Independent Practitioner

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President's Column — Pauline Wallin
Concussions and Psychology — Megan Jacobson and Stacy M. Stefaniak Luther
Facing My Money Ghosts: Psychological Residuals of Growing Up Poor — Anatasia S. Kim
'Cause I'd Rather Ride on My Motorcycle — Pat DeLeon
On the Disconnect Between Law and Psychology — David Shapiro
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Candidate Statements

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About the Independent Practitioner

Submission deadlines: February 10 for Spring issue
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Submissions:

All submissions (including references) must be formatted in APA style (with the exception that abstracts should be omitted) and emailed as an attached Word file to the Editor and Associate Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write two sentences about yourself for placement at the end of the article and provide contact information you would like published (e.g., address, phone, E-mail, web page). Photos are appreciated and should be sent directly to the Central Office. Most submissions should be limited to approximately 2,500 words (6 double-spaced pages), although longer submissions will be considered at the Editors' discretion..

All materials are subject to editing at the discretion of the Editors. Unless otherwise stated, the views expressed by authors are theirs and do not necessarily reflect official policy of Psychologists in Independent Practice, APA, or the Editors. Publication priority is given to articles that are original and have not been submitted for publication elsewhere.

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Table of Contents

From the President

President's Column — *Pauline Wallin* 4

Early Career Psychologists

Concussions and Psychology — *Megan Jacobson and Stacy M. Stefaniak Luther* 6

Multicultural and Diversity

Facing My Money Ghosts: Psychological Residuals of Growing Up Poor — *Anatasia S. Kim* 9

Opinions and Policy

'Cause I'd Rather Ride on My Motorcycle — *Pat DeLeon* 16

Focus on Forensic Psychology

On the Disconnect Between Law and Psychology — *David Shapiro* 18

Focus on Clinical Psychology

The Importance of Assessment and Treatment of Depression among Menopausal Women — *Dana Lasek* 20

Candidate Statements

President-Elect 24
Secretary 28
Member-at-Large 29
Division Representative to APA Council - Diversity Slate 30
ECP Member-at-Large - Diversity Slate 31

President's Column

Pauline Wallin

Greetings, fellow 42-ers.

On January 26-27, your Division 42 Board of Directors held its annual winter meeting in Charlotte, NC, a non-stop flight from many areas of the country – which kept travel time to a minimum for most of us. Incidentally, did you know that the Charlotte airport is famous for its super-friendly-and-fun-but-not-intrusive ladies' restroom attendants? (Google it.) Everyone leaves the restroom with a smile on their face.

We were booked at the DoubleTree by Hilton Hotel (recommended by Sally Cameron, executive director of the North Carolina Psych Association), just a quick shuttle ride from the airport. Of course, we all got a huge warm, gooey DoubleTree chocolate chip cookie on arrival, and some were even lucky enough to get an extra cookie from the van driver on the way from the airport to the hotel – a sweet start (or two) before getting down to business.

Our Friday evening 3-hour dinner meeting began with introductions, each of us relating one thing about ourselves that others probably didn't know. What happens in Charlotte stays in Charlotte, but I can tell you that while no deep secrets were revealed, not all of your esteemed board members were perfect angels in elementary school.

Now to the important business, with a few highlights from our board meeting over the two days (official minutes are available on the Division 42 website)…

Developments that may affect our practice and income

Our Advocacy Committee, led by Dr. Peter Oppenheimer, has been monitoring developments in APA. One issue is the consideration of creating accreditation standards and/or endorsing

credentialing for people with Master's degrees in psychology. Last August a work group of APA staff was assigned by the Executive Management Group (EMG) to do a literature review, and to explore parameters and implications. APA Council will examine the findings and then consider whether or not to create policy statements on these issues.

Dr. Oppenheimer emphasized that it is important that the EMG Workgroup respond to questions asked by the Committee for the Advancement of Professional Practice (CAPP) regarding the implications of these issues for practicing psychologists, and that the Council and the Association address these issues in a transparent fashion.

The Advocacy Committee has also been active in challenging APA's treatment guidelines for PTSD. These guidelines omit effective treatment modalities that don't fit within the randomized controlled trials (RCT) model of the Institute of Medicine. If insurance companies deem these limited guidelines (focused on cognitive therapies) as the "gold standard" of treatment, they may refuse to pay for psychoanalytic or other less quantifiable, yet effective therapies. The ultimate losers will be the public, whose options for affordable in-network treatment will be curtailed. Furthermore, if the RCT model is exclusively applied to the development of treatment guidelines for other psychological conditions, the access problem will widen.

At the time of this writing, APA Council has not met to address the above concerns. Our Advocacy Committee and our five APA Council representatives will keep you posted. Watch for further discussion of these issues on the Division 42 listserv.

Dr. Alex Siegel of the Association of State and Provincial Psychology Boards (ASPPB) gave us an update of the Psychology Interjurisdictional Compact (PSYPACT), created in 2015 to facilitate telehealth and temporary in-person practice of psychology across state lines. Three states have already approved PSYPACT through legislation, and eight others have introduced legislation to approve it. The program will become active when it is approved by seven states. For more information, see asppb.net/page/PSYPACT.

Division 42 finances

Division finances are in good shape, thanks to prudent budgeting and investment, overseen by our treasurer, Dr. Gerry Koocher. Our nest egg has also benefitted from the rising stock market.

Our new journal, *Practice Innovations,* under the expert guidance of editor Dr. Jeff Zimmerman, has already made a profit during its first year. *Practice Innovations* is included with your Division 42 membership, and the content is geared to clinicians who work in private practice. We hope you find the articles interesting and useful. If you'd like to write for the journal, submission guidelines are here: apa.org/pubs/journals/pri.

Diversity issues and beyond

Diversity Committee co-chair Dr. Armand Cerbone engaged the Board in a heartfelt discussion that drilled down to the personal experiences of stigmatized people. He reminded us that stigmatized populations are "under-reported and understated, and they have extra work to do at every stage of development." Dr. Cerbone added, "No matter where you are in the country, psychologists need to appreciate where geographic and population differences impact treatment delivery or reception." The Diversity Committee is working on increasing collaboration with other APA divisions.

New resources for Division 42 members

Our Student/Early Career Professionals Committee, chaired by Dr. Amy Van Arsdale is working diligently to finish a Resource Guide with lists of readings and other materials of interest to those who are contemplating or just starting a private practice. If the guide is not already posted on our new Member Resources web page, it will be soon. division42.org/resources/member-resources.

Speaking of the Resources page, it's a new Division 42 web page set up to collect intake forms, practice templates, letters of introduction, book recommendations…all the types of resources that members routinely ask for on our community listserv. Don't you think it's much more convenient to have these centrally available on demand? Please share your favorite resources, and find those contributed by colleagues here: division42.org/resources/member-resources.

Division 42 thanks you

Thank you for being a member of the Division 42 community. Our Membership Committee, led by Dr. Judy Patterson, is currently conducting surveys to better understand what our members need from the Division. If you receive a survey, please do fill it out, because your feedback will help determine the types of programs and services offered in the future.

We also welcome your participation in division activities. Each and every one of our members has something unique to contribute. If you'd like to get more involved, please consider joining a committee that fits with your interests. division42.org/about/2018-committees.

Pauline

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p.s. Division 42 welcomes new members. Please encourage your colleagues to join at division42.org/membership.

Concussions and Psychology

Megan Jacobson and Stacy M. Stefaniak Luther

Pervasiveness and Severity of Adolescent Concussion

An estimated 250,000 adolescents a year will experience a concussion (Guay et al., 2016). Given there are approximately 50 million children in the United States (Guay et al., 2016), the number of adolescents affected by concussions is astounding. Even still, many studies suggest the number of actual concussions a year, across all ages, is much higher due to a consistently low reporting rate on the injury (Harrison et al., 2017; Ip, 2016). In essence, the prevalence of concussions occurring in the adolescent population is large. Not only are there many concussions ensuing but the seriousness of concussions has also been called to attention. Emergency visits related to concussions increased by 70% between the years 2001 and 2010 (Guay et al., 2016). Involvement in sports makes the severity of concussions even higher. Approximately 50% of all emergency department visits for concussions (between the ages of 8 to 19 years old) are related to participation in sports (Ip, 2016). Clearly, the number and severity of concussions is large enough to create common concern for the public. Experts in the psychology field should also be aware of the current concussion issue because of possible interference in therapy and assessment sessions. As will be discussed later, concussions have been connected to emotional irregularity, depression, and other symptoms that mimic conditions of psychological disorder. Knowing a client's history of concussion as well as conducting assessment when a current concussion is possible can lead to accurate diagnosis and proper treatment.

Megan Jacobson (above) and Stacy Stefaniak Luther (below).

Potential Trouble

According to Guay et al. (2016), 234 studies associated with sports related concussions were published between 2008 and 2010. The mission was to discover possible reactions one might have due to experiencing a concussion. Researchers have broadened public understanding of damage caused by concussion. Studies indicate that individuals post-concussion often report feelings of irritability, depression, anxiety, and emotional upset (Guay et al., 2016; Henry et al., 2017; Ip, 2016). Ip (2016) explains these symptoms seem to pop up and disappear spontaneously and inconsistently among different individuals. This means no two people will have identical reactions to a concussion in symptom type, nor will the symptoms be held for the same duration or intensity.

