From the President
Jason Smith

We had a fairly good turnout at the spring conference, but the numbers were a little less than expected. For those of you who decided not to attend, you missed out on some good information and excellent presenters. I want to thank those IPA members who presented at the conference: Michele Greiner, Greg Febbraro, Tracy Thomas, Betsy Rippentrop, and Jon Weinand.

I thought I would list some interesting information presented by our keynote speaker, Barry Duncan, Psy.D.

• “With few exceptions, partisan studies designed to prove unique effects of a given model have found no differences – nor have recent meta-analyses.”
• “The client’s rating of the alliance at the second session is the best predictor of outcome across conditions”
• “Study after study, and studies of studies show the average treated client is better off than 80% of the untreated sample.”
• “Therapists with the best results are better at the alliance across clients; alliance ability accounts for therapist differences.” Alliance is “seven times the impact” of the model being used and account for most of the counselor variance.
• Dr. Duncan recommends being “friendly, responsive, and flexible” with the client and stay close to the client’s experience. “Legitimize the client’s concerns/basic worth and the importance of their struggle.”
• “Congruence between the client’s theory of change and treatment resulted in stronger
From the President
Jason Smith

From Page 1

Dr. Duncan believes that therapeutic alliances, longer duration in treatment, and improved treatment outcomes.

- The question Dr. Duncan believes psychologists should ask themselves is, “Is what I am doing and saying now building or risking alliance?” Dr. Duncan believes you can challenge, but you have to “earn the right and consider alliance consequences.”
- “Providers don’t know how effective they are” with their clients.

Overall, Dr. Duncan now has empirical support for his approach to measure a psychologist’s effectiveness with clients. He believes psychologists should be using structured assessments to solicit feedback from clients on outcome and alliance. In fact, Dr. Duncan reported that “client based outcome feedback improves outcomes more than anything since the beginning of therapy.” If you would like to learn more about Dr. Duncan’s approach you can visit his website at www.heartandsoulofchange.com.

I appreciate all of those IPA members who have contributed to the IPF initiative of raising funds for a post-doctoral position here in Iowa. At the time of this writing, IPF is reporting they have collected or received pledges for more than a third of the funds needed to reach the goal of $15,000. This has come from 21 contributors.

One of the areas I wanted to focus on during my term as IPA President was membership. If you have any thoughts or ideas about increasing membership please don’t hesitate to contact me. I would like IPA to remain a growing and valued organization for the psychologists it serves.

Seeking Hosts for IPA Salons Greg Gullickson

IPA is seeking volunteers who are willing to host an academic salon in their office or home. IPA would help pair hosts with presenters; if anyone willing to host also has a presenter in mind, that is certainly fine as well. IPA would also assist with planning and logistics. Attendees would be able to obtain CEUs, but we hope that these gatherings will be opportunities for colleagues to get to know each other better and to enjoy each other’s company as they hear presentations on interesting topics and participate in discussions afterward. Hosts could limit attendance as needed, but we hope that these gatherings could accommodate up to 20 colleagues.

Consider hosting a gathering and helping this IPA venture gain momentum across the state. If you would like to volunteer, or if you have questions, please contact me at ggullickson@mchsi.com. You can also contact Jeritt Tucker at jrtucker@iastate.edu or Carmella at ipa@iowapsychology.org. Thank you! See you all at fall conference.

IPA Meetings 2013

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Invitation to Iowa Colleges & Universities

All psychology programs in Iowa are invited to submit manuscripts on undergraduate and graduate activities, including educational, research, and service programs. Please feel free to contact the editor, Stewart Ehly (stewart-ehly@uiowa.edu), to receive additional information. All submissions are in electronic form (Microsoft Word if possible) and can be attached to an email sent to the editor.
The History of Psychopharmacology in Iowa and RxP Update

Bethe Lonning

I thought it might be helpful, before giving the most recent update on RxP in Iowa, to review the history of psychopharmacology in Iowa. This will be brief and hopefully informative.

In 2004, then President David Christiansen appointed a Psychopharmacology Education Task Force. At the time it was comprised of me and Dr. Brenda Payne as co-chairs. Our charge was to keep the association informed about pharmacology efforts in the field and to provide continuing education in this avenue. As a result, there was a conference that had a large part of its focus on psychopharm and several others that had presentations about the topic. In addition there were several presentations at other conferences about psychopharmacology. Because of medical reasons, Dr. Payne had to step down from the task force shortly after being appointed. The task force was ‘upgraded’ to a standing committee after a year or two and I remained as chair.

When Dr. Michele Greiner was president, she asked all committee chairs to submit a three-year plan for their committee to be approved by the Executive Council. Psychopharm provided a 3 year plan that included continuing to provide education to the membership, surveying the membership about the interest in pursuing prescriptive authority for psychologists, beginning to collect funding for this pursuit and ultimately introduce legislation for prescriptive authority for psychologists depending on the results of the survey. This plan was approved by Council in 2008 or 2009. In addition, IPA supported the Master of Science program from Fairleigh Dickinson University as the training of choice for pursuing further education in this area. The committee dwindled to just the chair during this time due to limited activity but a speaker was still secured for a conference, tables during the lunch hour for interested folks were held and a table for information about training continued to be available. IPA stayed in the first year of the three year plan for three years.

In 2012, IPA Executive Council approved introducing legislation for prescriptive authority for psychologists (RxP). A study bill was introduced in the House and the Senate during the 2013 legislative session. Before being assigned to a sub-committee, IPA’s RxP committee (Drs. Lonning, Payne and Smith) along with State Advocacy Chair Dr. Greg Febbarro and our lobbyist Craig Patterson met with the Iowa Medical Society which includes all medical disciplines to inform them of our intent. As predicted, they were not in support of this effort and offered some arguments as to why they disagreed. Their concerns were met with responses from the committee addressing how these concerns would be managed in the bill. They remained opposed.

A sub-committee hearing was held in the Senate. Two of the 3 members needed to support the bill for it to go in front of the whole committee. Sen. Bolkham and Johnson voted to move the bill forward while Sen. Mathis was not ready to support. It is important to note, she did not vote to oppose the bill, rather her response was that she needed more information before she could support the bill. In the House, the bill was assigned to a sub-committee and a hearing date was set. However, when the IPA contingent arrived, the sub-committee hearing had been cancelled due to the Education Committee needing to meet. However, Amy Campbell got the committee members to meet with us informally to discuss our bill. We met with Rep. Fry and Landon met with us together. While neither of them was willing to vote to move the bill forward, both of them asked questions and seemed interested in what psychologists would offer. Rep. Fry was concerned there was not a bridge between psychologists and the opposition (the psychiatrists) and wondered if we could work on that. We informed him that we have addressed the concerns they brought to our attention and there would most likely not be support from them due to scope of practice issues. We also met with Rep. Marti Anderson who was very supportive of the bill and said she would ‘champion’ for it when the time came. In this respect, the bill was dead in the House.

The bill went before the whole committee in the Senate and did not pass out of committee before the first funnel date. Therefore, it also died for this year. The good news is that since this is the first year of the legislative cycle, we can pick up where we left off this year.

We are very pleased with how our first effort went this year. Over the summer, we will work with key legislators in an effort to get the bill to pass out of the Senate committee and to discuss our bill with more Representatives for their support as well. In addition, we would like to compile a list of interested and supportive psychologists in the state who would be willing to contact their state legislators, encouraging them to vote for this bill when/if the time comes. If you are willing to be part of this effort, please contact Dr. Greg Febbarro, our State Advocacy chair.

