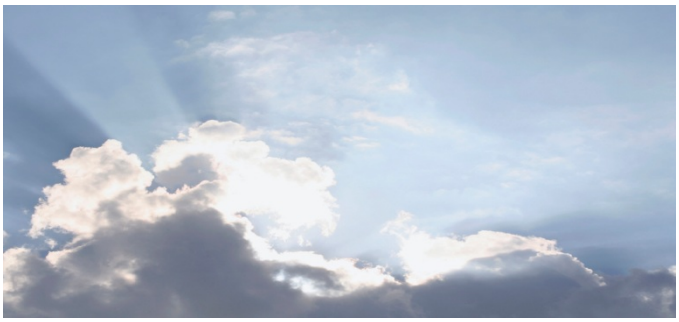
2014 Winter Newsletter

The President's Message

By Howard Friedman, Ph.D., ABPP



IN THIS ISSUE

Due to our newsletter deadlines, I am writing this largely before a number of holiday events will take place – I am looking forward to our annual holiday party, and hoping I will have seen many of you there by the time you read this.

I certainly want to thank Andy Pojman, John Rochios and Connie Concannon for their gracious hosting of our party at their Walnut Creek offices. It's always been a nice location for us and they're always great hosts. We should also give a round of applause to Alissa Scanlin for the tremendous work she's done in pulling this party together, following her efforts in organizing our programs.

I want to express my appreciation to Hengameh Maroufi for organizing the speakers for our October meeting with Dr. Gubkin and Dr. Norton on "Diversity and Acculturative Stress." It was particularly helpful in exploring issues related to the African American and Hispanic populations. This was one of our most well received presentations in my recent memory, with much interaction between the speakers and the audience. My only regret is that each presenter spoke so briefly, each having a wealth of information to share.

We're looking forward to another exciting presentation at the January 31 Annual Meeting with Dr. Mark Kamena, PhD, and colleagues on "The Impact of Critical Incidents and Natural Disasters on First Responders, Familes, and the Community." At that time, Dr. Kamena will be the past president of CPA. He'll be discussing dealing with responses to traumatic situations. This topic evolved out of our concern about what has happened with accelerating violence in our

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communities. In particular, the Board discussed what we could do following the shootings in Newton, Connecticut. We thought that as a community of psychologists, we should be apprised of how we can support people in trauma following these kinds of all too common tragic events.

This presentation is important, as work with first responders involves their unique subculture. Assessment involves using clinical interviews combined with other instruments such as the Detailed Assessment of Posttraumatic Stress (DAPS), Symptom Checklist (SCL-90-R), and the Trauma Symptom Inventory (TSI-2). Dr. Kamena will discuss the results of a new instrument that is being validated and has been normed on over 500 first responders. He will also discuss how psychologists can assist in critical incidents and natural disasters.

Dr. Kamena is board certified in police and public service psychology and is an oral examiner for candidates for board certification. He is a lead clinician for the West Coast Posttrauma Retreat and a treatment program for significant partners of first responders (SOS), the Director of Research, and a co-founder of the First Responders Support Network. He is a co-author of *Counseling Cops: What Clinicians Need to Know* (2013, Guilford Press). His private practice in Marin County specializes in first responder posttraumatic stress injury. Dr. Kamena was the 2013 President of the California Psychological Association and rotates to immediate past-president this year, retaining his position on the Executive Committee.

Another future program in the planning stages relates to how we can care for ourselves in the face of stressors we experience, whether we are in our early or later career phases.

I wish all of you a wonderful New Year, and I expect that we will have additional excellent programs throughout the year with good social opportunities as well. ◊

C.A.R.E.

Colleague Awareness Resources and Education

By Beth Feree, Ph.D.

Dear CCPA Members,

I am starting my second year as what was CLASP and is now CARE Chair for CCPA. CPA recently changed the name from CLASP to CARE (Colleague Awareness Resources and Education) in an effort to make it more relevant to all psychologists, recognizing that there are challenges particular to our field that can impact our own emotional well-being. On April 1 at our dinner meeting, Dr. Pearl Werfel (CPA CARE Chair) and two colleagues will present a discussion entitled, “Seeking A New Definition of Self Care.” The introduction to their presentation states, "It is estimated that 60% of psychologists have experienced psychological distress significant enough to affect their work. However, wellness and self-care that could ameliorate this are often presented as one-size-fits-all prescriptions of healthy eating, meditation and exercise. We don’t disagree with the value of these methods but posit that such prescriptions are incomplete and may be alienating. Self-care methods need to incorporate multiple facets related to the identity, culture, age, ability and situation of the mental health professional. In addition, personally relevant self-care necessitates a flexible definition of

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success." They will be doing the same presentation at CPA's annual convention in Monterrey two weeks later so we get an early preview of an issue they have been working on at the state level for over a year.