Research does show, as mentioned above, that symptoms vary based in individuals with concussions. While this may be true, the study conducted by Guay and colleagues (2016) found similarities in reported symptoms within their sample of concussion victims. In order of most reported to least reported, symptoms were as follows: headache (85.8% to 94.2%), dizziness (64.6% to 75.6%), concentration issues (47.8% to 54.8%), and confusion or disorientation (39.5% to 45%). Other cognitive symptoms reported by the sample included difficulties with attention, memory, and fogginess (Guay et al., 2016). Physical symptoms such as fatigue, sleep issues such as insomnia, and sensitivity to light were also commonly reported among participants (Guay et al., 2016).

Research has indicated that on one hand concussions do seem to generate a series of common short term symptoms that can be used for diagnosis and treatment recommendations. Research has also been done to explore long-term outcomes of concussions. However, in regards to long-term outcomes, there is some incongruence. Martini et al., (2017) tell of a study which concluded that concussions can negatively impact attention and decision making three to 30 years after obtaining a concussion. Upon attempting to recreate the study, Martini and colleagues (2017) found no conclusive results. Another study suggests long-term side effects to concussion could consist of depression, paranoia, agitation, impaired judgement, and aggressive behavior (Henry, Tremblay, & De Beaumont, 2017). Henry et al. (2017) propose some long-term symptoms could be due to temporal and frontal lobe damage which is a frequent occurrence in concussion and is shown by neuroimaging. Another potential area of concern in long-term concussion results is an increased risk of suicide, nonetheless studies here are also inconclusive (Henry et al., 2017). Overall, the research involving long-term effects of concussions are mixed. Increasing research precisely covering this topic would undeniably help. It would be wrong to assume that lack of research is the only reason why results are inconclusive; it is also possible that long-term effects are simply not present. Either way, nothing can truly be decided upon until available studies are added to. Psychologists may be able to help contribute to research and understanding of concussion symptoms and their influence on presentation of mental health symptoms by documenting noted differences before and after concussion or by reviewing medical records provided by a client or through agreement for the psychologist to obtain treatment records. Active involvement in research studies can also help enhance understanding of the impact of concussions, which may contribute to advancements in treatment recommendations and ways to decrease risk. Awareness of the impact of concussions, at the very least, can help psychologists share this understanding with other psychologists and further expand a general knowledge of how concussions can impact treatment.

Research shows that concussions have been linked to considerable neurological damage (Guay et al., 2016; Henry et al., 2017). Emotionally, physically, and mentally concussions can be troublesome. There is some indication that these effects have a probability of lasting several months or years. It is imperative that any persons associated with sports be aware of the risks involved regardless of age. One could argue the necessity of risk awareness increases exponentially when making decisions about childhood involvement in sports. It is up to parents and coaches alike to provide an environment of safety and caution so as to not permanently damage the still developing brains of their athletes. Psychologists can help promote awareness by learning about concussions and sharing the information with clients. Additionally, there are opportunities for research, public speaking, involvement with sports teams, and consultation with athletes, their families, and coaches to help reduce risk and raise awareness of the long term impact of concussions.

Treatment Considerations

Naturally, following a discussion of symptoms comes a discussion of treatment. Discussed

within the given research was potential screening and remedy when dealing with concussion. Before concussion occurs, a growing amount of sports institutions are requiring athletes to take a baseline concussion test (Guay et al., 2016). Baseline tests provide a comparison for medical professionals when assessing severity of brain damage resulting from concussion. Doctors can compare scores on the best pre-injury and post-injury. In addition, baseline tests can be utilized when determining when it is safe for athletes to resume play (Guay et al., 2016). Psychologists can contribute to these baseline tests by serving as consultants and by providing data via neuropsychological assessment. Having a neuropsychological assessment report can provide data that includes behavioral and mental status information to be used in the future for comparison of functioning and presentation of symptoms.

Post-concussion, researchers suggest a handful of techniques that can be used to nurture healing. Ip (2016) argues that immediately after concussion, a patient's doctors should educate and remind the individual and his or her caregivers of symptoms. A sense of what is to be expected and what is considered normal, in other words, should be provided. Johnson and colleagues posit that the best form of concussion treatment is cognitive rest (2017). Every day the brain is responsible for interpreting sound cues, visual cues, touch, thoughts, and much more. An uninjured brain can process a certain amount of stimuli in a given time frame, which is called a brain's metabolic rate (Johnson et al., 2017). When brain injury, including concussion, occurs the brain's metabolic rate slows (Johnson et al., 2017). Meaning, the amount of stimuli a brain can process decreases. It is suggested that the best way to treat concussions is to limit exposure to stimuli, allowing the brain to rest (Johnson et al., 2017). Johnson and colleagues (2017) propose cutting back on television, video games, cell phones, and other technology exposure to provide cognitive rest. Other things like job or school attendance, listening to music, light exposure, or movement can also be reduced to give the brain rest (Johnson et al., 2017).

Baseline testing pre-concussion and post-concussion intervention such as education and cognitive rest are backed by several studies (Guay et al., 2016; Ip, 2016; Johnson et al., 2017). Altogether, one must remember the most substantial thing needed when recovering from a concussion is time. Adults typically take seven to ten days after initial blow for concussion symptoms to fully dissolve (Guay et al., 2016). Concussions in children and concussions received in sports are linked to a longer recovery time (Guay et al., 2016; Henry et al., 2017). This suggests that a child with a concussion should be given ample time of cognitive rest to fully mend. Psychologists can help by providing psychoeducation to parents and athletes at the onset of sports seasons. It may also be valuable to educate clients who play sports on safety and symptoms to be aware of. When a psychologist is proactive, he or she can help parents and others involved in the individual's care know what to do in advance of the experience as a precautionary measure which can allow for early start for cognitive rest.

Studies have provided bountiful evidence of the vast number of concussions and the severity. Short-term effects are undeniably common, long-term effects are possible though further research is needed. When treating a concussion is imperative that the patient is given time and plenty of opportunity to rest. Concussions are a serious injury that many Americans are starting to take note of. Referring to children, even more significant care should be taken to ensure no permanent damage is done to brains that are still developing. Athletes, coaches, parents, doctors, and others involved with the individual's care owe it to the safety of athletes everywhere to resolve the current concussion crisis. By contributing to the research and advancing the general populations understanding of the impact of concussion as well as treatment recommendations, psychologists can help improve the understanding of this crisis and why the population should be concerned about the long-term impact of concussion.

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Biography:

Megan Jacobson is a senior attending University of Wisconsin Stevens Point. She is majoring in sociology and psychology with an emphasis in human services. Megan plans to pursue a doctoral degree in clinical child psychology after her undergraduate studies to become a child psychologist. Megan is also a USAG certified professional gymnastics coach and works at the Stevens Point area YMCA.

Stacy M. Stefaniak Luther, MS, is in the Clinical PsyD program at Capella University. She is currently completing her internship at the Behavioral Health Clinic (located in Wausau, WI) focusing on psychological and neuropsychological assessment. She has a background in education and child/adolescent development. Stacy's professional interests include attachment, parenting, Autism Spectrum Disorder, behavior intervention, and assessment.

Multicultural and Diversity

Facing My Money Ghosts: Psychological Residuals of Growing Up Poor

Anatasia S. Kim

Every now and then, predictably, I get money anxiety. Can I raise my private practice rates by another $25? Am I worth it? Do I *really* know what I am doing to charge that much? This is a long-standing and ongoing sore spot for me as a private practice clinician. Did I also mention that I'm terrible about mailing out invoices on time and following through with late payments? One time when a client didn't pay for multiple months and the case had been closed, I seriously flirted with the idea of just not collecting, even though the client was a successful medical doctor who could more than afford my services.

Avoidance, denial, insecurity, and general hang-ups define my relationship with

money, especially when it comes to my work as a clinician. This is in spite of the fact that beyond valuing my work with clients, the income I receive is an important source of financial support for my family. The irony that I work in private practice with mostly affluent, educated clients and families is not lost on me. Every time I think I've moved past my money issues, they always creep back in, reminding me again about the psychological residuals of growing up poor. (I use the term "poor" broadly. There is great spectrum to being poor. My family was persistently low-income but we were fortunately never homeless or unemployed for too long.)

After the countless years of education and tirelessly working to climb the socioeconomic ladder, I find that although I have technically moved into a higher income bracket and even a new zip code, the remnants of economic insecurity experienced during my developing years still linger and loom large in my psychological mind space. Invariably, it is reactivated around any activities related to money transactions with clients. By far, sending out invoices, following up on delinquent payments, and occasionally raising rates are the most challenging areas for me as a clinician. They all awaken and agitate the money ghosts from my past.

This essay is in large part my personal journey back to the origins of my money issues and what vestiges I have carried across time and into my new world of financial stability and privilege. I hope in traveling this path and sharing this story, we can together be reminded of the power, nuance, and complexities of how we are each indelibly shaped by the sociocultural forces in our world, in spite of which side of the couch we are sitting on.

