

Hawai'i Psychologist

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President's Message

APA Convention rides the wave of Aloha

by June W. J. Ching, Ph.D., ABPP
President, Hawaii Psychological Association

Did you know? Hawai'i Psychological Association welcomed the 112th Annual APA Convention from July 27 - August 1, 2004.

Did you know? The last APA Annual Convention was held in Hawai'i over three decades ago.

Did you know? The Board of Convention came close to canceling Hawai'i as the convention site after 9/11. Our very own Pat DeLeon pushed ahead when the calmer heads were predicting a disaster.

Did you know? Over 13,000 psychologists, with accompanying families, attended the recent APA Annual Convention here in Hawai'i.

Did you know? Convention attendees were treated to more than 1,200 symposia, invited addresses, paper, poster and continuing education sessions.

Did you know? Accolades are still pouring in. Here is a sampling, "The most enjoyable APA Convention I have ever attended. Anyone who chose not to go to the convention this year missed out on a very special

experience. The atmosphere was the most relaxing and friendly I have yet experienced at APA Conventions." "I was very impressed by this year's truly wonderful convention."

Did you know? The energy, synergy, and Aloha Spirit permeated throughout every aspect of this unique and impressive 112th Annual APA Convention. The success of the convention was due to the vision and hard work of many people – APA President Diane Halpern, the Board of Convention Affairs, and the Board of Directors. However, I believe that the winning ingredient had to do with you. As members of Hawai'i Psychological Association, it was **you** who extended yourselves and demonstrated what the Aloha Spirit is really like. Mahalo Nui Loa to all of you.

There were many highlights for me, in particular the Opening Session program, which was dedicated to the celebration of Hawai'i culture. Paul Pearsall, PhD, shared an *aha mele* (lecture concert) that included an *oli* (welcoming chant), an *auwana* (modern hula), and *kahiko* (ancient Hawaiian hula). The Opening Session also featured musical entertainment by

the Kamehameha School's Children's Chorus.

It was an honor to participate in the Opening Ceremony on behalf of the Hawai'i Psychological Association. I have heard that some of you would enjoy having me share my welcoming comments once more.

"President Halpern, APA Council and Board of Directors, honored guests, friends and esteemed colleagues, it is my distinct pleasure to extend a very warm **ALOHA** on behalf of the Hawai'i Psychological Association.

The last time that I addressed such a large audience was at my wedding reception, almost 28 years ago. I had wanted a small and intimate wedding. Little did I know that marrying into the Ching clan meant that I would then be related to half of Honolulu. From where I stand right now, you look like half of Honolulu!

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President's Message
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It is fitting that over 12,000 psychologists from one of the most learned professions are meeting together on the island of O`ahu which is known as the '**GATHERING PLACE**' for the Hawaiians. In Hawai`i, the family, or **OHANA**, is revered. While you are here on the islands, you will be part of our **extended ohana**, where the **Aloha Spirit** prevails. An expression of the Aloha spirit is the giving and receiving of **leis**, a circle of unending Aloha. When you give a lei of Aloha, you are literally sharing a breath of life, a part of you, your essence, your **mana**.

The wide array of program offerings at this unique 112th annual APA convention is almost overwhelming to select from. For IRS and tax purposes, you are attending the convention to 'feed your brain.' However, in addition to partaking in the substantive program, I would also like to encourage you to **MA'LAMA** or take good care of yourselves, by using your time here as a way to **relax the body** and **replenish the mind and soul** in our wonderful state of Hawai`i.

Enjoy the cultural diversity, the natural beauty of the islands, and let it '**all hang loose.**' Experience what island living is really like. While you

are here, do things '**island style.**' Make it a point to learn a few Hawai`ian words every day.

Let's start with the word **KAPU**. It is absolutely **KAPU** or **forbidden**, for you to wear suits or nylons in Hawai`i. You can always tell who the first day convention attendees are by their attire. They are wearing suits, ties, stockings, and somber colors. Second day conventioners tend to discard their ties and pack their Feragamo shoes away. In the third day of the convention, people are more relaxed and wear t-shirts along with rubber zoris. By the final day, attendees are clad in surfer shorts and bikinis...and of course their leis. Casual is the way to go! In fact, using the local pidgin dialect, we have a rule for dressing, '**mo loose, mo wild, mo colorful, mo betta.**'

Another important word is **HOLOHOLO**, which means to **get out or walk about**. It is **KAPU** to stay indoors all day. You must get out and **HOLOHOLO** each day. Enjoy a spectacular sunset, strolling on one of our white sandy beaches. Listen to the sound of the waves washing ashore. Take in the sight of our exotic mountain ranges. Find glimpses into Hawai`i's past. Savor some of the island delicacies – **ono** chocolate

covered macadamian nuts, malasadas, and mouth watering **shave ice** with lilikoi syrup. Although, if you were past APA President Dick Suinn, you might argue that pineapple flavor with li hing moi is the best.

The final Hawaiian words I would like to offer are **HANA HOU** which means '**do it again**' or '**encore**'. Do you realize that the last APA Convention was in Honolulu 32 years ago, in 1972?! If you have enjoyed having the APA Annual Convention here in Hawai`i and want it to return in the near future, let APA know by telling them **HANA HOU**. '**Let's do it again!**'"

Mark your calendars and stay tuned for the upcoming Hawai`i Psychological Association Annual Convention scheduled for October 21-22, 2004.

Warm Aloha

An outstanding return

by Patrick DeLeon, Ph.D.
Former APA President

Our recent APA Convention in Honolulu was truly outstanding. My sincerest congratulations to President June Ching, Carol Parker, and, of course, former HPA President Tom Glass who successfully maintained the APA Board of Directors' initial enthusiasm for returning to our State.

Kathy McNamara and BCA chairs Rodney Hammond and Brian Wilcox were absolutely instrumental in facilitating the visit of over 13,000 colleagues. Our deepest appreciation. Individuals can make a real difference. Since our Convention, two proposals promulgated by federal agencies concretely illustrate this policy perspective.

During his APA presidency, Marty Seligman stressed the importance of Positive Psychology. Accordingly, we were pleased that the US Department of Education, Office of Special Education and Rehabilitative Services, has now announced a priority under its Special Demonstration Programs, focusing on an area of national need, Positive Psychology. "Positive Psychology is the study and practice of counseling techniques based on cognitive-behavioral therapy to assist individuals to develop an increased awareness of their own positive character strengths, emotional processing, and belief systems (citing Marty). These techniques help consumers to build skills so that they can accurately assess beliefs about themselves that may create barriers to effectively coping with adversities that occur in their lives. These techniques may also expand their ability to challenge these beliefs in order to pursue flexible and appropriate responses to their adversities. Positive psychology techniques empower individuals to take control of their own lives, to increase their capacity

for effective decision-making, and to persist in pursuing goal-directed activities.

"Research in positive psychology has yielded a variety of approaches to assist individuals to identify their own beliefs and actions that are barriers to their ability to handle effectively life's adversities. These approaches are based on the techniques of cognitive-behavioral skills development and include models developed to change rigid and pessimistic beliefs and cognitive constructs to more flexible and positive ones. Major work in developing positive psychology approaches has been reported... However, no research literature was identified that applied these principles and techniques to individuals with disabilities in vocational rehabilitation (VR) settings. The overall objective of the positive psychology priority is to develop and demonstrate the validity of counseling tools and techniques based on the principles of positive psychology with individuals with disabilities in the VR system. The priority supports... specifically empowering consumers of VR by implementing techniques that will increase the skills of individuals with disabilities, enabling them to achieve high quality employment outcomes.

"Successful projects under this model demonstration program would address three specific aspects of positive psychology and their application to rehabilitation: learned optimism, strengths and virtues versus talents for employment, and subjective well-being..." Psychology can make a significant difference to the quality of life of our nation's citizenry. Mahalo. Three members of Hawaii's Congressional delegation served at an earlier point in their careers in our State (or Territorial) legislature.

Accordingly, we would rhetorically ask: How many HPA members have personally met with their own State House **and** Senate member during the past year? How many members or students are currently engaged as volunteers in this year's election process? And, how many truly appreciate the significant impact that one member, in particular, in our delegation can have upon colleagues employed by the Veterans Administration, due to his senior position on the Senate Committee on Veterans Affairs?

The Department of Veterans Affairs has proposed to amend its Patients Rights regulation to bring the provisions regarding medication into conformity with current law and practice. The changes are primarily intended to clarify that it is permissible for VA patients to receive medication prescribed by any health care professional legally authorized to prescribe medication... "When VA promulgated the patients' rights rule in 1982, physicians were generally the only health care providers authorized to prescribe medication... However, that is no longer the case. Under current law, other health care professionals are legally licensed to prescribe medication and typically do so in health care settings across the Nation. For example, licensed registered nurse practitioners are licensed to independently prescribe medication in virtually every state in the United States... VA is proposing to eliminate the specific references to physicians... and to substitute references to appropriate health care professionals.

A grass roots effort by HPA will definitely make a difference in ensuring that these timely changes are adopted. Aloha.