Iowa was not the only state to introduce legislation for RxP this year. As of this writing, the state of Illinois has had their RxP bill pass the Senate by a vote of 38-10 and New Jersey’s RxP bill passed their House of Representative’s by a majority as well.

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As always, questions, comments and willingness to help are welcome. Please contact me at doceal@aol.com or 563-359-4049.
The Heart and Soul of Change: Getting Better at What We Do

Barry Duncan

Editor’s note: Dr. Duncan, the Director of the Heart and Soul of Change Project, was the featured speaker at the spring IPA conference in Des Moines.

There seems to be a prevailing view that to be an accomplished psychotherapist one must be well versed in evidence based treatments (EBT), or in those models that have been shown in randomized clinical trials (RCT) to be efficacious for different “disorders.” The idea here is to make psychological interventions dummy-proof, where the people—the client and the therapist—are basically irrelevant (Duncan, 2010). Just plug in the diagnosis, do the prescribed treatment, and voila, cure or symptom amelioration occurs! This medical view of therapy is perhaps the most empirically vacuous aspect of EBTs because the treatment itself accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more. In fact, it is the factors common to all psychotherapies that matter the most.

The Common Factors

To understand the common factors, it is first necessary to separate the variance due to psychotherapy (see Figure 1) from that attributed to client/life factors, those variables incidental to the treatment model, idiosyncratic to the specific client, and part of the clients life circumstances that aid in recovery despite participation in therapy (Lambert, 2013)—everything about the client that has nothing to do with us. Calculated from the oft reported 0.80 effect size (ES) of therapy, the proportion of outcome attributable to treatment (14%) is depicted by the small circle nested within the larger circle at the lower right side of the left circle. The variance accounted for by client factors (86%), including unexplained and error variance, is represented by the large circle on the left. Even a casual inspection reveals the disproportionate influence of what the client brings to therapy—the client is the engine of change (Bohart & Tallman, 2010).

Figure 1 also illustrates the second step in understanding the common factors. The second, larger circle in the center depicts the overlapping elements that form the 14% of variance attributable to therapy. Visually, the relationship among the common factors is more accurately represented with a Venn diagram, using overlapping circles and shading to demonstrate mutual and interdependent action.

Therapist Effects

Therapist effects represent the amount of variance attributable not to the model wielded, but rather to whom the therapist is—it’s no surprise that the participants in the therapeutic endeavor account for the lion share of how change occurs. Recent studies suggest that 5-8% of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013), or 36-57% of the variance accounted for by treatment. The amount of variance, therefore, accounted for by therapist factors is about five to eight times more than that of model differences.

Although we know that some therapists are better than others, there is not a lot of research about what specifically distinguishes the best from the rest. Demographics (gender, ethnicity, discipline, and experience) don’t seem to matter much, and although a variety of therapist interpersonal variables seem intuitively important, there is not much empirical support for any particular quality or attribute (Baldwin & Imel, 2013). So what does matter? There are a couple of possibilities and one absolute certainty. First, highlighting the importance of recruiting client strengths and resiliencies suggested by the variance attributed to client/life factors, Gassman and Grawe (2006) found that therapists who spend more time in what they called “resource activation” than “problem activation” got better outcomes. The next possibility is experience, but not the generic kind that we were often told that would make us better. Recent studies suggest that specific experience with particular populations or “conditions” may yield better outcomes (Cris Cristoph, Connally Gibbons, & Mukherjee, 2013). And the absolute certainty: The clients view of the alliance—not only a robust predictor of therapy outcomes, but also is perhaps the best avenue to understand therapist differences. Research strongly suggests that clients seen by therapists with higher average alliance ratings have better outcomes (Cris Cristoph et al., 2013). And so the answer to the oft heard question about why some therapists are better than others is that tried and true but taken for granted old friend, the therapeutic alliance.

The Alliance

Researchers repeatedly find that a positive alliance—an interpersonal partnership between the client and therapist to

Duncan: To Next Page
achieve the client’s goals (Bordin, 1979)—is one of the best predictors of outcome. Horvath, Del Re, Fluckinger, and Symonds (2011) examined 201 studies and found the correlation between the alliance and outcome to be \( r = .28 \), accounting for 7.5% of the overall variance and 36-50% of treatment. The amount of change attributable to the alliance, therefore, is about five (counting other studies) to seven times that of specific model or technique.

We all have clients who rapidly respond to us. But what about the folks who are mandated by the courts or protective services or who just plain don’t want to be there (like almost all kids)? What about people who have never been in a good relationship or have been abused or traumatized? What about folks that life just never seems to give a break? Well, the therapist’s job, our job, is exactly the same regardless. If we want anything good to happen, it all rests on a strong alliance—we have to engage the client in purposeful work. The research about what differentiates one therapist from another as well as my personal experience suggest that the ability to form alliances with people who are not easy to form alliances with—to engage people who don’t want to be engaged—separates the best from the rest.

**Model/Technique: General Effects (Explanation and Ritual), Client Expectancy (Hope, Placebo), and Therapist Allegiance**

Model/technique factors are the beliefs and procedures unique to any given treatment. But these specific effects, the impact of the differences among treatments, are very small, only about 1% of the overall variance or 7% of that attributable to treatment. But the general effects of providing a treatment are far more potent. Models achieve their effects, in large part, if not completely through the activation of placebo, hope, and expectancy, combined with the therapist's belief in (allegiance to) the treatment administered. As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular approach used is unimportant.

**Feedback Effects**

Common factors research provides general guidance for enhancing those elements shown to be most influential to positive outcomes. The specifics, however, can only be derived from the client’s response to what we deliver—the client’s feedback regarding progress in therapy and the quality of the alliance. Although it sounds like hyperbole, identifying clients who are not benefiting is the single most important thing a therapist can do to improve outcomes. Combining Lambert’s Outcome Questionnaire System (Lambert & Shimokawa, 2011) and our Partners for Change Outcome Management System (PCOMS; Duncan, 2012), nine RCTs now support this assertion. A recent meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in feedback group had 3.5 higher odds of experiencing reliable change and less than half the chance of experiencing deterioration. In addition, collecting outcome and alliance feedback from clients allows the systematic tracking of therapist development so that neither client benefit nor your growth over time is left to wishful thinking. Visit heartandsoulofchange.com for more information (The measures are free for individual use and available in 23 languages.). PCOMS is listed by the Substance Abuse and Mental Health Administration as an evidence based practice. It is different than what is usually considered evidence-based because feedback is a-theoretical and therefore additive to any therapeutic orientation and applies to clients of all diagnostic categories (Duncan, 2012).

An inspection of Figure 1 shows that feedback overlaps and affects all the factors—it is the tie that binds them together—allowing the other common factors to be delivered one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximizes therapist-client alliance potential and client participation, and is itself a core feature of therapeutic change.

I was recently asked (Kottler & Carlson, 2014) what is it that I do, and who I am that most made my work effective (assuming that it is). What I do that is the most important in contributing to my effectiveness is that I routinely measure outcome and the alliance via PCOMS—it boils down to identifying clients who aren’t responding to my therapeutic business as usual and addressing the lack of progress in a positive, proactive way that keeps clients engaged while we collaboratively seek new directions.