Money Issue Beginnings

I come from a tightly knit, first generation immigrant family. The first year when we arrived in the United States, we lived in a small studio apartment in Indio, California. My father lied to the manager and told her he only had two young children and pleaded with her to overlook the building's one child policy. Well, there were actually four of us. My sisters and I ranged in ages from two to eight at the time. I was the oldest. I'm not sure my younger sisters really knew what was going on, but I definitely did. I knew why we could never leave or come home all together. I understood how we needed to space our goings and comings so that no one would notice how many kids my parents really had and how grossly we were violating that one child policy. I remember the constant sense of unease and anxiety. Every time there was a knock on the door, I hid, anticipating an unscheduled visit from the manager. I would imagine a hundred different and humiliating ways we would be found out. It was hard to feel at home in that studio, where I perpetually felt hijacked by fear of being kicked out and becoming homeless.

My parents had only graduated from high school, and it was not easy finding employment with their limited education and English proficiency. The salary from my father's first job with a local telephone company was insufficient to sustain a family of six. We had to make ends meet. So, we did whatever we could to stretch the dollar. My mother became a pro. She bought used clothing from the local Goodwill store and washed them by hand until they were practically new, missing only the department store price tag. I remember my first doll that my mother purchased for a mere quarter – a beautiful baby girl with golden curly hair and flickering eyelids that hid the most magnificent blue eyes (it was nearly impossible to find any dolls of color during those times). I adored her so much. But I couldn't quite play with or even hold her as the rough hands of her previous owner had rendered her parts asunder. So, she sat ever so cautiously up on the windowsill, away from the careless hands of my younger sisters, under our stiff, blue couch. I sat many a day just looking at my first American doll, talking to her, while every now and again readjusting her posture as the weight of her broken limbs caved to gravity.

Goodwill, garage sales, and swap meets became weekend rituals. The sweet smells of hot oily churros, juicy ripe mangoes, and warm bread to which we slapped on PB&J defined my formative years. We were constantly on a scavenger hunt for the best, most outrageous deals. My mother was fearless, even with what little English she had picked up here and there, mostly from her children. She was the slickest negotiator. "How much?" she'd ask picking up a set of used bowls. "Two dollars," the vendor would reply. After a brief, intentional moment of silence, she would turn over the bowls, scrunch her nose, shake her head ever so subtly, and say, "I give you 50 cent." This was predictably followed by some version of disgust or a disbelieving chuckle from the seller, whose response required no words. My mother, so proud and confident, would simply put the bowls down, collect her children, and start to walk away. At least 50% of the time, the vendor would call her back. "Ok, you can have it for $1.50." My mother would only half turn, consider the new offer without much enthusiasm, and flatly reply, "I give you $1." More than half the time, she'd get her way. I was constantly aware and even embarrassed that we couldn't afford to pay what the vendor was asking. But, I was also in awe of my mother – her moxie, fierceness, grace, and pride. They were unparalleled. One time, she told me that it would be stupid of anyone to not bargain, even if they were rich. "I'm not stupid," she'd say. If not for lack of access to education and opportunities, my mother would certainly have been one of the most successful businesswomen in the world. I'm sure of it.

Over the years, my parents and our family picked up odd jobs here and there. When we were not hunting for the cheapest deal, we were selling. Swap meets were not just places to buy 12 pairs of socks for $3, they were also where we laid out our $2.50 Michael Jackson and Menudo (Latino boy band popular in the 80s) watches in hopes of making extra income. My father also pumped gas at a local station and even drove down to San Diego (2 hours each way) for some period of time because there was work there. My mother worked at a neighborhood fast food shop washing dishes and flipping burgers. We also continued to hustle as a family, including assembling thousands of cubic zirconia necklaces at home for some unknown company that used a middleman to outsource cheap labor. Just before or after dinner, we would clear the living room furniture and spread out all the parts for assembly. I knew those diamonds were fake, but I was still amazed at how incredibly they sparkled. Once in a while, my mother would allow us to put one on. "Just to try it," we would beg. I would stand in front of the bathroom mirror marveling at its beauty, in spite of how out of place and unnatural it looked around my neck. Brief and fleeting stolen moments of fantasy.

During those formative years, especially as the eldest child and the primary translator in the family, I was eternally aware of our family finances. My mother proudly shares how her children never complained of wanting food or asked for material goods. This is true. It's also a testament to how my mother and father raised us. Like so many parents, they wanted more for us. Education, they said, was the ticket out. Education was a means to leave behind the challenges of growing up in a poor community. It would be a chance to not live in fear of another drive by shooting or having our home burglarized yet again or even feeling safe to walk home from school. Anxiety does run in my family across the generations. However, growing up in these social circumstances only reinforced and amplified my fears. They were fertile grounds for breeding my emotional vulnerability. Education meant access, including access to money. Money meant I could literally buy myself into a safer neighborhood. I was motivated to leave my fears behind. I also wanted more than anything to make my parents proud. So, I pursed education relentlessly. It was my ticket out.

Money Issues in a New SES

After years of indefatigable effort, I finally reached my destination. I made it out. I worked throughout college, starting freshman year. I lived off kimchee fried rice during graduate school; my mother supplied the big bags of rice and bottles of her famous kimchee, all I had to purchase was a carton of eggs. I eventually received my PhD and even landed a great job teaching. I also started my private practice. I was advised that the going rate at the time was $150 per session, a price tag I could hardly

fathom. I somehow talked myself into thinking and believing I was worth all 150 dollars for 50 minutes. I ignored the fact that I persistently exceeded the time limit, took ridiculously long and copious notes, and made myself unnecessarily available to clients outside of sessions without additional charge. Yes, I was just starting off, eager, and inexperienced. I was also beginning to manifest my money issues.

In the last 11 years since starting private practice, I'm not sure how much progress I have made in ameliorating my financial insecurities. In many ways, I am still just beginning. Far from being resolved, it's a journey I am trying to embrace more intentionally and with greater clarity. The very first steps, however, were far from effortless. During the six consecutive years I worked with one of my earliest clients, I never raised my fees, not once. I thought about it many times, maybe even constantly, particularly during the latter years. But I never acted on it. Too scared. Those money ghosts had resurfaced and paralyzed me. In the years that followed, I slowly gained more insight and awareness as my anxiety about collecting payments and raising fees became indubitable and downright distressing. I also began to observe clinicians around me navigating money matters with noticeably more ease and conviction. Of course, this only served to fuel my own sense of isolation, feeling different and out of place. An imposter. It began to affect my confidence, self-esteem, and overall well-being. Why couldn't I just get over this thing? What was my deal? Am I stupid?

Impacts of Poverty

Beyond the well documented, negative impact of poverty on children's physical health outcomes (McCann, 2010; Raphael, 2011), a growing body of literature is finding similar adverse impact for psychological and mental health outcomes (Pickett & Wilkinson, 2010; Twenge & Campbell, 2002), including decreased self-esteem and increased depressive symptoms (Ho et al., 2014). In addition, internalized financial stigma may contribute to social isolation and influence one's sense of belonging in ways that detrimentally affect physical and psychological health outcomes (Hirsch et al., 2017).

In essence, this was what was happening to me. I had internalized very early on the stigma of growing up in a low-income household, struggling to hold fast to economic security while fantasizing about upward mobility. Planted during my formative years, watered generously throughout my development, and cemented permanently into my psyche, it should have been no surprise stigma was driving my money issues all along. How naïve of me to think I had disposed of it somewhere far away, long ago. The newly acquired upper middle class status, though undeniable in its wealth of privileges, was no cover or cure for what had affected me so considerably and deeply as a child.

In so many ways, my sisters and I defied the odds. Research clearly indicates that children raised in families with economic insecurity are much more likely to be poor as adults (Corcoran, 2001; Duncan et al., 1998; Putnam, 2015; Sharkey, 2008; Sharkey & Elwert, 2011; Wagmiller & Adelman, 2009). Given this sobering reality, we most certainly beat the odds. We fulfilled the hopes and dreams my parents had quietly, and with cautious optimism, cultivated for many years. Yet beating the odds didn't come without a price. The psychological residuals of our early experiences have remained with us in ways that are too panoptic to fully capture. It's evidenced in the anxiety about what we purchase, what we don't purchase, who we befriend, who we have chosen as life partners, the work we do, and even how we raise our children. It has also undoubtedly played a central role in whether or not I have the confidence to raise my fees, collect my payments, and truly believe in my professional worth and integrity.

The detrimental effects of poverty have long-term implications on various domains of functioning, such as academic and economic achievements in adolescence and adulthood (Heckman, 2007). These long-term impacts also prove true even for those children who experience "transient family income decline" (Elders, 1999; Ramathan et al., 2013; Ramathan et al., 2017). What these and other studies clearly illustrate is that poverty and economic insecurity are powerful sociocultural forces that acutely transform the psychosocial development of a child and anyone else who experiences it. Unlike other, mostly immutable cultural identities such as gender and race, socioeconomic class can shift anytime and anywhere, without notice or mercy. As such, once experienced in a profound way, poverty and low-income can actualize reverberating residuals of financial anxiety for undetermined periods of time.

Intersection of identities additionally exacerbates the stress experienced from economic insecurity. For example, beyond the remnants of my family's financial challenges, my money issues have also intersected at the cross roads of gender and race. As a woman of color, I am invariably reminded of the income inequality between myself and my male counterparts and white colleagues. In fact, it has been found that among low-income communities, the intersections of poverty, gender, and race amplify the experience of these stressors (Stansfeld et al., 1998). I am continually astonished with male colleagues who, without the slightest hesitation, increase their fees, demand raises, and ask for consultation rates that leave me gaping in disbelief. I have had similar experiences with white colleagues, who appear, in my mind's eye, to possess an unwavering assurance about their professional worth as evidenced by how much they insist for their services. I often wonder what their socioeconomic narratives are. Certainly not all men and all those who are white grow up in wealth or financial stability. However, the additional marginalization I have faced as both a woman and person of color have most certainly intensified and aggravated my money issues.