To start your thinking about the more traditional approach to psychologist self-care, we are including an article written by Barbara Peterson, PhD almost 2 years ago when she was CLASP Chair for CCPA. As another part of self-care, I encourage all of you to attend our annual meeting on Friday January 31 at The Lafayette Library and Outdoor Learning Center from noon to 4pm. It is an opportunity to visit with colleagues, get an update on issues affecting local psychologists, eat a tasty lunch, and get 3 CE units. Dr. Mark Kamena, immediate Past President of CPA, will be presenting on "Disaster Response and Psychologists Roles." The cost is $100 for lunch and CE program and you can register on our website, cocopsych.org.

Please let me know if there are ways I can support you in our wonderful but often challenging profession.

Beth Ferree, Ph.D.
bethferree@comcast.net ◊

Colleague Assistance Program
(CLASP, now CARE): Professional Self-Care

By Barbara Peterson, Ph.D., Past CLASP Co-Chair (now CARE)

Published first in the CCPA Newsletter in 2012

Colleague Assistance Program (CLASP, now CARE): Professional Self-Care
By Barbara Peterson, Ph.D.
Past CLASP Co-Chair (now CARE)

My (now past) CLASP Co-Chair, Ellin Sadur, Psy.D. and I led a discussion at the meeting of the Early Career Psychologists last week on the topic of "Professional Self-Care". We were delighted to know that concepts such as "compassion fatigue", "vicarious trauma", and "burnout" are routinely addressed in graduate and clinical training programs. The field of psychology has come a long way in recognizing that the healers must take care of themselves if they are going to successfully continue to care for others. Though there have been articles in this newsletter and other publications in recent years on this topic, I thought a brief outline of the general principles of self-care might be a useful reminder for all of us.
The APA Board of Professional Affairs' Advisory Committee on Colleague Assistance
(ACCA) recently published a summary of recommendations on self-care. The first paragraph presents a critical shift in attitude toward stress among psychologists:

"Because of the nature of the work, every psychologist is at risk for occupational stress. Over the course of time, the interaction between events in the personal and professional life of a psychologist is certain to create stress, likely distress, and possibly impairment. This vulnerability to stress is not a reflection of pathology in the psychologist, but a reality of the challenge of our work."

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What are some indications that you are experiencing occupational stress? ACCA suggests the following:

Loss of pleasure in work
Depression (Sleep or appetite disturbance, lethargy, negative mood)
Inability to focus or concentrate; forgetfulness
Anxiety
Substance use/abuse or other compulsive behaviors to manage stress
More frequent clinical errors
Less contact with colleagues
Workaholism
Persistent thoughts about clients and their clinical material
Intrusive imagery from clients' traumatic material
Increased cynicism, over-generalized negative beliefs
Increased isolation from or conflict with intimates
Chronic irritability, impatience
Increased reactivity and loss of objectivity and perspective in work
Suicidal thoughts" (ACCA, 2000)

How can we protect ourselves from Occupational Stress?
First and foremost, make self-care a priority! Recognize that using ourselves as a therapeutic tool requires that we keep ourselves in the best physical and psychological shape as possible. Much like professional athletes care for their bodies year-round, so too must psychologists care for their psychological health and well being on an ongoing basis.
We do it with our clients; we can do it for ourselves. Here are a few tried and true strategies (thanks to the ECP Group for their input!):

--Make and maintain professional connections. This includes formal and informal consultative relationships. The key is to have relationships that are conducive to openly discussing the unique features of our work.
--Use formal consultation for specific ethical and clinical dilemmas. This can be an ongoing consultation group, or periodic use of resources available through local, state and national organizations, such as CPA's ethics hotline, or APAIT's legal consultation services.
--Balance caseloads: try to balance work with more challenging, complex populations with those that are less demanding. This helps to limit vulnerability to vicarious traumatization and compassion fatigue. Recognize when you are beginning to feel overly taxed, and take steps to improve the balance in your workload.
--Work to maintain work/life balance: pursue opportunities to attend to your emotional and spiritual well being regularly
--Identify multiple layers of sources of support. The concept of a "professional buddy" is quite useful. This is someone you can pick up the phone and call for a short "debrief" or "check-in" and who can do the same for you. Have several of them!
--Take care of your body: Get enough sleep, watch your nutrition, get some exercise, relax, and meditate
-- Take regular vacations. (my personal favorite)

