, and I strive to be your voice at APA.

We have not yet seen the final agenda for the March 8th to 10th Council meeting. However, because of recently increased transparency, we can at least see a faint outline of what it will be. There were 22 business items as of December 2017. When it lands in our Dropboxes in the next several weeks, it is guaranteed to be several thousands of pages. Since APA's new CEO, Arthur Evans, was introduced to us last August, we are beginning to see his imprimatur on the association. And with Katherine Nordall's retirement, we will see a new Practice executive and a reformulation of the four directorates.

1. Council may be voting on the entirety of APA becoming a C (6) organization, and the four Directorates being unified in their advocacy for the profession. OPA distributed an invitation to OPA members to review proposals and attend a webinar on the restructuring of APA, and I hope that you took advantage of that.

One item on the March agenda will certainly be…

2. …proposals for accreditation of master's degree educational programs, and eventually for licensure of master's degree practitioners. If so, this will be the first time since 1949 that there has been a modification of the doctoral scientist-practitioner credential requirement for entry into licensed practice. Oregon is one of only a few states to license master's-level psychologists, so it may not be such a deviation here.

A business item too controversial last August will return…

3. The proposal for transparency of voting. It was too controversial for adoption at last August's meeting. I belonged to the work group promoting this idea. But there was significant opposition. When the Hoffman Report (also called "the independent review") was leaked to the press and Council had to begin coping with it immediately at the Toronto convention, council members were traumatized by booing, heckling, coercion, and stalking by APA members in the gallery. So especially among that cohort, they are hesitant to have a transparent vote. For my part, I think that I should be accountable to my constituency, and have an opportunity to explain why I voted the way that I did. My estimation is that there is a 50/50 split in Council, so it will be very interesting to see how the vote goes.

The treatment guidelines will return to Council, and the question remains whether they should be broad and less rigorous, or narrow and more rigorous…

4. This item is likely to come to Council in the form of a proposal for adopting a professional guideline as a companion piece for each treatment guideline. If you haven't been following this closely, the distinction might be perplexing. I'll gladly go into more detail if that would be helpful.

Two policies with pending revisions are…

5. Archiving a policy that linked video games with violence. The scientific evidence has been too inconsistent to support the policy.

6. Clarifying that psychologists can provide services to military personnel who are working in security settings.

As always, I encourage you to contact me with your concerns about APA structure and functioning.

Imagine There's No Google, continued from page 4

I am convinced that I leave the profession in very capable hands.

P.S. I owe my successful admission into several APA-approved PhD programs to the education and mentoring I received in the Honors College at the U of O. To honor my retirement, I have established a fund for Honors College students who need money to do the required senior research thesis. You may donate to the Carol Carver Pay It Forward Thesis Research Fund (# 8057.12.1) at the University of Oregon Foundation, P.O. Box 1358, Eugene, OR 97440-1358 with a check to the Foundation and the notation of my fund. It is perhaps the best way I have found to give back.

The Bookshelf: Breast Cancer

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

Breast cancer is the most common women's cancer in the U.S. Mortality has significantly decreased over the last several decades, yet the current rate of 1 in 8 U.S. women affected means that therapists are very likely to work with clients who have had a breast cancer diagnosis. (Although men can also develop breast cancer, the rate is much lower at about 1 in 1,000.)

Sometimes written sources of information can be helpful for clients with a new medical diagnosis, and sometimes they are not a good fit for the client's needs. An informal inquiry to BreastCancer.org message board members asking for breast cancer books that they had found helpful returned some suggestions, but primarily the comment that books were not as helpful as direct online or in-person contact. Their reasons included not wanting to read accounts by people who had since died of breast cancer, not finding the book relevant to their experiences, others' stories being frightening or upsetting, or not enjoying the author's tone, humor, or politics. If your client chooses to read, it can be useful to know what she is reading and how it affects her. Therapists, of course, are not exempt from breast cancer, nor are our family and friends. If you are not familiar with general, contemporary breast cancer characteristics and intervention, or would find it useful to understand breast cancer from the perspectives of women having this experience, you may find the readings below helpful.

As with any media, review items yourself before making recommendations to clients or students. This is particularly important with reference works on breast cancer, which may use highly medicalized language, rapidly go out of date, or promote a particular treatment agenda. Breast cancer narratives and personal stories may reflect different treatments, different eras of care and sociocultural response, or opinions about allopathic, holistic, complementary, or alternative interventions. The passage of time elapsed since publication increases the possibility that the author has died, whether from breast cancer or other causes.