I would be remiss if I fail to acknowledge that this grim reality is immeasurably greater than just me; it's an unfortunate and discouraging phenomena globally. For example, the top ten richest people in the world have routinely been all men, almost all white, and mostly American. In 2017, it was reported that the world's 500 richest people increased their overall wealth by $1 trillion (Cox, 2017). This is in contrast to the exponentially growing income inequality between people in the poorest and richest countries, which, according to the Maddison Project, recently increased by 135%, tripled since 1960 (Hickel, 2016). Against this backdrop, the road ahead often feels like an uphill battle, though by comparison to those struggling in actual poverty worldwide, my problems are inconsequential. My battle is intrapsychic and psychological, one that comes with more privileges than I can conceivably count. And still, it's a battle.

Facing My Money Ghosts

So here is how I have been battling my money ghosts. Without a doubt, my journey has been decidedly humbling. First, I went in search for my people – others who grew up like me and are plagued by similar money issues. Not surprisingly, I didn't find too many comrades. Even so, I was lucky enough to form an amazing sisterhood with two women of color psychologists who have proved invaluable to my development. Whenever anxiety about raising my fees approaches the boiling point, I reach out to one of them (often both). They do for me what any great clinician does for their clients – they listen, reflect, affirm, challenge, and encourage me to face my fears. On one occasion, one of them literally stayed on the phone with me while I mailed out my fee increase notices to clients. She didn't trust that I'd do it after getting off the phone with her. She knows me very well.

Second, I have dedicated time to my own personal growth. My experience of being deeply seen by my sister colleagues has allowed me to turn softly into my complex and unresolved internal world with compassion and gratitude. From this space, I have experienced flickers of acceptance and hope. As I reconnect with not just the pains of growing up poor but as well the joys, I am reminded this is where my strength and resilience were birthed – in the studio apartment, swap meets, and assembling cubic zirconia necklaces. I am remembering that I am assuredly not stupid. I am after all, my mother's child. So, when the money ghosts come knocking unsolicited, I invite them in, and with patience and loving kindness listen

again to their stories. Stories that have been for a long time muted and suppressed. Stories that need to be told, heard, acknowledged, and celebrated.

Finally, I get to work. I remember that I defied the odds and that there were also friends I left behind. When I was in 9th grade, I decided to become a psychologist after taking a class on introduction to psychology. Since then I never veered off course. I had found a field and career through which I could corroborate that people who grow up under impoverished circumstances are no less important or worthy than anyone else. At the heart of my work as a psychologist, the mission has always been about serving marginalized communities. This is why I have dedicated myself to building a pipeline program aimed at increasing underrepresented students in advanced degrees in psychology, including first generation college students and students of color. I am also devoted to championing the dire and urgent needs of immigrant populations most recently under repugnant government assault. I remember how lucky I was to have become a citizen after graduating college and how differently my life would have unfolded without that piece of paper. In addition to developing programs and providing services, as a teacher, I have the awesome privilege of bringing these topics and issues to the learning and training of future psychologists. I am grateful for all the time and space I am afforded to unpack and grapple together with my students, the critical roles, complexities, and even contradictions of sociocultural issues that profoundly impact the human experience. So, I get to work. There is a lot to be done. Not surprisingly I find that I am almost always overcommitted and overworked. But then again, this is more than work. It's personal.

I hope that in some small way, reading this has stirred a deeper and more critical consideration of sociocultural influences in general and the impacts of poverty in particular. I also hope that you will have the benefit, as I have had, in sharing your own stories. It's a privilege to have the opportunity to practice what we preach – to turn inward, look deeply, and cultivate love and acceptance. I firmly believe that the practice of culturally affirming approaches in our work as psychologists must at the core involve critical and relentless examinations of ourselves. It's no easy task. But, like our work with clients, the potential gifts are boundless.

Epilogue

Five years ago, I made a ridiculous purchase. I bought a purse. It was not on sale and it was not cheap. The purchase also didn't happen without drama. That afternoon at the San Francisco Nordstrom, I didn't know that my casual browsing would lead me to a most fabulous purse. In many ways, this event was a critical turning point to my money issues. I stood in front of that purse and stared at it for who knows how long. Then I gingerly hooked it around my forearm then my shoulder. It was one of those merchandises connected to the display table by a rubber and metal line. As such, I couldn't put it against my body in all the ways I imagined I would carry it. Finally, I asked the Nordstrom sales woman to unhook the purse. The entire time she was watching me and asking if I had any questions, unbeknownst to her, I was having an epic, existential explosion of emotions. To say I was self-conscious would have been a gross understatement.

Why did I dress in sweats today?! OMG, I LOOK like I can't afford this purse! But seriously, can I really afford this purse? Yes of course you can! You're a successful working professional! Why do I need this purse? I don't NEED this purse. Who in their right mind would buy a purse this expensive?! You don't NEED it, but you want it, and you deserve something nice for yourself for once! But isn't this consumerism at its worst, buying something I don't need that is insanely overpriced?? Stop analyzing everything and chill out! It's just a purse!

This went on for at least 30 minutes, after which I decided to call my husband, who bless his heart, said I should buy it if I really wanted it. Of course, I only focused on the "really" part of his supportive response. Then I attempted to call all of my sisters to ensure that I had not unknowingly lost it. One answered and she was similarly encouraging, if not vehemently directing me to buy it. At one point, she exclaimed, *we* deserve it!

Long story short, I bought the purse. It's been five years and I have used it all but a handful of times. It's hidden away in my closet inside the care of a soft pouch. I still have the price tag. I heard that Nordstrom doesn't have an expiration date for returns. I would be lying if I didn't admit that every now and again when those money ghosts come back and I succumb to guilt and insecurity, I flirt with the idea of returning it. That urge has attenuated some over the years, though not completed disappeared.

More than serving the function of holding my wallet and keys, when I take that purse out from behind the closet and drape it over my shoulder, I am able to channel still unfamiliar but increasingly powerful feelings of courage and self-compassion. I know that might sound silly and superficial. But that purse is really a symbol, maybe even a transitional object, that connects my vastly different worlds of the past and present. When I stand in front of the mirror with my purse in hand, I see glimpses of that young girl with the cubic zirconia around her thin neck. Her dark round eyes are dancing, and she is smiling back at me.

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Biography:

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Opinions and Policy

'Cause I'd Rather Ride on My Motorcycle

Pat DeLeon

The Prescriptive Authority (RxP) agenda continues to mature quite nicely with Hawaii Psychological Association RxP Chair Kelly Harnick receiving enthusiastic support from Mental Health America of Hawaii which listed Prescriptive Authority for Advanced Trained Medical Psychologists (RxP) as its *first* Access To Care Advocacy Priority. Connecticut Psychological Association President Anne Klee reports that their state Department of Public Health (DPH) formed a Committee, which has now met three times, to consider CPA's request to expand their scope-of-practice to include RxP. DPH will ultimately make a recommendation to the Public Health Committee of the Connecticut General Assembly for the 2018 Legislative Session. One of the major lessons learned from the initial successes of Elaine LeVine (New Mexico) and James Quillin (Louisiana) is the political importance of developing broad-based grassroots support, especially from potential patient/client beneficiaries. Fundamentally, RxP is about increased access to *quality* healthcare.

Beth Rom-Rymer, who was absolutely critical in Illinois, in passing her state's RxP legislation in 2014, recently hosted her fourth Chicago evening event for those committed to advancing the agenda. "We had our biggest crowd, yet, for our Fourth Biannual Prescriptive Authority Networking Dinner, at my home, with over 100 people. We had two distinguished keynote speakers: Arthur Evans, our APA CEO, and Danny Carlat, the first psychiatrist, of whom I'm aware, to publicly support Prescriptive Authority for psychologists." Also participating in Beth's event, and receiving special commendations, were the Director of Medical Education, Vice Dean for Education, and Professor of Neurology at the Stritch School of Medicine, Loyola University Medical Center; and the President and CEO of AMITA Health Alexian Brothers Behavioral Health Hospital, who are committing their time, energy, and expertise to create a series of rotation experiences for prescribing psychology trainees. Because of their significant support of the Illinois Prescriptive Authority movement, a number of other community partners, including: the Illinois Psychological Association (IPA) and its lobbying team; Thresholds, the oldest and largest social service organization in Illinois; NAMI; the Illinois Department of Corrections; the Illinois Department of Mental Health; the Illinois Department of Children and Family Services; the Chicago School of Professional Psychology; Concordia University; Adler University; University of Illinois, Urbana-Champaign; Northwestern University; Midwestern University; Northeastern Illinois University; Rosalind Franklin University of Medicine and Science; Chicago Lakeshore Hospital; Erie Family Health Center; and, legal partners were all represented at the networking event.

As she neared the end of her prepared program, Beth asked all of the 12 Psychology graduate students to come to the front of the room and introduce themselves to the group. Two of the student leaders talked about why they are choosing to take joint degrees in Clinical Psychopharmacology along with their doctoral degrees in Psychology. Several Early Career Psychologists introduced themselves, explaining why they are taking the training to become Prescribing Psychologists. There was a strong feeling of accomplishment in how IPA has progressed in the implementation of its Prescriptive Authority statute and great enthusiasm for the prominent roles that prescribing psychologists will take in repairing a faltering mental health system.

