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Women's Perspectives and Lives

Valerie B. Jordan, PhD

The range of diversity among women and the broad scope of personal and professional issues affecting women continues to evolve and expand. Changing demographics, economics and social policy (among many issues) affect our knowledge and our interventions with women across treatment, work and personal settings.

The articles in this issue reflect a sampling of professional perspectives. First, Dr. Rachel Casas and Dr. Anastasia Kim address the intersection of gender and race as they impact women of color in psychology and offer some practical solutions such as mentorship, supportive networks and leadership pipelines to foster their professional journey. Next, Dr. Tomoe Kanaya and Gabriela Grannis discuss the challenges many young adult women face when looking ahead to their future lives and the challenges of work-live balance. They remind us of the consistent evidence that maternal employment is a viable necessity for many women and that in spite of myths to the contrary, does not impair their children or family's well-being. In fact, it is the many consequences of poverty and other social injustices that have more harmful effects on women and families than does a woman's employment status outside the home. Next, Dr. Susan McDaniel and Dr. Nadine Kaslow describe essential leadership skills and the many talents that women often bring to leadership roles, as they have both so eloquently demonstrated in their professional careers. Then Megan Reuter, MA reminds us about the importance of a social justice perspective in working with women who have experienced persistent poverty and how incorporating a broader system perspective can enhance our clinical work with them. Finally, Dr. Cary Watson addresses certain elements of the DSM-5 that impact diagnosis and treatment of women, specifically the inclusion of gender-specific information associated with all disorders, as well as both welcome updates and ongoing controversial areas.

I want to thank all the authors who participated in the open call for feature articles for this issue. This was the second time we adopted this process for the magazine, and I hope that this has expanded opportunities for authors who might not have had the opportunity to submit articles for consideration. While space limitations are a reality, I hope this process will continue on an occasional basis so that more voices from our professional community are heard. ■

FROM THE EDITOR

Valerie B. Jordan, PhD
(editor@cpapsych.org) is Emerita Professor of Psychology at the University of La Verne from which she retired after 30 years of graduate teaching, program administration and clinical supervision. She served on the CPA Ethics Committee and is currently on the CAPIC Board of Directors.

BE SURE TO CHECK OUT

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Share your expertise with your peers. The Call-for-Papers for CPA's 2015 Convention is a perfect opportunity.

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Hot topics in Ethics and Risk Management in Practice — Northern and Southern California in November. Watch for details and registration.

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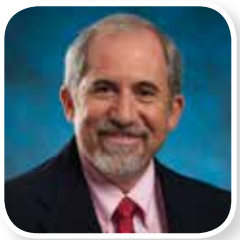
Help us thank our members who are PAC contributors and supporters. If you would like to join this generous group, let us know.

The Perks of our Profession

Robert deMayo, PhD, ABPP, 2014 CPA President



Robert deMayo, PhD, ABPP
(rdemayo@pepperdine.edu) is a licensed psychologist and board certified diplomate in clinical psychology. He is Associate Dean and Professor of Psychology at Pepperdine University, and maintains a private practice in Santa Monica.

Many years ago while in graduate school, I heard an instructor announce the first day in class, "Always remember, one of the true perks of being a psychologist is having the opportunity to reflect deeply on important psychological issues. That is a privilege afforded to relatively few people on this planet, so treasure the chance you have to learn." At the time, I thought it was a lame means of trying to motivate us to do the assigned course readings. However, with the benefit of perspective, I have come to see the wisdom in her statement. Our work as psychologists can be difficult and demanding, but it is also profoundly rewarding if we retain our passion to learn and grow. In that spirit, I am very excited that this edition of *The California Psychologist* focuses on Women's Issues. Regardless of the client populations you serve, you will find much information of relevance for the important work you do as a psychologist. I hope these articles will stimulate self reflection, productive dialogue, and remind all of us how fortunate we are to be in a profession that allows and requires us to learn something every day.

This quarter has been an eventful one for the California Psychological Association. In March, at the APA State Leadership Conference in Washington, D.C., CPA was named the Outstanding State Psychological Association in recognition of our efforts to advocate for Psychology in California, recruit student members, and successfully streamline our governance structure. Upon sharing the good news with our Board, I was asked by someone apparently accustomed to the current practice in children's sports of handing out trophies to everyone who participates, how many states got the outstanding award? I am happy to assure you that California is the only state, province, or territory that won the award this year!

Our good news in March was followed by a successful Annual Convention in Monterey, California, April 10th through the 13th. The theme of the conference was Innovative and Inspiring Practices in Psychology, and our presenters lived up to the theme. Attendance was strong, feedback from attendees was extremely positive, and we enjoyed an exceptionally high turnout among our student members – a very encouraging sign of our ability to engage the next generation of psychologists in our association. The CPA-PAC dinner broke records for tickets sold, and created wonderful momentum for our advocacy efforts. Most importantly, in this day of ready access to unlimited amounts of online information, the convention reminded many of us of the benefits of an interactive educational experience. In our post-convention wrap-up, our convention committee agreed that we wish to build on the successful interactive educational experiences at this year's convention and find ways to promote even more engagement at next year's convention.

In closing, I want to mention that the implementation of the Affordable Care Act makes this an extremely important time for all health care professions. There will be many struggles ahead which require effective advocacy for Psychology and the issues we care about. CPA is the only organization that protects your ability to practice in California. Your membership dues support our advocacy on behalf of our profession and allows you to earn up to 12 CE credits for free. Many of your colleagues may tell you they cannot afford to belong to CPA. Please remind them that if they value the right to practice in California, they can't afford to sit this one out. Thank you for your ongoing support of CPA! ■

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The Issue of Women

Jo Linder-Crow, PhD

Pick up a magazine, browse book titles, or do a Google search on women and you will find an abundance of information, advice, and food for thought. Sheryl Sandberg's 2010 Ted Talk entitled "Lean In" has now more than four million views and has sparked a worldwide movement of Lean In "circles" where women come together to talk about their experiences at home and at work. The cover story in the May issue of *The Atlantic* was about the "Confidence Gap" with the story suggesting that a mystifying lack of confidence is the dominating factor that holds women back. A personal friend has just completed a book on the complex roles of working and stay-at-home mothers, and my daughter tells me that a book entitled *Overwhelmed: Work, Love, and Play When No One Has the Time* is worth a read.

This issue is about Women. What is it like to be a woman student trying to navigate choices about work-life balance, a woman of color in the field of psychology, a woman in our society struggling to make ends meet, and/or a woman leader in psychology? What changes in the DSM-5 might have an impact on women? The authors for the issue have offered their perspectives; we hope you will use the issue within your own circles to enrich your discussions.

On other fronts at CPA, we are preparing to transition to a new database system and a new website design over the next few months. Technology moves on, and this new platform will allow us to create a more user-friendly site that will encourage all of you to be an active part of our online communities. There will be ways for you to interact in more robust ways with your colleagues who share your particular interests, and more options for you to get the information you want, when you want it. Stay tuned!

As we enjoy the summer I hope you will continue to tell with your colleagues why you believe CPA membership is valuable. We need your support and help in continuing to build CPA's membership so that we can continue to vigorously represent psychology. Please, pass the word, and thank you for your membership. It means a lot! ■

Jo Linder-Crow, PhD
(jlindercrow@cpapsych.org) is the Chief Executive Officer of the California Psychological Association. You can follow her on Twitter at http://twitter.com/jlccpa. You can "like" CPA on Facebook at www.facebook.com/cpapsych, and join the CPA Linked-In group at www.linkedin.com.

IN MEMORIUM

Paul Clement, PhD
1975 CPA President

Thank you for your service
to the profession of psychology.

MARK YOUR CPA CALENDAR

07/18/14 ..... *Santa Clara County* – Cyber-Bullying: Identification and Intervention

September ..... *CPA Board of Directors Election* – more information in the Fall issue of *The California Psychologist*.

09/11/14 ..... *Redwood Empire* – Dreaming on the Job

10/11/14 ..... *San Diego Psych Assn* – Annual Fall Conference

10/18/14 ..... *Los Angeles County Psych Assn* – Annual Fall Conference

10/25/14 ..... *CPA Fall Board Meeting* – Westin, San Francisco

11/8/14 ..... *CPA and The Trust* – Hot Topics in Ethics and Risk Management in Psychological Practice, San Diego

11/15/14 ..... *CPA and The Trust* – Hot Topics in Ethics and Risk Management in Psychological Practice, East Bay

FEATURE

Double Disadvantage or Social Invisibility?

Toward Recognition and Support for Women of Color in Psychology

Rachel Casas, PhD and Anatasia S. Kim, PhD

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Gender, Social Meaning, and Group Categorization

The social meaning ascribed to gender is not static or universal. How a woman experiences her gender varies based on the social categories or groups to which she belongs, and vice versa. Every woman belongs to multiple social categories, and her social identity both emerges from and is shaped by their interconnectedness. Because social categories differ with respect to relative social status and power, her group memberships are critically important.