Your client may be overwhelmed by the diagnosis or range of intervention options. She may not have the desire to read, or the concentration to do so. She may prefer to converse in person or online with other women facing similar issues, or focus on individual support and intervention with you.

This bookshelf might best serve as a way for therapists to become familiar with both a physical and medical overview of breast cancer, the varied experiences of women managing or living with this diagnosis, and our own assumptions, emotions, and countertransference when a client or someone close to us is affected by breast cancer.

Breast Cancer Memoirs

Hayden, J. (2015). *The story of my tits*. Marietta, GA: Top Shelf Productions.

This memoir is presented in graphic novel format, including images of breasts. Hayden interweaves her own story with narrative about her mother's mastectomy.

Jarvis, D. (2008). *It's not about the hair: And other certainties of life & cancer*. Seattle, WA: Sasquatch.

Jarvis, a chaplain working with cancer patients, describes her experience on both sides of the helping relationship. Engaging discussion of spiritual and interpersonal issues.

Lorde, A. (2006). *The cancer journals: Special edition*. San Francisco, CA: Aunt Lute Books.

Originally published in 1980, Audre Lorde's classic memoir provides an elegant, African-American perspective. Lorde is opposed to reconstruction, which remains a potentially contentious issue.

Marchetto, M. A. (2009). *Cancer vixen: A true story*. New York, NY: Pantheon.

Another graphic novel. Marchetto, who worked for *Glamour* at the time, is humorous and snappy, a style that may resonate with some readers more than others. Areas in which she has significant privilege and resources are good grounds for discussion.

Nielsen, J., & Vollers, M. (2002). *Ice bound: A doctor's incredible battle for survival at the South Pole*. New York, NY: Miramax.

Nielsen was a doctor wintering over in Antarctica when she discovered a suspicious breast lump. Her long-distance consultations, self-biopsy, and the dramatic delivery of chemotherapy drugs are fascinating reading, as are her reflections on the meaning of the experience for her.

Norton, M. (2009). *Lopsided, or how having cancer can be really distracting: A memoir*. London, England: Virago.

Norton, an African-American writer, tells her memoir humorously and sometimes outrageously.

Notaro, T. (2016). *I'm just a person*. New York, NY: HarperCollins.

Comedian Tig Notaro's mix of deadpan humor and alarm make this a more representative and subtle narrative than some. Notaro is honest about initially ignoring lumps in both breasts.

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The Bookshelf, continued from page 6

Rich, K. R. (2002).*The red devil: A memoir about beating the odds*. London, England: Methuen.

Rich, K. R. (2010). *Dreaming in Hindi: Coming awake in another language*. Boston, MA: Mariner.

The Red Devil describes Rich's diagnosis and treatment, including the sudden and horrific discovery that the cancer has metastasized. Ultimately a triumphant memoir, but one that may be difficult or frightening for some readers. *Dreaming in Hindi* is not cancer-focused, though cancer plays a role in Rich's experiences in India. This memoir may serve to mediate some of the fear evoked by *The Red Devil* because its focus is on other aspects of Rich's life.

Breast Cancer-Specific Reference Works

Friedman, S. (2014). *Zen cancer wisdom: Tips for making each day better*. Somerville, MA: Wisdom Publications.

Includes meditation activities and other Zen materials, as well as personal reflections and observations. Friedman was a Zen priest and doctor of medical qigong therapy.

Kaelin, C. M., Coltrera, F., Gardiner, J., &, Prouty, J. (2007). *The breast cancer survivor's fitness plan: Reclaim health, regain strength, live longer* (Harvard Medical School Guides). New York, NY: McGraw-Hill.

An easy-to-read, nicely illustrated exercise guide, generally organized by procedure or medical issue.

Love, S., Lindsey, K., & Love, E. (2015). *Dr. Susan Love's breast book* (6th ed.). Philadelphia, PA: Merloyd Lawrence.

The "breast cancer bible," Love's DSM-sized tome can be very informative and quite overwhelming. Much of the material will be irrelevant to any client's specific situation. Its tone is factual and medical, although she provides reasonably clear glosses of more technical data. A good reference book, but Port (below) or other client guidebooks may be a better starting point.

McKay, J. (2003). *The chemotherapy and radiation therapy survival guide: Everything you need to know to get through treatment*. Oakland, CA: New Harbinger.

Although much of the information is 15 years out of date, this is still a useful general resource, and suggests the types of information about chemo and radiation that could be gathered and considered.

Port, E. (2015). *The new generation breast cancer book: How to navigate your diagnosis and treatment options—and remain optimistic—in an age of information overload*. New York, NY: Ballantine.