In many ways, the essence of the public policy process intimately involves politics. Last fall the American Association of Nurse Practitioners (AANP) alerted their membership: "The American Medical Association (AMA) took steps at its recent meeting to call for the creation of a national strategy to oppose legislative efforts that grant independent practice to non-physician practitioners through model legislation and national and state level campaigns. While these tactics are not new, the AMA's ongoing physician protectionist resolutions are hurting patients and negatively impacting the health of our nation. As we all know, the evidence is clear: Nurse practitioners provide safe, high quality care; and states where NPs are prevented from independent license consistently rank among the poorest on health outcomes, access to primary care and geographic disparities in care. AANP has issued a statement in response to the AMA's resolution. We will continue to fight for our patients and their right to high quality care delivered by the provider of their choice."

The healthcare environment of the future will dramatically emphasize interprofessional team practice within closed networks (e.g., Patient-Centered Medical Homes and Accountable Care Organizations) as envisioned by the Patient Protection and Affordable Care Act (ACA) of President Obama. Mental and behavioral healthcare will increasingly be provided within integrated primary care settings. When psychology first embarked on its state-level RxP quest, visionary Linda Campbell developed an innovative training program with her colleagues at the University of Georgia College of Pharmacy. A similar visionary approach was taken by Judi Steinman at the University of Hawaii at Hilo.

At the national level, pharmacy has established The Board of Pharmacy Specialists which currently certifies specialists in eight different areas (e.g., ambulatory care, pediatrics, psychiatric pharmacy). The number of specialty certified practitioners has grown quite dramatically in recent years as the complexity of patient management increases. It is possible to find specialists by geographical region through the BPS website. Pharmacy has been steadily expanding its scope-of-practice on both the federal (especially within the VA, as Kathy McNamara has observed) and state level, commensurate with its doctoral level of educational training. As a result, an increasing number of states allow pharmacists to modify and initiate medication protocols. In 2003 there were approximately 4,000 board certified specialists in clinical pharmacy. By 2016 these numbers had increased to almost 28,000. We look forward to the time when those interested in the RxP agenda will develop collaborative continuing education and patient-centered case seminar initiatives with pharmacy and/or advanced practice psychiatric nursing (APRNs). The time has come for psychology's clinicians and educators to expand their vision in order to

embrace interprofessional training as proposed by former APA President Susan McDaniel.

The Advent of Telehealth: The transformation of healthcare is being significantly influenced by the expanding impact of technology on the delivery of care. Stephen DeMers will soon be retiring as CEO of the Association of State and Provincial Psychology Boards (ASPPB). We will greatly miss his vision and passion for the profession. Under his leadership, the APA Council of Representatives endorsed in principle ASPPB's Psychology Interjurisdictional Compact (PSYPACT), a joint initiative with APA and the APA Insurance Trust, during our Denver convention. The proposed "E-Passport" would allow the provision of psychological services by qualified licensed psychologists via electronic means across jurisdictional boundaries, without additional licensure, in the jurisdiction in which the client was physically present when receiving those services. At the end of last year, the House of Representatives passed legislation so that VA providers could practice telehealth in any state, regardless of whether the provider or patient was located on federal property. "Just want to ride on my motorcycle." Aloha,

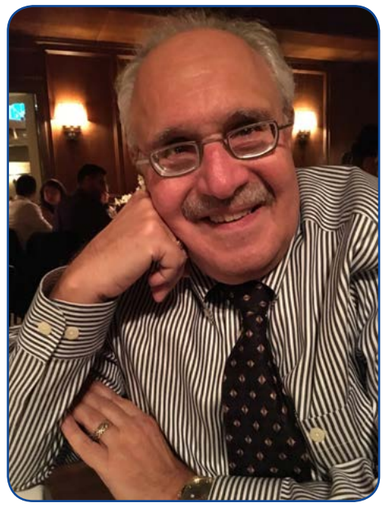
Pat DeLeon, former APA President – Division 42 – February, 2018

Focus on Forensic Psychology

On the Disconnect Between Law and Psychology

David Shapiro

In previous columns, I have spoken in an optimistic vein, of a growing rapprochement between psychology and the law, prompted largely by the acceptance by the United States Supreme Court of the arguments in briefs submitted by APA in Roper v. Simmons (2005), Graham v. Florida (2010), Miller v. Alabama (2012), and Hall v. Florida (2014). The first three dealt with the limited neurological development of adolescents in terms of their culpability and whether or not they could be executed; the last dealt with the concept of standard error of measurement in determining an IQ score.



There is one area in which the psychological research does not seem to have made much of an impact, the evaluation of what are called sexually violent predators. Approximately 20 states plus the federal courts and the District of Columbia now have such laws (Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, Wisconsin, District of Columbia.). These are laws designed to provide for continued confinement and treatment of people who, upon completion of their prison terms, are deemed to be too prone to sexually violent acting out to be released or placed on parole. Rather, they are involuntarily committed for treatment. They are distinct from previous laws, which were called sexual psychopath laws, which were an alternative to incarceration. In the previous laws the commitment was indefinite until such time as a mental health professional determined that the person was no longer sexually dangerous. In short, the current laws are post incarceration, based on a belief that we can easily predict future sexual acting out, and can provide treatment that will minimize the likelihood of such behavior. The empirical evidence for these assertions, however, is very limited. For instance, one of the frequently used treatment approaches is called "Good Lives Model." Looman and Abraham (2013) note, "there is very little available research demonstrating the effectiveness of the 'Good Lives Model.'" In a similar manner, regarding the assessment, Rittenberger et al. (2010) note that while some actuarial assessment instruments demonstrate some adequate predictive validity in evaluating future violence risk in general, when it is broken down into specific risk categories, there is virtually no ability to predict future sexual violence.

Let us look first at the definition of the term; while there are slight variations from state to state the essence of the laws is that a sexually violent predator is an individual who suffers from a mental abnormality or personality disorder that predisposes them to commit predatory acts of sexual violence in the foreseeable future. For instance, the Law in Washington State (the first to propose these laws) is found in Washington State Law 71.09020 and states: The individual suffers from a mental abnormality or personality disorder that predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others, and is likely to engage in predatory acts of sexual violence if not confined in a secure facility. In a similar manner, Florida (Florida Statute 394.912) states that a sexually violent predator suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined in a secure facility for long term control, care, and treatment. We must raise some questions regarding this definition, such as what is a mental abnormality, what kind of personality disorder predisposes someone to predatory acts of sexual violence? In fact, there is no such thing as a mental abnormality recognized in the mental health disciplines nor is there any such thing as a personality disorder that predisposes an individual to predatory acts of sexual violence. For example, the DSM-5 does not contain the term mental abnormality, nor do any of the diagnostic criteria for any of the personality disorders contain 'predatory acts of sexual violence.' The same is true of the ICD-10. These are both legislative constructs, in my opinion, fictions that have been passed by legislators in order to describe certain groups of people. What is perhaps more disturbing is the large number of psychologists who perform these evaluations, rendering an opinion regarding whether or not these individuals suffer from the specified mental abnormality or personality disorder, when in fact there is no such condition. Furthermore, they are asked to make a prediction based on this diagnosis whether or not the individual will be at risk for sexually violent behavior in the foreseeable future. At the present time, the research on this area is far from settled with predictive validity studies showing a wide range of results (Rittenberger et al., 2010). In fact, Franklin (2010) has studied the most frequent diagnoses made in such evaluations and has found that Personality Disorder N.O.S. is found most often; in my opinion, this is so broad as to be meaningless as a basis for involuntary commitment.

The next issue has to do with the idea that the "mental abnormality or personality disorder" can be successfully treated such that the individual no longer satisfies the criteria for being a sexually violent predator. Since the condition does not exist and there is no known treatment, it is unlikely that anyone could successfully complete a treatment program for this condition. In 1997, The United States Supreme Court considered whether this second incarceration without any effective treatment could be considered double jeopardy (being punished for the same crime twice). The Supreme Court concluded that it was not double jeopardy because the second commitment was for treatment, not punishment; they acknowledged that there was no effective treatment, but opined that just because there was no effective treatment did not mean there was no treatment at all.

Finally, legislators realized that not all individuals would be willing to be examined so they indicated in the law that it would be acceptable, if the person refuses evaluation, to base the report on a review of the record. While this may be acceptable legally, it raises some troubling ethical questions about making diagnostic statements about someone you have not examined. The APA Ethics Code in Standard 9.01 (2016) allows this, but only if the conclusions are extensively qualified in terms of their limited validity and reliability.

In short, what I have tried to do here is raise some concerns about a widespread use of evaluations that is based on flawed concepts, incomplete research, and questionable ethical procedure.

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The Importance of Assessment and Treatment of Depression among Menopausal Women

Dana Lasek

Although studies examining a causal relationship between menopause and depression have yielded inconsistent results (American Psychological Association, 2007; Vivian-Taylor & Hickey, 2014), data suggest depression and menopause can present as co-occurring conditions. This article will examine the most significant factors which contribute to depression among menopausal women, provide treatment options, and demonstrate practical applications of assessment and treatment of depression in menopausal women.

