

The Colorado Psychologist

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**March 2010
Special Issue On
Child Custody Determination**

**Colorado Psychological
Association**

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About This Issue



We were pleased to be asked to put together another edition of The Colorado Psychologist with a focus on child custody issues. There is never a problem in finding interesting material in this area of practice; the problem is one of deciding what to select. In this issue you will find articles related to some of the more complicated issues that are often subsumed within a custody dispute. We also thought it would be helpful to provide some information for early career psychologists and others who are considering expanding their areas of practice. Dr. Dan Mosley (guest editor) gives some insight on the role of the Child and Family Investigator (CFI) and what two Colorado Domestic Court judges are looking for from that work.

Dr. Bill Fyfe's article on standards for custody evaluators addresses some of those concerns including the question of the scientific basis for custody evaluations. Dr. Julie Van Heyningen reports on one of the frequently associated issues with custody resolution, complaints of domestic violence. She also offers us a summary of the November 2009 conference "Domestic Violence Assessment and Parental Responsibility: Using the Latest Research in Parenting Plans and Complex Cases" with well known researchers Janet R. Johnson, PhD and Loretta M. Frederick, JD, as well as a summary of the current research in this area. Dr. Kevin Albert discusses abduction as another potential issue to be investigated in the context of a custody evaluation. In this issue Dr. Albert offers a systematic approach to assessing for the potential of child kidnapping in the context of custody disputes. There is some question whether we have sufficient scientific basis to investigate these difficult issues and then make recommendations for children in those families.

Although we are guided by statute in how to conduct a custody evaluation or a Child and Family Investigation, there are continuing efforts to come up with creative ways to help families and children in divorce. Most of us know about alternative dispute resolution and the TCP issue in March 2009 offered some thoughts on alternatives to the usual evaluation process. Drs. Deborah and Robert Silver described a test run of a mediation strategy with several mediation couples. This is an extension of their "SIEVE" model of 10 stages of intervention. This time Nan Burnett, MA, has also written an intriguing piece looking at specific strategies within the mediation process.

We are fortunate in the Denver area to have many resources to assist the mental health professional entering this arena of practice. The Association of Family and Conciliation Courts (AFCC) has chosen Denver as the host city for their 2010 annual convention, early registration deadline is 3/12/2010—see specifics later in this issue.

Some other topics of interest will appear, one on the disparity of parity by Ivan Miller, PhD, from Boulder, CO in his article Disparity 2.0. The other is from our History Corner with a former chief psychologist at Denver Health and Hospitals. Dr. Pat DeLeon again refreshes us in two articles with the details of the national scene. Finally, Dr. Martha Pearce invites us to join the DRN (Disaster Response Network) and attend the next Red Cross Foundations of Disaster Mental Health training at ARC headquarters, 444 Sherman St. in Denver. To follow up contact: Dan Mosley EdD at Danjmosley@msn.com or J Benedict, PhD at JGBENEDICT@aol.com.

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So, You Want to be a Child and Family Investigator (CFI)?

By Daniel Mosley, EdD



A psychologist entering this area must have additional preparation beyond what most graduate programs provide.

Judge Russell suggests enlisting the help of a mentor who has already been in the field.

CFI was first the acronym for Colorado Fuel and Iron, as one of our esteemed colleagues who grew up in the Pueblo area has pointed out; but the Colorado legislature decided on the name Child and Family Investigator for the role previously referred to as Special Advocate (SA) and we have all adjusted to being called CFIs.

The statute under which a mental health professional or an attorney is appointed as a CFI is C.R.S. §14-10-116.5(1). One must be familiar with this statute and other custody related statutes to function in this role. Additional standards of practice for the CFI are offered by the Colorado Supreme Court in Supreme Justice Directive 04-08. Attorneys are much more familiar with the statutes and regulations related to custody matters than are most mental health practitioners, but you must know what you are doing according to the relevant statutes in CFI work or you will crash and burn on your first case. CFI work is not therapy work.

I was privileged to interview two District Court Judges for their words of wisdom on what it takes to be a CFI. The Honorable Robert Russell II was initially appointed as an Arapahoe County District Court Magistrate in 1985. He was appointed District Judge for Arapahoe County District Court in 1998. He now presides over Division 14 in Arapahoe County District Court. The Honorable Angela R. Arkin was initially appointed as an Arapahoe County District Court Magistrate in 2000. She was appointed District Judge for Douglas County District Court in 2002. She now presides over Division 4 in Douglas County District Court. Both Judge Russell and Judge Arkin have been very involved in the evolution of "custody" evaluation work within domestic relations cases in Colorado. They are frequent presenters and participants in annual Family Law Institute and Metropolitan Denver Interdisciplinary Committee activities. The collaboration that exists today between the family law community and the mental health community is much indebted to their efforts.

A psychologist or other mental health professional who considers entering this arena of practice must have additional preparation beyond what most graduate programs or post-doctoral programs offer. Specializations in forensics, family systems, child development, or divorce adjustment will each be very useful, but applying this knowledge to the real world of the legal system requires additional experience. Judge Russell suggested that a person wishing to add this area of practice should consider enlisting the help of a mentor who has already been in the field. It is also essential that the on-going training available through AFCC, Family Law Institute, and MDIC, be part of a prospective CFI's education. Drs. Les Katz and Andrew Loizeaux also offer a CFI preparation program that can be very valuable. Besides the training that is available through various organizations, these meetings and conferences provide the opportunity for connections with the law firms, judicial officers, and other mental health practitioners who will form your referral base.