A useful and easy to navigate guide in many ways. However, it includes some inaccurate overgeneralizations (e.g., that one's hair always grows back after chemo, which is not true for 6-10% of women treated with Taxotere). The number of inaccuracies and minor internal contradictions increases in later chapters, perhaps suggesting an editing issue.

Other Women's Cancer Memoirs

Drescher, F. (2002). *Cancer, schmancer*. New York, NY: Warner.

Drescher's account of her experience with uterine cancer.

Radner, G. (1989/2009). *It's always something: Twentieth anniversary edition*. New York, NY: Simon & Schuster.

Radner's account of her ovarian cancer may be read in conjunction wither her husband Gene Wilder's book (below).

Snetsinger, P. (2003). *Birding on borrowed time*. Delaware City, DE: American Birding Association.

Snetsinger, who was the first person to see over 8,000 bird species, periodically required treatment for melanoma, with grim prognoses. This memoir is about bird watching, with occasional reference to cancer recurrences. Snetsinger died in a vehicular accident, not of cancer.

Wilder, G. (2005). *Kiss me like a stranger: My search for love and art*. New York, NY: St. Martin's.

Sections of Wilder's autobiography describe his relationship with Gilda Radner (above), including the period of her diagnosis and death.

General Cancer Resources

Crowe, K., & McDowell, E. (2017). *There is no good card for this: What to say and do when life is scary, awful, and unfair to people you love*. San Francisco, CA: HarperOne.

Although not cancer-specific, this collaboration provides a useful starting point for family and friends who are unsure how to respond supportively to someone's cancer diagnosis or other distressing life event.

Goodhart, F., & Atkins, L. (2011). *The cancer survivor's companion: Practical ways to cope with your feelings after cancer*. Boston, MA: Little, Brown.

A self-help guide with tools and cognitive-behavioral self-interventions.

Ko, A., Dollinger, M., & Rosenbaum, E. H. (2008). *Everyone's guide to cancer therapy: How cancer is diagnosed, treated, and managed day to day (5th ed.)*. Kansas City, MO: Andrews McMeel.

Similar to Love (above), this enormous compendium may be useful, overwhelming, or both. It is about a decade out of date but still may serve as an accessible resource as long as relevant updates are

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The Bookshelf, continued from page 7

sought as well.

Mukherjee, S. (2010). *The emperor of all maladies: A biography of cancer*. New York, NY: Simon & Schuster.

Mukherjee's very readable history and exploration of cancer, which is also available as a video series.

Sontag, S. (1979). *Illness as metaphor*. New York, NY: Vintage.

Sontag's classic non-fiction text on the cultural meanings of cancer may be outdated in some ways (for example, at the time it was written, no one would have walked around their community in a tee shirt or with a badge proclaiming "cancer survivor"), but in others it is still highly relevant. A useful springboard for examining one's own metaphors for cancer as well as those encountered in medical and popular culture.

Not Recommended

Somers, S. (2009). *Knockout: Interviews with doctors who are curing cancer and how to prevent getting it in the first place*. New York, NY: Three Rivers.

An example of books by celebrities or self-proclaimed experts, promoting specific products or practices purporting to prevent or cure cancer with little empirical evidence. Somers's book is recommended online and in person with some frequency, so it is worth understanding why it generates concern. Useful articles include P. Wingert (10/23/2009, "BREAKING: Health Author Suzanne Somers Mostly Wrong about Science, Medicine," *Newsweek,* retrieved from http://www.newsweek.com/breaking-health-author-suzanne-somers-mostly-wrong-about-science-medicine-222546) and D. Gorski (10/26/2009, "Suzanne Somers' Knockout: Dangerous Misinformation about Cancer (Part 1)," Science-based Medicine, retrieved from https://sciencebasedmedicine.org/suzanne-somers-knockout-spreading-dangerous-misinformation-about-cancer-part-1/).

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).

Emotional Support Animals: Ethical Considerations and Conundrums

Jamie L. Young, PsyD, and and Steffanie La Torre, MS, MA, Oregon Psychological Association Ethics Committee

As many of us can attest, the frequency of requests for Emotional Support Animal (ESA) documentation seems to be on the rise, apparently coinciding with the expansion of the Air Carriers Access Act (ACAA) in 2003 and the Fair Housing Act (FHA) in 2013. Both expansions added Emotional Support Animals (ESAs) to their list of protected accommodations for people with disabilities (Trasvina, 2013; USDOT, 2003).