Depression in Women

Depression is one of the most common mental health issues in the United States (National Institute of Health, 2016). According to 2016 data, 8.5 % of female adults in the U.S. meet criteria for a major depressive episode (National Institute of Health, 2016). Women are almost two times more likely than men to be diagnosed with depression (Borkoles et al., 2015; NIMH, 2016; Vivian-Taylor & Hickey, 2014). Depression impacts overall quality of life including relationships, capacity to work, financial status, is associated with chronic disease, and can lead to self-harm and even suicide (Borkoles et al., 2015; Vivian-Taylor & Hickey, 2014). It has long been suggested that the significant difference in rates of depression between men and women is, in part, due to biological sex differences and the changes in gonadal hormones:estrogen and progesterone (Albert, 2015; Borkoles et al., 2015). Girls and women are at risk for developing depression during puberty, the postpartum period, and menopause (Albert, 2015). A particularly vulnerable time for women to develop depression is at the beginning of menopause due to the onset of hormonal fluctuations, primarily estrogen and progesterone (American Psychological Association; Borkoles et al., 2015; Judd, Hickey, & Bryant, 2012; Vivian-Taylor & Hickey, 2014).

Menopause and Its Effects on Women

The onset of menopause is referred to as "the menopause transition" which can last from three to nine years (Cyranowski, & Frank, 2006) and is defined as "…the period from infrequent and irregular periods until the final menstruation, this marking the beginning of the post-menopausal period" (Vivian-Taylor & Hickey, 2014, p. 142). A host of symptoms present during the menopause transition that affect multiple physiological systems. Core menopausal symptoms include vasomotor symptoms (VMS) such as hot flashes, night sweats and palpitations, vaginal dryness, and sleep disturbances (Judd et al., 2012). Additional symptoms can include neuromuscular symptoms such as headaches and joint and muscle pains (Briggs, & Kovacs, 2015). Psychogenic symptoms include poor concentration, forgetfulness, anxiety, depression, irritability, difficulty coping, and lack of drive (Borkoles et al., 2015; Briggs & Kovacs, 2015; Judd et al., 2012 ; Vivian-Taylor & Hickey, 2014). Urogenital symptoms include urinary issues such as overactive bladder (Briggs & Kovacs, 2015). In addition, the midlife can be a stressful period for women due to changes in job, health concerns, changes in sexual functioning, and changing family roles (Judd et al., 2012; Vivian-Taylor & Hickey, 2014). Typically, mid-life stress tends to coincide with the time of menopause, further complicating these issues.

The Intersection of Menopause and Depression Risk Factors of Depression During Menopause

Studies exploring a possible connection between depression and menopause have yielded mixed results (Sherwin, 2001), however, the literature has identified a number of risk factors which put a menopausal woman at risk for developing depression. Transition into menopause and fluctuating gonadal hormones, as well as stage of menopause and reported menopausal symptoms, are primary risk factors for the development of depression (Borkoles et al., 2015; Freeman et al., 2006; Vivian-Taylor & Hickey, 2014). In addition, a previous diagnosis of depression, including premenstrual mood issues and post-partum depression, can also increase risk that a woman will develop a depressive disorder during menopause (Judd et al., 2012). Finally, mid-life stressors and negative attitudes toward menopause and aging also significantly contribute to the development of depression during this phase of life (Borkoles et al., 2015; Judd et al., 2012; Sherwin, 2001; Vivian-Taylor & Hickey, 2014).

Prevalence Rates of Depressive Symptoms During Menopause

The menopausal stage and its associated symptoms have been found to be related to self-report symptoms of depression among menopausal women (Borkoles et al., 2015). In one study by Freeman et al. (2006), women were 1.5 times more likely to report depression in the early menopausal transition when compared to pre-menopausal women and three times more likely to report symptoms of depression in the late menopausal transition than the pre-menopausal women. Another study by Freeman et al. (2004) found that women were more than four times more likely to report depression in the menopausal transition than during the

pre-menopausal phase. Seventy-five percent of women in the peri-menopausal phase reported symptoms of depression (Borkoles et al., 2015). Longitudinal studies have found that, due in part to the onset of fluctuating hormones, women in the peri-menopausal period reported depressive symptoms 2-14 times higher than pre-menopausal women (Freeman et al., 2006).

The possible link between the presence of vasomotor symptoms (VMS) and depression has been widely studied (Vivian-Taylor & Hickey, 2014). VMS of menopause include night sweats, hot flashes, palpitations and sleep irregularity (Borkoles et al. 2015; Vivian-Taylor & Hickey 2014). There have been a number of studies which have found a connection between the presence of vasomotor symptoms and reported depression among menopausal women. Cyranowski and Frank (2006) note that a number of studies suggest that sleep disturbances during the menopausal transition often lead to symptoms of depression. Soutoul et al. (1977) suggested that VMS may lead to sleep disturbances which may then lead to depression, a "domino effect" as the authors suggest. Joffe et al. (2009) found that, while there may be an association between sleep disturbance and depression in the menopausal woman, the sleep wakening frequency was not associated with symptoms of depression. Additional studies have found that, while some women do report VMS and sleep disturbance leading to a lower mood the next day, the results were not significant (Burleson, Todd, & Ttrevathan, 2010; Strauss, 2011).

History of depression also was found to be a strong predictor of risk for depression during the menopausal transition (Avis et al., 1994). Avis et al. (1994) found that prior depression was the most predictable variable of subsequent depression as measured by the *Center for Epidemiologic Studies-Depression Scale* (CES-D). Specifically, women who experienced premenstrual mood swings or postpartum depression were found to be at risk for depression during the menopausal period (Judd et al., 2012). Freeman et al. (2004; 2006) also found that women with a history of depression were at risk for experiencing a recurrence of depression before and after menopause and were two times more likely to report depression during the menopausal transition than pre-menopausal women.

Life stressors have also been linked to the development of depression during menopause (Judd et al., 2012; Vivian-Hickey & Taylor, 2014). Mid-life typically occurs between the ages of 45-55 which may coincide with menopause (Judd et al., 2012). Mid-life can be a stressful time for many women in terms of changing family roles, career changes, the onset of physical health problems, and relationship and sexuality challenges (Judd et al., 2012; Vivian-Hickey & Taylor, 2014). Women's attitudes toward menopause and aging are also risk factors for developing depression during this time (Judd et al., 2012; Vivian-Hickey & Taylor, 2014). Many studies have examined how menopause is viewed not only by society but also by women throughout the stages of menopause. Historically, menopause has either been ignored or seen in a negative light. The "change", "a natural plague," and a disease of deficiency have all been used to describe menopause (American Psychological Association, 2007; DeAngelis, 2010b). One study assessed the attitudes of men and women toward menopause and found that the menopausal women were seen in the most negative light when compared to women at the other stages of life (DeAngelis, 2010b). Women who internalize society's negative beliefs about menopause and hold negative views about menopause and aging are not only more likely to have more problems with the menopausal symptoms yet also are at risk for developing depression (DeAngelis, 2010b; Judd et al., 2012).

Treatment Considerations

There are a number of treatment options to consider when working with the population of menopausal women in clinical practice. While a definitive link between hormonal fluctuations and depression cannot be established, data suggest that Hormone Replacement Therapy (HRT) may minimize the symptoms of depression during the menopausal phase (Schmidt et al. as cited in Vivian-Taylor & Hickey, 2014). These results should be taken with caution as the authors note the sample size was small and the HRT was used over a short period of time (Vivian-Taylor & Hickey, 2014); however, the authors note that women taking HRT for various VMS symptoms may experience improvement in mood, as a result (Vivian-Taylor & Hickey, 2014).

As a result of research suggesting women's internalizing negative societal messages about menopause is correlated with depression (DeAngelis, 2010b; Judd et al., 2012), the APA suggests replacing negative words such as degeneration and decline with more positive and empowering words such as growth, freedom, and opportunity when describing mid-life and the times of menopause (American Psychological Association, 2007). Therapy has also been shown to be effective in helping menopausal women deal with symptoms of depression (DeAngelis, 2010b). Therapy directed toward helping women cope with body dissatisfaction during the menopausal stage of life has shown to be helpful (DeAngelis, 2010b). In addition, couples work can help women communicate more openly with their partners about the physical and emotional changes inherent in menopause (DeAngelis, 2010b). Cognitive-behavioral therapy has been shown to be effective in helping women cope with physical and emotional symptoms of menopause. A 2009 study by Hunter et al., which utilized a CBT group intervention, found that the participants reported a reduction in the number and intensity of hot flashes and night sweats, fewer negative beliefs about these symptoms, less depression and anxiety, better sleep, and more energy (as cited in DeAngelis, 2010b).