Clinical Division Report

Clinicians meet with HMSA mental health staffers

by Sara Farnham, Ph.D., L. Martin Johnson, MBA, Psy.D., and Scott Hashimoto, J.D., Psy.D.
Clinical Division Representatives

Aloha Everyone!

We hope you enjoyed our recent APA convention. For us, it was a truly memorable, yet intensively active, experience.

In this past quarter, we had the privilege of meeting with Kuhio Asam, M.D. from HMSA's Behavioral Care Connection and Dawn Mandiola from HMSA. Dr. Asam highlighted the ongoing efforts with preventive programs and the gathering and the use of clinical data to support the delivery of best practices. Ms. Mandiola shared that the new HMSA Quest Fee Schedule is being discussed and will be disseminated soon. There is a new HMSA Behavioral Health Provider Resource Center Website, that is www.HMSA.com/portal/provider. In addition, ongoing efforts with HMSA include the possible use of CPT Behavioral Medicine codes for psychological interventions and the concept of Quest reimbursement for unlicensed post-doctoral providers working under supervision.

Ms. Mandiola also shared that a current goal is to have HMSA and Behavioral Care Connection become more integrated in terms of communication with the HPA, and providers, in general. Both Dr. Asam and Ms. Mandiola were very gracious with their time and have committed to continuing dialogue and feedback in strengthening their relationship with our HPA and service providers. Please feel free to provide your thoughtful input and comments regarding HMSA issues.

The Board of Psychology has recently welcomed two new psychologists to its board. Sue McCann, Ph.D., and Stanley Luke, Ph.D. have joined the board in July and now make up the full seven member board. Other board members are: Evelyn Yanagida, Ph.D. (Chairperson), Allison Tanouye, Ph.D. (Vice-Chairperson), Elaine Heiby, Ph.D., Laura Ozak, Esq., and Thomas Jackson. Currently, the majority of the Board's effort is focused on the continuing evaluation and consideration of licensure applicants. Also, the Board was

notified that Governor Linda Lingle, although urged by HPA not to do so, signed the "Professional Counselor's Licensure" Bill, SB 2595, allowing master's level counselors to provide treatment for all DSM disorders. The specific oversight mechanism, however, for the Vocational Licensing Division is yet uncertain.

A Clinical Division meeting took place at the end of August and further updates will be shared from that meeting.

We welcome your comments and participation. You may reach us: Sara Farnham, Ph.D. at (808)271-1620, farnham@hawaii.rr.com; L. Martin Johnson, MBA, Psy.D. at (808)538-7798, Martin@DrLMartinJohnson.com; Scott Hashimoto, J.D., Psy.D. at (808) 429-4432, sshashimoto@juno.com

The General's Corner

by Jared Yurow, Psy.D.

Welcome to the General's Corner: HPA's news about happenings in the Community and Public Service (CaPS) Division. The Division strives to represent issues of significant interest to those who provide psychological services in the public sector and/or community. Your voting representatives to the HPA Board serve for two years. Your current representatives are Jared Yurow, Psy.D. and Dirk Elting, Ph.D. You can reach Dr. Yurow by e-mail at drjyurow@msn.com or by cell phone at (808) 224-6507. You can reach Dr. Elting by e-mail at Dirkelting@cs.com or by cell phone at (808) 236-3222.

HB 2230

Although it's summer, the CaPS Division has not rested. At the time of this writing, your Division representatives have continued to work on HB 2230 (reported extensively in "The General's Corner" in the last *Hawaii Psychologist*). We have continued to work with psychologists at Hawaii State Hospital, HPA's Legislative Liaison Don Kopf and the HPA Board to prepare for the 2005 Hawaii State Legislative Session. Dirk and I scheduled a CaPS Division meeting at Hawaii State Hospital (to have taken place on Wednesday, August 4th at 2:30). HGEA planned to send a Bargaining Unit Representative. I plan to report on discussion from this meeting in the next "General's Corner" and will continue to report on this extremely important issue. If you work in public sector psychology, your input and voice are needed to effect positive change in the public sector salary structure.

HPA Convention

The HPA Convention will take place October 20-22 at the Ala Moana Hotel. Each of the HPA Divisions (Clinical, Academic, CaPS and

Student) will have meetings scheduled for Thursday or Friday afternoon. If you are a CaPS Division member, please join us for this meeting. Last year's landmark meeting, the culmination of months of work, resulted in the proposed name change from General Division to CaPS Division. Those who attended served as a driving force for this.

Felix Revisited

Back in 2001, you may recall that I decided to run for the HPA Board on a Felix platform. As a psychologist at that time who worked for the Child and Adolescent Mental Health Division, I became increasingly concerned at the negative publicity generated by the Felix Consent Decree. In particular, I felt discouraged by negative comments I heard about our profession locally, and it always bothered me that others viewed public sector professionals as somehow "less competent" than private sector peers. Nothing could be further from the truth.

For this reason, I decided to run for office. At the very least, I wanted Hawaii psychology and the community to see that public sector psychology takes its role seriously, especially as we often serve the most needy in our society. I also wanted to demonstrate that with our numbers, public sector psychology seeks to represent not only itself but also the interests of our profession both in Hawaii and nationally. Initially fearful of what colleagues might say about an "uppity" Department of Health Clinical Psychologist, I can say three years later that I feel that the HPA Board has accepted me and the public sector/community folks Dirk and I (and Scot Liepack before) represent. The HPA Board has accepted our mission and hears our voice.

Changes have also taken place within the Department of Health (DOH) in which I work. For many years, Child and Adolescent Mental Health (CAMHD), Adult Mental Health Division (AMHD) and Alcohol and Drug Abuse Division (ADAD) psychologists have worked in relative isolation from one another. A number of months ago, the DOH Behavioral Health Administration (BHA) formed a BHA Research Group, in which psychologists from each Division and others meet to discuss common interests in research and clinical service areas. This is truly unprecedented. As a regular participant in these meetings, I have had the opportunity to meet and work with colleagues with an exceptional level of knowledge and commitment.

The article that follows was written by Eric Daleiden, Ph.D. of CAMHD, a colleague I have come to know and respect through many BHA discussions (both at meetings and informally). A number of changes to our profession have taken place in CAMHD. While years ago psychologists initially provided direct services through the Family Guidance Centers on the islands, then provided indirect services through case consultation and coordination as a result of Felix, our profession continues to evolve in the provision of children and family services through CAMHD.

In future issues, I hope to highlight work done by psychologists in AMHD. (You have already heard about work done by their Courts and Corrections Branch). Who knows--I might even tell you about working in Division administration at ADAD.

Until the next issue, malama pono and a hui hou!

Psychology and the Public Mental Health System for Youth: More Than Meets the Eye

by Eric L. Daleiden, Ph.D.

Hawaii Department of Health Child and Adolescent Mental Health Division
and John A. Burns School of Medicine, University of Hawaii at Manoa

When I began working with the Hawaii Child and Adolescent Mental Health Division (CAMHD), I discovered very quickly that most people outside of CAMHD equated CAMHD services with Felix Consent Decree services. As I've come to understand CAMHD over the past two years, I can confidently say that there is more to CAMHD than meets the eye. If you have not looked at us lately, please look again. The purpose of this article is to provide a "bird's eye" view of CAMHD and to identify points of interaction between psychology and our public mental health system.

CAMHD has three primary "front doors" to its core services array. For convenience it can be helpful to think of these as education, health, and juvenile justice pathways. First, consistent with the Felix Consent Decree, CAMHD provides intensive mental health services to youth who need such services to benefit from their education. The Department of Education and CAMHD maintain regular "peer review" meetings at local schools that provide a mechanism for identification of youth and coordination of services between these systems. The second door to CAMHD is for Medicaid eligible youth with serious emotional or behavioral disturbances, who may receive CAMHD services as a benefit of their health plan. Anybody (including you) may refer these youth for CAMHD services through our Support for Emotional and Behavioral Development (SEBD) program by contacting the local SEBD coordinator at a regional Family Guidance Center (FGC) or by contacting the statewide SEBD coordinator at 800-294-5282.

The third primary door to CAMHD services is through our Family Court Liaison Branch that provides services and coordinates care for youth entering the Detention Home on O'ahu or the Hawaii Youth Correctional Facility.

In addition to these core pathways, CAMHD supports a host of other services. CAMHD's universal crisis services include a telephone hotline, mobile crisis outreach, crisis stabilization, and crisis residential care. CAMHD contributes to early intervention services and funds several organizations to provide youth and family outreach, including focused outreach to homeless, rural, and transgender populations. CAMHD strongly supports a statewide family organization, Hawaii Families As Allies, to provide advocacy, family support, and youth leadership. Finally, CAMHD supports training programs in psychology, psychiatry, and social work at the University of Hawaii.

When youth and families step through the doors of CAMHD, they have access to an array of service options. The cornerstone of CAMHD services is intensive care coordination provided through the regional FGCs. Additional services include comprehensive assessments, respite care, intensive home and community-based care (including Multisystemic Therapy), therapeutic foster homes, therapeutic group homes, community-based residential services, and hospital-based residential care. When appropriate, CAMHD arranges for additional individualized care through our flexible benefit services.

