Hello, I hope you are all enjoying a lovely holiday season and are getting ready for a fresh start in the 2016 New Year! Many changes are coming for our wonderful organization in 2016, the most substantial of which is that CPA is bidding farewell to our long term partner, Karen Wojdyla and the Great Western Association Management, Inc. (GWAMI). Karen will be retiring at the end of this year after having been the faithful executive director of CPA for the past decade. She has watched this organization shift, grow, and change many times over the years and has worked successfully with many different Board Members. Please join me in thanking her for her consistent service to all Colorado psychologists!!

Over the past 6 months, the newly formed Transitions Task Force and the Transitions Task Force Advisory Board have worked diligently with the Executive Committee to ensure CPA’s smooth transition to a new association management company and executive director. This team conducted an intensive search process by developing and distributing a request for proposals (RFP), reviewing all applicants, and conducting thorough interviews. This led to engagement with one company in contract negotiations that resulted in CPA securing a 3-year contract for services. I am happy to say that, through all of the collective hard work, CPA will be partnering with an association management company in the Denver Metro area called Civica.

Civica was ultimately chosen due to their strong reputation, impressive interviews with CPA, and clear commitment to and experience with membership associations in the health sector. Civica demonstrated significant strengths and expertise in several of CPA’s priority areas such as: existing infrastructure with procedures and systems to address the range of functions needed for strong association management, a team of staff with specific areas of expertise, experience and successful implementation (procedurally and financially) of a continuing education requirement, concrete strategies to increase association membership, comfort with and regular use of technology to support efficient operations and communication with CPA Leaders and CPA Members, utilization of data to
Message from the President – Continued

track progress across varied and relevant metrics (e.g., membership and financial trend analysis), and effective strategies for successful conference and event planning.

Although it is normative that substantial change such as this will come with challenges to work through, I am excited that CPA’s partnership with Civica will result in smoother and more efficient operations overall to ultimately better benefit CPA Membership! I encourage Members to reach out to me or other Board Members regarding your experience with Civica in the coming months so that we can learn and continually improve together as an organization.

In the spirit of the holidays, I want to recognize that none of this would have happened without a tremendous volunteer effort over the last several months. Please join me in offering sincere gratitude to the following CPA Members and Board Leaders for taking initiative, volunteering their leadership and time, and pulling everything together to make this transition happen successfully and on time!

Thank you to the Transitions Task Force Members, who helped organize, create, and distribute the RFP as well as conduct initial review of applications and interviews! Dr. Jane Hancock, Dr. Mimi McFaul, Dr. Angela Green, Dr. Shawna Urbanski, Dr. Chris Beasley.

Thank you to the Transition Task Force Advisory Board, which included former CPA Presidents and Leaders, who provided as-needed guidance, consultation, and support during the process! Dr. Chad Morris, Dr. Stephanie Kleiner-Morrissey, Dr. Bill Sobesky, Dr. Bill Porter.

And thank you to the CPA Executive Committee Members, who conducted final reviews of applications, final interviews, and all contract negotiations! Dr. Samantha Farro, Dr. Mimi McFaul, Dr. Charles Smith, Dr. Olga Vera, Dr. Dawn Jewell, Dr. Kristin Orlowski.

Through this amazing and collaborative team effort, I am hopeful that CPA is set up to have a fresh start in Jan 2016 that will set us up successfully for many years to come!

Have a wonderful and safe New Year,
Samantha A Farro, PhD

CPA Calendar of Events 2015

CPA Board Meetings.................................................................3rd Friday of January, March, May & November
(unless otherwise notified)
12:00 noon - 3:00 pm

CPA Executive Committee Meetings.........................................3rd Friday of February, April, June, & October
(unless otherwise notified)
12:00 noon – 3:00 pm

Articles due for The Colorado Psychologist.................................January 10, 2016
Submission commitments due to Brian Beaumund, PsyD at Brian.Beaumund@gmail.com

Integrated Care Committee Happy Hour........................................January 21, 2016
Location: TBD
Message From the Editors

Dear CPA Members,

The December issue of TCP features pieces relevant to neuropsychology. Highlighted are articles discussing the limitations of neuropsychological testing when applied with individuals of Hispanic ethnicity, traumatic brain injury affecting individuals in correctional facilities, and a commentary discussing our field’s increasing focus on explaining behavior through a brain-oriented lens. CPA President Dr. Samantha Farro shares her thoughts on changes within CPA and legislative updates are shared from the Forensic Task Force.

