Digital Commons @ George Fox University

Doctor of Psychology (PsyD)

Theses and Dissertations

4-1-2015

Barriers and Motivations in Mental Health Legislative Advocacy in Oregon

Bethany Webb

George Fox University, bzander11@georgefox.edu

This research is a product of the Doctor of Psychology (PsyD) program at George Fox University. Find out more about the program.

Recommended Citation

Webb, Bethany, "Barriers and Motivations in Mental Health Legislative Advocacy in Oregon" (2015). *Doctor of Psychology (PsyD)*. Paper 172.
http://digitalcommons.georgefox.edu/psyd/172

Barriers and Motivations in Mental Health Legislative Advocacy in Oregon

by

Bethany Michelle Webb

Presented to the Faculty of the

Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

of the requirement for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

May, 2015

An Exploration of the Differences in State Psychological Membership and Primary Place of

Practice Among Oregon Psychologists and Psychology Students Regarding Participation in

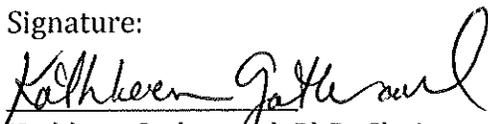Mental Health Legislation and the Barriers and Motivations to Advocacy

by

Bethany Michelle Webb

has been approved at the

Graduate Department of Clinical Psychology

George Fox University

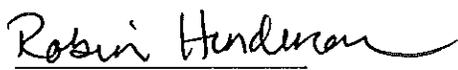as a Dissertation for the PsyD degree

Approval

Signature:

Kathleen Gathercoal

Kathleen Gathercoal, PhD, Chair

Members:

Mary Peterson

Mary Peterson, PhD

Robin Henderson

Robin Henderson, Ph.D.

Date: 6·19·14

Barriers and Motivations in Mental Health Legislative Advocacy in Oregon

Bethany Michelle Webb

Graduate Department of Clinical Psychology at

George Fox University

Newberg, Oregon

Abstract

Compared to other allied health fields, psychology continuously lags behind in representation on the state, national, and local level. The percentage of advocacy involvement by psychologists is very low compared with other professions. There is a great need for all psychologists to become advocates. Unfortunately, there has been limited research into the reasons why few psychologists actually engage in this process. The purpose of this study was to explore the differences in state psychological membership and primary place of practice among Oregon psychologists and students with regard to participation in mental health legislation and to identify barriers and motivations to participation. Graduate students from 3 National Council of Schools of Professional Psychology and a randomly chosen group of psychologists who are listed as American Psychological Association members were asked to participate in an email survey. This study's findings suggest that place of practice or involvement in a state psychological association may not be as relevant to advocacy behavior as one might expect. By far, most respondents indicated personal values as being their biggest motivator for involvement in advocacy. Lack of time continues to be an enormous barrier for many respondents. The

findings in this study suggest there is a continued need to stress the importance of understanding

advocacy behavior as a means to increasing advocacy participation. Greater awareness of

advocacy opportunities and issues can be achieved through an advocacy curriculum imbedded in

graduate programs or through mandated legislative advocacy training days.

Table of Contents

Table of Tables

Table of Figures

Chapter 1

Introduction

Despite the generally held positive attitudes the majority of psychologists have toward advocacy, few professionals engage in the process. The need for advocacy in the field of psychology is growing (Lating, Barnett, & Horowitz, 2009). A decade ago, only about 2% - 3% of practitioners provided the national total of psychology's political contributions and that has not changed much today (Fox, 2003). Whatever the nature and location of their employment setting, all psychologists must be equipped and willing to demonstrate the value of their work. In her dissertation study, Jennifer Gronholt explored the differences between faculty and graduate student participation in legislative advocacy and identified barriers to advocacy participation (2008). The purpose of this study is to investigate whether there are differences in respondents' level of advocacy participation based on their primary place of practice (i.e., academics vs. clinicians) and level of participation in their state psychology association, i.e., Oregon Psychological Association.

Advocacy Defined

Often, the term "advocacy" is simply misunderstood. Advocacy is the process of bringing to light social and political concerns at an individual, group, or societal level while invoking a call to action (Schwartz, Semivan, & Stewart, 2009). Essentially, advocacy is building relationships with people that you know can make a difference. Because advocacy is used as an umbrella term for many forms of legislation participation, it is often used interchangeably with

the terms "activism" and "lobbying." In this study "advocacy" is defined as a broad range of behaviors and attitudes focused on legislative advocacy as a means to bring greater relevance to the field of psychology.

A Brief History of Advocacy in Psychology

In his book *Bowling Alone: The Collapse and Revival of American Community*, Putnam (2001) posits that there has been a societal trend of increasing cynicism toward politics and a general sense of disengagement from community, especially regarding civic involvement. However, advocacy for the profession of psychology originated out of concerns for clients' well-being and thus became a phenomenon of the late 20th century (McClure & Russo, 1996). Because psychology is a relatively new member to the broader group of scientific disciplines, psychology is still early in its development of political activism and advocacy work. In "The American Psychological Association and the Rise of Advocacy," Wright (1992) comments how advocacy for psychology began in individual states and it was the state psychological associations' recognition of the American Psychological Association's (APA) inadequate efforts and disorganization that influenced the development of federal advocacy by psychologists.

It has become a standard practice for all professional agencies to have a strong advocacy component. Compared to other organizations, the field of psychology has failed in this regard. Some of the first advocates for mental health were social justice activists rather than psychologists. Perhaps because of the nature of their work, many social workers rather than psychologists today seem interested in championing for change regarding psychological concerns.

Many mental health practitioners are seeing a need to better understand how issues of oppression influence mental health needs. More recently, there has been a significant movement towards the development of a component of social justice as the "fifth force" among counseling paradigms in addition to the cognitive behavioral, existential-humanistic, and multicultural forces (Ratts, 2009). A variety of instruments have been designed for counselors to assess their effectiveness as professional advocates in accordance with the American Counseling Association (ACA) Advocacy Competencies (Ratts & Ford, 2010).

Core Competency

Advocacy is one of the core competencies of clinical psychology programs. In the article *Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels,* Fouad et al. (2009) breaks down clinical psychology's core competencies across three levels of professional development: readiness for practicum, readiness for internship, and readiness for entry to practice. Competency in advocacy is defined as having a certain level of awareness as indication of readiness for practicum; promoting change to enhance the functioning of individuals as indication of readiness for internship; and promoting change at the level of institutions, community, or society as indication of readiness for entry to practice.

Effective Advocacy

Advocacy is not self-promotion. Successful advocacy, as Cohen, Lee, and McIlwraith (2012) suggest, must transcend the self-interests of the group advocating for it. Persistence and perseverance are also key components. Advocacy effectiveness requires time, commitment, and patience. Considerable time and energy may be spent on what seems like very mundane tasks

and payoffs may not be immediately forthcoming. Oftentimes advocates do not perceive personal or very tangible benefits from the work they put in, but rather it is the small, gradual steps that provide indirect encouragement (DeLeon, Loftis, Ball, & Sullivan, 2006). This mindset or vision is needed when carrying out advocacy work; otherwise, one may experience significant burnout and discouragement.

Furthermore, DeLeon et al. (2006) also stress the value of relationships. Much of advocacy work involves building productive working relationships with legislators. "Effective advocates are knowledgeable about who they are professionally and what is meaningful to them, as well as how they may be able to advance the process in which they are advocating" (Schwartz et al., 2009, p. 56).

Central to effective advocacy is interest and passion (Schwartz et al., 2009). Energy, courage, willingness to take a risk, and genuineness of concern are all given components that make up investment to advocacy action. Ability to identify with those one is advocating for may seem like a natural given skill, but without this empathetic understanding, the power and authority of the advocate is greatly undermined.

State Psychological Associations

Because of increasing political and economic pressures around such issues as private practice and insurance reimbursement, it has become each state psychological association's responsibility to develop effective legislative advocacy methods. The Legislative Committee of the Massachusetts Psychological Association created one such state-level advocacy model (Portnoy et al., 1983). This model highlights several principles and tasks of the Legislative Committee that are key to the development of long-term strategies to enable psychology to grow

as a sustainable profession, including informing and educating the general membership of the association about the legislative and policy advocacy processes.

Many state psychological organizations have legislative committees or task forces, including the Oregon Psychological Association. During this past year (2013-2014), the OPA created a specific Student Board Member position on their Legislative Committee. It has become the job of state psychological organizations to provide advocacy initiatives and opportunities for the public and psychologists in the state. As more state psychological associations become grounded in the theory and practice of legislative advocacy, the American Psychological Association has expanded their services to include consultations and technical assistance around policy advocacy issues (Ginsberg, Kilburg, & Buklad, 1983).

Barriers to Advocacy

Although one may acknowledge his or her responsibility to share their knowledge in their area of expertise, there are several barriers that prevent regular engagement in advocacy issues. First, there seems to be a general lack of understanding of what advocacy work is and how to go about it. Advocacy is building relationships with people that you know can make a difference. Having a simple conversation can be considered a form of advocacy. Advocating may include a variety of activities such as voting, writing letters to legislators, meeting with key officials, increasing the public's awareness of programs or resources available, or heading up an organization that will increase the public's awareness of a certain topic.

Perhaps another deterrent preventing citizens from engaging in advocacy is the perceived notion that professional organizations will handle all issues that arise in public policy matters. This thinking is unfortunate given that advocacy needs are not only on the legislative level and it

devalues the need for individuals to engage at all levels. The Government Relations Office

(GRO) of the APA is one organization that helps interested psychologists advocate for the field

of psychology. The GRO maintains the Public Policy Advocacy Network (PPAN), which

provides updates and action alerts on federal legislative issues of importance. The GRO works

hard to inform Congress about the relevance of psychology as it relates to federal policy.

Because public policy evolves from available scientific knowledge, psychological research needs

to be freely shared in order to adequately and accurately address scientific social problems as

well as to contribute to the improvement of human welfare. No governmental organization is

capable of securing enough resources on its own, but rather it takes a whole army of

professionals collaborating together. Other professional organizations such as the World Health

Organization also play significant roles in strengthening the voice of psychology at the

legislative level but, again, without local support these organizations could not exist (Advocacy

for Mental Health, 2003).

DeLeon et al. (2006) in *Navigating Politics, Policy, and Procedure: A Firsthand

Perspective of Advocacy on Behalf of the Profession* have observed the psychologist's

professional orientation to be one that is predisposed towards helping individuals on an

individual basis. Furthermore, the authors also observed that those colleagues who are in

influential positions in government are often too willing to minimize their identity as

psychologists and are often hesitant to seek out and support psychology-based initiatives. Lating,

Barnett, and Horowitz (2010) seem to echo similar thoughts as DeLeon et al. (2006) as they also

posit that many individuals are drawn to the field because they are interested in interpersonal

issues as opposed to larger sociopolitical factors.

