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What's Inside

OPA President's Column

Social Justice as a Presidential Initiative

Natalie Kollross, PsyD, OPA President

First of all, I wanted to say how much I enjoy being a part of OPA and serving on the board. It is a thrill to be amongst so many passionate and dedicated volunteers. We are also so pleased to have Kori Hasti as our new executive director. She has big shoes to fill, but so far everything is going smoothly, making my job a lot easier.

As part of my presidential initiatives, I would like to put the spotlight on advocacy and social justice. We all got into this field to make a difference and many times we can get bogged down with day-to-day responsibilities and just trying to make a living. However, at this time in our nation's history, we are ripe with possibilities to make a difference and make our voices heard. When I attended the APA Practice Leadership Conference in Washington, D.C. this year, there was a workshop dedicated to advocacy. So many psychologists around the country are advocating in different ways, big and small. They meet with their elected officials, they speak at schools, participate in marches, they run non-profit organizations. I know many of you are passionate about social justice and are working hard to promote civil rights and equality in many forms. Many of you may feel that you are lost when it comes to advocacy and public policy, and you are not alone. Every one of you has something you are passionate about—beliefs and values that we hold dear. I want your voices to be heard and my hope is that over this next year OPA can help empower you to do so in whatever capacity suits you.

Moreover, I want to empower early career psychologists and students to let their voices be heard. Try not to get bogged down in starting your career so much so that your passion is lost and your voice becomes weak. Join, listen, advocate! You are the future of our profession and we need to hear from you.

I also want to put a call out to the rural parts of Oregon. I work and live in Pendleton, a town in Eastern Oregon. I know there are passionate voices outside of the metro areas. Your voice is strong and powerful. You can provide insight into issues that many Oregon psychologists cannot. Call upon us—we are here to support you.

OPA and its volunteers are always tirelessly working toward advocating for our profession, for Oregon psychologists, and for public policy to help us and the people we serve. We want to support you all in doing the same. Over the coming months, be on the lookout for changes within OPA to help support this initiative. We are looking at many different avenues including social media, revitalizing our student committee, and compiling tips for advocacy work. Join me as we advocate, promote, and advance together!

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**Through OPA's relationship with Cooney, Cooney and Madigan, LLC as general counsel for OPA, members are entitled to one free 30-minute consultation per year, per member. If further consultation or work is needed and you wish to proceed with their services, you will receive their services at discounted rates. When calling, please identify yourself as an OPA member.*

Reflections on Community Support

Jenny Huwe, Psy.D., OPA Confidential Peer Support Committee

I was sitting with colleagues, not long ago, in a private setting. We were gathered with the intention of sharing about personal and professional happenings in our lives. These colleagues are important to me. I have come to respect and care about them over time. It is not always convenient to make time to gather, but I feel grateful for our experiences with each other. During one memorable gathering, the conversation turned in the direction of a colleague sitting next to me. This colleague bravely told us she experienced a challenging loss during the previous week. Although she shared cautiously, there was no way to sugar-coat the profound tragedy of the news. I noticed a tightening in my own chest and a rush of sadness about the circumstances. However, rather than feeling fatigued by more bad news, I noticed that I was immediately invested in hearing more about how she was feeling and what kind of support she needed. By the conclusion of our gathering, I had a mixture of feelings that included not only sadness, but also a warm sense of connection to everyone in the group. I was moved and impacted by the ways the others responded to my colleague's needs, validating her feelings, expressing willingness to offer ongoing support, and empathizing with her sense of helplessness. I somehow felt safer with this small community of my peers, knowing in a new way that I will also be cared for when, inevitably, the time comes for me to ask for their support.

Recently, our colleague Charity Benham offered insightful thoughts about the term "self-care" in *The Oregon Psychologist*. If you have not read Charity's reflection and are in the mood for a cleansing sigh and a chuckle, I recommend looking up her article. Charity encouraged us to consider how worn-out the term "self-care" has become in our culture and, perhaps, in our profession. She conceded that caring for ourselves is necessary for healthy living and relating to others. We all feel better when we eat well, engage in physical exercise, obtain adequate sleep, and balance our work with enough play. What was interesting to me was Charity's assertion that these good principles of caring for ourselves are simply not enough to restore a sense of wellbeing and to fill our fluctuating reserves of empathy and connectedness to each other.

There is professional vulnerability associated with reaching out to each other for connection and support, particularly when this involves revealing our weaknesses or needs. The intimidating Duty to Report law looms large in Oregon, contributing to the sense that exposing our struggles could have a catastrophic impact on our professional lives, perhaps even our livelihoods. Our profession has put great collective energy into the necessary work of identifying and periodically updating an ethics code that mandates monitoring our own and others' professional conduct. These essential rules that encourage us to watch over each other can also promote feelings of shame and cause us to isolate from each other. This may limit our access to relationships that contain some of our best sources of empathy and support.

Reaching out for peer support can be difficult. We may even identify as deficient or needy when we take those risks with each other. Hopefully, with practice, we find that the benefits of peer support far outweigh the risks associated with reaching out. I know I am impacted in so many positive ways when my colleagues take those risks with me. In those moments, they are strengthening community relationship practices that normalize the need to give and receive support, making it easier for me to reach out for my own support.

Political Stress and the 2016 Presidential Election

Jessica L. Binkley, Psy.D., OPA Diversity Committee

According to a recent survey by the American Psychological Association (Stress in America: The State of Our Nation; 2017b), the 2016 American Presidential presidential election has contributed to increased stress across political, racial and ethnic, age, and gender demographics. For example, more than half of American adults surveyed reported that they consider this the lowest point in our nation's history that they can remember; the aforementioned perspective was endorsed across all adult age groups (i.e., millennials, Gen X-ers, baby boomers, and older adults). Further, a majority of Americans reported that they felt particularly stressed about current social divisiveness (59%) as well as the future of our nation (63%, with significantly higher endorsements from Democrats ([73%) %] compared to Republicans ([56%) %] or Independents ([59%)). %]). Overall, people of color reported higher levels of stress as well as specific concerns about hate crimes and the country's potential for improvement, with the majority of people of color surveyed expressing disagreement with the sentiment that our country is on the path to being stronger than ever.

Political Stress and the Therapeutic Relationship

In addition to reports of increased overall stress across multiple demographics, emerging data from popular media (APA, 2017b; Burnett-Zeigler, 2016) reveal that many Americans are reporting an increase in specific stress-related symptoms such as insomnia, anxiety, irritability or anger, and fatigue following the 2016 presidential elections. However, to date, only one group of authors (Solomonov & Barber, 2018) has published a study examining patients' perspectives on how the 2016 election has influenced their experiences in psychotherapy. In this study, 604 adults from 50 states completed an online survey regarding the manner in which the current political climate has impacted the therapeutic process. With respect to the clinical relationship, participants were asked a) whether their therapist disclosed their personal political orientation explicitly, implicitly, or not at all; and b) whether they believed that their therapist shared their same political orientation. Participants were also asked whether they discussed political topics (e.g., checks and balances; distrust of the government; distrust of journalists/media; environmental, educational, military, health, immigration, foreign, and tax policies) in their sessions, and whether they viewed such discussions as helpful or unhelpful. Lastly, participants were asked whether they expressed specific positive emotions (e.g., optimism, joy, hope, trust) or negative emotions (e.g., fear, hopelessness, despair, anger, confusion, disgust, contempt) during discussions about the Trump administration.

Solomonov and Barber (2018) discovered that the majority of patients (64%) surveyed reported that they had spoken about politics with their therapists. Nearly half of patients (46% total; 44% of Clinton supporters and 59% of Trump supporters) shared that they would have liked to discussed politics more in session, and a significant minority (38%) noted that although their therapist did not explicitly disclose their political views, patients could easily guess their orientation. Further, patients who believed that their therapist "probably shares" their political orientation reported a significantly stronger working alliance compared to those who believed that their therapist "definitely does not share" their political orientation. Importantly, patients who reported that their therapist only implicitly disclosed their political orientation reported the highest levels of alliance. The authors highlighted that on the whole, patients across the political divide expressed a desire to discuss politics in session, and that clinicians appear more likely to self-disclose their political orientation either implicitly or explicitly in the face of the current political climate. The authors noted that, consistent with prior research on appropriate self-disclosure, clinicians may want to increase their awareness of the impact of current political concerns on their patients as well as the therapeutic relationship; They suggested that clinicians be particularly attuned to monitoring the timing

Continued on page 5

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Political Stress, continued from page 3

of any political self-disclosures.

