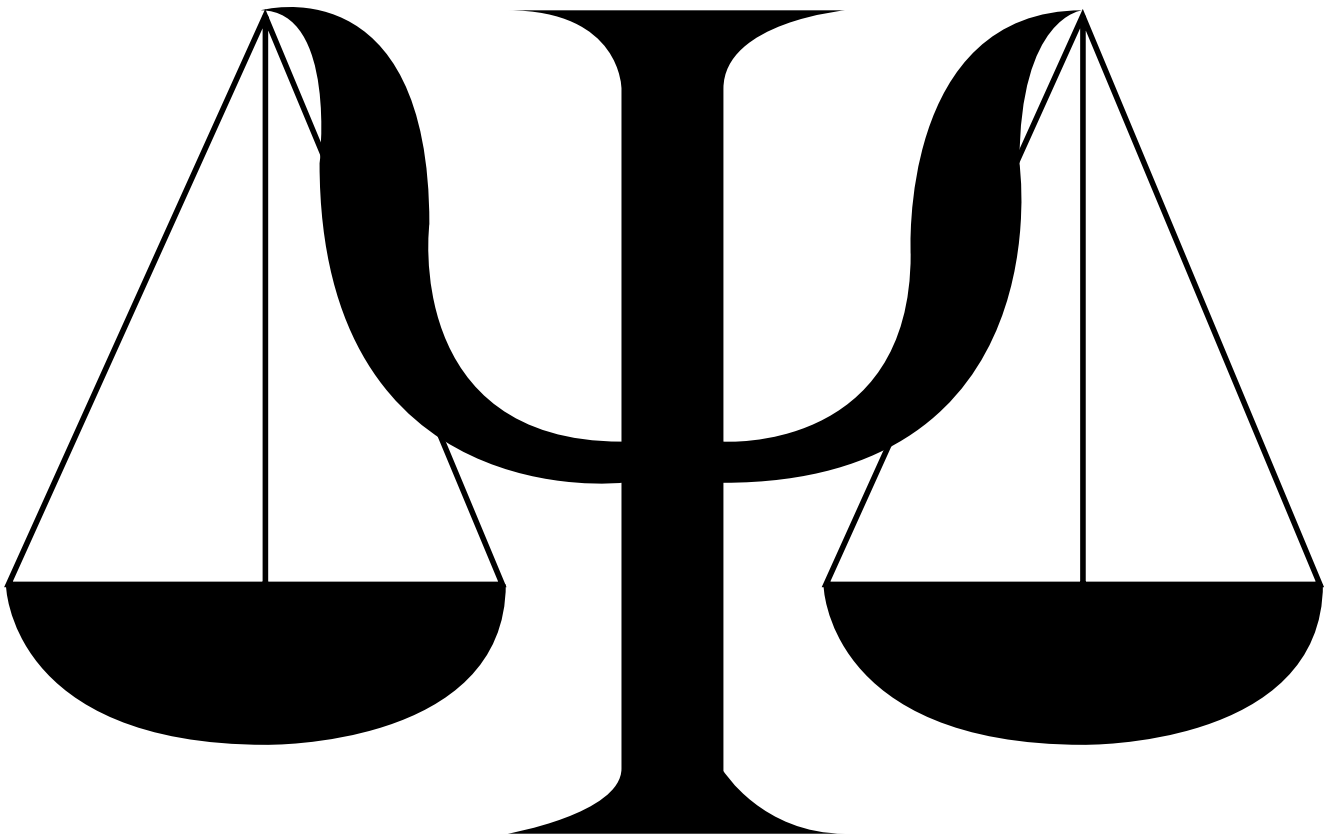
BC PSYCHOLOGIST

THE JOURNAL OF THE BC PSYCHOLOGICAL ASSOCIATION
VOLUME 4 · ISSUE 2 · SPRING 2015 · LAW & PSYCHOLOGY



LAW & PSYCHOLOGY

BC Psychologist

MISSION STATEMENT

The British Columbia Psychological Association provides leadership for the advancement and promotion of the profession and science of psychology in the service of our membership and the people of British Columbia.

SUBMISSION DEADLINES

December 1 | March 1 | June 1 | September 1

PUBLICATION DATES

January 15 | April 15 | July 15 | October 15

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BRITISH COLUMBIA PSYCHOLOGICAL ASSOCIATION

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Letter from the President

DOUGLAS CAVE, MSW, RSW, PH.D., R. PSYCH., MA, AMP, MCFP.
The President of the BC Psychological Association. Douglas Cave is an Assistant Professor in the Department of Family Practice in the Faculty of Medicine at UBC. His clinical work is at The Centre for Practitioner Renewal at Providence Healthcare. Contact for the Board of Directors at board@psychologists.bc.ca.

DEAR COLLEAGUES

I write this letter to you from Washington D.C. where I have been attending the State, Provincial and Territorial Leadership conference (SLC). I am excited to write about what I have witnessed here regarding psychology and how it influences a broad range of areas including law, this edition's focus.