That’s what I do. But what I bring to the therapeutic endeavor is that I am a true believer. I believe in the client and his or her irrepressible ability to overcome adversity. I believe in the power of relationship and psychotherapy as a vehicle for change, and I believe in myself, my ability to be present, fully immersed in the client, and dedicated to making a difference. The odds for change when you combine a resourceful client, a strong alliance, and an authentic therapist who brings him/herself to the show, are worth betting on, certainly cause for hope, and responsible for my unswerving faith in psychotherapy as a healing endeavor.

**References**


Duncan, B. (2012). The partners for change outcome management system (PCOMS): The heart and soul of change project. Canadian Psychology, 53, 93-104.


Taking Charge of Our Lives • Dr. Mike Rosmann

Editor’s note: Reprinted with permission. Dr. Rosmann will be our featured speaker at a future IPA conference.

After reading previous columns about depression and suicide among farmers, several readers asked, “How do I know when someone is depressed or suicidal and what can I do?”

While all persons and situations differ, there often are observable signs of excessive stress, depression and suicide:
- Verbalizations about hopelessness such as “It’s no use, nothing I do is working” or “I feel like giving up.”
- Verbalizations about loss of interest or pleasure in everything such as “I don’t care about anything anymore” or “I haven’t laughed in a long time.”
- Dramatic statements and threats such as “I feel like shooting every animal on the farm” or “I’m going to get that jerk if it’s the last thing I do.”
- Avoiding social or public events such as church or kids’ sports, especially when the person usually attends these activities.
- Persistent flat mood, isolation and retreating behavior.
- Deterioration in appearance of the livestock or farm, too high somatic cell counts in dairy animals’ milk, equipment and fences in worsening state of disrepair.
- Decline in personal appearance from the usual.
- Too many stressors occurring simultaneously such as inability to make payments on time, losses of loved ones, natural disasters like tornados. Note: Most of us can handle two major stressors at a time and sometimes even three temporarily, but seldom more without help.
- Persistent trouble falling or staying asleep or sleeping too much.
- Near tears, such as the “lump in the throat” phenomenon, but without actually crying.
- Emotional paralysis, such as inability to make a decision or go about working.

Proper antidepressant medication and professional counseling are “treatments of choice” for depression and prevention of suicide. But sometimes antidepressant medications can actually worsen the condition when the depressed individual has been exposed to certain pesticides.

It is important that physicians (doctors, nurse practitioners, physician assistants) managing antidepressants for farm people ask questions about possible recent pesticide exposures and even take blood samples for analysis. Physicians, nurses, pharmacists, veterinarians and other professionals can learn about these precautions in a continuing education course called Agricultural Medicine, which is taught at several universities and medical programs in agricultural regions around the country. The Agricultural Medicine course began at the University of Iowa about 20 years ago.

Besides Iowa, the Universities of Illinois, East Carolina, Vermont, North Dakota, the Nebraska Medical Center, and the National Farm Medicine Center are among the institutions that offer this training. The nearest available location for the course can be found through an online search of “agricultural medicine.”

AgriSafe Clinics (www.agrisafe.org) also are able to help interested persons learn about this specialized training and can help farm people with health issues, including behavioral health screening and personal protective equipment.

Sometimes seriously depressed persons experience a rebound after beginning antidepressant medication and are at higher than usual risk for self-harm. Robert Lincoln of Sydney, Australia, described this situation:

When they start a new medication their [energy level] returns before they start feeling better and that is when they are in the danger zone. The problem is that doctors, counselors and pharmacists fail to educate patients and their families what the road to recovery entails. Almost always, these events are complex and multi-faceted. In the end we can better understand the contributors but never fully understand what was going through a person’s mind when things like [suicide] happen.

Prevention of exposure to harmful chemicals is best. Dr. Paul Gunderson, Director of the Center for Technology-Optimized Agriculture in North Dakota, strongly urges chemical applicators to minimize exposure to crop protection products by wearing nitrile gloves, goggles, and aprons when mixing/handling products or adjusting spray nozzles. Applicators should use respirators when entering active spray paths and routinely wash hands. To insure good respirator fit, rid faces of beards and don’t wear caps or long hair.

What helps when we feel depressed? We can help ourselves and our loved ones with tips and support. Behaviors that increase our own production of serotonin and norepinephrine, the essential body chemicals needed to “feel normal,” include:
- Enjoyable physical work or play.
- Hearty laughter.
- Deep sleep with active dreaming.
- Meaningful prayer and meditation.
- Vigorous physical exercise.
- Talking to, writing, texting persons you trust.
- Physical/sexual intimacy with a loving partner.
- Receiving comforting touches.
- Interacting positively with pets.

The more we know about stress and depression, the better able we are to farm smarter and healthier.

Nine states have farmer-friendly hotlines/helplines. See the list at: www.agriwellness.org. The National Suicide Prevention Lifeline number is: 1-800-784-2433.
The Impact of a Therapist’s Social Class on Therapy Process

Anthony P. Rinaldi, MA

Editor’s note: Mr. Rinaldi is a student in the Counseling Psychology Program at The University of Iowa

Like race, ethnicity, or gender, social class is a facet of cultural identity that impacts professional helping relationships (Liu, 2011). The purpose of this study was to explore the effect that a therapist’s apparent social class could have on a participant’s rating of the therapist and of the therapy process. Dittmar and Pepper (1994) discovered that materialism was a primary indicator of affluence and that participants rated affluent individuals more favorably on measures of personal abilities and lifestyle favorability than non-affluent individuals. Kraus and Keltner (2009) found evidence that social class correlated with more distancing interpersonal behaviors, as members of higher social classes tended to be more disengaged and distracted during interpersonal interactions than those of lower social classes. Christopher, Westerhof, and Marek (2005) concluded that perceptions of affluence predicted lower ratings of the target individual’s ability and likelihood to engage in helping behaviors. It was therefore hypothesized that a therapist’s social class could be manipulated by means of self-presentation via dress, and that participants might rate higher social class therapists as more intelligent and expert, but less warm and helpful, than lower social class therapists.

One hundred two participants were recruited from an introductory educational psychology class at the University of Iowa. Participants completed an on-line survey, where they were presented with a photograph of a female therapist and asked to imagine they just completed their first session with that therapist. Participants were randomly assigned one of two photographs of the therapist: one in which she was dressed in a way that indicated she was of a higher social class, and one in which she appeared as being from a lower social class. Participants were then asked to complete a number of questionnaires that assessed their ratings of the therapist’s skills and helpfulness, and that measured their attitudes towards therapy and social class in general. These instruments included including a modified version of the Cultural Mistrust Inventory for Adolescents, the Empathic Understanding Scale of the Relationship Inventory, the Counseling Rating Form - Short, the Inventory of Attitudes toward Seeking Mental Health Services, the Self-Stigma of Seeking Help Scale, and the Working Alliance Inventory.

One-Way ANOVA was conducted on the assessment means between the two treatment groups. The results indicated no significant difference on any of the measures between the two groups: Working Alliance Inventory (M=57.97, SD=12.14), Self-Stigma of Seeking Help Scale (M=29.63, SD=5.10), Inventory of Attitudes toward Seeking Mental Health (M=70.14, SD=8.35), Modified Cultural Mistrust Inventory for Adolescents (M=26.54, SD=2.16), Counselor Rating Form – Short – Attractiveness (M=17.85, SD=3.19), Counselor Rating Form – Short – Expertness (M=12.55, SD=4.03), Counselor Rating Form – Short – Trustworthiness (M=15.29, SD=2.31), and the Empathic Understanding Scale of the Relationship Inventory (M=65.61, SD=12.58). Significant correlations were found between the Working Alliance Inventory and Counselor Rating Form – Short – Attractiveness (r=.533), the Working Alliance Inventory and Empathic Understanding Scale of the Relationship Inventory (r=.518), and Counselor Rating Form – Short – Attractiveness and the Empathic Understanding Scale of the Relationship Inventory (r=.508).

