Your Spring 2015 IP

President’s Column

Pat DeLeon

Public Health Consulting for Safety: The Welcome Mat is Out for Independent Practitioners

Limits of Confidentiality: Confusion Regarding Implementation

Essential Clinical Practice Strategies for the Prevention of Disciplinary Complaints

Featured Expert Review: Understanding and Treating Obsessive Compulsive Disorder using Cognitive Behavioral Therapy

Independent Practitioner Diversity Matters

Forensic Psychology Committee Report

Division 42 Candidate Statements
Independent Practitioner

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I n conducting our first Board Meeting of the year, my first agenda item was to encourage 42 Board members to participate in an interactive activity. I invited everyone to reflect on and share a core family or background value that they brought to the Division in perpetuating and shaping the culture of our Community. This opened a window of opportunity for the unfolding of fascinating personal family stories of Board members, most of which we knew very little about. In the process, there was the realization that we shared closely overlapping fundamental core values that guide and motivate us in our devotion to 42’s Community of Independent Psychologists. This included the importance of building relationships, along with creating a sense of belonging to a family, home and community of choice. The belief in education, hard work, overcoming challenges, respect, tolerance, education, humor, loyalty and the gift of helping others were also threads that ran through people’s descriptions.

Notably, there was also a distinct emphasis on standing up for principles of equality, fighting for rights, intolerance for social injustices, issues of independence and freedom, and advocating for our rights as practitioners. The advocacy focus resonated for me. Looking back to my journey, I was a quiet rebel even as a child, standing up for those who were bullied, and later when I “found my voice,” as an ally and advocate for those whose causes needed to be heard. Giving voice to what truly matters and fighting the good fight is my definition of advocacy and is the heart of my Spring IP presidential column.

Demystifying Advocacy for Psychologists

There are some common myths circulating about advocacy which I would like to debunk.

**Myth #1. Psychologists routinely advocate for their profession.** Consider these statistics pertaining to psychology advocacy, which were once offered by Mike Sullivan, Ph.D., former Assistant Executive Director for State Advocacy Practice Directorate: 5% make it happen. 10% watch it happen. The remaining 85% ask, “What’s happening?”

There are constant threats to professional practice. Some of these are externally derived such as eroding compensation for psychological services, legislation which attempts to limit our scope of practice, and abuses to parity implementation. Unfortunately, some of the hazards are internally driven, generated by complacency and by being content to stay on the sidelines. While the majority of psychologists recognize the constant threats to their livelihood, many are bewildered or inactive when it comes to advocacy for their profession, holding on to the belief that it is someone else’s job to promote, advance or defend the needs of practitioners. Yet others hold the erroneous assumption that advocacy is best left up to the government experts.

**Myth #2. Practice dues pay for all the advocacy activities needed to advance professional practice.** The APA Practice Organization (APAPO) Legal and Regulatory Affairs Department does an excellent job in trying to monitor and confront abusive policies that adversely impact the practice of psychology. APAPO’s Government Relations Department has been actively working to remove barriers in Medicaid and Medicare on a federal level that prohibit psychologists from providing the full spectrum of psychological services. However, the APA Practice Organization cannot do it alone. Strength is in the numbers which is why it is imperative that members themselves lobby their respective congressperson and senator on matters effecting psychology.

Some good news is that our APA Psychology Political Action Committee (PAC) is on the upswing, now ranking 39th among health care PACs, up from 46th last year. It still means that 38 health care PACs contribute more in their political contributions than psychologists. The reality is that contributions influence critical mental health legislation, programs, and policies of concern to psychologists and their patients.

**Myth #3. It is solely the legislative and advocacy com-
Who comprises the committees? Interested and invested members. It is you and I that need to work on removing barriers that prohibit psychologists from participating fully as healthcare providers in the healthcare marketplace. It is you and I that need to be at the table when there are discussions about psychology’s role in integrated healthcare and newly emerging models of care.

Additionally, every State Provincial and Territorial Association (SPTA) needs to be vigilant on a grassroots level. Each year, there are numerous bills submitted to the legislature that can potentially curtail the scope of practice for psychologists in their state. In the Hawaii Psychological Association, we have had to monitor policies of insurance companies to ensure that parity is being fully implemented and work to amend regulatory language that unfairly puts psychologists at a disadvantage for recoupments or “claw-backs.”

**Myth #4. Psychologists are valued by policy makers for their education and knowledge.** Actually, we have a ways to go in educating our communities and policy makers about psychology and helping them to appreciate the role and value of practicing psychologists. If the average citizen has trouble differentiating psychologists from other mental health providers, why would we expect legislators to be able to? Legislators cannot make informed decisions about health care initiatives if they are ill informed on the knowledge of psychologists’ range of services and appreciation of the cost-value of practicing psychologists. How many members are aware of their district state senators and representatives and have contacted them?

**Many Faces of Advocacy**

As a means of highlighting the importance of advocacy work, I approached some of our 42 colleagues who are in the trenches, working to promote, advance and defend practice. I asked them three questions: 1) What is your definition of advocacy? 2) Can you provide examples of your advocacy work? 3) What are your suggestions for membership involvement in advocacy?

Their responses are meant to encourage and inspire all 42 members to participate in some aspect of advocacy work. Those I interviewed were at various stages of their careers, ranging from a graduate student, an ECP, mid-career, to senior colleagues who are involved in a wide range of advocacy activities. They portray the many faces of advocacy through being at the table, leadership, collaborations, political giving and by spreading the message of psychologists.

**Planting Seeds of Advocacy in Graduate Programs.**

Derek Phillips, M.A., LPC is the Division 42 Student Representative on our Board, a recently appointed student member to the APAPO Committee for the Advancement of Professional Practice (CAPP) and co-chair of 42’s Student/Early Career Professional (ECP) Committee. In asking Derek for his definition of advocacy, he replied “advocacy is putting a voice to an issue that may not have had a voice previously. It is the act of coming together to represent a topic or constituency with the goal of progressing toward a particularly goal or outcome that benefits or advances that constituency. Advocacy is the foundation of democracy and what it means to live in a free society that is constantly aiming to improve itself by boosting public support for a myriad of issues.” Derek is an example of how advocacy seeds can sprout in graduate programs. His first entrée in advocacy work was through a 6-month placement in a non-clinical practicum with the Illinois Psychological Association. His project involved grassroots advocacy for the Illinois RxP movement. Derek learned firsthand how to contact and garner assistance from psychologists, physicians and mental health organizations in support of the RxP bill in the Illinois General Assembly. Derek suggests that great avenues for students and ECPs to become involved in advocacy is through their graduate program, local community organizations, SPTAs and Divisions, focusing on interests related to a particular division or state.

**Legislative and Political Advocacy.**

Advocacy was definitely on Lindsey Buckman’s, Psy.D. mind when I contacted her. She took the time to respond even though she was in the midst of trying to defeat a bill in the Arizona state legislature. Lindsey is a member of the Division 42 Advocacy Committee, the ECP member on CAPP, chair of the ECP Task Force with Division 31, as well as the Legislative Committee Chair for Arizona Psychological Association (PA). Lindsey thinks of advocacy in the following terms, “Education, assertiveness, collaboration, community, and action.” Advocacy requires that you educate yourself and others on the issues. It requires that you take a stand, while working together with opponents and proponents alike. It also requires that action be taken and the more people that take action the better the outcome.” Lindsey began her professional advocacy journey after the 2010 election, when she realized that none of her state legislators were psychologists and that her professional future could be in jeopardy if she stood by and let her state legislators make uninformed decisions about the practice of psychology. Lindsey knew very well that the people who make the decisions are the ones that show up, so she joined the Arizona PA Legislative Committee and became the chairperson soon thereafter. Lindsey regularly attends the APA State Leadership Conference to advocate for psychology on the national level. She is the PAC liaison for CAPP and regularly raises funds to support practice issues
at the federal level. In addition to her professional advocacy efforts, she also donates money to organizations that help female candidates and LGBT candidates get elected to local and national office. Lindsey’s suggestions for ways to get involved: Join your SPTA at their annual day at the legislature; contribute to the APAPO PAC and the ongoing efforts to protect the practice of psychology at the federal level.

Collaborations in Advocacy for Public Interest and Professional Psychology.

For the past 20 years, Peter Oppenheimer, Ph.D., has been an influential leader in Rhode Island (RI), advocating for legislation and public policy on behalf of the public interest and professional psychology. He is currently the Division 42 Vice-Chair of our Advocacy Committee, President and Chair of the RIPA Legislative Committee & Healthcare Task Force (TF), Chair of the Coalition of Mental Health Professionals of RI, and Chair of RI Board of Psychology. A core component of RIPA’s advocacy is to collaborate with other healthcare professionals, consumer groups, and healthcare institutions through their Coalition of Mental Health Professionals of RI for communications and coordinated action. Their Healthcare TF coordinates the Legislative Committee, Insurance and Managed Care Committee and Federal Advocacy. Peter noted that advocacy is a “long term process.” Through persistent advocacy efforts, they have had successes in confronting, containing, and sanctioning abusive practices in managed care organizations. RIPA has been involved with creating and modifying a number of laws that protect consumers through the regulation of insurance companies and healthcare providers. They successfully negotiated changes to a bill to enable qualified psychologists to practice applied behavioral analysis through their psychology license. They were the first state to modify a Professional Service Corporations law to allow co-ownership of medical services across disciplines so that psychologists can now partner with physicians in healthcare reform ventures. Additionally, they successfully lobbied to bring RI’s Insurance Coverage for Mental Illness and Substance Abuse law into parity with federal mental health parity. “Advocacy on behalf of our community and the profession is essential…(or) we will be relegated to irrelevance…and we strive to be a voice of integrity in the process,” says Peter.

Shaping Public Policy through Advocacy.

Pat DeLeon, Ph.D., J.D. is a trailblazer on enacting legislation for the advocacy of public health policy. Pat is Past President of APA, and former chief of staff for United States Senator Daniel Inouye. He was instrumental in creating the nursing and pharmacy schools at the University of Hawaii in Hilo. He and the late Senator Inouye were largely responsible for a 1988 measure that authorized psychopharmacology training for United States Department of Defense psychologists. Throughout his career, Pat has assumed distinguished roles in public health policy and research advocacy. Having worked on Capitol Hill for nearly four decades, his definition of advocacy is “personally bringing a cause one truly believes in to the attention of your elected officials, including their staff.” Pat provided a successful example of shaping public policy through advocacy. During President Ronald Reagan’s Administration, Hawaii’s Barbara Porteus brought to Senator Inouye’s attention that psychologists were not recognized as experts under the Federal Criminal Code. Dr. Porteus made her case elegantly and had the enthusiastic support of APA. After the unfortunate Hinckley incident, her suggestion became public law with the active support of the U.S. Department of Justice. Pat emphasized that to be a successful advocate, “One must believe in a cause. One must be personally present. One must be persistent and dedicated to the long haul. And, one must work closely with one’s natural allies.” Pat continued by saying that “change is always difficult for some” and “having a vision and a fundamental belief in the system is critical.”

Advocacy through Public Education.

Elaine Ducharme, Ph.D. is a Member-at-Large on the 42 Board, Public Education Coordinator (PEC) for the Connecticut PA, Blogger for 42’s Website along with WRCH radio and for APAs www.yourmindourbody.org. Laney’s expert role in educating the public about mental illness and providing information that supports mental health services is a prime example of Educational Advocacy for psychology and psychologists. She appears regularly on local radio and television, while also contributing psychological information to newspapers and web news. Working with the media has been Laney’s way of sharing information with thousands of people outside of her office. Many of those links are then tweeted out or put on social media platforms, thus reaching an international market. “Getting involved is easier than you think,” says Laney. She encourages members who are interested in public education interests to join their SPTA advocacy. Having worked on Capitol Hill for nearly four decades, his definition of advocacy is “personally bringing a cause one truly believes in to the attention of your elected officials, including their staff.” Pat provided a successful example of shaping public policy through advocacy. During President Ronald Reagan’s Administration, Hawaii’s Barbara Porteus brought to Senator Inouye’s attention that psychologists were not recognized as experts under the Federal Criminal Code. Dr. Porteus made her case elegantly and had the enthusiastic support of APA. After the unfortunate Hinckley incident, her suggestion became public law with the active support of the U.S. Department of Justice. Pat emphasized that to be a successful advocate, “One must believe in a cause. One must be personally present. One must be persistent and dedicated to the long haul. And, one must work closely with one’s natural allies.” Pat continued by saying that “change is always difficult for some” and “having a vision and a fundamental belief in the system is critical.”