Though these acts expanded protections to ESAs, ESAs continue to be excluded from the definition of Service Animals and, therefore, are not protected under the Americans with Disabilities Act. According to the US Department of Justice (2010), Service Animals are restricted to non-pet dogs, and in some cases miniature horses, that are trained to assist people with physical and/or mental disabilities to facilitate full participation in life activities. For instance, psychiatric service dogs are trained to detect the onset and to reduce the impact of psychiatric symptoms (Trasvina, 2013). In contrast, Emotional Support Animals provide comfort and mitigate emotional or psychological distress (Trasvina, 2013).

Clearly, the threshold for qualifying as an Emotional Support Animal is lower than for a Service Animal. Similarly, the threshold for meeting criteria for a DSM-5 (American Psychiatric Association, 2013) diagnosis is lower than the criteria for a disability. In order to qualify for a DSM-5 diagnosis, one must experience "clinically significant distress" (APA, 2013, e.g., p.21). In contrast, a legal definition of disability requires that the condition "substantially limits one or more major life activities" (USDOJ, 2009, p. 1). As we consider addressing our clients' requests for ESA letters, we must take into account the impact of their condition on their daily functioning and potential impact an animal would have on their lives. Further complicating our decision process is the discrepancy between the requirements of the Acts expanding protections for ESAs with our legal, ethical, and clinical standards. Fair Housing Act standards for ESAs require documentation from a "mental health professional that the animal provides emotional support that alleviates one or more of the identified symptoms or effects of an existing disability" (Trasvina, 2013). Similarly, the Air Carriers Access Act (USDTFAA, 2003) requires documentation from any licensed mental health professional stating (1) that the passenger has a mental health-related disability; (2) that having the animal accompany the passenger is necessary to the passenger's mental health or treatment or to assist the passenger; and (3) that the passenger is under the his or her professional's care.

In this article, we utilize current research findings and apply the American Psychological Association (2017) *Ethical Principles of Psychologists and Code of Conduct* to this conundrum to aid in clarifying potential pitfalls and areas of opportunity in this increasingly frequent request from the public: "I need a note for my dog."

Principle A: Beneficence and Nonmaleficence (APA, 2017)

Under the guidance of this principle, psychologists strive to benefit those they work with and to do no harm to humans or animal subjects. As this relates to ESA letters, psychologists must strive to balance their client's desire for an assistance animal with the impact that animal may have on others (e.g., neighbors with dander allergies) and the impact on the animal (e.g., consideration of client's capacity to care for another being; Deardorff, 2016). Our limited capacity to assess future possible impacts on clients and other, unknown, individuals strains our confidence in providing documentation, and recent media reports of dangerous (e.g., "Emotional Support Dog Attacks Passenger on Flight,"; Cook, 2017) and confusing (e.g., "Flying Turkey Ruffles Feathers About 'Emotional Support Animals' on Planes,"; Cutler, 2016) ESAs may give us pause. Hunt (2017) cautioned against writing letters without rigorous assessment to avoid providing documentation for people who "may feel better when a pet cat is around, but nonetheless [are] capable of living day to day without the animal's presence" (para. 13).

Principle B: Fidelity and Responsibility (APA, 2017)

Under the guidance of this principle, psychologists maintain awareness of their professional and scientific responsibilities to society and the communities within which they work. They uphold professional standards and strive to manage conflicts of interest. As this relates to ESA letters, psychologists pursue information about rules governing assistance animals and consider the impact of writing such letters on our field and on society. Psychologists should consider the potential conflicts of interest (Ethical Standard 3.06; APA, 2017), such as the impact of maintaining client revenue stream on the decision to provide an ESA letter (Boness et al., 2017; Deardorff, 2016). When considering documenting an ESA, psychologists must navigate conflicting mandates and recommendations from multiple authorities, making sense of how to abide by the recommendations of

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the ACAA/FHA, APA Ethics Code, local laws, and various clinical standards of care (1.02; APA 2017). In addition, psychologists should be thoughtful in selecting and applying assessments for the determination of disability and related ESA letters (2.04, 9.01, 9.02; APA 2017). This is not an easy task, given that ESA evaluation standards are not well-established, and the possibility of later court proceedings (e.g., if the accommodation is not honored by a landlord) necessitates a well-reasoned and well-documented basis for the professional judgment that an ESA is a reasonable accommodation (Boness et al., 2017; Clay, 2016; Ensminger & Thomas, 2013; Yonggren, Boisvert, & Boness, 2016). When selecting assessment methods, psychologists must consider whether a forensic assessment is warranted. Boness et al. (2017) expressed their belief that treating practitioners who write ESA letters are, inherently, engaged in dual forensic and treatment roles (3.05; APA 2017), thereby increasing their vulnerability to litigation. Yonggren et al. (2016) posited that a treating clinician's desire to advocate for their client may impair objectivity that is required for an accurate evaluation. However, other authors have opined that the treating clinician is in a strong position to provide documentation for an ESA given their knowledge of the client's symptomology and the impact of symptoms on the client's daily functioning (Gold, Metzner, & Wylonis, 2008). Further, Ensminger and Thomas (2013) reviewed ESA case law and encouraged providers to advocate for their clients, concluding that psychologists "should not be uncomfortable with helping a patient who wants to keep an animal to alleviate a symptom of a DSM condition or make life easier for a person with such a condition" (p. 113).

