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Psychologists Storm the Capitol to Protect the Profession and the Clients We Serve!

Amanda Levy, CPA Director of Government Affairs

CPA’s 2015 Leadership and Advocacy Conference at the State Capitol was another resounding success – demonstrating psychology’s continued strength for over 25 years. Over 100 psychologists and doctoral students convened for a morning of lobby training and boots-on-the ground lobbying! CPA’s members came to Sacramento to advocate for the protection and advancement of the profession and the clients we serve.

For several years, CPA’s Division of Clinical and Professional Practices (Division I) has generously sponsored an extended conference format, bringing Chapter Presidents, Division Chairs, and Local Advocacy Network (LAN) Representatives to Sacramento to discuss ways to build leadership in local chapters, increase grassroots advocacy efforts, and learn more about advocacy. CPA’s CEO Dr. Jo Linder-Crow and President Dr. Stephen Pfeiffer welcomed the delegates before moving on to a full day of panel presentations and small group breakouts.

CPA and local active chapter members shared their ideas for events that helped strengthen their advocacy presence in 2014. Dr. Cheryl Bowers discussed the Monterey Bay Psychological Association’s Summer Party where Assemblymember Luis Alejo (D-Watsonville) was honored. Sacramento Valley Psychological Association’s Dr. Daniel Rockers talked about his foray into local television where he invited local psychologists and Assemblymember Mariko Yamada (D-Davis) to discuss psychologists’ role in elder care. The 30-minute panel was broadcast on the local public television station. The delegates also heard from Dr. David Laramie and Ms. Tracey Wheeler about the work of the Los Angeles County Psychological Association to host a fundraiser for the CPA-PAC which featured Congressman and psychologist, Dr. Alan Lowenthal. We believe in leading by example and hope others took the good advice shared to shape their own legislative events this year.

Attendees had a chance to learn more about the CPA Political Action Committee (CPA-PAC), which raises money to donate to candidates and legislators who support psychology in the Capitol. We are very hopeful that our chapters will use this information to go back to their members and generate interest and revenue for the CPA-PAC. The day ended with a look at how bill positions are determined at CPA and a robust discussion on CPA’s current Legislative Positions. Input from our members is critical when representing the profession in the Capitol.

The next morning, Amanda Levy, CPA’s Director of Government Affairs, reviewed the Do’s and Don’t’s of a Legislative Meeting. In addition to speaking about legislation, members scheduled Distressed Constituent Guide trainings and asked legislators to provide suggestions of a local district business for the Psychologically Healthy Workplace Program, an award program whose recipients are honored at our annual Convention. Our 17 geographically-based lobbying teams reported positive interactions with legislators and their staff members. With that came the close of CPA’s 26th Annual Leadership and Advocacy Conference. We look forward to seeing you in 2016!

Amanda Levy (aley@cpapsych.org) is the Director of Government Affairs for the California Psychological Association, where she handles the day-to-day lobbying strategy, policy positions, and grassroots mobilization of all psychologists in the State of California.
Pain: Universal and Timeless

"Who except the gods, can live time through forever without any pain”…
Aeschylus (523-456BCE), Greek dramatist

Valerie B. Jordan, PhD

From the beginning of recorded time, humanity has experienced and often documented the human experience of pain. The word ‘pain’ evolved from the Western historical tradition of Greek and Roman goddesses of revenge, punishment and penalty (Poine the Greek goddess of penalty and Poene the Roman goddess of punishment), and humankind has endured and searched for treatments for the suffering it causes since ancient times. Historically mainly the domain of physicians and other healers, psychologists now play a vital role in the multi-disciplinary treatment and management of pain. As psychologists we understand the multifaceted diversity of those experiencing and living with pain across the lifespan and from all walks of life, as well as the range of best practices that provide psychological and physical relief from chronic pain. A recent special issue of the American Psychologist (2014 February-March) devoted to the role of psychology and chronic pain exemplifies the prominent role of psychology in pain management in the current healthcare arena.

This issue addresses the role of psychologists and pain management from several perspectives. First, Dr. Rhoda Olkin discusses how patients can more effectively describe their subjective experience of pain, and then addresses pain management issues confronting with people with physical disabilities. Next, Dr. Beverly Thorn reviews some contemporary research on CBT interventions for pain management with patients with lower health literacy skills, and the helpful adjustments that contribute to improved treatment adherence and outcomes. Next, Dr. William Deardorff describes risk factors for those potentially misusing prescription opioid medications. Finally, Dr. Eric Nadler discusses the role of psychologists in a health service setting that incorporates a multi-disciplinary team approach for patient care and opioid medication management.

In addition to the resources that Dr. Nadler recommends, other internet resources are the International Association for the Study of Pain (www.iasp-pain.org), specific APA resources (search for APA Fact Sheets at apa.org), American Academy of Pain Medicine (www.painmed.org), the US Pain Foundation (www.uspainfoundation.org), and numerous National Institute of Health (NIH) resources (www.painconsortium.nih.gov).

I hope this issue expands your awareness of and the value psychology provides in addressing this pervasive human experience.
Pain Management: A Health Priority Psychologists Must Recognize

Stephen M. Pfeiffer, PhD

One very nice privilege that is bestowed upon the CPA President is to be able to influence the content of each of the four CP Magazine editions published during the Presidential year. During the past three years since my return to active clinical practice, I have been struck by the staggering growth in the number of patients who are experiencing chronic pain. Pain, it turns out, is the most common reason that people see a physician. At least 100 million adults in the United States suffer from chronic pain, according to the Institute of Medicine. The American Academy of Pain Medicine reports that chronic pain affects more Americans than diabetes, heart disease and cancer combined and costs the nation up to $635 billion each year in medical treatment and lost productivity. Unfortunately, alleviating pain isn’t always straightforward.

If that data doesn’t get your attention, consider the growing body of data about the abuse of opioid medication. It appears that we are in the midst of a prescription painkiller overdose epidemic in this country. Since 1999, the amount of prescription painkillers prescribed and sold in the U.S. has nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report. On average, misuse was documented in approximately one out of four patients, and addiction in approximately one out of ten patients who were prescribed opioids as part of their treatment for chronic pain. While there are wide variations in reported rates of misuse, abuse, and addiction, all estimates clearly raise questions about the benefits of widespread opioid use for chronic pain, given the harmful consequences.

There is little doubt that chronic pain is a prevalent and costly problem that eludes adequate treatment. Persistent pain affects all domains of people’s lives and in the absence of cure, success will greatly depend on adaptation to symptoms and self-management. This is where psychologists can provide the greatest assistance.

There are many psychological models that have been used to conceptualize chronic pain: psychodynamic, behavioral, and cognitive-behavioral. Treatments based on these models, including insight, external reinforcement, motivational interviewing, relaxation, meditation, biofeedback, guided imagery, and hypnosis abound. Most techniques are geared to fostering self-control and self-management that will encourage a patient to replace their feelings of passivity, dependence, and hopelessness with activity, independence, and resourcefulness.

As none of the most commonly prescribed treatment regimens are sufficient to eliminate pain, a more realistic approach will likely combine pharmacological, physical, and psychological components tailored to each patient’s needs. Psychologists in the 21st century play an increasingly important role in the overall healthcare of the nation, as bona fide members of integrated care teams in the Medical Home, as included prominently in President Obama’s 2010 Affordable Care Act. Given the prevalence of pain problems experienced by a third of the population at large, it is incumbent upon all of us regardless of treatment modality to insure that, at the very least, we routinely conduct a thorough exploration of prescription drug use among our patients at all points along the treatment continuum, and provide appropriate interventions/referrals for pain management if necessary.
Help Us Help You!

Jo Linder-Crow, PhD

This is an invitation. We need your help as we re-examine the kinds of information and services that are the most helpful to CPA members. Don’t worry; we’re not thinking of eliminating those things that you value like the free consultations on ethics or practice issues. We know how important those things are! However, we want to be sure we are delivering answers to your most pressing questions; those things that keep you up at night or make you think “if I just knew more about...”

We also need your help to ensure that CPA remains strong in the short and long term by continuing to build a strong membership. Our advocacy on the behalf of all psychologists in California really deserves the support of all psychologists in California. To be honest, there are challenges on many fronts, and a strong membership means a more powerful voice with those who are making policy decisions every day that affect that way psychologists work.

To both these ends, here are ways you help right now:

- Get to know our website. Log on. Go to your profile and explore what’s there. We will be using our website more and more to keep you informed so visit often.

- Use our new “Idea Box” on the website to share your ideas about the kind of information you need from CPA. You can find the Idea Box under “Membership” on the homepage, or as an icon in your profile under “content and features.” Tell us what kind of information you would like to have instant access to (e.g. how do I opt out of Medicare?). Our goal is to build toolkits that will answer your most pressing questions. Tell us where you are in your career, too, because we will be analyzing these ideas to see if there are trends in the questions based on where you are in the life of your practice.