Before I get to that, I would like to make 3 comments. Firstly I would like to welcome back Dr. Joachim Sehrbrock to the board of directors. Dr. Sehrbrock was previously on the board of directors and he has returned with some invigorating ideas for BCPA members and the practice of psychology in British Columbia.

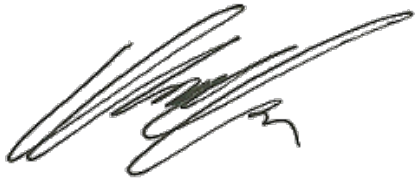
I would also like to congratulate the BCPA staff and the Community Engagement Committee for a superlative psychology month in February. Having been the BCPA delegate on the Council of Professional Associations of Psychologists (CPAP) (the national meeting of psychological associations in Canada) over the last couple of years and recently as this last week in Washington DC, it is very easy to say that BCPA held the most comprehensive series of activities as compared to other associations this year. I hope the momentum from this year's psychology month can be maintained.

Having been the BCPA delegate for CPAP, I am very pleased that our exceptionally skilled Executive Director (ED) Rick Gambrel has been voted by the board to be the new CPAP delegate. I will continue to attend as an observer and discuss with Mr. Gambrel about voting on issues. Mr. Gambrel will not be the only non-psychologist delegate to CPAP. The wisdom of having Mr. Gambrel as the BCPA delegate is multi-factorial. Since the ED has a longer presence with the BCPA board than a board member, BCPA will have greater constancy at the CPAP table in the future. The greater reason for this change is that Mr. Gambrel has been invited to be on the committee that oversees the new practice insurance initiative which is an agreement between CPA and the CPAP associations. With Mr. Gambrel's legal and business background, it is a very wise move.

Recently, the BCPA board again conducted a survey of all of us members. Listening carefully to our expressed interests, advocacy continues to be the most appreciated part of BCPA activities. Considering advocacy as one of the most important activities, it brings me to the SLC and psychology and the law. While psychology and the law is a broad area that includes both practice areas and legislative areas, I am struck by how much psychologists across the US are involved in shaping legislation regarding healthcare in general and mental healthcare specifically. Some individuals and associations are involved in legislative change that takes years to influence and create. It is inspiring to see and hear how our colleagues south of our border are so aligned and agentic in their pursuits. Examples of legislative influence include: defining scopes of practice for psychologists as compared to other people who do behavioural and other counselling-type work, working to increase access to psychologists for people who need psychological services, permitting trained psychologists to work medically in the area of psychopharmacology, and defining fee schedules for psychologists.

To better understand what BCPA members want BCPA to be focused on, including areas of advocacy, we are working to hold focus groups across the province. Please consider initiatives that are important to you and your colleagues. Between these surveys and the relationships we are working to develop with other healthcare associations, we expect to increase our ability to advocate on the behalf of all of us psychologists.

Wishing you all a pleasant spring.
Kind Regards,



Douglas Cave, MSW, RSW, PhD, RPsych, MA, AMP, MCFP
President, BCPA

Letter from the Executive Director

RICK GAMBREL, B. COMM., LLB.
The Executive Director of the BCPA. Mr. Gambrel has a Bachelor of Commerce in Finance and a Law Degree from UBC. Prior to working at BCPA, he was a trial lawyer for over 30 years, as well as Managing Partner of a number of law firms. He is Past President of both the Trial Lawyers Association of BC and of White Rock Concerts, one of Canada's leading classical music presenters. Contact: rick.gambrel@psychologists.bc.ca

THE NEW YEAR has indeed been especially busy at BCPA.

In January, President Douglas Cave and I attended the national Council of Professional Associations of Psychology meetings in Ottawa and provided valuable input at the national level, including on the national professional liability insurance program brokered by BMS (one of two programs endorsed by BCPA, the other being that brokered through Johnson Meir). I was honoured to be asked to join the 5 member national professional liability insurance steering committee which administers your BMS insurance plan. BCPA is the only provincial association to have its Executive Director on that committee.

January lead right into the busiest February (Psychology Month) in our Association's history. BCPA was the most active association in Canada, provincial or national, during Psychology Month. We obtained dozens of television, radio, print and online interviews during February, spreading awareness of psychologists, what distinguishes them from other professions, and how to access them through our free referral service. These interviews were seen or heard by millions of people. As well, we advocated for greater funding for psychological services. We publicized 10 free public talks, many in partnership with the Vancouver Public Library, which were attended by hundreds of people. A full list of the interviews and the talks was sent out in your February eblasts.

BCPA also exhibited at the Bottom Line Conference, presented by the CMHA BC, and chaired by BCPA member Dr. Marie-Helene Pelletier. There, we spoke to dozens of union representatives and employers, encouraging them to increase their extended benefits annual coverage limits for psychological services to $2,000 per year, just as the federal government has recently done for its employees.

March brings more opportunities for BCPA to learn how to better advocate on your behalf, as we attend the APA State Leadership Conference in Washington DC.