According to social dominance theory, social groups embody and reflect hierarchies of power and privilege within society (Sidanius & Pratto, 1999). A group's position within the social hierarchy is related to the allocation of both desirable resources (e.g., prestige, money, healthcare) and undesirable adversities (e.g., stigma), which are unequally distributed and experienced along this social ladder. Consequently, social group membership is associated with a range of meaningful outcomes, including experiences of oppression and discrimination, because the stratification of both material and non-material benefits and hardships is inequitable. Dominant groups enjoy favorable positions within this social stratification by receiving the most rewards and fewest costs, whereas devalued subordinate groups experience the opposite.

Gender, Race, and Psychology

Both gender and race/ethnicity are key categorizations in the social hierarchy. Women are consistently de-valued relative to men, and ethnic/ racial minorities are marginalized and oppressed relative to whites. Although limited, the best available evidence suggests that the effects of gender and racial/ethnic devaluation persist within psychology. For example, the "feminization" of psychology has raised concerns among some members of the profession because, a "field that becomes predominantly female runs the risk of lower salaries across the board" (Willyard, 2011). The gender disparity in psychology is particularly salient in higher education, where women represented just 48% of faculty in U.S. and Canadian graduate departments of psychology in 2009-2010, and only 46% of full-time faculty in these departments (Pagano, Kohout, & Wicherski, 2010).

The data are even more sobering for ethnic minority psychologists. According to the National Science Foundation (2009), 24% of psychology PhDs were awarded to ethnic minority graduates in 2008. However, within U.S. graduate departments of psychology, ethinic minorities represented just 13% percent of the total faculty in 2009-2010 (Pragano et al., 2010). Evidence also indicates that ethnic minority faculty, independent of their field, are less likely to maintain prestigious positions in higher education (e.g., academic rank, institution type) compared to whites (Lee, 2011).

Intersectionality: Women of Color in Psychology

Very little is known regarding the experiences of women of color in psychology; however, their joint social categorizations as both women and ethnic minorities have

led some to believe that they likely experience a "double disadvantage" or "double jeopardy" (Carter, Pearson, & Shavlik, 1969). Intersectionality theorists, on the other hand, have cautioned against an over-simplified, additive perspective. They argue that the experiences of ethnic minority women cannot be adequately or accurately encapsulated by the mere sum of their singular identities as "women" and "persons of color." Instead, they suggest that ethnic minority women are likely to experience "intersectional invisibility," or an inability to be fully recognized by either subordinate group, effectively rendering their voices and perspectives socially silent or neglected (Purdie-Vaughns & Eibach, 2008).

Within psychology, there seems to be at least some indirect support for this idea. To the best of our knowledge, there is no published data regarding objective outcomes (e.g., employment status, wages) for women of color in psychology. There is also a lack of empirical research regarding their subjective experiences as psychologists within the field (e.g., amongst their colleagues, students). We believe this is a critical area of oversight within our field, and we hope that this article will begin to address the "intersectional invisibility" that women of color may experience in our field. We focus now on offering recommendations and strategies that we hope will encourage, support, and give voice to the experiences of women of color within psychology.

Toward Solutions

In supporting the pipeline of women of color in psychology, we need to consider solutions to help with their overall experience, retention, and advancement toward upward mobility. Though limited in research, there are some writings including anthologies that speak to the experiences of women of color in higher education and the multidimensionality of their identities. These narratives offer a number of viable possibilities in supporting and promoting women of color in higher education. These include but are not limited to: mentoring, building supportive professional networks, and opportunities to build leadership.

Mentorship. It has been well documented that mentorship plays an important role in all educational training and certainly in higher education. In fact, mentorship for women of color in higher education cannot be adequately underscored. It is important to remember however that the identity of the mentor in this case is critical. Mentorship is not just mentorship; any old mentorship will not do. Mentorship from other women of color is imperative to successfully supporting women of color in higher education. Such relationships invariably involve being able to relate personally and professionally on the complex intersectionality of identities and experiences. Indeed successfully navigating through predominantly white and male led institutions requires an intimate understanding.

Of course an obvious challenge to this recommendation is the very limited number of women of color in higher education and especially in leadership positions. As such, a necessary mandate in this case is to hire more women of color. To be the sole representative – the "token minority" – of any cultural group in any institution contributes not only to inadequate support but as well to psychological distress and retention risk over time. Therefore, as institutions expand and strengthen their commitments to hiring more women of color, mentorship must be accompanied by supportive networks outside of one's immediate work place.

Supportive Networks. Building supportive networks is a mandate to the success and longevity of women of color in higher education. In Berry and Mizelle's 2006 book *From Oppression to Grace: Women of Color and Their Dilemmas within the Academy*, women of color from various academic disciplines share feelings of not belonging. Having obtained an advanced degree and working in predominantly white and male dominated institutions often result in psychological as well as sociological consequences. Not only are there cultural expectations and stereotypes to contend with in the professional setting, there are also expectations and stereotypes projected from one's personal and social contexts. Due to the multidimensionality of identities as a woman and a person of color living and working in a sexist and racist society, the experiences of women of color are rendered peripheral and vulnerable to invalidation. As such, and particularly in the absence of appropriate mentors within one's immediate work setting, building broad supportive networks is imperative to the survival of women of color in higher education. This can be met through various means including women of color support groups, professional development opportunities for women of color, research on the experiences of women of color in higher education, and of course significant contributions to the pipeline of women of color in higher education.

Leadership Pipeline. The final recommendation is the necessity for leadership pipelines for women of color in psychology. In spite of the fact that women constitute a numerical majority among those with psychology doctorates and the fact that the U.S. will very soon become a minority majority nation, women and people of color, and most certainly women of color, are sorely missing in leadership positions. Within and between the intersection of these identities, women of color are without question discouraged from taking on leadership roles. As such, their invaluable perspectives are notably missing from mainstream awareness and narrative. We must therefore create concrete opportunities for women of color to enter the leadership pipeline. This can be accomplished through various means including diversity training in all leadership initiatives within psychology, local and national leadership academies for women of color in psychology, release time for women of color to participate in leadership roles, and opportunities for women of color graduate students to engage in leadership development.

Ultimately, the success of psychology rests with the diversity of its members. To this end, we hope that this article challenges existing ideologies and practices that hinder this potential. In some small way, we hope these recommendations will contribute to the possibility in which experiences of women of color can be validated, legitimized, and celebrated. ■

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FEATURE

Young Adults and Adolescents:

Not Too Early to Be Worried About Work-Life Balance

Tomoe Kanaya, PhD and Gabriela Grannis

Tomoe Kanaya, PhD
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Gabriela Grannis
(ggrannis@cmc.edu) is the Program Coordinator at The Berger Institute for Work, Family, and Children, which was established in 2001 to be a leading source of research on significant issues impacting the intersection of work and family.

Working at the Berger Institute for Work, Family and Children at Claremont McKenna College, we consistently encounter young, talented and highly motivated undergraduates who express concerns regarding their current and future work-family balance. Comments like "I don't want to go into _____ (finance, law, graduate school) because I won't be able to have a life" or "if I go to grad school, I'll be too old to have kids by the time I am ready for them" are common, even for first-year students.

Indeed, the difficulties of balancing work and family have been well documented. The changing demographics of the American family and workforce (e.g., Americans are living longer and having fewer children) and the changes in wealth distribution such that dual-wage earning families and single parent families have increased made the issue of work-family balance a pressing concern for researchers, policy makers, and the media for decades (e.g., Halpern, 2005). Much of this attention has been focused on ways in which employers can modify their work practices in order to accommodate work-family issues. Comparatively less attention has been focused on the impact this is having on the career choices and mental health of today's adolescents and youth.

The increasingly high prevalence of anxiety and depression experienced by college students is becoming a growing concern among researchers, higher education administrators, and mental health professionals that serve this population. According to the National Institute of Mental Health (2014), women are 60% more likely to suffer from an anxiety disorder than men, so it's not surprising that female students are significantly more likely to be experiencing these symptoms. During college, most students feel pressure to succeed academically, but they are also adjusting, perhaps for the first time, to unfamiliar surroundings, new friends, and new ways of thinking and living. They are also beginning to prepare for their future. For most women, who are biologically limited in their number of childbearing years, this involves thinking not only of their career but also of how and when they might begin to plan for a family.

Students are also bombarded by the social media storm that gives mixed messages of whether to "lean in," like Sheryl Sandberg, or to accept that they "can't have it all," like Anne-Marie Slaughter. Their concerns are further fueled and seemingly vindicated by the predominance of statistics showing that although employers are more flexible than they once were, allowing employees to work from home on occasion or to leave early when necessary, many are reducing options that could provide substantially more flexibility, such as flextime, job sharing, and child care subsidies. In addition, many students may need only to look to their own families for examples of what many studies are indicating: mothers often spend more time with their children and more time multitasking than fathers. A further potential source of students' unease is the knowledge that, all other things being equal in a dual-wage earning family, women still shoulder the burden of housework (Halpern, 2005).