Clinical Considerations

Given that emerging research highlights increased stress regarding political concerns coupled with patients' expressed desire to discuss such topics, psychologists may be increasingly called upon to navigate personally and professionally challenging topics in session. Psychologists are tasked with attending to the general wellbeing of patients (beneficence) as well as avoiding discriminatory behavior based on factors including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status (Principle E: Respect for People's Rights and Dignity; 3.01 Unfair Discrimination; APA 2017a). Additionally, psychologists must operate within the bounds of their competence (2.01 Boundaries of Competence), attend to their own welfare, and monitor how personal problems may interfere with their work (2.06 Personal Problems and Conflicts). How, then, may psychologists appropriately initiate and/or respond to politically charged material in session, particularly when they themselves may be experiencing distress? Further, how might psychologists determine whether (and when) political self-disclosure is in the best interest of their patients?

Broaching Behaviors

Day-Vines, Wood, Grothaus, Craigen, Holman, Dotson-Blake, and Douglass (2007) write about strategies that clinicians can use to consider how sociopolitical factors influence patient concerns; they describe *broaching behaviors* as the consistent attitudinal set of openness and commitment by clinicians to invite patients to explore diversity factors. Day-Vines et al. also note that broaching enhances the clinician's ability to bring a patient's sociocultural and sociopolitical experiences into the therapeutic dialogue, thus increasing patient empowerment and resilience. These authors note that in addition to demonstrating positive regard and genuineness, clinicians are also responsible for initiating discussions around topics such as culture, race, and politics; that is, clinicians are responsible for offering patients an opportunity to discuss these topics as they are germane to the clinical relationship and/or presenting problems. When clinicians demonstrate the ability to initiate a discussion about topics that may be taboo in some contexts or communities, patients receive the messages that no topic is "off the table" in psychotherapy. Additionally, patients are able to observe that their clinician is able to sensitively explore intersections of identity (e.g., gender, geographical region, political orientation, race) which otherwise

Continued on page 6

Political Stress, continued from page 5

may be silenced (Day-Vines, Bryan, and Griffin, 2013; Jones & Welfare, 2016).

Day-Vines et al. (2007) discuss a continuum of five broaching styles (avoidant, isolating, continuing/incongruent, integrated/congruent, and infusing) as well as corresponding clinical behaviors. Broaching statements may include direct invitations to the patient to discuss specific aspects of their identity, or statements acknowledging differences or the potential for misunderstanding based on the cultural identities of the clinician (Bayne & Branco, 2018). For instance, a clinician may consider directly bringing up an issue when they believe differences between the clinician and patient to be affecting the clinical relationship (e.g., "I'd like to address something that you said about Hillary Clinton and your distrust of 'all' women. I'm curious what it has been like for you to work with me?"). A clinician may also consider indirectly broaching when the aim is to focus on broad themes, rather than specific differences between the patient and clinician-particularly if these differences may not be visible or obvious (e.g., "You mentioned you have no tolerance for Trump (or Clinton) supporters. I wonder if this has impacted your relationships with family or friends?").

When considering whether and when to broach, Bayne and Branco (2018) also recommend that clinicians observe the verbal and nonverbal communication of the patient to determine whether patients may be open to exploring particular topics. In addition, the clinician may want to consider what they know about the patient's prior dynamics in session. For example, has the patient been open previously to discuss other aspects of identity (e.g., class, education, gender)? What have been the patient's previous experiences when their perspectives or biases have been challenged? Which additional intersections (e.g., race, age, health status) may be playing a role in the client's presentation?

Conclusion

Broaching behaviors are consistent with an approach of cultural humility, wherein clinicians are engaged in a continual process of self-reflection and mindful curiosity, rather than assuming an attitude of knowing or making assumptions (Tervalon & Murray-Garcia, 1998). Further, broaching also requires clinicians to maintain an awareness of their own intersecting identities and biases and how these may affect the therapeutic alliance. For example, clinicians will need to be mindful of the salience of their own sociopolitical identities, whether these match those of the patient or not, as well as the degree to which their competence may be impacted by factors including personal distress.

Overall, emerging research suggests that patients and psychologists are likely to be experiencing an increase in politically-related stress. Operating within a stance of cultural humility, clinicians may consider broaching as an opportunity to explore if or in what way the current political climate may be affecting patients, as well as to what degree any implicit self-disclosures may positively contribute to the therapeutic alliance. Despite limited available research specific to post-election stress, broaching may be a helpful tool for thoughtfully and intentionally addressing political issues in session.

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An ACES Update: Nuances of the Questionnaire and Auxiliary Tools for Assessment of Childhood Adversity

Fiona Byrne, BA

With nearly 2,600 children currently being exposed to traumatic prolonged separation from their families at the border between the US and Mexico (Office of Senator Jeff Merkley, 2018), child advocates are reaching for data in their fight against the zero-tolerance policy. Empirical evidence that childhood trauma can cause deep and lasting harm is abundant and available, and much of it has roots in the Adverse Childhood Experiences (ACE) Study.

An epidemiological landmark, the ACE Study was a collaboration between Kaiser Permanente and the Centers for Disease Control, taking the form of a large scale survey of over 17,000 participants. Principal Investigators Dr. Robert Anda and Dr. Vincent Felitti collected self-report survey responses from over 17,000 participants, asking about experiences in their childhoods and their health as adults (Centers for Disease Control and Prevention [CDC], 2016a). To gather data on childhood trauma, researchers developed the ACE questionnaire, a ten-item survey which asks whether an individual experienced certain types of adversity before they reached the age of eighteen (CDC, 2016a). Though worded more colloquially, participants were asked questions which gathered information about the following experiences: Whether they had often witnessed domestic violence; whether they had experienced physical, verbal, or sexual abuse; whether they had been emotionally and/or physically neglected; and whether they lived with someone who had alcohol or drug problems, who had been incarcerated, or who experienced mental illness (CDC, 2016a).

The connection between early adversity and negative lifetime health outcomes was clear and strong. Data indicated a significant association between having an ACE score of 4 or more and an increased risk of negative health outcomes and physically harmful behaviors including alcoholism, drug abuse, and severe obesity (Felitti et al., 1998). Felitti and colleagues found that compared to those with an ACE score of zero, those with a score of 4 or more were twice as likely to be smokers, seven times more likely to have alcoholism, ten times more likely to have injected street drugs, and twelve times more likely to have attempted suicide (Felitti et al., 1998). Results from the same study showed a strong graded relationship between ACE scores and presence of risk factors for the leading causes of death in adults.

In interpreting the results of the original ACE Study, it is crucial to recognize that the sample was not representative of the general US population at that time. Study participants were volunteers from within the Kaiser health maintenance organization, meaning they were employed and had good health care coverage (Felitti et al., 1998). It is significant that a relationship between early adversity and negative health outcomes was observed even within a sample with a significant amount of socioeconomic and social privilege.

Many subsequent studies have employed the ACE questionnaire within a variety of contexts nationwide and have upheld the finding that childhood trauma is associated with negative physical and mental health outcomes (see CDC, 2016b for a list of articles which utilize the ACE questionnaire). While the ACE Study remains a cornerstone of the field of psychological trauma research, more recent studies have identified caveats that contribute to a more nuanced understanding of the power and limits of the questionnaire.