Psychology Advocacy – Collective Strength in Numbers

My mission is to rouse the advocacy voice within each of us and to galvanize our members to contribute and become strategically involved in some aspect of advocacy. Advocacy doesn’t happen randomly. Neither does advocacy occur overnight. However, Division 42 is over 3,500 members plus strong. Imagine if each Division 42 member engaged in at least one advocacy activity this year. The accumulation
of those 3,500 acts would create a tipping point to produce substantive changes.

- Look within. Find what matters, what you believe is worth fighting for as a practicing psychologist. I firmly believe that psychology advocacy involves getting in touch with one’s values, beliefs and principles that strike at one’s core and making a commitment to take a first step in promoting, advancing, and taking action for the cause that moves you.

- Find a vehicle for your voice. It may be writing an Op Ed piece, giving psychology a face through presenting on a topic your are familiar with, providing testimony on a psychology bill being heard, making an appointment to meet with the legislative representative from your district, or covering advocacy in psychology education classes.

- Networking and Collaborations. There is effectiveness through visibility and numbers. Whenever possible, network with other likeminded stakeholders and constituents in your advocacy work. Become a member of your SPTA or APA practice division, join the legislative, advocacy or insurance committee of your SPTA, lobby on the hill with your colleagues, attend a fundraising event honoring a psychology ally, make it your professional responsibility to pay for practice dues, or contribute towards our psychology PAC.

Be part of the advocacy group that makes it happen. It will ultimately be the cumulative effect of the messages we carry about the value of psychologists beyond our own that will enable us to succeed.

Warm Aloha, June

Opinions and Policy

Alice’s 50th Anniversary Tour

—Pat DeLeon

Having A Timely and Visual Presence: One of the most exciting aspects of being personally involved in the public policy/political process, which definitely would include participating in the APA governance, is having the opportunity to listen to, and spend unforgettable time with, visionaries who are truly dedicated to their cause. Psychologists often do not appreciate that they are among our nation’s educated elite and as such, have a special responsibility to provide proactive leadership in addressing society’s most pressing needs. I was particularly fortunate to serve as APA President just prior to Norine Johnson’s term. Norine truly appreciated how the nation would benefit from psychology’s calming presence right after the horrific 9/11 events and with Rhea Farberman’s steady guidance, passionately addressed the concerns of our nation’s children and their families by engaging the media.

In the days and weeks following, APA, with Norine as its national spokesperson, was active with the news media to help the American public understand the traumatic effect the attacks would have on some individuals. In the first three days, APA received 166 interview requests. In one lead interview Norine was part of an hour long CNN special segment. By mid-October, she had done a number of national interviews and over 2,000 APA members had been interviewed on both the 9/11 and the anthrax attacks. At her behest, the Public Communications Office created a public information brochure containing advice on how to deal with trauma, what is normal traumatic response, and how to recover. APA teamed with the Advertising Council and the National Mental Health Association on a public service announcement encouraging parents to talk with their children about the events of 9/11. Norine also understood the fundamental changes gradually occurring within our nation’s health care environment and worked tirelessly to have the APA Council of Representatives, and ultimately the full membership, include “promoting health” in our Association’s bylaws. As President Obama’s Patient Protection and Affordable Care Act (ACA) is now being steadily implemented, Norine’s vision of more than a decade ago is clearly coming to fruition.

The Administration’s Budgetary Priorities: The Administration’s Fiscal Year 2016 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $3.7 billion, which includes an additional
percent of U.S. adults currently suffer from mental illness in the top five chronic illnesses in the U.S. An estimated 25
call it was emphasized that: "Mental health disorders rank on the nation’s evolving health care system was most prophetic.Norine’s vision of her profession embracing its role within
better.”
does not get the services they need. The nation can do
illnesses and 90 percent of people with substance use disor-
expanded healthcare system allowing the specialty behavioral health system to focus on the needs of people with the most severe illnesses and/or addictions. However, even with expanded access to treatment, more than half of people with mental illnesses and 90 percent of people with substance use disorders do not get the services they need. The nation can do better.”

Norine’s vision of her profession embracing its role within
the nation's evolving health care system was most prophetic. On a recent HRSA national advisory committee conference
call it was emphasized that: “Mental health disorders rank
in the top five chronic illnesses in the U.S. An estimated 25
percent of U.S. adults currently suffer from mental illness and nearly half of all U.S. adults will develop at least one
mental illness in their lifetime. In 2007, over 80 percent of
individuals seen in the emergency room (ER) had mental
disorders diagnosed as mood, anxiety and alcohol related
disorders.” We would suggest that integrated care will become the vehicle for psychology’s expansion into the more
generic health care environment of the next decade.

**Being At The Table:** Heather O’Beirne Kelly heads up APAs Military & Veterans Policy (MVP) team, devoted to supporting military personnel and veterans, their families, and their communities, as well as psychologists who conduct research with and provide direct services to these populations. Her priorities for the coming year range from funding for research within the VA and DoD, the provision of high quality mental health care in the Service Member and Veterans communities, and establishment of prescription authority for appropriately trained and certified psychologists in the VA, matching that which DoD has granted for 17 years.

**Voices For The Future:** It is similarly informative to reflect upon the views proffered by those colleagues who have expressed a willingness to run for the APA Presidency, which is actually a very small and select group. Jack Kitaeff, a lawyer and former U.S. Army psychologist, expressed his
deep and abiding respect for those who have put themselves “in harm’s way” and feels that the issue of veteran's mental health should be of monumental importance. He would press for psychologists to be trained in treatment regimens targeting post-traumatic stress disorder (PTSD), including prolonged-exposure therapy, cognitive-processing therapy, and cognitive restructuring. Amazed by how many psychologists are not members of APA, or have never considered becoming involved in the governance, he would seek to actively attract colleagues back to the Association and demonstrate to members that “they are indeed valued.” He would also focus on addressing the chronic shortage of professional psychologists dedicated to serving diverse and marginalized communities (e.g., the poor, those with HIV, diverse family structures, and the workplace), as well as underserved regions of the country. And finally, Jack called for psychology to remain scientific and affirmatively seek to avoid allowing its advocacy efforts to be driven by ideology rather than science. Throughout these enumerated aspirations are a number of national policy agendas which could serve the profession admirably. “And friends they may think it’s a movement. And that’s what it is….“ (Ron Levant, Opening Session, 2005). Aloha,

**Pat DeLeon, Former APA President.**
This seems to be an era when mental health professionals are moving, especially because of the dramatic demands of the Affordable Care Act, into new venues for professional services. With their evidence-based knowledge of behavioral science research, independent practitioners will find an open door for their services in the realm of public safety.

Subsequent to the 1963 Comprehensive Community Mental Health Centers Act, a public health movement developed. For several years, it shaped all health care, and mental health services and higher education were no exceptions. However, politically motivated shifts in funding at both the federal and local levels led to the public health model being diminished greatly.

Going through a public health services doctoral program (i.e., Doctor of Science, University of Pittsburgh), I experienced penetrating (i.e., social consciousness raising) messages about broad applications for a public health model: “a community-based approach to mental and physical health in which agencies and organizations focus on enhancing and maintaining the well-being of individuals by ensuring the existence of the conditions necessary for them to lead healthy lives” (VandenBos, 2007, p. 758). So-called public health psychology has interests that “include advocacy, access to services, education and training, public policy formulation, research and program evaluation, and prevention efforts” (p. 758). Again, training programs that adhere to behavioral science prepare psychologists well for these thrusts.

When applying a public health model to public safety, it is critical to educate and enforce individualized responsibility for safety behavior, directed at minimizing catastrophes (e.g., lessening the risks for accidents, victimization, health hazards). “Safety psychology” embraces “safe and unsafe attitudes and behavior, relevant personality and physiological considerations, and stress conditions” (p. 810). Behavioral science research is replete with information about increasing self monitoring and adopting personal responsibility.

In an ideal society, perhaps, governing laws would create a shield against certain risks, such as crime, negligence, and violence. However, the United States Constitution protects human rights from governmental intrusions, and seldom (if ever) will pre-emptive legislation or policing by law enforcement sources prove to be adequate to preclude and eliminate risks to safety, even in a rather narrow sphere of life (Janus, 2006). Consider the great number of traffic violations that occur, creating grave jeopardy for people, notwithstanding a plethora of driving-related legal mandates. When addressing safety, psychologists must be mindful of limitations imposed by law.

What is needed? Countless public services that, while honoring Constitutionally protected freedoms, will craft environmental and other conditions intended to provide safe living. Many logical and essential safeguards are beyond plausibility for an individual to accomplish. Consequently, these safe conditions must be provided by human services, whether in an organizational context or from an independent practitioner.

In today’s world, many organizations that have had little or no expectation, explicitly or implicitly, to provide public safety services are “stepping up to the plate” to safeguard their particular constituents. In the case of colleges and universities, over the past several decades, social values have allowed higher education to sidestep the in loco parentis (“in place of the parent”) principle. However, there has been, and continues to be, elevated legal liability (e.g., premise liability) for alleged failure to safeguard persons connected to the campus.

As a result, colleges and universities are establishing departments of public safety, which have much greater scope of service than campus policing for parking permits and the like. In general, departments of public safety in colleges and universities share the goal of prevention of and protection by offering services that will protect the public (i.e., human constituents and property) from danger, injury, or damage, whether from criminal conduct, negligence, or natural or man-made disasters. Higher education administrations can benefit from psychological consultation about healthful conditions, systems analysis, risk management, determining policies and objectives, and selection of safety personnel.

— Robert Henley Woody
Said bluntly, every organization needs a risk management plan. Even the most hallowed of institutions are not exempt from needing strategies for optimizing safety, which would include public and private schools, day care centers, hospitals and other health care facilities, shopping malls, and the list goes on and on. The public health model has, of course, included psychological services from the outset, and provides a new focus for fee-for-services for independent practitioners. With the turmoil and risks that plague society today, there should be a positive reception for safety psychology.

References

Robert Henley Woody is a Professor of Psychology at the University of Nebraska Omaha. He is the author of Legal Self Defense for Mental Health Practitioners (Springer, 2013).

Liability, Malpractice, and Risk Management
Limits of Confidentiality: Confusion Regarding Implementation
— David Shapiro

In a previous column, I discussed the concepts of confidentiality, privilege, and privacy, and touched upon some of the limits of confidentiality. I would now like to look at some of the “wrinkles” in trying to implement appropriate ways of dealing with these limits in a specific area.

The limit of confidentiality that is perhaps most well known to practitioners is that of mandated reporting of abuse, most often child abuse, but in some jurisdictions, other areas such as elder abuse, and abuse of disabled people. It is relatively rare for the parameters of such reporting to be clearly delineated. Most often the terms “have reason to suspect abuse” or “reasonable suspicion that abuse has occurred” are used in the statutes with no definition of the term “reasonable.” There is also ambiguity regarding the need to report abuse if the referral comes to the practitioner from the Department of Children and Families, who have already determined the presence of abuse. The need to report abuse that has already been reported and is already under the jurisdiction of the Department of Children and Families seems counter intuitive. Nevertheless, in a recent case in the state of Florida, the state brought criminal charges against a psychologist for failure to report child abuse, despite the fact that the child was already in the custody of the state due to a prior abuse report that had been investigated and found to be accurate. The psychologist was not even asked to evaluate the abuse which had already occurred, but was tasked with evaluating the child’s developmental disability. Ultimately the charges were dismissed, but the psychologist who was arrested suffered tremendous anguish and damage to her reputation. In fact there is a provision in the state law that specifically excludes the need for re-reporting, which the prosecutor’s office seems to have ignored.

Another issue has to do with the need to report prior abuse; different states interpret this differently. Some say that there is no need to report it, unless the perpetrator is in a position where he or she may abuse others in the future. Others stipulate that past abuse must be reported (In one state a report must be made even if the abuser is deceased).

There is, therefore, no consistent approach that would be acceptable for practitioners in all states; the practitioner must familiarize himself or herself with the laws in the jurisdiction in which they are practicing and not assume that the law is the same as that in the state where they used to practice. Having ongoing consultation with an attorney intimately familiar with the individual state laws is the most prudent course of action, along with familiarizing oneself with specific changes in the law; a recent change in one state (Florida) makes everyone, not just health care professionals “mandatory reporters.” There is, however, no good description of the parameters of this new obligation, nor what form the reporting must take, no consideration of the fact that social service agencies are already overworked and under-staffed, and no description of the behaviors included (if one sees a parent berating a child in public, is that reportable?).