Principle C: Integrity (APA, 2017)

Under the guidance of this principle, psychologists seek the path of honesty and transparency. As this principle relates to ESA letters, psychologists seek to represent their work honestly and to avoid sanctioning fraudulent claims of disability (1.01, 5.01; APA 2017). Potential areas for fraud or exploitation of ESA regulations include the financial benefit of having one's animal documented as an ESA (Clay, 2016). Under the ACAA and the FHA, entities are prohibited from charging people fees associated with their animal (e.g., pet deposit, pet airfare; USDOJ, 2010; USDOT, 2015). Additional concerns are drawn from the field of forensic psychology. Boness et al. (2017) asserted that any evaluation for an ESA requires a disability assessment, including assessment for malingering,

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noting that an ESA letter "impl[ies] that the individual is disabled by their psychological condition and therefore requires the presence of the ESA to remain psychologically stable" (p. 221). They found, in their comparison of general and forensic practitioners, that forensic practitioners were significantly more likely to include standardized measures, including malingering in their assessments for ESAs.

Principle D: Justice (APA, 2017)

Under the guidance of this principle, psychologists seek to serve all people and to be aware of their own biases, boundaries of competence, and the limitations of their expertise. As this relates to ESA letters, psychologists seek to understand their biases regarding the provision of such letters, and to identify boundaries of competence with regard to providing ESA documentation (2.01, APA, 2017). This may include engaging in training and consultation to increase competence (2.02, APA 2017). Because federal law recognizes ESAs as reasonable accommodations for people with disabilities, writing an ESA letter constitutes a formal disability determination under the law (Boness et al., 2017; Yonggren et al., 2016). Boness et al. (2017) warned treating clinicians against making disability determinations due to the likelihood of being held to the standards of a forensic specialist should the determination be questioned, yet the ACAA requests documentation from the treating clinician, stating that the ESA is a part of current treatment (Trasvina, 2013).

Principle E: Respect for People's Rights and Dignity (APA, 2017)

Under the guidance of this principle, psychologists strive to respect all people and to protect the rights of confidentiality, dignity, and self-determination. As this relates to ESA letters, psychologists strive to advocate for clients with psychological disabilities and to aid them in having equal access to basic human rights and quality of life. In addition, psychologists should engage in ongoing informed consent as they engage in shifting therapeutic and/or assessment roles with clients (3.10, APA 2017). Yonggren et al. (2016) recommended clarifying your role in the provision of ESA letters in your initial informed consent process with clients (e.g., stating that this is a not a service that you provide, if that is the case). Additional recommendations include providing information about the potential costs and benefits of the ESA letter (10.01, APA 2017). Such as the potential difficulty gaining security clearance after having a mental disability documented on record (Boness et al., 2017). Recommendations for documenting an ESA vary from providing minimal information, in line with protecting client privacy (4.04, APA 2017) to providing in-depth information with a goal of advocating for the client and improving odds that claims of disability will be accepted (Ensmiger & Thomas, 2013).

Conclusion

Requests for Emotional Support Animals have been on the rise in recent years, resulting in confusion among psychologists on how to handle such requests with integrity and disagreement on standards of ethical practice with regard to assessing and providing documentation (Boness et al., 2017; Clay, 2016; Kogan, Schaefer, Erdman, & Schoenfeld-Tacher, 2017). We have utilized existing literature and the APA (2017) *Ethical Principles of Psychologists and Code of Conduct* to highlight common ethical dilemmas to consider when asked to write an ESA, and we are aware that this is a complicated issue with multiple perspectives. Therefore, we encourage further reading into clinical and legal factors that we did not fully address and encourage you to contact the OPA Ethics Committee for further consultation as you consider how you will make your own way through this process.

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The Future of Advocacy and Leadership in Psychology

Roseann Fish Getchell, Chair Elect, American Psychological Association of Graduate Students (APAGS)

This article previously appeared in the Division 31 Integrated Care Taskforce Blog at http://www.apadivisions.org/division-31/news-events/blog/health-care/index.aspx. It is reprinted by permission of the author.