Schwartz (2009) list a handful of risks and limitations associated with advocacy, which include time, emotional demands, relationship vulnerability, job stress, and role confusion. It is not uncommon for advocacy efforts to spill into one's personal life, which may damage relationships when others do not share the same views. The emotional demands may vary from a feeling of helplessness when roadblocks come up to guilt over not being able to do more to anger when others may hinder efforts. Myers and Sweeney (2004) surveyed leaders in state, regional, and national professional and credentialing associations in counseling regarding advocacy efforts, needs, and obstacles. Some of the top barriers in order of relevance included: inadequate resources, inadequate funding, opposition by other providers, lack of collaboration, resistance from public policy makers, lack of advocacy training, not enough time, lack of advocacy leadership, lack of awareness, not a priority, little interest, and not having training materials.

Another major barrier appears to be the acculturation of psychologists through their education and training that indirectly discourages them from getting involved. Levant et al. (2001) state, "The training of psychologists emphasizes a critical –even skeptical –yet passive approach that involves a thorough accounting of all possibilities and extreme caution about the limitations of evidence" (p. 83). Because of the profession's emphasis on ethics and operating within one's scope of practice, psychologists seem to err on the side of caution when it comes to transferring their skills to unfamiliar territory. Similarly, Levant et al. go on to suggest that the profession's emphasis on expertise may cause some psychologists to be reluctant in seeking help, supervision, or a mentoring relationship when exploring this new role.

Unfortunately, many psychologists often associate advocacy solely with legislative activities and political giving (Lating et al., 2009). In her dissertation, *Professional Counselors'*

Perceptions of Knowledge, Barriers, Support and Action of Professional Advocacy, de la Paz

(2012) noted that the top three barriers to advocating are: lack of time, roadblocks caused by

other professionals, and lack of knowledge of professional advocacy strategies. According to

Gronholt's (2008) study, faculty members reported significantly more advocacy experiences than

students. The top three barriers identified for both students and faculty were being unaware of

advocacy opportunities, being unaware of the current advocacy issues, and being uninterested in

advocacy work.

In addition to the lack of time, the lack of training/understanding of advocacy, and having

no guarantee of success, Hill (2013) points out that many find professional satisfaction in other

elements of their role as psychologists, which may partially explain the disinterest in advocacy.

He goes to comment on how monumental social advocacy may seem to psychologists that it is

naturally easier to focus on more familiar tasks.

McClure and Russo (1996) go as far as to defend the argument that advocacy for the

profession "involves siphoning resources away from client concerns by focusing them on areas

of intraprofessional conflict" (p. 466). Thus, advocacy for the profession rather than for clients

appears self-serving. However, one would not be able to serve clients' needs if the profession

ceased to exist because of a lack of advocacy efforts.

Motivations for Advocacy

In her article *Are Politics for You?,* Buffmire (1995) comments on the pros and cons of

her experience of serving in a state legislature. While she experienced some of the difficulties

and stressors that come with the role, Buffmire reassures that the "possibilities are boundless"

and the benefits far outweigh the sacrifices. She mentions how her training as a psychologist

enhanced her ability to listen carefully, reflect, network, and sometimes make rapid decisions.

Buffmire's main motivation for her involvement as a state legislator was simple. She stated,

"What is done in our legislatures affects our lives dramatically. It affects our clients' lives, our

profession, our earnings, our culture, and even our country as a whole. I know that sounds overly

dramatic, but it is true" (p. 453).

Current Advocacy Training in Graduate Programs

Graduate school is a critical time to become involved in advocacy. It is often during one's

training that the importance of advocacy first becomes evident. It is during this formative time

that students develop habits that will influence their professional lives. Advocating for clients is

a fundamental part of a psychologist's practice and is reflected in ethical codes. If psychologists

and psychologists in training are to become effective advocates for their clients and the field as a

whole, then an understanding of actual and potential barriers as well as perceived motivations

will help define how advocacy work can be made more effective.

Graduate students are in the unique position to advocate for psychology because they

often have knowledge of the most recent advances in the field and have a heavy influence on the

trajectory of the field. Unfortunately, as Lating et al. (2010) point out, psychology is one of the

few professions that is rigidly retains a high-level academic training model as the norm. Most

training programs – specifically PhD programs –are focused on developing academic portfolio

including publications and research studies that sometimes overpower the professional practices

on the institutions. More recently, however, there has been a push in counseling programs to

establish training competencies to ensure that social justice and client advocacy issues are being

addressed in supervision (Chang et al., 2009).

One of the barriers already mentioned is the lack of knowledge of professional advocacy strategies. This barrier emphasizes the great need for graduate programs to implement advocacy training into their programs. Learning how to tailor psychological research to relevant political issues is not something that is often taught in graduate programs (DeLeon et al., 2006). Graduate programs need to train, mentor, and prepare their students to enter the world of advocacy. Educators need to be intent on modeling what it looks like to carry out this very important professional duty and responsibility. By creating in students a culture of advocacy involvement during their training, they will know how to better integrate advocacy work in their future professions.

Unfortunately, advocacy skills are rarely a part of graduate school training. However, there are a few special programs that see this need; hopefully, other schools will follow in their example. One such school that has implemented a program that adds a component of advocacy training is the counseling psychology program at the University of Tennessee, Knoxville (Wojcik, 2012). In 2007, they developed the "Scientist-Practitioner-Advocate" model that requires their students to take an additional 15 credit hours of advocacy training and a social justice practicum the year before internship. Through this program, students learn how research initiatives and methodologies can be influenced by an awareness of social justice. More graduate as well as undergraduate programs need to consider adding a similar advocacy training component to their curriculums. Through adoption of this kind of training, students will be better equipped to advocate for their clients more effectively.

Without formal graduate training, the whole process of becoming involved in advocacy may seem quite daunting at first. DeLeon et al. (2006) in their study *Navigating Politics, Policy,*

and Procedure: A Firsthand Perspective of Advocacy on Behalf of the Profession suggest getting plugged into local grassroots organizations, particularly through state, territorial, and provincial psychological associations or through one of the several APA advocacy networks through the Practice, Education, Science, and Public Interest Directorates. These grassroots connections provide countless resources including many alerts of critical legislative and administrative activities that typically call for letters and phone calls to representatives. APA has all kinds of tools available to make the process a lot smoother and more understandable. APA has state officials' contact information and other resources on how to become a successful advocate.

By joining a state association, one will be more connected to issues directly affecting them. Engaging in issues of advocacy on the state and national level is important but getting involved in local community organizations and efforts are equally important and often begin on that level. It is also helpful to stay in frequent contact with colleagues as ideas and strategies for advocacy efforts may be shared. Through advocacy involvement, one is also simultaneously developing a new set of professional skills as well.

Lating et al. (2009) make a very practical suggestion: it may be beneficial if graduate programs dedicate one or more of their colloquia each semester to discussing aspects of advocacy as the central topic. Faculty members would be invited to share knowledge and expertise. Furthermore, in order to increase faculty awareness, it might be helpful for faculty to incorporate advocacy discussions as ongoing agenda items for their faculty meetings.

A great need exists for increased funding for psychological research and access to psychological services (Cohen et al., 2012). In their article *Envisioning and Accessing New Roles for Professional Psychology*, Levant et al argue that training should support the development of

"entrepreneurial skills" that will give students the knowledge and ability to know how to create new roles for themselves (Levant et al., 2001).

Fortunately, the National Council of Schools and Programs of Professional Psychology (NCSPP) has begun paving the way in breaking down some of the barriers between education and practice. Many state, provincial, and territorial psychological associations (SPTPA's) have started creating graduate student divisions, which foster increased student membership and participation (Lating et al., 2010). SPTPA's send delegations to the annual APA State Leadership Conference to attend workshops on advocacy, briefs on Congressional issues, and visits to legislators' offices to lobby various issues for the profession. Some states host annual legislative days where members visit the state capital to meet with legislators to discuss important issues at hand affecting the profession. Members of SPTPA student organizations have numerous opportunities at their disposal. It is the hope that these activities will plant seeds of future involvement.

Students who want to become directly involved in advocacy at the national level can become members of the American Psychological Association of Graduate Students (APAGS), which has existed since 1988 to distribute information about education and training, legislation, and future directions in the field. One of APAGS four specialized subcommittees is an advocacy coordinating team of which is comprised of students who engage in legislative advocacy work such as lobbying.

If we want to see psychology survive as a profession, we must step outside of our therapy rooms and research labs. Fox (2008) argues in his study "Advocacy: The Key to the Survival and Growth of Professional Psychology" that if psychology is to attempt to gain rank as a nationally

recognized health care profession then political action will be necessary to put in place the funding and support needed to influence policy changes.

Statement of the Problem

Very few professionals participate in issues of advocacy. It would be helpful to know what some of the barriers and motivations are in explaining why individuals do or do not participate in advocacy and if an intervention can be implemented. By examining the influences of place of practice and OPA membership on advocacy participation, it is hoped that some insight gained as to why some of the barriers and motivations to advocacy exist among psychologists.

Purpose of the Study

The very survival of psychology as a profession is largely dependent on a strong advocacy base. No profession is able to survive without the financial and human resources necessary that come through the leadership of advocacy efforts. The word advocacy comes from the Latin term "to give voice to;" as professionals steeped in rich knowledge of psychological research and invaluable clinical experience, it is only ethical that we give voice to the current issues in our world by sharing some of that knowledge and experience (Thompson et al., 2012).

> Fostering an attitude of advocacy is instilling the notion that as psychologists we may
> need to be the active voice for those who cannot speak for themselves … we may need to
> be the active voice that advances and protects our profession. (Lating et al., 2009, p. 203).

As psychologists and psychologists in training, advocacy is not only an important extension of our citizenship but also a mandatory extension of our professional identity.

The purpose of this study is to investigate legislative mental health advocacy activities, barriers and motivations to advocacy, and how place of practice and state psychological membership may play a role in influencing advocacy involvement in psychologists and student psychologists. The majority of legislative mental health research has focused on the involvement and attitudes of practicing psychologists. To date, there have not been any studies exploring the differences in advocacy participation among psychologists and student psychologists with regard to the status of their state psychological association membership and practice setting. Additional research on specific groups involved in legislative mental health advocacy is needed.

Summary

In this study the involvement of psychologists and student psychologists in advocacy activities was investigated. Specifically, this research explores (a) the differences in advocacy participation of respondents who are members of the Oregon Psychological Association and those who are not members, (b) the differences in advocacy participation between primary practice settings, (c) what barriers exist that prevent greater engagement in advocacy activities, (d) do differences exist between this current study's findings and Gronholt's findings, (e) what motivations exist that encourage greater engagement in advocacy activities, and (f) what are the common issues that were advocated for in the past.