The results suggest the style of dress expected of therapists might not be salient enough to activate social class judgments. Therapists thus have a degree of flexibility in their dress with regards to social class stimulus value. However, they should be aware of how their dress could communicate social class. Therapists might therefore wish to enforce a minimum dress code, so as to attenuate any social class judgments based on appearance.

References


Several months ago, I attended the State Leadership Conference in Washington, D.C. It happened to fall right after the Spring issue deadline so reporting the takeaways from that conference to members is a little delayed. However, it is important for you to be privy to what the conversation is at the national level and what they are telling us.

SLC was titled Countdown to Healthcare Reform. The conference is always launched with a keynote address by the Executive Director of Professional Practice, Katherine Nordal, Ph.D. She is a pointed speaker and her three-part summary of challenges for the Affordable Care Act can be summed up thusly:

1. Medicaid Expansion Challenges: Barriers to Medicaid expansion, which has restrictions on psychological services, can only be confronted at the state level.
2. Relationship Building Challenges: Of course this is about advocacy and what SLC is all about but the main point was that building relationships with policy makers is key to accomplishing the inclusion of Psychology in health care reform.
3. Individual Challenges: This one is about anxiety and anger management associated with adapting to new codes, mandatory reporting regulations and erosion of reimbursement rates.

Dr. Nordal’s answer to the challenges posed was no surprise. After noting that psychologists are one-sixth of the behavioral health workforce and pointing out that it took 25 years for psychology to get caught up after its exclusion in 1965 from Medicare, she stressed that we must self-advocate. To borrow from the title of the recent book by Sheryl Sandberg addressing women’s issues in the workplace, Dr. Nordal seems to want us to Lean In. She clearly believes that psychologists must build relationships to forge change and that psychology will only be included in the delivery of health care if we do that.

At SLC there are times when the delegation divides up to cover as many as we can of six concurrent sessions. Some sessions are very specific to practice and we try to make sure that one of your colleagues attends. I attend those relevant to association management if they are available, but sometimes they aren’t. One of the sessions I attended was about partnerships between practice and education to address funding issues impacting the internship imbalance. Interestingly there is little data regarding the workforce need for psychologists as there has not been a work-force analysis done. The idea of partnering is that a c6 partnered with a c3 would allow more comprehensive collection of relevant data to identify workforce needs. Overall, my take away from the session was that four-year colleges are accepting more students into their psychology programs than the profession can place in internships … to the extent that last year 957 applicants were left unmatched.

The words “truth in advertising” were mentioned multiple times when referencing university programs. It seemed to me that the partnering between practice and education they are suggesting and the resulting ability to collect data on workforce needs would resolve that issue. For the sake of the university’s reputations, the profession itself, and most importantly the students left without an internship match I hope there is some movement on the partnership idea.

Over the two days of meetings I attended the CESPPA specific breakfast as well as the annual CESPPA business meeting. I also presented on a CESPPA panel about how to engage association leadership. Apparently that is a challenge for some states. Though others on the panel had pretty PowerPoint presentations I thought my brief comments and suggestions offered some no-cost, applicable, and simple ideas that I think can be effective. I could have said, but resisted, “my leaders are better than your leaders.” I’m not much of a political player but I have figured out when to keep my thoughts to myself.
Non-Pharmalogical Interventions
Susan Smith, BCBA, LMHC

Editor’s note: Ms. Smith was a presenter at the spring IPA conference in Des Moines

First, I would like to say thank you to IPA for inviting me to talk at the Spring Conference. It gave me an opportunity to meet new people and also share ideas and strategies that have been useful in my work.

Second, I would like to share a little background information about myself. In the past, I have provided individual and group therapy at the Woodward Resource Center (WRC), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ID), many of whom also have mental illness diagnoses. More recently, I served as the Director of the I-PART (Iowa’s Program and Assistance Response Team) program, which has provided over 360 on-site behavioral consultations to individuals of all ages, throughout the State of Iowa, who have various levels of intellectual ability and either a mental illness diagnosis or an autism spectrum disorder. These experiences have heightened my awareness of the great need for community-based clinicians who will support individuals with ID, as well as a desire to promote non-pharmalogical interventions that are well suited for individuals who may not experience success with traditional therapy formats. While there are several from which to choose, “Mindfulness” is a great place to start as it has received much attention in the recent past.

Jon Kabat-Zinn defined Mindfulness as “Paying attention in a particular way, on purpose, in the present moment, non-judgmentally.” Scott Bishop attempted to operationally define Mindfulness using a two-component model. The first component is the self-regulation of attention, from moment to moment, so that it is maintained on immediate experience. The second component involves adopting a particular orientation toward one’s experience in the present moment which is characterized by curiosity, openness, and acceptance.

Bishop reports that combined, these components of Mindfulness lead to a feeling of being very alert to what is occurring, which is often described as a feeling of “being fully present and alive in the moment.”

Mindfulness is not a relaxation technique nor a process of thought suppression. Rather, according to Bishop it is “…mental training to reduce cognitive vulnerability to reactive modes of mind that might otherwise heighten stress or perpetuate psychopathology.” This suggests Mindfulness may have tremendous utility within the curriculum of young students as well as persons of any age who want to escape stress or mental illness, which includes almost everyone.

A classic example of Mindfulness is “sitting meditation” in which the learner attempts to maintain his attention on a particular focus while sitting upright. Whenever the learner’s attention wanders to other thoughts, feelings and/or sensations that arise in his stream of consciousness, the learner curiously and receptively takes notice of the event, but lets it go without further elaborate thinking or responding to it. Instead, the learner returns his attention to the original focus, e.g. his breath.

As the learner experiences success, he is encouraged to use the same approach outside the formal practice sessions, throughout the day to both proactively experience the joys of being mindful, as well as to escape ruminating on worrisome thoughts, feelings, or sensations should he find himself captivated by them.

Several Mindfulness-Based psychotherapies exist. Mindfulness-Based Stress Reduction Therapy was founded by Jon Kabat-Zinn in the late 1970’s and used for chronic pain management at the Department of Medicine within the University of Massachusetts. However, the therapy now attracts people with a variety of situations that hamper their well-being.

Mindfulness-Based Cognitive Therapy was influenced by Kabat-Zinn’s approach and has been used extensively by Zindel Segal to prevent relapse of major depressive episodes. Within this psychotherapy, the objective is to “focus less on how to manipulate the content of our thoughts and more on how to change their contexts so they can’t push us around,” which Selgas refers to as “disidentifying with thoughts.”

Nirbhay Singh is well-known for his work using Mindfulness-Based Cognitive Behavior Therapy with individuals with ID. His program, “Meditation on the Soles of the Feet (SoF)” has been beneficial in facilitating the learner’s ability to self-manage anger, inappropriate sexual behavior, obesity, and smoking. Singh reports individuals being “more accepting of unanticipated changes in their daily schedules” which suggests the program may have utility...
Non-Pharmaceutical Interventions  Susan Smith

From Page 7

for individuals who find change aversive, which is common within the Autism Spectrum Disorders.