CCPA offers many opportunities to increase connections with colleagues from our CE meetings, to social gatherings, to the Networking and Early Career groups. Want to learn more about professional self-care? Check out the CPA CLASP

(CARE) materials on the website: (you do not have to be a CPA member to access this material).
http://www.cpapsych.org/displaycommon.cfm?an=1&subarticlenbr=112
APA also has information. There are references, self-care tips, self-assessments, and articles about burnout, compassion fatigue, and vicarious trauma.
http://www.apapracticecentral.org/ce/self-care/index.aspx
http://www.apapracticecentral.org/ce/self-care/trauma-clients.aspx
References:
Board of Professional Affairs' Advisory Committee on Colleague Assistance. (2000) Professional Health and Well-being for Psychologists. Web Page ◊

Sublet in Walnut Creek

I am interested in subletting my office on Wednesdays. It is a lovely large office large enough to accommodate a small group.

33 Quail Court in Walnut Creek.

Please contact Nurit Mussen, Ph.D.

925-926-0535

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Progress Notes

January 2014

Updated CMS 1500 Claim Form Version 02/12, to be Accepted By Anthem Blue Cross Beginning January 6, 2014

In June 2013, the National Uniform Claim Committee (NUBC) announced the approval of an updated 1500 Claim Form (version 02/12) that accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3. Anthem Blue Cross will begin accepting the updated 1500 Claim Form version 02/12 starting on January 6, 2014. Please follow the guidelines set forth by the NUCC for completing the new claim form, or your claim may be rejected. For more information about the revised 1500 Claim Form, please visit the National Uniform Claim Committee website, which provides helpful resources such as a list of changes between the 08/05 and 02/12 claim versions and the 1500 Instruction Manual. Please note that the NUCC's transition timeline for use of the 1500 Claim Form version 08/05 includes a dual submission period from January 6, 2014 - March 31, 2014. Effective April 1, 2014, paper claims should be submitted using only the revised 1500 Claim Form version 02/12.

Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care

Tara F. Bishop, MD, MPH[1,2]; Matthew J. Press, MD, MSc[1,2]; Salomeh Keyhani, MD, MPH[3]; Harold Alan Pincus, MD[4]

JAMA Psychiatry. Published online December 11, 2013. doi:10.1001/jamapsychiatry.2013.2862

Importance There have been recent calls for increased access to mental health services, but access may be limited owing to psychiatrist refusal to accept insurance.

Objective To describe recent trends in acceptance of insurance by psychiatrists compared with physicians in other specialties. Design, Setting, and Participants We used data from a national survey of office-based physicians in the United States to calculate rates of acceptance of private noncapitated insurance, Medicare, and Medicaid by psychiatrists vs physicians in other specialties and to compare characteristics of psychiatrists who accepted insurance and those who did not.

Main Outcomes and Measures Our main outcome variables were physician acceptance of new patients with private noncapitated insurance, Medicare, or Medicaid. Our main independent variables were physician specialty and year groupings (2005-2006, 2007-2008, and 2009-2010).

Results The percentage of psychiatrists who accepted private noncapitated insurance in 2009-2010 was significantly lower than the percentage of physicians in other specialties (55.3% [95% CI, 46.7%-63.8%] vs 88.7% [86.4%-90.7%]; P < .001) and had declined by 17.0% since 2005-2006. Similarly, the percentage of psychiatrists who accepted Medicare in 2009-2010 was significantly lower than that for other physicians (54.8% [95% CI, 46.6%-62.7%] vs 86.1% [84.4%-87.7%]; P < .001) and had declined by 19.5% since 2005-2006. Psychiatrists' Medicaid acceptance rates in 2009-2010 were also lower than those for other physicians (43.1% [95% CI, 34.9%-51.7%] vs 73.0% [70.3%-75.5%]; P < .001) but had not declined significantly from 2005-2006. Psychiatrists in the Midwest were more likely to accept private noncapitated insurance (85.1%) than those in the Northeast (48.5%), South (43.0%), or West (57.8%) (P = .02).