Clinical Case

I work within a multidisciplinary group practice. I have long been interested in women's reproductive mental health, and I routinely see a number of patients dealing with mental health issues related to PMS, infertility, the postpartum period, and menopause. While seeing an increase in women presenting with depression in mid-life, I became interested in the link between depression and menopause. One patient, who I will refer to as Ruth*, was referred by her medical provider for relationship issues. As we progressed in therapy, it became clear to me that she was experiencing symptoms of depression including lack of motivation, irritability, feelings of hopelessness, and sadness and tearfulness. She had been diagnosed with bipolar disorder after her son was born yet had been stable on her medication for the last 10 years. Why then was she now reporting an increase in depressive symptoms? She had started bioidentical hormones at the start of menopause, which had helped with her core menopausal symptoms, yet she continued to report symptoms of depression. As we met and explored what was occurring, a number of issues came to the surface. She had recently quit her full-time job, which she reported that she had enjoyed a great deal. Her adult sons were living out of state with their families, and she was not able to visit them as often as she liked. She reported feeling "older" and less attractive than when she was younger. It also came to light that her weight was below her ideal weight, and that she was eating very little each day. She was seeing a nutritionist, yet she had developed very strict rules around the types of foods she would eat and how often she would eat. Finally, she was experiencing significant marital issues related to the amount and type of sex her husband wanted. She was able to set limits with him at times yet would often then feel guilty about saying "no" to him, and she reported fears that he would find another, younger woman who would meet his sexual needs. She denied any verbal, sexual, or physical abuse and denied any suicidal ideation or plan.

This complex case demonstrates the challenges women in mid-life face as they enter the menopausal transition. Women entering menopause often experience significant life changes and stressors related to family and work roles. Ruth's history of bipolar disorder, changes in career and family roles in addition to the marital strain were all risk factors for a recurrence of her depression during this phase of her life. She was taking HRT and medication for depression yet continued to report depressive symptoms. She engaged in regular therapy for some time, and she reported that this was helpful. With

her permission, her Reproductive Endocrinologist and I worked together to assist her in managing her symptoms of depression.

Importance of Identifying Depression and Engaging in Treatment

Women in mid-life face a number of stressors in addition to the hormonal changes and onset of menopause. Medical and mental health providers can use the transition into menopause as an opportunity to screen their patients for depression. Hormone Replacement Therapy (HRT) is often prescribed for women who experience especially severe VMS (Sherwin, 2001). In addition, HRT, specifically estrogen, has been shown to improve mood and may decrease vulnerability to depression in anti-depressant treatment-resistant patients (Cyranowski & Frank, 2006; Sherwin, 2001; Stahl, 1998). Anti-depressant medication, in combination with HRT, has shown some success in helping women manage the symptoms of depression during the postmenopausal stage (Cyranowski & Frank, 2006).

In the therapy setting, providing psychoeducation regarding the typical symptoms of menopause, what patients can expect during menopause, and treatment options is particularly valuable. Cognitive-behavioral therapy has been shown to be effective in helping women cope with their bothersome symptoms of menopause (DeAngelis, 2010b). Helping patients view menopause in a more favorable light such as a time of growth, freedom from menstruation and traditional family responsibilities, and a time of opportunity to pursue new interests may help women reframe the negative social stigma around menopause and view menopause in a more positive light (DeAngelis, 2010b; Sherwin, 2001).

Conclusion

While the literature does not support a causal connection between menopause and depression, there are a number of risk factors which must be taken into consideration when treating menopausal women. Identifying these women at risk, and helping them get the appropriate treatment, is essential in helping women weather the changes that menopause brings.

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Dana Lasek, PhD, HSPP is a psychologist in the Indianapolis area with over 17 years of clinical experience. She earned her Master's of Education degree in Human Development Counseling from Vanderbilt University and her PhD in Counseling Psychology from Indiana State University. Dr. Lasek has worked in a variety of settings including VA medical centers, community mental health, college counseling centers, and private practice. Dr. Lasek is currently working within a multidisciplinary behavioral health group practice. Dr. Lasek works with adolescents and adults specializing in treatment for anxiety, depression, relationship issues, ADHD, and reproductive mental health issues. Dr. Lasek has led presentations and webinars in the areas of emotional dysregulation, anxiety in children and adolescents, weight management, understanding the DSM, and personality disorders just to name a few. Dr. Lasek is currently serving as the American Psychological Association Council Representative for Indiana and has been past treasurer on the board of the Indiana Psychological Association.

Candidate Statements

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

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

President-elect (one to be elected)

Lauren Behrman

The most critical issue facing practitioners today is how to build and sustain high quality thriving practices in the face of economic uncertainty. Threats to the practice community are multifaceted (e.g., legislative, economic, our own passivity and disorganization, the proliferation of lesser trained practitioners, and how we work with insurers).

As your president I will strive to ensure that 42 remains an empowered home community for psychologists in independent practice to share resources, expertise and advocacy. Many, if not most, independent practitioners across the country don't know we exist. We need to put 42 on the map. We need to be the voice of independent practice inside APA and outside- to the public on a local, state and national level. We need to capture the attention of our colleagues who don't know we exist.

I have been active in 42 as your Member at Large, and have been Program Chair, mentor for ECP's and on the Fellows, Awards, Diversity and Fast Forward committees.

Throughout my 33 years of practice, I've also contributed to the field in the following ways:

- Spearheaded the creation of a New York Chapter of the Association of Family and Conciliation Courts, and was its first Co-President.
- Co-Founder of The Practice Institute, an organization dedicated to helping psychologists in all stages of their careers build thriving independent practices.
- Governance in two interdisciplinary organizations representing interests of mental health professionals
- Author and frequent presenter at national and international conferences

Please be sure to vote.

Robin McLeod

Division 42 must advocate for the vital role independent practice psychologists play in the healthcare system. Four issues dominate the landscape for independent practice, and Division 42 must take definitive stands on all of them:

- Doctoral degrees must remain the only acceptable education credential for Psychologists.
- With exponential growth of masters-level providers, Division 42 must definitively clarify the value of the doctoral degree.
- Clinical practice guidelines must incorporate all acceptable standards of evidence and not rely solely on randomized controlled trials. Guidelines excluding acceptable methodologies must include qualifications indicating that effective evidence-based treatment interventions were excluded.
- Division 42 should only support APA membership transformation that includes increased funding for federal and state advocacy that supports independent practice.

As President-Elect, my service to Division 42 would be based on my work as an independent psychologist for 20+ years, founding a successful group private practice, and developing a financially self-sustainable program in integrated behavioral health that is staffed by independent psychologists.

My service to Division 42 includes: Chair: Continuing Education; Committee Member: Advocacy, Entrepreneurial TaskForce, Collaborative Conference, President-Elect Endorsement.

If elected, my focus will be grounded in experience serving my state association (President; Co-chair: Membership committee, Private Practice Division; Chair: Diversity Committee; Committee Member: Legislative, Outcome Measures TaskForce), Division 35 (Liaison to CAPP), Division31 (Secretary, Advocacy Committee),- Committee of State Leaders (Chair: Advocacy Mentoring Subcommittee), and member of the Minnesota Psychology Board.

By voting for me, you will be bringing to Division 42 governance a psychologist devoted to *keeping independent practice viable and vital* in our rapidly changing healthcare arena.

Judith E. Patterson

Thank you for your nomination for President-elect of Division 42. I am in my second term on the 42 Board and believe I bring broad perspectives for service to our members. Your vote is much appreciated.

In my service to 42, I have represented issues of importance to us as practitioners. I am proud to be involved in forwarding the practice agenda. I am Fellow of 42, served on Council, as Fellows Chair and as member of Finance. Presently I am Chair of the Membership Committee and member of Advocacy Group.

I held positions at state and national levels, focusing on practice issues. I was president of NJPA, served as Chair of the Board of Professional Affairs and on CAPP and presently serving the Commission on Accreditation. I chaired the State Caucus and membership for the Women's Caucus, was President of Association of VA Psychologist Leaders and was subject-matter expert on national qualification standards for psychology.

We are faced with erosion of practice by external forces. Decline in reimbursement and outside attempts to define practice requires vigilance. We at Membership will be surveying you to learn what you need the Division to provide to protect, enhance and preserve your practice. As President, I will lead 42 to meet your expectations in every way we can by offering services tailored to your needs and by advocating to protect the doctoral standard and practice variability.

Thank you for the continued opportunity to serve 42 and to enrich the Division's responsiveness to YOU.

Secretary (one to be elected)

Derek C. Phillips

Previous service to the Division includes serving on the Strategic Planning Committee, Student Representative to the Board of Directors, Co-Chair of the Student/ECP Committee, member of the Nominations and Elections Committee and Communications Work Group, and Co-Chair of the Listserv Moderation Team. Currently, I serve as Co-Chair of the Social Media Team.

Relevant experience in leadership: I am a member of the Division 55 BoD as their representative to the APA CoR. I am also a member of the APA Central Programming Group and Ad Hoc Committee on Film and Other Media. Previously, I was the inaugural student member of APAPO CAPP. Regarding SPTA involvement, I am the Associate Chair of the Illinois Psychological Association's Social Responsibility Section andwasthe 2017 ECP Chair of the Florida Psychological Association and Liaison to their BoD.

In the current health care climate, there are many issues facing independent practitioners. Perhaps one of the most critical of these issues is stagnant or declining reimbursement rates for psychologists from third party payers. Another serious concern for independent psychologists is being excluded from the Medicare definition of "physician," as well as infringement from other mental health disciplines into psychologists' scope of practice.

Division 42 is uniquely poised to develop and implement pragmatic and effective solutions. First, Division 42 should continue to partner with other practice divisions and the APAPO to address reimbursement rates and parity issues. Communication from individual members of both divisions and SPTAs on the "front lines" is crucial for successful advocacy.