One such limitation is the formatting of the questions, wherein each experience is forced into a binary: "yes" or "no." Research has shown that few yet chronic ACEs have a stronger impact on health outcomes than do more numerous in variety yet infrequent ACEs (Thompson et al., 2015). Therefore, although the binary format makes large-scale data processing and evaluation more manageable, the 0-10 point scale format is perhaps too reductive to capture the whole picture, leaving significant variables between experience and outcome unobservable. For example, a respondent may have experienced physical abuse nearly daily for the majority of their childhood, and yet their ACE score could be as low as 1. Another respondent may have experienced several types of adversity once or twice and have a significantly higher score, although they may not have endured comparable levels of toxic stress and chronic sympathetic nervous system activation (the "fight or flight" response), factors which manifest lived experience in altered physiology (Nurius, Green, Logan-Greene, Longhi, & Song, 2016). While the survey does ask whether certain experiences happened to an individual "often," that term is subjective and nonspecific. Trauma does not need to be chronic to cause life-long harm. Single-instance, acute trauma can have very significant impacts. However, if not enhanced by a scale of chronicity, ACE questionnaire results should be interpreted with the understanding that the 0-10 point score communicates a general trend but does not capture the entire scope of childhood experiences of adversity.

Another useful index which researchers have been utilizing in conjunction with the ACE questionnaire is a resilience survey. Research shows that children who have protective factors in their

Continued on page 8

Childhood Adversity, continued from page 7

lives are less harmed by stress; a meta-analysis of the impacts of protective factors found such factors to have a moderate effect on sleep behavior, mental health, and physical heath domains (Lavoie, Pereira, & Talwar, 2016). Researchers also found the presence of protective factors to have a larger effect on physiological resilience to adversity than did the presence of vulnerability factors (Lavoie et al., 2016). This finding suggests that programs with strength-based approaches will have a larger impact on children's health than programs designed to minimize risk factors (Lavoie et al., 2016).

Empirically-founded protective factors include supportive family environments, finding meaning in challenging and stressful situations, the presence of social support, and community connectivity (Lavoie et al., 2016). One comprehensive measure of protective factors is the Adolescent Resilience Questionnaire, which measures resilience factors in the realms of self, family, peer groups, school, and community via 93 items and 12 scales (Gartland et al., 2011). A list of resilience surveys is available from Montgomery (2016).

There is a large body of evidence that the occurrence of acute, chronic, or complex traumatic events can take a significant toll on a child's developing brain. Early trauma dysregulates serotonin production and functioning, which can disrupt crucial brain cell development (De Bellis & Zisk, 2014). Such serotonin dysregulation is also associated with depression, anxiety, and aggressive behavior (De Bellis & Zisk, 2014). The presence of early childhood maltreatment is also associated with poor immune system functioning (De Bellis & Zisk, 2014). There is a growing body of evidence that early trauma can have epigenetic impacts, influencing the very way genes are transcribed (National Scientific Council on the Developing Child, 2010). The types of events measured by the ACE questionnaire have the potential to directly impact lifetime mental and physiological health.

Another way to interpret an ACE score, however, is as an index of the quality of the context in which a child grew up. That context may be the beginning of a trend which carries through to adulthood, continuing to impact health beyond the scope of the onset of initial trauma. Low socioeconomic status, for example, may be indicated by an individual responding "yes" to the ACE question about whether they often felt like their basic food, shelter, and clothing needs were not being met. One individual's poor health in adulthood may be due not to trauma caused by an early lack of resources but by a current lack of resources. In that way, the impacts of ACEs may be confounded with the impacts of social disadvantage. An approach taken by Nurius, Logan-Greene and Green (2012) is to control for co-occurring social disadvantage. The researchers found ACEs to have an impact on later adult mental health even after controlling for demographics and social disadvantage (Nurius et al., 2012). These results suggest that the ACE questionnaire is a robust measure which can illuminate trends of the impacts of childhood adversity on adult mental health beyond co-occurring disadvantageous social factors. Another approach is not to separate out the influence of social context but rather to examine the occurrence of ACEs within that context to determine how early trauma and demographic factors interplay to impact adult mental and physical health outcomes. In a study with this format, Nurius and colleagues found disproportionately high levels of ACEs among those who were demographically and economically disadvantaged as well as among those with poorer psychosocial resources (Nurius, Green, Logan-Greene, Longhi & Song, 2016). Consideration of how the incidence of ACEs increases as social advantage decreases across a population is key to the development of effective prevention and intervention for early childhood maltreatment and adversity.

The ACEs questionnaire is a powerful tool that has enabled researchers to investigate associations between childhood adversity and health outcomes of both children and adults. When understood with all of its nuances, the questionnaire is key to identifying the insidious and toxic effects that early trauma can have and validating the gravity of the endured experience. This research is also a path towards powerful prevention

Continued on page 9

Childhood Adversity, continued from page 8

and intervention efforts informed by the psychological, neurological, and physiological mechanisms through which experience can get under the skin. Such robust and effective prevention and intervention methods are necessary to best meet the needs and rights of children and adults impacted by the childhood adversity caused by living in warzones, be they inner-city, country-wide, or at the border of a country with hostile policy. Early-psychological trauma research is also an essential element in informing and replacing the policies and practices that have led to so many humans experiencing so much adversity so early on in their lives.

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Learning from the Humble Table: Reflections of Student Members on the Ethics Committee

Christopher Watson, MA; Steffanie La Torre, MA; Morgan Bolen, MS, MA, OPA Ethics Committee

Throughout our educational studies and clinical training placements, we have each confronted and experienced ethical dilemmas. These issues have ranged in their intensity and complexity, and each circumstance has taught us the limits of our competence and our need for further growth as clinicians. As we look forward to our future roles as psychologists, we recognize we will continue to encounter ethical issues defined by their uncertainty. We have also recognized that as our knowledge and skills grow, we are likely to feel better prepared to meet these ethical events with confidence. However, our experiences as student members of the Oregon Psychological Association's Ethics Committee has taught us that we must constantly seek new opportunities to challenge and fortify our understanding of how to approach ethical issues. We have seen that we will need help to do this.

Being student members of the OPA Ethics Committee has been an incredible opportunity to learn from licensed psychologists how ethical issues and nuances may present in clinical work. The 2-year student position provided experiences that exceeded our individual expectations. The format provided us the ability to feel competent and valued among esteemed professionals that varied in their roles and experiences. Indeed, as student members we never felt professionally inferior or inexperienced; this provided an invitation for us to participate in the discourse and further our knowledge and understanding of ethical decision-making. Each meeting was a forum to engage and challenge our understanding of the ethical tenets we each have committed to follow in our clinical roles. The committee's approach was at times informal and relaxed, but also provided a structured setting to support real ethical issues from community members struggling to decide what course of action to take on a particular ethical dilemma.

The most relevant and impactful take-away from our experience was "do not be afraid to consult." Often community members are struggling with complex issues that can be further complicated by shame that they are somehow responsible for this issue or *should* do a specific action to resolve the situation. It is inevitable that any clinician working in the complex field of mental health will face a multitude of ethical dilemmas throughout their career. However, it is also inevitable that individuals may fear voicing these issues out of fear of judgment of punitive reconciliation. During our tenure on the committee, this was never the tone or role of the OPA Ethics Committee. The committee was defined externally by its stated commitment to provide non-punitive support to OPA member's struggling with ethical issues. Furthermore, internally, the decorum and empathy demonstrated by each member exemplified this defined purpose.

Being part of this committee's process was impressive. Each member provided a unique perspective, and the combined synergy of the committee embodied the critical thinking, professionalism, insightfulness, and acceptance defined within the American Psychological Association's aspirational tenets: Respect, integrity, justice, beneficence, and responsibility. Furthermore, each case was meticulously assessed with careful consideration of the legal, ethical, and clinical ramifications of the potential decisions available to the community member. As student clinicians, we have begun to see how these same approaches apply to our own clinical work. In all situations, the committee demonstrated dedication to helping clinicians in need uphold the integrity and responsibility expected of their role as a psychologist.

We were honored to be selected to sit on this highly respected committee for the past two years. Our work on the committee has humbled us, and we have spent these final days reflecting on our experiences. We see ahead the lifelong learning required to meet the multitude of ethical issues that may present throughout our careers. It has been a rewarding and invaluable experience, one that will forever contribute to our understanding of ethical decision-making and the benefits of utilizing resources such as this committee when facing any individual ethical issue.

If you are considering applying for the OPA's Ethics Committee or would appreciate a well-developed second opinion concerning an ethics matter, call for consultation or join the committee; each member is kind, passionate, and dedicated to helping.