Many researchers (e.g. Gottfredson, 1981) have found that children incorporate work-family considerations as part of their gender socialization development in early childhood. In this study, even the youngest children preferred an occupation that seemed appropriate for their own sex; boys were typically more concerned with fi-

nancial values while girls were more concerned with helping others. It is not until the college years, however, that individuals have the choices and opportunities to make significant career-altering choices, such as whether to select a major that would hypothetically lead to one of the Science, Technology, Engineering, or Math (STEM) fields. Eccles and colleagues (e.g., Frome, Alfeld, Eccles & Barber, 2006) have repeatedly shown that women are less likely to choose these fields during the high school and college years because of the perceived work-family flexibility – or lack thereof – provided by these professions.

More disturbingly, when women do choose these fields (presumably after they have already realized that they are already interested and motivated in this subject area and are aware they will be in the gender minority), they are also more likely to drop out, causing a "leaky pipeline" pattern. Indeed, in their longitudinal study (Frome et al, 2006), 83% of the females who had male-dominated, STEM-oriented career aspirations in 12th grade switched to female-dominated, non-STEM aspirations within seven years. Further analyses revealed that the desire for family-flexible jobs significantly predicted this high attrition rate. After all, if the statistics are correct and working women can reasonably expect to perform the lion's share of child care and housework, they might try to make at least one aspect of life easier by opting for what may be perceived as a more family-friendly career.

Therefore, it is important for those who serve the mental health needs of college students (particularly women) and emerging adults in general, to be aware of the potential work-family stress they may be experiencing as part of their identity and career development. In particular, aspiring professionals with family interests should consider three reliable findings regarding work-family balance (Halpern, 2005).

First, maternal employment does not have a negative impact on their children's development. Parents worry that full-time maternal, or dual-earning, employment means their children will suffer developmental or academic setbacks, but there are effectively no meaningful differences between children of employed mothers and children of mothers who do not work outside the home. In fact, some studies have shown that maternal employment has a positive effect on children.

Second, it is important that children are shielded from the negative detriments of poverty while also being raised in a supportive and loving home environment. More often than not, both parents find that they must work in order to be able to provide a comfortable, healthy lifestyle for their families. This awareness alone is key for positive child development. Working parents, married or not, can focus on creating a supportive, consistent and nurturing environment (whether it is with the parent, another family member, or a child-care provider) for their children while still pursuing their own professional interests and financial stability.

Third, even the most stressful career paths can be work-family friendly if you believe you can control the stressful aspects of it. Identifying the causes of your work-related stress (long hours? unmanageable workload?) is an important first step. Finding a way to navigate these stressful aspects of a job is a valuable skill (ask to work from home one day a week, ask to have more colleagues work on a project so that the workload is more evenly distributed) that can and should be applied to all aspects of life, whether that translates to being a supportive family member, successful student, or productive worker.

Helping individuals navigate and deal with the stress and depression that can accompany a challenging work-life balance during college years might be the best preparation for them as they pursue their profession ambitions after graduation. Furthermore, doing so will also give them the knowledge and tools to provide supportive and nurturing environments for their future children while still working to attain the occupational goals that fulfill them. ■

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FEATURE

Stepping Up to the Plate:
Opportunities and Challenges for Women in Leadership

Susan H. McDaniel, PhD, ABPP and Nadine J. Kaslow, PhD, ABPP

Susan H. McDaniel, PhD, ABPP
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Nadine J. Kaslow, PhD, ABPP
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"A leader takes people where they want to go. A great leaders takes people where they don't necessarily want to go, but ought to be."
Rosalynn Carter

"There are 3 essentials to leadership: humility, clarity, and courage."
Fuchan Yuan

"As we look ahead into the next century, leaders will be those who empower others."
Bill Gates

The two of us have traveled similar paths, having met in Houston when Susan was a postdoc in family therapy and Nadine was a practicum student in child psychology. Since then, we've both taken on leadership roles in academic health centers (Susan as a Division Chief in Psychiatry and an Associate Chair of Family Medicine, Nadine as Vice Chair of Psychiatry and Behavioral Sciences and Chief Psychologist at Grady Hospital). We both did national leadership training: Nadine following Susan in the HHS Primary Care Policy Fellowship, and Susan following Nadine in the Executive Leadership program for women in Academic Medicine (ELAM). We have both been active for years in APA governance: Nadine is now APA President and Susan is on the Board of Directors and running for President. Susan has built a career developing primary care psychology; Nadine has focused on suicide and family violence research, psychology education and training, and family psychology. Both are experienced journal editors. Both have much experience with the internal and external barriers to women in leadership roles of all kinds.

Answering the phone:

"This is Dr. McDaniel."

"Can I leave a message for Dr. McDaniel?"

"No, this is SHE. How can I help you?"

How many of us have had this experience? When we started working in our respective academic health centers in the 80s, there were few women, and we were almost always assumed to be secretaries. How do we move from there to here – an era when many women want to "lean in," step up to the plate, and provide leadership to their organizations?

Women often have good interpersonal skills and high emotional intelligence. That's how we were raised. These are VERY helpful in leadership roles. However, there are plenty of other skills we must learn to be good leaders. Many women can come to the work world expecting that, like in their childhood, they will be rewarded for being good girls and not causing trouble. Unfortunately, at least in academic health cen-

ters, this behavior often results in taking the woman's skills for granted rather than developing her abilities and maximizing her contributions.

We will address some of these challenges, starting with assessing the alignment of the system with the woman's goals, then reviewing issues of power and dependency in leadership, and concluding with conflict management skills. This treatment is only an appetizer in a very rich meal; we hope you will consider some of the references for more in-depth treatment of these subjects.

Alignment

Opportunities for leadership can arise in planful or very unexpected ways. One key consideration is the alignment of the mission, values, and culture of the institution or agency with your own. We find it *very* useful, as a first task, to write a personal mission statement. Most of us have participated in writing mission statements for our department or organization. Spend 20-30 minutes writing one for yourself. Whenever we're making difficult decisions about priorities, we return to our personal mission statements and ask what is most important in achieving our personal goals. Not who will we please, or will we be good for the job, but is it in line with what we care about most? Is it how we want to spend our energy, our precious time? Personal mission statements are also useful to read just before going into a difficult meeting. They ground us in our commitments, and help to quell the reactivity so common to our species. They also evolve over time, and are worthy of rewriting annually.

After writing a personal mission statement, the next step is to assess the psychological health of the organization for which you may become a leader (McDaniel, Bogdewic, Holloway & Hepworth, 2008). Does it have a clear mission and identified goals? How do these match with your own?

More generally, do its leaders communicate clear expectations and responsibilities for its workers? Does it have a mentoring system and foster career success? Are its resources aligned with its stated priorities? Does it conduct formative reviews? Does it acknowledge employee value and contributions? Do leaders have strategies to help individuals who are having difficulty? Does it afford latitude for employees with changing life events? Does it have fair and systematic mechanisms for dealing with disruptive behavior?

Power and Dependency

Leadership, by definition, means confronting issues of power and dependency. The American Heritage Dictionary lists four definitions of power, the first being "the ability or capacity to act or perform effectively." This certainly sounds consistent with collaborative care. Not until the 4th definition do we get to "the ability or official capacity to exercise control or authority." It is this definition that implies domination, and can be problematic for physicians in relation to patients and other team members. The antidote to power as domination is shared power, or caring. Caring consists of being present, listening, demonstrating a willingness to help, and an ability to understand – people talking *with* each other rather than *to* each other, interactions based on a foundation of respect and empowerment (McDaniel & Hepworth, 2003). Sometimes that means finding out the behaviors that the other person experiences as respectful or empowering, or reporting on behaviors we appreciate.

The sociology of superordinates tells us that there are predictable feelings and behaviors experienced by those higher in the hierarchy, as well as by those perceived as lower (Goode, 1980). In particular, those higher tend to experience their position in terms of feeling burdened and responsible rather than powerful, blessed or lucky. Those lower can feel that their talents or accomplishments go unrecognized. They can be vulnerable to feeling invisible, unappreciated, disrespected, and eventually, resentful. Understanding these dynamics can help to provide appropriate support to leaders or followers, and move the culture towards one of collaborative respect.

Conflict Management

Competence in conflict management is essential for effective leadership. Effectively managed conflict promotes cooperation and builds healthier and more positive relationships (Coleman, Deutsch, & Marcus, 2014). Conflict management refers to using strategies that facilitate the movement of the parties in conflict toward resolution without escalation or the destruction of relationships. A strong overall approach to conflict management includes an appreciation that conflicts are complex and thus require differential tactics of management based upon the people involved, the situation, and the style of the parties. It entails thoughtful consideration of the myriad sources of conflict (e.g., misunderstandings and miscommunications, fear, failure to establish boundaries, negligence, need to be right, mishandling differences in the past, hidden agendas, and the intention to harm or retaliate). Conflict management efforts must involve a detailed analysis (i.e., scientific approach) of the facts of the situation and attention to the feelings and perceptions of the parties.