Conclusions and Relevance Acceptance rates for all types of insurance were significantly lower for psychiatrists than for physicians in other specialties. These low rates of acceptance may pose a barrier to access to mental health services.

Commonly Used Depression Questionnaire Can Help Identify Suicide Risk
The American Psychiatric Association issued the following news release:
Release No. 13-73 Provided courtesy of Dr. Ken Pope

Patients who reported frequent thoughts of death or self-harm as part of a standard questionnaire used in depression treatment were at increased risk of subsequent suicide attempt and suicide death. Researchers found that a response to a single question on the Patient Health Questionnaire (PHQ- 9) predicted increased risk of a later suicide attempt or death over a period of several months. The research is presented in the December issue of Psychiatric Services, a journal of the American Psychiatric Association.

Suicide accounts for some 38,000 deaths each year and there are some 600,000 non-fatal suicide attempts each year resulting in emergency department visits. Because there is no evidence to date that any screening test accurately identifies people in the general population who are at risk of suicide, the U.S. Preventive Services Task Force and others do not recommend such screening.

A research team from Seattle's Group Health Cooperative (GHC), a large integrated health system, conducted the study. Since 2006, all GHC primary care and mental health providers have been advised to administer the PHQ-9 at every visit for depression treatment and clinicians frequently encounter patients who report suicidal ideation on these routinely administered questionnaires. Item 9 of the PHQ-9 asks "Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?" Response options include, "not at all," "several days," "more than half the days," or "nearly every day." While the PHQ-9 was designed to measure depression severity not identify risk of suicidal behavior, the researchers were seeking to "provide practical guidance regarding a measure that is widely and increasingly used in everyday practice."

The research team used electronic medical records, insurance claims, and death certificate data to document what happened to more than 84,000 outpatients age 13 and older who completed the PHQ-9 at every visit for

depression between 2007 and 2011. They found that the cumulative risk of suicide attempt over one year was 0.4% among outpatients reporting thoughts of death or self-harm "not at all" compared to 4% among those reporting thoughts of death or self-harm "nearly every day."

After adjustment for age, sex, treatment history, and overall depression severity, responses to item 9 of the PHQ-9 remained a strong predictor of suicide attempt and a moderate predictor of subsequent suicide death. Even though the age and sex patterns were very different for suicide attempts and deaths, response to PHQ item 9 predicted both. The authors, led by Gregory E. Simon, MD, MPH, note that the immediate risk of suicide attempt was low but increased over several days and continued to grow for several months, indicating a need for sustained and organized follow-up care to address ongoing risk. "Suicidal ideation should be viewed as an enduring vulnerability rather than simply a short-term crisis," the authors concluded.

Mental Health Parity Rule Clarifies Standards for Treatment Limits, Coverage of Intermediate Care

By Michelle Andrews
From kaiserhealthnews.org

The Mental Health Parity and Addiction Equity Act of 2008 required health plans that offer mental health and substance use disorder benefits to cover them to the same extent that they cover medical/ surgical benefits. Among other things, it prohibits having treatment limits or financial coverage requirements such as copayments or deductibles that are more restrictive than a plan's medical coverage. Interim regulations issued in 2010 clarified some issues about implementing the law. The final rules, issued last month by federal officials, spell out more specifics. I spoke with Jennifer Mathis, director of programs at the Judge David L. Bazelon Center for Mental Health Law in Washington, about the parity law and the new regulations. This transcript was condensed and edited for clarity.

Q. What issues does this final mental health parity rule address that will be important to consumers?

A. The rule offers a number of clarifications about the parity law. Some of these clarifications concern how parity requirements relate to the Affordable Care Act, and others relate to issues that were not addressed in the interim rule.

Plans don't have to cover mental health benefits, but if they do, they generally have to cover inpatient and outpatient services, emergency care and prescription drugs. This final rule says that within a category, such as outpatient care, plans can treat preferred providers differently than non-preferred providers. So it might mean a consumer could have higher copays for non-preferred providers in their insurer's network for mental health outpatient services than for preferred providers, for example.

The regulation also said that services some would label as intermediate-level mental health services, including residential treatment and intensive outpatient services, are within the scope of the parity law. The regulations say they should be covered at parity. That hadn't been clear in the interim rules.