- Use the new “Refer a Friend” tool on our website. Almost everyone knows at least one person who could (and should) be a member of CPA. When you log on to the website, check the bottom right corner under the heading “My Profile.” You will see, at the bottom, the “refer a friend” link. It’s easy – just send a friend a message inviting them to join CPA! We will reach out to them too, but the personal touch of receiving a message from you is the best!

Thank you for your help with these three things. As always, we thank you for your membership. Have a wonderful summer!

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

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There has been increased attention to pain as a factor in health care, well-being, and recovery (Arwood et al., 2015), as well as the cognitions that influence the pain experience (c.f., Yoshida et al., 2012). The standard way that pain is assessed in the medical field is by using a number from one (low) to ten (high). If you were to see a doctor about lower back pain, the doctor might ask “What number would you give it on a scale of one to ten?” Then there might be two pictures of a body, front and back, standing upright with arms a little ways from the sides. You would be asked to put an X on the spot(s) that have pain. Lastly, you might be asked to choose the words that best describe the pain, such as aching, burning, shooting, pins and needles, tingling, electric, itching, numbness, throbbing, or hot. The words help a doctor begin to understand if the pain is neuropathic (damage or dysfunction of the peripheral or central nervous system) or nociceptive (stimulation of pain receptors). These three methods – a number, Xs on a body image, and words, have become the standard in medicine. The ideal drug for pain would reduce pain that is five or above to below five, by at least two points, and have little to no side effects.

But should this be the standard way to describe and understand pain? First I will present two other ways of describing pain. Then I make recommendations for how psychologists might gain understanding of the pain experienced by some of their clients.

Let us return to our hypothetical person experiencing lower back pain. This person has been experiencing lower back pain that is new to her, and for about a week. She believes she might have strained it gardening ten days ago. She describes the pain as aching, sometimes sharp when she moves, and hot to the touch (probably indicating inflammation). She rates it a five in general, and eight briefly when she moves the wrong way and the pain shoots through her. She is told to put ice on the pain, then heat, and avoid lifting or strenuous activity until it subsides. She has every reason to expect the pain to subside within a few weeks.

First of all, what is a five, or an eight for that matter? Suppose this woman has experienced childbirth and active labor for three hours. If she would call that pain a ten, is pain that lasts for fewer than twenty seconds really an eight? Is pain that leads to the birth of a newborn experienced differently than intense pain that has no known purpose? Does duration of pain affect its rating? What is the effect of a level of pain...
rated as five over a brief period of time versus over a longer pe-
period of time? Imagine you have a mild toothache. It’s perfectly
tolerable for a day or two but by day three the same level of pain
becomes less tolerable. The absolute number on the one to ten
scale hasn’t changed but the perception of tolerability has.
This idea of tolerability may be key to understanding per-
ceptions of pain in those with chronic pain. In a study of 53 out-
patients with persistent pain that was moderate to severe due
to osteoarthritis, cancer, or lower back problems, participants
did not use the one-to-ten scale, nor did they like the term ac-
ceptable pain (Zelman et al., 2001). Instead, they preferred the
term manageable pain or tolerable pain. What emerged from
this study is that a manageable level of pain allowed perform-
ing valued activities, relief from dysphoria and irritability, and
socializing. Medication was described as taking the edge off,
and was itself tolerable if the side effects of the medication did
not interfere with manageability. Zelman et al. argue that a
measure of a manageable day of pain control would be more
useful, and more closely align with how persons with chronic
pain think about their own pain experiences. The ideal of be-
ing pain free was not sought, as the reality of pain associated
with the various conditions was acknowledged. Rather, par-
ticipants wanted more days of manageable pain.
In my own experience as a person with polio and post-polio
syndrome (new pain, fatigue, and weakness), I found that I
developed a scale similar to the idea of Zelman’s manageabil-
ity scale. But duration is key to my experience of pain. The
meaningful periods for me would be under one day, several
days, weeks, or longer (how much longer quickly becomes ir-
relevant). The second variable is constancy, whether the pain
is at baseline level (i.e., rarely or never goes below that level),
short bursts (of increased intensity), intermittent (unpredict-
able from day to day), or constant (becoming less tolerable
over time). Keeping these factors in mind, I have a five-point
scale. A level one means the pain is out of consciousness un-
less I focus on it. If I were to stop and inventory my body, I
would notice and locate the pain, but I could then resume
activities and the pain experience would again recede out of
consciousness. Level two means that the pain is still out of my
awareness, but it is affecting my mood and behavior. This is
when my children would say “Mom, you’re crabby, go put your
foot up.” They have made an association between pain and my
mood that I only become aware of once it is pointed out to me,
and then it seems obvious. At a level three I am conscious of
the pain, and use it as information to change my behavior or
plans. I might postpone an activity, or cease a task I know
increases pain, or rest more, or put ice or heat on an affected
spot. At a level four I am very conscious of the pain, and take
steps to make immediate alterations in my day (e.g., cancelling
events for later in the day, putting in a rest period, taking off
shoes, elevating my feet, etc.). At level five pain is the primary
event in my consciousness, and I halt whatever I am doing to

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take steps to ameliorate the pain. In this admittedly personal and untested scale, the critical factor is the effect of the pain on my awareness, mood, activities, plans, and sociability. To go back to the Zelman scale, I would label levels one and two manageable, level three tolerable, level four a fight for manageability, and level five unmanageable.

What do the above methods of pain assessment mean for psychologists, particularly clinicians who see clients experiencing pain? Using suggestions from Zelman et al. (2001), Linton and Shaw (2011), Arwood et al. (2015), and Olkin (in progress), I would recommend the following:

1. Ask clients about pain. Even if it is not part of the presenting problem, more people experience pain than we know, and it could be a relevant factor in treatment.

2. Understand the client’s way of explaining pain. Use the three methods discussed here as options, but allow for idiosyncratic ways of description.

3. Understand the pain history. Whether the person previously has experienced nothing more painful than a bee-sting, or serious injury in an accident, or torture, these prior encounters with pain will influence the current experience of pain.

4. Understand the context of the pain. This includes people’s beliefs about pain, their understanding of the causes and effects of the current pain, the role of the family in the pain management, and cultural beliefs about pain.

5. Assess multidimensions. Assess cognitions about pain, emotions and emotional regulation abilities, and overt pain behaviors or pain avoidance behaviors.

6. Assist with understanding. Help clients know about the multidimensional nature of pain; how pain is recognized, assessed, and measured; and the myriad avenues for pain management.

7. Discuss the goal. Although cessation of pain may be desired, it may not be possible. But a fulfilled life is possible, even with varying levels of pain. Increasing the number of manageable days is a viable goal.

REFERENCES


Reducing the Cognitive Demands of Psychosocial Treatments for Chronic Pain: Clinical Research

Beverly Thorn, PhD

This article highlights my clinical research adapting psychosocial pain treatments so they are less cognitively demanding for patients. A specific focus of my more recent work has been to simplify traditional cognitive-behavioral treatment formats to reduce the literacy level and cognitive load of the materials, homework, and the treatment itself. Using randomized controlled trials, I then tested whether these modified programs reduce reported pain intensity and dysfunction more than medical treatment as usual (i.e., drugs and surgery, which offer partial relief at best). I began this particular line of clinical research after the publication of my practitioner-oriented book (Thorn, 2004). Following its publication, a number of clinicians contacted me to tell me they found the included treatment manual useful in working with patients who have chronic or recurrent pain, but they also wanted to know how this approach would work with people with lower literacy levels, or with those who might have limited cognitive capacity. Individuals with these limitations often suffer from multiple healthcare disparities and they tend to be more challenging in terms of comorbidities and lack of resources. These are often patients who need more and get less. I have spent the last 10 years trying to simplify the treatment and then testing whether this streamlined approach is still effective. The ultimate goal is to reach more people with psychosocial pain treatments.

The Problem of Pain and Healthcare Disparities

The number of Americans with chronic pain is greater than for diabetes, heart disease, and cancer combined, and the prevalence of chronic pain is likely to continue increasing rapidly due to the aging of the population and increases in obesity (Institute of Medicine, 2011). Chronic pain interferes with functioning through elevated pain levels, disrupted sleep, decreased physical functioning, work loss and unemployment, reduced quality of life, and decreased social functioning (Institute of Medicine, 2011). Clearly, persistent pain serves as a chronic stressor that can trigger psychological disorders such as depression, which in turn worsens pain outcomes (Hall et al., 2011). In fact, patients with chronic pain have twice the risk of suicide relative to others (Tang & Crane, 2006).