As our profession hurtles into a new era of innovation and creative approaches to population health, I am struck with the question: How do we continue to have a seat at the table? More importantly, how do we increase the impact our psychological community has in making pivotal decisions regarding funding, access, and impact of psychological research and practice? Whether the table represents a neighborhood association, a local board, or even state and federal government, psychologists at every level have the potential to impact the health of our communities for the better.

One pivotal piece in our psychological community that holds boundless potential is our group of graduate students and early career psychologists. As emerging leaders in the field, APAGS members and EPCs enter into the profession with several strengths that can be harnessed in the field of advocacy—with the direction and mentorship of seasoned psychologists. Whether we are focusing on harnessing knowledge of technology and social media, supporting social justice movements, or energizing conversations with new ideas, our next generation of psychologists are ready to pull up a chair to the table and impact population health in a major way.

This type of dynamic leadership including graduate students and early career psychologists has the potential to reach across many types of legislative structures, impacting integrated care at its core. As a graduate student myself, I have reflected on the impact my own legislative advocacy training has had in my ability to stay informed of relevant hot topics in healthcare, understand how changes in policy impact patient access to care, and engage in contacting legislators in my community whose decisions impact the health of thousands every day. This training started with my mentors, who welcomed me to the table and guided me through the process of legislative advocacy on a fundamental level.

I have hope that when graduate students like myself are introduced to such a dynamic process early on in our careers, we are much more likely to advocate for the guild and for mental health access as we grow into our own professional selves. Furthermore, early career psychologists and graduate students have the potential to engage in this type of leadership across many domains. It is entirely possible for psychologists across the country to not only make an impact as researchers, teachers, clinicians, and administrators, but to also engage as government representatives and experts in our field.

As we continue to think of new ways to impact our community's health on a population scale, I urge our psychological community to think outside the box when it comes to leadership and advocacy. Who knows, the next early career psychologist you meet may one day have a seat on the Senate.

Here are some helpful links to advocacy resources for psychologists and graduate students nationwide. Feel free to share them!

- http://www.apapracticecentral.org/advocacy/index.aspx
- http://www.apa.org/advocacy/index.aspx
- http://www.apa.org/apags/resources/advocacy/toolkit.aspx

Group Term Life Insurance

Your vision for financial protection

Life insurance can provide essential financial protection for the ones you love. Ever wonder how your family will move on when you're not around? Car payments, mortgages, groceries… you'll need to think about all of these as you prepare to provide for your financial responsibilities to your family.

How does it work?

Term Life Insurance can play an important role in your family's continued financial security should you die prematurely. Whether you need initial coverage or want to add to what you have, Trust Group Term Life Insurance[1] is affordable and has the features you will need to keep pace with changing family and financial responsibilities.

Call us at 1-877-637-9700 or visit trustinsurance.com for a no-obligation consultation.

[1] Available in amounts up to $1,000,000. Coverage is individually medically underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. Plans have limitations and exclusions, and rates are based upon attained age at issue and increase in 5-year age brackets.

[2] Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.

Great Coverage at Affordable Premiums Including These Features:

- **Inflation Safeguard —** designed to prevent changes in the cost of living from eroding your death protection.[2]
- **Living Benefits —** allows early payment of death benefits if you become terminally ill.
- **Disability Waiver of Premium —** waives your premium payment if you become totally disabled.

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Religious Diversity Counseling for Spiritual Health

Deborah Kettle, MDiv., PhD, Oregon Psychological Association Diversity Committee

We experience diversity in many ways; from culture to culture, in communities, families, and in other areas of social grouping. One of the greatest areas of diversity is religion, but it has been a difficult topic for psychologists to embrace. It is important for clinicians to remember that faith is one of the core parts of most people's experience. It needs to be assessed for how it contributes or hinders our client's psychological well being.

Many clinicians still want to separate a person's faith from his mental health, but that is not treating the whole person. In my own practice, I find that people who have a strong faith tradition which excludes the patient in some capacity, leads to the patient feeling less than or not good enough. It is important that we as clinicians also rule out any religious or spiritual causes in order to fully assess our patient's mental health.

In order to do this, we must bracket our own beliefs and instead look at whether a patient's spiritual beliefs help or harm their mental health. The following is a list of factors to consider when determining if religious beliefs are healthy or harmful to your patient:

1. Does the belief strengthen or weaken the patient's self-esteem?
2. Does the belief give the patient a sense of belonging and well-being?
3. Does the belief allow for the patient to question?
4. Does the belief show respect for other religious or spiritual traditions?
5. Does the belief allow for reconciliation and acceptance or is it punitive and punishment-based?