CAMHD routinely monitors the process and outcomes of our care.

Though it is beyond the scope of this article to provide a detailed description of our findings, program evaluation results and system analyses are routinely posted on the CAMHD website

(<http://www.hawaii.gov/health/mental-health/camhd/index.html>). In brief, analysis of the three-year period from July 1, 2000 to June 20, 2003 found that approximately 75% of youth are discharged from CAMHD services within 18 months and approximately 10% are readmitted over a two-year period (Daleiden, 2003). Analysis of standardized child status measures (e.g., Child and Adolescent Functional Assessment Scale; Hodges, 1998) revealed that, on average, youth enter CAMHD services with severe functional impairment requiring intensive services and multiple supports and are discharged with dramatically improved functioning appropriate for management in outpatient care. Over an average follow-up period of eight-months after admission, approximately two-thirds of youth show significant improvement in functioning, as indicated by the Reliable Change Index (Jacobson & Truax, 1991).

Psychologists are active in numerous roles throughout the CAMHD system. The most conventional role of clinical psychologists as direct service providers continues through the regional FGCs and CAMHD provider network. Services provided by state-employed FGC psychologists emphasize assessment and consultation. These psychologists provide a host of other services to their FGCs and committees in the

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form of technical assistance, professional development, and strategic leadership. Clinical psychologists' activities differ by region and are designed to support the strategic focus of their branch. Several of the FGC Branch Chiefs are also psychologists. The Branch Chiefs are regional systems administrators who manage system operations and provide local leadership. CAMHD also employs several psychologists as specialists in key strategic areas including evidence-based services, behavioral support, transitions, and research and evaluation. These specialists provide statewide case consultation, training and technical assistance, and system design and development. Although exclusive positions do not exist for industrial-organizational psychologists, personnel with expertise in I-O have played an important role in specific initiatives to improve team functioning and streamline work processes. Another growing role for psychologists at CAMHD is as research partners. Within CAMHD psychologists are active on almost every quality improvement and management committee and are expected to play key roles in the

promotion of evidence-based services throughout the state.

I am the research and evaluation specialist for CAMHD and have a unique job. As a scientist-practitioner in clinical psychology by training, my activities at CAMHD focus on applying psychological science to improve clinical services and system efficiency. My job is very diverse and I work with projects involving all of CAMHD's operational sections – administration, clinical services, family guidance branches, and performance management. I provide consultation that includes cognitive modeling of clinical and administrative decision-making, business process modeling, identifying and designing relevant evidence-bases, and designing feedback systems to improve service decisions, supervision, and system management. I also perform in-depth program evaluation, and coordinate activities among internal and external researchers.

How you can get involved with CAMHD

The investment of the Felix Consent Decree has positioned Hawaii to be a national leader in mental health services. The opportunity exists for psychology to be a driving force in helping our state to continue reaping

the benefits of this investment. You can help by promoting awareness of and facilitating referrals for CAMHD services. Specifically, we believe that many Medicaid-eligible youth who would qualify for and benefit from our SEBD program are not yet connected to services. Please help identify and refer these youth and families. Second, you can help by adopting and promoting the use of evidence-based practices. You are welcome to participate on the statewide evidence-based services committee and CAMHD has technical assistance resources available to help you develop evidence-based services. Third, contact me if you are interested in partnering with CAMHD in research. Finally, add our website to your favorites list and check back often.

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Psychologists involved in diabetes guidelines

The Hawaii State Diabetes Prevention and Control Program (HSDPCP) in the Department of Health has recently published the *2004 Hawaii State Practice Recommendations for Diabetes Mellitus*. The guidelines focus on procedures which form the basis of quality medical care for people with diabetes and are directed toward primary care physicians.

This year, two psychologists were invited to participate on the Hawaii State Diabetes Task Force, a volunteer committee of diabetes professionals responsible for updating the

recommendations. Dr. Keawe`aimoku Kaholokula and Dr. Kamana`opono Crabbe led the discussion on the link between depression and diabetes and were the driving force in the adoption of a new guideline addressing this connection.

The new guideline advises primary care physicians to screen for depression at least twice a year in patients with diabetes. If indicated, a referral should be made to a behavioral health specialist. The addition of this guideline is an attempt to reduce the disproportionate

prevalence of depression among people with diabetes.

Acknowledging the link between chronic diseases and mental health in the primary care setting is the first step toward improved health outcomes. It is the hope of the HSDPCP that the incorporation of this guideline into standard practice will help people with diabetes experience fewer complications and better diabetes control.

News about Members

HPA Fellow RAYMOND CORSINI, who recently celebrated his 90th birthday, has published another new book, *Handbook of Innovative Therapies (Volume 2)*. Along with Dr. Mary Martini, Corsini is restarting the Family Education Center of Hawaii (FECH). For his lifelong accomplishments, Corsini was recognized last Fall by HPA with the Lifetime Achievement Award and received a similar award at the APA Annual Convention in Hawaii. At the

APA symposium entitled, "Reviewing and Celebrating the Lifetime Achievements of Raymond J. Corsini," various colleagues spoke of Corsini's impressive accomplishments. The participants included Co-chairs Frank Dumont and Robert Perloff, and Nicholas A. Cummings, Anthony J. Marsella, ROSEMARY ADAM-TEREM, Albert Ellis, Michael Wertheimer, Larry Nisan, and Danny Wedding.

After 14 years on the mainland, NADA MANGIALETTI has opened her private practice office on Oahu. She has had multiple publications as a science writer. She is starting a Chinese language home daycare (Her husband is Chinese.).

Aloha, New Members!

Members

BERNARD O. CARVALHO
Retired Psychologist, Hilo, Hawaii
PhD Psychology, UCLA

FRAN LYONS
Private practice, Honolulu
PhD Psychology, UH-Manoa

BERNARD A. JARMAN
Psychologist, D.O.E. Hawaii
PhD Counseling Psychology, Arizona State University

ROBERT E. JACKSON
Tripler Army Medical Center
PhD Psychology, Fuller Theological Seminary

WILLIAM R. ZWICK
Psychologist, Research Center of UH
PhD Psychology, University of Rhode Island

Student Members

TRICIA K. CASTRO
Student assistant, Hamilton Library
Undergraduate student, UH-Manoa

JANA Y.H. DOW
Skills Trainer, CARE Hawaii
Undergraduate student, UH-Manoa

LYNN S. MA
Graduate student, Argosy University

CYNTHIA C. DANG
Graduate student, Argosy University
M.S.C.P., Chaminade University

WINTER C. HAMADA
Research Assistant, Mental Health Services
Research and Evaluation
Graduate student, UH-Manoa

KRISTY K. NISHIMURA
School Psychologist, D.O.E., Central District
Graduate student, Capella University

PsySR announces Anthony J. Marsella Prize

Psychologists for Social Responsibility is pleased to announce the establishment of the Anthony J. Marsella Prize for the Psychology of Peace and Social Justice.

This award will be given annually to recognize outstanding contributions in scholarship and action by psychologists in one or more of the following areas:

Peace and Nonviolence
Poverty, Human Rights, and
Humanitarian Assistance

Spirituality and Social Action

Friends and colleagues have created an endowment to fund the prize in recognition of Professor Marsella's lifetime achievements (see biographical sketch below). The prize will be administered by Psychologists for Social Responsibility and was awarded annually at the recent annual convention of the American Psychological Association. A call for nominations will be publicized at a later date.

Tax-deductible contributions to the Marsella Prize may be sent to:

Psychologists for Social Responsibility (Attn: Marsella Prize)

Tax ID Number 52-1253316
208 "I" Street, NE Washington, DC 20002.

For more information, call (202) 543-5347 or write psysr@psysr.org.

General information on PsySR is available at www.psysr.org.

Biographical Information: Anthony J. Marsella, Ph.D., D.H.C.

Anthony J. Marsella received his B.A. degree with Honors in Psychology from Baldwin-Wallace College, Berea, Ohio, in 1962, and his Ph.D. in Clinical Psychology from The Pennsylvania State University, University Park, Pennsylvania, in 1968. After completing an internship at Worcester State Hospital, Worcester, Massachusetts, he was appointed as a Fulbright Research Scholar to Ateneo De Manila University in the Philippines where he taught and conducted research on social stress and psychopathology in urban Manila. In 1968, he served as Project Director for a large-scale psychiatric epidemiology study of Iban, Malay, and Chinese populations in Sarawak, Borneo. In 1968-69, he was awarded an NIMH Culture and Mental Health Fellowship and an East-West Center appointment at the University of Hawai'i, Honolulu, Hawai'i. In 1970, he joined the faculty of the Department of Psychology at the University of Hawai'i, a position he held until 2003 when he retired.