Pain disproportionally affects vulnerable populations, especially economically disadvantaged individuals, ethnic minorities, women, and older adults. These risks are especially relevant for ethnic minorities and those with low income, who have disproportionately higher risks for a number of health-related disparities (Sullivan & Eagel, 2005). Those with low income and ethnic minorities experience higher rates of chronic pain, higher likelihood of pain-related disability, and higher rates of major chronic physical and psychological comorbidities such as depression and anxiety than non-minorities and those with higher income. However, they also obtain less support and care for their conditions (Green et al., 2003; McWilliams, Cox, & Enns, 2003).

Among disparities at the patient level, low health literacy presents a significant and widespread difficulty for many disadvantaged populations. National assessments have found that over 30 million Americans (14%) function at a “Below Basic” literacy level and are only capable of simple, concrete literacy activities, while another 63 million (29%) function at only a “Basic” literacy level (Kutner, Greenberg, Jin, & Paulsen, 2006). Recognizing the extent of this problem for healthcare, “clear communication” initiatives have been promoted to help reduce literacy barriers (National Institutes of Health, 2011). Increasingly, health care providers are providing written materials that are more easily understood in underserved populations as well as more appropriate for the majority of the population. However, due to the complexity of their core components, psychosocial interventions present unique challenges to health literacy adaptation efforts.
Adapting Psychosocial Treatments to Reduce their Cognitive Demands

Although deficits in literacy can limit a patient’s ability to understand and benefit from psychological treatments, there are other reasons that simplifying our treatments makes sense for everyone. Pain itself demands attention, leaving fewer cognitive resources available to devote to other matters, including understanding, remembering, and adhering to many medical and psychological regimens. Compounding the problem of pain on cognition is the cognitive impairment associated with myriad medications often prescribed to patients with pain. Chronic health conditions that frequently co-occur with chronic pain also contribute to the drain on one’s (limited) cognitive capacity, as does the aging process (Block & Cianfrini, 2013; Kuhajda, Thorn, Klinger & Rubin, 2002). Arguably, anyone dealing with a chronic, stressful medical condition would greatly benefit from simpler and more straightforward treatment approaches.

How did we go about reducing the cognitive demands of psychosocial pain treatment, and how can practicing clinicians incorporate some of these principles into their ongoing practices? First, we reduced the reading level of all patient materials (workbook, handouts, worksheets) from the original 10th grade level (Thorn, 2004) to the 5th grade level. Other adaptations of the written materials for patients included reducing the number of words in general, increasing the font size and white space on the page, and including relevant illustrations where appropriate. For example, to illustrate the connection between thoughts, emotions, and behavior, we included a simple diagram of a man with a negative “thought cloud” over his head, which stated “This pain has ruined my life,” leading to an illustration of a negative emotion (depressed mood) as well as an unhelpful behavior (going to bed). We also present a limited number of concepts per session and make liberal use of a flipchart (a white board will do) to enhance interactive discussion. In this way, patients are learning collaboratively with the therapist, rather than being a passive recipient of information and skills training. We have learned to reduce our use of jargon during treatment sessions and avoid three-syllable words when a simpler word will do. Before we assign any homework, we do some of the work for patients by working together through an example in session. We also provide audio recordings after every session which briefly summarize the session and encourage patients to “think, feel, and act” (even if they don’t write a single word on their homework sheets). Patients particularly like the audios they are given because they can go back and review the material that was presented; the audios also serve as a reminder for them to be thinking about and working on their new coping skills in between sessions.

In terms of simplifying our treatment rationale, we have opted for a cartoon version of the gate-control model of pain (Melzack & Wall, 1965) to teach patients that their thoughts and emotions greatly influence their experience of pain. This allows us to present the larger concept that the brain processes all pain and that thoughts and emotions are part of the pro-
cessing system. Per the gate-control model, the brain receives pain signals from the body, but it also sends messages down the spinal cord to increase or decrease pain transmission. In effect, one’s thoughts and emotions open or close metaphorical gates that allow pain signals into the brain. We emphasize that this does not mean that the pain is “all in your head,” but rather, that patients can learn to “train their brain to close (or narrow) the gate.” This treatment rational makes a great deal of sense to patients and they frequently want to know why no one has ever told them this before. Shortly into the 10-session program, patients are talking about strategies they learn as “gate closers.” The ability to image the functioning brain allows behavioral inferences that were not possible a decade ago, and we now know that psychosocial treatments like cognitive-behavioral therapy result in lasting changes in brain structure and function (Shpaner et al., 2014). Findings such as these provide a neurophysiological basis for what we do.

**The Research Evidence**

In our initial research funded by the National Institutes of Health, we simplified two psychosocial group-administered treatments for rural Alabama patients with low health literacy: cognitive-behavioral therapy (CBT) and pain education (Kuha- jda, Thorn, Gaskins, Day, & Cabbil, 2011). The pain education condition was structurally equivalent to the CBT intervention on treatment modality, therapist attention, and treatment duration. There is a heavy emphasis on enhancing common therapeutic factors such as therapeutic alliance, positive treatment expectancy, and group cohesion in both conditions. Both types of groups received the same pain-relevant information, but the education condition did not contain active skills-building components that were specific to CBT. We obtained significant treatment effects on the main pain outcome variables (pain intensity and pain interference in physical functioning) for both interventions, with no significant differences between them at posttest or at 6 months follow up (Thorn et al., 2011). However, CBT showed significant pre–post reductions in depressive symptoms that were maintained at follow-up, but this effect was not observed with pain education alone.

Three important observations were derived from our findings. First, the effectiveness of the education intervention suggests that in this low health literacy population there is an urgent need for user-friendly pain information. These patients benefit from the provision of relevant, simplified, pain facts presented using an interactive discussion approach. Second, CBT reduced depression; education did not. Since this study did not include a large number of participants, we do not yet know if this finding is reliable. Third, and most problematic to us, there was a much higher dropout rate in the CBT vs. education (35% vs 15%) groups. When we examined possible factors that might have accounted for attrition, we found that lower educational attainment, lower reading levels, and lower income were the most important predictors (Thorn et al., 2011). Qualitative interviews completed after treatment suggested that of those patients who did complete treatment, those with the lowest literacy levels appeared to have the greatest difficulty understanding and engaging in CBT (Day, Thorn & Kapoor, 2011).

We have continued to modify the CBT intervention to further reduce its cognitive load and dependence on complex written assignments, to prioritize more accessible behavioral tasks that can lead to early successes, and to include weekly relaxation exercises known to reduce negative mental states and improve cognitive functioning. We are currently conducting a comparative effectiveness trial funded by the Patient-Centered Outcomes Research Institute comparing group CBT, education, and medical treatment as usual, to see if psychosocial treatments result in a value-added outcome. Further, we want to know if CBT is reliably more effective than pain education for reducing depression. We are two years into a three-year trial and, for treatment integrity reasons, cannot do interim outcome analyses. With almost 200 participants now treated we are gratified that there is no differential dropout rate across conditions and attrition is somewhat lower than typical national averages for psychosocial treatment dropout (20% vs. 25%).

**Summary and Conclusions**

Millions of individuals suffer daily from chronic painful conditions. For many reasons, their cognitive reserves are taxed and optimal benefit from psychological treatment is compromised. Simplifying psychosocial treatments can make them more accessible to patients, and may enhance their ef-
**AWARDS OF HONOR 2015**

CPA annually honors psychologists and others for their commitment to the betterment of the Association, the profession and public mental health. These awards were presented at the CPA Annual Convention on April 23-26, 2015.

**Silver Psi**
Mark Kamena, PhD, ABPP  
Sheryn T. Scott, PhD

**Bronze Psi**
Eric A. Samuels, MS, MA

**Distinguished Contribution to Psychology as a Profession**
Jeffrey Tirengel, PsyD, MP

**Distinguished Contribution to Psychology**
Steve Frankel, PhD, JD

**Distinguished Humanitarian Contribution**
Jei Africa, PsyD

**Distinguished Scientific Achievement in Psychology**
Thema Bryant-Davis, PhD

**Jerry Clark Advocacy Award**
Michael G. Ritz, PhD

**Student Advocacy Award**
Tracey Wheeler, MA

**Outstanding CPA Chapter**
Los Angeles County Psychological Association

**Outstanding CPA Chapter Newsletter**
San Gabriel Valley Psychological Association

**Division of Clinical and Profession Practice (I)**
Award for Distinguished Service  
Mark Kamena, PhD, ABPP  
Craig R. Lareau, JD, PhD, ABPP

**Division of Clinical and Profession Practice (II)**
Award for Distinguished Contribution to Psychology  
Janet Hurwich, PhD

**Division of Education and Training (II)**
Award for Distinguished Service  
Rick Williamson Jr., PhD  
Allison Parelman, PhD

**Division of Clinical Psychopharmacology (V)**
Chuck Faltz Advocacy Award  
Keith Valone, PhD, PsyD, MSCP

**Division of Diversity and Social Justice (VII)**
Award for Distinguished Contribution to Psychology  
Rut Gubkin, PhD

**The Division of Neuropsychology (VIII)**
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Identifying Patients at Risk for Prescription Opioid Misuse

William W. Deardorff, PhD, ABPP

oral opioids are commonly prescribed pain medications like hydrocodone (Vicodin, Norco, Lorcet), oxycodone (Percocet), hydromorphone (Dilaudid), and oxycodone in a sustained-release form (Oxycontin). Opioids such as these have both analgesic and euphoric effects. Whether or not you routinely work with pain patients, it is important for all psychologists to be aware of how to identify patients at risk for opioid abuse/misuse.