The court values hearing what the CFI saw during the investigation of the family. A psychological understanding of the parents as it relates to the children is especially useful. The court is always hoping that the parents can shift their focus to the children's needs and the CFI's report and testimony can be instrumental in that refocus. Judge Arkin explained that the court will sometimes question the CFI specifically to help elucidate for the parents what is really going on with their children. Hearing from someone in addition to the court about where the children are in the process can shift parents away from their accusatory posturing. Judge Russell added that the court will sometimes ask the CFI a particular question in order to underscore an important issue or point for the parents.

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Strengthening Standards and Practice in Custody Evaluations

By Bill J. Fyfe, EdD

Criticisms of PRE/CFI assessments have intensified in recent years (Tippins & Wittmann, 2005; Emery, Otto & O'Donohue, 2005). Primary criticisms include: unsupported "best parent" recommendations, the lack of scientific support for the best interest of children's standard (BIC), poor integration of research findings in PRE/CFI reports, and concerns about the admissibility of "limited science" expert testimony as part of a flawed psycho-legal system (Emery, Otto & O'Donohue, 2005). These criticisms have led to recommendations concerning a moratorium on "ultimate issue" (parental responsibility) recommendations in PRE/CFI matters as well as a blanket rejection of PRE/CFI as having little of the scientific foundation necessary to provide testimony.

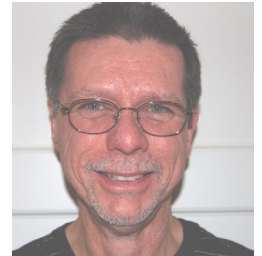
Critics of PRE/CFI focus on these two areas: BIC recommendations and a rejection of PRE/CFI processes altogether. But competent evaluators use systemic data collection procedures and divorce related research data as starting points for generating hypotheses about a specific family. While Tippins and Wittmann site limitations in our data inference ability, they do not recommend the prohibition of evaluations in divorce conflicts. Other professional writers defend the use of psychological constructs in making appropriate recommendations (Stahl, 2005; Kelly & Johnson, 2005).

In their text *The Art and Science of Child Custody Evaluations* (2007), Gould and Martindale state: "A well-researched and well-written report is an important step in helping the family understand how to rehabilitate itself and how to assist specific family members in gaining the management skills and emotional competencies needed to move children toward their psychological potential" (Gould and Martindale, 2007, page 8).

In short, competent evaluators can assist the courts in understanding parent comparative goodness-of-fit in child management and emotional competence skills related to raising healthy children. Parental capacity can be defined as those skills needed to move children towards their psychological potential. Essentially, determining psychological best interests of children involves an investigation of what family situation will likely assist children in achieving competence. Teaching competence can be viewed as the over-arching parenting factor which includes regulated, goal driven conduct, academic achievement and social relatedness.

Increased attention to the scientific foundation of evaluative procedures has led to the development of practice standards by various interest groups: the American Psychological Association (APA), the Association of Family and Conciliation Courts (AFCC), and the American Psychiatric Association (ApA). Guidelines from these groups include the AFCC Model Standards of Practice for Child Custody Evaluations (2007), the AFCC Guidelines for Brief Focused Assessment (2009), the APA Guidelines for Child Custody Evaluations in Family Law Proceedings (2009), the APA Ethical Principles for Psychologist and Code of Conduct (2002), the APA Specialty Guidelines for Forensic Psychology (draft 9/08) and the American Academy of Child and Adolescent Psychiatry Parameters for Child Custody Evaluations (1997).

[Click here to see full article and references.](#)



Criticisms of CFI assessments include:

Unsupported "Best Parent" recommendations

Lack of scientific support for the best interest of children's standard

Poor integration of research findings in reports

Concerns about the admissibility of expert testimony in this area

Domestic Violence and High Conflict Divorce

By Julie Van Heyningen, PsyD



High Conflict Divorces

Generally require litigation to settle

Take up most of the court's resources

Generally require professionals as evaluators and therapists

Domestic violence is a serious societal issue and it occurs within families of all economic and cultural classes. Therefore, it is not unexpected that allegations and findings of domestic violence frequently occur in families that show up in the family court system when they are divorcing or separating. High conflict divorces, those which generally require litigation to resolve, take up most of the court's resources and generally require professionals in the form of evaluators and therapists. High conflict divorce occurs with and without domestic violence and the two should not be equated. However, when domestic violence allegations occur within the context of a high conflict divorce, issues become more complex, have greater safety implications and it is very likely that some type of parenting evaluation will be ordered. Johnston, Roseby, and Kuehnle (2009) estimated about one-half to three-fourths of families litigating divorce include claims of domestic violence. Therefore, professionals involved in parenting evaluations should have a good degree of education, training and experience in working with these families to ensure proper screening and assessment of issues related to safety and appropriate child access. Ethically, if a case involving domestic violence comes to an evaluator and he or she does not have expertise in that area, the Court should be notified that another evaluator will be needed to ensure that the evaluator does not practice outside of the scope of his or her expertise.