State laws need to hold clinicians only to the standard of care in their own professions, rather than expecting them...
Essential Clinical Practice Strategies for the Prevention of Disciplinary Complaints
— Jeffrey E. Barnett

Recently, I read Bourne and colleagues’ (2015) article, a study on the effects of being the subject of a disciplinary complaint. In their study of 7926 physicians in the United Kingdom, the authors found that of those who had recently been the subject of a disciplinary complaint 26% reported moderate to severe depression and 22% reported moderate to severe anxiety. Further, thoughts of suicide were twice as likely in these physicians in comparison to their peers (Bourne et al.).

Why is this so Stressful for Psychologists?

What makes being the subject of an ethics or licensing board investigation so stressful for psychologists? There are a number of potential reasons, and individual psychologists may even experience several of them simultaneously. As described by Montgomery, Cupit, and Wimberly (1999) even if one is exonerated, the following may be relevant if one is the subject of an investigation:

- The significant potential for loss of one’s professional reputation and status among colleagues and the public.
- Fear over loss of one’s livelihood and ability to support oneself and one’s family.
- The potential for a civil lawsuit and its possible consequences.
- Feelings of incompetence, self-doubt, self-degradation, and shame.
- Professional isolation and lack of emotional support from colleagues who may assume that one is guilty until proven innocent.
- The financial and emotional cost of having to defend oneself.

The Role of Prevention

As I have shared relevant to my time on ethics committees: “Too often I have experienced that sinking feeling in the pit of my stomach when reviewing an ethics complaint, seeing how costly it is to the individuals involved and often how easily it could have been avoided” (Barnett, 1997, p. 20).

Years of reviewing ethics complaints has solidified for me that the best remedy to the stress and other adverse consequences associated with being the subject of a complaint and/or investigation is a thoughtful focus on prevention.

While there are no prevention strategies guaranteed to prevent all complaints and investigations, psychologists who follow the recommendations below will find themselves much better prepared to effectively respond in these situa-
tions. While this brief article is not intended to replace the extensive risk management literature currently available, it does provide information that should be of value to every practicing psychologist.

**Key Prevention Strategies and Orienting Principles**

**Positive or Aspirational Ethics**

It is recommended that each psychologist be guided by the approach to ethics that Handelsman, Knapp, and Gottlieb (2002) have described as positive ethics (also known as aspirational ethics). This approach emphasizes a focus on doing the best we can in all situations on behalf of those we serve as opposed to merely seeking to do the minimum needed to meet ethics standards and legal requirements. Knapp and VandeCreek (2012) expand on this idea of aspirational or positive ethics, emphasizing that psychologists should not focus on the ethical floor by doing the minimum to avoid adverse consequences (termed remedial ethics), but rather should aspire to seek the ethical ceiling at all times, always striving to provide the highest quality services possible with the client’s best interest being our primary motivation. Thus, while remedial ethics focuses on what to do or not do, positive or aspirational ethics emphasizes how to think about fulfilling our roles and obligations as psychologists in keeping with the highest ideals of our profession.

The General Principles of the APA Ethics Code (APA, 2010) provide psychologists with aspirational principles intended to guide us in our decision-making. “Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession” (APA, 2010, p. 3). These General Principles are based on a set of underlying ethics, virtues that form the basis for ethical reasoning, decision-making, and practice: Beneficence, Nonmalfeasence, Fidelity, Autonomy, Justice, and Self-Care (Beauchamp & Childress, 2009). Being guided by these aspirational principles and integrating them into our professional identity as psychologists is an important preventive step recommended for all psychologists.

**The Basics of Risk Management**

Knapp, Younggren, VandeCreek, Harris, and Martin (2013) describe the basics of risk management to include informed consent, documentation, and consultation. To these I add clinical competence and self-care/the promotion of our ongoing wellness. While risk management seeks to minimize the risk of a complaint or lawsuit being filed against the psychologist, when done appropriately, it is entirely consistent with the positive ethics approach described above.

**Informed Consent.** When a client files a complaint against a psychologist something has gone wrong or not according to the client’s expectations or plan. Thus, it is essential that clients have a realistic understanding of the parameters of the professional relationship as well as realistic expectations of the likely course of treatment and each party’s roles and responsibilities. Informed consent should be viewed as an ongoing process in which there is sharing and discussion of the information relevant to the client’s decision to participate. That is, one can ask: “What information would most individuals want to have, and need to understand, prior to making a decision about participation in the services being proposed?” For guidance on the specific issues to be addressed in the informed consent agreement, readers are directed to the APA Ethics Code (APA, 2010), relevant laws and regulations in their practice jurisdiction, and the professional literature on informed consent. But, informed consent should be seen as an ongoing process, not a one-time event; as a discussion, not a set of documents to be signed; and as a vehicle for setting a collaborative tone for the professional relationship (Barnett, Wise, Johnson-Greene, & Bucky, 2007).

**Documentation.** Documentation of our clinical work is typically required by state laws and regulations. Additionally, psychologists should review the APA Record Keeping Guidelines (APA, 2007) for the profession’s consensus statement on record keeping practice. While documentation of the professional services provided (to include informed consent) is essential for exceeding the ethical floor, it also is essential from a positive ethics perspective. Further, what is documented, how it is documented, when it is documented, and the like are all relevant and can be addressed in the context of aspiring to provide clients with the highest possible quality of services.

Timely, thorough, accurate, and relevant documentation can be beneficial in several ways. It can:

- Assist you to provide better ongoing care to clients by monitoring progress, difficulties experienced, your responses to them, and the like.
- Be of benefit if a client discontinues treatment and then returns at a later date, either with you or another professional.
- Assist with communication about clients among colleagues on a treatment team to promote better coordination of care.
- Document your reasonable good faith efforts to meet the standards of the profession as well as the client’s level of cooperation/participation and responses.

Psychologists may rightly ask how much detail should I include in my documentation, what should I include or exclude, and when should I document the professional services I provide? Consider the possible uses of your docu-
Extensive research demonstrates that psychologists, like all other health professionals, are rather ineffective at self-assessing our levels of competence and the effects life stressors and challenges may have on our clinical competence (c.f., Davis et al., 2006; Dunning, Heath, & Suls, 2004; Dunning, Johnson, Ehrlinger, & Kruger, 2003). Further, professional isolation and lack of social connections with colleagues is often directly related to an increased risk of disciplinary complaints (Knapp & VandeCreek, 2009). Based on all of the above, the following recommendations are made with regard to clinical competence:

- Practice ongoing self-care to help mitigate the effects of life stressors on your clinical competence.
- Regularly consult with colleagues and participate in a peer supervision or support group on an ongoing basis. Be open, honest, and transparent in sharing about your challenges and struggles.
- When unsure if you possess the competence needed to treat a particular client or to utilize a particular technique, do not decide this on your own. Confer with trusted members of your professional community.
- Actively participate in your professional associations, continuing education activities, and the pursuit of lifelong learning to stay current with developments and changes in our profession.
- Before pursuing new areas of practice, consult relevant practice guidelines, consult with expert colleagues, pursue any needed didactic training, and obtain any needed clinical supervision.

**Summary and Conclusions**

It is hoped that this brief review of prevention, risk management, and aspirational ethics has illustrated how we may minimize the risk of being the subject of an ethics or licensing board complaint while at the same time working to fulfill the highest ideals of our profession as we provide high quality care to those we serve. While not a foolproof system with guarantees, the information reviewed here is intended to be a helpful reminder for psychologists and a starting point for self-reflection and additional discussions on this important topic.

**References**


Barnett, J. E., Wise, E. H., Johnson-Greene, D., & Bucky, S. F.
Obsessive-Compulsive Disorder (OCD), one of the most complex and puzzling of all psychological disorders, continues to evolve in our diagnostic nomenclature. Subsumed under Melancholia in the fourth century, this “doubting disease” was conceptualized as a form of satanic possession during the middle ages, as religious melancholy in the seventeenth century, and as either disordered will or intellect in the 18th and early 19th centuries. The term OCD comes from the German word Zwangsvorstellung (compelled presentation or idea), which encompasses both the mental experiences and the actions that form the essence of what is now called Obsessive-Compulsive Disorder. The term neurasthenia subsumed OCD and other disorders in the late 19th and early 20th century, however, OCD was viewed as separate from other disorders by Pierre Janet and Sigmund Freud who believed that it arose in the deepest (psychasthenic) stage of illness. Freud theorized that OCD developed from unconscious conflicts between unacceptable, unconscious sexual or aggressive id impulses and the demands of conscience and reality, and that the imperfect success of these defenses gave rise to OCD symptoms.

Advances in pharmacology, neuroanatomy, neurophysiol-
Anxiety, achieve a feeling of completeness, or to prevent feared event or situation (McGinn & Sanderson, 1999). Compulsive rituals may also be performed to reduce general anxiety, achieve a feeling of completeness, or to prevent "bad" ones and so on.

Sufferers may also engage in myriad other behaviors that create a sense of safety, including passive avoidant behaviors (e.g., not using the stove), and thought suppression (e.g., trying not to think of their obsessions) (McGinn & Sanderson, 1999). They may also overanalyze the meaning of obsessions, often to achieve exactness or to seek reassurance, may distract themselves, confess to imagined sins, and perform activities slower than considered normal. Although the list of ways in which individuals with OCD engage in avoidant behaviors may seem endless and overwhelming, it is important for clinicians to keep in mind that the function of the behavior is critical in determining if the individual is engaging in a compulsive ritual or if they are experiencing obsessions. Specifically, avoidant behaviors, including compulsive rituals are actions that reduce anxiety and promote feelings of relief whereas obsessions increase distress or anxiety.

Multiple themes may be present and the content of obsessions and compulsions may shift over time. A diagnosis of OCD is made if obsessions or compulsions cause significant distress or are time consuming and if symptoms are not explained by the presence of another disorder. In addition to experiencing anxiety, individuals with OCD also experience other emotions that can become targets of treatment. They experience high levels of guilt and shame, have a tender conscience, and may experience disgust, particularly in contamination-based OCD.

OCD also commonly occurs with other illnesses. Fifty-sixty percent of community samples have an additional disorder over their lifetime, a figure that is even higher in individuals presenting for treatment. In most cases, OCD is the principal diagnosis and is often the primary target of treatment. For example, individuals with OCD commonly become reactively depressed, but in most cases experience relief from symptoms of depression as their OCD symptoms subside. However, depression may become the primary target of treatment if it becomes severe. Anxiety disorders and substance abuse disorders are also common and sleep is often disrupted in individuals with OCD. As indicated above, OCD also co-occurs with Body Dysmorphic Disorder, Hypochondriasis, and other conditions now included in the larger category of Obsessive Compulsive and Related Disorders.
orders. Comorbidity has also been observed with Tourette's and Tic Disorder, Attention Deficit Hyperactivity Disorder, and eating disorders.

**Demographics**

Initially thought to be rare, OCD is actually quite prevalent. The lifetime prevalence of OCD in the US is 2.3% and the annual prevalence is 1.3% (Kessler et al., 2005a and b; Ruscio, Stein, Chiu, & Kessler, 2010). OCD appears to be consistent across cultures and countries (US, Canada, Korea, Puerto Rico, New Zealand, Singapore, and Germany) with lifetime rates from 1.9%-2.5% and annual prevalence rates of 1.1-1.8%. (Canals, Hernández-Martínez, Cosi, & Voltas, 2012; Subramaniam, Abdin, Vaingankar, & Chong, 2012).

Some racial and ethnic differences have been observed. Taiwan appears to have lower rates – (lifetime prevalence - 0.7%; annual prevalence, - 0.4%). Observed racial and ethnic differences may reflect differences in symptom reporting, or utilization of mental health treatment. For example, African-Americans with OCD are less likely to present for treatment compared to other ethnic groups (Williams et al., 2012). Although OCD is likely to be misdiagnosed in general (Glazier, & McGinn, in press), it is especially misdiagnosed among African-Americans (Adebimpe, 1981), which may also account for some observed differences.

OCD appears to be evenly divided in adult samples or may be slightly more common in females. However, boys are twice as likely to develop OCD in childhood as compared to girls. OCD typically begins in adolescence or young adulthood, and rarely after age 50. However, men generally develop OCD between the ages of 6-15 while women present with OCD between the ages of 20-29. The onset is gradual in most cases and OCD does not usually remit spontaneously. A majority of individuals suffer for years before presenting for treatment. OCD is a stress sensitive, chronic condition that waxes and wanes in severity for a majority of cases. Individuals experience significant impairment in occupational, social, and health functioning, which in turn, places significant burden on their caregivers.