Opioid abuse/misuse occurs for a number of different reasons including recreational use, self-medication, addiction, and diversion for profit (Sehgal, Manchikanti, & Smith, 2012). Consider the following sobering facts about opioids: Americans consume 80% of the world’s opioid supply and 99% of the global hydrocodone supply (Manchikanti, Fellows, Ailinani, & Pampati, 2010); approximately 20% of Americans report using prescription opioids for nonmedical use (Manchikanti et al., 2010); and, according to the Centers for Disease Control (CDC), the number of unintentional overdose deaths from prescription opioids has more than quadrupled in the U.S. since 1999 (CDC, 2011).

Epidemiological data suggests a significant increase in prescription abuse/misuse in the U.S. especially over the past two decades (CDC, 2011). The problem has become such a significant societal health concern that the federal government has termed prescription opioid abuse/misuse as “epidemic” (Office of National Drug Control Policy, 2011). Interestingly, this epidemic in abuse/misuse correlates with a four-fold increase in the prescribing rate of opioids nationally (CDC, 2009). To what can we attribute this change in prescription practices and epidemic misuse? Several factors have likely contributed to the prescription opioid abuse problem. These include drastic increases in the number of prescriptions written and dispensed due to a change in how the medical community views pain treatment, greater social acceptability for using medications for different purposes, and aggressive marketing by pharmaceutical companies. These forces combined have created the broad “environmental availability” of prescription opioid medications.

Prior to the 1980s, physicians were almost “terrified” to prescribe opioids due to the fear of causing abuse and/or addiction in their patients. However, this changed as a result of two factors: First, the publication of an article by a physician Russell Portenory suggested that opioids could safely be used in the long term treatment of chronic non-cancer pain (CNCP) without fear of addiction or abuse (Portenoy & Foley, 1986). These authors estimated an approximate 1% risk of opioid misuse/abuse in a patient group selected for chronic opioid therapy (COT). However, later studies that are more generalizable to actual clinical practice put the rate of aberrant drug-related behavior in COT at 15-20% or more (See Sullivan & Howe, 2013). In fact, one study estimated the rate of lifetime aberrant drug behavior to be 80% among patients who receive opioids for chronic pain in a primary care setting (Fleming, Davis & Passik, 2008).

Second, the American Pain Society and other groups advocated for making pain the “fifth vital sign” for healthcare professionals to monitor and treat. These organizations argued that opioids should have a role in the treatment of CNCP (Haddox, Joranson et al., 1997). The pain treatment milieu went from emphasizing a fear of addiction and withholding opioids to an increased level of physician comfort in prescribing opioids more liberally for cancer and non-cancer pain. Of course, this attitudinal shift has been positive as related to cancer pain treatment, but caused problems when related to the treatment of chronic non-cancer pain.

Risk factors for opioid misuse/abuse

Psychologists who work with chronic pain patients, either individually or within a multidisciplinary setting, are accustomed to assessing for opioid misuse/abuse. In fact, psychological screening-evaluation and concomitant treatment are recommended as part of any multidisciplinary pain or COT program (see Chou, Fanciullo, Fine, Adler, et al., 2009). However, psychologists working with other patient populations may not regularly consider the possibility of opioid misuse in their patients.

Research has identified a myriad of risk factors for prescription opioid misuse including sociodemographic factors, pain and drug-related factors, genetics and environment, psychosocial and family history, psychopathology, and alcohol/
substance use disorders (See Sehgal, et al., 2012 for a review). No one single risk factor is strongly predictive, but abuse potential is greatest when risk factors from three categories are found in the same individual (Sehgal, et al., 2012). These risk factors can be grouped into broad categories as follows and being aware of these predictors can help the psychologist evaluate for possible prescription opioid abuse/misuse.

**Sociodemographic and psychosocial factors:** Those with a potential toward opioid misuse are more likely to be young, white and male (Boscarino, Rukstalis, Hoffman, et al., 2010). Women are more likely to misuse due to emotional issues and affective distress whereas men misuse because of legal and problematic behavioral issues (Jamison, Ross, Michna, Chen, Holcomb, & Wasan, 2010).

**Pain and medical factors:** Patients who report more subjective pain, multiple pain complaints and a greater degree of pain-related limitations are at increased risk for opioid misuse (Sullivan, Von Korff, Banta-Green, Merrill, & Saunders, 2010).

**Substance use factors:** The risk of opioid misuse is increased with substance disorders including a personal or family history of aberrant alcohol and drug-related behaviors, and/or concomitant active substance abuse (see Sehgal et al., 2012 for a review). For instance, in a survey of individuals entering treatment for opiate abuse, Cicero, Lynskey, Todorov, Inciardi, and Surratt (2008) found that the first exposure to an opioid in 79% of males and 85% of females was a legitimate prescription for pain. However, the data suggested that the opioid abuse in this group most likely represented the end stage on a continuum of substance abuse of different types (e.g. alcohol, marijuana) beginning at a very early age.

**Co-morbid psychopathology:** The presence or history of psychological problems, a mood disorder or psychosocial stressors increases the risk for prescription opioid misuse. Specifically, according to one literature review, panic disorder, social phobia and agoraphobia, low self-rated health status, and other substance misuse...
Assessing for opioid misuse in psychological practice

If 20% of Americans have used opioids recreationally (non-medical purposes) and misuse is associated with psychopathology, chances are pretty good that there are one or more patients in your practice that are misusing opioids. This rate is higher if you treat chronic pain. Assessing for opioid misuse is best done using a risk-stratification approach. Not every patient needs to undergo a detailed screening for opioid misuse; however, as risk factors are noted, a more detailed inquiry should ensue. A summary of important risk factors to assess as appropriate is as follows:

- A history of physical, emotional, or sexual abuse.
- Personal or family history of a severe depression or anxiety disorder.
- Personality disorders with poor impulse control (borderline, antisocial, psychopathic).
- Family history of substance abuse/dependence or antisocial personality disorder.
- A pain diagnosis including somatoform features along with a low threshold for any adverse bodily symptoms (stimulus augmenter).
- Limited stress management skills and previous episodes of "chemical coping."
- Current dysfunctional or chaotic living environment (drug abuse in a close family member).
- Regular contact with high-risk people (e.g., drug-using friends) or involvement with high-risk activities (e.g., regular time spent in a bar or on the street).
- Previous criminal behavior.
- Male, younger age, and/or smoker or prior tobacco abuse.
- Previous treatment in a drug or alcohol rehabilitation facility.
- Many previous automobile accidents, previous DUI convictions, or if a work injury case, has not worked for more than six months.
- Receiving pain or other medications from more than one physician.

What to do if opioid misuse is suspected

Opioid misuse might range from something fairly benign such as a patient not taking the medicine quite as directed (e.g., due to a misunderstanding of the prescription) to a fully developed opioid abuse substance disorder. Once the nature of the misuse is determined, it should be confronted within the psychotherapeutic relationship. Aside from it being its own problem, opioid misuse will likely be impacting all other aspects of psychological treatment. When dealing with misuse, it is usually most appropriate to work in concert with the prescribing physician(s) if at all possible. This is fairly easy in a multidisciplinary setting but may be more challenging for the solo practitioner.

REFERENCES


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In the United States the death rate caused by opiate medications has risen fourfold since 1999 to more than 16,000 people in 2011 (Chen, Hedegaard, & Warner, 2014). The pendulum has swung in regards to opioi
d medication, leading to more cautious prescribing practices for patients with chronic non-cancer pain. Psychologists can play a key role in identifying patients at risk for adverse opioid-related events and support patients in the process of tapering opioid medications by providing evidence-based treatment for their underlying pain condition and concomitant psychiatric symptoms. Howe and Sullivan (2014) point to evidence that chronic pain patients with psychiatric disorders are more likely to receive chronic opiate medication than patients without psychiatric or substance abuse comor-
bidity, and more likely to have adverse events related to opiate use. This article will review risk factors associated with misuse of opioid medications and highlight helpful strategies for patients who are tapering down or off opiate medications.