The issue of evaluating domestic violence within the context of divorce has received a good deal of attention over the years. Our understanding about the issue has changed over time, especially in the past decade. Most recently, in July 2008, *Family Court Review*, the journal of the Association of Family and Conciliation Courts (of which there is a division in Colorado) published a special volume on domestic violence based on the 2007 Wingspread Conference on Domestic Violence and Family Courts. This conference brought together experts in the field of domestic violence from both the advocacy and family court arenas to discuss their views and findings about domestic violence and access to children. In the later half of 2009, *The Journal of Child Custody* published a special issue on Domestic Violence Issues in Child Custody. Finally, in November 2009, the Boulder and Metro Denver Interdisciplinary Committees, in conjunction with the Colorado Chapter of the Association of Family and Conciliation Courts sponsored a conference entitled "Domestic Violence Assessment and Parental Responsibility: Using the Latest Research in Parenting Plans and Complex Cases." Loretta M. Frederick, J.D., and Janet R. Johnston, Ph.D., were the two primary speakers.

It is clear that opinions within the field of domestic violence differ in a number of areas. As those of us who have had the experience of getting caught in the middle of these different views know, the "war" and attempts to discredit evaluation findings and recommendations from the "other side" can be intense and prolonged. Often experts from the different communities get caught in tautological arguments as they attempt to demonstrate that their way of doing things is the only correct way. In Denver, it was not too many years ago when audience members left a presentation when the speaker reviewed research findings that women, too, can be perpetrators of domestic violence. In an attempt to find a way to bridge the gap between the advocacy and custody communities, the Wingspread Conference was an opportunity for experts within the advocacy and family court communities to find commonalities in their work and findings and to co-educate each other on issues of violence and how it impacts divorce and parenting plans.

[Click here to see the full article and references.](#)

Evaluation/Investigation Issues Concerning Parental Abduction

By Kevin Albert, PsyD and James S. Bailey, Esq.

Child abduction is a serious problem: a study commissioned by the Office of Juvenile Justice and Delinquency Prevention estimated that 262,000 children were abducted in 1999; of these almost 80 percent, 203,900 were abducted by a parent or family members. While Colorado changed the language regarding parenting disputes a number of years ago, opting for "parenting time" and "parental decision-making responsibilities" instead of "custody," research and literature on the national level still refer to custody when referring to these issues.

This article proceeds on the belief that preventing a family abduction is in a child's best interests. Despite this elemental truth, there are parents who decide to take child custody matters into their own hands by abducting a child. Legally, abduction may be referred to as "the wrongful removal or wrongful retention of a child" or as "one parent taking, detaining, concealing, or enticing away a child from another parent who has custody or visitation rights." The risk of parental or family abductions may be minimized or prevented by the identification of risk factors and the use of preventative measures.

Identification of Risk Factor: Johnston and Girdner (1998) defined a number of risk factors for parental abduction. It should be noted that these factors have been adopted in assisting the courts in assessing whether a child may be at risk. These risk factors are:

- **The tendency to dismiss the value of the other parent to the child.** These parents tend to believe that only they know what is best for their child. They may have little or no understanding of how the other parent may be of value to the child, fail to identify the other parent's strengths as a parent, and tend to focus almost exclusively on the other's weaknesses. When asked directly about the other parent's strengths, they may provide only left-handed compliments or use "yes, but" language.
- **Younger children are more likely to be abducted.** The median age for children being abducted is between two and three years of age. In part this is because younger children are easier to conceal and transport and in part because these children tend to be under parental control. (Which may not fit for anyone who has attempted to travel with a two year old.) It should be noted that older children may also be either under parental control, overly aligned with, or protective of the abducting parent.
- **Abducting parents are likely to have the support of a social network** (family, friends, and cultural communities) that can assist with practical matters such as money, food, or lodging, as well as providing emotional support. Parents who abduct a child may believe they need to "go underground." These parents may be able to convince others that there is a real and immediate danger to themselves and the child; and their support system may agree with the moral correctness of the abducting parent's actions. These parents are likely to see their behavior as legal and moral.



The risk of parental or family abductions may be minimized or prevented by the identification of risk factors and the use of preventative measures.

[Click here to see the full article and references.](#)

Child Focused Negotiation of Parenting Plans

By Deborah Coe Silver, PsyD, ABPP, NCSP and Robert B. Silver, PhD, ABPP



Deborah Coe Silver
PsyD, ABPP, NCSP

Summary of Article

By J Benedict, PhD, ABPP and Dan Mosley, EdD

This article describes an innovative alternative to the more common court-based adversarial divorce that too often creates more problems than it solves. The Child Focused Facilitation Team (CFFT) Model represents an alternative method to the adversarial model for deciding post-divorce child sharing plans. The CFFT puts the child(ren)'s need(s) in the forefront. The focus of the process remains that of the child's needs rather than the parents' "rights" or desires. The CFFT Model embodies the best of what family law professionals have to offer divorcing parents. This model incorporates three-dimensional expertise integrating four major pertinent vantage points, in order to address the needs of children who will be transitioning to function within two separate households.



Robert B. Silver
PhD, ABPP

The concept is the brainchild of family law judge the Honorable Hugh E. Starnes, family law attorney Shelly Finman, accountant JoAnne Holt and clinical psychologist Deborah Coe Silver. These family law professionals have implemented this approach in three cases thus far, all of which led to a settlement. This inaugural CFFT sought an appropriate vehicle for implementing research completed by a committee tasked through the auspices of the Florida Association of Family and Conciliation Courts (Carter, D., et. al, 2010). Divorcing parents are offered the opportunity for coordinated group consultations with a seasoned family law judge, an attorney, a financial expert and a mental health professional. The appeal of this approach comes from the fact that costs of a litigated divorce begin at \$50,000, compared to this comprehensive settlement process that ranges between \$10,000 and \$12,000.