Chapter 2

Method

Participants

Participants ($N = 837$) were recruited from the APA membership directory and from National Council of Schools and Programs in Professional Psychology (NCSPP) member programs in the state of Oregon. The numbers from the total participant pools are the following: 125 participants from George Fox University, 44 participants from the University of Oregon, 250 participants from Pacific University, and 418 participants randomly chosen from the APA membership directory. Two hundred seventeen participants attempted the survey with 185 participants completing the survey. Five participants who indicated that they were licensed professional counselors, or were counselors practicing with a Masters degree in counseling, or who were retired from the field were eliminated from the sample. An additional four participants were eliminated from this sample because they completed only one-third of the survey.

Two hundred and eight participants were included in this study. Of the survey participants who disclosed their gender, 68.9% were female ($N = 127$) and 31.1% self identified as male ($N = 57$). The average age was 42 with a range from 22 years old to 89 years old ($N = 170$). Most respondents were White (89%), followed by Asian (3.1%), Hispanic/Latino (3.1%), African American (1.6%), American Indian/Alaska Native (2.1%), Native Hawaiian/Pacific Islander (0.5%), and one respondent self-identified as multi-racial ($N = 191$).

Instruments

A questionnaire was adapted from a previous dissertation study conducted by Gronholt (2008) entitled "An Exploration of the Differences in Psychology Faculty and Graduate Students' Participation in Mental Health Legislation and Barriers to Advocacy." Gronholt's survey was originally designed to gather demographic information as well as to measure attitudes about advocacy among students and faculty. The various questions address participants' level of advocacy activity, the value they place on it, and the perceived barriers that are preventing them from possible further engagement. The survey for the current study was further developed to include questions surveying participants' perceived motivating factors influencing their participation in advocacy (see Appendix A). Some of the demographic information includes gender, age, ethnicity, place of practice, and state association membership. The researcher adapted the current survey after researching the literature on psychologists' involvement in and attitudes about advocacy. The current survey also asks participants to rank their barriers and motivations to advocacy participation on a five-point Likert-scale ranging from *Not Relevant* to *Very Relevant* and *Not Influential* to *Very Influential*, respectively. A pilot version of the current survey was given to three faculty members and two doctoral students to solicit feedback to improving the design and wording of the items. The final version of the survey addressed questions regarding participants' primary place of practice and training experiences.

Procedure

An email was sent out to all participants inviting them to participate in the online survey. The survey took approximately five to ten minutes to complete. After two months of data collection, the survey results were entered into a spreadsheet for data analysis.

Chapter 3

Results

Participants ($N = 208$) were Oregon psychologists recruited from the APA membership

directory and from NCSPP member programs in the state of Oregon. Because not every

respondent answered every question, a sample size will be given for every question.

Advocacy Activity

The majority of respondents (65.4%) have engaged in legislative advocacy at some point

in their life ($N = 136$). Of the respondents who indicated advocacy involvement, more

respondents (79.67%) have advocated for issues outside of the field of psychology than for

issues within the field (66.67%).

Question 1: Are there Differences in advocacy involvement between OPA leaders, OPA

members, and non-members of OPA?

Approximately 88.9% of respondents indicated they are members of APA ($N = 185$),

while 37.5% indicated they are members of OPA ($N = 78$). Of those who were members of OPA,

6.3% indicated they have served on the OPA Board ($N = 13$), 15.4% indicated they have served

on an OPA Committee ($N = 32$), and 6.3% indicated they have served in some form of leadership

position within OPA ($N = 12$) while 2.9% indicated other ($N = 6$). This information was used to

create three groups in which advocacy involvement can be compared: OPA members who are

actively involved ($N = 34$), OPA members who are not actively involved ($N = 44$), and non-OPA

members ($N = 130$).

Table 1 shows the three levels of OPA engagement (i.e. OPA leaders, OPA members, and non-members of OPA) with regard to advocacy activities. All advocacy activities were ranked on a five-point Likert scale, where 1 indicates *never* and 5 indicates *frequently*. It should be noted that most activities are occurring infrequently. Emails/letters and donations were more frequently endorsed than phone calls or visits.

Table 1

Means for advocacy activities comparing three levels of OPA activity

Activity	OPA Active[a]		OPA Members[b]		Not OPA Members[c]	
	M	SD	M	SD	M	SD
Emails/Letters	2.80	1.27	2.61	0.78	2.21	1.12
Phone calls	1.73	1.20	1.83	0.94	1.52	0.84
Visits	1.93	1.28	1.43	0.84	1.51	0.88
Donations	2.93	1.46	2.91	1.65	2.58	1.39

Notes: [a] OPA Active $n = 30$; [b] OPA Members $n = 23$; [c]Not OPA Members $n = 67$.

A three (OPA activity levels) by four (advocacy activities) repeated-measures ANOVA was conducted to determine whether there were significant differences in the endorsement of advocacy activities and whether the level of OPA engagement influenced advocacy activity. There were significant differences among advocacy activities, Greenhouse-Geisser $F(2.54, 297.70) = 42.19$, $p < .001$, such that donations occurred significantly more often than sent emails or letters, which occurred significantly more often than phone calls and visits. There was no significant difference between the overall legislative activities and level of OPA engagement,

$F(1, 117) = 2.52$, $p = .09$, and there was no interaction of OPA level of engagement with the type of legislative activity, Greenhouse-Geisser $F(2.54, 297.70) = 0.83$, $p = .53$. There was no interaction of activity and OPA engagement level, Greenhouse-Geisser $F(2.54, 297.70) = 0.83$, $p = .53$.

Question II: Are there differences in advocacy involvement based on respondents' primary place of practice?

Just over half of respondents indicated their primary place of practice being an academic setting (53%), followed by private or group practice (24%), and then a hospital, county mental health clinic, or other agency (19.7%), with six respondents indicating they are retired and one respondent indicating they are not currently practicing. About 34.1% of respondents indicated they are students working towards a PsyD/PhD ($N = 71$). Thirty-nine students indicated they are enrolled in a clinical psychology program, while 12 students indicated they are in a counseling psychology program. Thus, 89 participants identified as clinicians and 95 participants identified as students or faculty ($N = 184$). Levels of advocacy were compared for these two groups.

Table 2 shows the advocacy activities for clinicians and academics. Advocacy activities were rated on a scale from 1 to 5, where 1 indicates *never* and 5 indicates *frequently*. Again, it should be noted that most activities are occurring infrequently. Emails, letters, and donations were more frequently endorsed than phone calls or visits.

Table 2

Means (M) and Standard Deviations (SD) for Advocacy Activities Comparing Clinicians and Academics (Students and Faculty Combined)

	Overall		Clinicians[a]		Academics[b]	
Activity	*M*	*SD*	*M*	*SD*	*M*	*SD*
Emails/Letters	2.44	1.13	2.42	1.22	2.46	1.02
Phone calls	1.64	0.96	1.66	0.97	1.61	0.96
Visits	1.61	1.00	1.60	1.01	1.61	1.00
Donations	2.74	1.46	2.98	1.45	2.44	1.44

Notes: [a] Clinicians *n* = 89; [b] Academics *n* = 95.

Once again, there were significant differences among the advocacy activities, Greenhouse-Geisser $F(2.61, 305.24) = 45.61$, $p < .001$, such that donations occurred significantly more often than emails or letters, $t(119) = 2.19$, $p = .03$, while sending emails and letters occurred significantly more often than phone calls and visits, $t(119) = 8.16$, $p < .001$. There was no significant difference in the frequencies of phone calls and visits, $t(119) = 0.35$, $p = .73$. There was no effect of practice setting, $F(1, 117) = 0.73$, $p = .40$, and there was no interaction of practice setting with the type of legislative activity, Greenhouse-Geisser $F(2.61, 305.24) = 2.71$, $p = .053$.

Question III: What barriers exist that prevent greater engagement in advocacy activities?

Table 3 shows the perceived barriers to advocacy activities for the three levels of OPA engagement, i.e. non-members, members, and leaders. All barriers were rated on a scale from 1 to 5, were 1 indicates *not relevant* and 5 indicates *very relevant*. Thus, lower ratings indicate that

there is less perception of a factor as a barrier. It should be noted that most barriers are of

moderate relevance. Lack of time, knowledge, and competence were perceived as the greatest

barriers. Lack of need and poor past experiences were the least relevant barriers to advocacy.

Table 3

Means for advocacy barrier questions comparing three levels of OPA activity

Question	OPA Active[a]		OPA Members[b]		Not OPA Members[c]	
	M	SD	M	SD	M	SD
I do not have the time	3.81	1.15	3.84	1.24	4.01	1.29
I am unaware of any opportunities for advocacy	2.29	1.14	3.00	1.43	2.90	1.41
I do not have the knowledge needed to participate in advocacy	2.63	1.13	2.57	1.32	2.77	1.37
I do not have much interest in participating in advocacy	2.41	1.21	2.57	1.39	3.12	1.41
I do not feel like there is a need for advocacy	1.19	0.54	1.46	0.84	1.57	0.96
I do not feel like my participation will have much of an effect	2.03	1.03	2.70	1.05	2.61	1.17
I have had poor experiences in the past with advocacy	1.47	0.80	1.65	1.18	1.72	1.17
I do not want to be put on any "lists" or contacted frequently	2.38	1.45	2.89	1.45	3.20	1.46
I do not feel competent enough to discuss legislative issues	2.84	1.40	2.73	1.35	3.00	1.39
I do not feel that I am able to be persuasive enough	2.34	1.12	2.46	1.22	2.51	1.21
I am unaware of the current issues that need to be advocated	2.13	1.01	2.57	1.17	2.53	1.29

Notes: [a] OPA Active *n* = 32; [b] OPA Members *n*= 37; [c]Not OPA Members *n*=115.

A three (OPA activity level) by 11 (advocacy barriers) repeated-measures ANOVA was

conducted to determine whether there were significant differences in the endorsement of

advocacy barriers and whether the level of OPA engagement influenced perception of advocacy

barriers. There are significant differences among the barriers, Greenhouse-Geisser $F(6.74,$

$1,219.58) = 47.31$, $p < .001$. There are also significant differences among the three OPA

engagement levels with regard to perceived barriers, $F(2,181) = 4.31$, $p = .015$. For all 11 barrier

questions, non-members perceive barriers as a greater obstacle than did OPA leaders. OPA

members did not differ significantly from either non-members or OPA leaders, i.e., their ratings

were mid-way between the others. Finally, there is no significant interaction of OPA engagement

and perception of barriers to advocacy, Greenhouse-Geisser $F(13.48, 1,219.58) = 1.07$, $p = .38$.