Although several factors are linked to poor prognosis, developing OCD at younger ages appears to be associated with an especially poor prognosis (Taylor, 2013). In fact, individuals who develop OCD at especially young ages seem to differ considerably from those who develop OCD as young adults. The mean age of such individuals is 11 years and they are almost inevitably male. These individuals have a greater severity of illness, poorer functioning, and a higher prevalence of most types of obsessive-compulsive symptoms. They tend to present with more comorbidity with tics (10-40%) and spectrum conditions (but not anxiety, depression or ADD), have greater neuropsychological impairment, possibly higher brain iron, and may have a higher frequency of alleles of the serotonin transporter promoter gene. They also tend to have a greater prevalence in first-degree relatives, and a poorer response at post-treatment.

Ten percent of early onset cases may have pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection (PANDAS). These cases of OCD present with sudden onset and a strep infection and have a mean age of onset from age 3 to puberty. Physicians may diagnose PANDAS by obtaining a positive throat culture for strep infection but the presence of motoric hyperactivity or choreiform movements may also help with the diagnosis. Individuals are given antibiotics to treat the strep infection if one is diagnosed and are given standard treatment for OCD symptoms. The infection can recur, leading to an exacerbation of symptoms. Although some studies find that a strep infection is associated with a later increase of OCD, others find no relationship.

By contrast, those who develop OCD as young adults (mean age of 23 years) may be either male or female or slightly more likely to be female. This subtype of OCD is associated with a milder form of the illness, is less familial, has a greater comorbidity with anxiety and mood disorders, a lower rate of comorbidity with tics and spectrum conditions, and is associated with a better treatment outcome.

**Efficacy of Cognitive Behavior Therapy**

Psychodynamic therapies and many psychotropic medications have proved ineffective for OCD thus far. Traditionally considered to be treatment resistant, the prognosis for OCD has greatly improved since the development of cognitive behavioral therapies and serotonergic medications.

CBT treatments have demonstrated efficacy for the treatment of OCD in a number of studies, are comparable to serotonergic medication treatments (Abramowitz, 1997; McKay et al., 2015; Olarunji, Davis, Powers, & Smits, 2013), and may even be more effective than medication in some cases (Foa et al., 2005). Separating the effects of behavior therapy and cognitive therapy are difficult as both use elements of the other. An immense body of research supports the efficacy of behavioral treatments (exposure and response prevention). Fifty to seventy-five percent of patients are substantially improved and the majority of individuals maintain gains after treatment is discontinued. Although by comparison, a smaller body of research supports the efficacy of cognitive treatments, studies supporting their efficacy have grown and suggest that cognitive strategies may be comparable to behavioral strategies (Abramowitz, 1997). A recent meta-analysis showed that
CBT outperformed controls in all 16 studies used in the meta-analysis and that the type of CBT used did not affect the strength of the treatments (Olatunji et al., 2013). However, exposure and response prevention is still considered the first line treatment for individuals with OCD given that to date the number of studies supporting the efficacy of behavioral treatments is far greater than those using cognitive therapy. However, research substantiating the efficacy of cognitive therapy is growing and indicates that cognitive treatments are not only effective in improving symptoms and reducing emotional distress, but may also be effective in improving treatment adherence and reducing treatment drop-out (McKay et al., 2015).

**Treatment**

Cognitive behavioral treatments are based on cognitive and behavioral models of psychopathology and are systematically implemented following a thorough case conceptualization of presenting symptoms and problems (McGinn & Sanderson, 1997). Although structured assessments (Self-report and clinician administered) are used to determine diagnoses, assess severity of illness, and to clarify how treatment should proceed, cognitive behavior therapists also conduct functional analyses of specific episodes of distress or problematic behaviors to help establish how symptoms and problem behaviors are linked, and to determine which symptoms and behaviors should become the primary targets of treatment.

Results of the structured clinical evaluation and the functional analyses are also used to develop shared goals for treatment and to gather information in order to develop a comprehensive treatment plan. For example, using both types of assessments, clinicians will identify internal (e.g., physical sensation) and external anxiety triggers (e.g., garbage can), cognitions including catastrophic fears (e.g., I will get infected if I touch the garbage can), passive avoidance behaviors (e.g., not using knives), ritualized thoughts (e.g., mentally saying God is Love) and compulsive behaviors (e.g., washing hands), and will determine how they are linked and sequenced so that treatment strategies can be used effectively.

Clinicians present the results of the multi-method assessments to patients, educate them on their illness, and then socialize them into treatment by describing treatment strategies and the rationale for why they will be used. This allows clinicians and patients to develop a shared understanding of the problems and develop shared goals for treatment.

**Cognitive Models and Treatments**

Cognitive models theorize that a faulty cognitive style may underlie the dysfunction in emotional disorders, including in OCD (Beck & Emery, 1985). The most comprehensive and specific cognitive model of OCD to date suggests that obsessional thoughts are normal and that the dysfunction in OCD is not in the experience of obsessions themselves but in the way obsessions are processed (Salkovskis, 1985a; 1985b). The model suggests that the individuals with OCD experience secondary automatic thoughts that arouse anxiety (e.g., my obsession that my son will die will actually lead to his death) and result in avoidance behaviors (e.g., urge to stop thinking about obsessions), including compulsive rituals (e.g., checking on him repeatedly). These automatic thoughts are based on dysfunctional assumptions (e.g., thinking about something is the same as doing something) and represent beliefs held by such individuals (e.g., I am evil).

Cognitive therapy is used to help patients modify their secondary automatic thoughts and accept symptoms of OCD as part of their illness and in doing so, helps reduce the myriad emotions that plague OCD sufferers such as anxiety, guilt, shame, and sadness, and reduces their urges to ritualize (McGinn & Sanderson, 1997). These strategies also help prepare them for undergoing exposure and response prevention. Cognitive therapists use “Socratic questions” (e.g., what did it mean to you that you had a sexual thought during church services?) to guide patients to discover and modify their secondary automatic thoughts (e.g, I am going to hell) and the beliefs on which they are based (e.g, I am immoral).

Characteristic beliefs held by individuals with OCD include a sense of inflated responsibility for negative outcomes (e.g., it will be my fault if the attendant gets fired because I didn’t go back to make sure I gave her the correct change), an exaggerated vulnerability to harm (e.g., My baby will die if I don’t check on her every few minutes), and an underestimation of their ability to cope with negative outcomes (e.g., I will not be able to handle the anxiety from not knowing).

Individuals with OCD are consumed with doubt and uncertainty (e.g., what if I didn’t clean my hands sufficiently and I infect my baby with germs?), tend to place overimportance on thoughts and control over thoughts (e.g., I must be able to control what I think), are highly perfectionistic and rigid in their thinking, and find it hard to tolerate the doubt and uncertainty they experience. Many individuals tend to fuse thought and action (e.g., thinking is the same as doing) and have numerous magical thoughts (e.g., I may kill my baby if I imagine that I am killing him).

Cognitive restructuring helps individuals normalize obsessions and modifies the degree to which they uncritically believe their faulty appraisals, and in doing so, helps decrease anxiety, and the resulting obsessions and compulsions. Towards that, the therapist first helps patients understand that obsessions are normal, and guides them to identify their secondary automatic thoughts (e.g., I will get infected and die) and to understand their impact on how they feel (e.g., anxious) and behave (e.g. washing hands).
during specific moments of distress. By educating them that obsessions are normal and by creating awareness of secondary automatic thoughts and the impact they have on their lives, the therapist helps patients begin the process of distancing themselves from their experiences and thoughts. Patients are taught to understand the function of their thoughts during each episode of distress and to understand the entire sequence or chain of events, thoughts, emotions, and behaviors that lead up to and comprise an “OCD attack.” Patients regularly monitor episodes in which they have obsessional anxiety and/or the urge to ritualize and by doing so, learn not to simply accept their experiences and thoughts as if they represent truth or reality (e.g., I am having an obsessional thought about killing my baby, I am not actually killing my baby or planning to kill my baby).

The cognitive therapist also uses Socratic questions to guide patients to further modify the believability of these secondary cognitions. The goal is to help patients understand that OCD is an illness that continually torments them with doubt and fear and to guide them to realize that the content of their obsessions is irrelevant, is not predictive of what will actually happen in the future, and is not a reflection on their character. Depending on the specifics of each obsessional episode, the therapist may examine the evidence for the secondary thoughts (e.g., have you ever committed a crime?), or help them decatastrophize (e.g., what is the worst thing that could happen if you catch a cold from touching a doorknob?).

Given that the danger inherent in their secondary automatic thoughts leads to a narrowing of their perceptual field, the therapist also guides patients to consider alternative, more benign explanations for their obsessional experiences (e.g., it is possible that I had a spontaneous image of strangling my husband last week because I was angry with him and not because I want to strangle him). Asking patients to place themselves in the position of an objective observer is yet another cognitive strategy to guide patients to accept that obsessions are simply symptoms of their illness and to help give them distance from their secondary automatic thoughts (e.g., what would you tell your friend if she was having these obsessions?). Patients are also guided to see that their secondary automatic thoughts are adding to the burden they already experience (e.g., it is not helpful for me to judge myself for having obsessions, it makes me feel worse and gives me an added problem beyond having OCD).

The cognitive therapist conducts behavioral experiments by asking patients not to suppress their obsessional thoughts or to do anything to “undo” them and instead, helps patients to direct their attention towards obsessive thoughts. Patients are helped to see that their attempts to stop their obsessional thoughts often backfire by making their obsessional thoughts increase in frequency (e.g., trying to stop thinking of a pink elephant makes them think of nothing but a pink elephant). Patients are asked to allow obsessions thoughts to flow in and out naturally so that they can tolerate their anxiety and realize that their worst fears are unfounded.

Behavioral Model and Therapy

The behavioral model is based on learning theory (Dollard & Miller, 1950; Mowrer, 1939, 1960) and suggests that obsessional fears and behaviors are acquired through a process of associative learning (e.g., neutral stimuli develop anxiogenic properties because they are inadvertently paired with stimuli that naturally produce anxiety) and are maintained by negative reinforcement (e.g., feelings of relief when rituals are performed). Patients are informed that obsessional anxiety is learned (via classical conditioning) and continues if left unchecked (via operant conditioning). Exposure is used to help break associations between conditioned stimuli and anxiety (e.g., touching a doorknob) and response prevention is used to break formed associations between compulsive rituals and feelings of relief (e.g., not washing hands) (Foa & Goldstein, 1978; Foa, Steketee, & Ozarow, 1975; Meyer, 1966; Meyer & Levy, 1973).

The therapist and patient first create a hierarchy of specific obsessive fears and avoidance behaviors and then determine the type of exposure to be implemented. Imaginal exposure is used to target internal triggers of anxiety (e.g., images) and to confront obsessive thoughts, images, or urges in the form of specific catastrophic fears (e.g., images of someone being hurt). It can be used as a preparation for in vivo exposure (e.g., imagining touching a toilet seat before actually touching a toilet seat) and/or used when in vivo is contraindicated (e.g., helping patients imagine their loved ones die).

In vivo exposure is used for external triggers of anxiety (e.g., garbage cans) and when patients cannot identify specific consequences for their fears (e.g. I just feel uncomfortable unless things are symmetrical). In the latter case, an effective cognitive functional analysis may often identify specific consequences (e.g., I will have a nervous breakdown if I don’t order things symmetrically) even if patients are initially unaware of their specific fears. In vivo exposure is ideally used along with imaginal exposure for patients to gain maximum benefit but may be used alone if patients do not need preparation before conducting in vivo exposure or are unable to benefit from imaginal exposure (e.g., are unable to have physiological arousal during imaginal sessions).

The process of conducting Exposure and Response Prevention (ERP) involves first gathering a list of phobic stimuli in the form of objects, situations, people, and collecting the relevant paraphernalia (e.g., garbage cans, narrative scenes) and then requiring patients to confront these stimuli in their imagination and/or in reality in a graded fashion. The therapist prepares the patient by reiterating the rationale for ERP, addresses their apprehensions, and then records
their anxiety on the Exposure Monitoring Form both before exposure is initiated and in an ongoing fashion until the session is terminated (McGinn & Sanderson, 1999). Patients are helped to attend to the feared medium and are asked to re-expose themselves to the stimulus if ritualization occurs during exposure. Anxiety is allowed to spiral upward naturally and all attempts to artificially block anxiety are prohibited.

The exposure session is terminated when anxiety is substantially lower, when cognitions are disconfirmed, or when the urge to end the exposure session has subsided. Although therapist should take care not to sensitize the patient to anxiety (e.g., picking the highest item on the hierarchy without assessing if the patient is capable of undergoing it or ending the session prematurely), complete habituation is not necessary to terminate the exposure session. The therapist takes care to obtain feedback at the end of exposure to assess and modify patients' reactions to the session, and to ensure that cognitions are disconfirmed.