The first step to managing a conflict is identifying the critical issues related to the situation, as well as associated organizational, personal, and cultural factors. With regard to the conflict situation, attention needs to be paid to pertinent issues, history of the conflict, primary players, and other stakeholders. Organizational factors to be examined include current policies/objectives, environmental influences, and working conditions. Examples of personal factors to assess are personal issues, personality styles, usual methods of anger management and conflict resolution, and beliefs about the behaviors of others that trigger intense feelings. Cultural factors to be identified pertain to cultural differences in communication styles and emphasis placed on individualism versus the common good.

The next step is to encourage each party to ask him/herself a series of questions, such as "how does my behavior contribute to the dynamics? What elements of the situation am I able and willing to change? What matters most to me/to the other party in the situation." If you are a party to the conflict ask yourself these questions.

Finally, take a clear and direct, but respectful and caring approach to addressing a conflict. Doing this requires focusing only on issues directly germane to the situation. It is critical that you define the situation in terms of a problem that calls for a solution (Fisher, Ury, & Patton, 2011). All parties must acknowledge their feelings in composed manner and listen to and acknowledge the feelings of the other(s). Then ask for specific behavior change and hear the behavior change requests of the other party(ies). This involves being clear about the outcome you want, accepting what you can get, giving up on having to be right, and demonstrating your willingness to hear the other party's perspective and to work collaboratively. Following this, share what you are willing to do to improve the situation and strive to do your best to make these changes.

In conclusion, women bring many talents to leadership. Like other important decisions in life, it takes courage to "step up to the plate" but it is also a rewarding opportunity to serve. We all need ongoing coaching and feedback regarding challenges related to defining our personal mission; ensuring its alignment with the institution, agency or organization; and managing issues of power, dependency, and conflict. We need your talents in this time of transition! ■

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FEATURE

Women, Poverty, & Trauma:
A Social Justice Perspective

Megan Reuter, MA

According to the United States Census Bureau, the percentage of individuals living in poverty from 2000 to 2012 has jumped from 12.2% to 15.9% (Bishaw, 2013). Single female-households (versus married-couple households) have higher rates of episodic and chronic poverty, and they have the lowest poverty exit rates (Edwards, 2014). As a result, poor women are often disenfranchised from society and held in a vulnerable, oppressive state.

We often see poor clients in our community mental health clinics, and as practitioners we can feel an isomorphic powerlessness to help them in the face of societal oppression. How does a clinician work against the systemic injustice of poverty within the confines of the therapy hour? The purpose of this article is not to definitively provide answers to this social problem. If the answer were that easy, the struggle would not be present. Rather, just as with the beginnings of all processes of change, the first step is consciousness-raising about this topic, which I attempt to facilitate within discussion of the lived experience of poor women.

Poverty as Trauma Itself

In their seminal article, Goodman, Saxe, and Harvey (1991) brand the experience of homelessness as a psychological trauma in and of itself. As they discuss, the poor carry with them their trauma histories and have the additional trauma of living in poverty, which further exacerbates psychological distress. They argue that many mental health professionals focus on the traumatic antecedents and consequences of being in such a vulnerable position, such as homelessness, rather than focusing on the experience as a trauma in and of itself. Researchers have also found that occurrences of physical trauma and residing in a homeless shelter were two significant life stressors that contributed to an increase in clinically significant depression symptoms when measured over a 6-month span of time (Rayburn et al., 2005). Other findings indicate that women have been disproportionately abused physically, mentally, and sexually over the course of their lifetime, which is a factor not to be dismissed (APA, 2007). Along with extensive trauma histories and living in poverty, poor women continue to be traumatized by the role they are placed into in society, which in turn, contribute to psychological distress and increased levels of depression (Rayburn et al., 2005).

According to the American Psychological Association's (APA) *Guidelines for Psychological Practice with Girls and Women* (2007), both girls and women experience discrimination and oppression by society in spite of the strides of the feminism movement and more focus on women's issues. Therefore, the oppression piles upon the different layers of experience in society for poor women.

Working with Poor Women from a Social Justice Perspective

In addition to my hope of consciousness-raising about the societal injustices of women experiencing poverty, it is my hope to transmit the importance of self-reflection, before and during the delivery of psychological services to poor women. It is important to self-reflect on our judgments and biases of poor women before entering the therapy room. Self-reflection is not just an exercise to go through before meeting

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> ***I cannot say whether things will get better if we change; what I can say is that they must change if they are to get better.***
>
> Georg Christoph Lichtenberg,
> German scientist
> (1742 – 1799)

with the client; rather, it is an ongoing conversation that clinicians and researchers must have with themselves.

Traditional models of psychopathology often place the "problem" within the individual, but as Smith, Chambers, and Bratini (2009) write, "oppression is the pathogen." Therefore, from a social justice perspective, we begin by externalizing the pathology by contextualizing it in terms of the greater forces of oppression in society. Smith (2010) notes that clinicians are trained in psychotherapy to employ interventions and techniques to "fix the problem" that resides within the individual, whereas the social justice perspective both acknowledges greater societal contributing forces, as well as integrates this acknowledgement into treatment planning with the client.

Providing basic resources (i.e., food & clothing) and having emergency homeless shelters in place are band aids to this systemic problem, and while they are needed and appreciated, homelessness and poverty still exist. Providing basic resources can be life-saving, but it returns the focus of the deficit on those who are poverty-stricken. Some researchers have focused their efforts on measuring successful interventions of arbitrary variables, such as housing quality and substance use problems, and they have seen clinically significant improvements in these domains (Toro et al., 1997). This "case management" approach, no matter how holistic, is not working. Poor women, and poor individuals in general, are at increased risk for a subsequent experience of poverty based on a history of poverty and homelessness, even with the best intentions of the case management approach (Edwards, 2014).

Goodman, Smyth, and Banyard (2010) sum up the issue concisely, as they write, "Researchers and practitioners interested in the mental health of impoverished communities must therefore consider not only barriers to access mental health treatment but the very relevance of the treatment itself"(p. 4). For example, cognitive therapies focus on challenging maladaptive thoughts and changing core beliefs (Beck, 1993). If we take a step back and look at the general premise of cognitive therapies, it not only infers that the problem lies within the individual, but it also assumes that these maladaptive thoughts and core beliefs prevent them from bettering their lives. It is the opinion of this author that we need to not place responsibility within poor women; rather, we need to challenge society's maladaptive values, attitudes, and judgments that contribute to the exacerbation of oppression.

Conclusion

Returning to the original question, how does a clinician work against the systemic injustice of poverty within the confines of the therapy hour? In some ways, clinical work done within the confines of the therapy room seems like a grain of sand on the beach, in terms of impact on society. However, as clinicians we can start with self-reflection, as previously mentioned. We are not only clinicians, but we are members of society at large who have prejudices and biases against poor women. Secondly, we need to advocate for poor women in the community by providing them with the basic resources needed on a day-to-day basis.

However, providing these basic resources does not challenge societal oppression. So, lastly, I would encourage researchers to investigate more psychological treatments, reaching beyond the confines of cognitive therapy. There are already some promising approaches to working with this population that have been developed, such as, Kidd and Kral's Participatory Action Research (as cited by Smith, Chambers, & Bratini, 2009). There are no easy solutions to addressing societal oppression; however, our awareness of this greater systemic issue is key to moving forward with research and practice. ■

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FEATURE

The DSM-5: Through a Feminist Lens

Cary Watson, PhD

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The arrival of the DSM-5 in May 2013, published by the American Psychiatric Association, written by a collective of researchers, clinicians, and mental health advocates, was greeted with equal parts anticipation and dread by the mental health community. This article will not take a position on the various controversies related to the 5th edition of the *Diagnostic and Statistical Manual*, however healthy the debates. Many organizations, including the American Psychological Association, the American Counseling Association, the Association for Women in Psychology, as well as three editors of previous editions, have spoken out with concerns about the DSM-5, especially the processes involved in the manual's development. The DSM-5 task force and other spokespeople for the APA have asserted its usefulness in diagnosis and treatment planning, its modernization and alignment with medical practice, and its targeted effort to make use of two decades' worth of empirical and epidemiological research since the last edition. Whatever our degree of acceptance, the DSM remains the main classification system of mental disorders in the United States.

As a feminist psychologist, I am among those clinicians who look at the DSM-5 through a particular lens – one that considers the impact of changes, some of them controversial, on women. In this article I will describe 1) some feminist criticisms of the diagnostic process outlined in the DSM-5, 2) some of the general changes, seen throughout the DSM-5, that impact women, and 3) some specific diagnoses that will differentially impact women and probably be watched closely as our health care system finishes the transition to DSM-5 over the remainder of 2014.