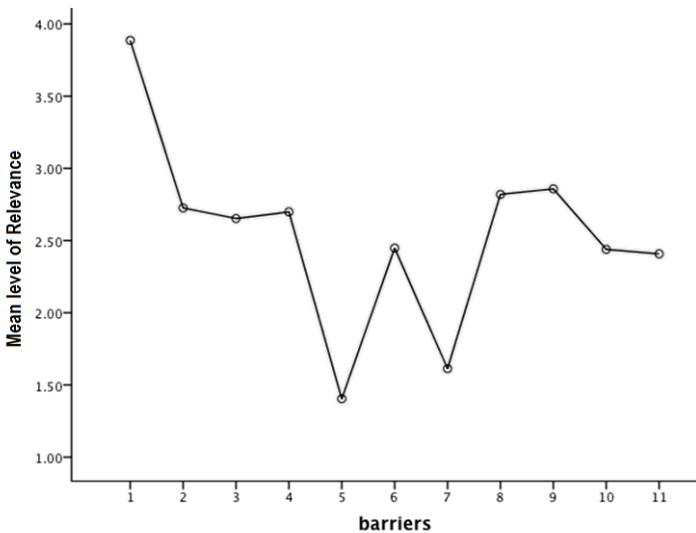*Figure 1.* The mean scores for barrier questions for the total sample.

Higher numbers indicate a greater barrier.

Figure 1 shows the mean perceive relevance for the eleven barriers to advocacy. Pair-

samples t-tests indicate that there are four groupings of barriers. Question 1 (I do not have the

time) stands alone as the greatest barrier. A second group, composed of questions 9 (I do not feel

competent), 2 (unaware of opportunities), and 8 (don't put me on any "lists"), pose the next

highest level of barriers. The third group of barriers is composed of questions 8 (don't put me on

any "lists"), 4 (not much interest), 3 (don't have the knowledge), 11 (unaware of issues), 10 (not

persuasive), and 6 (I won't have an effect). Finally, questions 7 (poor past experiences) and 5

(there is no need) had the lowest effect as barriers.

Table 4 shows the perceived barriers to advocacy activities for the clinicians and

academics. Again, all barriers were rated on a scale from 1 to 5, where 1 indicates *not relevant*

and 5 indicates *very relevant*. Thus, lower ratings indicate that there is less perception of a factor

as a barrier. It should be noted that most barriers are of moderate relevance. Lack of time,

knowledge, and competence were perceived as the greatest barriers. Lack of need and poor past

experiences were the least relevant barriers to advocacy.

A two (academics/ clinicians) by 11 (barriers) repeated-measures ANOVA was

conducted. There were significant differences among the barriers, Greenhouse-Geisser $F(6.88,$

$1251.24) = 66.49, p < .001$. There was also a significant difference between the perceived

relevance of barriers for clinicians and academics, $F(1, 182) = 6.52, p = .01$, and an interaction of

clinicians and academics with the type of barrier, Greenhouse-Geisser $F(6.88, 1251.24) = 2.43, p$

$= .02$. Further analysis of the interaction was conducted using paired-samples t-tests and these

results are shown in Table 4. These results indicate that academics feel they are less aware of

opportunities for advocacy; less competent to discuss legislative issues, they feel less persuasive,

and they feel they are less aware of the current issues.

Table 4

Means for barrier questions comparing clinicians and academics (students and faculty combined). Higher numbers indicate a greater barrier

Question	Clinicians[a]		Academics[b]				
	M	*SD*	*M*	*SD*	*t*	sig	*p* < .05
I do not have the time	3.84	1.36	4.03	1.13	-1.02	.310	
I am unaware of any opportunities for advocacy	2.49	1.42	3.11	1.29	-3.04	.003	*
I do not have the knowledge needed to participate in advocacy	2.52	1.31	2.87	1.31	-1.85	.067	
I do not have much interest in participating in advocacy	2.81	1.47	2.96	1.34	-0.72	.474	
I do not feel like there is a need for advocacy	1.52	0.94	1.44	0.82	0.57	.567	
I do not feel like my participation will have much of an effect	2.44	1.12	2.61	1.17	-1.03	.306	
I have had poor experiences in the past with advocacy	1.69	1.21	1.64	1.02	0.26	.794	
I do not want to be put on any "lists" or contacted frequently	2.99	1.58	2.99	1.38	-0.00	.997	
I do not feel competent enough to discuss legislative issues	2.63	1.41	3.19	1.30	-2.81	.006	*
I do not feel that I am able to be persuasive enough	2.28	1.23	2.65	1.13	-2.14	.035	*
I am unaware of the current issues that need to be advocated	2.17	1.17	2.75	1.22	-3.28	.001	*

Notes: [a] Clinicians *n* = 89; [b] Academics *n* = 95.

Question IV: Do the current results differ from Gronholt's findings?

Gronholt (2008) examined a national sample of students and faculty. She asked them to indicate the relevance of 11 barriers to engaging in advocacy. In general she found that the most significant barriers were lack of awareness of issues and opportunities and a lack of interest in engaging in advocacy.

Table 5 shows the mean relevance ratings for the 11 barriers for the respondents in the current sample and those in Gronholt's study. For all of the barriers except 5 (I do not feel like there is a need for advocacy) and 7 (I have had poor experiences in the past with advocacy), the current sample reported that the barrier was more relevant than did Gronholt's sample. Interestingly, for both samples, barriers 5 and 7 were also considered the least relevant among the 11 barriers listed. Since Gronholt's sample had only included academics, Table 6 provides a comparison of Gronholt's sample of academics and the academics from the current study. Again, for all of the barriers except 5 and 7 the academic sample reported that the barrier was more relevant than did Gronholt's sample. Finally, Table 7 compares the clinicians in the current sample with Gronholt's sample of academics. The current sample of clinicians found barriers less relevant than the current sample of academics did and did not differ from Groholt's sample on 6 of the 11 barriers (i.e., barriers # 2, 3, 5, 7, 9 and 11).

Table 5

Means and standard deviations for barrier questions for the total sample (n = 184) compared with Gronholt's (2008; n = 159) means. Higher scores indicate greater barrier strength

Question	Current Total		Gronholt			
	M	*SD*	*M*	*SD*	*t*	sig
1. I do not have the time	3.94	1.25	3.31	.80	6.83	<.001
2. I am unaware of any opportunities for advocacy	2.81	1.39	2.43	.95	3.71	<.001
3. I do not have the knowledge needed to participate in advocacy	2.70	1.32	2.38	.97	3.30	<.001
4. I do not have much interest in participating in advocacy	2.89	1.40	2.18	.96	6.84	<.001
5. I do not feel like there is a need for advocacy	1.48	.88	1.42	.65	.90	.37 ns
6. I do not feel like my participation will have much of an effect	2.53	1.14	2.09	.87	5.20	<.001
7. I have had poor experiences in the past with advocacy	1.66	1.11	1.55	.80	1.38	.17 ns
8. I do not want to be put on any "lists" or contacted frequently	2.99	1.48	1.99	.99	9.17	<.001
9. I do not feel competent enough to discuss legislative issues	2.92	1.38	2.38	.97	5.30	<.001
10. I do not feel that I am able to be persuasive enough	2.48	1.19	2.01	.85	5.27	<.001
11. I am unaware of the current issues that need to be advocated	2.47	1.23	2.29	1.02	1.96	.052

Table 6

Means and standard deviations for barrier questions for the Academics (n = 95) compared with Gronholt's (2008; n = 159) means. Higher scores indicate greater barrier strength

Question	Current Academics		Gronholt			
	M	*SD*	*M*	*SD*	*t*	sig
1. I do not have the time	4.03	1.13	3.31	.80	6.20	<.001
2. I am unaware of any opportunities for advocacy	3.11	1.29	2.43	.95	5.09	<.001
3. I do not have the knowledge needed to participate in advocacy	2.87	1.31	2.38	.97	3.66	<.001
4. I do not have much interest in participating in advocacy	2.96	1.34	2.18	.96	5.67	<.001
5. I do not feel like there is a need for advocacy	1.44	0.82	1.42	.65	.26	.79
6. I do not feel like my participation will have much of an effect	2.61	1.17	2.09	.87	4.34	<.001
7. I have had poor experiences in the past with advocacy	1.64	1.02	1.55	.80	.88	.38
8. I do not want to be put on any "lists" or contacted frequently	2.99	1.38	1.99	.99	7.06	<.001
9. I do not feel competent enough to discuss legislative issues	3.19	1.30	2.38	.97	6.07	<.001
10. I do not feel that I am able to be persuasive enough	2.65	1.13	2.01	.85	5.55	<.001
11. I am unaware of the current issues that need to be advocated	2.75	1.22	2.29	1.02	3.65	<.001

Table 7

*Means and standard deviations for barrier questions for the clinicians sample (*n = 89)
compared with Gronholt's (2008; n = 159) *means. Higher scores indicate greater barrier*
strength

	Current Clinicians		Gronholt			
Question	*M*	*SD*	*M*	*SD*	*t*	sig
1. I do not have the time	3.84	1.36	3.31	.80	3.68	<.001
2. I am unaware of any opportunities for advocacy	2.49	1.42	2.43	.95	.43	.67
3. I do not have the knowledge needed to participate in advocacy	2.52	1.31	2.38	.97	.99	.33
4. I do not have much interest in participating in advocacy	2.81	1.47	2.18	.96	4.04	<.001
5. I do not feel like there is a need for advocacy	1.52	0.94	1.42	.65	.97	.33
6. I do not feel like my participation will have much of an effect	2.44	1.12	2.09	.87	2.97	<.001
7. I have had poor experiences in the past with advocacy	1.69	1.21	1.55	.80	1.05	.30
8. I do not want to be put on any "lists" or contacted frequently	2.99	1.58	1.99	.99	5.95	<.001
9. I do not feel competent enough to discuss legislative issues	2.63	1.41	2.38	.97	1.67	.09
10. I do not feel that I am able to be persuasive enough	2.28	1.23	2.01	.85	2.07	.04
11. I am unaware of the current issues that need to be advocated	2.17	1.17	2.29	1.02	-.98	.33

Question V: What motivations exist that encourage greater engagement in advocacy activities?

The mean for the six motivational questions are shown in Table 8 (see also, Figure 2). A repeated-measures ANOVA indicates that there are significant differences in the responses to the six motivators, Greenhouse-Geiser $F(3.94, 468.76) = 225.74$, p < .001.

Table 8

Means and standard deviations for motivation questions. Higher numbers indicate more influential motivational factors.

	Entire sample[a]	
I became involved with advocacy…	*M*	*SD*
1. because of my personal values	4.34	1.04
2. because of social connections	2.77	1.33
3. to add items to my CV	1.48	0.76
4. to fulfill a job expectation	1.30	0.77
5. grad school requirement	1.12	0.55
6. interesting learning experience	1.95	1.20

Notes: [a] *n* = 120.