Remember that religious and spiritual traditions pattern in the same way as other social constructs; there is a continuum in how religions and spiritual traditions are observed. The tradition can be very conservative on one end to very liberal on the other. Most religions have a conservative, moderate, and liberal, way of practicing their faith.

We as clinicians do not make judgments about our patient's beliefs. Instead, we examine the belief with the patient and allow them the safety to explore its impact upon their lives. When needed, we refer the patient to their spiritual leader for further clarification. Faith can be misinterpreted by the individual just like other core beliefs. Religious beliefs are usually learned very early in a person's life and may need to be examined for misinterpretation. Conversely, the patient may be hearing the tradition correctly and will need to decide for themselves how they reconcile what they understand.

As clinicians, we sometimes have patients whose beliefs are so opposed to our own that we must refer them. This is a necessity if we cannot bracket our own beliefs. If a belief leads to physical harm to the patient or to others around them, we must determine if this rises to the level of duty to safeguard and then make all necessary communication to those who can provide safety.

As in all areas of diversity, acceptance and compassion help us live together on this increasingly smaller planet we share. The more we accept each other's diverse natures, the more we are likely to live in peace.

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Diversity Resources on the Web

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

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

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

Inside the Colleague Assistance Committee (CAC): A Student's Perspective

Adrian Egger, MA, Oregon Psychological Association Colleague Assistance Committee, Student Member

Upon arriving at the CAC as a student member I wasn't sure what to expect, and with limited practical experience I was excited for the opportunity to learn from more distinguished professionals. During our first meeting I was greeted with warm conversation and the committee's heartfelt commitment to assisting colleagues in need. I was amazed at the connectedness between committee members and the genuineness with which they communicate.

Additionally, I was intrigued that the committee is solely comprised of volunteer psychologists, each with an in-depth understanding of professional ethics. As such, committee members are particularly well-suited. They have a profound understanding of our ethical code, and insight into the occupational vulnerabilities related to the professional practice of psychology. This unique understanding allows committee members to efficiently assist other psychologists on a range of professional and personal issues, including clinical matters, complaints or lawsuits, how to navigate concerns with other colleagues, patient suicide, family conflicts, and any other distress affecting one's professional capacity to perform.

The Colleague Assistance Committee has also developed a mentor program. This program is designed to help assist professionals who are going through a licensing board complaint process and would benefit from confidential support from a colleague with knowledge about this process.

Psychologists work within a discipline of confidentiality and this can be very isolating, so creating outlets for the discussion of professional concerns is imperative. While the majority of psychologists sustain a career of competent service delivery, many experience professional concerns that could be aided by seeking support from the Colleague Assistance Committee. Research shows that psychologists' personal investment in their clinical work may actually represent the most significant risk factor, as it gradually taxes the emotional and physical resources of the clinician (Engle, 2015). The American Psychological Association (APA) has shown an awareness of professional stress and responded by encouraging state psychological associations to create Colleague Assistance Programs like OPA's CAC (APA, 2006).

As a budding professional, it is relieving to know that the CAC exists, and that there are psychologists that care enough to donate their time and efforts to support colleagues in need. My time as a student member on the Colleague Assistance Committee thus far has been impactful, and has strengthened my perspective on the positive influence that specialized service can have on the field of psychology. I feel grateful for this experience and hope to continue on as a part of the committee as I move forward in my professional development.

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OPA Elections and Annual Meeting Notice

The following is information on OPA's upcoming board of director's election and annual meeting. Voting members of OPA will be mailed a ballot in late March and returned ballots are to be postmarked by April 27th in order to be tabulated. The OPA annual meeting will take place during our Annual Conference on May 4-5, 2018 at the Monarch Hotel and Conference Center in Portland, Oregon.

2018-2019 Elections Slate of Candidates

The following is the slate of candidates that the nominating committee presented to the board of directors.

Officer Positions

- Alan Ledford, PhD - President Elect
- TBD - Treasurer
- Carilyn Ellis, PsyD – Secretary

Director Positions

Please note that you will be asked to vote for 2 candidates total.

- Michelle Guyton, PhD, ABPP - two year position
- Esther Lerman Freeman, PsyD – two year position
- Shea Lott, PhD – two year position

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

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

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!

Growth and Renewal in Community
A Gestalt Therapy Retreat & Training

Buckhorn Springs Retreat Center in Ashland, Or
July 6-10, 2018

You are invited to join Peter Cole, LCSW, Eva Gold, PsyD, Daisy Reese, LCSW, and Steve Zahm, PhD for this opportunity to recharge and rejuvenate in a tranquil setting with others seeking personal and professional growth along with renewal and connection.