Ideally, a diagnosis gives us information about the cause of a disorder, enables us to make predictions about the course of a disorder, and suggests treatment options. At the very least, a diagnosis gives us a common language about a disorder. Every edition of the DSM, but especially the last 3 editions, have made an effort to be as scientific and objective as possible. However, the DSM classification system and the medical model it emulates only give the illusion of objectivity. As long as the diagnostic criteria are based on behavioral signs and symptoms of a *syndrome*, which remains true of the DSM-5, diagnosis will always involve clinical judgment, and therefore, subjectivity. As long as diagnosis requires clinical judgment and its inherent subjectivity, it will carry the risk of potential bias.

Feminist critiques (e.g. Brannon, 2008; Cook, Warnke & Dupuy, 1993) have always suggested that women are more likely to be diagnosed with problem behavior simply because our di-

agnostic system has always used male-based norms to define healthy vs. pathological behavior (e.g. independence, assertiveness = good, emotional expressiveness = bad). In her still-timely argument, Phyllis Chesler (1972) proposed that diagnosis is fundamentally gender-biased because of this basis for norms, and she pointed out that women who *either* overconform (e.g. are too submissive) *or* underconform (e.g. are too aggressive) to the traditional feminine gender role are subject to diagnosis (Chesler, 1972). Sandra Bem (1993) suggested that women will always be considered less psychologically healthy than men as long as men constitute the standard for what is mentally healthy. Critics of the DSM-5 assert that the new edition of our diagnstic manual continues to propagate this bias (e.g. Ussher, 2013).

Feminists have suggested (e.g. Brannon, 2008; Chesler, 1972) that the prototypes and diagnostic criteria for most of the personality disorders (previously known as "Axis II disorders") are simply portraits of extreme gender role traits, and the gender bias in diagnosis is thus predictable: paranoid, antisocial, narcissistic, schizoid, and schizotypal traits describe male gender stereotypes, whereas borderline, histrionic, and dependent traits depict stereotypical female behavior. The argument could be extended to other mental disorders in which we see significant gender differences in prevalence rates: in addition to histrionic, borderline, and dependent personality disorders, women are more likely than men to be diagnosed with depression, anxiety disorders, and eating disorders (Flanagan & Blashfield, 2005), as well as somatic symptom disorders, sleep disorders, and dissociative disorders (Ussher, 2013). Equally evocative of gender role stereotypes are substance use disorders, and other "bad behavior" disorders (e.g. impulse control disorders), where men are over-represented (Flanagan & Blashfield, 2005).

The result of such pervasive gender bias is not simply that women are more likely to be diagnosed with a mental disorder. When we operationalize so many disorders as exaggerations of gender role traits, we perpetuate the myth of women as "mad" and continue to place the locus of disorder on an individual person, rather than on possible contextual and environmental factors. Women are more likely to be labelled and stigmatized as "ill" when they express discontent with their lives, when their coping skills and resources have failed them in the face of stress, or when they fail to live up to unrealistic cultural ideals (Ussher, 2013). Women are more likely than men to be prescribed SSRI's, given electro-convulsive therapy, or hospitalized for psychiatric illness (Brannon, 2008). The fact that women are more likely to seek mental health care than men only accounts for between 10 and 28% of the gender difference in treatment rates (SAMHSA, 2005). The other 71-90% of the gender difference is

presumably due to factors that come from systemic bias.

While many vocal critics feel the DSM-5 has fallen short (e.g. Ussher, 2013), the new edition makes a concerted effort to counter this systemic bias by including new features and taking the first steps away from a categorical classification system toward one that is more dimensional. All aspects of culture, including ethnicity, age, and *gender*, are now explicitly described as possible factors influencing the course and expression of every disorder listed in the manual. Every diagnosis includes a section ("Gender-Related Diagnostic Issues") addressing gender differences in prevalence rates as well as any other influence of gender. For example, the section on Post-Traumatic Stress Disorder (PTSD) describes how PTSD is more prevalent among females than males across the lifespan, that females experience PTSD for a longer duration than males, and that some of the increased risk appears to be due to greater exposure to tramatics events (e.g. rape, abuse, etc.).

Among the examples of efforts to be more dimensional than categorical in diagnosis, the DSM-5 has included a new model for personality disorders, originally proposed to replace the existing model but now consigned to the section on "Emerging Measures and Models." As the criticisms of gender bias have been more frequent for Axis II disordes than Axis I (Brannon, 2008), this new model should garner attention and careful evaluation from the feminist community. In their efforts to improve the research basis for personality disorders as well as reduce the inflated rate of Axis II diagnoses, the task force created a new conceptual prototype of personality disorder, in which self-concept and interpersonal patterns are given equal weight in consideration of "impairment" as personality traits. The proposed new diagnostic criteria for all personality disorders are more stringent and more precise. In this new model, histrionic and dependent personality disorders, both criticized as among the most gender-biased and sexist, drop out of the line-up entirely.

Outside the section on research initiatives and proposed new tools, the DSM-5 contains many new official diagnoses and changes two old ones that have generated plenty of controversy. Two that have particular relevance to women are Pre-Menstrual Dysphoric Disorder (PMDD) and Binge-Eating Disorder (BED). Both disorders have voluminous amounts of empirical research support behind them, and both have their critics. A diagnosis like PMDD, limited only to women, was destined to provoke controversy, despite its generally accepted status among researchers and clinicians (Hartlage, Breaux & Yonkers, 2014). Critics of PMDD may point out that the diagnosis stigmatizes the natural, normal reproductive cycle of women, implying that all women are impaired by "PMS" and providing fuel for sexist and discriminatory policies or decisions. Supporters of the diagnosis point out that the mere existence of a *disorder,* clearly defining impairment and consistently found in 2% of women, highlights the fact that most women do *not* experience such impairment (APA, 2013). Binge-Eating Disorder, with decades of research from the fields of eating disorders, food addiction and obesity, has been welcomed by practitioners treating clients with eating disorders as a long overdue addition to the eating disorders chapter. Whereas women will certainly make up a sizable portion of those receiving this diagnosis – perhaps the vast majority – the fact that cultural and psychosocial factors are influential in its prevalence rate among women does not take away the suffering they experience nor the help they seek.

As was true with previous editions of the DSM, the 5th edition will continue to spark debate and generate controversy among clinicians and researchers, including feminists in both "camps." How we use the new diagnostic criteria and supports for considering gender as a factor in the diagnostic process will become clearer with time. One hopeful reminder is that the DSM is and always will be a dynamic tool for diagnosis – there will certainly be more revisions of the DSM in the future. ■

Complete references for this article can be found at **www.cpapsych.org** – select *The California Psychologist* from the **Professional Resources** menu.

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What You Should Know About False Claims

David K. Leatherberry, JD

A psychologist called recently to report he had been providing individual psychotherapy to a 21-year-old Tricare beneficiary. The therapy had begun as face to face meetings every two weeks, but the beneficiary had been accepted into college in another part of the state. The beneficiary had formed a close bond with his psychologist and hoped to return and resume employment in the same community after graduation. Therefore, he and his psychologist decided at the time he left for college six months ago to have him call by phone on roughly the same bi-weekly schedule. The psychologist continued billing Tricare for reimbursement of individual psychotherapy services, but now wondered whether there should be a separate CPT code for billing for individual therapy provided over the phone, and if so, what he should do with respect to reporting to Tricare.

A quick review of Tricare's online policy manual revealed that while telemental health services may be covered under certain circumstances, Tricare requires the use of multimedia, audio-visual communication between the patient and practitioner. [1]

The psychologist was rightfully concerned about whether the individual therapy CPT code he had been using accurately reflected the services he was providing. Yet, because he never formed the conscious intent to commit billing fraud, he was surprised to find we were suddenly discussing the potential for an investigation into claims of billing fraud and abuse under state and federal law. By way of comparison, on similar facts in June 2011, in response to allegations by the U.S. Department of Health and Human Services' Office of Inspector General ("OIG"), a psychotherapy practice and its owners agreed to be excluded from participating in federal health care programs for a period of three years in settlement of allegations that they submitted claims for payment to Medicare for mental health services that were falsely represented to have taken place face to face. (See http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp.)

In its report of False and Fraudulent Claims, OIG regularly reports cases of settlements in response to allegations of billing fraud and abuse against healthcare providers.[2] Allegations include:

- Submitting claims for reimbursement of services billed at levels not supported by the documentation;
- Billing for services that are not reasonable and necessary;
- Providing services that do not comply with reimbursement criteria;
- Billing for individual services that are provided concurrently (unbundling); and
- Billing for services provided by individuals the provider knew or should have known were excluded from participation in federal healthcare programs.