A list of compulsive rituals is also gathered so that the therapist and patient can create a plan for response prevention. Although completely abstaining from rituals is the final goal, the therapist may use various strategies to achieve this goal (e.g., reducing number of repetitions per ritual or time between rituals) (Steketee, 1993). One strategy I find particularly effective is to require patients to abstain from performing rituals for items to which they are being confronted, or were confronted in prior sessions, but, to permit them to ritualize to items to which they have yet to be exposed. I have also incorporated various habit prevention and behavior modification strategies to help facilitate the implementation of response prevention strategies (McGinn & Sanderson, 1999). When necessary, I use strategies to build motivation, increase their awareness that they are performing rituals, assign a co-therapist, and use behavior modification principles to maximize the likelihood that patients are successfully refraining from performing rituals. If all else fails, patients are re-exposed to the feared stimuli and are encouraged to minimize self-criticisms if rituals are inadvertently performed. ERP is continued until the patient has been exposed to all facets of each stimulus triggering anxiety and patients are required to conduct ERP in multiple contexts, and both in-session and in their natural environment. As patients become adept at conducting ERP, the therapist encourages more patient controlled sessions.

**Tackling Complications**

Many complications may occur during treatment. Given that patients have potentially spent a lifetime avoiding things that make them anxious, asking them to engage in treatment can be anxiety producing and patients may not comply with treatment as a result. For example, identifying automatic thoughts may create anxiety or writing down automatic thoughts could worsen obsessional fears. Clinicians should identify such task-interfering cognitions and formulate a plan to cope with a lack of compliance beforehand. For example, clinicians should prepare patients in advance that they might initially experience more anxiety when they begin treatment. They can emphasize that avoidance is a natural reaction to anxiety but it is a reaction must be overcome for symptoms to improve in the long-term. Therapeutic tasks may also be broken down into smaller steps that are initially more manageable for patients. For example, the patient could orally recount automatic thoughts before attempting to write them down or exposure tasks could be broken down into even smaller steps than initially planned.

At times, therapists may find that treatment strategies are ineffective in some situations. For example, they may find that cognitive restructuring does not reduce anxiety on some occasions, that patients have difficulty habituating during some exposure tasks, or that anxiety drops too rapidly during exposure sessions but is not sustained. Often the solution may be simple. For example, therapists may simply increase the length of exposure sessions to see if habituation occurs or may find that exposure tasks need to be broken into smaller steps to reduce overarousal. However, conducting a good functional analysis will help therapists understand exactly what is going on in most cases. In some instances, patients may be engaging in some form of avoidance. As an example, patients may distract or “cognitive avoid” the stimuli to which they are being exposed, not expose themselves to all parts of the stimulus, or may perform mental rituals during exposure sessions, thereby feeling immediate but only temporary feelings of relief. Uncovering passive or active avoidant behaviors that artificially reduce anxiety is important for strategies to be maximally effective. In those occasions, re-exposing patients to all aspects of the feared stimuli is essential for treatment strategies to work.

Often, patients’ guilt and shame may derail treatment. As mentioned above, patients with OCD often have a tender conscience, take personal responsibility even for events out of their control, and experience guilt over many areas of their life. Often their guilt may extend to their inability to engage in the treatment at the intended pace. It is critically important that therapists express validation and non-judgmental acceptance about the fact that obsessions and compulsions are part of their illness and as such, are hard to give up even as they continue to help patients reduce symptoms and improve functioning.

Finally, a big complication in OCD is that sometimes treatment strategies may themselves become ritualized. For example, a patient may begin to systematically repeat the revised cognitions over and over again or may begin to
conduct exposure in an overly systematic, rigid fashion. A patient may appear as if she has given up her rituals but on close examination, it may be that her rituals now involve systematic ways of preventing herself from ritualizing. The therapist and patient must collaboratively be alert to any signs that treatment strategies are becoming ritualized and implement strategies to modify how they are being used. In general, all tasks and strategies should be individualized and flexible so that they do not become routine or systematic. CBT is a systematic treatment approach which is typically helpful in ensuring that the treatment is administered effectively and is helpful to many patients. However, overly systematic attempts may backfire for patients with OCD. For example, using flashcards containing common revised thoughts, systematically going up the exposure hierarchy without any variability, or methodically reducing rituals all have the potential to become become ritualized. Patients are cautioned against routine and therapists should continually strive to break up systems and keep therapeutic exercises individualized and flexible.

Conclusion

OCD is a complex disorder to assess and treat. Symptoms are heterogeneous, and even experienced professionals often misdiagnose the disorder. Studies in my lab have found that misdiagnosis rates are high both among primary care physicians and mental health professionals and tragically lead to non-evidence based treatment recommendations (Glazier et al., in press; Glazier, Swing, & McGinn, 2013). Taboo obsessions, such as religious and sexual obsessions are more easily misunderstood than common obsessions such as contamination fears or fears of harm. However, we found that OCD diagnosis rates substantially improved when we gave clinicians-in-training a psychoeducational assessment designed to understand the heterogeneity of symptoms that comprise an OCD diagnosis (Glazier & McGinn, 2014, July). Incorporating such structured training in graduate programs, and in continuing education for mental health professionals and primary care physicians, is essential so that patients don’t suffer needlessly, or worse, receive treatments intended for other conditions.

As discussed earlier, treatment for OCD is often complicated, and treatment strategies may themselves become ritualized. As a result, treatment is often a moving target, which makes the therapeutic work continually challenging yet interesting. Cognitive behavior therapy for OCD is not for the faint of heart as it requires that clinicians tolerate their own anxiety and help patients engage in work that is often distressing (e.g., touching contaminants or helping a patient imagine having sex with a parent). However, working with OCD patients is extremely rewarding. It is gratifying when patients, who have grown up believing they are immoral or who have lost years of their lives to their illness, finally achieve symptom relief and improved functioning.

Although many patients respond to treatment, CBT does not help everyone. Hence future studies are needed to further examine how treatment benefits could be enhanced. For example, as indicated above, research suggests that there may be two distinct profiles of individuals with OCD, those with a younger age of onset and those with an older age of onset. Understanding these differences and how they impact treatment may allow researchers to better tailor cognitive behavioral treatments to address the needs of the two groups, and thereby maximize treatments for both. Future studies are also needed to identify the mechanisms through which strategies are effective so that treatments may be further refined.

References


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**Early Career Psychologist Bylaw Change**

In January 2015, the Division 42 Board of Directors voted to authorize the following bylaw amendments regarding the Division’s definition of the Early Career Psychologist. Voting will take place via our website at [http://division42.org/vote](http://division42.org/vote) for 45 days beginning April 1, 2015 and ending May 15, 2015.

**Article II Membership, H. Early Career Psychologist Definition.**

In order to be consistent with APA’s definition of an Early Career Psychologist (ECP) the board authorizes a bylaw amendment be sent to the membership for vote requesting the definition of an ECP member of Division 42 be extended from 7 years to 10 years after completion of the doctoral degree.

**Article VI Board of Directors, A4.**

A Representative of the Division’s Early Career Psychologist members (those who are within ten (10) years of the year in which they received their doctorate), who shall be elected for a three (3) year term as ECP Member-at-Large.

 *(This sentence replaces the first sentence in this section changing “seven (7)” to “ten (10)”)*
Multiple Group Memberships and Ageism

As practitioners, we often work with older adults who experience negative work-related outcomes because of their chronological and/or subjective age. Marcus and Fritzsche (2014) reviewed literature on situational factors that determine age salience as well as the major and competing theories on the intersections between multiple social group memberships. The authors discussed the need for a model to address the overlap between multiple group memberships, noting that “every older worker is either an older male worker or female worker; every older worker is either a member of the dominant societal group or a member of a minority group” (p. 9).

The authors proposed a theoretical framework for the intersectional salience of ageism, such that salience of age moderates the relationship between work outcomes and multiple group memberships including age, gender, and tribe (race, ethnicity, nationality, and religion). More specifically, they suggested that social context makes age salient, resulting in discrimination for older workers, the impact of which will vary depending upon multiple group memberships. A number of propositions based on eight archetypal representations of age were also offered including Younger White male, Older White male, Younger Minority male, Older Minority male, Younger White female, Older White female, Younger Minority female, and Older minority female. I/O psychologists as well as other psychological professionals working in a managerial, leadership, or supervisory capacity might be interested in a reprint of the full article for a detailed discussion of the proposed framework and accompanying propositions.

Marcus, J., & Fritzsche, B. A. (2014). One size doesn’t fit all: Toward a theory on the intersectional salience of ageism at work. Organizational Psychology Review. Advance online publication. doi: 10.1177/2041386614556015. Reprint requests to Justin Marcus at justin.marcus@ozyegin.edu.tr

Targeting Rumination as a Means of Reducing Depression

When we work with individuals who have a diagnosis of depression, finding the right combination of interventions to not only manage symptoms but also reduce risk can be challenging. Sachs-Ericsson et al. (2014) interviewed a sample of 375 parent-offspring dyads to investigate the role that parental depressive symptoms and neuroticism have in the development of adult children’s rumination and depression. Past research suggested that parental depression and neuroticism were not only risk factors for the development of depression in offspring, but additionally that an intermediary role for rumination exists, whereby “neuroticism leads to rumination, which is in turn related to depression” (p. 308). The data were analyzed using structural equation modeling (SEM). Results showed that parental depression and neuroticism predicted depressive symptoms in adult children, and adult children’s rumination predicted adult children’s depressive symptoms. In addition, although parental depression did not predict adult children’s rumination, parental neuroticism was found to predict rumination. Lastly, “adult children’s rumination fully mediated the relationship between parental neuroticism and adult children’s depression” (p. 315).

The collective results suggest that focusing on treatment options that target rumination may prove beneficial in reducing the risk of depression. Clinicians might be interested in a full reprint of the article for more specific discussion of the variables studied and the associated implications for treatment.


Collaborative Treatment for ADHD

Psychologists are often one of a number of providers utilized by children with ADHD and their families. Treatments for ADHD might involve psychotherapy, skills training programs, neurofeedback, medication, and school based interventions just to name a few. Chacko et al. based their work off of four assumptions about current ADHD treatments: 1) Combination behavioral and pharmacological interventions work in the short term but do not generalize well nor demonstrate long term effectiveness once the treatment concludes, 2) executive functioning deficits may be larger than originally thought and have a greater impact, 3) neurocognitive training needs increased specificity for ADHD, and 4) better neurocognitive training might lead to greater efficacy for skills training approaches. The authors propose that the underdeveloped neurocognitive functions of individuals with ADHD can be improved
with next-generation neurocognitive training thus paving the way for skills-based approaches to be more effective. It is argued that “novel interventions are needed to more specifically target what we believe to be the core neurocognitive deficits for many if not most children with ADHD: sustained attention and central executive working memory deficits” (p. 377). While neurocognitive training will lead to benefits in functioning, to increase overall outcomes adult-mediated interventions will be needed (e.g., skills training, behavioral skill practice, supportive instruction, etc.). Clinicians might be interested in the full reprint for more information on ADHD etiological models as well as a review of research on neurocognitive training.


The Effects of Ostracism Involving a Romantic Partner

As clinicians, we often work with individuals who want to improve the dynamics within their romantic relationships. Using a sample of 127 couple members, Arriaga, Capezza, Reed, Wesselmann, and Williams (2014) conducted a between subjects experiment to investigate the effects of a partner’s ostracism on need satisfaction and explored differences in reactions to ostracism based on attachment security. Previous research suggested that although ostracism is detrimental to needs satisfaction, the effects are mitigated when a person is reminded of a close relationship. In an effort to determine if the effects are similar when the ostracism is perpetrated by a romantic partner, Arriaga et al. (2014) manipulated ostracism (inclusion versus exclusion) and partner involvement (partner involved versus partner not involved) to determine their effects on need satisfaction and relationship evaluation. The data were analyzed using multilevel modeling. With regard to need satisfaction, results showed that exclusion lowered need satisfaction, and that a partner’s presence reinforced feelings of belongingness and meaningful existence. For the exclusion condition, a partner’s involvement in the act of ostracism had no effect on needs satisfaction, suggesting that exclusion, regardless of the perpetrator, is perceived similarly. With regard to relationship evaluations, results showed that individuals who were avoidantly attached had a tendency to evaluate their relationships negatively across all conditions. Collectively, these results suggest that exclusion can make individuals feel that their needs are unmet, regardless of whether the exclusion involves a partner or strangers. Those feelings can in turn lead to negative evaluations of the romantic relationship, and ultimately cause the person to “call into question…the very reason for being in a relationship” (p. 568). Clinicians might be interested in a full reprint of the article for a more detailed discussion of the effects of ostracism by a romantic partner on relationship expectations and belonging needs.