Assessing for Misuse and Opioid Use Disorder

Research has elucidated predictors for opioid misuse. These include current cigarette smoking, personal or family history of substance abuse, the presence of a psychiatric disorder, history of childhood sexual abuse or neglect, involvement in the legal system, and significant psychosocial stressors (Chang & Compton, 2013). Additional risk factors include younger age, regular contact with high-risk individuals or environments, and prior history of treatment for addiction (Jamison & Edwards, 2013). Aberrant behaviors, or behaviors suggestive of a substance use disorder, include concurrent abuse of alcohol or illicit drugs, forging prescriptions, injecting or snorting oral formulations, seeking prescriptions from multiple providers, stealing or borrowing drugs from others, selling prescription drugs, recurrent loss of prescriptions, deteriorating occupational or interpersonal functioning, or a strong resistance to change treatment despite poor response to opioid medication (Jamison & Edwards, 2013).

Opioid Use Disorder under DSM-5 eliminates tolerance and withdrawal as criteria for patients prescribed opiate medica-
Several DSM-5 criteria for Opioid Use Disorder need to be carefully assessed to discriminate normal responses to chronic but appropriate use of opiate therapy for chronic pain. These include using larger amounts and for longer periods of time, unsuccessful attempts to cut down, and a great deal of time spent using the substance. The remaining criteria may be more apparent and relevant in diagnosing patients on opioid therapy who have Substance Use Disorder. These consist of important activities that are reduced or given up, continued use despite harm, craving, use in hazardous situations, and ongoing use despite social problems. Research examining rates of opioid abuse disorders in patients with chronic pain has found prevalence rates ranging from 3% to 26% depending on the population being studied (Miotto, Kaufman, Kong, Jun, & Schwartz, 2012).

Psychologists may have more time with patients to conduct a thorough assessment compared to primary care and other physicians who prescribe opiate medications. Regular communication with physicians, nurses, pharmacists, and other providers who are working with patients helps to align all providers to create a consistent treatment plan and facilitate adherence to recommended treatment, which may include substance abuse treatment. At Kaiser Permanente, the integration of the departments of medicine, psychiatry, chemical dependency, and chronic pain within an HMO, utilizing a shared computerized record system, assists in the coordina-

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tion of treatment for patients with chronic pain. Physicians are available by phone or secure message for treatment planning and to discuss medications for pain as well as concerns about misuse. Informed consent, including what information will be shared and with whom, should be discussed with patients at the outset of treatment.

Patient Education

When a decision is made to taper or wean opiate medications, the goal is to improve a patient’s life by improving function, reducing side effects of the medication, or reducing the risk of an adverse event including accidental overdose. It can be a challenge for some patients to perceive the taper as moving toward more successful coping of chronic pain symptoms and not as a form of punishment. There are a number of psychoeducational topics in which psychologists may engage patients who are in the process of tapering their opiate medication dose. Patients may not be fully aware of the risks associated with chronic narcotic pain medication use. In addition to common side effects of constipation, nausea, and drowsiness, chronic opioid use has been shown to affect the endocrine and immune systems, lead to increased fall and fracture risk in older adults, sleep problems including sleep apnea, and accidental overdose and death (Franklin, 2014). A large epidemiological study found that, for each fatal overdose related to opioids, there were seven non-fatal overdoses (Dunn et al., 2010).

The timing and method of providing education about the side effects and potential harm caused by chronic opioid therapy is important because offering information may create discord in the therapeutic relationship if patients are not interested or ready. Strategies from Motivational Interviewing and Harm Reduction Therapy can be useful in engaging patients. Asking permission to provide information may facilitate a patient’s receptiveness, such as “would it be OK if I tell you what other patients have experienced in tapering their opiate medications?” Open-ended questions allow patients to provide information and can lead to the identification of shared treatment goals. Using reflections can help reinforce a patient’s reasons for reducing opiate medication.

Addressing Anxiety

The majority of patients who have been taking opiates for long periods of time demonstrate significant fear around tapering opiate medications. Common fears include fear of withdrawal symptoms, concern they will not be able to manage their physical symptoms or function at work or home, and concern that their provider will be unwilling to increase their dose if their symptoms become unmanageable. Previous attempts to stop opiates in the past, often in a self-directed “all or nothing” approach, may have led to severe withdrawal symptoms including anxiety, dysphoria, insomnia, and increased pain. Educating patients about how their past experience may differ from a slow, thoughtful taper may help change their beliefs and expectations concerning the current treatment plan.

Physicians with experience in opioid tapers have suggested that a taper of 5% to 10% at each step, particularly in the beginning of their taper, should cause only minimal symptoms, and often for only the first few days of the reduced dose. Patients can be taught to manage these symptoms using cognitive and behavioral tools: cognitive restructuring of catastrophizing thoughts; prioritizing, planning and pacing activity particularly during those first few days of the reduced daily dose; sleep hygiene techniques to address insomnia; and engagement in mindfulness, self-hypnosis, progressive muscle relaxation or other relaxation techniques. Teaching patients to use behavioral medicine strategies when they experience increased symptoms builds a sense of control while moving away from automatically reaching for more opioid medication.

The Meaning of Pain

The meaning of pain is important. Helping patients view pain as a reminder to utilize skills like body mechanics, posture, and activity pacing may further reduce their symptoms and the need for more pain medication. Pain is a common, and often the first, symptom of withdrawal and may not be a sign of injury or underlying tissue damage. For example, having episodic pain each day may be caused by decreasing blood levels of the opiate medication, particularly with short-acting medications like Dilaudid, Norco or Percocet. When patients attribute some of their discomfort to the opiate medication itself, they may see the benefit of reducing opiate use. The concept of opioid-induced hyperalgesia, or having increased pain as a result of taking opiates, needs more study but seems a compelling argument for tapering patients who are on high doses of opiates.

Psychologists can create a space for patients to talk about their fears associated with reducing opiates, from the taper itself to how they will be able to function on fewer opiates. Fear and anxiety about the taper can be minimized when patients feel supported by their treatment providers and have a clear understanding about the plan and who they can call with questions or concerns. Teaching communication skills and encouraging patients to contact providers when problems arise may improve compliance with the taper protocol.

Finally, the role of the psychologist may include advocating for patients in this process. Physicians with experience in tapering patients off of opiates have indicated that a reduction of 25% or more will lead to significant discomfort from withdrawal symptoms. Unless there are reasons for a rapid taper, such as high risk associated with misuse, it may not be necessary or helpful to rapidly taper a patient. Communication with the prescribing physician about the possibility of slowing the rate of taper may reduce the physical and emotional demands and may lead to more successful outcomes. The longer a patient has been taking opiates, the slower the taper may need to be. It is not a race. The best taper is the one that works for the particular patient.
Finally, the Northern California Association of Pain Psychologists (NCAPP) is a place for psychologists to educate, network, advocate, and share information regarding the practice and study of pain treatment, and can be a useful resource for psychologists seeking to provide better quality of care for patients with chronic pain. Another helpful resource for both psychologists and patients is the American Chronic Pain Association (www.theacpa.org).

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Clinical practice in couple and family psychology (CFP) requires special consideration with regard to documentation. Individual sessions with family members, collateral contacts, and requests for records can pose dilemmas and require greater attention to risk management. Please see Kaslow, Celano, and Stanton (2005) and Patterson, Claiborne and Russaw (2013) for a more detailed discussion.

From an ethical, clinical, and legal perspective, it is clear that clinical records must be kept for each case we open and agree to treat. The aphorism “If it’s not written, it didn’t happen” applies. When treating a couple, family, or parent child dyad conjointly, systems theory informs us that the group is the client, rather than the individuals we are treating. This can involve complex decisions regarding precisely whom to treat, in which combination, how often, who holds the legal privilege, and what type of records to keep. Fundamentally, the question of fidelity to our client unit leads us to ask: How can we serve the best interests of the couple or family unit when individuals may have competing interests?

As we begin treatment with a couple as the client, for instance, we initiate a clinical record containing standard intake information, an assessment, and a treatment plan (separate records under HIPAA are not being considered here). These involve what we would include for an individual client: background information, consent forms, telephone and e-mail contacts, completed tests and inventories, consultation notes about the case, and other ancillary information. We know that the couple possesses the legal right (privilege) to this information and it may be subpoenaed through a court order. Anyone else we might include in a session of couple therapy for any reason (children, parents, etc.) is not our client but a collateral contact, and this information should also be part of the clinical record. Should we change format (see Gottlieb, 1995; Gottlieb, Laser, & Simpson, 2008) from the couple to family or individual therapy (after considering ethical issues such as confidentiality and multiple relationships), the couple record should be closed and another one started for the new client unit.