Dr. Marsella is currently Emeritus

Professor of Psychology and Past Director of the World Health Organization Psychiatric Research Center in Honolulu, and Past Director of the Clinical Studies Program. In the years before he retired, he organized and directed the Disaster Management and Humanitarian Assistance Program at the University of Hawaii. Dr. Marsella is a consultant to numerous national and international agencies and organizations. Between late 1985 and 1989, he served as Vice President for Academic Affairs at the University of Hawaii. He has been a Visiting Professor in Australia (Melbourne University and Monash University), Korea (Korea University), India (King George Medical College), China (Shanghai Psychiatric Institute), and the Philippines (Ateneo de Manila University). In addition, he has been a visiting professor at Johns Hopkins University (Baltimore, Maryland) and a Visiting Lecturer at numerous national and international universities and research centers.

Dr. Marsella has published ten

books and more than 140 book chapters, journal articles, and technical reports, and he has been awarded numerous research and training grants and contracts in the areas of cross-cultural psychopathology and psychotherapy, PTSD, social stress and coping, schizophrenia, and global challenges. He has served on numerous journal editorial boards and scientific and professional advisory committees. He was an Associate Editor for the Encyclopedia of Psychology (John Wiley & Sons) and was one of ten Senior Editors for the Encyclopedia of Psychology (Oxford University Press/American Psychological Association). He is currently senior book series editor for cultural and international psychology for Kluwer Academic/Plenum Press.

Dr. Marsella is widely known nationally and internationally as a pioneer figure in the study of culture and psychopathology who has challenged the ethnocentrism and

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racial biases of many assumptions, theories, and practices in psychology and psychiatry. His literature review articles on "depression across cultures," "culture and mental illness," "ethnocultural aspects of PTSD," and "the history of cross-cultural studies of psychopathology" have been termed "essential readings" by many in the field. His article on "global-community psychology" published in the *American Psychologist*, December, 1998, calls for the development of a new psychology that is relevant and responsive to our changing global community.

Dr. Marsella has directed 96 doctoral dissertations and masters theses, many of them with international and minority students. He received the College of Social Sciences Award for Teaching Excellence, and was selected by the

American Psychological Association as a Master Lecturer Award for 1994 for his contributions in cross-cultural psychology and psychopathology. In 1994, he was selected as the "Best Teacher" by the "Best of Manoa Student Poll" at the University of Hawai'i.

The Hawai'i Psychological Association selected Dr. Marsella for its Significant Professional Contribution Award for his scholarly and professional achievements in 1996. He is the first recipient of the "Kathryn Grover Harrington Scholar Award" from Baldwin-Wallace College, Berea, Ohio, his alma mater. He received the "Medal of Highest Honor" from Soka University in Tokyo, Japan, for his contributions to the academy and to the promotion of international peace and understanding. In 1996, the American Psychological Association selected Dr. Marsella

for the Distinguished Contributions to the International Advancement of Psychology Award. He has been listed in *Who's Who in America* since 1996. In November, 1999, he was awarded an honorary doctorate degree *Doctoris Honoris Causa* by the University of Copenhagen, Copenhagen, Denmark at a ceremony presided over by the Queen, and in 2004, he was awarded the International Psychologist of the Year Award by Division 52 of the American Psychological Association.

At the recent APA Convention in Honolulu, Dr. Marsella was the proud recipient of the Asian-American Psychological Association Presidential Award for distinguished contributions to Asian-American psychology. He also received the APA International Psychologist of the Year Award from the International Division.

Kubany authors new book on battered women with PTSD

Hawaii psychologist Edward Kubany is the senior author of a new workbook for formerly battered women with PTSD. *Healing the Trauma of Domestic Violence: A Workbook for Women* (New Harbinger Publications) represents the work of Kubany as a specialist in treating survivors of domestic violence and a researcher with the National Center for PTSD (Pacific Islands Division). His co-authors are Mari McCaig, MSCP, a victim and witness counselor, and Janet Laconsay, MA, a therapist.

The authors offer a program based on cognitive trauma therapy, a treatment developed by Kubany that has significantly reduced symptoms of PTSD in 90% of those who complete treatment. Some studies

show that as many as 85% of battered women suffer from PTSD. By contrast, 35.8% of Vietnam veterans who experienced intense combat have PTSD.

Kubany and his coauthors provide

1. A primer on PTSD, which includes a self-assessment questionnaire, key symptoms, and an examination of the role it plays in the post-abuse life of women who have been battered.
2. A complete tool kit for recovery, which includes strategies for relieving guilt, depression, stress and shame; stress management techniques; exercises for overcoming a

sense of powerlessness and becoming a strong self-advocate; and skills for expressing anger in a healthy way.

3. What readers need to know when they have to face their former abuser.
4. Help to avoid the difficulties that lead women to be back to their abusers.
5. Tips for identifying potential abusers.

(In 1998, for his pro bono work Dr. Kubany received the *Unsung Hero Award* from the *Safety Network*, a community-based group of domestic violence survivors and supporters in Honolulu.)

Wisdom tales: Using storytelling traditions to understand and treat eating disorders

by Anita Johnston, Ph.D.

(The following article appeared in the Spring 2004 issue of the Georgia Psychologist, and is reprinted with the kind permission of its editor.

Dr. Johnston is Director of the Anorexia and Bulimia Center of Hawaii and author of Eating in the light of the moon: How women can transform their relationships with food through myth, metaphor, and storytelling.)

Traditional folk tales and multicultural myths can be used as powerful tools in the treatment of eating disorders because they are repositories of ancient wisdom about the human condition and because they teach the language of symbolism, imagery, and metaphor. These wisdom tales can help clients gain insight into their disordered eating behavior and can function as effective catalysts for bringing about change in eating patterns.

Through storytelling, clients can learn the language of metaphor, which can help them intuit the existence of deeper meanings and truths. As they become proficient with this language, they are better able to understand how food can be a symbol for emotional nourishment, how eating can be an attempt to feed inner hungers, and how food restriction can be an attempt to deny these hungers.

Accessing the truth within

According to Marion Woodman, Jungian analyst and author on addictions and eating disorders, the healing power of metaphor lies in its ability to provide us with images that can transform unconscious material into conscious awareness. She believes storytelling and the use

of metaphor have more of an immediate impact than abstract analysis when working with eating disorders. "So long as it's theory, it's removed from the actual feeling...if I put it in a story form or use images, the mind may not hear it, but the body responds. And if it's reverberating in the body, sooner or later it's going to get through to consciousness."

Our ancestors used traditional tales as vehicles for transmitting ancient wisdom accumulated over millennia to inform, instruct, and to heal. Myths, for example, are stories that have stayed alive in human imagination over long periods of time because there is a ring of truth in them about shared human experience. According to Joseph Campbell, myths, guide us in the "experience of being alive." They are told to enlighten us about our origins, our inner realities, and what it means to be human.

Season for growth

For example, the Greek myth about the mother goddess of the harvest, Demeter, and her daughter, Persephone, can be valuable in treating eating disorders. In the tale Persephone is kidnapped by Hades and taken to the Underworld to be his queen. Demeter becomes so distraught over the loss of her daughter that the land becomes barren and no food can be harvested. Zeus, king of the gods, eventually agrees to help Demeter rescue her daughter, cautioning her that Persephone can only return if she has not eaten anything in the Underworld. As it turns out, Hades fed Persephone three pomegranate seeds and, although she could be

reunited with her mother, she would have to return to the Underworld three months of each year thereafter.

Girls and women struggling with eating disorders can often relate to Persephone's experience. They know what it's like to feel estranged from their mothers (either their biological mothers or their internal mothering capacities), to be overtaken by unconscious forces that seem to come out of nowhere, and to have dark moods that hold them hostage. The pivotal role food plays in this story can be especially compelling and poignant by providing a way to work with resistance that may be encountered when exploring eating behavior. In therapy, discussion of the first question Demeter asks her daughter when they are reunited ("What did you eat?") can help a client discover what underlies her own reactions to that question and explore issues around her own eating behavior. It becomes obvious that what appears to be a simple question can actually be fraught with tremendous meaning. Through this exploration, a client can begin to examine the symbolic meaning of her relationship with food and find connections between her eating behavior and her relationships with others.

Lesson learned

Persephone's journey to hell and back can provide a beacon of hope and understanding for a client's personal journey into the darkness of an eating disorder. By understanding her own tale of

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Our liberties we prize and our rights we will maintain

by Deems Ortega, Ph.D.

(Dr. Ortega is a former President of the Iowa Psychological Association. She is a practicing psychologist in Des Moines, Iowa.)

You probably recognize the title of this piece. It was not lifted from a libertarian manifesto. It is the motto on the Iowa State flag. I have come to the disturbing conclusion that our liberties and rights are being trampled under a stampede of over-regulation. The main thesis of this essay is that governing bodies are far exceeding their constitutionally circumscribed authority and are intruding into every aspect of our personal and professional lives. This invasion is no more evident than in the proliferation of laws, codes, and mandates dictating professional practice. It is my intention to outline some of these personal and professional infringements and suggest principles for relief.

My conclusion, that there has been systematic erosion of personal freedom, is based upon several compelling facts. First, the United States has the highest imprisonment rate on the planet. With five percent of the world's population, the USA has 25% of the world's prison population. Our rate of incarceration is six times that of China and Australia, the latter having been colonized by deported criminals (International Centre for Prison Studies, 2004).