Acceptance and Commitment Therapy (ACT), founded by Steve Hayes is a third wave behavior therapy which is particularly sensitive to the context and functions of the psychological phenomena, not just their form. Similar to the above psychotherapies, ACT identifies that “it is not about resisting your emotions; it is about feeling them completely and not turning your choices over to them.” ACT also places value on the project of building a meaningful life aligned with the client’s goals. Hayes reported using ACT with a 22 year old female who had both ID and undifferentiated schizophrenia who was experiencing command auditory hallucinations that told her to kill herself. Pre post intervention Likert scale scores reflected substantial improvement.

Dialectical Behavior Therapy (DBT) is another form of Mindfulness-Based Cognitive Behavior Therapy and was originally developed by Marsha Linehan for work with individuals who exhibited suicidal or parasuicidal behaviors. Mindfulness skills are the core of this program, although it also includes modules on relationships, emotional regulation and distress tolerance.

Lindehan’s DBT breaks Mindfulness skills into two categories, the “what” skills and the “how” skills. The “what” skills include: 1) Mindfulness Observe—experiencing without labeling or describing; 2) Mindfulness Describe—putting words on your thoughts; and 3) Mindfulness Participating—responding smoothly to the demands of the task with alertness and awareness. The “how” skills include: 4) Mindfulness Non Judgmentally—focusing on the facts, rather than opinions; 5) Mindfulness One Mindfully—focusing the mind and awareness in the current activity rather than splitting attention among several activities or between a current activity and thinking about something else; and 6) Mindfulness Effectively—focusing on what works.

I am fortunate to have been a member of a clinical team from WRC who received intensive training in DBT philosophy. However, our team has since been challenged to transform the philosophy into activities and materials that would be effective for individuals with mild ID, as the overwhelming majority of the published curriculums are designed for individuals with IQ’s above 70. For this task, behavioral technology has proven to be quite useful. Utilizing a most-to-least prompt hierarchy, group members contact reinforcement nearly each time they engage in an activity. The rate of success experienced by group members may be much higher than the rate of success the individuals have experienced in other current or past environments. The differential rate of reinforcement typically results in the skills group itself becoming conditioned as a reinforcer, which increases the probability that members want to attend.

The individual’s “participating” behavior is reinforced by the success he or she experiences, which also increases the probability they will engage in the same behavior in the future.

Visual aids are an important aspect of teaching new skills to learners with ID. When the visual aid matches the interests of the group members, it is even more effective. For example, groups with females have responded well to the analogy: “Relationships are like flowers. If you don’t water them they will wilt and eventually fade.”

However, groups with male members have responded better to the analogy: Relationships are like muscles. You have to keep working on them if you want to keep them.”

Another variable believed to influence outcome has been providing opportunities in which the learner can actively experience the concept at hand, rather than the group facilitator trying to impose wisdom on them. Once the learners have experienced the concept, they are much more likely to comprehend and remember the concept.

Mindfulness approaches teach the learner to become more aware of thoughts and feelings and to relate them to a wider perspective as mere “transient mental events” rather than reflections of the self or as accurate reflections on reality.

It also shapes the learner’s ability to pause between the instant they perceive a thought, feeling, or sensation and the moment they act on it. In other words, it may facilitate their ability to act less impulsively.

In addition to the Mindfulness activities, a variety of additional activities were shared during my conference presentation including an “Emotion-Intensity Charades” activity which is intended to develop the learner’s ability to identify and label the social cues of others, which is an important empathy skill.

Another activity, “The Emergence of I” is one that comes from the literature of Functional Analytical Psychotherapy, a behavioral therapy derived from Skinner’s Radical Behaviorism. It involves shaping the learner’s ability to pair verbal words with her private events, a skill that fails to develop when an individual spends her early years in an invalidating environment where emotional expression is discouraged or punished, and therefore comes under the control of public stimuli rather than private stimuli.

The activity includes a systematic process in which the group members gradually, over several sessions, finish a hierarchy of sentences, e.g. “I see…,” “I hear…,” “I feel…” These sentences describe the sensation(s) experienced when the learner’s sensory receptors contact stimuli. Initially, the sentences involve activity from the exteroceptive sensory system, which includes seeing, hearing, smelling, tactile touching, and tasting. However, as the learner acquires skills in pairing words with her private bodily states, the sentences she is asked to complete are then associated with private bodily states which correspondence with her interoceptive nervous system, (viscera, glands, ducts, and the vascular systems). These bodily states (e.g. changes in heart rate, pupil dilation, glandular secretions, muscle contractions, etc.) are associated with the sensations commonly labeled as “emotions.”

Feel free to contact me at smith7@dhs.state.ia.us with questions regarding this presentation, or for information about the DHS funded I-TABS program which is available to provide Technical Assistance and Behavior Support, free-of-charge, to community stakeholders who support Iowans who are Medicaid eligible.
The Iowa Psychological Association (IPA) continues its efforts to increase the psychology workforce by consulting with sites to develop, implement, and sustain postdoctoral training programs. These efforts are critical as access to psychological services in Iowa remains insufficient. In 2005 Iowa had approximately 15 psychologists per 100,000 persons. It is not likely that this figure has improved substantially since that time. Compared to recent figures, Iowa would need to more than double the number of psychologists to reach the national average number of 36 psychologists per 100,000 persons. This will be difficult as Iowa psychologists continue to be one of the oldest, if not the oldest group of health professionals with 53% of psychologists age 55 or older.

Since 2008 IPA has worked with sites to develop, implement and sustain postdoctoral training programs. IPA has received state funds to support training at rural and underserved sites as designated by federal health professional shortage areas criteria. Through Poweshiek County Mental Health Center, the original program site, six psychologists completed the required postdoctoral clinical supervision necessary for independent practice. Four of those professionals remain in Iowa providing services to its citizens. Those psychologists are: Dr. Cora Schuhmacher, Dr. Jill Jordahl Ball, Dr. Jennifer Kauder, and Dr. Amanda Johnson. Unfortunately, Poweshiek County Mental Health Center ceased operation in May of 2013. Dr. Michelle Cushman, a trainee who was with Poweshiek County Mental Health Center at the time, is continuing her postdoctoral work in Iowa under the supervision of Dr. Tony Tatman. Dr. Cushman plans to remain in Iowa after she completes her postdoctoral work.

Central Iowa Psychological Services (CIPS), another rural and underserved training site, has provided the necessary postdoctoral training to Dr. Danah Barazanjii. Barazanjii, an Iowa native, will remain in practice at CIPS after completing her postdoctoral training. In the late summer of 2013, CIPS will welcome two new postdoctoral trainees. Kayla Davidson, a student at Fuller Graduate School of Psychology, who is currently completing a pre-doctoral internship at Premier Psychiatric Group in Lincoln, NE will join CIPS in September, 2013. Tina Hoffman, a student in the University of Iowa Counseling Psychology program who is currently on internship at the University of Missouri (Columbia) Counseling Center, will begin providing service at CIPS in the late summer/early fall.

While IPA can only offer financial support to sites in rural and underserved areas, the Association, through Training Director Michele Greiner, has been able to offer some consultation services to sites in urban areas that follow recommended postdoctoral training practices. Urban sites that the Association works with include Innovative Learning Professionals (ILP) and the 5th Judicial District Correctional Services Drug Court. In the summer of 2013 a total of three psychologists will have completed their postdoctoral training at ILP. Those psychologists are: Dr. Amy Catanzaro, Dr. Matt Cooper, and Dr. Leann Waterhouse. Stephanie Bruss, who will receive her doctoral degree from Minnesota School of Professional Psychology at Argosy University - Twin Cities, after completing her pre-doctoral internship at GeoCare Inc./South Florida Evaluation and Treatment Center in Florida City, FL will begin postdoctoral training at ILP in the late summer of 2013.