Other situations must also be considered, such as when we arrange to have an individual session to build rapport, to assess a partner more carefully as an individual, or if a critical issue such as domestic violence arises. It may not be advisable for the other partner to have access to the information obtained in the individual session. Records of separate sessions should not be co-mingled; in other words, separate records are advised for individual sessions, even when the primary treatment modality is conjoint couple therapy. This protects the individual who may have expressed concerns that would embarrass them or even put them in danger if revealed to their partner.

It is also fairly common for an individual to reveal a secret that would be important to address in conjoint therapy (such as an affair) either in an individual session, by phone, text, or e-mail, or in an informal situation such as while waiting for the partner to arrive to the session. Our policy on secrets is best covered during the informed consent process, and is obviously a sensitive ethical and clinical matter. The legal concern is that if the therapist chooses not to be the one to divulge the secret, it should not be part of the conjoint clinical record which both partners can access.

From this brief discussion it is apparent that treatment planning, record keeping, and confidentiality in couple, parent-child, and family therapy raise complex clinical, ethical, and legal issues, and a high level of competence is needed in order to navigate successfully and serve the best interests of clients.

REFERENCES
“Can we do some sessions by telephone?” Most psychologists have heard this request on many occasions. This scenario often occurs when the patient will be out of town for vacation or business travel. However, sometimes patients request more prolonged treatment using telecommunications, such as when the patient relocates either temporarily or permanently to a new city or state. Some psychologists occasionally honor such requests and others routinely provide services using telecommunications technologies. However, before agreeing to do therapy across state lines, psychologists should be familiar with relevant laws and policies regarding both interstate practice and telehealth and should carefully consider the risks and benefits.

Telehealth can be defined broadly to include all interactions between healthcare professionals and their patients that utilize telecommunications technologies such as phone or videoconferencing. It is a rapidly expanding area that offers business opportunities for psychologists and improved access to care for patients. The American Psychological Association (APA), recognizing the significance of this topic, recently adopted guidelines for the practice of telepsychology developed jointly by APA, the Association of State and Provincial Psychology Boards (ASPPB), and The Trust (Joint Task Force, 2013). The growth in this area is supported by considerable research demonstrating the effectiveness of telehealth services (e.g., Hilty et al., 2013) and by the increasing availability of insurance reimbursement. It is important to recognize, however, that when a psychologist licensed and located in one state provides telehealth services to a patient who is located in another state, the psychologist is arguably practicing in both states. Many states have adopted laws or licensing board policies that require licensure in the state in which the patient receives services (see APA Practice Organization, 2014). For example, the California Board of Psychology has posted a notice to consumers on its website stating that individuals who provide psychotherapy or counseling, either in person, by telephone, or over the Internet to persons in California are required to be licensed in California (http://www.psychology.ca.gov/con sumers/internet_thrpy.shtml). Some state boards have further specified that the psychologist must be licensed in both the state where the psychologist is located and the state where the patient is located when services are provided remotely.

Several national organizations, including APA and the American Telemedicine Association (ATA) have taken similar positions emphasizing the importance of addressing all relevant laws in both the patient’s and the psychologist’s jurisdictions (Joint Task Force, 2013; ATA, 2013). However, so far there is no clear guidance about which laws takes precedence when there are significant differences between relevant state laws, for example regarding the duty to protect when working with a dangerous patient.

According to the U.S. Department of Health and Human Services (DHHS) Health Licensing Board Report to Congress, physicians and other licensed health professionals are “considered to be practicing their professions in the state where the patient is located and are subject to that state’s licensing law unless there is an exception in statute” (DHHS, 2011, p. 7). The following paragraph of that report, however, says that in the absence of specific agreements, states may not discipline healthcare professionals not licensed in their state. In other words, typical sanctions for in-state psychologists (e.g., license revocation) would not be available. Nonetheless, the licensing board in the patient’s state can take actions such as issuing cease and desist orders or notifying the licensing board in the psychologist’s state.
Another area of risk is that an out-of-state psychologist could be charged with practicing without a license or sued for malpractice in the patient’s state if a court determined there were sufficient “minimum contacts.” As discussed in Harris and Younggren (2011), the minimum contacts rule allows the patient’s state to assert jurisdiction over an out-of-state healthcare provider only if the provider has made purposeful attempts to promote or provide services in the patient’s state. Even if the patient’s state is found to lack jurisdiction, however, the patient retains the options of filing a lawsuit or licensing board complaint in the psychologist’s home state.

Given these complexities, the likelihood of action being taken against an out-of-state psychologist is uncertain. Harris and Younggren note that the risks of an out-of-state psychologist being prosecuted are low and conclude that “[a]s a practical matter, in the immediate future, the primary disciplinary exposure for psychologists engaging in interstate practice will be from the board that licenses them” (2011, p. 416).

Fortunately, there are mechanisms in place and new efforts underway to facilitate interstate practice. Most states have adopted laws that allow psychologists with an out-of-state license to practice temporarily. These temporary practice laws generally cover both services provided in person and services provided remotely using telecommunication technologies. For example, California Business & Professions Code § 2912 authorizes doctoral-level psychologists licensed in another state to provide services in California for up to 30 days per year.

Although some states’ laws are similar to California’s and automatically allow temporary practice, many require the out-of-state psychologists to meet additional requirements, such as obtaining a permit or notifying the licensing board in advance of providing services.

ASPPB recently announced the Psychology Interstate Compact (PSYPACT), a major new initiative designed to facilitate interjurisdictional practice (ASPPB, 2015). PSYPACT allows for an agreement between states to enact legislation that authorizes psychologists with specified credentials to provide telehealth services and temporary in-person services across state lines. It also provides for improved coordination between state regulatory bodies. PSYPACT will come into effect in participating states when at least seven states have enacted its provisions.

In addition to licensure requirements, many states have laws, regulations, or other guidance specifically pertaining to telehealth services. In California, Business and Professions Code § 2290.5 defines telehealth broadly as including delivery of health care services and public health “via information and communication technologies” and requires that providers obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering services. Definitions of telehealth and the requirements for providing such services vary considerably between states, and some are more restrictive than in California, so it is important to be aware of the applicable requirements.

Psychologists should also be familiar with the APA telepsychology guidelines, which address key topics including competence, standards of care, informed consent, confidentiality and security (Joint Task Force, 2013). From a risk management perspective, the informed consent process is particularly important and should cover topics including risks and benefits, how technology will be used, how technology failures will be handled, billing, emergency procedures and limits to confidentiality. Due to the potentially increased risks, protecting patient confidentiality is a critical consideration. Whatever method of communication is used, HIPAA and related state requirements need to be addressed.

Additionally, psychologists should be aware of third party payment policies and bill accurately when providing services through telehealth either in-state or across state lines. At least 23 states, including California, currently mandate insurance coverage for at least some types of telehealth services (ATA, 2015). Psychologists may also be eligible for reimbursement for telehealth services under Medicare or Medicaid (Medi-Cal), subject to program requirements. For example, Medicare requires that patients receive services via interactive audio-video communication technology at a qualified medical site located outside of a metropolitan area. Reimbursement under Medicaid varies by state, with the majority of states, including California, allowing for at least some coverage of telehealth services (see California Telehealth Resource Center, 2015).

Ultimately, patient welfare is a key factor when deciding whether or not to provide services to a patient who is located out of state. Are equally effective services available where the patient is located? Is there an ongoing therapeutic relationship that would be beneficial to continue? Are the clinical issues appropriate for distance services? In some cases, such as when the patient has significant mental health challenges and is moving permanently out of state, it would be in the patient’s best interest to obtain treatment with a local therapist. In other cases, such as when an ongoing patient is on an out-of-state trip and requests an appointment that is clinically indicated, providing services across state lines would benefit the patient. There will of course be grey areas in between, such as when a college student moves out of state for the summer, that need to be considered on a case-by-case basis.

In some cases, it would arguably be unethical to refuse to provide interjurisdictional treatment, even if the psychologist is not licensed in the state in which the patient is located and has not had time to comply with temporary practice laws. For example, what if a current patient who is temporarily out of state requests an emergency appointment? From a clinical and risk management perspective, it makes sense to provide services in such circumstances. It would also be consistent with the APA Ethical Principles of Psychologists and Code of Conduct Principle A: Beneficence and Nonmaleficence (APA, 2010). Most importantly, it would be in the best interest of the patient.

Please note: The information in this article does not constitute legal advice and should not be used as a substitute for obtaining personal legal advice and consultation.