In other news, a new-to-Colorado psychologist is welcomed and interviewed for our regular Interview with a Psychologist column and information on the Disaster Response Network, soon to be Disaster Resource Network, is summarized. Finally, check out announcements and advertisements relevant to you as a CPA member.

Announcing themes for 2016!
   Addiction
   Trauma
   Geriatrics
   Integrated Care

Interested in submitting something for publication? Please contact Dr. Brian Beaumund at: brian.beaumund@gmail.com.

Thank you to all contributors for your commitment to TCP. As always, we appreciate the time and expertise you give to membership each issue!

Wishing you a wonderful winter season with opportunities for relaxation and rejuvenation.

Barbara Gueldner, PhD, MSE
Limitations to Neuropsychological Assessment of the Hispanic Population: Assumptions of Homogeneity

Jason A Kacmarski, MA, EdS, Kirsten M Allen, MA, & Lindsey F Colbert, MA

The terms “Latino” and “Hispanic” refer to a collection of individuals from various ethnic backgrounds including individuals of Mexican, Puerto Rican, and Spanish origin, among many others. While often mistakenly thought of as describing a homogenous race, these terms instead encompass individuals of different heritages, nationalities, birth countries, lineages, and familial countries of origin (Benuto, 2013). For the purpose of this article, the term Hispanic will be used to refer to the plethora of individuals of Spanish and Latin American (i.e., Caribbean and Central/South American) origin for whom a derivation of Spanish has historically been a primary or secondary language.

In the United States, the Hispanic population is projected to increase approximately 115% from 55 million to 119 million between 2014 and 2060 (US Census Bureau, 2015). As of July 2013, 54 million Hispanics resided in the United States, accounting for approximately 17% of the total US population. Of these individuals, roughly 74% indicated that Spanish was the primary language spoken in their home. Approximately 2.1% of the US Hispanic population resides in the state of Colorado, accounting for 21% of Colorado’s total population. Twenty-five percent of Colorado’s Hispanic population is foreign born with a primary language other than English. Given the projections that the Hispanic population within the United States will continue to grow, it is essential for the field of neuropsychology to take into account the complexity of the Hispanic population while developing appropriate and useful normative data (Benuto, 2013).

Awareness that multiple variables, such as culture, race, socio-economic status, and ethnicity can affect results of neuropsychological examination is fundamental (Ponton & Ardila, 1999). Benuto (2013) noted that many assessments do not emphasize “language differences, validity of tests for ethnic minorities, [or] the influence of cultural and social factors,” (p. v11) and often do not take into account the psychological impact of the acculturation process. As many assessment measures utilize verbal language to present stimuli, respond to stimuli, etc., it is imperative that practitioners consider the potential effect of language factors on neuropsychological test performance (Benuto, 2013). For example, research has shown that an individual’s first language (Boone, Victor, Wen, Razani, & Ponton, 2007), as well as their status as bilingual versus monolingual (e.g., Tamar, Fennema-Notestine, Montoya, & Jernigan, 2007), can have a tremendous impact on neuropsychological test performances.

Several efforts have been made to develop a culturally informed neuropsychological assessment battery and normative data for the Hispanic population. Examples include the Spanish and English Neuropsychological Assessment Scales (SENAS), Consortium to Establish a Registry for Alzheimer's Disease (CERAD) and Spanish Multicenter NEURONORMA Project (NEURONORMA) batteries as well as an adapted version of the Wechsler Adult Intelligence Scales, the Escala de Inteligencia Wechsler para Adultos (EIWA). While each of these measures has their strengths, they have tended to use restricted samples and therefore struggle to effectively capture the true complexity of the Hispanic population, including differences in culture, race, ethnicity, language, SES, etc. For example, the NEURONORMA relied exclusively on a sample of Spanish individuals, and the EIWA was normed on a strictly Puerto Rican sample more than 45 years ago (Benuto, 2013). Inherent in the development of these batteries is an assumption of cultural homogeneity that has repeatedly been shown to be erroneous.