OPA Ethics Committee Benefits

Do you have an ethics question or concern? The OPA Ethics Committee is here to support you in processing your ethical dilemmas in a privileged and confidential setting. We're only a phone call away.

Here's what the OPA Ethics Committee offers:

- **Free** consultation of your ethical dilemma.
- **Confidential** communication: We are a peer review committee under Oregon law (ORS 41.675). All communications are privileged and confidential, except when disclosure is compelled by law.
- **Full consultation**: The committee will discuss your dilemma in detail, while respecting your confidentiality, and report back our group's conclusions and advice.

OPA Ethics Committee members are available for contact. For more information visit the Ethics Committee section of the OPA website and page 20 of this newsletter.

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-Ron Kurtz

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Assessing Political Leaders Psychologically

William A. McConochie, Ph.D., Political Psychology Research, Inc.

In July, Anne Flaherty of the Associated Press discussed President Trump and his supporters' use of the term "Trump Derangement Syndrome," not to describe Trump himself as deranged, but his *critics* as deranged (2018). According to Flaherty, this term was coined by the late columnist Charles Krauthammer, who was trained in psychiatry before his career in journalism. Krauthammer, a conservative opinion writer, used this term derisively to discount liberals' criticism of President George W. Bush as mentally unstable. He described this as "acute paranoia in otherwise normal people in reaction to the policies of Bush" (Flaherty, 2018).

Trump's recent meeting with Russian leader Putin has drawn criticism from some leaders in Washington, some even accusing him of treason for pooh-poohing investigations of the Justice Department that have found several Russians responsible for election meddling in support of Trump.

Many reputable psychiatrists have considered Trump to be psychiatrically unfit for the presidency, as detailed in their recent book, *The Dangerous Case of Donald Trump: 27 Psychiatrists and Mental Health Experts Assess a President* (Lee, 2017). Others have raised the issue of professional ethics when diagnosing politicians from afar. These ethics discourage diagnosing a leader's mental health without face-to-face clinical interviews and related formal assessment tools, such as questionnaire tests like the Minnesota Multiphasic Personality Inventory-2. Indeed, presidential candidate Barry Goldwater successfully sued critics who publicly labeled him psychiatrically unfit for the presidency during his unsuccessful campaign years ago.

I am a clinical psychologist who has been in practice and graduate studies since 1965 and who has done hundreds of diagnostic evaluations for the Social Security Administration and the Veterans Administration, and who has studied and done research measuring traits in both clinical and political psychology for many years. I have some suggestions about addressing the mental and emotional conditions of the presidency.

I have designed reliable and valid questionnaire measures of common psychiatric symptoms including depression, anxiety, PTSD, traumatic brain injury and violence-proneness, and over 80 psychological dimensions of traits related to and definitive of the liberal and conservative political worldviews. I have developed a very reliable and valid measure of warmongering-*proneness*, based on research demonstrating the relationship between measures of warmongering *endorsement* and many other traits, including human rights endorsement, peaceful foreign policy endorsement, fundamentalist and kindly religious beliefs, social dominance orientation, authoritarianism, openness, agreeableness and violence-proneness. Many of the elements of these traits are publicly observable, which I thought might make it possible for members of the general public who are familiar with leaders to rate leaders on these traits.

I created a 50-item rating scale and had adults fill this out on political and military leaders past and present with whom they felt familiar through various sources (biographies, news reports, history studies, etc.). I averaged the scores for the raters for each leader. I compared these scores to independent ratings of the leaders' warmongering behavior while in power. These second ratings were done by a separate group of adults familiar with the leaders, also through reading biographies, news reports, etc.

The ratings for leaders by these separate techniques yielded very similar results that could be described statistically and lead to the scientific conclusion that this 50-item scale thus used was very reliable and valid.

For current leaders, the warmongering-proneness ratings are made by citizens who base their judgments on observed public behavior, based on news reports in papers, journals, and radio and television reports. The scores based on these ratings are low for Mandela and Gandhi, moderate for like Bill Clinton and Churchill, and high for Hitler and Stalin. This scale demonstrates that important traits of political leaders can be measured accurately without any traditional clinical interviews or tests completed by the person assessed. And warmongering-proneness is an extremely important trait to assess when considering a candidate for high political leadership.

Warmongering-proneness is not the only important trait. We can ask political scientists to suggest other traits. For example, I suggest that it is desirable for a candidate for president to have the following traits:

1. Ability to negotiate skillfully, tactfully, politely and fairly with other leaders, both locally and internationally,
2. Being reasonably concerned for the welfare of all humans, in one's own nation and in other nations,
3. Respecting the mission of the United Nations and other such organizations that promote the common good, such as the Red Cross, the NAACP, Boy Scouts, Girl Scouts and the many religions of the world,
4. Dealing wisely in social relationships, e.g., with one's own children and spouse, business partners and customers, friends and the general public,
5. Dealing wisely and honestly with money, at the personal, business, and government levels. Being willing to report one's recent tax returns before the election,

Continued on page 13

Assessing Political Leaders, continued from page 12

6. Being a generally moral person, including being truthful,
7. Honoring the responsibilities and traditions of the presidency, and previously in one's offices and roles in business, politics, religion, etc.
8. Being cheerful, having a sense of humor, being able to take a joke about oneself, being kind and loving when kidding others,
9. Respecting of and caring especially for the disadvantaged members of society,
10. Being wise in respecting the roles of others when in political office, especially those in other branches of government, and not overstepping the power of one's own role, especially when it comes to war and peace,
11. Being physically and mentally healthy and fit enough to handle the stresses of the job,
12. Being able to accept criticism gracefully, apologizing for one's own offensive or insensitive or foolish behavior and not denying that one does make mistakes,
13. Being firm and confident in representing one's nation when in negotiations with other nations.

Many of these traits are publicly observable, reported by journalists, and don't require a clinical diagnostic evaluation to assess. A seriously depressed or anxious candidate can be identified by crying, never smiling, or by suicidal gestures or acts. An alcoholic or drug abuser can be recognized by reckless driving, falling down in public, incoherent speech in media interviews, failing to keep appointments, etc. Lying can be detected by comparing conflicting public statements on a topic from one month to the next. Difficulty dealing with related branches of government can be evident in chronic indifference to or conflict with other branches. Family disloyalty can be manifested in having affairs. Poor money management can be evident in bankruptcies and failure to pay bills.

In general, the best predictor of future behavior is past behavior. Knowing how well or poorly a person has performed in the past is a reliable and valid clue as to how he or she will behave in the future. Journalists do research and report on the past behavior of candidates for political office. We can hope that if they find unflattering information the candidate will not retaliate cruelly, as political leaders in some countries do, even by assassination. We can ask journalists to reveal information on the traits we deem appropriate for a president to have.

And we can ask candidates for political office to respect the reports of respected journalists and to respect majority public opinion about how well candidates manifest the above traits. This can be accurately measured by questionnaires, as demonstrated for warmongering-endorsement above. For an elected official to ignore accurately measured public opinion would be a dangerous sign. It would suggest an indifference to the common good. Such indifference can be a symptom of dictatorship tendencies. Some dictators become extremely cruel to many and sometimes to most or even all the people of their nation, as epitomized by the consequences for all Germans of endorsing Hitler.

And so, it behooves citizens to carefully size up candidates for political office, especially the presidency, and to base one's choices on the most important characteristics. In every presidential election in the United States, the tallest candidate has won. But it is doubtful whether there is any correlation between height and performance in office. Thus, height is irrelevant, though humans may have subconscious tendencies to be positively biased toward tall leaders. They may also be biased toward persons of certain ethnic groups, religious beliefs, or even golf scores.

Public opinion can be accurately measured. For example, here's how you can turn the list of my preferred presidential traits into a rating form that you and your friends and neighbors can use to size up candidates. Journalists can use this technique, too. It's a technique perfectly suited to a democracy that purports to serve the common good, government of, by, and for the majority of citizens as a whole rather than just for a minority of the wealthiest and privileged. The following example is based on my list. Your list or a list created by journalists, political scientists or the

Continued on page 14

Assessing Political Leaders, continued from page 13

general public could be processed in the same manner.