Second, the value of private assets seized by government agents in 2002 exceeded \$1.25 billion (U.S. Department of Justice, 2003). Under civil asset forfeiture laws, agents may confiscate private property from a person carrying large amounts of cash or even paying cash for an airline flight. If a drug dog scratches at your luggage,

the luggage and all of its contents are forfeit. In New York, cars have been confiscated because the car's stereo was played too loudly.

This can happen because confiscation rules require only "probable cause" to justify the seizure. Hearsay and innuendo forms of evidence, inadmissible in court, are sufficient to cause confiscation. Fully 80% of the people whose property is seized under federal drug laws are never charged with a crime, let alone convicted (Schneider & Flaherty, 1995). Seized property is forfeit even after the defendant is acquitted of criminal wrongdoing. As bizarre as this sounds, the seized property becomes the defendant (e.g., United States v one 1998 Mercedes Benz), and property does not have personal rights. Seized property is sold at public "government auctions," the proceeds typically going to the law enforcement agencies that seize them.

Third, after imposing a multitude of regulations upon many professions, government agents are allowed to perform warrantless searches of "closely regulated" industries" (U.S. v Bizwell, 1972). Such pervasively regulated businesses now include junkyards and pawnshops, liquor stores and taverns, massage parlors, coal mines, trucking companies, and pharmacies. Citing "pervasive regulation" of the profession, the New Jersey State Board of Medical Examiners had their Enforcement Bureau conduct a warrantless search of a physician's entire office, including all medical records, billing records, and appointment

books (Crane, 1998). This action was taken because the Board received a complaint that free samples of an NSAID, given to a patient by the physician had passed their expiration date. In a condemnation of warrantless searches, Supreme Court Justice Louis Brandeis wrote that, "the greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning, but without understanding" (U.S. v Olmstead, 1928).

While the infringements upon every citizen's personal freedom have been dramatic, licensed healthcare professionals have been regulated, mandated, and criminalized to the point of absurdity. Once professional standing is designated a "privilege" instead of a right, many liberties are forfeit. Compounding this has been the tendency to make secondary the rights of licensed healthcare providers under the banner of "protecting the public."

There are numerous examples of healthcare profession overregulation at both the national and state level, with state professional licensing boards at the vanguard of freedom's desiccation. First, the Iowa State Board of Psychology Examiners has imposed a continuing education (CE) mandate on licensees. Without fulfillment documentation, the license will not be renewed. Not all state licensing boards require CE. The states of New York, New Jersey, Connecticut, Illinois, Michigan, Indiana, South Dakota, Colorado, and **Hawaii** (emphasis

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added) do not oblige licensed psychologists to complete any CE. Their licensing boards may be reluctant to perform policing functions or they may object to mandates. They may also be aware that there are no data to show that CE mandates reduce the number of ethical complaints or ethical violations. My 2004 PsychARTICLES literature search for papers on “continuing education” produced articles dating back to 1987, none of which addressed ethics-related accusations or convictions.

Beyond an absence of data linking CE to ethicality, Bickman (1999) declared it a “myth” that post-graduate CE improves clinical efficacy. In fact, CE may do no more than cause recipients to overestimate their prowess. Pekarik (1994) provided one group of psychotherapists with 10 hours of CE training in brief therapy. These CE therapists subsequently claimed better treatment outcomes than non-CE therapists did. Conversely, the clients of non-CE therapists had a 36% reduction of symptom scores compared to only 23% for CE therapists.

Second, Iowa Code establishes psychologists as mandatory reporters of suspected abuse inflicted on children and dependent adults. Rather than establishing healthcare professionals as “protected reporters” who are held harmless for abuse reports, the professional is stripped of discretion and becomes criminal for failing to report any suspected harm. As a result, all decision-making is left to unlicensed paraprofessionals in a Department of Human Services whose failures of judgement and action are the stuff of nightmares. Further, the Iowa State Board of Psychology Examiners enforces the

requirement that licensees must receive ongoing training about abuse recognition and reporting, with license forfeiture being the consequence of noncompliance.

Third, current Iowa law places healthcare professionals in a “duty to warn” Catch-22. This is because such duty (*Tarasoff v Regents of the University of California*, 1976) has not been codified in this state. Since the duty to warn is not mandated by law, the breach of confidentiality inherent in warning remains illegal. Nonetheless, psychologists remain vulnerable to *Tarasoff*-based civil suits if they do not warn.

Fourth, the Iowa law “protecting” psychological test items makes psychologists who release such materials subject to arrest, prosecution, conviction, fine, and imprisonment. The law is intended to maintain test validity by keeping the public naïve to the items. Yet a list of MMPI-2 items is provided in a book for sale to the public (Pope, 2000). The Rorschach inkblots were published in the Sports Section of the *St. Petersburg Times* on 3 November 2003. World Wide Web searches provide the curious with ready access to protected psychological tests. The end result of the Iowa law is that psychologists are criminalized for releasing test materials that are readily available to the public.

Fifth, Federal and Iowa State antitrust laws make it illegal for healthcare professionals to speak freely among themselves about fees and business practices. Through these prohibitions, the “spirit of competition” has superceded the constitutionally guaranteed right of free speech. Apparently, any open discussion between psychologists about professional matters is akin to yelling “fire” in a crowded theater. Further, these antitrust laws prohibit healthcare professionals from

forming collective bargaining units to negotiate fair reimbursement from health insurance companies. It should be noted that Article 23 of the United Nations’ Declaration of Universal Human Rights asserts the general right “to just and favourable conditions of work” and the specific right, “to form and join trade unions for the protection of their interests.”

Sixth, the overreaching and convoluted APA Ethical Principles of Psychologists and Code of Conduct 2002 is an appalling infringement upon freedoms. Principle 10.06, known as the *The Prince of Tides* rule, makes it unethical to have sexual intimacies not only with clients but also with the “close relatives, guardians, or significant others of current clients/patients.” Principal 10.07 prohibits the converse of having sex with patients, forbidding psychotherapy with past sexual partners. It is unclear what work of fiction triggered this exclusion. Principle 1.05 compels psychologists to police others in the profession, making it a violation to fail to report ethical violations by other psychologists. However, Principle 1.04 makes it unethical to report a violation without first trying to resolve the matter with the offending party. Principle 5.03 makes it unethical for a psychologist conducting a workshop to fail to “ensure that they accurately describe the audience for which the program is intended” in the workshop brochure. Such mandates would be comical were it not for the fact that the Iowa State Board of Psychology Examiners has adopted the code for evaluating professional conduct. Non-compliance with the Code can result in license forfeiture.

Insidious encroachment upon liberty by well-meaning zealots is ongoing. A recent issue of *American* (Continued on p. 14)

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Psychologist included an article with recommended guidelines for “building a firewall” between the pharmaceutical industry and professional psychology (Antonuccio et al., 2003). These guidelines are prohibitions that the authors want added to the APA Ethics Code. One guideline states that, “continuing education should generally be prohibited for training sponsored by drug companies” (p. 1036). Another guideline asserts that, “contact between drug company representatives and students should be prohibited” (p. 1036). To enforce the latter prohibition, the authors recommend that students be “protected” by a policy similar to that imposed on student-athletes by the NCAA. The NCAA aggressively punishes student-athletes that make illicit contacts, the standard consequence being loss of eligibility. Applied to psychology students, this would mean expulsion from the program and/or school.

In an environment of insidious erosion of just and favorable working conditions, it becomes necessary to establish a Bill of Rights for Licensed Healthcare Professionals.

A Bill of Rights for Licensed Healthcare Professionals

To prevent the government from committing “misconstruction or abuse of its powers” condemned by the U.S. Bill of Rights and to “secure the Blessings of Liberty to ourselves” described in the U.S. Constitution, Licensed Healthcare Professionals claim for themselves the following specific rights:

1. Licensure as a Healthcare Professional shall not be construed as a “privilege,” but shall be the right of any person meeting the licensure criteria.
2. Healthcare professions shall not be considered “closely regulated industries.”
3. Recipients of healthcare services shall not be construed as having special rights or diminished capacity simply as a result of seeking or receiving those services.
4. Licensure shall not be revoked except as a result of felony conviction.
5. No policing functions shall be required of Licensed Healthcare Professionals.
6. Licensure shall not be a mechanism for diminishing any rights or freedoms.
7. Free speech rights of Licensed Healthcare Professionals shall not be infringed except for the protection of confidential patient information.
8. The confidentiality of all information gathered by a Licensed Healthcare Professional in the performance of professional functions is fully protected.
9. Collective bargaining rights of Licensed Healthcare Professionals shall not be limited.
10. All actions taken by Licensed Healthcare Professionals to protect the public or any individual are fully protected.

* * *

The primary reasons that psychologists originally pursued a state licensure law were title protection and third-party reimbursement. Policing of licensees might be the “third leg of the stool,” but this activity has grown to overshadow the other two. Antitrust laws shackle our ability to collectively bargain with health insurance companies. The title

“Psychotherapist,” which is also protected by our licensure law, is used with impunity by non-psychologists. Yet the governmental scrutiny applied to licensed psychologists has made us a closely regulated industry.