Such practices represent just a few of the many that may bring a psychologist face to face with potential liability under the False Claims Act ("FCA"). In this hypothetical case, the psychologist had presumably submitted false documentation in that the supporting record would have reflected "individual psychotherapy" without specifying that it was accomplished over the phone. At the very least, he would face potential FCA claims based on billing for services that failed to comply with reimbursement criteria. Both paths lead to potential FCA liability.

The Federal FCA, 31 U.S.C. § 3729 *et seq.*, provides that any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or (C) conspires to do so, violates the FCA.[3] The Act permits private persons, known as "*qui tam* relators" or "whistleblowers," to file FCA cases on behalf of themselves and the government or governmental entity.[4] Whistleblowers then receive a percentage of the recovery depending

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on their level of contribution and on whether the government chooses to intercede. In 2009, Congress passed the Fraud Enforcement and Recovery Act of 2009 ("FERA") in part to clarify that liability under the Federal FCA attaches whenever a person knowingly makes a false claim to obtain money or property, any part of which is provided by the federal government, regardless of whether the person deals directly with the federal government or an agent or contractor of the federal government.[5] Under the State's FCA, such liability extends to any situation where the property or service is to be spent or used on behalf of, or to advance the interest of, the state or any of its political subdivisions including counties and health care districts.[6]

Health care providers may be assured that they cannot be held liable under the FCA for innocent mistakes. When analyzing potential liability under the FCA, there must be some degree of intent beyond inadvertence, innocent negligence or mistake.[7] Still, health care providers such as my hypothetical caller may be surprised to learn that it is not a sufficient defense that they did not consciously form the intent to submit a false claim. "Knowing" and "knowingly" under the FCA refer to persons who have actual knowledge of the information, but also refer to those who act in deliberate ignorance or reckless disregard of the truth or falsity of the information. No proof of a specific intent to defraud is required.[8]

Thus, while the FCA imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who is found to have acted in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the FCA. In sum, the FCA imposes liability on any person who submits a claim to the federal government that he or she knows or should know is false. In the case of my psychologist caller, the OIG may try to show that the Tricare policy provision was a condition of payment provided to the psychologist, and thus the psychologist should be deemed to have known or should have known about the policy's limitations on billing.

If a health care provider is found to have violated the Federal FCA, the OIG is authorized to seek a penalty of up to $10,000 for each item or service improperly claimed, and an assessment of up to three times the amount improperly claimed.[9] Thus, in the case of our psychologist, each telemental health reimbursement claim would result in a civil money penalty of $10,000 plus three times the amount of the claim. Over the course of six months, he could be looking at a potential penalty of over $120,000 in addition to exclusion from federal programs.

In response to what the psychologist should say or do with respect to reporting to Tricare, the FCA provides a strong incentive to health care providers to monitor and self-report their own claim errors. Providers found to have violated the FCA are entitled to a significant reduction of penalties if the provider self-reports the FCA violation with all information known to the provider about the violation *within 30 days* after the date on which the provider first obtained the information. The provider must fully cooperate with any government investigation, and at the time of self-reporting, there must be no criminal prosecution, civil action, or administrative action pending. The provider must also not be motivated by (i.e. "have actual knowledge of") the existence of an investigation into such violation.[10]

Thus, psychologists should have in place a plan of compliance which includes identifying any potential revenue streams that make the practitioner subject to false claims liability. A compliance plan will be impacted by individual factors of the psychologist's practice such as size and payer mix. However, any compliance plan should include:

- A Non-Retaliation Disclosure Program designed so that any person who is aware of any instance of non-compliance is able to make disclosures to their supervisor without fear of retribution;
- Employee Screening Requirements to ensure that no employee or contractor is an "Ineligible Person" under the FCA; and
- An Overpayment Policy designed to guide the timely reporting and refund of overpayments to federal, state, and individual payers. ■

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1. Section 22.1, Ch. 7, Tricare Policy Manual 6010.54-M (Aug. 1, 2002).
2. *Ibid.*
3. 31 U.S.C. § 3729 *et seq*. Because of the brief nature of this article, discussion focuses on liability under the Federal FCA only. A similar analysis would also occur under the State's False Claims Act beginning at Gov. Code § 12650.
4. 31 U.S.C. § 3730.
5. S. 386, 111th Cong. (2009) (enacted).
6. Cal. Gov. Code § 12650 *et seq*.
7. *United States ex. rel. Mikes v. Straus* (2001) 274 F.3d 687, 703.
8. *Supra*. 31 U.S.C. § 3729.
9. 42 U.S.C. § 1320a-7a(a).
10. 31 U.S.C. 3729(a)(2).

Collaboration and Competence:
The Impact of Women's Health Issues in Psychotherapy

Alann D. Dingle, PhD

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Psychologists aim to be familiar with and knowledgeable about medical conditions that may impact patient functioning and to collaborate effectively with relevant medical providers. Certain patient groups, such as women, have more complicated medical issues (e.g., lupus, menopause) than others. There are numerous ethical and clinical challenges for psychologists who treat women with medical conditions. Generally… "the physical and mental health concerns of women and girls are related to complex and diverse economic, biological, developmental, psychological, and sociocultural environments," affirming the need to focus on the unique needs of women presenting for psychological treatment (APA, 2007).

Obtaining a thorough medical history during the psychological evaluation process is essential as many women, reconciled to having a medical disorder, seek psychotherapy for seemingly unrelated reasons. Knowing that a patient with multiple sclerosis may be fatigued or in pain, allows the psychologist to be flexible regarding certain aspects of treatment (e.g., last-minute cancellations, phone sessions). Another patient seeking treatment during her divorce may be reluctant to acknowledge fears of infertility or changes in hair growth, caused by polycystic syndrome (PCOS). Reviewing and possibly altering office policies to accommodate women's medical needs is particularly appropriate during the informed consent process (APA, 2010:10.01).

Medical conditions can simulate psychological symptoms (Pollak, 2011). Frequently patients enter psychotherapy to manage anxiety or depression that seemingly is triggered by life stressors, unaware of an underlying medical condition. Depending on the severity, women with undiagnosed thyroid disorders may experience weight changes, palpitations, emotional lability, or poor sleep. Women, especially those in their 30s or 40s, may not know that their mood swings, insomnia, weight gain, panic attacks or hair loss are indicators of perimenopause. Psychologists are encouraged to develop a working knowledge of common medical disorders to ensure accurate diagnosis and effective treatment (APA, 2013).

> ***… "the physical and mental health concerns of women and girls are related to complex and diverse economic, biological, developmental, psychological, and sociocultural environments," …***

Unfortunately, patients may be inappropriately diagnosed (e.g., a teenager with an undiagnosed eating disorder diagnosed with delayed growth or tooth decay). Unrecognized medical disorders that produce psychological symptoms can be found in the caseloads of all primary care and mental health professionals (Grace & Christensen, 2007). Over a 100 medical disorders are capable of mirroring psychological conditions (Schildkrout, 2011). For example, women suffering from ischemic cardiac events can be misidentified as having anxiety (Pilote, Pelletier & Humphries, 2014). Rather than just relying on information from the patient's physician, psychologists can conduct a thorough evaluation, including personal and family medical histories, accidents, serious illnesses, surgeries and medications. It is advantageous for psychologists to be familiar with the symptomology of common medical disorders and medication side effects, as well as the potential impact of these issues on individual functioning.

During her initial session, Ms. G. complains of insomnia, anxiety, weight gain, and headaches. She has a stressful job, working 14-hour days with a two-hour commute on L.A. freeways. Ms. G. tends to pick up dinner on the way home after the gym. She also takes medication for acne and indigestion. These symptoms have been present for months, but she recently went to her doctor because her

hair started falling out. Ms. G.'s physician recommended psychotherapy.

Fortunately, through ongoing continuing education and consultation, her psychologist, Dr.W. has maintained competence (APA, 2010: 2.03) and is highly aware of the comorbid relationship between medical conditions and psychological symptoms. Furthermore, he knows there are numerous medical conditions with medication regimes that have significant psychological side effects. However, Dr. W. is unclear about whether Ms. G.'s physician has evaluated her for possible medical disorders.

Dr. W. explains the complexity of the mind and body relationship and the importance of a comprehensive medical evaluation. He requests permission to speak to her physician.

He explains that he intends to collaborate with her physician (APA, 2010: 3.09) so that all of Ms. G's physical and psychological problems can be adequately addressed. Dr. W. and Ms. G.'s physician work together to manage the physical and psychological aspects of what was ultimately diagnosed as hypothyroidism.

With the current and planned changes in the healthcare system, particularly the focus on the integration of physical and mental health care, psychologists can be most effective with all populations and particularly women through a good working knowledge of common medical disorders, flexibility as necessary in their office policies, and collaborating effectively and ethically with primary care physicians. ■

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The Sandwich Generation Redux : New Challenges and Opportunities for Geriatric Psychology

Morton H. Shaevitz, PhD, ABPP and Amy J. Ahlfeld, PsyD

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Complete references for this article can be found at **www.cpapsych.org**. Select *The California Psychologist* from the **Professional Resources** menu.