Training Director Greiner and the Training Task Force which consists of Dr. Sam Graham, Dr. Bob Hutzell, Dr. Amanda Johnson, Dr. Mike March, Dr. Catalina D’Achiardi Ressler and Dr. John Tedesco continue to look for funding for additional sites; both in rural and urban areas. Through the work of Training Director Greiner, lobbyist Amy Campbell and state advocacy chairperson Dr. Greg Febbraro, the possibility exists for an additional $12,000 from the state for fiscal year 2013-2014. Additionally, Greiner and the Task Force are grateful to the Iowa Psychological Foundation which kicked off a fundraising campaign to provide $15,000 in financial support to CIPS for a postdoctoral trainee for 2014-2015. Please consider making a contribution to this worthwhile campaign. For more information about the campaign, contact Dr. Suzanne Zilber at szilber@catalystcounseling.com

For more information about the Association and training, please contact Dr. Michele Greiner at mgreiner@lisco.com or 641-472-4888.
In Memoriam: Dr. Thomas Sannito

Editor’s note: This obituary was reprinted with permission from the Dubuque Tribune Herald

Dr. Thomas Sannito, 74, passed away Monday, April 1, 2013, after an extended illness, surrounded by his loving family.

Services were held Monday, April 8, at St. Joseph’s the Worker Church, Dubuque.

Tom was born the son of Carl and Betty (Crean) Sannito. He attended Mount Carmel High School and went on to earn his Ph.D. from Loyola University. He married the love of his life, Carol Pletz, on June 5, 1965, in Lakefield, Minn., and they raised seven children together.

Tom was a professor at Loras College in Dubuque, where he taught psychology for more than 30 years. He enjoyed teaching and was popular with students for his generous spirit and colorful stories. He was also well-respected by his peers. While at Loras, Dr. Sannito founded the Talent Salvage Program where he mentored and taught learning techniques to students, enabling them to attend and graduate from Loras College. In addition to his work as an educator, Dr. Sannito had a private clinical and forensic practice in Dubuque. He was highly respected by his peers and was a member of the American Psychology Association.

During his years as a professional psychologist, Tom helped hundreds of patients recover from mental health issues so they could begin their journey to rebuilding their life. He also was a published author, writing “Courtroom Psychology,” a reference book still used today by many trial lawyers. He was considered an expert in the field of jury selection and was often called upon by attorneys to assist in difficult cases.

Tom was a wonderful, caring husband and father who provided for his wife and kids and taught them the importance of family, kindness and generosity. He enjoyed following the Chicago Bears and was an avid tennis player. Tom was most proud of the life he created with his wife Carol and their seven children. He will be sadly missed by his family.

Surviving are his wife of 48 years, Carol; son John Sannito, of Madison, Wis., and his children Mike, Mark, Tom, Tessa and Jaynie; a daughter, Mary (Kyle) Mork, of Lino Lakes, Minn., and their children, Claire and Grace; a daughter, Elizabeth (Dave) Cox, of San Diego, and her children, Arianne and Brett; a daughter, Kathleen (Brian) Craven, of West Des Moines, and their children, Zac and Matt; a daughter, Jeannette Sannito, of Dubuque and her children, Jake and Jonah; a daughter, Carol (Dale) Molback, of Rosemount, Minn., and their children, Hannah, Christian and Megan; and a daughter, Amy (Dan) Zeh, of Centerville, Minn., and their daughter, Katie; a sister-in-law, Nancy Sannito (Waldbilling), and her children, Carl, Dennis, Tony, Brian and Nick; and many dear cousins.

He was preceded in death by his parents, Carl and Betty (Crean) Sannito; and brother, Denny.

In lieu of flowers, memorials may be sent to Agrace Hospice of Madison, Wis., at www.agrace.org.

Online condolences may be left for the family at www.hoffmannschneiderfuneralhomes.com.

The family wishes to extend its gratitude to all of the caregivers at Oak Park Place 2, Madison, for their care of Tom during his illness as well as to Agrace Hospice of Madison, especially Leah and Donna, for making his final days peaceful.

HANSEN, McClintock & Riley

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Editor’s note: Randy Cole of the 6th Judicial District Department of Correctional Services and Lettie Prell of the Deputy Director of Research, Iowa Department of Corrections gave this presentation at the IPA Conference on April 20, 2013, in Des Moines.

In 1995, federal law mandated that each state develop and maintain a sex offender registry (SOR). In 1997, federal law mandated a public notification component to the sex offender registries. For many states, including Iowa, the state legislators then required a sex offender specific risk assessment to be implemented as a part of that notification.

At the time, there were not any validated sex offender specific risk assessments within the public domain. The state of Iowa developed a Sex Offender Task Force that embarked upon this journey of assimilating risk assessment instruments into sex offender management. Initially, Iowa adopted a tool from the state of New York that was empirically based. Simultaneously, we worked with Criminal and Juvenile Justice Planning researchers to develop our own hybrid sex offender risk assessment instrument. Collectively, we combined factors from the then Minnesota, Wisconsin, and New York sex offender risk assessment instruments, as well as a three page worksheet of additional potential risk factors, and conducted the original sample study for the Iowa Sex Offender Risk Assessment. This was a live study of approximately 1,107 adult Iowa sex offenders that were convicted of any offense that required registry on the Iowa SOR. The sample consisted of male and female adult sex offenders; 32 women were in the original study. (Please see the attachment for a copy of the coding form identifying each factor). This led to the ISORA-8 (eight factors). Average time at risk was 3.3 years. Here are the recidivism results from that original study:

<table>
<thead>
<tr>
<th>Score</th>
<th>Sample Size</th>
<th>Person Sex</th>
<th>Person Convict</th>
<th>Person Convict</th>
<th>Recid y/n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>330</td>
<td>6.1%</td>
<td>1.8%</td>
<td>4.5%</td>
<td>12%</td>
</tr>
<tr>
<td>4-5</td>
<td>348</td>
<td>7.8%</td>
<td>2.3%</td>
<td>5.2%</td>
<td>11%</td>
</tr>
<tr>
<td>6-8</td>
<td>306</td>
<td>15.7%</td>
<td>4.2%</td>
<td>13.1%</td>
<td>4.2%</td>
</tr>
<tr>
<td>9+</td>
<td>123</td>
<td>27.6%</td>
<td>11.4%</td>
<td>22.8%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Total</td>
<td>1107</td>
<td>11.7%</td>
<td>3.7%</td>
<td>9.1%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

The ISORA-8 original study also had impressive ROC data as outlined below:

**ROC Curve**
- .726 conviction new sex crime
- .678 arrest new sex crime
- .679 conviction new crime against persons
- .666 arrest new crime against persons

By 1999, Dr. Karl Hanson with Solicitor General Canada and his team of researchers had recently validated the STATIC 99 on a sample of sex offenders from Canada and Great Britain. The predecessor instrument to the STATIC 99 was the Rapid Risk Assessment Sex Offender Rating (RRAJOR, 1997; Hanson). The ROC curve for the STATIC 99 for conviction new sex crime was also impressive: .70 (STATIC 99). This would improve to .72 with further research and the development of the STATIC 99-R. At that time, The STATIC 99 was the only sex offender risk assessment tool in public domain that had validation. The STATIC 99 also had impressive data in the original study, having a 95% confidence interval:

<table>
<thead>
<tr>
<th>Score</th>
<th>n</th>
<th>P</th>
<th>Low C.I.</th>
<th>Hi C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>107</td>
<td>.13</td>
<td>.07</td>
<td>.19</td>
</tr>
<tr>
<td>1</td>
<td>150</td>
<td>.07</td>
<td>.03</td>
<td>.11</td>
</tr>
<tr>
<td>2</td>
<td>204</td>
<td>.16</td>
<td>.11</td>
<td>.21</td>
</tr>
<tr>
<td>3</td>
<td>206</td>
<td>.19</td>
<td>.14</td>
<td>.24</td>
</tr>
<tr>
<td>4</td>
<td>190</td>
<td>.36</td>
<td>.29</td>
<td>.45</td>
</tr>
<tr>
<td>5</td>
<td>100</td>
<td>.40</td>
<td>.30</td>
<td>.50</td>
</tr>
<tr>
<td>6+</td>
<td>129</td>
<td>.52</td>
<td>.43</td>
<td>.61</td>
</tr>
</tbody>
</table>

Because Iowa was given a mandate by the state legislature to have a risk assessment instrument in use within six months, the task force agreed to bring the STATIC 99 on board while we continued the study of the ISORA-8. (Please see the attachment for a copy of the original STATIC 99 Coding form identifying each factor). However, the STATIC 99 has limitations; it is not validated for female offenders, statutory offenders, or juvenile offenders, and did not examine dynamic risk factors. (see www.static99.org and coding manual for more details).

This first generation of sex offender risk assessment instruments were primarily actuarial and were limited to...
historical data about the offender and offending history, with the exception of the treatment factor on the ISORA-8. By 1998, Dr. Hanson and his team of researchers began to study dynamic factors as well and called this the Dynamic Predictors Study. This study resulted in an empirically based instrument called the Sex Offender Needs Assessment Rating (SONAR). By 2001, Dr. Hanson and the researchers were ready to implement a wide live study of sex offenders that they called the Dynamic Supervision Project. This was a study of approximately 1,000 sex offenders across multiple jurisdictions; Canada, Alaska, and Iowa. This study resulted in the development of the STABLE 2000 and ACUTE 2000 dynamic risk assessment instruments. As we continued to collect data for almost 60 months, these instruments were revised to their current form; STABLE 2007 and ACUTE 2007. (Please see attached copy of coding forms to identify each factor).

While Iowa was involved in the Dynamic Supervision Project, we were also planning the further tracking of Iowa sex offenders for a validation study of the ISORA-8. By 2010, we had another new sample of 987 male and female adult sex offenders in Iowa to conduct this validation study. There were 23 adult female sex offenders in this sample. Lettie Prell, Deputy Director of Research for IDOC conducted this validation study (www.doc.state.ia.us; publications). Again, the data were impressive, and resulted in ISORA-8 being revised into the six item ISORA:

ROC Curve:
- .713 conviction new sex or violent crime
- .770 conviction new sex crime (strict definition)
- .786 conviction new sex crime or crime

Lettie Prell then proceeded to conduct a validation study of the ISORA and STATIC 99-R (revised for age factor through Dr. Hanson’s research). The results were developing an overall actuarial risk prediction more accurate when the instruments were combined then either instrument independently, especially in identifying a low risk group and very high risk group of sex offenders:

<table>
<thead>
<tr>
<th>If ISORA is:</th>
<th>Low</th>
<th>Moderate</th>
<th>Moderate-High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>And Static-99R is:</td>
<td>Low</td>
<td>Low</td>
<td>L-M</td>
<td>L-M</td>
</tr>
<tr>
<td></td>
<td>L-M</td>
<td>L-M</td>
<td>M-H</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>M-H</td>
<td>M-H</td>
<td>M-H</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>High</td>
<td>Very High</td>
<td>Very High</td>
</tr>
</tbody>
</table>

Because the Iowa Sex Offender Risk Assessment (ISORA) research has always focused on the normative sample being adult male and female sex offenders required to register on the Iowa Sex Offender Registry (ISOR), the ISORA risk assessment instrument does not have the limitations applied to the STATIC 99, STATIC 99-R. As far as we know, it is also the only sex offender risk assessment instrument that has been validated specifically for adult female sex offenders.

By utilizing a systematic research driven focus to sex offender management in Iowa we now have one of the most comprehensive validated sex offender risk assessment models implemented to guide our decision making and strategies concerning sex offender supervision, treatment, and monitoring. The STATIC 99-R and ISORA provide the foundation and that baseline for actuarial risk; historical data, criminal history, sex offense history, victim/offender relationship, etc. The ISORA also identifies the very important treatment factor. The STABLE 2007 is then utilized to identify dynamic variables that increase risk and determine treatment needs for the offender; intimacy deficits, general self-regulation issues, sexual self-regulation issues, and cooperation with supervision. And then, the ACUTE 2007 looks at those same dynamic needs in the context of targeting what can change very rapidly and intervening at the earliest possible indication of a problem.

When we add this model of risk assessment into a three phase (Intake/Assessment- Primary Treatment- Aftercare) approach to sex offender management we have one of the most comprehensive sex offender management programs in place across Iowa. Our research and work in sex offender management has been spotlighted in numerous national publications and resources across the country and we continue to perform research and implement evidence based practices into our sex offender management (SOM) approach.

Editor’s note: Readers interested in receiving a copy of the attachments cited in the article can contact the Editor at stewart-ehly@uiowa.edu

Resources
“”The Importance of Assessment in Sex Offender Management: An Overview of Key Principles and Practices, CSOM, July 2007””
“The Dynamic Supervision Project”, Dr. Hanson & Andrew Harris, Solicitor General Canada
“Iowa Sex Offender Risk Assessment: An Overview of the ISORA with Focus on Female Offenders”, Lettie Prell, Deputy Director of Research, IDOC
A Call for 2013 Ann Ernst Retired Psychologist Public Service Award Nominees

This award honors a psychologist, active or retired, who has made on a pro bono basis, significant contributions of a psychological nature that have benefited society as a whole. The contribution(s) may have been a single major contribution or reflect a consistent history of volunteer service to the community at large.

A call for letters of nomination will be distributed to voting members no later than July 1. The letters of nomination will be reviewed by the Council at its August meeting. The Executive Council may select a person to receive the award, which may be given annually at the Fall Conference. The Elections/Honors Task Force and the Executive Director will be responsible for ordering an appropriate award.

With this nomination form, please enclose a letter of recommendation for the person(s) you nominate. Postmark deadline for consideration is Aug. 1, 2013. Mail to:

IPA Ann Ernst Public Service Award
48428 290th Ave
Rolfe, IA 50581
Email: ipa@iowapsychology.org

I nominate the following candidate(s) for the 2013 IPA Ann Ernst Retired Psychologist Service Award:

Nominee: ________________________________________________________________

Nominee: ________________________________________________________________

Nominee: ________________________________________________________________

Your name: ___________________________________________________________________

Former Recipients of this Award:

Ann Ernst (2006)
Charles McDonald (2008),
Mike Rosmann (2010)
Darshan Singh (2010)
Call for Nominations to IPA Executive Council

Nominations are being solicited for position openings on the IPA Executive Council.

This is an excellent opportunity to nominate yourself or any other member whose strengths, experience and ideas could make a significant contribution to IPA. Good leaders are people who are creative, consensus building, bright, and flexible individuals. These nominations will be used by the Elections Committee to prepare a slate of candidates. THIS CALL FOR NOMINATIONS WILL NOT BE SENT IN A SEPARATE MAILING. IF YOU WISH TO MAKE A NOMINATION PLEASE USE THIS FORM. If you are an IPA member with voting privileges, you may volunteer yourself or nominate a colleague to serve as a member of the Council. Please indicate if the person has agreed to be a nominee. Sorry, but student members and associate members of less than five years are not eligible to nominate candidates for office.