Given the lack of adequate data related to neuropsychological test performance within the incredibly diverse Hispanic population, practicing psychologists should be aware of the potential shortcomings of utilizing current assessments with this population. Clinicians and researchers alike are encouraged to think critically about assessment results that may be impacted by an individual’s language or...
Limitations of Neuropsychological Assessment - Continued

or cultural status. Additionally, it is imperative, especially given evidence of a growing Hispanic population in the US, that researchers make efforts to develop means of stratifying individuals based on language proficiency in order to develop useful and effective norms for assessing neuropsychological functioning among this heterogeneous group.

References

Jason A Kacmarski, MA, EdS is obtaining his PhD in Counseling Psychology at the University of Northern Colorado. Contact him at: jason.kacmarski@icloud.com. Kirsten M Allen, MA is obtaining her PsyD in Clinical Psychology at the University of Denver. Contact her at: Kirsten.Allen@du.edu. Lindsey F Colbert, MA is obtaining her PsyD in Clinical Psychology at the University of Denver. Contact her at: Lindsey.Colbert@du.edu.

COPAGS Social

Come end the semester/quarter right with your fellow students and join us for a pint and chat at Echo Brewing.

2:30 on Sunday December 6th
Echo Brewing Company
Frederick Taproom
5969 Iris Parkway Unit C
Frederick, CO 80530
Contact kiersten.eberle@unco.edu if you have any questions.
Research Corner

Traumatic Brain Injury and Traumatic History
Thomas Eddy, BA, Kim Gorgens, PhD, ABPP, Laura Meyer, PhD, Judy Dettmer, MSW, & Neil Gowensmith, PhD

Inmates living with traumatic brain injury (TBI) are an understudied, vulnerable population, and are overrepresented in correctional facilities. TBI has been linked to poor impulse control, aggressive behaviors, deficits in attention span, and higher risks for substance use disorders (Timonen et al., 2002). Symptoms often negatively impact behavior within corrections and contribute to increased recidivism rates (Williams et al., 2010).

The prevalence of TBI within corrections is very high; although rates vary among sites, recent research at the Denver County Jail Mental Health Transition Unit suggests that up to 96% of those inmates have a history of at least one complicated TBI (Gorgens et al., 2015). Despite emerging research on TBI history in corrections, gaps exist in understanding the larger history of these individuals. The current study aims to better understand the population at hand by creating a “snapshot” of the individual living with TBI. We were specifically interested in the prevalence of trauma history and mental health diagnoses in addition to TBI history.

Several entities in Colorado collaborated to investigate the prevalence of TBI history among residents at correctional sites and to design and deliver educational interventions in those settings (Gorgens et al., 2015). Grants were awarded to the Colorado Brain Injury Program by the Colorado Office of Behavioral Health (OBH) and the Health Resources and Services Administration (HRSA) to fund this project.

Participant demographics (n=216) from this data set were analyzed to better understand the population through descriptive and inferential statistics. Participants included individuals with TBI histories affiliated with the following: Denver County Jail Transition Unit, Denver County Jail RISE unit, Boulder County Jail, Larimer County Jail, Adams County Veteran’s Court, Denver District Problem-Solving Court, and Denver Juvenile Probation (Gorgens et al., 2015). Subjects participated in an unstructured clinical interview, the Ohio State University Traumatic Brain Injury Identification Method (OSU-TBI-ID), effort testing (Rey 15-Item Memory Test, Trail Making Test Parts A & B, Test Of Memory Malingering, and/or M-FAST), and completed either the Automated Neuropsychological Assessment Metrics (ANAM) Core Battery or the Neuropsychological Assessment Battery (NAB) Screening Module. We utilized SPSS to view frequencies and distributions of an wide array of nominal data: gender, ethnicity, history of TBI, modality of injury, risk factors (e.g., victim of violence, suicidality), suspensions and/or expulsions in schools, whether or not developmental milestones were met, veteran status, diagnosis of mental illness, psychiatric medication and compliance, and substance abuse.