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Q. The parity law doesn't allow quantitative differences in coverage, such as fewer office visits or higher copayments for mental health services. But what about other limits that may be harder to measure?

A. The rule provides some clarification on that. These are things like requiring plan members to get prior authorization before receiving services and setting up protocols to determine whether treatment is medically necessary. What the final rules say is that plans must use the same type of processes to determine what is medically necessary or to require prior authorization for both mental health and medical services. If they have a rigorous process for justifying prior authorization for medical services they must have a similarly rigorous process for mental health services prior authorization as well.

Q. What does it clarify about mental health coverage and the Affordable Care Act?

A. The ACA says plans can't have annual or lifetime dollar limits on the 10 essential health benefits, one of which is mental health and substance use disorder treatment. Normally, under parity you can have those dollar limits as long as they're at parity with medical service limits. This rule clarifies that the ACA trumps parity in this regard.

Q. Who's affected by this rule, and by parity more broadly?

A. People who get counseling, psychotherapy, prescription drugs are likely to see the biggest benefit from these rules because those are the services that commercial health plans usually cover. And they already have benefited since the law passed in 2008. This is not a brand new set of rules, this is an update of the rules that already apply. They have benefited and will continue to benefit.

And people on the exchanges who previously had no insurance or bad insurance not only will be able to get insurance now but also insurance with mental health parity.

The ACA also applies parity requirements to insurance plans in the states that adopt the new Medicaid expansion for adults with incomes up to 138 percent of the federal poverty level ($15,856 for an individual in 2013). These regulations do not apply to those plans, but the government says that it will be issuing further guidance about how parity applies to those plans. Parity is likely to be a very important requirement in those plans, which in many cases will cover more mental health services than are typically covered by commercial insurance plans, including services that are used by people with significant psychiatric disabilities. Thus a wider variety of services, used by a wider group of people with mental health needs, will be subject to parity requirements.

Q. What types of health plans are covered by the rule?

A. It generally applies to both fully insured and self-funded large group plans as well as individual and small group plans sold on and off the health insurance exchanges.

Q. What if states have mandated mental health benefits of their own?

A. State parity laws that are more stringent than federal parity laws are not pre-empted. For example, some states' parity laws require coverage of particular services or benefits on top of the federal requirements. Some states require autism coverage, for example.

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Q. What about providers that don't accept insurance. Does the parity law or this rule affect them?
A. No. That is an issue, certainly for psychiatric services. That's becoming an increasing concern.

Q. Since the mental health parity law passed, is there any evidence that companies have dropped mental health benefits from their plans so as not to have to comply?
A. According to these regulations, a 2010 study sponsored by the department of Health and Human Services found that, since the 2010 parity regulations came out, only a small percentage of plans have dropped mental health or substance use coverage.

Verifying your patients' eligibility and benefits in 2014 may save your practice some money
The beginning of a new year means calendar year deductibles and visit frequency limitations start over. Remember, with open enrollment there may be changes to patients' benefit plans, or they may even be insured through a new payor. Practitioners are urged at this time of the year to be diligent in verifying patients' eligibility and benefits to ensure that you will be paid for services rendered.

2014 also brings a host of other challenges that could affect your ability to be paid:

- Medicare patients can modify their enrollment choices from October 15 through December 7, allowing them to switch between Medicare fee-for-service and Medicare Advantage (MA), or switch from one MA plan to another.
- Under the Affordable Care Act (ACA), California opted to expand Medi-Cal eligibility to childless adults ages 19-64 with incomes up to 138 percent of federal poverty level, effective January 1, 2014. The state estimates an additional 1.6 million individuals may become eligible for Medi-Cal/Medi-Cal managed care under the ACA expansion.
- In 2013, over 900,000 children transitioned out of the Healthy Families program into Medi-Cal managed care, while another 274,000 transitioned from fee-for-service Medi-Cal into Medi-Cal managed care through the rural expansion project. Many of these enrollees transitioned toward the end of 2013.
- With the ACA requirements on minimum benefit levels that must be offered by plans, approximately 900,000 individuals have received policy cancellation notices from their current health plans. Many of those patients will have different plans and/or benefits effective January 1, 2014.
- Approximately 600,000 patients previous insured through the Low Income Health Program will be transitioned in to Medi-Cal managed care plans on January 1, 2014.
- It is estimated that anywhere from 150,000 to 450,000 individuals will enroll in an exchange plan through Covered California in 2014.