Nominations must be signed to be valid, and should be sent to the IPA Office by Aug. 24, 2013.

I wish to nominate the following individual(s) for IPA Executive Council:

For President-Elect, 2014-2015 (will be President in 2015):

Name: _____________________________________________________________________________
I have _____ have not _____ verified this member’s willingness to be nominated.

For IPA Rep, 2014-2016:

Name: _____________________________________________________________________________
I have _____ have not _____ verified this member’s willingness to be nominated.

For Recording Secretary, 2014-2016:

Name: _____________________________________________________________________________
I have _____ have not _____ verified this member’s willingness to be nominated.

Write In Candidate: For Position _____________________________________________________________________________

Name: _____________________________________________________________________________
I have _____ have not _____ verified this member’s willingness to be nominated.

Your signature: ______________________________________________________________________

Send completed form to: IPA Call for Nominations, 48428 290th Ave., Rolfe, IA 50581
Office: 712-848-3595 Fax: 712-848-3892 Mobile: 712-358-1621
Email: ipa@iowapsychology.org
Editor’s Note: These minutes were approved at the 2013 Spring Conference and are printed as a matter of organizational record.

Meeting was at Iowa State Center in Ames

Members Present: Dr. Don Damsteegt, Dr. Greg Febbraro, Dr. Ron Nelson, Dr. Stewart Ehly, Dr. Thomas Ottavi, Dr. Dan Courtney, Dr. David Towle, Dr. Greg Gullickson, Dr. Kevin Krumvieida, Dr. Brenda Crawford, Dr. William Stearns, Dr. Phil Laughlin, Dr. Scott Young, Dr. Elizabeth Lomning, and Executive Director Carmella Schultes.

The meeting was called to order by President Greg Gullickson at 5:18 p.m.

Approval of Agenda. Motion to approve agenda by Dr. Nelson and seconded by Dr. Damsteegt. Friendly amendment to add Item IV. F. TIP Newsletter report was offered and accepted. Amended Agenda was approved unanimously.

Approval of Minutes. Motion to approve the Minutes of the 2011 Annual Business Meeting by Dr. Febbraro. Seconded by Dr. Ottavi. The motion to approve the minutes was unanimously approved.

Reports

Membership Committee Report—Dr. Brenda Crawford. Oral presented. It was noted that 53% of Iowa licensed psychologists are members of IPA. Membership includes:

- 152 Full Members
- 15 Advocacy Exempt Members
- 6 Partial Retired Members
- 38 Retired Members
- 2 Voting Associate Members
- 1 Associate Members
- 20 Student Members

Treasurer’s Report—Dr. Dan Courtney. Written report distributed and reviewed. He reported a budget surplus for 2011 of $5,609. It was noted that the Advocacy Assessment increased from $75 to $115 and the income from the Advocacy Assessment increased to $17,139 from the previous year’s total of $11,450. The difference of $5689 was very close to the overall budget surplus for the year. Total financial assets are $250925.52. Dr. Courtney reported that the Executive Council approved the recommendation by Steve Hall, investment advisor, to rebalance the investment portfolio to 60% exposure to equities from 57%.

President’s Report—Dr. Greg Gullickson. Oral report. Dr. Gullickson reported on the SLC. He stated that not much will happen legislatively in the near future. He stated there is research and review being conducted on electronic health records. Specific recommendations may be announced in December. The topic of Integrated Health Care will be featured in future conferences, as this is seen as a relevant and timely topic for IPA members.

Training Director’s Report—Dr. Michelle Greiner. Oral report. Dr. Greiner reported on funding for 2011-12 from the DPH. She stated we have a good relationship with DPH and they have been generous in awarding additional money when available.

APA Representative Report—Dr. Elizabeth Lomning. Oral report. Dr. Lomning reported on funding restructuring and proposed changes in the by-laws. She reported there will be a change requiring that APA presidential nominees wait 10 years after their Past-President term before running again.

TIP Newsletter Report—Dr. Stewart Ehly. Oral report. Dr. Ehly reported that initially he has relied on publishing longer articles. His goal is to include more short articles on education, research, and practice. He will continue working to shape the newsletter with this in mind.

Other Business

Announce 2012 Award Winners—Dr. Ottavi—Award winners and outgoing Executive Council members were recognized at the Awards Luncheon earlier in the day.

Meritorious Achievement Award was presented to Bob Hutzell, Ph.D.

Service Award was presented to Chuck Palmer.

Outgoing Executive Council Members were acknowledged for their service. This included Dr. Rachel Heiss, Dr. Alex Casillas, and Dr. Susan Enzle.

Dr. Mike Rosmann received the APA State Leadership Award.

Adjournment. Dr. Nelson moved for adjournment and Dr. Krumvieida seconded the motion. With unanimous approval, the meeting was adjourned at 5:34 p.m.

New IPA Members

<table>
<thead>
<tr>
<th>Charles Bermingham</th>
<th>Jeffrey K. Ellens, Ph.D.</th>
<th>Michelle Nanji</th>
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<tr>
<td>Iowa City (student)</td>
<td>West Des Moines</td>
<td>Iowa City (student)</td>
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</tbody>
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EXECUTIVE COUNCIL

President: Jason Smith
Recording Secretary: David Towle
Past President: Greg Gullickson
Treasurer: Elizabeth Altmaier
President-Elect: Brenda Crawford
APA Representative: Elizabeth Lonning
IPA Representative: David Beeman
IPA Representative: Catalina D’Achiardi-Ressler
IPA Representative: Molly Nikolas
State Advocacy: Greg Febbraro
Federal Advocacy: Brenda Payne
APAGS Representative: Jeritt Tucker

COMMITTEE CHAIRS

Ethics: David Johnson
Federal Advocacy: Brenda Payne
State Advocacy: Greg Febbraro
Membership: TBA
Finance: Elizabeth Altmaier
Professional Issues: Derek Grimmell
Editorial/Newsletter: Stewart Ehly
Public Education: Amanda Johnson
Elections Task Force: Greg Gullickson
Developing Psychologists: Scott Young
Diversity Initiative: Jane Daniel
Psychopharmacology Education: Elizabeth Lonning
Internship Ad Hoc: Michele Greiner
IPA Website: Phil Laughlin
Training Director: Michele Greiner
Integrated Healthcare Task Force: Jon Weinand

LIAISONS

Medical Assistance Advisory Council: Stacy Carmichael
Disaster Relief Network: Earl Kilgore
Psychology in the Workplace Network: Jeffrey Ellens
Iowa Board of Psychology (IBP): Morgan Hall
APA Rural Mental Health: Ruth Evans
APA Committee on Women in Psychology: Lauri Lehn
IPH Health & Longterm Care Access: Michele Greiner
IPH Prevention & Chronic Care Council: Michele Greiner
APA Committee on Socioeconomic Status: Jane Daniel
APA Presidential Task Force on Psychological Ethics and National Security: Holly Sanger

THE IOWA PSYCHOLOGIST

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June issue – May 15
September issue – August 15
December issue – November 15

All submissions must be typed and may be sent to the editor as e-mail attachments (Microsoft Word preferred). Deadlines for issue content are the same as the advertising deadlines. To submit content or for more information, contact:

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