Changes in the Marital Beliefs of Emerging Adults

As clinicians, we often work with young adults to help them navigate the challenges associated with transitioning from adolescence into emerging adulthood. One of the most salient challenges associated with that transition relates to romantic relationships and the decision to marry. Willoughby, Medaris, James, and Bartholomew (2014) conducted a one year longitudinal study using a sample of 134 emerging adults to investigate changes in marital beliefs and the predictors therein. Previous research showed that although the average age of marriage has increased over time, the vast majority of emerging adults continue to support the decision to marry. Despite that fact, fewer emerging adults view marriage as an important step in becoming an adult. Four hypotheses were tested. Hypothesis 1 predicted that marital beliefs among emerging adults would become more positive over time. Hypothesis 2 predicted that being Caucasian, male, maintaining a romantic relationship, and cohabiting would be associated with more positive marital beliefs. Hypothesis 3 predicted that higher marital salience, centrality, and permanence beliefs and an earlier expected age of marriage would predict decreases in the use of alcohol and pornography, as well as decreases in sexual intercourse. Hypothesis 4 predicted that religiosity and gender would moderate relationships between demographics, relational experiences, and changes in marital beliefs. The data were analyzed using a combination of repeated measures multivariate analysis of covariance and hierarchical regression models. Results showed that religiosity was associated with increased marital salience, whereas staying single or breaking up with a romantic partner were associated with declines in marital salience. Sexual orientation was associated with marital permanence, such that heterosexual participants showed higher belief in the permanence of marriage. Cohabitation
and number of hours of paid employment were associated with marital centrality, such that cohabitation and increasing hours of paid employment were associated with a decrease in marital centrality. Collectively, these results suggest that emerging adults experience quite a bit of developmental growth over the course of a year, much of which is focused on the importance they place on marital paradigms. Clinicians and other practitioners of developmental psychology might be interested in a full reprint of the article for a more detailed discussion of the variables studied, their predictive weights, and the associated outcomes.


Maternal Expressed Emotion and Children’s Behavior

In working with children we strive to view the children within their various systems and examine the reciprocal influences. Han and Shaffer explored maternal expressed emotion (EE) as it related to children’s behavior. “Expressed emotion (EE) is a construct describing family interactions that are marked by criticism and emotional over-involvement” (p. 1497). Difficulties in emotional regulation in children have been studied in relation to psychopathology. However, the complex relationship between family emotional climate and children’s behaviors and outcomes would benefit from further investigation. Han and Shaffer’s study examined caregiver’s emotional over-involvement and criticism as they relate to children’s psychopathological symptoms. They studied 60 mother-child dyads from a diverse community sample with the children’s ages ranging between 8 and 11. The dyads engaged in a designed conflict discussion task and were observed by research assistants. The dyad was then separated and completed questionnaires independently including the Emotional Regulation Checklist (ERC) and Child Behavior Checklist (CBCL). The mothers also completed the Five Minute Speech Sample (FMSS), discussing their relationship with the child. Hans and Shaffer found that mothers who were more critical, less warm, and less positive to their children tended to have children with higher levels of emotional dysregulation as well as internalizing and externalizing difficulties. Mothers who conveyed greater levels of detail about their children as well as overprotective behaviors tended to have children with lower emotional dysregulation and lower externalizing difficulties. Clinicians might be interested in the full article for further background on expressed emotional as well as the tables illustrating the mediating relationship between EE, emotional regulation, and behavioral outcomes.

Han, Z. R., & Shaffer, A. (2014). Maternal expressed emotion in relation to child behavior problems: Differential and mediating effects. Journal of Child and Family Studies, 23(8), 1491-1500. Reprint requests to Z. R. Han at rachhan@bnu.edu.cn

Focus on Diversity

Independent Practitioner Diversity Matters — Michi Fu and Doug Haldeman

In January 2015, over 750 psychologists, graduate students, and friends convened in Atlanta, GA for the National Multicultural Conference and Summit (NMCS) http://www.apadivisions.org/multicultural-summit.aspx, or what is affectionately referred to as “The Summit.” The biennial Summit gathers scientists, practitioners, scholars and students in psychology and related fields to inform and inspire multicultural theory, research and practice. During this gathering, multiculturalism was envisioned as inclusive of experiences related to age, disability, ethnicity, gender, gender identity and expression, indigenous heritage, national origin, race, religion, sexual orientation, social class and socioeconomic status, and other social identities. The NMCS occurs every other year and will occur again in 2017. The Division 42 board held our mid-winter meeting in conjunction with the Summit, as do many other APA Divisional boards, due to President June Ching’s support of diversity issues. I was heartened to see several Division 42 members and board members among the NMCS conference participants. Hopefully you had an opportunity to be present and enjoy the networking and educational opportunities presented by the Summit.

Perhaps a brief history of the summit may help to give context as to why there is yet another conference to consider attending. In 1999, Rosie Phillips-Bingham, Lisa Porche-Burke, Derald Wing Sue, and Melba Vasquez represented four of APA’s Divisions (17-Society of Counseling

NMCS programming sessions include symposia and workshops, but perhaps what sets the Summit apart are the Difficult Dialogues that encourage people to have honest, raw, unfiltered dialogue that can sometimes lead to mending. Additionally, the Elders Awards Ceremony is typically a place where distinguished elders share of their journeys and those who came before them. It is oftentimes inspiring to hear their stories. In addition to this year’s 60+ programming, a film festival was offered for CE credits where conference participants learned how to incorporate film into their clinical work, teaching and training. Thought-provoking and moving keynote speakers included: Dr. Vivian Ota Wang, Dr. Beverly Daniel Tatum, and Commissioner Janet LaBreck.

I was the Division 45 appointed coordinator for this year’s summit. I defined my charge as the Awards & Entertainment coordinator to include hospitality. Therefore, if you were in attendance, you might have enjoyed hospitality items sprinkled throughout the hotel (including personal amenities in the restrooms), posted photos from our virtual photo booth (http://eventstagr.am/view/national-multicultural-conference-and-summit), traveled home with a drumming instrument party favor from our community drumming group during the Elders Awards Ceremony, or brought home an Asian tea kit from the Closing Town Hall Ceremony’s Asian tea pouring ceremony.

Missed the Summit this time around? There is a place at the table for allies and those who are open to dialoguing about diversity issues. Perhaps you will consider sharing some of the work you do with diverse communities. Or, perhaps you will enjoy simply learning and networking with others who are interested in culturally responsive and cutting edge work.

But first, let’s start in our own backyard. Want to get more involved in diversity issues within Division 42? Please consider submitting your narratives to the Diversity Narrative Project and introduce yourselves to our Division 42 community. As mentioned in the previous IP, this endeavor helps us to understand a little about how members see themselves contributing to the Division and the field in the general from the perspective of culture. Please send us a statement that describes (1) the culturally sensitive work you engage in, (2) what diversity issues interest you, and (3) ideas for how to make Division 42 more culturally responsive. Statements forwarded to either of the co-chairs may be shared with the rest of the membership. Better yet, join the Division 42 Diversity Committee. Doug Haldeman (Co-Chair) and I are looking for a few good folks to help us establish and further diversity-related goals for our division. We look forward to hearing from you.

Michi Fu is Member-at-Large & Diversity Committee Co-Chair. Correspondence regarding this article can be send to Michi Fu, Ph.D. at drmichifu@gmail.com. Doug Haldeman can be reached at: Doughaldeman@aol.com.

Mark Your Calendars!

Division 42’s Fast Forward 2015
Join us at the fabulous Hard Rock Hotel Chicago October 2-4, 2015
Details to follow on the Division 42 website www.division42.org
The Forensic Psychology Committee began in 2010. Our mission has been twofold: 1) to increase member benefits in the area of forensic psychology for those who are already members of Division 42, and 2) to encourage forensic psychologists who are not currently members to join Division 42. In addition to all the other member benefits of the division, we continue to work on a number of initiatives that will specifically focus on forensic issues.

Our third annual conference, “Psychological Assessment, Ethics, and Expert Testimony” will be held in Silver Spring, MD (a suburb of Washington, DC) on May 1-3, 2015. The first two forensic conferences (2013 in Miami, 2014 in Chicago) were received quite well. We gained approximately 75 new Division members from those two years and provided excellent training in mental health law issues from a diverse group of nationally-known forensic psychologists. Please go to www.regonline.com/division42forensic2015 to view this year’s conference. We hope to see you there.

Division 42 and Division 41 obtained a CODAPAR (Committee on Division/APA Relations) grant from APA to work on a joint project, the Forensic Practitioner’s Toolbox, a website designed as a resource for psychologists and other mental health professionals to learn about Forensic Psychology as a field and area of practice. Topics include: Ethics and Professional Issues, Cross Cultural Issues, Competency, Criminal Responsibility, Personal Injury, Assessment of Testamentary Capacity and Undo Influence, and Family Law. You can access the Forensic Practitioner’s Toolbox at www.forensictoolbox.com. Steve Walfish and Bill Foote were co-chairs in this endeavor.

We have begun to initiate a Forensic Consultation Program, chaired by David Shapiro. The purpose is to have a senior forensic practitioner on-call each month available to consult on forensic cases, forensic ethics, and forensic practice building issues. We are currently looking for volunteers for those interested in providing the consultation services for a month. Please contact David Shapiro at psyfor@aol.com for more information.

I have appointed Steve Bloomfield to serve as the Advocacy chair of the Forensic Committee. He represents forensic interests in the Division’s Advocacy committee but he and I will also meet with Division leaders to discuss how best to: a) facilitate forensic practice mobility across state lines, b) helping modify state licensing laws regarding the practice of psychology that takes into better account the nature of forensic practice (such as record keeping requirements, consent forms, release of data, etc.), and c) minimize ethics/licensing complaints and civil suits against forensic practitioners, particularly in regards to parenting/custody evaluations.

We have approximately 15 members from Division 42 have thus far volunteered to get involved to help with what we are attempting to accomplish. They comprise the Forensic Committee. If you would like to help, please contact me and let me know what area of forensic practice would be of most interest to you. You can call me with any suggestions or questions. I can be reached at BFlumkin@aol.com or at 305-666-0068.

I. Bruce Frumkin is Chair, Forensic Psychology Committee, Division 42.
Search for Associate Editor of *The Independent Practitioner*

The Associate Editor (AE) assists the Editor in the development of quarterly issues of the Bulletin. This includes the solicitation of articles appropriate for the Bulletin, review of submissions to be considered for publication, and proofreading the galley proofs just prior to the publication of each issue. The AE may also write Editorials that will appear in the IP.

It is the charge of the Editor and AE to make the Independent Practitioner (IP) a publication of excellence that Division 42 members will want to read, find useful in their clinical and business aspects of their practice. While final responsibility of the content of the IP lies with the Editor it is expected that the Editor and AE will develop a collaborative and close working relationship to produce an outstanding resource for Division 42 members.

The AE will also participate in Division committee meetings. These may be directly related to the IP, as well as other publication and communication outlets of the Division. In addition, the AE will participate in Division Board meetings as a nonvoting member. If funds are available they may attend the Division Mid-Winter meeting.

This is a volunteer position and runs for a three year term. It is expected that the AE will become the next Editor of the IP at the conclusion of the three year term, though the responsibility for this decision lies with the Division 42 Publications and Communications Committee. The position of Editor does carry a small stipend.

Those interested in applying should send a Statement of Interest and a copy of their CV to Jeannie Beeaff at Div42apa@cox.net

**Candidate Statements**

The Division asks its candidates to answer the following questions within the statement.

1. What has been your history of service to Division 42?
2. What experience have you had relevant to the position you are seeking?
3. What are the most critical issues confronting independent practitioners?
4. How do you propose that Division 42 address these issues?

**President-elect (one to be elected)**

**Norman Abeles**

First let me thank those of you who voted for me a while back when I ran for APA president (and won) I hope you will vote for me as your incoming Division 42 President. So—what have I done for Division 42? You may remember that I commissioned a brochure on “What the Practitioner should know about working with Older Adults” which was later published in Professional Psychology. Over 7000 of these brochures were printed.

At the February 2015 meeting of the Council of Representatives which met in Washington DC I attended a meeting held by the APA Practice Organization (APAPO). I heard updates on unnecessary physician supervision required in Medicare programs and exploring legislative options to address reimbursement for psychologists through this program.