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

Christopher Ebbe, PhD, ABPP

CPA Division II is now offering Division II members an opportunity to consult with designated consultants regarding difficulties and dilemmas that they may face in their supervision of practicum students, interns, post-doctoral fellows, or psychological assistants. These consultations might address supervisor-supervisee relationships, supervision contracts and goals, supervisor-supervisee differences, dealing with supervisees who have difficulty learning or changing, remediating performance problems, dealing with disciplinary issues, and evaluation issues. This service is a “first” for Division II and perhaps for CPA as well. We have made every effort in the planning of this service to make it as professional, ethical, and confidential as possible. The Division II board and its own consultants have a wealth of experience and knowledge about supervision (viz., the annual Division II conference on supervision), and we hope that this service will make that expertise available to more supervisors for the benefit of the larger community.

Consultants will have at least five years of experience doing clinical supervision, and will have at least three years of program responsibility for the supervision of trainees by others and therefore will have familiarity with the regulatory, legal, and ethical issues involved in supervision. Consultants will work from the latest version of the APA ethics code, APA accreditation guidelines, and California Board of Psychology regulations regarding supervision for licensing. Consultants will be approved individually by the Division II board.

The Program Coordinator (currently Christopher Ebbe, PhD, ABPP) will assign a consultant to each requestor, who will acknowledge in writing before the consultation begins that he/she understands the roles of consultant and consultee – i.e., that regardless of the consultation, the supervisor/consultee continues to hold total clinical and legal responsibility for the supervisee’s actions and for the supervisee’s clients’ welfare.

Members may consult by telephone (not e-mail) with the consultant, in single or multiple contacts. Multiple relationships between consultant and member will be avoided. Before discussing their problematic situation, members will be advised to think carefully about any confidentiality considerations and decide how to proceed (including identifiable information).

Consultants will help members clarify the problem issues in their situations and think through possible solutions, including ethical/legal considerations and best practices in supervision. The consultant will not make specific recommendations or advise the member regarding what specifically to do but will remain clearly in the consultant role. All information received from the consultee will be treated as confidential (although all parties acknowledge that there are legal scenarios in which information about the consultation could conceivably be sought by courts). Consultants will keep a record of each
Child Sexual Abuse

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Contact, noting the main issues and content of the consultation (including suggestions made by the consultant).

If the consultee’s question involves ethics, the consultant may consider referring the member to the CPA Ethics Committee for assistance. Consultants may consult with each other or with the Program Coordinator to ensure providing the most helpful information to the consultee. Consultants will not discuss content of the supervisee in question with others in the member’s organization and will not be available in court matters.

The Program Coordinator will compile records of all consultations for the consideration of the Division II board, and feedback on the quality of the service will be sought from previous consultees.

We are hopeful that this consultation service will be a useful resource for Division II members and will significantly benefit supervisors and their supervisees.

Finally, we will be hosting our Division II Conference in Northern California Saturday, October 17, 2015, at the Alliant International University San Francisco campus. Nadine Kaslow, PhD, ABPP, 2014 APA President will be the featured speaker, discussing “Supervisees who worry their supervisors: Ethical, culturally responsive, and strategic approaches for working with supervisees who do not meet professional competence requirements.” Plan to join us for a memorable day!

The e-mail contact to begin a consultation is being provided to all Div. II members and will be posted on the Div. II members-only page on www.cpaapsych.org. Information about joining Div. II is also on the website.

San Jose State University San Jose, California
ANNOUNCEMENT OF POSITION AVAILABILITY, Department of Counselor Education,
Subject to Budgetary Approval

Position: Lecturer
Rank: Part-time or Full-time, temporary
Salary: Commensurate with rank and experience. Salary information is available at: http://www.sjsu.edu/facultyaffairs/
Minimum Qualifications: Ph.D. in Counselor Education, or Counseling Psychology or closely related field, or ABD in these fields, or a Master's degree with licensure (LPCC, MFT, MSW). Clinical and teaching experience are required. Awareness of and sensitivity to the educational goals of a multicultural population as they have been gained in cross-cultural study, training, teaching and other comparable experience is required. Candidates must demonstrate ability to work collegially with other members of the academic community.
Brief Description of Duties: Teach undergraduate courses in Counselor Education, supervise graduate interns, hold regular office hours; work cooperatively with staff, chair, and other faculty members; participate in course assessment and accreditation activities; and address the needs of a student population of great diversity – in age, cultural background, ethnicity, primary language, and academic background.
Eligibility: Employment is contingent upon proof of eligibility to work in the United States. Starting Date: Fall 2015
Application Procedures: Please send a letter of interest, a current CV and names of three professional references to Lewis Apteck, Professor and Chair, Department of Counselor Education, San Jose State University, San Jose, CA 95020-0073 Lewis.apteck@sjsu.edu For full consideration, applications must be submitted by June 30, 2015. Later applicants will be considered pending on the Department's need. Applicants not selected will be notified by e-mail.

San Jose State University is California’s oldest institution of public higher learning. The campus is located on the southern end of San Francisco Bay in downtown San Jose (Pop. 945,942), hub of the world-famous Silicon Valley high-technology research and development center. Many of California’s most popular national, recreational, and cultural attractions are conveniently close. A member of the 23-campus CSU system, San Jose State University enrolls approximately 29,000 students, a significant percentage of whom are students of minority groups. The University is committed to increasing the diversity of its faculty so our disciplines, students and the community can benefit from multiple ethnic and gender perspectives.

San Jose State University is an Affirmative Action/Equal Opportunity Employer. We consider qualified applicants for employment without regard to race, color, religion, national origin, age, gender, gender identity/expression, sexual orientation, genetic information, medical condition, marital status, veteran status, or disability. This policy applies to all San Jose State University students, faculty, and staff as well as University programs and activities. Reasonable accommodations are made for applicants with disabilities who self-disclose. Note that all San Jose State University employees are considered mandated reporters under the California Child Abuse and Neglect Reporting Act and are required to comply with the requirements set forth in the CSU Executive Order 1083 as a condition of employment. The latest San Jose State University Safety 101 Uniform Campus Crime and Security Report is available. You may request a copy of San Jose State University’s annual safety report by contacting the University Police Department at (408) 924-2221 or by visiting the University Police Department website at (http://www.sjsu.edu/police/).
When Pain Trumps Productivity: Managing Chronic Pain in the Workplace

Jennifer Fowler, MA & Eric Prensky, PhD

Chronic pain is an exceedingly common and disabling condition in the United States; in fact, approximately 100 million Americans deal with chronic or recurrent pain on a daily basis (Institute of Medicine of the National Academies Report, 2011). This condition not only has emotional consequences, but it also incredibly costly for the workforce. The Institute of Medicine estimates that the annual cost of lost productivity is more than $340 billion. This lost productivity is comprised of three main calculations including days of work missed, hours of work lost, and lower wages. Yet, these are simply numbers. The true cost comes with the loss of satisfaction one experiences in their career, inability to perform at their optimal level, and the fear of losing income and self-worth associated with their condition (American Chronic Pain Association, 2011).

Psychological distress and chronic pain are strongly correlated and therefore psychologists should understand the variety of ways in which chronic pain affects productivity (Byrne & Hochwarter, 2006). Furthermore, burnout related to stress at work has been shown to result in a two-fold increase in musculoskeletal pain among employees (Armon, Melamed, Shirom, & Shapira, 2010) suggesting that work-related stress takes a physical toll on our bodies over time. Cognitive issues, including mental fatigue and inability to maintain goal-directed behavior, cause employees to feel unable to initiate and complete work-related projects (Byrne & Hochwarter, 2006).

The role of psychologists in helping patients manage chronic pain is multifaceted. The APA Center for Organizational Excellence is taking a leading role in well-being at work by offering recommendations for companies on how to create a psychologically healthy workplace in order to increase productivity and wellness among employees. As psychologists, we are fortunate to be able to have an impact on different levels (e.g., individual and organizational) including providing individual therapy with those in the workforce experiencing chronic pain, engaging managers and leaders to better understand how to support employees experiencing pain, or engaging organizations through seminars to educate employees about chronic pain management techniques in the workplace. Two hallmarks of the psychologically healthy workplace include promoting the health and safety of employees and encouraging work-life balance to improve employee ability to balance multiple competing demands (http://www.apaexcellence.org/resources/creatingahealthyworkplace/).

Psychologists can urge patients to reach out to their supervisors to address how the workplace can facilitate them in managing or coping with their disability. More specifically, appropriate managerial support for employees has been found to help those suffering from chronic pain to increase productivity and performance (Byrne & Hochwarter, 2006). To reduce stress in the workplace, psychologists can teach employees and managers meditation practices and relaxation training exercises. Mind-body stress reduction practices such as mindfulness meditation, have been shown to improve sleep, immune functioning, and reduce anxiety (Wolever, Bobinet, McCabe, Fekete, Mackenzie, & Kusnick, 2012). In our role as
psychologists we can have a deep impact on both the personal and occupational lives of individuals by improving well-being and productivity.