A total of 209 participants reported a history of at least one TBI; additionally, 43.7% of the subjects were given referrals to the Brain Injury Alliance of Colorado (BIAC). The pool of subjects was comprised of 153 males and 62 females. Of the total population, 46% identified as White, 23% as Hispanic, 18% as Black or African American, and 13% as another race. Modality of injury was also examined, with 75% of participants reporting injury due to motor vehicle accidents, 62% reported a fall injury, 57% reported injuries from multiple blows to the head, and 24% reported exposure to blast. Additionally, 80% reported their injuries required hospitalization. Sixty eight percent of individuals reported being a victim of childhood violence and 67% reported victimization in adulthood, and 40% of this population reported a suicide attempt. Sixty six percent reported school suspension, and approximately 32% of individuals reported they did not meet developmental milestones on time. Fifteen percent reported veteran status.
Research Corner - Continued

In this population, 77% of individuals reported at least one mental health diagnosis; the most common disorders were mood disorders at 50%, followed by anxiety disorders at 34%, and psychotic disorders at 18%. Additionally, 62% of individuals reported taking psychiatric medication, with 33% of inmates using antidepressants, and 9% using antipsychotics. Finally, 96% of the population reported a history of substance abuse/misuse.

From these data, it is apparent that a majority of persons with TBI also have comorbid substance abuse issues and mental health diagnoses. Additionally, these same individuals have higher rates of self-harm and previous suicide attempts compared to base rates of the general population. Base rates for suicidal ideation and attempts in the general population of China are estimated to be 1-5% (Cao et al., 2015). In the current study, that rate is 10 times higher. Their risk for being the victim of interpersonal violence is also higher with 67% of this sample endorsing violence relative to a population base rate of 2% (National Institute of Corrections, U.S. Department of Justice, 2014). All of these risk factors should be taken into consideration when developing and implementing treatment plans for this vulnerable population.

References

Thomas Eddy is second year graduate student studying forensic psychology at the master’s level at the University of Denver, Graduate School of Professional Psychology. He is working closely as a research assistant for Dr. Kim Gorgens, Dr. Laura Meyer, Judy Dettmer, MSW, and Dr. Neil Gowensmith on the traumatic brain injury study mentioned above. Contact him at tomryanreddy@gmail.com.

Welcome New & Returning Members

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- Heidi Arden, PhD
- Samantha S’ Piper, PhD
- Cynthia L Tems, PhD
- Rachel D Wells PhD

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- Bronwyn Lehman
- Charlynn Odahl-Ruan, MA
- Bethany Vibert, MA

**Early Career Psychologist Members**
- Jill A Hersh, PsyD
- Briana M Johannesen, PsyD
- Adam Altschuh, PsyD
- Erin Baurle, PsyD

**Academic Member**
- Jodie Benabe, PsyD

**Out of State Associate**
- David Hickel, PhD
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² Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.
Why I Don’t Care How the Brain Works
Michael Karson, PhD, JD

Everywhere you turn, there’s an article telling you that you turned that way not for any psychological reason, but because your brain told you to. The brain is the new homunculus, that miniature person sitting in your mind, making decisions, pulling levers, and driving the human body. I don’t remember where I left my keys, my brain does. I don’t feel love when my wife comes home, my brain is activated in the same way chocolate activates it. It’s a wonder my brain doesn’t melt my true love down and pour her on strawberries, but I suppose my brain must know the difference. A colleague claims that identifying which areas of the brain are activated by various situations is the new phrenology (Brian Beaumund, private communication, 2015).

A way of framing an experience—biologically, psychoanalytically, developmentally, cognitive-behaviorally—is like a key in which to play a piece of music (Goffman, 1974). A song may sound better in E-flat than in G, or it may better fit a singer’s range in F than in C, but there is no key that is the ultimate or fundamental key. Notwithstanding, many people think there is a fundamental key—usually C because of the way pianos are built. Similarly, almost everyone has some way of framing situations that seems fundamental; indeed, Goffman says that the presence of framing elements that seem to us not to be arbitrary are how we define what is real. Contemporary psychology’s conflation of non-arbitrary with the medical has made the brain seem more real than what people do.