And don't forget that under the ACA, patients receiving premium assistance through federal tax subsidies are given a 90-day grace period in which to pay their portion of the premium. During the first 30 days of the grace period, the plans must pay for services incurred. However, during days 31-90 of the grace period, plans are allowed to suspend the patient's coverage. If the patient doesn't true-up by day 90, the plan can terminate the

policy, potentially leaving 60 days worth of unpaid claims. While practitioners can pursue the patient for the balance incurred during days 31-90 of the grace period, it seems unlikely a patient would be able to pay a doctor's bill if unable to pay for the plan premium.

This reinforces the importance of verifying patient eligibility–particularly for exchange patients—each time they are seen. If the exchange patient's eligibility verification states coverage is suspended, the practice can treat the situation as it would any other patient who has had a lapse in coverage. For nonemergency services, patients would have the option to either pay cash to see the practitioner or not be seen. The grace period issue only applies to exchange enrollees receiving federal tax subsidies; however, information on whether or not they are receiving subsidies will not be noted on their ID cards.

Don't get stuck with unnecessary denials or an upset patient. Do your homework before the patient arrives by obtaining updated insurance information at the time of scheduling, if possible, and making copies of the insurance card at the time of the visit.

Taking proactive steps to protect your practice by preventing denials, delays in payment and disgruntled patients goes a long way toward ultimately saving time and money. ◊

Letter from the Editor

The CCPA newsletter is a forum for sharing information. I invite submissions about 1) groups that you offer, 2) reviews of workshops you have attended or book that you have found useful or 3) a variety of other topics relevant to the community. Occasionally, I include an interview with a CCPA member, so if you would like to respond to a list of questions about yourself and your practice, please contact me. It is a great way to be better known within the organization.

Please consider contributing to future newsletters. The following dates are deadlines by which I must have your submission. Thank you in advance!

April 15, 2014 - Spring edition
July 15, 2014 - Summer edition
October 15, 2014 - Fall edition

The following prices are in effect for advertisements:
¼ Page Ad $30 ½ Page Ad $60 ¾ Page Ad $100

Note: Advertisements for office space are free to CCPA members.
All professional advertisements are free on the listserv for CCPA members.

Email submissions by the deadline to sarahewoodphd@hush.com ◊

CONTRA COSTA PSYCHOLOGICAL ASSOCIATION

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Calendar of Events

Mark Your Calendars!

Annual CCPA Meeting
The Impact of Critical Incidents and Natural Disasters on First Responders, Families, and the Community

Date: January 31, 2014
Time: 12:00 –1:00 pm Annual Business Meeting and Lunch
1:00 – 4:00 pm Presentation
Place: Lafayette Library and Learning Center
3491 Mt. Diablo Blvd., Lafayette
Presenter: Mark Kamena, Ph.D.

Seeking a New Definition of Self Care

Date: April 1, 2014
Time: 6 – 6:45 pm Social hour
6:45 – 8:45 pm Presentation
Place: TBA
Presenters: Dr. Perle Werfel, Dr. Janie Pinterits, and Dr. Camerin Ross

Professional Networking Group

Date: 3rd Friday of every month (see listserv for specific dates)
Time: Noon
Place: Office of Dr. Goldberg0Boltz, 2930 Camino Diablo, #305, Walnut Creek
Contact: Dr. Goldberg-Boltz (925) 788-7888

Early Career Group

Date: 2nd Friday of every month
Time: 5 – 6 or 6:30 pm
Place: ATC, 61 Moraga Way #6, Orinda
Contact: Dr. Nicole Sucre (415) 999-3294

RSVP to: Dr. Alissa Scanlin 3468 Mt Diablo Blvd, Ste. B203, Lafayette, CA 94549 PHONE: (925) 283-3902
EMAIL: drscanlin@pacbell.net Include your Name, Address, License#, Phone and Email
(All event locations are wheelchair accessible. Please let me know if you need any special accommodations.)