It is often said that with rights come responsibilities. We must bear in mind that with our professional responsibilities come rights. Licensed psychologists must awaken to the threats posed by governing bodies willing to undermine our liberty. We must remain vigilant for any further attempts to shrink the rights of caregivers and mobilize to reverse the insidious erosion of our freedom.

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Pennsylvania survey reports stress for psychologists

by **Samuel Knapp, Ed.D.** and
Director of Professional Affairs
Pennsylvania Psychological Association

Peter Keller, Ph.D.
Mansfield University

(The following article appeared in the January 2004 issue of The Pennsylvania Psychologist, and is reprinted with the kind permission of its editor.)

Overall, psychologists tend to live their careers. Nonetheless, the work of psychologists places them at risk to experience certain negative life events. Consider these incidents that happened to psychologists in Pennsylvania this last year: a psychologist received hate mail from an unknown client; a patient purchased a gun and threatened to kill persons at work (he had a background of violence and drug abuse); a patient suddenly began to disrobe in the presence of her psychologist (he immediately left the room and refused to return until she had her clothes back on); a psychologist had a patient commit suicide.

Throughout their careers, psychologists can expect to encounter these and other stressful life events. The 2003 annual survey of Pennsylvania Psychological Association (PPA) members showed that a substantial number of psychologists had experienced stressful events in the practice of psychology over the last 12 months (See Table 1). Admittedly most of these events are rare, but they can have a substantial impact on the psychologists who are affected.

Table 1
Frequency of Professional Stressful
Events
in the Last Twelve Months

	Once	Never	Twice
Been stalked by a patient	94%	<1%	5%
Been robbed by a patient	97%	<1%	2.3%
Been assaulted by a patient	97%	1%	2%
Threatened with assault	88%	3%	8%
Had patients assault 3 rd party	82%	4%	9%
Had patients threaten to assault 3 rd party	11%	5%	4%
Had patient commit suicide	86%	2%	10%
Had patients attempt suicide	68%	8%	16%
Had patients make suicidal gesture	46%	15%	17%
Had patient threaten suicide	46%	12%	18%
Been sexually harassed by a patient	94%	25%	3%

Although the survey data asked for information only for the past year, the results were consistent with what has been found in other

surveys. This survey found that 14% of psychologists had at least one patient commit suicide in the last year. Kleespies and Dettmer (2000) found that 29% of psychologists had a patient commit suicide sometime in their career.

This survey found that 3.5% of psychologists were assaulted in the last year. Guy, Brown, and Poelstra (1990) found that almost 40% of psychologists reported being attacked by a patient at least once in their career. In their study, two thirds of the attacks occurred against psychologist working in hospitals, and about 23% of the attacks resulted in physical injury to the psychologist.

About 6% of the psychologists in the PPA survey reported being stalked in the last year. Gentile, Asamen, Harmell, and Weathers (2002) found that about 10% of psychologists reported being stalked sometime in their lives. A majority of the stalking victims in the general population are female. However, Gentile et al. found that about half of the stalking victims among psychologists were male, and the PPA survey found that about 40% of the psychologists who were stalking victims were male.

About 6% of the psychologists in this survey reported being sexually harassed. Dr. deMayo (2000) found that many psychologists in training had experienced sexual harassment from their clients/patients, including

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sexual remarks, asking for a date, brushing up against, touching or grabbing, exposing themselves, or attempting to solicit sexual activity. Although deMayo found that most of the events involved male patients and female psychologists or interns, PPA's survey found that men and women psychologists were nearly equally likely to report sexual harassment.

For the most part, psychologists who experienced these events were victims of a random sequence of events. For example, a psychologist may just have happened to be treating the patient with the combination of life circumstances and mental illness that made a suicide very likely to happen, regardless of who the treating professional might be. Nonetheless, awareness of the possibility that these events can occur may help psychologists stay alert for signs indicating problems. For example, psychologists can ask themselves: Do you screen patients carefully for suicidal ideation? Are you up-to-date on suicide prevention techniques? Do you screen patients

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separation/individuation, identity formation, and integration, she can see that her story of innocence lost and wisdom gained is not unlike that of a goddess. By plumbing the depths of her darkest emotions in the underworld of her unconscious, she can gain the understanding and skills necessary for nourishing herself and for navigating more confidently and safely through life.

for violence toward others, especially domestic violence? Are you up-to-date on violence prediction and interventions? Do you know how to set limits with patients early in your relationship? Are you able to stick to those boundaries? Do you know how to diffuse tense situations by talking patients down? Are you quick to refer patients who have problems beyond your capacity to treat?

Finally, these events point out the necessity of self-care for psychologists. Psychologists need to continually focus on their own mental state and to create a social climate that can mitigate the impact of these and other stressful events. They should ask themselves: Are you careful to monitor your own mental health and to seek support and assistance from others when you need it? Are you embedded in a supportive social network?

We recommend that any psychologist who has been exposed to one of these stressful events consider consultation with a colleague to review their treatment decision-making process or to consider therapy to help them deal

The practice of psychotherapy, which actively invites clients to tell and retell their stories, to recount tales of woe or success, and to replay the mini dramas of their lives, may be one of the few places where story telling and story listening remains valued and utilized. The clinician's office may provide a modern context for integrating current psychological theories with the wisdom of our ancestors and for introducing

with the emotional consequences of surviving the event.

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traditional storytelling as a way of making sense out of patterns of behavior and emotions that appear to have no meaning.

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An ethics question: What do you think?

by David Woodsfellow, PhD

(Ed.: The following article is reprinted from the Winter 2004 issue of the *Georgia Psychologist*, with the kind permission of its editor.)

This article provides a discussion of ethical decision-making based on the ethics code of four professional organizations, including the 2002 APA Ethical Principles of Psychologists and Code of Conduct. The opinions expressed in this article are those of the author and do not reflect any official policy, opinion or endorsement of the Georgia Psychological Association Ethics Committee. This article is designed to be educational in nature and is not intended to provide legal advice. The reader is encouraged to consult a colleague regarding specific clinical situations or to contact an attorney for legal advice regarding state laws governing professional conduct.

Question:

A client wants to shift from individual therapy to couples therapy. Is it okay to do this?

- YES
- IT DEPENDS
- NO

My answer is:

d. ALL OF THE ABOVE.

Here's why.

a. YES, his shift, called *Consecutive Therapy*, is not disallowed in the ethics codes of the four psychotherapy professions (*Ethical Principles of Psychologists and Code of Conduct*, American Psychological Association, 2002; *Code of Ethics*, National

Association of Social Workers, 1999; *AAMFT Code of Ethics*, American Association for Marriage and Family Therapy, 2001; *ACA Code of Ethics*, American Counseling Association, 1995).

Also, Consecutive Therapy is done so often enough in our community that it could be considered within the "standard of care."

b. IT DEPENDS, because all parties need to be clear about best-interest, changing loyalty, confidentiality, and informed consent for this shift to be ethical.

The therapist must believe that the new arrangement would be in the *best interest* of each client.

All parties must be clear about, and comfortable with, the therapist *shifting loyalty* from the original client to both clients.

The original client must make an informed decision about the *confidentiality* of material from the previous individual therapy. The therapist must abide by this decision and feel comfortable proceeding with this decision. The new client needs to be informed about this decision.

Both clients must give *informed consent*. Both must have appropriate information about the new arrangement and adequate opportunity to consider and discuss the issues involved.

c. NO, I personally suggest that we therapists should NOT make this shift. I think the potential problems with consecutive therapy are quite

substantial. If an individual client wanted to shift to couples therapy, I would refer them to someone else.

I'm worried that we might never really achieve neutrality in the new couples therapy. How could we not be affected by the individual therapy? How could we really form an unbiased opinion of the new client, after having heard so much about them in the previous therapy? Maybe we'll be too sympathetic to the original client. Or maybe we'll go so far trying to compensate, that we'll be too sympathetic to the new client. And, even if we were truly neutral, would each of the clients perceive us as neutral?

If the original client wants the material from his or her individual therapy to remain confidential, that might become a problem in the couple's therapy. Perhaps at some crucial moment, we won't be able to speak about something that feels essential to progress. There could be a direct conflict between the confidentiality of the original client and the best interests of the new client.

Also, if couples therapy doesn't work out well, what happens then? Would the original client continue their individual therapy? There's no way to be certain how the couples therapy will unfold. If difficulties develop in the couple's therapy, the original client may not feel able to continue the original individual therapy. In terminating couples therapy, the original client might also be losing their individual therapist without the opportunity to fully process that closure.

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I think referral to a second therapist is better than a shift of treatment with the same therapist. The loyalties stay clear. The individual therapist continues in undivided loyalty to the original client. The new couples' therapist meets both clients at the same time, is loyal to the couple, has neutrality uncompromised by previous therapy, and has no secrets to keep. If couples therapy doesn't work out,

the original individual therapy is undisturbed, and remains a source of support for the original client.