Each of the thirteen items in the list of important president traits presented above can be converted into a rating scale item, as the example below demonstrates:

"To rate candidate for office [John Doe], please indicate how strongly you agree or disagree with each of the items below by circling one number for each, using this code (See Fig. 1):

Additional items based on the list would be added.

In summary, we should be wise and careful when using psychological and psychiatric concepts in assessing our presidents and other political leaders. Mental health and stability is important, as are a wide range of additional psychological traits, when it comes to choosing political and other leaders, especially military leaders.

And we should not misuse psychological concepts for political propaganda to degrade or inflate a president's behaviors without carefully measuring the traits. This measuring can be done with reliable and valid rating scales. Reliable and valid rating scales can assist journalists, scientists and voters to accurately measure desired traits of candidates for the office of president, for all elective offices, and even appointed offices, such as members of the Supreme Court. All opinions of all citizens are important in a democracy and especially in a democracy that purports to be of, by, and for the people, all the people, not just of, by, and for an exclusive, wealthy, self-serving elite. Citizen opinions can be scientifically quantified by using well-designed rating scales.

I'm not suggesting we depend blindly on citizen opinions as expressed by a mindless mob, one driven by panic, propaganda, or unfettered greed. Such public "voice" could be a destructive form of government that some might fear and condemn as "socialism," "communism," or "populism." We should not ignore any minority group, such as an ethnic group or the minority of very wealthy citizens. But we must be careful to honor and trust the opinions of the majority of citizens, all participating, whose opinions are carefully measured.

My many years of research have convinced me that such measured opinion yields a very constructive political agenda, and one on which self-identified strong liberals and strong conservatives are rather close together, strange as that may seem. We're not as separated on our political worldviews as some media pundits would have us believe. Extremes of both the left and right are *both* off-base, when compared to the average scores of strong liberals and strong conservatives taken as a group.

We have many very serious problems that we need to be attending to. We can't waste time fighting among ourselves or let the extreme voices from either the left or right dominate the conversation or dictate political policy for our nation. We need to see ourselves as in this lifeboat, the ship of state, together, and figure out how to cooperatively sail it in a meaningful direction. We can plot our political course with reliable and valid opinion scales. But I'm drifting a bit off topic. Back to our scale for measuring opinions with a rating scale.

You can experience the citizen opinion rating process by adding the additional criteria to and making copies of the above questionnaire. Fill it out and have 3 or 4 of your friends do it. Add your scores on the 13 items and divide by 13 to get your average score for each leader. These scores can range from 1 to 5. Then find the average across you and your friends (for example, one average score for Trump, one for Hillary Clinton). I expect the scores of your raters for Trump will cluster together, and the same for Clinton, and that the clusters won't overlap. Make a guess ahead of time as to which leader will have the

Continued on page 15

Fig. 1

Strongly disagree 1	Disagree 2	Neutral between 2 and 4	Agree 4	Strongly agree 5
1 2 3 4 5	Has the ability to negotiate skillfully, tactfully, politely, and fairly with other leaders, both locally and internationally.			
1 2 3 4 5	Seems to be reasonably concerned for the welfare of all humans, in our own nation and in other nations.			
1 2 3 4 5	Respects the mission of the United Nations and other such organizations that promote the common good, such as the Red Cross and the NAACP.			
1 2 3 4 5	Deals wisely in social relationships, e.g., with other politicians, family members, business partners and customers, friends, and the general public.			

Cliff's Notes

Cliff Johannsen, PhD, APA Council Representative for Oregon

Hello, colleagues.

As the Oregon representative to APA Council I represent those of you who are both OPA and APA members. To your credit, a substantial portion of you already hold dual membership and hooray for you! If you don't yet hold dual membership, I offer you the most sincere encouragement to start a new era in your career. Those holding dual membership are my constituency, and I strive to be your voice at APA.

I am just returned from the APA Council meeting in San Francisco. We had a full agenda, and some contentious issues which I will outline here.

On the consent agenda, there were numerous recognitions, extensions, and renewals:

- Sport Psychology as a Proficiency in Professional Psychology
- Family Psychology as a Specialty in Professional Psychology
- Clinical Health Psychology as a Specialty in Professional Psychology
- Group Psychology and Group Psychotherapy as a Specialty in Professional Psychology
- Behavioral and Cognitive Psychology as a Specialty in Professional Psychology
- Clinical Neuropsychology as a Specialty in Professional Psychology

The Presidential Work Group on an Expanded APA Advocacy Model introduced 4 motions and all 4 were passed. This pertains to creation of both c3 and c6 organizations across all directorates.

1. Receive the report of the work group
2. Support the concept of a unified Finance Committee and a single Board of Directors
3. Approve 2019 dues allocation of 60% to the c6 and 40% to the c3
4. Approve amendments to the APAPO bylaws to reflect an organizational name change, broader mission, and Advocacy Coordinating Committee.

Only the 4th motion created much controversy. That was centered on the creation, duties, and work flow of the Committee.

The Society for Industrial and Organizational Psychology introduced a motion to adopt the Principles for the Validation and Use of Personnel Selection Procedures 5th Edition. The 4th Edition had expired, leaving no standards in place. Controversy existed between SIOP and the Committee on Socioeconomic Status. Much effort had been made to find a compromise, to no avail. The objectors were demanding that standards not apply to minority applicants. The proposed amendments would have hurt minority applicants and involve breaking federal employment laws. I voted in favor of the original motion, which passed.

A motion was introduced to remove the web site posting of the amended "Hoffman Report" or alternatively the "Independent Review." A substitute motion was introduced to remove the report from its own landing page on the APA website and place it instead in the context of a timeline of related events beginning in the mid-1980s up to the present. It will still be viewable

Continued on page 16

Assessing Political Leaders, continued from page 14

higher average score. Compare this with your results. Were you and your friends all correct? My guess is that most or all of you will be.

This is a mini-example of citizen involvement in government at the grass roots level. To expand this concept to a practical, community level, we'd need to include many citizens in the selection of items for the "Ideal President Traits" rating scale, or, we could call the "Traits of Ideal Presidents" scale, the TIP scale for short.

A valid and reliable version of this scale will "TIP" you off as to which candidate is likely to make the best leader.

We could invite any interested citizen to submit traits, then we could have a committee of politically liberal, conservative, and moderate citizens decide how to select perhaps 30 of these to put in a questionnaire format. I'd recommend a committee of 1/6 liberals, 1/6 conservatives and 2/3 in between, as this is the proportion of citizens who fall in these categories. Then, a random sample or samples of citizens could use this questionnaire to rate various local, state, and national politicians to explore the reliability and validity of the scale and tweak it until it is accurate. Then, citizens could look for ways to offer the scale to journalists, the League of Women Voters, and university professors of political science. The Democratic and Republican parties might be interested too.

For more on this and related topics, consider my book for the lay audience, *Party Time! How You Can Create Common Good Democracy Right Now* (McConochie, 2017). You can leaf through it free on Amazon. For my formal research papers, visit the Publications page of my non-profit web site, Politicalpsychologyresearch.com.

References

Flaherty, A. (7/18/2018). Trump's diagnosis for critics: "Trump Derangement Syndrome." Retrieved from https://www.apnews.com/48225d1360864dcb861b12e5cda12a32

Lee, B. X. (Ed.) (2017). *The dangerous case of Donald Trump: 27 psychiatrists and mental health experts assess a president*. New York, NY: St. Martin's Press.

McConochie, W. (2017). *Party time! How you can create common good democracy right now*. No city: Amazon Digital Services.

Cliff's Notes, continued from page 15

for study and reference. Aspects of the report were still in contention, including a lawsuit. The substitute motion passed and I voted in favor.

A motion was introduced to address the roles of psychologists in national security settings. This was done in executive session because of non-compliant, disruptive, and intimidating press and protestors. Also, speakers on behalf of Division 19 and the Department of Defense were not authorized to speak with anyone but the Council. The motion would have allowed psychologists in the military to treat service family members and detainees. The existing APA policy only allowed independent private psychologists to provide care when requested by detainees. The DoD had never allowed independent private psychologists into national security settings, so that was a moot point. The arguments against the motion suggested that providing care would support the idea of detention and torture in violation of international standards. I voted in favor of the motion because other international standards held that any nation detaining another nation's combatants or citizens has an obligation to provide reasonable healthcare to those detainees. The question of torture has been a settled matter for several years, APA is staunchly against it. The motion was defeated, so APA policy remains as it was before.