This approach is based on the principle that professional efforts have to keep in mind the basic position: the child's needs come first and a good outcome for all is the intent. The authors illustrate how the process moves from beginning to end. In fact, the entire process is described in a stepwise fashion from beginning, through hitches and glitches, to the financial and emotional solutions and conclusions.

One of the hidden strengths is the role of the Judge as an instrument of reality. Exactly who is on the CFFT and what are their various responsibilities is not always clear. How the handling of a specific case moves from identification, through intake and obtaining of clinical-financial-legal details and history to recommended solution is identified. It appears that the final solution is a set of non-binding recommendations to the parents. The parents, on advice of their attorneys, then develop an agreement which is then submitted to the court for final approval. It is assumed that the report of the CFFT to the court helps the court to know the credibility of effort, the details of the agreed upon steps and points and the sincerity on the part of the parents for the recommended solution. [Please click here to see the full article.](#)

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High Conflict Mediation as a First Intervention with Intractable Couples

By Nan Waller Burnett, MA

The definition of insanity is doing the same thing over and over again and expecting a different result.”

Albert Einstein

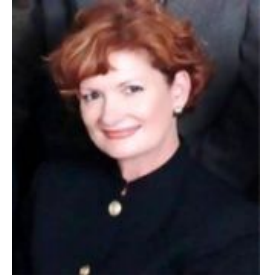
For decades, the court system has struggled with how to resolve co-parenting issues in high conflict situations. New professional categories such as Child and Family Investigators, Parenting Coordinators, and Decision Makers, can leave families strapped financially while issues remain unsolved. Iatrogenic damage from well-meaning professionals also leaves a mark on the family system for a long time. The systemic neuroses take on a whole new dimension. These families cause great concern for the courts, as children are affected for a lifetime due to intractable conflict.

As a first step in court orders, I propose an intermediate approach. High Conflict Mediators, brief interventionists, with experience with high conflict populations could be ordered into the case before the expense of a court appointed CFI, DM/PC professional. An afternoon with a specialist could potentially save the family thousands of dollars. Mediators with a psychotherapeutic background should be well versed in chaos and systems theory as well as be experienced in brief solution focused interventions.

Therapeutic high conflict mediation is an approach to the engagement of conflict that aims to develop more effective and preventive skills with reactive couples. It is short term and goal directed. Therapeutic mediation should have preventive anger management and negotiation strategies that enhance collaboration and do not create a distributive bargaining process. The goal of this type of mediation is the same as other models, an agreement that is durable and one that allows access for both parents. It is imperative that in the opening statements, the mediator make clear to these reactive couples that they aim to hold the best interests of the children in the forefront of all structured interventions. There is no neutrality when unrepresented children become collateral damage for a hyper-conflicted duo.

I also believe that it is the duty of a high conflict mediator to educate, coach, and inform parents on the destruction that can arise when conflict is not kept away from the children. Teaching the parents ways to mitigate anger and prepare before each interchange is paramount. Resources for parents such as collaborative negotiation skills should be made available to these co-parents and the mediator should attempt to model and/or have them practice such skills at sometime during the process.

Editor's Note: Burnett's article continues, outlining the benefits of mediation, especially in high conflict situations. Once she defines what constitutes a high conflict couple, Burnett explores available mediation tools and addresses their effectiveness. To read more about the process of mediation and obtain some practical suggestions for incorporating it into your work with high conflict couples, please [click here](#).



High Conflict Mediators:

Brief Interventionists

With experience with high conflict populations

Who can be ordered into the case before the expense of a court appointed DFI is incurred

The Association of Family and Conciliation Courts (AFCC)

47th Annual Conference
June 2-5, 2010
Sheraton Denver Downtown.

Traversing the Trail of Alienation: Rocky Relationships, Mountains of Emotion, Mile High Conflict

The family law conference will focus on the often-debated issue of a child's alienation from a parent, and will feature nearly 200 mental health, attorney and judicial presenters from the United States and around the world. The conference offers six full-day Pre-conference Institutes from which to choose, and will offer 80 workshops, with nationally-known research and clinical psychologists, such as California's Joan B. Kelly, Ph.D.; Richard Warshak, Ph.D., of the University of Texas; Peter Jaffe, Ph.D., of the University of Western Ontario; the MMPI-2-RF's Yossef Ben-Porath, Ph.D.; and Robin Deutsch, Ph.D., of Massachusetts General Hospital and a past president of AFCC. Many Colorado psychologists will also be presenting, including Peter Adler, Ph.D. (Keystone); Ed Budd, Ph.D. (Highlands Ranch); Shirley Thomas, Ph.D. (Longmont); Jessica Pearson, Ph.D. (Denver); Shelley Bresnick, Psy.D. (Golden); William Austin, Ph.D. (Steamboat); Marian Camden, Psy.D. (Centennial); and Kathleen McNamara, Ph.D. (Fort Collins).

In addition to the knowledge you will gain from attending this rich, full program, you will also have the chance to be part of thought-provoking discussions that continue well after the conference has ended. There are many networking opportunities available and if you haven't been to an AFCC conference in the past, AFCC is a very welcoming group. Each evening the AFCC Hospitality Suite offers the opportunity to socialize and network with other attendees, AFCC board members and leadership in an informal, relaxed atmosphere. Thursday evening, young professionals, students and those changing fields can meet established professionals to network and arrange mentorships. Thursday and Friday enjoy morning yoga, led by certified yoga instructor and AFCC member, Rebecca Stahl, J.D.