Personal values is a greater motivator than any of the others, $t(119) = 11.97$, $p < 0.001$. Social connections is a better motivator than adding items to a curriculum vita, fulfilling a job or school requirement, or pursuing a learning experience, t(119) = 11.75, $p < 0.001$.
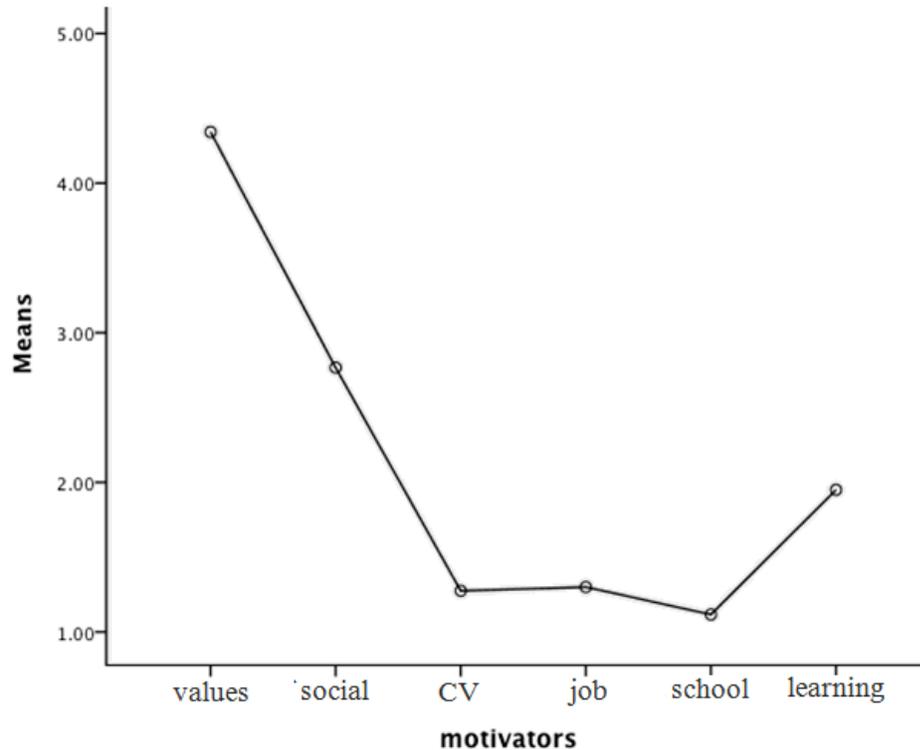
Figure 2. The mean aggregate ratings for each of the six motivators.

The third most effective motivator was pursuing an interesting learning experience, which was more motivating than adding items to a curriculum vitae or fulfilling a job or school requirement.

The three least motivating factors, in order of effectiveness, were fulfilling a job expectation, which was significantly more motivating than adding items to a curriculum vita, which was significantly more motivating than a school requirement.

Table 9 shows the mean responses to the six motivational questions by respondents at three levels of OPA engagement. A 6 (motivators) by 3 (OPA engagement level) repeated-measures ANOVA revealed a main effect for motivators (Greenhouse-Geisser $F_{(3.93, 460.33)}$ =

198.10, $p < .001$), but no effect for OPA engagement level (Greenhouse-Geisser $F(2, 117) =$ 1.77, $p = .18$), and no interaction of OPA engagement by motivator (Greenhouse-Geisser $F(7.87, 460.33) = 1.84$, $p = .07$

Table 9

Means and standard deviations for motivation questions for three OPA engagement levels. Higher numbers indicate more influential motivational factors

I became involved with advocacy…	Non-members ($n = 130$)		OPA members ($n = 44$)		Active members ($n = 34$)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*F*	sig
because of my personal values	4.21	1.14	4.61	0.99	4.43	0.82	1.43	.24
because of social connections	2.66	1.32	2.83	1.23	2.97	1.40	0.59	.56
to add items to my CV	1.31	0.82	1.09	0.29	1.33	0.84	0.89	.41
to fulfill a job expectation	1.27	0.69	1.39	0.94	1.30	0.84	0.21	.81
grad school requirement	1.18	0.72	1.04	0.21	1.03	0.18	0.97	.38
interesting learning experience	1.67	1.01	2.09	1.13	2.47	1.36	5.05	.01

Similarly, Table 10 shows the mean responses to the six motivational questions by clinicians and academics. A 6 (motivators) by 2 (practice settings) repeated-measures ANOVA revealed a main effect for motivators (Greenhouse-Geisser $F(3.92, 458.71) = 220.83$, $p < .001$), but no effect for practice setting (Greenhouse-Geisser $F(2, 117) = 2.61$, $p = .11$), and no

interaction of practice setting and motivator (Greenhouse-Geisser $F(3.92, 458.71) = 0.82$, $p =$

.51).

Table 10

Means and standard deviations for motivation questions comparing clinicians and academics
(students and faculty combined). Higher numbers indicate more influential motivational factors.

	Clinicians[a]		Academics[b]			
I became involved with advocacy…	*M*	*SD*	*M*	*SD*	*t*	sig
because of my personal values	4.20	1.20	4.52	0.80	-1.73	.086
because of social connections	2.78	1.41	2.76	1.24	.10	.918
to add items to my CV	1.17	0.60	1.41	0.90	-1.66	.101
to fulfill a job expectation	1.17	0.49	1.46	1.00	-1.97	.053
grad school requirement	1.12	0.70	1.11	0.31	0.12	.907
interesting learning experience	1.91	1.11	2.02	1.31	-0.50	.619

Notes: [a] Clinicians *n* = 89; [b] Academics *n* = 95.

Question VI: What were the issues that respondents advocated for in the past?

Respondents were asked to list the issues that they have engaged in advocacy around.

The open-ended responses were then grouped in categories. The following categories are

presented in order of prominence: healthcare reform (28%), marriage equality/LGBTQ issues

(20%), environment (14%), prescription privileges (12%), women's rights (12%), funding

(10%), licensure (8%), education (8%), political issues (8%), student loans (5%), cannot

remember (5%), religious issues (2%), and the small remainder of uncategorized issues included

topics such as child abuse, aging, human trafficking, child hunger, gambling, tobacco control,

and suicide prevention.

Chapter 4

Discussion

This study was concerned with exploring the differences in advocacy involvement between OPA members, OPA leaders, and non-members and between clinicians and academics. Very few studies have examined the advocacy behavior of groups of people based on where they work and their activity in state associations. The intended goal of this descriptive study was to discover what might motivate or hinder these unique groups of respondents.

The majority of respondents have some kind of advocacy involvement or experience. Interestingly, slightly more respondents indicated that they have advocated for more issues outside the field of psychology than inside the field. Most advocacy activities occurred infrequently with emails, letters, and donations were more frequently endorsed than phone calls or visits. There was no significant difference found between clinicians and academics in relation to advocacy activities. There was also no interaction of practice setting with activities. Furthermore, higher levels of engagement with OPA did not correlate to less perceived barriers to advocacy.

Gronholt (2008) found that the most significant barriers were lack of awareness of issues and opportunities and a lack of interest in engaging in advocacy. In this current study, lack of time, knowledge, and competence were perceived as the greatest barriers. Lack of need and poor past experiences were the least relevant barriers to advocacy among respondents in the current study and in Gronholt's study. Compared to clinicians, academics feel they are less aware of

opportunities for advocacy, less competent to discuss legislative issues, less persuasive, and less aware of the current issues that need advocacy. Personal values was ranked as the greatest motivator followed by social connections. The top three issues advocated for were healthcare reform, marriage equality/LGBTQ issues, and the environment.

Implications for Practice and Research

This study's findings suggest that place of practice or involvement in a state psychological association may not be as relevant to advocacy behavior as one might expect. In one comparison, academics, predominantly composed of students, indicated they felt less aware, competent, and persuasive than clinicians. It seems reasonable to suggest that more seasoned clinicians had more opportunities to engage in advocacy efforts and learn of advocacy opportunities while students and faculty are less exposed to issues. Adding advocacy training as core curriculum or requiring advocacy-focused colloquium might help to increase students' knowledge and awareness. As this study has found, several other studies have identified barriers to advocacy and some of these have included lack of awareness of public policy issues, lack of training, lack of time, disinterest, inadequate resources, and uncertainty (Heinowitz et al., 2012; Myers & Sweeney, 2004).

It seems that lack of time continues to be an enormous barrier for many people of all professions. Hill (2013) comments that it would be helpful if psychologists had more professional associations that are built into the workplace to help employees to more easily navigate the political landscape with their organization. Clearly, this ideal model cannot be as smoothly implemented at all organizational levels because of the higher rates of private and independent practices among psychologists than other professionals. Psychologists interested in

organizational advocacy may be able to influence much change through serving as a consultant to various organizations or systems.

By far, most respondents indicated personal values as being their biggest motivator when getting involved in advocacy. This suggests that people can and do get involved in advocacy when an issue arises that they feel the urge to defend because it reflects their value system or they feel the need to be an advocate for the voiceless regardless of the issue at stake.

More research is needed to parse out why other professions seem to have greater local, state, and national representation. One potential reason may be the lack of parity between mental health and medicine, for example. The arena of mental health as a profession and field of study continues to experience stigma, which may account for less public funding and advocacy work on the part of both professionals and laymen.

Furthermore, a gender disparity may account for some of the representation discrepancy. Although women are increasingly outnumbering men throughout higher education, women continue to outnumber men in the field of psychology more than most other fields of study. One loose correlation that may be hypothesized is that other fields have greater representation because of the greater power, prestige, and status that if often associated in the more male dominant fields such as those of law, medicine, science, and engineering. With this greater status naturally comes a louder advocacy voice.

Lastly, the need for advocacy involvement and a call for action are obvious. A sense of urgency must be fostered. Further exploration of behavior change is necessary. Some interventions might include incorporating principles from motivational interviewing (MI) and acceptance and commitment therapy (ACT) into conferences to raise awareness and activate

change. Miller and Rollnick define motivational interviewing as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2013). They propose there are five stages of change all individuals go through before committing to a behavior and these include pre-contemplation, contemplation, preparation, action, and maintenance. The main principle of ACT involves helping the client to see how their actions align or do not align with their values, beliefs, and wishes.

Future research may involve considering behavioral factors that are influenced by a sense of urgency or vice versa. A delay in reinforcement between advocacy activity and outcome may explain why some individuals lose momentum with the consequent delay of gratification. Various personality factors may also explain why some individuals more readily engage in advocacy behaviors.

Limitations

The generalizability of this study is limited to graduate students and psychologists in the state of Oregon. The slightly low response rate inhibits broad generalizations regarding advocacy behaviors of graduate students and psychologists across the nation. A randomized sample of psychologists from the APA membership database were asked to take the survey. It is possible that APA membership is a confounding variable positively correlated with their advocacy behavior. Future research should focus on assessing a more diverse population. It is also possible that those respondents who chose to complete the survey had a greater interest in advocacy and perhaps more experiences as well.