A motion was introduced by the Workgroup on APA Policies and Procedures. I was a member of the workgroup which addressed a handful of topics, but only Transparency of Decisions was moved for Council approval. The item Transparency of Decisions had been on the Council floor twice before, and each time it was highly controversial and its adoption was delayed to the next Council meeting. It was revised multiple times, and the President and CEO made the final revisions. It finally passed without further discussion and of course I voted in favor. What a relief! The topic that I developed for the workgroup was Managing Power Differentials.

A motion was introduced to archive the 2015 resolution on Violent Video Games Due to Inconsistent Evidence Based on Effects. There was controversy about the adequacy of the research review underlying the 2015 resolution. There also appeared to be some self-interest (as opposed to science) in the positions taken. A substitute motion to update the research review was passed. I voted against it because the question seemed pretty settled already.

A motion was introduced to approve creation of a task force to study Differences in Sex Development. It was moved from the consent agenda because it had a financial component. The motion passed and I voted in favor of it.

A motion was introduced by Bob Resnick and Ron Rozensky to specify the terminology designating people who receive care from Health Service Psychologists as "patient" and not "client." This had no impact on other specialties using "client" or other terms. This passed and I voted in favor of it.

A motion was introduced to revise Association Rules to update finance procedures. This passed and I voted in favor.

A motion was introduced to require more frequent strategic plans. One is underway now, but they have seldom been carried out. The motion passed and I voted in favor. I hope all APA members will participate in the current process.

A motion was introduced to approve guidelines for Psychological Practice with Boys and Men. It passed and I voted in favor.

As always, I encourage you to contact me with your concerns about APA structure and functioning.

OPA Confidential Peer Support Committee Mentor Program Is Available

The goals of the Mentor Program are to assist Oregon psychologists in understanding the OBPE complaint process, reduce the stress-related risk factors and stigmatization that often accompany the complaint process, and provide referrals and support to members without advising or taking specific action within the actual complaint.

In addition to the Mentor Program, members of the Confidential Peer Support Committee are available for consultation and support, as well as to offer referral resources for psychologists around maintaining wellness, managing personal or professional stress, and avoiding burnout or professional impairment. The CPSC is a peer review committee as well, and is exempt from the health care professional reporting law.

Confidential Peer Support Committee

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Allan Cordova, PhD, 503.546.2089
Jennifer Huwe, PsyD, 503.538.6045
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The Bookshelf: Male Breast Cancer

Shoshana D. Kerewsky, PsyD, HS-BCP, Editor, The Oregon Psychologist

Many people are not aware that men may also be diagnosed with breast cancer. The rate is about 1 in 1,000 males, and about 1% of all breast cancer diagnoses (Breastcancer.org, 2018). Because this is an unusual diagnosis and males are not routinely screened for breast cancer, they may be diagnosed at a more advanced stage.

Few resources on male breast cancer are available, potentially causing the data and accounts that exist to be over-reported in secondary sources. The paucity of research on male breast cancer leaves a great deal uninvestigated, making treatment recommendations that much more tentative. Medical staff may have little experience with male breast cancer. Male clients may need support in their decision-making and in coming to terms with a diagnosis that is seen as a female disease. While much of the available literature may be relevant, it is helpful to be familiar with some male-specific resources.

As with any media, review items yourself before making recommendations to clients or students. Works on breast cancer may become outdated rapidly.

Memoirs

Herbert, A. F. (2016). *The pink unicorns of male breast cancer*. North Yorkshire, Great Britain United Kingdom: Blossom Spring Publishing.

As is true of many memoirs in this genre, Herbert's story is self- or small press-published. At points he can be a little difficult to follow, but his story is engaging and provides a non-U.S. cultural perspective.

Johns, A. (2011). *The lump: A gynecologist's journey with male breast cancer*. Austin, TX: Live Oak Book Company.

Johns brings a medical perspective to his experience of breast cancer diagnosis and treatment. His experiences, which are conveyed engagingly and leavened with humor, in turn shape his responses to his female patients with breast cancer. Johns is heterosexual and culturally typically masculine.

Kovarik, M. W. (2014). *Healing within: My journey with breast cancer*. Bloomington, IN: Balboa Press.

Kovarik, a gay educator raised Catholic, interweaves his story of breast cancer as a stimulus for spiritual awakening. with meditative and related practices. He trends toward alternative and unsupported treatments such as past life and energy work, and ascribes to the belief that one's emotions cause or activate cancer.

Willis, J. (2008). *Saving Jack: A man's struggle with breast cancer*. Norman, OK: University of Oklahoma.

Willis is a retired professor of journalism. His memoir includes a significant focus on the effects of his diagnosis on his family.

Professional

Boyages, J. (2015). *Male breast cancer: Taking control*. Beecroft, New South Wales, Australia: BC Publishing.

Boyages has published several books on breast cancer. His encouragement to "take control" may appeal to more instrumentive clients, and the color-coded information straightforward style make this a useful text.

Samuels, A. (2011). *Male breast cancer*. No city: CreateSpace.

A good basic introduction to male breast cancer and its treatment. The few illustrations confusingly include a female having a mammogram.

Web resources

Breastcancer.org. (2018). Male breast cancer. Retrieved from https://www.breastcancer.org/symptoms/types/male_bc

Breastcancer.org. (2018). Male breast cancer [forum]. Retrieved from https://community.breastcancer.org/forum/51

No author. (2018). The Male Breast Cancer Coalition. Retrieved from https://malebreastcancercoalition.org/

Ritchie, R. (2017). Dealing with breast cancer, now prostate cancer. Retrieved from http://malebreastcancercoalition.org/Survivor%20Stories/rod-ritchie/

You will find many related books by entering these titles on Goodreads, Library Thing, Powell's, Amazon, or other online book review and sales sites.

What's on your bookshelf? You're welcome to submit your own annotated list with APA-style references for main entries to kerewskyopa@gmail.com. Single book reviews of interest to psychologists are also welcome. If you've published a book, you're welcome to write an article describing it (please identify yourself as the author in your write-up).

References

Breastcancer.org. (2018). Male breast cancer. Retrieved from https://www.breastcancer.org/symptoms/types/male_bc

Oregon Psychological Association

Deadline Changes for *The Oregon Psychologist*

Beginning with the next issue, articles are due to the editor at kerewskyopa@gmail.com by these dates:

- March 1
- June 1
- September 1
- December 1

Tips for submitting articles:

- Any OPA member or student member may submit articles. We are willing to consider articles from others on relevant topics.
- If you are writing your committee's column, be sure you leave time for your committee's review and vetting of content, and your revision.
- Before you submit your article, review it for content, accuracy, and mechanics.
- Sources referred to in your text need APA in-text citations and APA reference listings. We have some leeway on things like a Sojourner Truth quote at the top of your article or lists of URLs provided as resources, but most other sources need complete APA style referencing. Articles submitted with omitted or incomplete citations, or major APA reference style errors, will be returned for revision and may be resubmitted for the next issue.
- After you have completed revisions, turn off the "Track Changes" function.

Here is our basic style sheet for submitting articles:

Title

Author(s), highest relevant degree(s), OPA committee (if relevant)

If Used, Section Headings Should Conform to APA Style But Be Bolded

Tabbed, single-spaced, Times Roman 12-point type for content. One space after end punctuation. APA style in-text citations including those for URLs (Kerewsky, 2014). Blah, blah, blah. Blah, blah, blah, blah. Blah, blah, blah. Blah, blah, blah, blah.

Here are some other guidelines: No space between paragraphs. Set line spacing to *0 before paragraph, 0 after paragraph, single-spaced.*

No document headers, footers, or page numbers, please. Hanging indents should be accomplished with the document ruler, not by hitting the space bar (Kerewsky, 2014). This is true for tabs as well. If you don't know how to format something like a hanging indent, I will take care of it. If you're not sure how to write the reference list entry for a non-standard source, do the best you can and make sure you include all of the information I will need to edit your reference.