The electronic version of the conference brochure is available on AFCC's website: www.afccnet.org. AFCC is an interdisciplinary and international association of mental health, legal and other professionals dedicated to improving the lives of children and families through the resolution of family conflict. The Colorado AFCC Chapter has over 100 members from around the state and there are over 3,700 members of the parent organization in the United States, Canada, Australia, and 24 other countries. Members receive a quarterly issue of the *Family Court Review*, an interdisciplinary family law journal published in cooperation with The Center for Children, Families and the Law at Hofstra University School of Law and Wiley-Blackwell. The January 2010 special issue of *Family Court Review* titled, *Alienated Children in Divorce and Separation: Emerging Approaches for Families and Courts*, examines alienation between parents, and will be a focal point of the plenary sessions during the annual conference.

Pamela Brody and the Depression Center: Thinking Globally, Acting Locally

By Mary-Elizabeth Callaway, PhD



Pamela Brody, PhD

The Colorado Psychologist presented several knowledgeable and forthright voices on evidence-based practices in our January-February issue. Fittingly, the subject of this profile article, the life and work of Pamela Brody, continues that lively discussion. Dr. Brody exemplifies the journey the field of psychology has been taking over the last couple of decades. The daughter of a psychoanalyst is now the Director of Psychotherapy services at the brand new, cutting-edge Depression Center at the University of Colorado School of Medicine. The new facility and the versatile Dr. Brody illustrate the integration of infrastructure, research, and treatment strategies that characterize the profession today. While the mystery of behavior change still unfolds in a private, intimate setting with a therapist and perhaps a few group members, their interaction is encased in a national, sophisticated structure of researchers, academics, advocates, and clinicians.

The Depression Center, which opened a scant 15 months ago, straddles the academic and private health care spheres. It is housed and administratively supported by the University, yet it hardly resembles a traditional academic institution. It belongs to a national network of 16 centers that was envisioned by a private philanthropist, George Wieggers. The first center was founded at the University of Michigan and the others were created at schools with a historically strong interest in mood disorders, such as Harvard, Duke, and the University of Pennsylvania.

Mr. Wieggers is a former investment banker whose mother had a long struggle with bipolar depression. After his retirement to Vail, Mr. Wieggers wanted to contribute in a systemic way to the advancement of care for people with depression. After reading about the University of Michigan's Depression Center, he helped develop the idea of a national network of research and treatment centers, modeled on the national cancer centers. In Colorado, he partnered with Dr. Robert Freedman and Dr. Marshall Thomas from the Department of Psychiatry at the Health Sciences Center, donated \$3 million as seed money, and the University of Colorado Depression Center was founded.

Mr. Wiegger's vision is a group of state-of-the-art research and treatment facilities staffed by experts where innovations could be developed and tested more quickly and robustly than can be done by individuals in isolated academic departments. He also hopes to lessen the stigmatization that people with depression confront in our society. The infrastructure of the centers has been built to increase communication and collaboration and to win grant money for research. The centers have regular conference calls so that they stay on the cutting edge of practice and research. Their affiliation also permits them to bypass the historically slow dissemination of knowledge that is typical in academia and science. Moreover, the centers can recruit more subjects for research trials and the samples will be true national rather than regional samples.

Dr. Brody is the Director of Psychotherapy and the Clinical Practice Manager who runs the daily operations of the practice. She is responsible for developing psychotherapy programs and hiring and training staff. This may seem like an improbable work setting for a young psychologist whose father was a psychoanalyst and who studied Self Psychology at the California School of Professional Psychology in Berkeley/Alameda. Cognitive-behavioral therapy (CBT) was not emphasized in her graduate school and appeared a tad mechanistic to her at first blush. However, during internship at the Belmont Center in Philadelphia, Dr. Brody put together a group for people with panic disorders and tried out David Barlow's panic control therapy. It was the first time she had attempted an evidence-based therapy and was pleased with the results for both her patients and herself.

[Click here to see the full article.](#)

Disaster Response

By Martha Pearse, PhD



Psychologists have big hearts. Really big hearts. When it comes to disaster work, that's the good news and the not so good news.

Many of our colleagues assume that their current level of training will prepare them to help all people in crisis. That may be true for a psychotherapy or agency client, but it is not a trustworthy assumption when volunteering for a natural or man made disaster such as the earthquake in Haiti or the aftermath of a Colorado flood or fire.

Thus, you are invited to join in a free one day training sponsored by the American Red Cross in partnership with CPA. Then you will be a member of our Disaster Resource Network (DRN). These trainings are scheduled on a regular basis by the American Red Cross (ARC) and are held at ARC headquarters, 444 Sherman St. in Denver. You can register by following the directions in **Sign Up** below, or by contacting Dan Mosley EdD. at Danjimosley@msn.com, or 303 794 7761. Training topics will be on the foundations of disaster mental health, and psychological first aid.

Disasters happen, and they happen here. Preparation is free, simple and straightforward. If you do not have the proper credential(s), sadly, your big heart and best of intentions will be neither helpful nor appreciated. Untrained volunteers inadvertently add to the chaos. That's the bad news.