I think our Division needs to address three crucial and related issues facing practitioners:

1. Declining incomes from independent Practice
2. Difficulty in providing psychological services because other (often unlicensed) individuals provide such services at lower costs.
3. Lack of sufficient detailed information as to access and availability of other marketable psychological activities

For points one and two we need to work closely with APAPO. For point three, We need to provide further information and education to those of our members who seek to expand their practicet. For example, what additional activities are available to practitioners? These include performing competency evaluations, custody assessments, forensic assessments (note Dr. Frumkin’s workshops), fitness assessments, pediatric child and adolescent assessment, pain management, group therapy in prisons, feminist therapy, developmental disability work, LGBT issues, Ethnic minority and cultural issues, and so on. I will present a plan to access additional part time psychological work in the practitioner’s general area of residence with the help of volunteer psychologist consultants on our website. Feel free to contact me at abeles@msu.edu and please vote.
I. Bruce Frumkin

It is an honor to have been nominated for President-Elect. I completed my Member at Large term last year. Currently I am the Forensic Psychology Committee Chair. I consider the Division my home and have spent easily more than 100 hours yearly organizing the two Psychology and Law conferences as well as other projects. The forensic conferences brought in $33,000 in revenue and approximately 75 new members. A third conference is scheduled for May. In determining for whom to vote, consider my track record of contributions to the Division as well as spending all of my professional career involved with private practice. I will devote time and energy needed to our Division.

I have been in the independent practice of psychology since 1982 and hold memberships in three state psychology associations (Illinois, Florida, Pennsylvania). I am a Fellow of Division 42 and hold a Diplomate in Forensic Psychology from ABPP.

I finished my second three-year term at APA Counsel representing the Florida Psychological Association in 2013. I was Chair in 2013 for the Caucus of State, Provincial, and Territorial Representatives (CSPTR) and was previously Chair for the Caucus for the Optimal Utilization of New Talent (COUNT). In 2013 I finished my final year as a Commissioner for the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). I have served as the liaison to the Committee for the Advancement of Professional Practice (CAPP) for Division 41 and earlier represented large and medium-sized state psychology associations for the CAPP Integration Group. I have been President of the Florida Psychological Association.

I will bring a fresh voice to the practice needs of the Division, working on such issues as the expansion of independent practice, parity, fee for service issues, micromanaging by state liscensure boards, interjurisdictional mobility including telehealth, professional liability, standards of practice, and ethics. I believe we can be a force in bringing about change, in part based on us having a strong presence at APA Council and at CAPP, as well as expanding our income revenue sources from beyond what we get from membership.

Secretary (one to be elected)

Lauren J. Behrman

Throughout my 30 years of practice, my energy and involvement with governance and other “extracurricular” professional activities has been balanced by the developmental needs of my growing children. Now, with my youngest child going off to college, it’s time to spread my own wings!

I am currently the incoming Program Chair for the 2016 Convention. I am hoping that this position will allow me to develop and deepen my relationships with the amazing wealth of dedicated, committed and talented colleagues in our division. I’m also a Fellow of our division and Division 29, and I’m currently serving on the Fast Forward Steering Committee for the 2nd time.

I have had a great deal of experience in organizational governance, having founded the New York Chapter of the Association of Family and Conciliation Courts, serving as its first co-president, and on the Board of Directors for over 10 years. I also served two terms on the Board of Directors of the New York Association of Collaborative Professionals. I was one of the first Mental Health professionals to join what had previously been a board composed solely of attorneys, and on the small steering committee that supported the organization’s transition from an attorney-only organization. As an active member of the Training Committee, Professional Standards Committee, and Protocols Committee, I have been involved in policy-making decisions, strategic planning, training, and conference planning.

The most critical issue facing independent practitioners today is how to build and sustain thriving practices in the face of economic uncertainty, Obamacare, and growing competition in the marketplace from other mental health professionals. We need to use the wealth of skills we have acquired, find the areas of practice that inspire us, and learn the necessary entrepreneurial skills to effectively manage our independent practices. These were not the courses offered to me in graduate school, but the life lessons I learned in my 30 years since graduating my PhD program. We have so much to offer one another!

I see Division 42 positioned as a home for Independent Practitioners across the spectrum of our careers and as our professional community.
Michael E. Schwartz

It has been an honor to serve Division 42 as Secretary these last three years and I am excited to be nominated for a second term. I have been actively involved with Division 42 since January 2005 and I have been a vocal participant as a member and leader asking difficult practice questions while always remaining open to learning from my colleagues and teaching others what I have learned.

Since I was elected as the first ECP Board Rep in 2008, Member-at-Large in 2011, and Secretary in 2012, I have been involved in various Division governance and mentorship projects. These include increasing and retaining our student and ECP membership through specialized programming, making policy and financial decisions for the Division, moving us forward with technology/social networking innovation, organization and participation of educational programs focusing on the “nuts and bolts” of business of practice, assisting in the coordination and implementation of each of our Fast Forward conferences, being active on the Membership Committee, co-chairing our revised Mentorshoppe program, and fund raising for the division.

The Secretary position has allowed me to better serve the membership via the Executive Committee and the full Board of Directors. I have been involved in the lengthy project of reviewing and editing our Policy and Procedures to ensure that we are in compliance with our By-Laws. I am looking to have a revised and up-to-date manual by year’s end. I am working with the board in increasing transparency by making our Board Minutes accessible to members on our website.

I remain committed to Division 42 and shaping our role in advancing the needs of psychology by continuing to support the necessity of doctoral level psychology, the expansion of scope of practice through prescriptive authority without sacrificing our theoretical, historical, and multi-cultural roots, continuing to provide leadership, mentorship and support for all psychologists, and creating collaborative and sustaining relationships with other psychology organizations.

I am excited about Division 42’s future. There is much we can accomplish and I look forward to doing that together. Thank you for your consideration.

Member at Large (one to be elected)

Bruce D. Nystrom

I am running for the Division 42 Board of Directors as an at-large member. While this would be my first formal work for Division 42, I have been a ‘lurker’ for some time. I have been in independent practice for thirteen years plus another ten years where I essentially functioned as an independent practitioner within the context of a not-for-profit organization. I have also been the Federal Advocacy Coordinator for Kansas for some fifteen years, the representative to the APA Council of Representatives for KPA for five years, twice been President of the Kansas Psychological Association, and been the chair of the KPA legislative committee. I am just starting my tenure as a member-at-large of the Division 31 Board of Directors. I feel that I bring a depth and breadth of experience that qualifies me for this position.

I feel strongly that the critical issues for independent psychologists lie in our relationship with other professions and our participation in the larger mental health system. After several years of other, less well trained professions either attempting or actually making incursions into restricting our scope of practice or at times equating our scope of practice with theirs, as a profession independent psychologists need to create more separation between what it means to be a psychologist trained at the doctoral level and those professions with a master’s degree. I would like to see Division 42 work with others toward enhancing our doctoral training programs and internship training. Of course active support of efforts at the state level to promote and protect licensure issues is an area where I feel Division 42 can act as a support. Perhaps Division 42 could assist in the efforts to make psychology a STEM discipline. Of course promotion of state prescriptive privileges would strategically place psychology on a level playing field with medicine and other allied health professions. I see Division 42 being able to work effectively on these issues while maintaining its strong history.

David L. Shapiro

History of Service to Division 42: I have served as Member at Large since 2013; in that position I write a regular column for our Newsletter on Professional Issues and Malpractice; I have also set up a forensic consultation service for those members needing input on forensic matters.

Experience: prior to my service on the Division 42 Board, I have had
extensive involvement with APA and other psychological organizations: member APA Ethics Committee 1994-1996; Chair of Ethics Committee American Board of Professional Psychology 1990-1994; Member at Large APA Division 41 1998-2000.

Critical Issues: I support the involvement of psychologists in a broad range of activities, but am concerned about the degree of training many people have before embarking on new ventures; I see many examples, especially in the courts, of poorly trained psychologists rendering opinions without having adequate training in a specialty area, resulting in harm to the people involved.

Ways of addressing these Issues: I believe Division 42 is in a unique position to coordinate Specialty Guidelines in a variety of areas of clinical practice and I would be glad to help in this project. We previously had Niche guides and I would like to bring these up to date and expand them.

Diversity Member-at-Large (one to be elected)

Lindsey R. Buckman

I would be honored to serve as the Diversity Member at Large for Division 42. I am an independent practitioner in Phoenix, Arizona; where I serve a diverse client population with specialties in LGBT concerns and multiple minority status issues. I currently serve as the Division 42 Co-Chair for Social Media and I am a member of the Division 42 Advocacy Committee.

In addition to my service to Division 42, I also serve on the Committee for the Advancement of Professional Practice (CAPP) as the Early Career Psychologist (ECP) member. I am the Division 31 ECP Task Force Chair, and I serve as my SPTA's Legislative Chair. My commitment to diversity is both personal and professional. As a female, lesbian, early career psychologist, and small business owner both the personal and professional are political. I am a strong advocate for my clients, students, and fellow professionals and strive for fairness, equality, and to cultivate a space for the rich perspectives that diverse issues and experiences bring to the table. I have experience in shaping public policy, as well as creating resources to expand the attitudes, knowledge, and skills of psychologists working with diverse populations.

Independent practitioners are facing a number of challenges. Reimbursement rates for services are low, increasing numbers of masters level practitioners are entering the field, we have an aging population of leaders and struggle to attract ECPs to serve in governance, and we have the challenge of creating innovative practices that can compete in the evolving healthcare marketplace. I would like to assist Division 42 in creating innovative practice resources that support psychologists in independent practice and help them thrive in the marketplace, while enhancing and protecting our status as the highest trained mental health practitioners in the field. I would like to create business of practice resources for ECPs, which will help attract a new generation of psychologists to Division 42. In addition, I would like to collaborate with APA Divisions that focus on issues related to diversity and develop resources for independent practitioners, which support personal and professional identity as well as cultivate leadership.

April Harris-Britt

Dr. April Harris-Britt received her doctorate in Clinical Psychology from the University of North Carolina at Chapel Hill in 2003. She currently owns a multidisciplinary private practice which focuses on promoting mental health and wellness for children, adolescents, adults, and families from diverse backgrounds. She provides a wide range of services including psychological testing, forensic services, and therapy for individuals with developmental disabilities/autism, trauma and abuse issues, family conflicts, and mood disorders. Her main research interests focus on understanding how culture and race impact the assessment and treatment of childhood disorders; and promoting resilience against trauma and victimization (e.g., IPV, abuse, racial and gender discrimination).

This is Dr. Harris-Britt’s second year as a member of Division 42. She has been active with NCPA since she was a graduate student, having served on the Student Academic and Standards and the Public Sector Committees. Dr. Harris-Britt previously committed several years in various positions for APA Division 12, Section 6. Most recently, she was a member of the APA Committee for Professional Practice Standards (COPPS) for three years, including as Chair from 2013-2014.

“Our field is being tested to assert and maintain our professional identity. Independent practitioners must contend with the complexities of managed care and healthcare reform, which have undoubtedly impacted the “traditional” private practice model. It was not until I recognized the unique breadth and depth of my own training and experiences, that I was able to reinvent my practice in a way that has allowed my entire team to fulfill our personal and professional goals. If elected, my three major areas of focus would include advocating for better mental health care for the disadvantaged, providing mentorship and training for early-career psychologists, and encouraging mechanisms that will allow psychologists to thrive amidst the social and political pressures of our society.”
Diversity Representative to Council (one to be elected)

Armand R. Cerbone

I wish to thank my colleagues in Division 42 for the trust that this nomination to the Council of Representatives signifies.

During 30+ years of solo practice I have benefitted from Division's efforts to advance and protect practice. This and the Division's mission to supporting diverse and multicultural psychologists like myself have earned my loyalty to the Division. I have served as a member-at-large on our Board, as chair of its Diversity Task Force, and as chair of the program mentoring senior members seeking ABPP certification. I know well the aspirations and operations of the Division's leadership and members.

From 10 years on Council reviewing, crafting and lobbying especially to promote appropriate care for marginalized groups I possess a solid grasp of Council's workings. Those years included a term on the APA Board of Directors. As president of the Illinois Psychological Association, I proposed mandatory CE's for psychologists that is now law, made RxP its first legislative priority that is also law now, and, as its first out-gay president, fostered diversity in leadership. I presided over Division 44 (LGBT Psychology) and am president-elect of Division 29 (Psychotherapy). Having chaired several boards and committees, most recently the APA Ethics Committee, I have a thorough knowledge of APA governance. I have received awards for advancing diversity, including recognition as an Elder at the National Multicultural Summit this year. Finally, I am a Fellow of seven divisions, including Division 42.

It is vital to our interests that, as APA forges major structural change in governance, the Division sends strong voices to shape those transformations. As an appointee to the working group that drafted the first iteration of those changes, I enjoy experience that would bring balanced judgment to the process and a love of psychology that is informed by wide and deep experience.

Your vote would allow me to represent the interests of independent practitioners in general and diverse psychologists in particular in Council.