Eva Gold and Steve Zahm are Co-Directors of Gestalt Therapy Training Center—Northwest. They have practiced and taught Gestalt therapy for many decades and also present and train internationally. Both have studied Buddhist psychology and practiced Insight meditation for over 15 years. Their soon to be published book is *Buddhist Psychology and Gestalt Therapy Integrated: Psychotherapy for the 21st Century.*

Peter Cole and Daisy Reese are Co-Directors of the Sierra Institute for Contemporary Gestalt Therapy. In addition to practicing and teaching Gestalt therapy they train internationally. Graduates of the Washington, DC School of Psychiatry's Group Therapy training program, they specialize in Gestalt group therapy, and their recently published book is *New Directions in Gestalt Group Therapy*.

GGTCNW and **SICGT** are both approved by APA to offer continuing education for psychologists. SICGT maintains responsibility for this program and its content.

FOR APPLICATION AND FURTHER DETAILED PROGRAM AND FEE INFORMATION:
email:sicgt.gestalt.training@gmail.com
phone:916 444-1786 or visit gttcnw.org or sicgt.org

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.

2018 Schedule

April 14, 2018

Dilemmas in Ethical Practice and Strategies for Decision Making (3 hours) and The Ethic of Self-Care: Enhancing Personal and Professional Lives (1 1/2 hours)

By Melba J T Vasquez, PhD ABPP

May 4-5, 2018

OPA Annual Conference

Monarch Hotel & Conference Center - Clackamas, OR

June 1, 2018

Addiction as Attachment Disorder

By Philip Flores, PhD, ABPP, FAGPA

October 26, 2018

Registration will be available in late summer

Practice Management/Ethics

By Paul Cooney, JD and David Madigan, JD

December 7, 2018

Registration will be available in fall

If I Didn't Have a Brain, I Wouldn't Have Pain

By Scott Pengelly, PhD

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

Brianne DeYoung, BS
Keizer, OR

Angela Gunn, LCSW, CST
Portland, OR

Winifred Ju, PhD
Salem, OR

Karolina Kovalev
Beaverton, OR

Jacob Lowen, PsyD
Salem, OR

Marie McMahon, PsyD
Portland, OR

Nancy Russo, PhD
Corvallis, OR

Madison Smith
Beaverton, OR

Peter Steele, MA
Portland, OR

Jill Strasser, PsyD
Portland, OR

Kari Sulenes, PsyD
Portland, OR

Kathy Thomas, PhD
Oregon City, OR

Johnna Voght, PsyD
Portland, OR

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.

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 -

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

OFFICE SPACE

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

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.

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
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
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

Portland United Against Hate

Free and open to the public, this series of 15 workshops will provide attendees with the information, skills and resources necessary to support their actions in resistance to hate and bias. Online RSVP Required

Saturday, March 24, 1-4 p.m., Cheryl Forster, PsyD
"I'm Scared and Angry": Using Neuroscience and Intercultural Skills to Engage Effectively

Saturday, March 31, 9 a.m.-4 p.m., Jenn Burleton
Transgender in America: Looking Back and Moving Forward

Saturday, April 7, 1-4 p.m., Reiko Hillyer, PhD
The Origins and Mutations of Racism: Understanding History to Change the Future

Wednesday, April 18, 6-7:30 p.m., April Slabosheski, MA
Places of Remembrance: Legislation and Human Rights in the Third Reich and the U.S. Today

Friday, April 27, 1:30-4:30 p.m., Meg Garvin, MA, JD
Hearing in Silence & Listening Past Noise: Creating a Foundation for Advocacy at First Contact

View full training schedule, including workshop descriptions, presenter biographies, online registration and more, at go.lclark.edu/PUAH

Additional Spring Trainings

May 4 Acting as Partners in Resistance to Ableism and Violence

May 12 Anti-Discrimination Response Training (ART): A Social-Emotional Learning Workshop for Active Listening

May 19 Connecting Across Differences: Moving Beyond Hate, Indifference, and Tolerance with Intercultural Communication

May 30 Knowledge is Power: Your Legal Rights in a Time of Uncertainty

June 8 Intersections of Hate: Trans Exclusionary Radical Feminism (TERF), the Alt-Right and Extremist Ideology

This project is supported by the City of Portland, Office of Neighborhood Involvement and Office of Management and Finance, Special Appropriations for Portland United Against Hate. The content is solely the responsibility of the grantee and does not necessarily represent the official views of the City of Portland.

Lewis & Clark Graduate School of Education and Counseling

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

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)

**Schedule subject to change*

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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