Jared L. Skillings

Thank you for the opportunity to run for Secretary of Division 42. I would be a strong, independent voice for psychology practice. I formerly held an executive leadership role in a large group (240+ clinicians) in Grand Rapids, Michigan. In this role I learned-to effectively manage clinical, financial, and regulatory challenges for independent practice. Currently I am Chief of Psychology at the Spectrum Health Medical Group (a $5.7B enterprise with 25,000 employees); I also perform pre-surgical evaluations and psychotherapy. I am ABPP board-certified in 3 specialties – Clinical Psychology, CBT, and Clinical Health Psychology.As an expert about integrated care, I can provide guidance to the Board and division members about how to best prepare ourselves and our practices for the future.

Regarding leadership experiences, I have served as President/Chair of 4 distinct psychology governance boards within the first 12 years of my career. This includes my current role as President of the Michigan Psychological Association, two executive roles in the ABPP organization, as well as Former Chair of APA's Board of Professional Affairs. Additionally in Division 42, I was pleased to serve as APA convention chairperson two years in a row (2017-2018), where we have emphasized business of practice, evidence-based care, multicultural practice, and ethics.

If I am elected Division 42 Secretary, I will contribute strong leadership and energy so that we can achieve real progress together. Thank you for your consideration and for your vote.

Member-at-Large (1 to be elected)

Sarah Smucker Barnwell

I am an independent practitioner licensed in Washington State, as well as a partner in a local group of independent practitioners. I serve as Clinical Faculty at the University of Washington Department of Psychiatry and Behavioral Sciences, and am a former president of the Washington State Psychological Foundation. I am a coauthor of the APA/ASPPB/The Trust Telepsychology Taskforce *Guidelines for the Practice of Telepsychology.* My research and publications focus on ethical, practical technology use in behavioral health.

During the Division 42 Fast Forward Conference, I had the pleasure of speaking on a panel addressing themes related to telehealth. As is typical, I learned more than I imparted through my participation in the panel. Division 42 members asked questions that are critical to the future of independent practice: How can independent practitioners balance the ethical and legal considerations of technology use with patients' desire to communicate efficiently? How can we integrate commonly used mobile technology while remaining thoughtful about remaining within my practice's licensure jurisdiction? How does insurance reimburse outpatient care when technology is involved? These are critical questions relevant to most independent practitioners who use email and mobile phones.

Exciting new innovations emerge daily in healthcare. Division 42 possesses the opportunity to participate in thought leadership regarding how independent practitioners can ethically and thoughtfully harness these innovations. Clear, practical guidance will advance the state of independent practice and the care we deliver. I hope to offer my experience in and passion for these topics as we take these steps together.

Nancy McGarrah

I am pleased to be a nominee for Member at Large for the Division 42. I joined APA after licensure in 1984. My "home" in APA is Division 42, and I become a Fellow in 2011. My career has been in private practice in Atlanta. I am completing two terms on the Council of Representatives. This experience has demonstrated how crucial divisions are to governance. I have served on the APA Ethics Committee and participated in APA Public Education initiatives.

In Division 42, I have been a mentor for several years. I have written for the Independent Prac-

titioner and received the publication award. I chaired the "ETIPS" program for the division and participate actively on the list serve. I am currently on the membership committee.

I hope to bring my experience and ideas to the Board. This is a critical time for private practitioners. We are faced with more competition than ever. APA is struggling with the Master's in Psychology issue and we can give important input to this discussion. There is also a proposal to restructure APA and APAPO to form one organization. Practice and advocacy interests must be protected during any reorganization.

A strong board of directors can lead the division in facing our ongoing challenges. We must remain a strong presence on the APA Council and hopefully regain lost seats. Continued efforts in mentoring students and emerging psychologists will lead to increased membership in the division.

Please consider me for the Member at Large position. Thank you.

Division Representative to APA Council - Diversity Slate (1 to be elected)

Lindsey Buckman

I would be honored to serve as the Division 42 Diversity Council Representative. I am an independent practitioner in Phoenix, Arizona, where I serve a diverse population with specialties in LGBTQ concerns and multiple minority status issues. I currently serve as the Division 42 Diversity Member at Large, Co-Chair of the Social Media Team and a member of the Division 42 Advocacy Committee. In addition to my service to Division 42, I also serve as the Chair of the APAPO's Committee for the Advancement of Professional Practice (CAPP), I am the President of Division 31, and serve as my SPTA's Professional Practice Representative. My commitment to diversity is personal and professional. As a female, lesbian, and small business owner both the personal and professional are political. I am a strong advocate for my clients, students, and fellow professionals and strive for fairness, equality, and cultivating space for the rich perspectives that diverse issues and experiences bring to the table. I have experience in shaping public policy, as well as working with individuals with divergent viewpoints to meet a common goal.

Independent practitioners are facing a number of challenges in the current healthcare climate and we need strong advocates to lead us through this period of change and uncertainty. I am eager to assist Division 42 and APA in creating innovative practice resources that support independent practitioners and help them thrive in the marketplace, while enhancing and protecting our status as the highest trained mental health practitioners in the field.

Armand R. Cerbone

I am seeking re-election as the Diversity Representative to the Council of Representatives. During this term in office I have successfully reinforced the Division's commitments to the interests of its diverse members prinicipally by promoting the existing Diversity Task Force into a standing Committee. Because the Committee is now a voting member of the board, it is better able to advance and protect diversity interests.

It is because I bring decades of proven leadership and advocacy in APA as a past member of the APA Board of Directors and other major governance boards, as well as 6 years on our division's board that I can further the interests of independent practitioners, especially where those intersect with diversity. Last August I received the Association's highest recognition for contributions to the APA and the profession, the Raymond Fowler Award. Two years earlier I received the practice community's highest award, the Heiser Award, for successfully influencing the passage of a state law advancing or protecting psychology.

Today 42 needs to form strong alliances with other practice divisions to find practical and effective answers to the questions that plague practice: should APA support licenses for MAs to practice independently? How should we ensure that clinical practice guidelines do not impede independent judgment? What conditions do we have to support APA's proposed major transformation into an American Psychological Institute? My record of achievements for practice and for diversity has positioned me to be an effective advocate for your interests. I ask and need your vote.

ECP Member at Large - Diversity Slate (1 to be elected)

Eric A. Samuels

I am honored to be nominated for Member-at-Large as an ECP on the Diversity Slate. I am recently-licensed and joined Division 42 a year ago.

Within APA, I am Co-Chair of the Disability Taskforce for APA Division 44, a former APAGS Liaison to APA's Committee on Disability Issues in Psychology, and a former member of the APAGS Committee on Sexual Orientation and Gender Diversity.

I am gay and a person with a disability. I'm also a former Chair of the California Psychological Association of Graduate Students and currently serve as the Local Advocacy Network Chair of the Alameda County Psychological Association.

I started my private practice in the Bay Area in September 2017 and am participating in Division 42's Mentorshoppe program.

If elected, I would work to be a voice for other ECPs who are seeking to transition into private practice. Personally, I have found the process of opening a practice to be daunting and overwhelming. Graduate students receive no formal training on how to operate private practices, and ECPs often must rely upon advice that they receive ad hoc to make decisions about how to create and maintain their practice.

If elected, I would work with the Student/ECP Committee to create more resources about how to create and maintain an independent practice. If elected, I would strive to have more Virtual Learning Hours, more resources on the Division 42 website, articles in the *Independent Practitioner*, and programming at APA conventions and Division 42 Fast Forward Conferences on this topic.

Krystal Stanley

I joined Division 42 in 2010 as a newly licensed psychologist who was plunging head-first into private practice. Three years ago I joined the Division 42 S/ECP Committee and served a two-year term. One of our goals was to increase the visibility of Division 42 to graduate students and ECPs, and I hosted an event for students and ECPs in the DC Metro Area that included a panel of Division 42 members who currently owned or had previously owned a private practice.

I enjoyed serving on the Division 42 S/ECP committee and look forward to the opportunity to serve in another capacity as an At-Large member. I believe that I am well-suited for this position as I've spent the entirety of my almost eight years as a licensed psychologist engaged in private practice. I started my practice part-time as a solo practitioner, but for the past 6 years I've been full-time as the owner of a group practice in the DC metro area that has four offices and 28 therapists.

One of the critical issues confronting independent practitioners is how to maintain aspects of the traditional models of private practice while also preparing for changes, such as the push towards integrated care. Individuals in independent practice are often strained to balance the business of practice while also remaining abreast of changes. I'd like to see the leadership of Division 42 create practical guides and/or trainings for practitioners to help them understand how to adjust to the changes and how to create the tools and strategies to adjust to these newer models.

Practice Innovations

Call for Submissions

We are looking for thoughtful articles relevant to clinicians in practice.

For more information contact:

Jeff Zimmerman, PhD, ABPP
Editor
drz@jzphd.com

New Member Resource Area on Division website

Do you have a favorite Form, or practice Template that you would like to share with your colleagues. How about an online resource that you frequently utilize?

You are invited to contribute forms, templates and other documents to share with colleagues, and to download documents that others have contributed.

You are also invited to submit annotated links of books, movies, TV series and other media that you have found helpful in your work, or that you have enjoyed in your leisure time.

If you would like to share a resource or take advantage of what others have shared, log in to the Division website and go to the Member Resource page under the Resources tab.

Disclaimer: The resources and links below are provided by individual members of Division 42. They are not produced or endorsed by Division 42 or by APA. To ensure compliance with the laws and ethics in your jurisdiction, you are advised to consult with your own attorney and/or insurance risk manager prior to adopting them for your practice.

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