Regardless of the election’s outcome, I will be faithful to the best interests of the Division and the advancement of psychological science for the welfare of all people.

Michi Fu

I am the current Member-at-Large, Diversity Slate of Division 42. I've also recently been appointed as co-chair of the Diversity Committee. I've held various leadership positions for state and national psychological associations to help prepare me as an advocate on behalf of our organization, including the following: APA's (1) Division 31's Diversity Chair, Diversity Member & Blog Coordinator & OEMA Alliance Representative, (2) Division 45's Member-at-Large, Asian Slate and 2015 National Multicultural Conference and Summit Coordinator, (3) Asian American Psychological Association two-time past board member & Executive Task Force of Social Justice & Advocacy Chair, and (4) California Psychological Association's Governmental Affairs Committee Co-Chair and Secretary.

Some of the most crucial issues I hope to address as a council representative confronting independent practitioners are:

Protecting and expanding our reimbursement rates by helping the public and key decision makers of the value of our doctorate level services. Public education can lead to increased awareness. I’ve served on California Psychological Association's Public Education Campaign since 2010 and have enjoyed seeing the impact of “giving psychology away” in order to help the public see us as a household name. Through such avenues, we can help others realize what psychology has to offer, thus reducing the trend towards cutting our reimbursement rates.

Protecting our scope of practice by observing related disciplines and their intentions to practice mental health services. Making available to colleagues from related fields the most current information regarding best practices. Also serving as advocates to ensure public safety when minimum standards of treatment may be threatened. I’ve served on my state association’s governmental affairs committee and believe that we can combine our voices as practitioners to advocate on behalf of our profession and public safety.

Ensuring best practices, especially for our emerging diverse communities by understanding the impact of culture on traditionally approved treatment approaches. Examining how empirically validated treatments may or may not be the best fit for all those whom we serve. Instead, encouraging sharing of resources for how to optimally work with diverse clientele.
Division Representative to Council (two to be elected)

**Todd Finnerty**

I first became interested in the activities of the COR in 2012 when policies were proposed which I thought would have a negative impact on many current and future psychologists. I’ve followed the activities of the COR ever since and I’ve tried to educate my fellow members about their activities. This past year I even had the benefit of being subscribed to the COR’s own listserv; this was a benefit extended to me while I was running for APA President. I’ve followed the listserv conversations of the current COR members and this puts me a step-ahead of the other candidates. I’m aware of the issues currently being debated by COR and can hit the ground running.

Independent Practice is alive and well, but there are threats to it. Unfortunately, some of the critical issues confronting us come from otherwise well-meaning APA leaders who advance policies in the APA Council of Representatives (COR) which can make it harder for us to succeed. Division 42 can address this by supporting practical and rational policies which serve to increase opportunities for Independent Practitioners, not reduce them. Any proposed innovation should also allow Independent Practitioners to succeed. It’s imperative that the voice of Independent Practice remains bold and strong at the COR.

I joined Division 42 in 2012 after Dr. Keely Kolmes tweeted about it. I’ve worked for myself as an Independent Practitioner for over a decade. Division 42 is the only APA division I’m a member of. Like many of my fellow members, I’ve benefited from Division 42’s excellent listserv; I hope that I’ve been able to give back by being helpful to other members on the listserv as well. In the past I’ve done my best to help Dr. Pauline Wallin on the Division 42 Public Education & Marketing Committee and Dr. Gordon Herz on the Division 42 Internship Consortium Task Force. I volunteer on APA’s Public Education Campaign as the Public Education Coordinator for Ohio. In this role I also serve on the Board of Directors of the Ohio Psychological Association. You can learn more by going to www.toddfinnerty.com and twitter.com/DrFinnerty

**Russell M. Holstein**

After serving on the New Jersey Psychological Association Council on Legislative Affairs which ultimately put me at NJPA Board Meetings, I was asked by Stan Moldawsky to serve on a new endeavor, the Interdivisional Task Force on Managed Care and Health Care Policy. My activities here focused my interest on the question, “How can independent practitioners survive and even thrive in a hostile payer environment?”

My research and work with the Task Force informs me. We must think of those who need our services. Many face insurmountable access problems. If they don’t find us we don’t survive and they don’t receive needed help.

As I write this I see a Wall Street Journal article entitled “Where Are the Mental Health Providers?” It mentions a shortage of mental health clinicians.

We know that the “shortage” is manufactured by insurers and my data certainly proves it. In my state, 23 and 26% of psychologists participate in the two largest insurance plan networks. Despite the law requiring mental health parity, insurers have used low fees and other harassments to reduce in-network participants. This vitiates parity law gains.

I see inadequate access to mental health care as the single most important issue for Division 42, APA and its constituencies to press via legislation and litigation.

I wish also to press for new directions to help our membership. I would like to see Division 42 providing consultation to members about how to deal with practice issues such as, insurance concerns, business of practice Q & A and more business of practice programs at APA, Fast Forward and offering expertise to our state associations. I would like to see more boldness in dealing with issues that come to the line, but do not cross it with regard to anti-trust. I see us as being too timid in testing how far we can go to help each other. For example, I have negotiated fees for my practice with some insurers. This is legal. But I have been shut down at APA in offering my expertise to others, even in other states, who are not my competitors.

**Thomas M. Kozak**

As a Private Practice Psychologist since 1982, I am honored to be nominated to represent DIVISION 42 on the APA Council of Representatives. I have written for the Private Practitioner even made one of your videos. I have helped many of our listserv members with surviving audits, petition for higher payment by MCOs and compose a properly worded Medicare Opt Out letter.

Having previously been a Director of a MCO mental health division, I can discern good from bad practices and guide us through manipulative policies MCOs use to reduce reimbursement. Having been a SPA legislative officer, I am...
familiar with both the legislative process and the carefully crafted language necessary to survive these waters.

Today Psychologists face wage reduction relative to the economy, encroachment by courts using our records as a kind of “free discovery” to impugn those we help, a failure to define ethics in a manner that also protects us. We must protect language in our states’ practice acts without which our ability to provide services would be threatened. We must work to correct recent changes to CPT codes where the full session psychotherapy has been compromised and at least one MCO has used this change to reduce our income by disallowing full sessions via this awkward revision. In addition, we lost a code for longer term therapy for PTSD cases. This should be restored.

Having completed a Psychopharmacology program I am a strong supporter of RxP Privileges for psychologists but consider this sub-specialty no more important than all the other services we provide. My first love remains psychodynamic psychotherapy.

I propose, as DIV 42 members, we use the representatives’ role to start asking the right questions to the APAPO and press for solutions and action whether legally or through other forms of influence. They want our financial support, we want direct answers. The APA is the most powerful organization we have. We can’t afford to lose any more members. We are the organization and it’s time to wake up, DIV 42 members. Remember when the public thinks of psychologists, they think of us!

Peter M. Oppenheimer

I am honored to seek election as Council Representative for Division 42. Independent practice is at risk. Changes in our healthcare system will greatly impact how and how many professional psychologists will be able to in the future. Division 42 must aggressively represent the interests of psychologists in independent practice in all realms of APA and APAPO governance. Our Representatives must speak for concerns of our membership at Council. It is imperative that APA, APAPO, practice divisions and STPAs use their resources synergistically to address the threats to our future and help psychologists create new opportunities. We must not allow the APA to be tangled in internal association issues.

I currently serve on Division 42’s Advocacy Committee and as our Liaison to the Board of Professional Affairs. I am serving my second term as President of the Rhode Island Psychological Association. I have lead RIPA’s legislative advocacy since 1998. I am also a member of Division 31 (Secretary), Division 55, Division 56 and the Massachusetts Psychological Association.

I have served on Council as the Representative of the Rhode Island Psychological Association. During my term I served as Chair of the Caucus of State Provincial and Territorial Representatives, the Rural Health Interest Caucus and the Very Small Caucus. I advocated for the inclusion of all of APA’s constituencies in governance, and for APA to do better addressing the needs and concerns of all its constituencies. I also advocated for the protection of the CAPP Grants in 2011 when funding was threatened by committee members. Subsequently, I served a term on the Committee for the Advancement of Professional Psychology (CAPP) where I advocated for CAPP to become a solely C6 Committee of the APAPO, more transparent and to its elect members by direct election as is happening this year.

I have been in independent practice for nearly 30 years, and I am currently leading Rhode Island’s statewide innovative practice strategy where we seek to enhance the role of independent professional psychologists in healthcare reform. Thank you for your consideration. For more information please link to: www.fopsych.com/Div42-COR2015.oppenheimer.pdf.

Robert J. Resnick

Division 42 has been my home for years and have held both elected offices: President, Member-at-Large, and three terms as Council Representative. And appointed: three task forces, several invited contributions to the Independent Practitioner and authored the Division’s niche guide on ADHD. I was honored by our division as its Distinguished Psychologist of the Year and, also, by the American Psychological Foundation’s with its Gold Medal for Lifetime Contributions to the Practice of Psychology.

Similarly, I have been quite active in APA: elected to Board of Professional Affairs, Committee for the Advance of Professional Practice (CAPP), the APA Board of Directors, and APA President. As a former Council representative from Virginia and former President of the Division of Psychotherapy, I view Council’s many intricacies, from a state, psychotherapist and independent practice perspective.

At this moment in time, we are challenged from within and without. From without: Integrated care mandated by the Affordable Care Act, psychological primary care, reimbursement and our Medicare identity are issues that impact the
very core of our practice. Additionally, with passage of the Illinois RxP bill, the prescriptive authority movement needs much more attention and support.

From within: APA is in the germinal stage of a massive reorganization of Council and the Board of Directors and the associated allocation of responsibilities. The Council is in the first of a three-year trial of reassigned roles and duties that will require multiple by-law changes to become permanent. If, passed, they will significantly alter the checks and balances of Council, the Board of Directors and the relationship of APA to its members. One example: APA members would elect directly some of the Board of Directors in addition to the president. The need for experienced Council representatives will be crucial during this experiment that may alter the size and function of the APA governance and related costs.

I seek re-election to Council to represent you in addressing these challenges. I pledge to protect, defend, and enhance the practice of psychology while providing a reasoned, fiscally tempered approach to next iteration of the APA governance. Thank you for your support.

Lenore E. Walker

As one of six currently elected Division 42 representatives to the APA Council of Representatives, I am asking for your vote again, to serve another three-year term. I have been on and off the Council for the last 35 years and understand both the goals and politics of the organization. I have loved working with our other representatives these past three years and believe we have made significant contributions to the reorganization efforts by standing strong for our needs as practitioners.

Council is the policy-making arm of APA and without a continuous voice for practice, we will not be part of important policy-making efforts. I can provide that strong voice adding history to the forward-looking policies necessary to compete in the health care world today. The changing role of the APAPO, which is our advocacy organization for practice, leaves a gap in APA that Division 42 along with the other practice divisions must fill. Psychologists’ provision of health care services is at a critical time as all health care delivery struggles to become a new system under the Affordable Care Act. The APA as well as the APAPO can assist in this process. We need to develop new training curricula to meet these needs, which the APA Council will review as one of its major policies. How best to use the resources of the APA to help with public education is another policy topic that Council will be undertaking.

I am currently a Professor of Psychology at Nova Southeastern University’s Center for Psychological Studies where we train both Ph.D. and PsyD psychologists. Prior to this academic position in a professional school, I was in full time independent practice of psychology for twenty years. I continue a small, part time practice of forensic psychology and consulting, where I travel internationally speaking about psychological services for those who have experienced gender violence. These activities keep me in touch with what practitioners in the field need to continue to provide excellent services to our clients and patients. Please vote for me, Lenore Walker, as Council Representative when you get your ballot.

Student Representative (one to be elected)

Sam Marzouk

I am currently finishing up my third year at the University of Tulsa clinical psychology PhD program. I first joined Division 42 in the fall of 2013. Joining the division provided me with access to knowledge and information that has not been and will never be covered in my graduate training program.

From observing the unfolding conversations on the listserve to engaging in insightful discussions with my Division 42 mentor, I feel as though I now have a broader arsenal of knowledge pertaining to practical issues of clinical psychology practice.

In the spring of 2014, I joined the early career psychologist and student (ECP/S) committee. With fellow students and ECP’s, I have worked to help improve Division 42’s student and ECP community. Currently, I am heading a task force within the committee that will reach out to students in doctoral programs across the nation as part of a large scale student recruitment effort. Through this recruitment effort, I hope to recruit as many students as possible from across the United States to join our division.

There are many critical issues confronting independent practice today. Most notably, I see the field of clinical psychology moving further toward an integrated care model. From an independent practitioners (IP’s) perspective, more information should be available for how IP’s can both adapt to and create their own practice embedded in this model.
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