If you work with other therapists, it might be particularly appropriate to refer a couple like this to one of your colleagues who does couples therapy. If the clients agree to releases of information, you and your colleague would be in a good position to consult and

coordinate future treatments as needed.

Those are my thoughts on this question. I'd be glad to hear yours.

Dr. David Woodsfellow is Director of Center for Relationship Therapy, Atlanta, Georgia. References available upon request. Please address any comments or questions to woodsffellow@mindspring.com or (404) 325-3401.

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Grossman speaks

Pennsylvania psychologist's 7-year ordeal

by Jan C. Grossman, Ph.D., J.D.

I am the “Grossman” in “Commonwealth v. Grossman.” I want to thank Dr. Sam Knapp, Rachael Baturin, and everyone at PPA for their amazing support. PPA filed two amicus briefs on my behalf and greatly contributed to our Supreme Court Petition. This seven year licensing ordeal was rendered barely bearable only because I could call Sam periodically and be reassured that from PPA’s perspective, what my Board was doing made no logical, professional, legal or administrative sense.

I say “my Board” because the make-up of the State Board of Psychology keeps changing. Today’s Board is manifestly different in temperament and vision than my Board. In fact, my Board was really two different Boards, one that heard my case, then one, with some change of members, who adjudicated my case. Then, my Board was, like a will-o-the-wisp, quickly gone and transformed by resignations and new gubernatorial appointments into a different and more enlightened Board.

I would like to be angry at the members of my Board. That might be therapeutic. But, to this day, I don’t know which or how many of my Board members voted to convict me, because the final vote was held in “Executive Session,” with only the final anonymous result announced publicly.

One of the lasting legacies of my Board will be *Commonwealth v.*

Grossman and the unfortunate effects that this precedent will have on future Board decisions and every one of us in daily practice. My Board’s Adjudication and Order and our Commonwealth Court Appellate decision are now both binding law. Sam and our colleagues at PPA saw the precedential problems of my case early in my prosecution. That is why we appealed my reprimand through Commonwealth Court and to the Pennsylvania Supreme Court. We ultimately lost and so, in my opinion, did our profession.

On a very personal level, it is to my profound sadness that, if I am remembered as a psychologist, it will be probably not be for any good work I have tried to do, but for the legacy of Pennsylvania psychology practice problems presented by my case. Future prosecutors will now use *Commonwealth v. Grossman* as justification and precedent for prosecuting others who may, in the prosecutor’s opinion, run afoul of one of the many aspirational, non-mandatory APA Guidelines.

In 1996, at the request of an attorney, I examined a child in the presence of her joint legal custodian mother, who was in the middle of custody litigation. The child had been previously evaluated. I limited my evaluation to a second opinion of limited areas of the child’s functioning. I followed up with a second visit with the child to evaluate allegations of parental neglect against the father made by the mother. I found no neglect. I

made no comment as to any custodial resolution. I made no custodial recommendation. A year later, the father of the child filed a licensure complaint against me.

At the time, I believed (and still believe) that my limited examination of the child was within the American Psychological Association’s Child Custody Guidelines, which I knew very well from having taught them since they were published in 1994. I believed the guidelines, when they stated that they were “aspirational” and not to be used for disciplinary purposes. In 1995, I even attended the then-Board’s presentation at PPA’s annual meeting and heard from them that Pennsylvania had not formally or informally adopted any rules or procedures pertaining to child custody issues.

Who could have imagined that, five years later, I would be prosecuted for violating my Board’s retroactive 2001 interpretation of an aspirational APA Guideline? When my attorney, who is used to defending professionals who defraud Medicare, abuse drugs, or sexually exploit clients, read the Order to Show Cause, which essentially charged me with

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Grossman speaks
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examining a child, his first question to me was, “Does someone at the Board have it in for you?”

At various times over the years of my case, the prosecutor offered us “plea bargains” to induce me to sign a consent decree (the administrative equivalent of a guilty plea). These “generous” offers ranged from large fines, restrictions on my practice, probation, and reprimands. At some level, at my stage of mid-life, even these “deals” looked very attractive, compared to the stress and cost of years of litigation and appeals. I have known innocent psychologists who have reasonably taken such deals because their lives and health couldn’t support years of litigation. These are very personal decisions. I didn’t believe I had done anything wrong and I knew that if I signed a consent decree, that decree would be used to prosecute others. Ultimately, when we refused to accept any deal, the prosecutor demanded of my Board, in her closing argument at my hearing, that my psychology license be suspended.

My hearing lasted two days. Sam Knapp testified as an expert on my behalf. So did Dr. Barry Bricklin, Director of the Professional Academy of Custody Evaluators. A 1996 Licensing Board member was set to testify that I did nothing that would have been a prosecutable offense in that year, but my Board wouldn’t let him testify, ruling that his testimony wouldn’t be relevant.

When all the procedures and appeals were over, I ended up with the least amount of disciplinary action my Board could administer: a reprimand. But, as Mercutio cried, upon being mortally wounded in *Romeo and Juliet*, “No, ’tis not so deep as a well, nor so wide as a church-door; but ’tis enough, ’twill serve.” In Pennsylvania, murderers can some day be pardoned by the governor, but there is no “pardon” for any Board disciplinary action. As a forensic psychologist, the lifetime stigma of a reprimand is a practice killer for me. Who wants to hire an expert witness who is, as one attorney friend joked with me, “certified unethical?”

I can still make a living as a psychologist, though my forensic referrals are certainly down. I have spent countless hours explaining my conviction in writing to the National Register, PPOs, HMOs, professional societies, insurance carriers, and to courts during cross examinations. My malpractice carrier put me through major hoops before they agreed to keep me on.

But, I want you all to know that there is life after reprimand. My family still loves me. My wife, who has been there for me through it all, is, amazingly, still there. My friends and colleagues at the Philadelphia Society of Clinical Psychologists have stood by me before and after my conviction. As many of you probably would, I envisioned my conviction to be the worst thing in

the world, but, compared to other stuff in life, it really isn’t. My coping mechanisms are working. I still have a sense of whimsy and perspective on things. One of the few “high points” of this experience was the irony of giving a CE workshop with Sam on the subject of my own conviction at last summer’s PPA annual meeting.

Thanks to all of you who have offered your comfort and support. Many of you have come up to me at meetings with a hug or words of encouragement. In the rumor mill that is psychology, there have been black humorous moments. One well-meaning professional acquaintance approached me at a meeting and told me that she had heard of my “ethical problems” and would “stick by [me] even if [I] had slept with a client.” Another colleague asked, disingenuously, what I would be doing for a living now.

Finally, it is obvious that a minority of my colleagues have been hesitant to approach me at meetings. There’s an uncomfortable feeling ... like they don’t quite know what to say. Guys, it ain’t like I’m dying. Please, don’t feel awkward. Just walk right up, shake my hand and say, “Jan, how have you been, you old unethical so-and-so.”

(If anyone finds him- or herself in a licensure predicament, feel free to get in touch with me for peer support, sympathy, or humor. I can be reached at 215-788-8089 or JanCGrossman@AOL.com.)

Debating Debriefing

by Sandra Wartski, Psy.D.
Disaster Response Coordinator

Disasters, ranging from wars to weather, have been in the news at an alarmingly increasing rate. This increased focus seems to have put disaster mental health response services in the spotlight as well. While such focus is positive for broadening the public's awareness of mental health and of the potentially positive impact of psychology in general, another less positive focus has also emerged.

There is currently a heated debate going on among the clinicians and researchers in the field of disaster mental health services. The once revered method of debriefing has apparently come under scrutiny. The most popular method of formal debriefing, CISD (Critical Incident Stress Debriefing), had typically been utilized as an attempt to promote speedy recovery from the trauma and to prevent PTSD. The formal CISD methods include a very specific seven-phase process, though CISD has become known as a more generic term and is sometimes used interchangeably with debriefing in general. (This latter confusion resulted in the formal CISD becoming more specifically known and incorporated into the multicomponent system known as CISM, Critical Incident Stress Management.) For many years, workers and victims were routinely debriefed following a severe trauma or disaster. Some organizations even made debriefing mandatory among their workers or responders. Now, there is question

as to whether debriefings are doing what they are intended to do.

Although the debate seems to have been simmering for several years now, the intensity of the debate seems to have increased in the recent year and is creating a flurry of articles, e-mails, letters to the editors, on-line discussion groups and general re-examination of the field. Some have labeled it as a debate between Mitchell (who is considered the father of CISD) versus the Kenardy and Carr group. Snelgrove has posited arguments against group CISD and evidence of harm coming to its recipients. The recent research presented by Rose, Bisson & Wessely (2001) through the Cochrane Library which boldly stated that "compulsory debriefing of victims of trauma should cease" has created more upheaval. Even the American Red Cross and American Psychological Association have been caught in the crossfire to some degree, though neither organization fully supports or affiliates itself solely with one method or another.

It would not be possible to provide a full history or overview of all events surrounding this debate; however, some of the primary issues which have been raised will be briefly presented as a means of keeping our readers informed and interested in attending to future information. This review is not intended to reflect a particular position of the NC Disaster Response Network,

NCPA/F or this newsletter but rather as a hopefully relatively objective presentation of the issues.