The good news is that, in most cases, learning to do disaster work is easy. Partly, it is a matter of undoing the deep/critical thinking involved in psychological analyses. Displaced persons have clear and often simple needs. If you are willing to work with the basics, and you can walk around while doing it, you will have provided your community with the best help anyone can ask for. Service is, of course, always voluntary. By the way, you may need sturdy shoes.

Service opportunities come in many venues, from neighborhoods to the international front, and from many causes such as Acts of God or acts of humankind. The agencies doing disaster work are varied also. All will be explained in the trainings.

SIGN UP: Go to www.denver-redcross.org, then click Take A Class on left hand side, then click Disaster Response on left hand side, then scroll down to Foundations of Disaster Mental Health. You will need to set up a password but the process should be simple from this point.

Here are some web resources for both professional training, and for public interest.

- www.apahelpcenter.org has brochures, articles and tips for handling many types of stress.
- www.icisf.org is headquarters for the International Critical Incident Foundation in Baltimore MD. Psychologists Dr. Jeffrey Mitchell and Dr. George Everly, who developed the CISM model, are the founders and directors.
- American Red Cross mental health disaster response services.



Letter to the Editors

Summary: Mental Health Disparity Version 2.0

An Open Letter About Financial Discrimination Against Mental Health Services

By Bill Semple, MSW and Ivan J. Miller, PhD

Mental health advocates have won the battle to achieve parity for mental health services paid by health insurance. A disparity remains, however, in the pattern in which managed care systematically removes treatment funds from mental health services. Managed behavioral health care organizations (MBHCOs) currently underfund psychiatric hospitals to such an extent that programs are forced to close. In outpatient services, MBHCOs have lowered provider reimbursements below the level of other health care providers, driving many of the most qualified professionals away from providing treatment services.

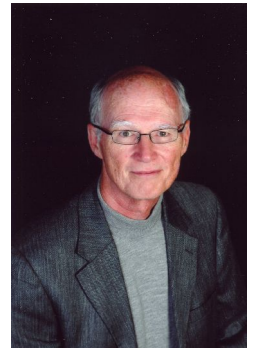
Historically, when patients pursued mental health care, in comparison to physical health care, insurance imposed significantly higher copayments, much lower annual and lifetime maximums, and larger deductibles. This Version 1.0 Mental Health Disparity between physical and mental health was obvious discrimination, and the campaign to end it was called the mental health parity campaign.

Unfortunately, MBHCOs were not adequately constrained by the parity laws. The most dramatic example of Disparity 2.0 is the closure of psychiatric inpatient units. There is a nationwide shortage of inpatient psychiatric beds, and this shortage causes a crisis in hospital emergency rooms. These ERs end up housing psychiatric patients for days at a time while staff searches for an empty hospital bed. If the economic laws of supply and demand were operating, there would be new psychiatric units opening to meet the crisis. However, MBHCOs are able to manipulate the mental health marketplace, and prevent the system from developing a supply to meet the demand.

MBHCOs are able to do this because they have established discriminatory and different reimbursement rules for mental health care than are used for physical health care. MBHCOs under-pay psychiatric hospital units for the cost of keeping the unit open. In physical health care, private insurance pays a sufficient reimbursement rate to keep the units open. From the insurance industry's perspective, the lack of inpatient treatment availability is seen as an advantageous reduction in expenses. In physical health care, there would be no tolerance for reimbursement policies that resulted in the closure of physical health care hospitals.

Outpatient mental health treatment has barriers that do not exist for physical health care. Outpatient mental health patients are screened by a special referral system, treatment often requires more complex re-authorization processes than in physical health care, there is often difficulty finding an appropriate therapist within a panel, and recommended therapists on the treatment panels frequently are not available.

Not obvious to patients, there is a pattern of declining reimbursement rates for mental health providers over the past 20 years. Most managed mental health care entities have not increased mental health reimbursements for 20 years, and in many cases, they have decreased reimbursements. The discriminatory policies of MBHCOs are apparent when MBHCO reimbursements are benchmarked to Medicare reimbursements.



Bill Semple, MSW



Ivan Miller, PhD

[Click here to see the full letter.](#)



All Politics is Local

By Pat DeLeon, PhD, Former APA President

During his State of the Union address, President Barack Obama: "From the day I took office, I have been told that addressing our larger challenges is too ambitious – that such efforts would be too contentious, that our political system is too gridlocked, and that we should just put things on hold for awhile. For those who make these claims, I have one simple question: How long should we wait? How long should America put its future on hold?... And it is precisely to relieve the burden on middle-class families that we still need health insurance reform.... (B)y now it should be fairly obvious that I didn't take on health care because it was good politics. I took on health care because of the stories I've heard from Americans with pre-existing conditions whose lives depend on getting coverage; patients who've been denied coverage; and families – even those with insurance – who are just one illness away from financial ruin. After nearly a century of trying, we are closer than ever to bringing more security to the lives of so many Americans.... Here's what I ask of Congress.... Do not walk away from reform. Not now. Not when we are so close. Let us find a way to come together and finish the job for the American people."