Only this week, after discussing systemic approaches to clinical phenomena, a student asked me for an example. Well, I said, imagine that a woman is depressed because it makes her marriage work better, perhaps because it makes her husband feel competent in comparison to her depressed status. Find another way to make her husband feel competent, and she won’t need to be depressed. The student said, “But will that change the chemistry in her brain?”

We ought to frame events in a way that fosters successful action. As a clinician, I prefer to frame events as caused by occasioning environments, by relationships in other words, and not as caused by the mind or the brain. This works well for me, because I happen to be in the client’s occasioning environment, in a relationship with the client, where I can cause alternative responses, and I am not in the patient’s mind except metaphorically and I am certainly not in the patient’s brain. Even when there’s something wrong with the brain, the import is typically that old reinforcers are no longer effective, or that the person is incapable of old behaviors. A brain injury changes the way the environment works on the person, but it can only cause respondents (like seizures).

An angry dog snarls at me and I back away. Sure, the dog—by virtue of some gene I have or some learning history of mine—creates a certain impression on my retina that activates an area of my brain that produces a release of adrenalin that occasions a flight response. But what good does all that biology do me when my neighbor buys a dog and I don’t want to feel unreasonable fear every time I collect my mail?

To say that I back away because of the retinal-brain-adrenal connection is to make the process inaccessible. The capacity to feel one way or another implies a brain that works in a manner that makes that feeling possible, so there’s no added value in saying the brain does such-and-such when you can just say, I felt thus-and-so. To say that I back away because of the dog is much more promising.

I suppose I could take a pill to calm my flight reaction, but I don’t have to understand how the brain works to know that downers work best when I overreact and uppers work best when I underreact. The problem with a pill, of course, is that the fear is often the burglar alarm and not the burglar, and I might need a flight reaction at some future point that the pill would mute.
Why I Don't Care - Continued

It’s good advice to befriend the dog, to understand what threatens it, and to insist its owner keep it leashed. Wondering about the areas of my brain that it activates is at best an amusing diversion. Of course, if you wanted to give the dog a valium, I wouldn’t mind.

References

Michael Karson’s brain makes him teach clinical and forensic psychology at the University of Denver’s Graduate School of Professional Psychology. His latest book, written with Lavita Nadkarni, is Principles of Forensic Report Writing, published by APA. He can be reached at Michael.Karson@du.edu.

Disaster Response Network (DRN)
Daniel J Mosley, EdD

Twenty-four years ago, APA created the Disaster Response Network (DRN) of licensed, disaster-trained psychologists across the United States to offer onsite mental health services to Red Cross workers and victims of disaster. Today, approximately 2,500 members of DRN engage with APA to help individuals and communities prepare, respond and recover from disaster.

APA is a recognized leader in the disaster mental health field because its members conduct the majority of research, publications, training, and evaluations. Federal agencies and non-profit organizations contact the association for psychologists’ expertise and program resources. APA gains positive visibility nationwide through its Disaster Response Network (name change effective January 1, 2016 to Disaster Resource Network). Its engaged members actively contribute to the association’s mission to benefit society and improve people’s lives.

APA/DRN distributes health and coping information to the public via the Psychology Help Center (APAHelpCenter.org) and through APA Public Education Campaign (See the links below for a sample of articles related to disaster mental health). Psychological research is shared with the American Red Cross, Department of Health and Human Services, FEMA and other governmental and non-governmental agencies to help shape decision-making about mental health and disasters.

The DRN is organized nationally with coordinators in each state, territory, or province. Each state psychological association selects a coordinator who then serves in a leadership role as a committee (DRN) chair. Currently, Daniel J Mosley, EdD serves as the DRN coordinator for Colorado and Heidi Ardern, PhD has been nominated as co-coordinator. The Colorado Crisis Education and Response Network (CoCERN) – led by Curt Drennan, PsyD, Manager, Disaster Behavioral Health Services for the State of Colorado - was established to coordinate disaster mental health response within Colorado among the various response agencies. CPA and the American Red Cross (Colorado chapters) are among the signatories to the CoCERN protocols.