If you use figures, provide them in Word (in which case, they can be in-text), or as a separate PDF with the caption in the text of the article so I know where you want it. Don't insert non-Word figures or images into the Word text.

Fake References

Kerewsky, S. D. (2014). URLs: Bane or boon? Retrieved from www.online-shoshana-all-the-time/fqqr44w/articles/content.htm

Kerewsky, S. D. (2013). Hanging indents are your friend. *Journal of Shoshana Science, 5*(12), 341=346. doi: xxxxxxxxxxxxxxx

Thank you—your attention to these details helps ensure that your article appears as you intended it.

OPA Mentorship Program

Dear Colleagues,

We are happy to announce that the OPA Mentorship program is up and running. We had 10 psychologists and two mentees respond to our request at the annual conference. We are working to get the two forms for the Mentorship program on the OPA website. The first form is for the interested parties to give some details of their practice setting, training, interest and location. The second form is for informed consent, limits of confidentiality etc.

Please join your colleagues and offer to serve as a mentor and to learn or ask questions as a mentee. Monthly phone or in person meetings are set up by the mentor and mentee once a "match" is made. Enjoy a bit of colleague support, new information and conversation regardless of age, orientation, or years of experience.

OPA Public Education Committee Facebook Page—Check it Out!

Please take a moment to check out the OPA Public Education Committee Facebook page. The purpose of the OPA-PEC Facebook page is to serve as a tool for OPA-PEC members and to provide the public access to information related to psychology, research, and current events. The social media page also allows members of the Public Education Committee to inform the public about upcoming events that PEC members will attend. Please visit and "like" our page if you are so inclined and feel free to share it with your friends!

You will find the OPA Public Education Committee's social media policy in the About section on our page. If you do "like" us on Facebook, please familiarize yourself with this social media policy. We would like to encourage use of the page in a way that is in line with the mission and ethical standards of the Association.

Go to https://www.facebook.com/pages/Oregon-Psychological-Association-OPA-Public-Education-Committee/160039007469003 to visit our Facebook page.

OPA Continuing Education Workshops

The Oregon Psychological Association sponsors many continuing education programs that have been developed to meet the needs of psychologists and other mental health professionals. The Continuing Education Committee works diligently to provide programs that are of interest to the wide variety of specialties in mental health.

The Oregon Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists.

The Oregon Psychological Association maintains responsibility for the program and its content.

OPA Current Education Offerings

All workshops are held in Portland, Oregon unless otherwise noted. In order to register for OPA workshops on-line, you will need a credit card for workshop payment to complete your order. Registration fees for workshops will not be refunded for cancellations as of one week prior to the scheduled event or for no-shows at the event. Prior to that, a $25 cancellation fee will be assessed. For other events, check their specific cancellation/ refund policy.

Links for more information and registration are available at www.opa.org.

2018 Schedule

October 19, 2018

Register here: www.opa.org

Practice Management/Ethics

By Paul Cooney, JD and David Madigan, JD

December 7, 2018

Register here: www.opa.org

If I Didn't Have a Brain, I Wouldn't Have Pain

By Scott Pengelly, PhD

May 3-4, 2019

OPA Annual Conference

Hilton Eugene Conference Center
Eugene, OR

Oregon Psychological Association

If you are interested in diversity CE offerings, cultural competence home study courses are offered by the New Mexico Psychological Association (NMPA) to OPA members for a fee. Courses include: Cultural Competency Assessment (1 CE), Multicultural Counseling Competencies/ Research (2 CEs), Awareness-based articles (3 CE), Knowledge based articles (3 CE), Skills-based articles on counseling (3 CE) and Skills-based articles on assessment (3 CE). Go to www.nmpsychology.org for more information.

Calendar items are subject to change

To register go to www.opa.org

Join OPA's Listserv Community

Through APA's resources, OPA provides members with an opportunity to interact with their colleagues discussing psychological issues via the OPA listserv. The listserv is an email-based program that allows members to send out messages to all other members on the listserv with one email message. Members then correspond on the listserv about that subject and others. It is a great way to stay connected to the psychological community and to access resources and expertise. Joining is easy if you follow the steps below. Once you have submitted your request, you will receive an email that tells you how to use the listserv and the rules and policies that govern it.

How to subscribe:

1. Log onto your email program.
2. Address an email to listserv@lists.apapractice.org and leave the subject line blank.
3. In the message section type in the following: subscribe OPAGENL
4. Hit the send button, and that is it! You will receive a confirmation via email with instructions, rules, and etiquette for using the listserv. Please allow some time to receive your confirmation after subscribing as the listserv administrator will need to verify your OPA membership before you can be added.

Questions? Contact the OPA office at info@opa.org

OPA Ethics Committee

The primary function of the OPA Ethics Committee is to "advise, educate, and consult" on concerns of the OPA membership about professional ethics. As such, we invite you to call or contact us with questions of an ethical nature. Our hope is to be proactive and preventative in helping OPA members think through ethical issues. The committee is provided as a member benefit only to members of OPA. for a confidential consultation on questions of an ethical nature. At times, ethical and legal questions may overlap. In these cases, we will encourage you to consult the OPA attorney (or one of your choosing) as well.

If you have an ethical question or concern, please contact Dr. Jill Davidson at dr.jilldavidson@gmail.com. Include a description of your concerns, your phone number, and good times for her to call you back. She will make contact with you within 2 business days. She may ask for more information in order to route your call to the appropriate person on the Ethics Committee, or she may let you know at that time which committee member will be calling you to discuss your concerns. You can then expect to hear from a committee member within a week following Dr. Davidson's phone call. The actual consultation will take place over the phone, so that we can truly have a discussion with you about your concerns.

Following the consultation call, you can expect the committee member to present your concern at the next meeting of the committee. Any additional comments or feedback will be relayed back to you via a phone call.

Ethics Committee Members

Morgan Bolen
Student Member

Jill Davidson, PsyD

Irina Gelman, PsyD

Steffanie La Torre
Student Member

Catherine Miller, PhD

Nichole Sage, PsyD—Chair

Christopher Watson, MA
Student Member

Jamie Young, PsyD

Petra Zdenkova, PsyD

Psychologists of Oregon Political Action Committee (POPAC)

About POPAC… The Psychologists of Oregon Political Action Committee (POPAC) is the political action committee (PAC) of the Oregon Psychological Association (OPA). The purpose of POPAC is to elect legislators who will help further the interests of the profession of psychology. POPAC does this by providing financial support to political campaigns.

The Oregon Psychological Association actively lobbies on behalf of psychologists statewide. Contributions from POPAC to political candidates are based on a wide range of criteria including electability, leadership potential and commitment to issues of importance to psychologists. Your contribution helps to insure that your voice, and the voice of psychology, is heard in Salem.

Contributions are separate from association dues and are collected on a voluntary basis, and are not a condition of membership in OPA.

Take Advantage of Oregon's Political Tax Credit!

Your contribution to POPAC is eligible for an Oregon tax credit of up to $50 per individual and up to $100 per couples filing jointly.

To make a contribution, please fill out the form below,
detach, and mail to POPAC at PO Box 86425, Portland, OR 97286

- POPAC Contribution -

We are required by law to report contributor name, mailing address, occupation and name of employer, so please fill out this form entirely.

Name:_____ Phone: _____

Address: _____

City_____ State:_____ Zip: _____

Employer:_____ Occupation:_____

Senate District (If known):_____ House District (If known):_____

Amount of Contribution: $_____

Notice: Contributions are not deductible as charitable contributions for state or federal income tax purposes. Contributions from foreign nationals are prohibited. Corporate contributions are permitted under Oregon state law.