**Change is
Difficult!!**

***It often takes
considerably
longer to enact
than one might
initially expect.***

***Substantive
change takes
patience,
persistence,
effective
partnerships,
meaningful
interpersonal
relationships, and
a long term vision.***

Over the years, I have come to appreciate that change is difficult for many of our colleagues and that it often takes considerably longer to enact than one might initially expect. To effectively bring about substantive change through the political process – no matter how meaningful -- takes patience, persistence, effective partnerships, meaningful interpersonal relationships, and a long term vision. What can and should psychology bring to the citizens of Alabama? As the late Speaker of the U. S. House of Representatives Tip O'Neil stressed, "All politics is local." And, as former APA Congressional Science Fellow Neil Kirschner noted: "More often than not, research findings in the legislative arena are only valued if consistent with conclusions based upon the more salient political decision factors. Thus, within the legislative setting, the research data is not used to drive decision-making decisions, but is more frequently used to support decisions made based upon other factors. As psychologists, we need to be aware of this basic difference between the role of research in science settings and the legislative world. Furthermore, it emphasizes the importance of efforts to educate our legislators on the importance and long-term effectiveness of basing decisions on quality research data. If I've learned anything on the Hill, it is the importance of political advocacy if you desire a change in public policy."

The Institute of Medicine recently released its report Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, with five colleagues serving on the IOM committee. The report emphatically called upon the nation to make prevention of mental, emotional, and behavioral disorders and the promotion of mental health of young people a high national priority. "By all realistic measures, no such priority exists today." These disorders incur high psychosocial and economic costs for the young people who experience them, for their families, and for the society in which they live, study, and will work. Traditionally, we have awaited their emergence and then attempted to treat them, to cure them if possible, or to limit the damage they cause if not. Minimal attention is devoted to preventing future disorders or the environmental exposures that increase risk. Following up on the 1994 IOM prevention study, this report documents that an increasing number of mental, emotional, and behavioral problems in young people are, in fact, preventable and that highly cost-effective, evidence-based prevention interventions are at hand.

Reprinted from the Alabama Psychological Association February 2010 newsletter.
[Click here to see the full article.](#)

The Highest Possible Quality of Care: Change is Definitely Coming

By Pat DeLeon, PhD, Former APA President

One of the hallmarks of a maturing profession is its collective willingness to adapt to change and, we would suggest, focusing upon meeting society's evolving needs. Earlier this year the Institute of Medicine (IOM) reported on its roundtable on Evidence-Based Medicine: Value In Health Care. One participant was the brother of President Obama's chief of staff; another was the Director of the Agency for Healthcare Research and Quality (AHRQ). For decades, the rise in health care costs in our nation has outpaced growth in the economy as a whole. In 2008, annual healthcare costs grew at 4.4% which is their lowest rate of growth in almost half a century, but this was primarily due to the effects of the recession. Healthcare spending as a proportion of our gross domestic product (GDP) reached \$2.3 trillion in 2008, or an average of \$7,681 per person. Unfortunately, as our GDP shrinks in the current economic crisis, the percentage of healthcare costs continues to grow, and HHS Secretary Sebelius noted that for the first time, in 2009, growth in healthcare spending exceeded 17% -- over double that of most industrialized nations.

Notwithstanding that we have the highest per capita spending on health care of any industrialized nation, it has become increasingly clear that Americans are not gaining benefits commensurate with these expenditures, as many countries possess superior life expectancy and lower infant mortality, and in almost all instances, recipients of healthcare in other countries receive higher quality care and, (in spite of scare-tactics raised by special interests opposed to healthcare reform), give far higher satisfaction ratings of care received than do American citizens.

The IOM roundtable's vision was to "help foster the development of a *learning healthcare system* in which the processes and information systems used throughout health care engineer both the natural delivery of best care practices and the real-time generation of new evidence." Presently, 20-30% of health care expenditures employ either over-, under-, or misutilization of medical treatments and technologies. At the same time, there was a clear concern for the preservation of incentives for innovation and the need to maintain a central focus on the patient; not to foster a "one size fits all" approach.

A number of converging themes emerged.

- **Urgency.** The urgency to achieve greater value from health care is clear and compelling.
- **Perceptions.** Value means different things to different stakeholders, so clarity of concepts is key.
- **Elements.** Value in any endeavor is a reflection of what is gained relative to what is invested. Value from health care has dimensions beyond the nature, cost, and effectiveness of a particular intervention, including those related to elements such as preference, satisfaction, and appropriateness to circumstance.
- **Gain.** Improving value requires reliable information, sound decision principles, and appropriate incentives.
- **Decisions.** Sound decision principles are rooted in issues specific to the patient, the evidence, the social context, transparency, and learning.
- **Information.** The ability of information to guide efforts aimed at improving value from care delivered derives from the nature of its origin, processing, transparency, interpretation, and clarity.
- **Incentives.** Incentives should direct attention and rewards to outcomes, quality, and cost.
- **Limits.** Value may be inversely related to the level of system fragmentation.
- **Communications.** System-level value improvement requires more seamless communication among participants.
- **Providers.** Provider-level value improvement efforts depend on culture and rewards focused on outcomes.
- **Patients.** Patient-level value improvement stems from quality, communication, information, and transparency.
- **Tools.** Continually improving value requires better tools to assess both costs and benefits in health care. And,
- **Opportunities.** Health payment reform is essential to improve value returned but steps can be taken now.

Reprinted from the Iowa Psychological Association February, 2010 newsletter.

[Click here to see full article.](#)

COLORADO PSYCHOLOGICAL ASSOCIATION

ANNUAL BUSINESS MEETING

MARK YOUR CALENDAR

Members are encouraged to join the Board of Directors for an afternoon of recognition, celebration, refreshments and networking.