Furthermore, there are an infinite number of barriers and motivations that affect advocacy participation. The current study assessed only 11 barrier factors and 6 motivation factors. Future

research may look at additional factors or may utilize an open-ended format that allows respondents to offer their own barriers and motivations. Also, categorizing "primary place of practice" into only four groups is limiting. Again, using an open-ended format may be more beneficial.

Conclusions

The findings in this study suggest there is a continued need to stress the importance of understanding advocacy behavior as a means to increasing advocacy participation. Knowing lack of time is a relevant barrier but social connections is a top motivator perhaps suggests a need for more organized advocacy initiative groups where the amount time devoted to advocacy projects is shared and distributed. As society becomes increasingly more digital, ways of engaging in advocacy are becoming more digital, which can save on the time and expense of travel. Greater awareness of advocacy opportunities and issues can be achieved through an advocacy curriculum imbedded in graduate programs or through mandated legislative advocacy training days. Regardless of place of practice, all psychologists everywhere have a role to play. Education and awareness needs to begin at the graduate or undergraduate level. Increasing advocacy awareness involves reminding psychologists and psychologists in training that we need to be the voice for those who are not able to speak for themselves. A profession is only advanced and protected when there is an active voice advocating for it (Hill, 2013).

Participation in advocacy work takes time, energy, organization, commitment, and sometimes, technical expertise. It is imperative that we find ways to increase the awareness and importance of advocacy and the need for more participation. We cannot deny the fact that advocacy in its multitude of forms is an inherent part of the profession. Graduate school training,

role modeling, and mentoring need to be implemented. More research is needed to not only fully

uncover the barriers and motivations to advocacy, but also to develop a proven intervention that

will encourage participation.

References

Advocacy for Mental Health. (2003). *Mental Health Policy and Service Guidance Package*, WHO Library Cataloguing-in-Publication Data.

Buffmire, J. A. (1995). Are politics for you? *Professional Psychology: Research and Practice, 26*(5), 453-455. doi: 10.1037/0735-7028.26.5.453.

Chang, C. Y., Hays, D. G., & Milliken, T. F. (2009). Addressing social justice issues in supervision: A call for client and professional advocacy. *Clinical Supervisor, 28*(1), 20-35. doi: 10.1080/07325220902855144.

Cohen, K. R., Lee, C. M., & McIwraith, R. (2012). The psychology of advocacy and the advocacy of psychology. *Canadian Psychology/Psychologie Canadienne, 53*(3), 151-158. doi: 10.1037/a0027823.

de la Paz, M. M. (2012). Professional counselors' perceptions of knowledge, barriers, support and action of professional advocacy, *Dissertation Abstracts International*, 72(10-B), 6412.

DeLeon, P. H., Loftis, C. W., Ball, V., & Sullivan, M. J. (2006). Navigating politics, policy, and procedure: A firsthand perspective of advocacy on behalf of the profession. *Professional Psychology: Research and Practice, 37*(2), 146-153. doi: 10.1037/0735-7028.37.2.146.

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P., Madison, M. B., & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*(4), S5-S26. doi: 10.1037/a0015832.

Fox, R. E. (2003). From the desk of the chair: The cold hard facts. *Advance: Newsletter of the Association for the Advancement of Psychology*, p. 3.

Fox, R. E. (2008). Advocacy: The key to the survival and growth of professional psychology. *Professional Psychology: Research and Practice, 39*(6), 633-637. doi: 10.1037/0735-7028.39.6.633.

Ginsberg, M. R., Kilburg, R. R., & Bukland, W. (1983). State-level legislative and policy advocacy: An introduction and systemic review. *American Psychologist, 38*(11), 1206-1209, doi: 10.1037/0003-066X.38.11.1206.

Gronholt, J. M. (2008). *An exploration of the differences in psychology faculty and graduate students' participation in mental health legislation and barriers to advocacy.* (Doctoral dissertation). George Fox University, Newberg, OR.

Heinowitz, A. E., Brown, K. R., Langsam, L. C., Arcidiacono, S. J., Baker, P. L., Badaan, N. H., … Cash, R. (2012). Identifying perceived personal barriers to public policy advocacy within psychology, *Professional Psychology: Research and Practice, 43(4)*, 372-378. doi: 10.1037/a0029161.

Hill, J. K. (2013). Partnering with a purpose: Psychologists as advocates in organizations. *Professional Psychology: Research and Practice, 44*(4), 187-192.

Lating, J. M., Barnett, J. E., & Horowitz, M. (2009). Increasing advocacy awareness within professional psychology training programs: The 2005 National Council of Schools and Programs of Professional Psychology self-study. *Training and Education in Professional Psychology, 3*(2), 106-110. doi: 10/1037/a0013662.

Lating, J. M., Barnett, J. E., & Horowitz, M. (2010). Creating a culture of advocacy. In M.

      Kenkel, & R. L. Peterson (Eds.), *Competency-based education for professional*

      psychology (pp. 201-208). Washington, DC US: American Psychological Association.

      doi: 10.1037/12068-011.

Levant, R. F., Reed, G. M., Ragusea, S. A., DiCowden, M., Murphy, M. J., Sullivan, F.,

      …Stout, C. E. (2001). Envisioning and accessing new roles for professional psychology.

      Professional Psychology: Research and Practice, 32(1), 79-87. doi: 10/1037/0735-

      7028.32.1.79.

McClure, B. A., & Russo, T. R. (1996). The politics of counseling: Looking back and forward.

      Counseling and Values, 40(3), 162-174.

Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change. New

      York, NY: The Guilford Press.

Myers, J. E., & Sweeney, T. J. (2004). Advocacy for the counseling profession: Results of a

      national survey. *Journal of Counseling & Devlopment, 82*(4), 466-471.

Portnoy, S. M., Friedland, S. J., Norman, M. M., Calveric, B. R., Eisman, E. J., & Zapf, R. F.

      (1983). Effective state-level advocacy: A model for action. *American Psychologist,*

      38(11), 1220-1226. doi: 10.1037/0003-066X.38.11.1220.

Putnam, R. D. (2001). *Bowling alone: The collapse and revival of American community.* New

      York: Simon and Schuster.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among

      counseling paradigms. *Journal of Humanistic Counseling, Education and Development,*

      48(2), 160-172.

Ratts, M. J., & Ford, A. (2010). Advocacy Competencies Self-Assessment (ACSA) Survey©: A

    tool for measuring advocacy competence. In M. J. Ratts, R. L. Toporek, & J. A. Lewis

    (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (pp. 21-

    26). Alexandria, VA US: American Counseling Association.

Schwartz, R. C., Semivan, S. G., & Stewart, T. A. (2009). The art of advocacy: Strategies for

    psychotherapists. *Annals of the American Psychotherapy Association, 54*(12), 54-60.

Thompson, A, Kerr, D., Dowling, J., & Wagner, L. (2012). Advocacy 201: Incorporating

    Advocacy Training in Health Education Professional Preparation Programs, *Health*

    Education Journal, *71*(3), 268-277.

Wojcik, E. (2012, October). Innovative education. *Monitor on Psychology, 43*(9), 66.

Wright, R. H. (1992). The American Psychological Association and the rise of the advocacy,

    Professional Psychology: Research and Practice, 23(6), 443-447. doi:

    10.1037/0737028.23.6.443.

Appendix: A

Survey:

Informed Consent

1. You are invited to participate in a survey that focuses on the advocacy activities of
    psychologists and psychology students. It will take approximately 5-10 minutes to
    complete the questionnaire.

    Your participation in this study is completely voluntary. This study has been approved by
    the IRB at George Fox University. There are no foreseeable risks involved; however, if
    you are uncomfortable answering any of the questions, you can withdraw from the survey
    at any time. Your survey responses will be kept completely confidential. Once you
    complete the survey, you will have the opportunity to enter a drawing for a gift card from
    Amazon.com.

    In this study "advocacy" is defined as a broad range of behaviors and attitudes focused on
    legislative advocacy as a means to bring greater relevancy to the field of psychology.
    Advocacy engagement may include, but is not limited to, writing or emailing a letter to
    an editor or legislator, visiting or calling a legislator, and donating money to various
    organizations.

    I have read the above and wish to proceed with the survey:
    a. Yes
    b. No

Section I
Advocacy Participation:

2. I am a member of the American Psychological Association:
    a. Yes
    b. No
3. I am a member of the Oregon Psychological Association:
    a. Yes
    b. No
4. Please choose the most appropriate response:
    a. I have never been a member of OPA and I do not plan to become a member.
    b. I have never been a member of OPA, but I plan on becoming a member.
    c. I have been a member, but my membership has lapsed.
5. While a member of OPA, have you ever:
    a. Served on the OPA Board?
    b. Served on an OPA committee?

    c. Held a leadership position within OPA?

    d. None of these

    e. Other (please specify)

6. Have you ever engaged in legislative advocacy? (Advocacy engagement may include, but is not limited to, writing or emailing a letter to an editor or legislator, visiting or calling a legislator, and donating money to various organizations).

    a. Yes

    b. No

7. Within the past five years, I have:

    a. Written emails or letters to the editor: (5-frequently….1-never)

    b. Written emails or letters to elected officials or other agencies: (5-frequently….1-never)

    c. Made phone calls to elected officials or other agencies: (5-frequently….1-never)

    d. Made visits to elected officials or other agencies: (5-frequently….1-never)

    e. Donated money to legislative issues or groups: (5-frequently….1-never)

8. If you have ever participated in legislative advocacy, what was the issue(s)?

    a. Not applicable: I have not participated in legislative advocacy.

    b. Issue(s):

9. How many issues have you advocated for within the field of psychology?

    a. Number of issues:

10. How many issues have you advocated for outside the field of psychology?

    a. Issue(s):

11. By what means did you engage in legislative advocacy?

    a. Not applicable: I have not participated in legislative advocacy.

    b. Please list below the ways you have engaged in legislative advocacy (e.g. email, letter, visit with legislator, etc.):

12. In the past year, have you visited the Oregon State Legislature in response to advocacy efforts?

    a. Yes

    b. No

13. At what level(s) of government did you participate in legislative advocacy? (Check all that apply)

    a. Local

    b. State

    c. Federal

    d. None of the above

14. With what organization(s) did you participate in legislative advocacy? (Check all the apply)

    a. OPA

    b. APA

    c. Independently –not affiliated with an organization

    d. Others

    e. None of the above

Section II
Motivations to Advocacy:

15. Please indicate how strongly the following factors influenced your participation in advocacy:
    a. I became involved with advocacy because of my personal values (5-Very Influential…1-Not Influential)
    b. I became involved with advocacy because of social connections (5-Very Influential…1-Not Influential)
    c. I became involved with advocacy to add items to my curriculum vitae/resume (5-Very Influential…1-Not Influential)
    d. I became involved with advocacy to fulfill a job expectation (5-Very Influential…1-Not Influential)
    e. I became involved with advocacy to fulfill a core requirement of my graduate school training (5-Very Influential…1-Not Influential)
    f. I became involved with advocacy because it seemed like an interesting learning experience (5-Very Influential…1-Not Influential)