OPA Classifieds

JOB OPENING

Seeking a full-time child psychologist to join The Children's Program; a multi-disciplinary team of clinicians committed to serving families with a wide-range of behavioral, social, emotional and developmental concerns for the past 25+ years. Candidate is a graduate of an APA accredited program and licensed in Oregon/license eligible. Individual has experience/expertise in evaluation and treatment of a wide range of behavioral, social, emotional and developmental concerns in children 10 years and younger with particular interest and expertise in evaluation/treatment of children with AD/HD, anger and temper, emotional regulation, anxiety and depression. Expertise with group therapy is a plus. Candidate is experienced in administering/interpreting psychological testing, completing written reports for family/school/professional use, providing individual/family evidence-based treatment with a short term problem focused orientation and maintaining client records to current standards of care. Applicant demonstrates ability to function independently and with colleagues, members of the community and referring providers. Competitive salary and generous vacation/leave time with health, life and disability insurances, retirement and pre-tax flexible spending account. In-house continuing education opportunities, consultation groups and 8 hours paid CE time per year. Fun and dynamic work environment. We are located in southwest Portland, OR. Please visit our website, www.childrensprogram.com to learn more and submit your resume and letter of interest.

OFFICE SPACE

Wonderful office available in 2nd floor 3 office suite. $750 including internet. Great location in Beaverton just off Hwy 26. I have an established psychotherapy practice and I'm looking for some one who would be a good fit to share the suite. Elizabeth 503.681.8041.

Office Space to Share and Lease. Shared space: Available, M, Th after 11, F & Weekends. Desirable NW location close to 23rd street, Rent: $350. Office Spaces to lease in Beaverton. Sq footage: 119 to 285, Rent: $707 to 1254. Incentives Available. 503.531.9355 to schedule a tour.

Office Rental: Professional office space, 160 sq ft, furnished or unfurnished, with waiting room in charming English Tudor near Good Samaritan Hospital, NW Portland. Bus/streetcar/freeway access. Full or part-time. 503.225.0498.

Group of 12 independent full and part time psychologists, psychiatric nurse practitioners, social workers, and a psychiatrist has an office (198 sq. ft.) available full time. Located (I-5, I-205, SR 500) class A building near Vancouver Mall. Free parking, large waiting room, full time staff person. Please contact: Judy Leonard, Professional Mgmt Servs, 360.253.6425, drkennethshultz@comcast.net.

Beautiful large office in 2 office suite to rent. Large windows, trees, close to route 26 and 217 intersection, west side, close to Max with lots of parking. Share suite with health medical Psychologist referrals possible. Call 503.292.9183 for details.

PATIENT TREATMENT GROUPS

Pacific Psychology Clinic in downtown Portland and Hillsboro offers both psychoeducational and psychotherapy groups. Sliding fee. Group information web page www.pscpacific.org. Phone: 503.352.2400, Portland, or 503.352.7333, Hillsboro.

PROFESSIONAL SERVICES/EQUIPMENT

Pain Management small group workshops will be offered starting this fall. The workshop will be based on my new book. It Hurts: A Practical Guide to Pain Management. The workshops are open to all allied health care providers who work with pain patients. The cost is 275 for 6 hours of instruction which will be spread out over 3, 2 hour different days. For more information or to sign up please contact me at: kernolson@comcast.net.

Confidential psychotherapy for health professionals. Contact Dr. Beth Kaplan Westbrook, 503.222.4031, helping professionals since 1991.

Go to Testmasterinc.com for a variety of good online clinical tests for children and adults, plus manuals. Violence-proneness, PTSD, ADHD, Depression, Anxiety, Big Five Personality, etc. Bill McConochie, PhD, OPA member.

VACATION RENTALS

Sunriver Home 2 Bd, 2 ba, sleeps 5, minutes to the river and Benham Falls Trailhead. Treed, private back deck, hot tub, well maintained. $150-$225/night. Call Jamie Edwards 503.816.5086, To see photos go to vrbo.com/13598.

Alpenglow Chalet - Mount Hood. Only one hour east of Portland, this condo has sleeping for six adults and three children. It includes a gas fireplace, deck with gas BBQ, and tandem garage. The lodge has WiFi, a heated outdoor pool/hot tub/sauna, and large hot tub in the woods. Short distance to Skibowl or Timberline. $200 per night/$50 cleaning fee. Call 503.761.1405.

Manzanita, 4 blks from beach, 2 blks from downtown. Master Bdrm/bath w/Qn, rm with dble/sngle bunk & dble futon couch, extra lrg fam rm w/Qn Murphy-Bed & Qn futon couch, living rm w/Qn sleeper. Well eqpd kitch, cable. No smoking. $140 summers, $125 winters. http://home.comcast.net/~windmill221/SeaClusion.html Wendy 503.236.4909, Larry 503.235.6171.

Ocean front beach house. 3 bedroom, 2 bath on longest white sand beach on coast. Golf, fishing, kids activities nearby and dogs (well behaved, of course) are welcome. Just north of Long Beach, WA, 2 1/2 hour drive from Portland. $150 per night, two night minimum. Week rental with one night free. Contact Linda Grounds at 503.242.9833 or DrLGrounds@comcast.net.

Welcome New and Returning OPA Members

Alison Bort, PhD, JD
Portland, OR

Lindsey Bratland
Portland, OR

Alison Chapman
Salem, OR

Niles Cook, PsyD
Portland, OR

Alana Duschane, PsyD
Portland, OR

Karrie Ehlers
Hillsboro, OR

Brent Horner, PhD
Eugene, OR

Kiersten Kelly
Beaverton, OR

Claire Metzner, BA
Hillsboro, OR

Sean Robertson
Newberg, OR

Bradley Schultz
Beaverton, OR

Amber Valenkamph, PsyD
Bend, OR

Brian Parks, PhD
Eugene, OR

Ahsley Brimager, PhD
Medford, OR

Adam Rodriquez, PsyD
Portland, OR

The Oregon Psychologist Advertising Rates, Policies, & Publication Schedule

If you have any questions regarding advertising in the newsletter, please contact Kori Hasti at the OPA office at 503.253.9155 or 800.541.9798.

Advertising Rates & Sizes

Advertising Rates & Policies Effective January 2017:

1/4 page display ad is $100

1/2 page display ad is $175

Full page display ad is $325

Classifieds are $25 for the first three lines (approximately 50 character space line, including spacing and punctuation), and $5 for each additional line.

Please note that as a member benefit, classified ads are complimentary to OPA members. Members will receive one complimentary classified ad per newsletter with a maximum of 8 lines (50 character space line, including spacing and punctuation). Any lines over the allotted complimentary 8 will be billed at $5 per additional line.

All display ads must be emailed to the OPA office in camera-ready form. Display ads must be the required dimensions for the size of ad purchased when submitted to OPA. All ads must include the issue the ad should run in and the payment or billing address and phone numbers.

The Oregon Psychologist is published four times a year. The deadline for ads is listed below. OPA reserves the right to refuse any ad and does not accept political ads. While OPA and the *The Oregon Psychologist* strive to include all advertisements in the most current issue, we can offer no guarantee as to the timeliness of mailing the publication nor of the accuracy of the advertising. OPA reserves the right not to publish advertisements or articles.

Newsletter Schedule*

2018

4th Quarter Issue - deadline is December 1 (target date for issue to be sent out is mid-December)

**Schedule subject to change*

OPA Attorney Member Benefits

Through OPA's relationship with Cooney, Cooney and Madigan, LLC as general counsel for OPA, members are entitled to one free 30-minute consultation per year. If further consultation or work is needed and you wish to proceed with their services, you will receive their services at the discounted OPA member rate. Please call for rate information. They are available to advise on OBPE complaints, malpractice lawsuits, practice management issues (subpoenas, testimony, informed consent documents, etc.), business formation and office sharing, and general legal advice. To access this valuable member benefit, call them at 503.607.2711, ask for Paul Cooney, and identify yourself as an OPA member.

The Oregon Psychologist

Natalie Kollross, PsyD • Shoshana D. Kerewsky, PsyD, Editor

The Oregon Psychologist is a newsletter published four times a year by the Oregon Psychological Association.

The deadline for contributions and advertising is listed elsewhere in this issue. Although OPA and *The Oregon Psychologist* strive to include all advertisements in the most current issue, we can offer no guarantees as to the timeliness or accuracy of these ads, and OPA reserves the right not to publish advertisements or articles.

147 SE 102nd • Portland, OR 97216 • 503.253.9155 • 800.541.9798 • FAX 503.253.9172 • e-mail info@opa.org • www.opa.org