Friday, June 25, 2010

**The Children’s Hospital
Gary Pavilion, Denver Seminar Room
13123 East 16th Avenue, Aurora, CO
3:30 p.m. – 5:00 p.m.**

Note the date change from previous correspondence

**Watch your emails and check the website for additional information
Colorado Psychological Association**

CPA Calendar of Events

- CPA Board Meeting**.....Third Friday of every month (*except August and December*) 12:00 noon - 3:00 pm
- Articles Due for *The Colorado Psychologist***.....Monday, April 19, 2010
- Psychology and Health Care Reform: An Evening of Answers**.....Thursday, March 25, 2010
6:30 pm, Valley Country Club
- Membership Dues Renewals**.....March 31, 2010
- CPA Annual Business Meeting**.....Friday, June 25, 2010
3:30 p.m. – 5:00 p.m. Denver Seminar Room, Gary Pavilion on the campus of The Children's Hospital
NOTE: this date changed from previous information sent out.

History Corner: Edited by Sid Glassman, PhD, ABPP

Psychology in the Late Sixties

By Dale LeNoue, PhD

Psychology for me in the late 60s was a mixture of routine, excitement and unusual stresses. The routine came in doing what I was trained to do: psychotherapy and diagnostic psychological testing. The excitement came in helping establish the City and County of Denver's first Neighborhood Health Program at the East Neighborhood Health Center (ENHC) in Five Points in northeast Denver. It was also exciting to be an integral part of the beginnings of the Community Mental Health movement in the Sixties.

The unusual stresses included taking a gun away from a patient (before we could start his therapy session), working with militant Black Panthers (both in therapy and in community organization meetings), and having to vacate the East Neighborhood Health Center (ENHC) every Wednesday evening because of bomb threats. It was a time of civil and racial unrest related especially to Dr. Martin Luther King, Jr.'s assassination as well as to other assassinations, the Vietnam War, and rapid societal changes. When I came to work one Thursday morning to find an injured security guard and a large hole in the front of the building due to a bomb being set off, I knew that the Wednesday threats were serious.

I found many opportunities to expand my professional horizons. After nine months as a staff psychologist at ENHC, I became Team Leader of the Health Center's mental health staff of eighteen professionals and paraprofessionals. After five years at ENHC, I moved to Denver General Hospital where I was again challenged by being appointed "Lead Psychologist." (They disliked the term chief psychologist). I also administered the psychology internship program there and was proud to win APA accreditation for it. In addition, I was doing part time private practice throughout these times.

In 1982 I left Denver Health and Hospitals and, while still continuing my part time private practice, I subsequently directed two other psychology internship programs: one at Bethesda Mental Health Center in southeast Denver and later one at the Mental Health Corporation of Denver. In my career, I participated in the professional training of more than eighty psychologists, a role I enjoyed immensely.

I also enjoyed serving the Colorado Psychological Association in multiple capacities through the years including editor of the CPA newsletter and a member of the CPA Board and the Ethics Committee, as well as serving as president of CPA. I retired in 2000 and continue to enjoy skiing along with teaching and leading study groups for the Osher Lifelong Learning Institute, OLLI, an educational program in which hundreds of seniors in the Denver area participate. I found my career in psychology to be very fulfilling.



Memories of practicing psychology in a time of civil and racial unrest:

Working with militant Black Panthers

Vacating the Center because of bomb threats

Dealing with the impact of Martin Luther King, Jr.'s assassination

Welcome New and Returning CPA Members

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Cindy Buchanan, PhD

Early Career Psychologists

Kelly L. Nicholson, PsyD
 Millie M. Riss, PsyD, LPC

Student Members

Davitta Love, MA, Aurora Mental Health Center
 Katrin Seifert, MA, Salud Family Health Centers

Psychology and Health Care Reform: An Evening of Answers

With all the news swirling around, it can become difficult to tease out how any sort of health-care reform might affect psychologists. From clinicians serving low-income clientele to clinicians focused on research, we all are left wondering just how the reform will influence certain aspects of our work. The mind and body are inextricably linked and health care reform efforts should help to bridge the current divide. As part of a health care team, psychologists can help patients make lifestyle changes that last, and as researchers, they can help develop effective treatments. Join the Colorado Psychological Association and the Early Career Psychologist Committee to explore health care reform and untangle the confusion and learn how we all can advocate for greater mental health coverage, including the areas of wellness, health behavior change, and prevention.

Featured Speakers:

George DelGrosso - Executive Director of the Colorado Behavioral Healthcare Council

Ben Miller, PsyD - Associate Director of Primary Care Outreach and Research
 University of Colorado Depression Center

Stephanie Smith, PsyD - CPA Public Education Coordinator

Moira Cullen - CPA Lobbyist

Samantha Monson, Ph.D. - Colorado Health Foundation Fellow

Date/Time:

Thursday, March 25th

630-830pm

www.valleycountryclub.org

Location:

Valley Country Club

14601 Country Club Drive

Aurora, CO 80016

303-690-6373

Light appetizers and Cash Bar (cash only please) will be available.

Classified Advertisements

Licensed Psychologist: Contract work available providing assessments, psychotherapy and Health counseling. For more information go to the website www.seniorcounselinggroup.com. To schedule an appointment email EdnaD@seniorcounseling.com.

May/June 2010 TCP
Special Issue
American Psychological
Association
State Leadership Conference
Guest-Editors
CPA Board of Directors
Articles due: Monday, April 19, 2010

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The Colorado Psychological Association advances the profession of psychology through advocacy and education for the promotion of psychological health and well being.



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