Section III
Previous Training in Advocacy:

16. Have you ever participated in advocacy training?
    a. Yes
    b. No
17. How effective in increasing your understanding of advocacy methods and theories did you find this training? (5-Very Effective…1-Not Effective)
18. To what extent did your previous advocacy training teach you effective advocacy skills? How effective in increasing your understanding of advocacy methods and theories did you find this training? (5-Very Extensively…1-Not at All)
19. How well do you feel your previous training prepared you to interact in a legislative setting? (5-Very Prepared….1-Unprepared)
20. How effective in increasing your probability of participating in future advocacy events did you find this training? (5-Very Effective…1-Not Effective)
21. Has your previous advocacy training been a part of your current school curriculum or an independent event outside of your graduate training?
    a. School
    b. Outside of School
    c. Both

Section IV
Barriers to Advocacy:

22. Please rank how significant each factor is in keeping you from participating in advocacy activities.

a. I do not have the time. (5-Very Relevant…1-Not Relevant)
b. I am unaware of any opportunities for advocacy. (5-Very Relevant…1-Not Relevant)
c. I do not have the knowledge needed to participate in advocacy. (5-Very Relevant…1-Not Relevant)
d. I do not have much interest in participating in advocacy. (5-Very Relevant…1-Not Relevant)
e. I do not feel like there is a need for advocacy. (5-Very Relevant…1-Not Relevant)
f. I do not feel like my participation will have much of an effect. (5-Very Relevant…1-Not Relevant)
g. I have had poor experiences in the past with advocacy. (5-Very Relevant…1-Not Relevant)
h. I do not want to be put on any "lists" or contacted frequently. (5-Very Relevant…1-Not Relevant)
i. I do not feel competent enough to discuss legislative issues. (5-Very Relevant…1-Not Relevant)
j. I do not feel that I am able to be persuasive enough. (5-Very Relevant…1-Not Relevant)
k. I am unaware of the current issues that need to be advocated. (5-Very Relevant…1-Not Relevant)

Section V
Demographics:

23. If advocacy opportunities were not as available to you as they currently are, would you readily seek them out?
    a. Yes
    b. No
24. What is your age?
    a. I prefer not to say.
    b. Age:
25. How do your self-identify?
    a. Female
    b. Male
    c. Other (please specify):
26. What is your ethnicity? (Check all that apply)
    a. African American or Black
    b. American Indian or Alaska Native
    c. Asian
    d. Hispanic or Latino
    e. Native Hawaiian or Other Pacific Islander
    f. White
    g. Other (please specify)
27. Please indicate your primary place of practice:
    a. Academic (student or faculty)

    b. Institution (e.g. hospital, county mental health, or agency)
    c. Private or group practice
    d. Other (please specify)

28. What is your approximate average personal income annually? (Optional)
    a. $0 -$24,999
    b. $25,000-$49,999
    c. $50,000-$74,999
    d. $75,000-$99,999
    e. $100,000-$124,999
    f. $125,000-$149,999
    g. $150,000-$174,999
    h. $175,000-$199,999
    i. $200,000 and up

29. Please select any of the following items that described you (check all that apply):
    a. Student working towards PhD/PsyD
    b. Student in a clinical psychology program
    c. Student in a counseling psychology program
    d. Licensed psychologist who holds PhD/PsyD
    e. Non-licensed resident who holds PhD/PsyD
    f. Psychologist with a degree from a clinical psychology program
    g. Psychologist with a degree from a counseling psychology program
    h. Other (please specify)

Thank you for participating in this survey! If you would like to be entered in a drawing for a $50 gift certificate from Amazon.com please send an email to webbb11@georgefox.edu.

Appendix B

Curriculum Vitae

Bethany Webb

22315 SW Nottingham Ct. • Sherwood, OR 97140
219.793.2360 • bzander11@georgefox.edu

E D U C A T I O N

Expected   **Doctoral of Psychology, Clinical Psychology**
May 2016   *George Fox University, Newberg, OR*, APA accredited
                  Doctoral Dissertation: Defended June 2014

May 2013   **Master of Arts, Clinical Psychology**
                  George Fox University, Newberg, OR

January 2011   **Bachelor of Arts, Psychology**
                  Taylor University, Upland, IN

C E R T I F I C A T I O N S

August 2014   **Workforce Development for Integrated Behavioral Healthcare Training**
                  George Fox University, Newberg, OR
                  • 40 hours of lecture, discussion, and role play that covered a variety of concepts in integrated primary care including primary care models, role of a Behavioral Health Consultant, billing, record keeping, evidenced-based interventions and assessment, psycho-education, stages of change, and motivational interviewing.

March 2013   **Acceptance and Commitment Therapy Bootcamp Training**
                  Contextual Change LCC, Reno, NV
                  • An intensive, 4-day long training including experiential and conceptual material designed to equip participants with the knowledge and skills to use ACT in everyday therapy practice.
                  • Speakers: Steven C. Hayes, PhD, Robyn Walser, PhD, Louise Hayes, PhD, and Jason Luoma, PhD

S U P E R V I S E D   C L I N I C A L   T R A I N I N G

June 2014 -   **Practicum Pre-Intern: Behavioral Health Consultant: Oregon Health and**

Present   **Science University Family Medicine Richmond Clinic –Portland, OR**

Setting: Primary Care
Supervisors: Joan Fleishman, PsyD, Marie-Christine Goodworth, PhD, and Darren Janzen, PsyD
Population: Low-income individuals and families, including those with Medicaid/Medicare and the uninsured

Responsibilities: Provided therapeutic services, including individual psychotherapy, couples, family, and group, psychological assessment and report writing within an integrated primary care model, and treatment planning for underserved populations. Other responsibilities included electronic medical notes and review, report writing, consultation with medical providers and supervisors, and warm hand-off sessions. Participated in weekly multidisciplinary consultations, case presentations and discussions, and didactic trainings.

May 2013 –   **Supplemental Practicum: Behavioral Health Intern: On-Call Emergency**
Present   **Department Providence Newberg Medical Center and Willamette Valley Medical Center – Newberg, OR and McMinnville, OR**

Setting: Hospital
Supervisors: Mary Peterson, PhD, Bill Buhrow, PsyD, and Joel Gregor, PsyD
Population: Diverse population of high-risk patients

Responsibilities: Provided 15-hour behavioral health consultation services for Emergency Department, Intensive Care Unit, and Medical/Surgical unit twice a month. Assessed patients for suicidality, chronic pain, dementia, and mental status exam, and various other psychological factors affecting medical care. Obtained dependent practitioner credential from hospital board of physicians (two-year tenure). Participated in weekly group supervision, which included case presentation, case discussion, and discussion of psychopharmacology topics.

2014 –   **Supplemental Practicum: Western Psychological and Counseling Services**
Present   **Tigard, OR**

Setting: Community Mental Health Clinic
Supervisors: Rodger Bufford, PhD
Population: Low-income individuals and families, including those with Medicaid/Medicare and the uninsured

Responsibilities: Provided individual, couples, family, and group therapy and assessment to children and adults with a variety of presenting problems including depression, anxiety, personality disorder, ADHD, bipolar disorder, grief/bereavement, and major life adjustments. Responsible for managing schedule and handling all of my own billing. Participated in individual supervision.

June 2013 –   **Practicum II: Master's Level Behaviorist: Oregon Health and Science**
June 2014   **University Family Medicine Richmond Clinic –Portland, OR**

Setting: Primary Care
Supervisors: Marie-Christine Goodworth, PhD and Tami Hoogestraat, PsyD
Population: Low-income individuals and families, including those with
Medicaid/Medicare and the uninsured

Responsibilities: Provided therapeutic services, including individual psychotherapy,
couples, family, and group, psychological assessment and report writing within an
integrated primary care model, and treatment planning for underserved populations.
Other responsibilities included electronic medical notes and review, report writing,
consultation with medical providers and supervisors. Participated in weekly
multidisciplinary consultations, case presentations and discussions, and didactic
trainings.

2013   **Supplemental Practicum: Oregon Rehabilitation Association –Salem, OR**

Setting: Private Practice
Supervisors: Marie-Christine Goodworth, PhD
Population: Patients applying for disability insurance: mostly patient with learning
disabilities and developmental delays

Responsibilities: Conducted eligibility assessments, including cognitive and
neuropsychological screeners, to assist county and state entities to determine if
individual qualifies for services.

2012 - 13   **Practicum I: North Clackamas School District: Rex Putnam High School –**
              Milwaukie, OR

Setting: High School
Supervisors: Fiorella Kassab, PhD and Marie-Christine Goodworth, PhD
Population: Mostly students who were on an Individualized Education Plan

Responsibilities: Provided individual and group psychotherapy. Provided consultation
to district administrators for student academic and behavioral issues as well as IEP
planning. Provided feedback to parents, students, and teachers regarding assessment
results and interpretation. Conducted cognitive and behavioral assessments and
report writing. Participated in weekly individual and group supervision

2012 -   **Clinical Team**
Present   *George Fox University, Newberg, OR*
              • Weekly faculty led clinical training

- Case presentations, diagnositic and treatment planning, theoretical discussion, and report writing training
- Supervisors: Bill Buhrow, PsyD, Marie-Christine Goodworth, PhD, Mary Peterson, PhD, and Carlos Taloyo, PhD

2012   **Pre-Practicum II: George Fox University Health & Counseling Center**
Newberg, OR
- Individual outpatient psychotherapy for volunteer undergraduate students
- Videotape feedback of sessions
- Supervisors: Mary Peterson, PhD and Rusty Smith, MA

2011   **Pre-Practicum I**
George Fox University, Newberg, OR
- Learned basic counseling skills with clinical team members
- All sessions were taped and reviewed during individual supervision
- Supervisors: Mary Peterson, PhD and Rusty Smith, MA

CLINICAL EXPERIENCE

2013   **Grief Support Group Facilitator**
The Dougy Center: The National Center for Grieving Children & Families, Portland, OR
- Co-facilitated a group of children ages 6-12 who lost a parent or primary caregiver to death
- Facilitated activities included process group and unstructured play therapy
- Supervisor: Jana DeCristofaro, LCSW

2011 - 12   **Parent Advice Line (PAL) Program: George Fox University Behavioral Health Clinic**
Newberg, OR
- Responded to messages and answered live calls involving common parent-child struggles such as tantrums, toilet training, defiance, shyness, divorce problems, and developmental delays
- Monthly training seminars
- Supervisor: Joel Gregor, PsyD