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List of Groups

A Healthy Divorce/Separation Group

Meeting Day:	Monday's
Meeting Time:	7:00 – 8:30 pm
Group Leader:	Shendl Tuchman, Psy.D.
Contact Number:	510-201-3435
Email:	dr.tuchman@earthlink.net

Breakthrough Weight Loss and Maintenance Group

Meeting Day:	Thursday's
Meeting Time:	6:00 - 7:30 pm
Group Leader:	Candia Smith, DMH
Contact Number:	(925) 254-7823
Email:	candia.smith@comcast.net

Introduction to Meditation for Stress Reduction Group

Meeting Day:	1st and 3rd Tuesday of each month
Meeting Time:	6:00 -7:00 pm
Cost:	Free, small donation asked for rent
Group Leader:	Candia Smith, DMH
Contact Number:	(925) 254-7823
Email:	candia.smith@comcast.net

Men's Group

Meeting Day:	Monday's
Meeting Time:	7:30 -9:00 pm
Group Leader:	Bruce H. Feingold, Ph.D.
Contact Number:	(925) 945-1315

Men's Group

Meeting Day:	Wednesday's
Meeting Time:	6:00-7:30 pm
Group Leader:	Bruce H. Feingold, Ph.D.
Contact Number:	(925) 945-1315

Mindfulness-Based Stress Reduction Class

Group Leader:	Susan O'Grady, Ph.D.
Contact Number:	925-938-6786
Website:	www.ogradywellbeing.com

Dialectical Behavior Therapy Group (ages 19+)

Meeting Day:	Tuesday's
Meeting Time:	5:30-7 pm
	And
Meeting Day:	Wednesday's
Meeting Time:	9:30 – 11 am
Group Leaders:	Elizabeth Rauch Leftik, Psy.D.
	(925) 314-6354
	Sarah E. Wood, Ph.D.
	(925) 680-1844
Website:	www.mtdiablopsychologicalservices.com

Interpersonal Psychotherapy Group: Co-ed

Meeting Day:	Wednesday's
Meeting Time:	5:00-6:30 pm
Leader:	Ann Steiner, Ph.D., MFT, CGP
Contact Number:	925-962-0060
Website:	www.DrSteiner.com

Chronic Medical Illness Group

Meeting Day:	Wednesday's
Meeting Time:	12:30 - 2:00 pm
Group Leader:	Ann Steiner, Ph.D., MFT, CGP
Contact Number:	925-962-0060
Website:	www.DrSteiner.com

Psychotherapy Group for Psychotherapists

Meeting Day:	Thursday's
Meeting Time:	12:30 - 2:00 pm
Leader:	Ann Steiner, Ph.D., MFT, CGP
Contact Number:	925-962-0060
Website:	www.DrSteiner.com

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List of Groups (cont'd)

Psychotherapy Group for Pre-Licensed and Early Career Therapists

Meeting Day: Thursday's
Meeting Time: 9:00 - 10:30 am
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com
Website: www.PsychotherapyTools.com

DBT Skills Group for Adults in Orinda

Meeting Day: Friday's
Meeting Time: 3:00 – 4:30 pm
Location: Orinda
Group Leader: Amanda Gale, Ph.D. and Katherine Schulz, LCSW
Contact Number: Dr. Gale at (415) 295-1549 or Katherine at (925) 465-7474
Email: AmandaGaleSF@gmail.com or therapy@katherineschulz.com

DBT Skills Group for Parents and Teens in Lafayette

Meeting Day: Wednesday's
Meeting Time: 4:30 - 6:00 pm
Location: Lafayette
Group Leader: Patricia E. Zurita Ona, Psy.D.
Contact Number: 619-578-3974
Website: www.eastbaybehaviortherapycenter.com

Grief Integration Group for Parents Who Have Lost a Child (child of any age)

Meeting Day: Tuesday's
Meeting Dates: Eight weekly sessions starting on February 4th and ending on March 25th.
Meeting Time: 6:15 - 7:45 pm
Group Leader: Nurit Mussen, Ph.D.
Contact Number: 925-926-0535
Email: n.mussen@gmail.com
Website: www.nuritmussen.com
Fees: $45 per session
Location: 33 Quail Court, Suite 200 Walnut Creek, CA 94596

Anger: "Becoming Curious Instead of Furious"

Meeting Day: Monday's
Meeting Time: 5:30 - 7:00 pm
Location: Lafayette
Group Leader: Patricia E. Zurita Ona, Psy.D.
Contact Number: 619-578-3974
Website: www.eastbaybehaviortherapycenter.com

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2014 Board of Directors & Committee Chairs

Contra Costa County Psychological Association

President:
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