Psychologists who wish to volunteer for disaster preparedness, response, and/or recovery efforts can receive training through CoCERN and/or the American Red Cross.

References
DRN - Continued


Daniel J Mosley, EdD is a licensed psychologist and partner in the Colorado Family Center, PLLC, providing parental responsibilities evaluations and court related services. Dr. Mosley has been an active volunteer in the disaster mental health field since 1995 – through the American Red Cross and the Disaster Response Network. In addition to numerous national and local deployments to disaster response operations, Dr. Mosley is also an instructor with the American Red Cross for the core disaster mental health training: Psychological First Aide and Disaster Mental Health Fundamentals. Contact him at: 303-794-7761 or danjmosley@msn.com.

CPA News

Forensic Task Force: Recent Legislative Updates

Nicole Schneider kitei, PhD

The Forensic Task Force has been hard at work! In April 2013 our task force, in collaboration with the Colorado Psychiatric Society (CPS) successfully changed a law that previously allowed only psychiatrists to conduct first opinion, court ordered not guilty by reason of insanity (NGRI) evaluations despite forensic-specific training and qualifications. Following testimony before the House and Senate by Forensic Task Force members, Governor Hickenlooper signed senate Bill 116 into law, which now allows qualified forensic psychologists to also conduct said NGRI evaluations. While that was a huge success, the task force did not stop there.

Shortly after celebrating that success, we got to work with our highly skilled lobbyist, Jeannie Vanderburg, again in collaboration with CPS to fight for fair and equitable pay for forensic psychologists and psychiatrists who conduct forensic mental health examinations for the courts, public defenders, the Office of Alternate Defense, and district attorneys. Since the 1980s there has been a cap on the hourly rate and number of hours such professionals can bill for their work with these agencies (as noted in the prior version of the Chief Justice Directive or CJD 12-03). It is important to note that the evaluations that come to the attention of forensic psychologists and psychiatrists, especially by the above named agencies, are often highly complex and high profile and can require dozens (in some cases hundreds) of hours to competently complete. The highly publicized cases of James Holmes, Edward Timothy Romero, and Richard Kirk have all come before forensic mental health professionals who are tasked with pouring over thousands of pages of discovery, conducting interviews with collateral sources, and often traveling hundreds of miles to interview a defendant multiple times. When rates and hours are capped, it can and has proven to be a roadblock to accurate and thorough opinions. When less than well-researched opinions are offered to courts, second and third evaluations are often requested, costing the state significantly more money than if the initial (forensically trained) psychologist (or psychiatrist) had been appropriately compensated.
Forensic Task Force - Continued

As a result of the above noted awareness on the part of CPA and CPS and subsequent meetings with each of the above noted organizations, the Chief Justice Directive was amended by the Supreme Court of Colorado this July (2015) to reflect an increase in the hourly rate qualified forensic psychologists and psychiatrists can bill for specific types of evaluations. More specifically, competency to proceed (CTP), not guilty by reason of insanity (NGRI), and mental condition (MC) evaluations, and some other unique and pre-approved cases involving capital charges or complex psychological issues, will be reimbursed at a higher rate this year with an additional increase in hourly pay next year. The goal of this effort is to produce higher quality first evaluations thereby reducing the need for multiple opinions thereafter as well as to equitably reimburse the good, hard work these qualified forensic mental health professionals do. The forensic task force is thrilled to report this change to the antiquated compensation policy and is eager to report back to CPA next year with more legislative successes!

Nicole Schneider Kitei, PhD is a qualified forensic psychologist and president of Colorado Clinical and Forensic Psychology, PC. She has worked on some of our state’s highest profile cases. She is also a confidential consultant to the United States Air Force and a supervisor at the University of Denver’s Professional Psychology Clinic. She received her PhD from the University of Arizona and completed post-doctoral training at Yale University School of Medicine and the University of Massachusetts Medical School’s Law and Psychiatry fellowship program. She would like to acknowledge the contributions and support of Dr. Jane Cleveland, Dr. Neil Gowensmith, and Dr. Tom Gray. She can be contacted at coloradoforensicpsychology@gmail.com.