The term "Sandwich Generation" describes women "sandwiched" between their children, mates, and aging parents (Miller, 1981). With an aging population and deferred childbearing, a contemporary definition may be the "Panini Generation" (Woodruff, 2009). Nearly half of adults in their 40s and 50s have a parent age 65 or older, are raising a young child and/or partially supporting an adult child (Bureau of Labor Statistics, 2004). Additionally, one in seven provide financial support to an aging parent and a child (Parker, 2013).

Why is this happening? First, adults are living longer and wanting independent lives. The average American life span is approaching 78 (Centers for Disease Control and Prevention, 2007). The number of 65+ Americans will double in the next 25 years (ibid). By 2030, older adults will account for roughly 20% of the U.S. population (ibid). World War II generation adults do not want to live with their adult children (Fetterman, 2007). Older adults prefer to keep close to their communities of origin, maintain friendships, and remain active. Second, adults are marrying and having children later (Bureau of Labor Statistics, 2004). Increasing numbers of middle-aged adults have personal, financial, and emotional responsibilities for growing children, aging parents, and a young adult child living at home (Parker & Patten, 2013).

While many older adults enjoy good health into their 80s, at some point medical, emotional or cognitive challenges emerge, and their children are expected to help (Cohen, Bloom, Simpson, & Parsons, 1997). 41% of baby boomers care for an aging parent (Fetterman, 2007). 29% worry about nursing home costs, which can range from $9,000 to $12,000 a month (Parker & Patten, 2013).

Assisted living and Continuing Care Residential Communities are possible solutions. When middle-aged adults feel that their aging parents are in a "safe" environment, they can relax. However, many older adults do not share this view. A growing "Aging-in-Place" movement supports older adults remaining in their homes. Non-profit "villages" provide many services. For a $500 annual fee, older adults receive transportation, technology assistance, lists of approved repair people, and access to social clubs and activities (Straight, 2012; Bertolucci, 2012).

Home-monitoring systems check an individual's movements, turn off stoves automatically and dispense medications (ibid, ibid). Physical therapy can be received at home paid by Medicare to help maintain independence. Twenty states require private insurers to reimburse Telehealth services (Jaffe, 2014; Landro, 2014).

What is emerging is a new model we call "Geriatric Family Therapy." Increasing numbers of middle-aged adults are engaging in conversations and negotiations with aging parents who want to stay in their own homes. In our experience, mental health and health professionals are not prepared to address their issues. This is both a challenge and an opportunity for Geriatric Psychology.

To be successful, psychologists need to update their concept of "interdisciplinary" to include consulting with physicians, attorneys, accountants, and residential care administrators, while maintaining their professional integrity and protecting confidentiality. This means becoming familiar with how other professionals function, plan, and think. Those willing to expand their knowledge base and acquire additional expertise can successfully meet the needs of older adults and their middle-aged children, while developing new and exciting practice models. ■

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We ask that you serve as a content leader rather than a lecturer. We discourage over-reliance on PowerPoint slides, and if you must use them we ask that you plan to use them only as a guide through your presentation. We are seeking exciting presentations that explore interesting and emerging developments in all fields of psychology, and that will leave our attendees wanting more!

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All presenters are required to register for the convention; a discounted presenter rate is available. Please consider this before submitting a proposal.

Proposals must be submitted online. Go to www.cpapsych.org to view the submission instructions. If you have questions contact Sabrina Cullivan at CPA, at 916-286-7979 ext. 122 or via e-mail at scullivan@cpapsych.org. You will be notified of the review committee's decision in late October 2014.

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For more information contact Dr. Lisa Osborn at losborn529@aol.com or go to http://phwp.cpapsych.org.

A Communitarian Approach to Maintenance of Professional Competence

Christopher Ebbe, PhD, ABPP

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The individual psychologist is expected to self-assess accurately and to take the initiative to maintain competence and to make good ethical decisions (Johnson et al, 2012). Since human beings, including psychologists, are prone to fool themselves about their effectiveness and about their motivations and the impact of their actions on others, since psychologists' behavior can be affected by their emotional ups and downs and by illness, both physical and emotional, and since psychologists' cognitive abilities begin to decline before they retire, this "individual model" of maintaining competence and acting ethically is subject to breakdown. Johnson and colleagues (2012) introduced the concept of the "competence constellation," a network for each psychologist of colleagues, peer consultants, supervisors, therapists, close family members, and others who will help the psychologist to stay oriented to the crucial importance of maintaining competence, to be more self-aware, and to make better ethical decisions. This network could prevent problems from developing, by catching them early and by keeping everyone more conscious of competence and ethical issues. This communitarian view recognizes the fact that our happiness and sanity are largely dependent on our connections and relationships with others—a fact that our individualistic culture plays down. The communitarian view has similarities to models of "collaborative mentoring" (two-way mentoring between equals) and "transformational supervision" (paying significant attention to the emotional needs of the supervisee). The communitarian ethic holds that it is an ethical obligation for each of us to take care of our colleagues.

There seems little doubt that a network of caring, trusted colleagues and others could help each of us to see ourselves more accurately, maintain competence, and avoid lapses in competence and ethics, but this calls on all of us to be able to participate in this type of relationship – not just those of us who are involved in training and therefore familiar with evaluating and giving feedback. Most psychologists do not share their work with colleagues for a variety of reasons. We may not trust our colleagues to be able to objectively evaluate our work or offer objective feedback. A few internships focus on helping interns to become comfortable with being exposed and imperfect and using this relative comfort to seek feedback throughout their careers. Even if these communitarian networks of helpers were established, there would be a tendency currently for network members to stay quiet in hopes that others would stay quiet about them.

For this more communitarian approach to competence and ethics to work properly, more psychologists will have to develop skills in (1) understanding and assessing others' professional work, (2) judging accurately and humanely when feedback is needed and justified, (3) giving feedback sensitively and expertly, (4) risking relationship damage from giving feedback in an ongoing relationship, (5) accepting feedback non-defensively and using it wisely, (6) managing the feelings generated by such feedback, and (7) managing the relationships in which such feedback is generated. Many psychologists may think that they have such skills, but if that is so, then why are we all so reluctant to have our work seen by others?

In addition, we will need clarification of whether the members of such networks will bear some legal or ethical risk if they themselves act ineptly or do not act or if the person being assisted becomes the focus of a licensing board or ethical complaint. California psychologists are urged to consider this useful communitarian concept and further develop the skills listed above. ■

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Paradigm Shift and Psychologists' Social Responsibility

Rut Gubkin, PhD

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As of 2012, 16.9% of the American population is of Hispanic and Latino origin, making this the largest ethnic minority group in the US (US Census Bureau, 2012a). California has the largest Hispanic/Latino population (14.5 million) and this number is predicted to grow making it a minority-majority state. By 2060, 31% of the total U.S. population will be of Hispanic/Latino origin (US Census Bureau, 2012b). The terms Hispanic and Latino are frequently used interchangeably when referring to Spanish speaking people. However, Hispanic excludes people from Brazil and Latino/a includes people from Mexico, Central, South America and the Caribbean while excluding Spain.

Acculturative stress (Berry, 1997) can negatively affect the psychological well being of marginalized groups living in the US (Hovey & Magaña, 2000). Latino/a adults and adolescents have higher rates of depression and anxiety than non-Hispanics Whites (Torres Stone, Rivera & Berdahl, 2004). American born Latino/as have higher rates of depression than Latino/as immigrants (Alegria, Shrout, Woo, Guarnaccia, Sribney, Vila, et al., 2007) and higher rates of anxiety are associated with increased number of years living in the US (Cook, Alegria, Lin & Guo, 2009). Mexican American college students also experience depression and anxiety resulting from acculturative stress, even though they are regarded as more acculturated (Crockett, Iturbide, Torres Stone & Raffaelli, 2007).

The traumatizing impact of the experiences of migration and acculturation can place this population at high risk for ongoing psychological deterioration. Pre-immigration experiences of political violence and/or poverty, and traumatizing border crossing experiences tend to leave enduring wounds in this population (Ornelas & Perreira, 2011). The experience of separation from family members given their family-oriented culture and the uncertainty of reunification due to visa refusal and/or lack of finances may also deepen these wounds.

Migration stress from culture shock, the struggle for daily survival, minority status and the constant fear of deportation are among the many obstacles that can exacerbate pre-existing vulnerabilities. Cultural differences in values, roles and gender expectations lead to intergenerational conflicts within the family. The complex shifting between two cultures without socially established environmental support challenges Latino/as' cultural identity. What was once considered as safe and grounding family and social systems are now volatile and fragile.