REFERENCES
Central Coast Psych Assn  Numerous trainings have occurred in 2015 on subjects as diverse as cultural competency, Mental Health, aging, and sex therapy; and a DBT training will take place later this year. We held monthly case consultation meetings where CCPA psychologists had the opportunity to discuss their cases and get feedback. For social activities, CCPA members attended two Members Dine Out this year that enhanced community involvement and networking opportunities. The CCPA membership continues to grow and there are plans in the works to continue increasing membership.

Los Angeles County Psych Assn  In keeping with LACPA’s theme for 2015 of Complexities of Culture, our convention and various committees will have presentations and events on subjects of diverse interests. LACPA’s 27th Annual Convention in the Fall, will feature David Barlow, PhD, an internationally known expert on anxiety disorders. The CE Committee has a great line up of presenters on subjects of wide interest including, Digital and Social Media Ethics. This year LACPA is celebrating its 70th year anniversary with a meet and greet summer event, organized by the Diversity Committee and open to all neighboring psychological associations, called Building Bridges – Honoring the Diversity Among Us. The Community Outreach Committee is putting together Mirrors of the Mind 4: The Psychotherapist as Artist with the theme of Culture, Creativity and Community.

Marin County Psychological Assn  had a very busy spring. We held several mini networking meetings hosted by our board members where approximately 50 MCPA members met in small informal groups throughout Marin County to let other members know more about their work and establish collegial relationships. In May our MCPA Social Chair arranged a Saturday hike and our CE Chair offered an event with Dan Kalb, PhD titled CBT for Non-CBT Therapists. This July we will hold our third annual summer party – always a lot of fun and well attended – organized by our MCPA Social Committee.

San Diego Psych Assn  held a Fiesta Fundraiser in March to honor our Past Presidents. With 120 attendees, we recognized 23 Past Presidents and displayed their Presidential summaries. As a direct result of a 2014 member survey we have begun to restructure our Association. A Task Force is in place to look at ways to maintain financial stability and better meet the needs of SDPA members. Our Fall Conference and other CE offerings this year are about the changing landscape of psychology. SDPA is on the move to meet member requests for information related to niche practices, and the business of private practice in general. Besides CE, we are holding many free networking events this year for members, and with our Association partners in the community.

San Francisco Psych Assn  has been busy coordinating with other chapters to provide educational experiences to our members and hosting social events in our fair city. With a renewed focus on the value proposition of organizational membership, we are continuing to consider how to best serve our current members as well as become more inviting to potential members. At SFPA, we are excited to see the future developments with the Board of Psychology’s changes in the Continuing Professional Development requirements. Our intention is to capitalize on the opportunity by developing ways of helping members to meet these new requirements and fostering the professional interactions and interplay desired by the BOP.

San Gabriel Valley Psych Assn  was grateful to receive the 2015 CPA Award for Outstanding Newsletter at the CPA convention. We are proud to make our newsletter available to the public on our website: www.sgvpa.org. Our association continues to focus on networking, self-care, and advocacy; hosting events including early career mixers, a C.A.R.E. event at the Norton Simon Museum, and our New Member event. We also hosted an internship panel to help students preparing to apply or attend internship this Fall. For advocacy, our chapter focused on increasing awareness of the workings of BOP, the CPA PAC, and the allegations towards the APA in regards to involvement with torture during the Bush administration.

San Mateo County Psychological Assn  has been quite active on behalf of its members and governance so far this year. We have several new Board members and Committee Chairs who have brought abundant energy and creative ideas to advance our mission of advocacy and education. We are updating our Bylaws, Policies and Procedures, and web presence. We have several continuing education and community educational offerings planned that include contemporary psychoanalytic practice, professional wills, parenting skills for young children and teens, LGBT youth, and procrastination. We sponsor Network Gatherings and New Member Lunchees. We are also planning a legislative advocacy event and our holiday gathering.

Division II (Education and Training) is pleased to announce its new supervision consultation service. This service is for Division II members and provides interactive consultation by experienced supervisors for members experiencing difficulties in working with specific supervisees at any level of training. Consultants must have at least five years of experience doing clinical supervision and at least three years of program responsibility for the supervision of trainees by others. The consultee will sign a form acknowledging that he/she retains full clinical and legal responsibility for the case. Consultants will help members clarify the issues in their situations and think through possible solutions, including ethical/legal considerations and best practices in supervision. Brief content records will be kept, for the protection of the service. The contact for this service is Dr. Ebbe at cebbe@verizon.net.
WELCOME TO OUR NEWEST MEMBERS

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Please note: These members joined CPA between 2/16/15 to 5/31/15. As a CPA member, you may access other member's contact information online in our Member Directory under the Membership section of our website or by contacting CPA's central office at (916) 286-7979, ext 122.

2015 CPAGS Officers to serve in 2015/2016

On behalf of the California Psychological Association of Graduate Students (CPAGS), I would like to extend my sincere gratitude to the talented and dedicated group of graduate student officers who volunteered to serve for the 2015-2016 academic year. On July 1, 2015, the incoming officers begin their term. I am excited by this list of intelligent and dedicated leaders that will make up a strong team and I look forward to expanding student commitment to psychology and diversity. Our team will take on the difficult but enriching task of bringing culture, social justice, and diversity to the top of the list of priorities when making decisions that impact the CPAGS membership. I am deeply and personally grateful to Eric Samuels (2014-2015 Chair) for teaching me to lead with hard work and integrity, and I hope to pass on such a tradition to this year's team.

Please join me in welcoming the 2015-2016 CPAGS Leadership Team! To learn more about our outstanding group of graduate student leaders, please visit www.cpapsych.org.

Alyssa Aguilar, MA
CPAGS Chair 2015-2016

2015-2016 CPAGS Election Results

Chair-Elect
My Linh Vo

Secretary
Emily Artusio

Treasurer
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About the Program

The body’s intelligence is a largely untapped resource in psychotherapy. Few educational programs in clinical psychology or counseling emphasize how to draw on the wisdom of the body to support therapeutic change, leaving therapists mostly dependent on the verbal narrative.

The Level I Training, first of three in SPI’s Training Program, provides participants with foundational Sensorimotor Psychotherapy® skills that can be used to explore the somatic narrative that is arguably more significant than the story told by the words. By tapping into somatic expressions participants can illuminate implicit processes that shape the brain and body and communicate meaning that not only influences the manner in which content is formed and expressed, but may also essentially determine the content itself.

This 80-hour training provides participants with a repertoire of body-oriented interventions for tracking, naming, and safely exploring trauma-related somatic activation, creating new competencies, and restoring a somatic sense of self, as well as effective, accessible interventions for working with disruptive behavioral patterns, disturbed cognitive and emotional processing, and the fragmented sense of self experienced by so many traumatized individuals.

Participants will learn:

- Foundational theoretical principles of Sensorimotor Psychotherapy®
- To work with physical action to harness the body’s wisdom
- The body’s role in procedural learning
- Embedded Relational Mindfulness™ for working with present moment experience
- Information processing levels and top-down, bottom-up approaches
- Sensorimotor Psychotherapy® phase oriented treatment model and the five stages of the therapeutic process
- Somatic resources for stabilization
- Interventions to reinstate adaptive orienting habits
- Techniques to restore adaptive, flexible boundaries
- The body’s role in maintaining dissociative parts
- Interventions to process and integrate implicit and explicit memories
- To identify and capitalize on pretraumatic resources
- Sensorimotor Sequencing for recalibrating the nervous system when working with traumatic memory

Underpinning Theory

“Sensorimotor Psychotherapy blends theory and technique from cognitive and dynamic therapy with straightforward somatic awareness and movement interventions... that promote empowerment and competency.”

- Dan Siegel, MD, clinical professor of psychiatry at the UCLA School of Medicine

Founded by Dr. Pat Ogden, Sensorimotor Psychotherapy®, is a method of somatic psychology informed by interpersonal neurobiology, neuroscience, and research in trauma and attachment. Sensorimotor Psychotherapy® approaches the body as central in the therapeutic field of awareness and builds upon the body-oriented interventions common to other somatic approaches with unique observational skills, theories, and interventions within a phase-oriented treatment model.

Mason A. Sommers, PhD, LCP, has over 34 years of clinical experience and is a clinical instructor at the David Geffen School of Medicine. Dr. Sommers is an ambassador at an organ procurement organization and speaks often on the need for organ and tissue registry and donation. He is past President of the Board of Directors of the Maple Counseling Center. Dr. Sommers combines analytic, psychodynamic, and somatic psychotherapies in his private practice in Beverly Hills, CA, and specializes in couples and adult individual therapy.

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