Interview With a Psychologist

Psychologist: Lynn Paulus, PsyD

Interviewer: Patricia Knox, PsyD

Patricia Knox: Lynn, welcome to Colorado! Tell me about your transition here.

Lynn: I moved to Colorado in August, 2015, after having lived and practiced in New Hampshire for the last 29 years. I was drawn to Colorado, first and foremost, because my daughter and grandbaby are here. Each time I have visited here over the last few years, I have fallen more in love with the beauty of the Colorado landscape and the warmth of the people I’ve met. This is a time in my life in which I have the freedom to start something new and creative. My children are launched, and anything is possible. I wanted to begin this portion of my life in an area of the country that is known for its independent thinkers, open mindedness and spirituality. Although it has only been three months that I’ve been here, it already feels like home to me.

Patricia: Can you tell me about your practice and your specialties?

Lynn: I work with an adult population doing Individual Therapy and Marital & Couples Therapy. I enjoy working with adults in life transition, when the potential for growth is greatest. I was trained in Bowen’s Intergenerational Couple’s Therapy Model while working in Chicago years ago, and also use Family Systems and Attachment Theories to inform my Marital & Couples therapy work. I believe it is essential for couples to appreciate how their family of origin legacies and experiences impacted who they are in their current relationships, and how it impacts their expectations of their partners.

I have developed a specialty in Post-traumatic Stress Disorder, having worked as a researcher for 16 years with the VA studying the psychophysiology of PTSD. In addition to working with combat veterans, I have worked with people who have a history of sexual trauma and child abuse.
Interview With a Psychologist - Continued

I was also trained in Mindfulness-Based Stress Reduction (MBSR) at The Center for Mindfulness, U Mass. Medical Center, Worcester, Massachusetts, and in Mindfulness Psychotherapy. My own yoga and meditation practices, along with MBSR training, allow me to help people manage their stress more effectively so that they can settle themselves and live more mindfully and meaningfully. For example, in New Hampshire I specialized in working with many higher level executives who were at the top of their careers, but felt dissatisfied with their lives, realizing that success did not bring them happiness and fulfillment. Their marriages and their relationships with their children were suffering, and they felt alienated and disconnected. Mindfulness Psychotherapy is very helpful in bringing people back to themselves and learning to live more fully in each moment.

Although I was traditionally trained as a psychodynamic clinician, I do not view clients’ problems through a lens of psychopathology. Rather, I want to understand how my clients are suffering over events in their lives and what they have done to try to overcome them. My belief is that my job as a therapist is to ease suffering, help clients see what is possible instead of what is not, and to promote connection to one’s self, one’s family, friends and community. Connection, as opposed to disconnection, is curative and healing. These ideas are central to my own life and to my work (Carl Jung’s Collective Unconscious). I believe we all have the potential to be great in our own right and psychotherapy can bring people back to that awareness. I also believe in alternative therapies and refer to an Integrative Energy Therapist for non-verbal body memory work. It has proved to be a great supplement to traditional therapy.

Patricia: Lynn, since you’re moved here I’ve had the good fortune of getting to know you. I am struck by your sense of joy and balance. What do you think has most contributed to that?

Lynn: Meditation, yoga and being out in nature keep me grounded. I keep aware of the millions of reasons there are to be grateful in life, even at terrible moments. I try to live with an open heart as much as possible.

Patricia: Where are you practicing?

Lynn: I have offices in Golden at 17301 West Colfax, Building 200, Suite 200 and in Denver at 4500 E. 9th Ave., Suite 660-S. Phone numbers 603-325-0404; email:lynnpaulus26@gmail.com; Website: http://www.drlynnppaulus.com

Dr. Patricia Knox received her doctorate from the University of Northern Colorado and completed her internship at Duke University. She has been in private practice in Denver since 1985, working with individuals. She has a general practice with a specialty in the treatment of PTSD. For more information about her practice please visit http://www.patriciaknox.com.
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