Findings show that being subjected to racial discrimination and the pressure to learn English are linked to high levels of lasting depression among Latino/as (Torres, 2010). In addition to the emphasis on conformity to the English language and stigmatization of Spanish, Leuck and Wilson (2011) state that existing social ecosystems in the U.S. inherently increase the acculturative stress and poor well-being of this group. Linguistically appropriate psychological services to this diverse population are few, limited and often insensitive to their psychological, social and cultural needs (Russell & Doucette, 2012). Recognizing the magnitude of this condition and addressing it accordingly will have a positive human, social and economic effect on this population.

Cultural integration requires substantial negotiation and reciprocal accommodation from all groups involved (Berry, 2005). Globalization has already changed the face and voice of psychology but the discipline, as a whole, has not yet embraced this paradigm shift. Multiculturalism requires a new way of relating to each other professionally and personally. With increasing globalization, we are becoming children of the world rather than a single country. As psychologists we must break through our own prejudices and create affordable conditions to allow our services to be accessible to everyone in need. Psychologists can either exacerbate the suffering or be part of a compassionate solution that will ultimately benefit us all. Which path will you choose? ■

Complete references for this article can be found at **www.cpapsych.org** – select *The California Psychologist* from the **Professional Resources** menu.

Alameda County Psych Assn had an unprecedented turnout of Alameda students and psychologists at the CPA Convention where we happily accepted the Chapter of the Year Award. Our new and improved website will soon go live. Recent CE events include Michael Tompkins, PhD on *Using CBT for Pediatric Anxiety Disorders in May* and in June Karen Franklin, PhD presented with Keely Kolmes, PsyD on *Ethics and Social Media*. Our largest summer gathering in history was at the home of Dr. Gilbert Newman where we hosted APA Presidential candidate, Dr. Jessica Henderson Daniel.

Central Coast Psych Assn has been active, hosting and/or sponsoring social as well as educational opportunities. Two 'Member Dine Outs' have taken place at local restaurants, Drs. Dworkin and Sandberg presented on professional wills to the Santa Barbara Chapter, and approximately 25 CEs have been available through trainings/workshops on topics such as Chronic Pain, Clinical Supervision, Tobacco Recovery, Disaster Mental Health, and the Treatment of Bipolar Disorders. This Fall a discussion on treating college-age students and a training on the DSM-5 are scheduled to take place, both with collaboration from Cal Poly.

Los Angeles County Psych Assn celebrated July as National Minority Month and July 2nd as NO SHAME day. Our SIGs, clubs, and committees have been encouraged to highlight these issues, and the Diversity Committee will hold a breakfast on July 19th. Looking ahead, Carol Falender, PhD will present *Clinical Supervision: Skills for Enhanced Competence* on Saturday, September 13. This interactive, multimedia presentation will satisfy the BOP's supervision requirement. October 18th is our 26th Annual Convention with compelling presentations on a wide variety of topics, food, exhibits, networking, and a keynote address by the acclaimed happiness researcher, Sonja Lyubomirsky, PhD.

Marin County Psych Assn is busy. In March, Mark Kamena, PhD, ABPP and Dana Nussbaum, PhD presented on *Critical Incidents and their Impact on First Responders*. We held a networking social in April and will have a summer networking party in July. On June 6 we have an early career presentation and panel on *How to Market Your Psychotherapy Practice*. In May and June, we will jointly sponsor a free CARE event with the San Francisco Psych Assn on using biofeedback both for self-care and as an adjunct to psychotherapy, presented by DeLee Lantz, PhD.

Napa Solano Psych Assn (NSPA) invites you to networking brunches on the 4th Sunday of each month. To find the next location, visit www.napapsychologists.org where it will be posted about three weeks prior. Please also see other website features such as an events calendar, psychologist locator service, newsletters, and automated routine member activities (e.g., joining, renewal, info updates). Consider joining – at $55/year we are a great bargain! We invite you to our salon discussions on CE articles from *The California Psychologist*. We are doing these events several times a year to network, learn, and come together as a community.

Orange County Psych Assn Thinking about joining OCPA? In May & June, we sponsored six different member-run CE events. Thanks to Dr. Ralph Kuechle, we held a successful joint networking event with The OC Psychiatric Society and a chapter of The American Academy of Pediatrics. Join us in July for our bimonthly Happy Hour and on Aug 19th, join us for our annual networking brunch with LA County Psych Assn to meet our friends who work nearby and exchange info for referrals. We will be holding the same event with San Diego Psych Assn in the fall. Watch for our first OCPA Convention on October 12.

San Joaquin Valley Psych Assn was well represented at the CPA Leadership and Advocacy Day. Seven attendees were rewarded with direct contact with assembly member Jim Patterson, who had just been appointed to the Health Committee. We talked about mental health issues in our community. We look forward to providing trainings to our district offices in the Central Valley as well as a "Meet and Greet" event with our legislators to be held this fall. Ron Teague, PhD will provide a workshop on *Integrated Psychodynamic Principles* and a second on the *Mythic Mind in Clinical Practice*. Details about upcoming events can be found at www.sjvpa.org.

San Francisco Psych Assn actively celebrates its rich cultural heritage and diversity through gastronomical adventures at board meetings. Napa wine tasting socials are bringing members together and successful SFPAGS and ECP career events were held in April and May. We are working with a local tech giant to customize a special project to meet our technology and social media needs. Interprofessionally we are building collaborative partnerships with our psychiatric colleagues and planning a joint educational movie, wine and cheese night. We are also working with a legislator's office in planning a distress constituent training. Come join us and rediscover how fun psychology can be!

San Gabriel Valley Psych Assn focused on building community, connections, and self-care by hosting a lunch with our chapter president, Dr. Stephanie Law, a new member welcoming event, and a diversity panel with local psychologists discussing being a multicultural psychologist. We also launched the new CARE program by hosting a meet-up at a local park so members with young children could connect on how to navigate professional and personal growth. SGVPA's advocacy focus included a strong showing at CPA's Advocacy Day in Sac-

ramento, as well as local meetings with Assemblyman Chris Holden and Mike Gatto to promote psychology, build relationships, and create a presence locally.

Santa Barbara County Psych Assn participated in the Annual Mental Health Fair sponsored by the Santa Barbara Cottage Hospital, providing mental health education to providers and consumers. Members also came together for the Mental Health Awareness 5K walk/run to support the community Mental Wellness Center. Our social committee provided a unique opportunity to attend the closing exhibition of fine art prints from C.J. Jung's Red Book. Monthly Salons provided ongoing CE for members and we are continuing the student assistantship program and special interest discussion groups. We continue to increase the Chapter's visibility in the community while focusing on the promotion of the science, practice and profession of Psychology.

Division I - Clinical and Professional Practice sponsored a Master Lecture at the CPA Convention on integration of care within medical settings. Along with the CPA Health Care Task Force we put on a one-day workshop in June on skills needed to gain competency in working in primary care settings. Our quarterly newsletter features articles from our sections, clinical resource links, student updates, an advocacy corner, and summaries of Board Meetings. We have formed an Early Career focus group to provide strategies to the division so that we can meet their needs. We are motivated to benefit clinical practice: Div I is a Lifesaver for your clinical practice.

Division II - Education and Training If you are a psychologist involved in graduate education or clinical training then we welcome you to join us. We provide exceptional training opportunities by experts representing the field's cutting edge. Several of our members gave excellent presentations at the CPA convention: Melodie Schaefer, PsyD spoke on *Remediation in Clinical Training*, Latonya Wood, PhD spoke on *Research Findings in Evidence Based Practices with Children & Adolescents*, and Carol Falender, PhD, a national thought leader, on *Clinical Supervision*. This October, the Division will hold its annual Northern California Supervision Conference. Nick Ladany, PhD will be our featured speaker.

Division V - Clinical Psychopharmacology hosted a 2 day conference in February, drawing over 70 attendees, enhancing our prescriptive authority outreach. Alan Lincoln, PhD, MCSP led a very well-attended Institute at CPA's spring conference on new DSM-5 definitions of developmental disorders and the psychopharmacological implications of treating this population. Division V recognized three outstanding psychologists including Drs. Pam Van Allen, Rob Woodman, and Julie Myers. We are proud that we were among the largest contributors to the PAC dinner, with over 13 seats purchased, many of which were donated to students to foster an understanding of the importance of political process involvement. In closing, "Like prescriptive authority? CPA's Division V makes it possible!" Join today!

Division VII – Diversity and Social Justice received outstanding feedback for being a unique, meaningful, safe and a model of how to discuss challenging issues of inclusivity with a town hall at CPA convention. We thank our panelists and monitor Drs. Jorge Wong, David Lechuga, Rut Gubkin and Rhoda Olkin. Close to 30 members attended our social hour – we laughed, shared backgrounds and addressed diversity related topics. Many thanks to all who support our activities and mission, and to the 19 new members who joined at convention. Our Division is blossoming. Join the pursuit to increase inclusivity and minority representation in leadership positions.

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