2011   **Depression Recovery Group Leader: Newberg Seventh-day Adventist Church**
Newberg, OR
- Led a psychoeducational and process group that focused on symptom reduction
- Population: adults 18-75 years old
- Supervisors: Tami Rodgers, MD, Mary Peterson, PhD, Joel Simons, BA

2010   **National Youth Advocate Program**
Griffith, IN

- Reviewed case files and attended court hearings
- Participated in foster care classes
- Supervisor: Lauren Peterson, MSW

2010   **Children's Tree House, Inc.**
Crown Point, IN
- Supervised and recorded visits between non-custodial parents and their children
- Supervisor: Judith Haney, MA

2010   **Autism Society of Indiana Northwest, Indiana Chapter**
Saint John, IN
- Learned how to recognize and properly rectify problem behavior using positive reinforcement techniques
- Supervisor: Jill McNeil, MA

ADVOCACY TRAINING & PROFESSIONAL DEVELOPMENT

August 2012 - **Oregon State Coordinator**
July 2014   *American Psychological Association Graduate Students (APAGS) –Advocacy Coordinating Team (ACT)*
- Wrote a monthly report to the Western Regional Coordinator of APAGS regarding the status of Oregon schools
- Connected with Oregon's three Campus Representatives to ensure the disbursement of Action Alerts via the listserv to Oregon psychology students
- Stayed informed of professional issues impacting the profession and APA's involvement in working towards solutions

June 2012 - **Student Representative Elect and Student Board Member**
June 2014   *Oregon Psychological Association (OPA).*
- Served as Student Representative Elect on the board of the Oregon Psychological Association. Worked with a team of professionals to develop student communication, coordinate poster submissions, awards, and student breakout sessions for the OPA annual conference.
- Promoted membership in OPA and awareness of professional news at local and national level.

February   **Legislative Training Day**
2013   *Capitol Building, Salem, OR*
- Organized and led an all state legislative training day
- Attended legislative sessions on psychology related issues, met congressional members and lobbyists

P R O F E S S I O N A L   T R A I N I N G   &   E D U C A T I O N

Primary Care/Health Psychology Training:

- Primary Care Behavioral Health
    Brian Sandoval, PsyD, Juliette Cutts, PsyD
- Motivational Interviewing
    Michael Fulop, PsyD
- OHSU Pain Awareness and Investigation Network
    Stephen Americ, PhD, Tim Brennan, MD, PhD, Anna Wilson, PhD
- Insignia Health: Patient Activation Measure (PAM)
    Jason Gray, MBA

Assessment Training:

- Assessment and Treatment of Anger, Aggression, & Bullying in Children and Adults
    Ray DiGuiseppe, PhD
- The Mini-Mental State Examination -2nd Edition
    Joel Gregor, PsyD
- Assessing Mild Cognitive Impairment and Dementia
    Mark Bondi, PhD
- Using Tests of Effort in a Psychological Assessment
    Paul Green, PhD
- Cross-Cultural Psychological Assessment
    Tedd Judd, PhD
- Understanding and Treating ADHD in Children
    Erika Doty, PsyD
- Learning Disabilities: A Neuropsychological Perspective
    Tabitha Becker, PsyD

Military Populations Training:

- Evidenced Based Treatments for PTSD in Veteran Populations: Clinical and Integrative Perspectives
    David Beil-Adaskin, PsyD

- Portland Veterans Administration Medical Center Suicide Prevention Program
    Monireh Moghadam, LCSW and Aimee Johnson, LCSW

Diversity Training:

- African American History, Culture, and Addictions & Mental Health Treatment
    Danette Haynes, LCSW, Marcus Sharpe, PsyD

- Working with Gay and Lesbian Clients
  Jennifer Bearse, MA
- Sexual Identity: Working with Sexual Minorities
  Erica Tan, PsyD
- Treating Gender Variant Clients: Christian Integration
  Erica Tan, PsyD
- Mindfulness and Christian Integration
  Erica Tan, PsyD
- The Person of the Therapist: How Spiritual Practice Weaves with Therapeutic Encounter
  Brooke Kuhnhausen, PhD

R E L E V E N T   E M P L O Y M E N T

2010   **Resident Advisor of Irish Studies Program**
Taylor University, Greystones, Ireland, UK
- Counseled undergraduate students
- Led a small group where issues such as homesickness, loneliness, culture shock, and family pain were commonly discussed
- Handled logistics of weekend trips around the country
- Overall attunement to the balance and dynamics of a twenty-six member group

2010   **Admissions Counselor**
Taylor University, Upland, IN
- Provided guidance to prospective students
- Operated the university's central switchboard

T E A C H I N G   E X P E R I E N C E

Fall
2014   **CBT Coach**
George Fox University, Newberg, OR
- Assisted professor in teaching PSYD 552 Cognitive Behavioral Therapy

Spring
2014   **Teaching Assistant**
George Fox University, Newberg, OR
- Assisted professor in teaching PSYD 513 Research Methods and Design.

October
2013   **Guest Lecturer: Biological Aspects of Personality**
George Fox University, Newberg, OR
- Taught undergraduate students enrolled in Personality Psychology about the biological aspects of personality.

Spring   **Certified Substitute Teacher**

2011   *Lake Central School Corporation, Saint John, IN*
- Substitute taught grades K-12th at eight different schools within the corporation
- Classroom management, schedule planning, and disciplinary action

2011   **International Volunteer Teaching: Rwanda, Uganda**
- Undergraduate Summer
- Taught English in Rwandan and Ugandan universities, elementary school, hospital, and community based programs

2009   **International Volunteer Teaching: Czech Republic**
- Undergraduate Inter-term
- Primarily taught English as a second language in grades 3-12
- Tutored minority, underprivileged Gypsy population

R E S E A R C H   E X P E R I E N C E

2012 - 14   **Zander, B**., Gathercoal, K., Peterson, M., & Henderson, R. (June, 2014). **Doctoral Dissertation:** *Barriers and Motivations in Mental Health Legislative Advocacy in Oregon.* Poster presented to the Annual meeting of the American Psychological Association, Washington, D.C.
            Defended: June 2014, Full Pass

2013   Kruszewski, M., McConnell, C., **Webb, B**., Seig, C., Weiss, C., Swartz, J., & Gathercoal, K. (July, 2013). **Fees paid and therapeutic satisfaction in community mental health.** Poster presented to the Annual meeting of the American Psychological Association, Honolulu, Hawaii.

2013   **Research Assistant**
            George Fox University, Newberg, OR
- Administered the WRAML-2 to adult volunteers as part of data collection for a dissertation assessing the memory implications from mild to moderate hearing loss.
- Supervisor: Heather Deming, M.A.

2013   **Data Collector**
- Paid data collector for the Phonological and Print Awareness (PPA) Scales Standardization study.
- Administered tests to preschool age children assessing seven tasks that measure different elements of phonological and print awareness skills which often demonstrate a strong, predictive relationship with later measures of reading and writing.

2013   **Research Assistant**
            George Fox University, Newberg, OR

- Coded qualitative data for dissertation study exploring spiritual/religious issues in therapy at a community mental health clinic
- Supervisor: Courtney McConnell, M.A.

Sept. 2012 -   **GFU Research Vertical Team**
Present   *George Fox University, Newberg, OR*
- Twice monthly small group for developing research competencies
- Supplemental research projects
- Development of dissertation

2012   **GFU Gender Issues Committee**
               George Fox University, Newberg, OR
- Research and discussion of issues across the gender spectrum
- Book reviews of gender-related topics

2010   **Center for Research and Innovation**
               Taylor University, Upland, IN
- Performed quantitative data analysis for the High Altitude Research Platform (HARP)
- An assessment designed to measure the impact of the program on the students participating using a pre-test/post-test

2009   **Research Assistant**
               Taylor University, Upland, IN
- Gathered qualitative data concerning children's conceptions of God
- Self-guided research of religious belief and death attitudes

P U B L I C A T I O N S

Engle, N., Schloemer, J., & **Webb, Bethany**. (2013). **Ethical webs: Multiple relationships and practicum training sites**. *The Oregon Psychologist: Bulletin of the Oregon Psychological Association. 32*(1). 11-12.

P R E S E N T A T I O N S

2014   **Graduate Student Involvement in Advocacy**
               APA Annual Convention, Washington, D.C.
- Organized and moderated a symposium for Division 31, which provided information on advocacy as a continuum and curriculum, personal stories on advocacy involvement, and ways on how students and psychologists alike may get involved in advocacy work.

2014   **Traumatic Brain Injury and Post-Concussion Syndrome**
               Oregon Health and Science University, Portland, OR

- Presented on the treatment and considerations of TBIs and post-concussion syndrome during a weekly training seminar for the behavioral health department and family medicine residents.

2013 **Mental Health Awareness in Ministry and Outreach**
Rolling Hills Community Church, Tualatin, OR

- Provided training on building understanding and awareness of mental illness and how to respond to encounters with mental illness in ministry and outreach programs.

ACADEMIC SERVICE

2014 - **Student Supervisor**
Present *George Fox University, Newberg, OR*

- Providing supervision to a second year student, which involves giving feedback on reports and evaluations, planning graduate educational and professional goals, tracking hours, preparation for internship, building time management and self-care habits, etc.

2012 -13 **Admissions Interviewer for Doctoral Student Candidate**
George Fox University, Newberg, OR

- Chosen by faculty to interview applicants for the clinical psychology program

2012 -13 **Peer Mentor**
George Fox University, Newberg, OR

- Assisted first year PsyD student in adjusting to graduate school by providing academic and professional guidance and support.

SCHOOL INVOLVEMENT

2013 Gender Group
2013 Military Interest Group
2011 - 12 Multicultural Committee
2010 Taylor University Psychology Club
2010 Irish Studies Program, *Greystones, Ireland*
2010 New Testament Studies, *Greece and Italy*
2009 Spanish and Cultural Studies, *Cuenca, Ecuador*

SERVICE

2011 - 14 GFU Community Serve Day
2010 Taylor University Cancer Ministry Cabinet
2010 St. Martin Community Center, *Marion, IN*

2010   The Boys and Girls Clubs of Northwest Indiana, *Cedar Lake, IN*
2009   Habitat for Humanity, *Galveston, TX*
2008   Orphan Outreach, *Guatemala City, Guatemala*

H O N O R S   &   A W A R D S

2013   APAGS "Excellence in State Leadership" award in Empowerment
2011 - 12   GFU Multicultural Scholarship
2008 - 11   Dean's List
2007 - 11   Indiana University Northwest Full Academic Scholarship

P R O F E S S I O N A L   A F F I L I A T I O N S

2013 -14   APA Division 29, Psychotherapy
2013 -14   APA Division 44, LGBTQ
2012 -14   Society for Relational Theory and Theology
2012 -14   Oregon Psychological Association (OPA)
2012 -14   Christian Association for Psychological Studies (CAPS)
2009 - 14   American Psychological Association (APA)