Cause for Concern

There has been building concern that debriefing and CISD methods have demonstrated no benefits and may even be found to do harm. It has been suggested that the idea of having people focus on the trauma may re-victimize or undermine innate coping techniques. The issue of opening people up to emotions and then leaving them to handle the increased stress on their own is reported to be a problem. There is apparent worry that debriefings have been used indiscriminately and without thought to the situation of the receivers of services.

Those raising concern in this area remind well-intentioned mental health professionals to refrain from responding inappropriately following disaster situations because of the risk of making matters worse. Many of the scientists raising concern have argued that CISD has never undergone adequate efficacy testing. There is concern that debriefing has become too popularized and thus used without attention to research outcomes. The overriding concern is that good intention does not excuse bad outcome.

Over the past several years, trials of single-session debriefing procedures (Continued on p.22)

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have been conducted with adults who have experienced different types of trauma. Results have suggested that no treatment may be better than debriefing procedures, with some of the subjects who received debriefing reportedly experiencing a higher level of PTSD than those who received no treatment. The Cochrane Review provides the most detailed summary of such results. This group posits that the issue of compulsory debriefing is especially problematic as it could pose a professional liability issue. Carlier, Voerman, & Gersons (2000) is another group who made similar conclusions, and Hamling has completed some interesting reviews as well. There is repeated reminding of the notion that high face validity and client satisfaction should not be regarded as a substitute for solid research evidence.

Responses and Rebuttals

The initial response for most clinicians, even those not heavily immersed in disaster response issues, was surprise. And for many of the clinicians who were very involved in disaster responding, the presentation of this information was shocking and somehow counter-intuitive. For the many mental health responders who have conducted debriefings and received or witnessed positive responding, the claims of possible harm were difficult to swallow but certainly warranted further study.

Several points of disagreement with the claims of no benefit or harm from debriefing have been put forth. The fact that much of the research to date, such as the extensive information presented through the Cochrane report, has not been completed with situations of mass disasters is a concern. Other types

of trauma, such as traffic accidents or violent crimes, have been used more often. Naturally, the issue of debriefing workers versus victims will be different as well.

Differentiating the mandatory versus voluntary debriefing process is also important. The use of peer debriefers/supporters versus mental health professionals may make a difference in outcomes. And there are reminders that single-session model with individual debriefings is considered to not be the best course of treatment in all situations, especially with the newer Mitchell and Everly's CISM model which suggests a comprehensive, integrative, and multicomponent crisis intervention system.

With more disasters in the news, there are going to be more responders in the news as well. Naturally, some of the people arriving on the scene of disasters without any program affiliation may indeed not be following protocol, and this is unfortunate. The main arguments coming from Mitchell and colleagues within the ICISF (International Critical Incident Stress Foundation) suggest misunderstanding or misrepresentation of the CISD intervention. CISD/CISM is not intended as the sole intervention and is not touted as being therapy or a substitute for therapy. There seems to be not as much disagreement about the elements of the intervention as there are about the methods of implementation, which avid CISD users suggest are routinely tailored to the needs of the situation and individuals. Some other reviewers of the results, such as Hamling, have attempted to possible over-use or over-reliance on only a portion of an appropriate intervention method. And the supporters to proper debriefing methods state that effectiveness of CISD and CISM programs have indeed been empirically validated

through analyses and controlled investigations (see Everly & Mitchell, 1997).

Awaiting Outcomes

As with so many areas in the field of psychology, especially those still in the early stages of development, we are awaiting outcomes from future investigative studies. We are again reminded of the importance of the scientist-practitioner model and finding a way to combine efforts rather than divide. Designing valid evaluation methods deemed acceptable by both camps will, however, undoubtedly be difficult.

It is important to again reiterate that some of the difficulty with this debate may relate to the definition of debriefing. The Mitchell model of CISD is not interchangeable with more general term of debriefing. The former is more specific, while the latter is more general. When an organization requests debriefing more generally, the process is dependent upon the training, experiences, and preferences of the mental health professional conducting the debriefing.

Those in the disaster mental health field are eager to receive confirmation or validation of methods which have become the backbone of their work in this arena. As traumas and crises in our world continue to increase, we will be needing informed guidance in this area. It is naturally possible that two distinct camps emerge, as in the childhood sexual abuse memories debate, or that current debriefing methods are further refined, defined and improved. While we may hope for the latter, the field of disaster mental health responding may need to brace itself for more of the former type of divergence, at least for a time.

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And what of the disaster mental health professionals responding to disasters? The best advice, it seems, which is not to be underestimated in any format: Proceed with caution!

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2004 HPA Officers

President

June Ching, Ph.D.
1833 Kalakaua Ave., #800
Honolulu, HI 96815
Work: (808) 949-9502
Fax: (808) 951-9282
e-mail: junewching@hawaii.rr.com

President-Elect

Tanya Schwartz, Ph.D.
REHAB Hospital, Psychology Services
226 N Kuakini St
Honolulu HI 96817
Work (808) 566-3761
Fax (808) 566-3859
e-mail: tanyaschwartz@hawaii.rr.com

Past President

Gloria Neumann, PsyD
c/o Honolulu Police Dept.
801 S Beretania St
Honolulu HI 96813
Work: (808) 529-3715
Fax: (808) 540-8005
e-mail: gneumann@co.honolulu.hi.us

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President
Argosy University / Honolulu
400 Pacific Tower, 1001 Bishop St.
Honolulu, Hawai'i 96813
Work (808)536-5555 ext 200
Fax: (808) 536-5505
e-mail: rcrossman@argosy.edu

Rep. From the Neighbor Islands

Darlene Ashley, PhD
75-5744 Alii Dr.
Kailua-Kona, HI 96740
Work: (808) 329-5800
Fax: (808) 329-4800
e-mail: darlene@apollohawaii.com

Kauai County Rep.
Bradley Klontz, PsyD
P.O. Box 529
Kapaa, HI 96746-0529
Work: (808) 821-6956
Cell: (808) 645-0067
e-mail: btklontz@aol.com

Maui County Rep.
Richard Sword PhD
135 S. Wakea Ave., #207
Kahului, HI 96732-1385
Work: (808) 871-7958
Fax: (808) 877-7797
e-mail: sword@maui.net

Academic Div. Rep.

Patrick Uchigakiuchi, Ph.D.
3140 Waiialae Ave
Honolulu HI 96816-1578
Work (808) 739-4604
Fax (808) 739-4607
e-mail: puchigak@yahoo.com

Clinical Division Reps.

Brian Combs, Ph.D.
Queen's, Psychology Dept.
1301 Punchbowl St
Honolulu HI 96813
Work: (808) 547-4401
Fax: (808) 537-7814
e-mail: bcombs@queens.org

Brian Goodyear, Ph.D.
98-211 Pali Momi #707
Aiea HI 96701
Work: (808) 483-8800
Fax: (808) 483-8800
e-mail: Bsgoodyear@aol.com

L. Martin Johnson, MBA, PsyD
1210 Auahi St., #107
Honolulu, HI 96814
Work: (808) 589-1750
Fax: (808) 589-1750
e-mail: martin.johnson7@verizon.net

General Division Reps

Scott Liepack, PhD
75-5744 Alii Dr., #327
Kailua-Kona, HI 96740
Work: (808) 329-5800
Fax: (808) 329-4800
e-mail: drliepack@aol.com

Jared Yurow, Psy.D.
601 Kamokila Boulevard, Room 360
Kapolei, HI 96707
Cell (808) 224-6507
e-mail: drjyurow@msn.com

Student Division Rep

Kim Nghiem-Gianforti
66-219 Kamehameha Hwy, #B
Haleiwa, HI 96712
e-mail: Nghiemkt@aol.com

Committee Chairs and Representatives

Legislative Chair & Federal Adv Coordinator

Donald Kopf, Ph.D.
P.O. Box 240162
Honolulu HI 96824
Work (808) 375-1177
e-mail: drkopf@hawaii.rr.com

APA Council Rep. & Ethics

Jack S. Annon, Ph.D.
680 Ainapo St
Honolulu HI 96825
Work (808) 396-5450
Fax (808) 395-5157
e-mail: jack@drjannon.com

CE Coordinator

Kathleen S. Brown, Ph.D.
1188 Bishop St #1412
Honolulu HI 96813
Work (808) 433-3338
e-mail: brown.kathleen.s@att.net

PEC Coordinator

Graham Taylor, Psy.D.
1188 Bishop St #1112
Honolulu HI 96813
Work (808) 545-5711
Fax (808) 737-5885
e-mail: hawaiiathletes@aol.com

BOPN Representative

Craig H. Robinson, Ph.D.
1188 Bishop St #2608
Honolulu HI 96813
Work (808) 533-6133
Fax (808) 521-6654
e-mail: craigrob@compuserve.com

Executive Director

Carol Parker
Hawaii Psychological Association
1188 Bishop St #912
Honolulu HI 96813
Work (808) 521-8995
Fax (808) 521-8994
e-mail: cparker@hawaiipsych.org

Hawai'i Psychologist Staff

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