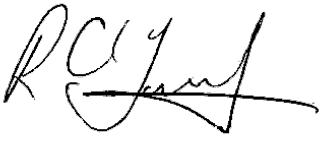
Your opportunity to take advantage of BCPA educational programs continues this month, with a very popular workshop, Impact Therapy with Dr. Ed Jacobs — a workshop that demonstrates a series of tools and techniques to make your therapy more effective. You can find registration information inside this issue.

In March we welcomed back to the board Dr. Joachim Sehrbrock, who will serve until the next AGM in November. Thank you Joachim, for bringing your enthusiasm and hard work back to the board.

And preparations are well underway for our third annual Piece of Mind Art exhibition, which asks artists to express through art what psychological health means to them. This year's exhibit runs May 1 – 15 at the Vancouver Public library Central Branch, Moat Art Gallery. Please join us for our opening night on Monday, May 4th at 6:30PM. You will see moving works of art and here moving stories from the artists, about what inspired their pieces.

Because I am limited to just one page, these are but the highlights of the recent past activities at BCPA.

If you have any questions, or you would like to join a committee and do some of the volunteer work of the association, please call me at 604.730.0501.



Council Focuses on Advancing the Field

THE AMERICAN PSYCHOLOGICAL ASSOCIATION'S COUNCIL OF REPRESENTATIVES adopts standards for competencies for health-service providers and accreditation of health-service psychology programs.

By Rhea K. Farberman
Monitor executive editor

AT ITS FEBRUARY MEETING, the APA Council of Representatives focused much of its action on the training and skills required for psychologists to work in health-delivery settings. In addition, council members discussed translating psychological science into public policy and received a report on the Association's finances.

In one of its most far-reaching actions, the Council adopted an inter-organizational document that outlines competencies for the practice of psychology in primary care. The document is the product of a nine-organization work group comprised of APA and three of its divisions, the Association of Psychologists in Academic Health Centers, the Council of Clinical Health Psychology Training Programs, the Society for Behavioral Medicine, the Society of Teachers of Family Medicine, and the VA Psychology Training Council.

The competencies document identifies the knowledge and skills that health-service psychologists need in order to practice effectively in primary-care settings. It will serve as a resource for graduate-level psychology education and training programs, students, and current practitioners. (See www.apa.org/ed/resources/competencies-practice.pdf.)

In a related action, by a nearly unanimous vote, the Council voted to approve the Commission on Accreditation's new *Standards of Accreditation for Health Service Psychology*. The new standards will replace the current Guidelines and Principles for Accreditation and will go into effect for all accredited programs on January 1, 2017. The original Guidelines and Principles for Accreditation were adopted in 1995. The new standards reflect changes in the profession since 1995, when the original guidelines were adopted. Look for a full report on the new guidelines in the May *Monitor.*

A third action concerning professional practice was the adoption of a new policy document, *Professional Practice Guidelines: Guidance for Developers and Users*. It replaces two earlier documents on practice guidelines from 2002 and 2005. The new policy document provides updated guidance for creating professional practice guidelines and gives current examples of such guidelines.

TRANSLATING SCIENCE INTO PUBLIC POLICY

Council devoted a full day of its two-and-a-half-day meeting to a strategic issue discussion focused on the goal of translating psychological science into public policy. The topic was opened by panel presentations by four council members and APA General Counsel Nathalie Gilfoyle (see sidebar). After the presentations, council members participated in one of three break-out discussions, each focused on a central goal: advocacy, educating the public, and translational research.

Council also received a report from APA Treasurer Bonnie Markham, PhD, PsyD, and Chief Financial Officer Archie Turner. They reported to the Council that the Association's finances are strong despite a small deficit budget this year. Overall, APA is in compliance with all of its debt covenants and continues to benefit from sizable long-

term investments. Furthermore, the Association's real estate holdings, its headquarters building and a second nearby office building, are fully leased and continue to grow in value.

OTHER ACTION

In other action, the council:

- **Approved a change in the Association rules to require boards and committees to have at least one member who is an early career psychologist.** Early career psychologists are defined as psychologists who within 10 years of earning their doctoral degree. A few boards and committees will be exempted from this rule due to their special requirements for service, such as the Fellows Committee, since members of this group must have attained fellows status, which requires candidates to have 10 years of postdoctorate experience. APA's boards and committees will have until 2017 to fully comply with the new rule.
- **Approved plans to implement changes in the Association bylaws and rules as per votes taken at the Council's August 2014 meeting.** The changes are related to the composition and election of the Board of Directors and are an outgrowth of the Good Governance Project, which was designed to open the Board up to direct representation by the general membership. All bylaws changes require a vote of the membership. That vote is expected to take place this fall by mail ballot.
- **Approved APA's endorsement of the 2012 San Francisco Declaration on Research Assessment,** which calls for improvements in the ways that the impact of scientific research is measured. In particular, it recommends against reliance on journal-impact factors as measures of the quality of individual research articles or of an individual scientists' contributions.
- **Approved a change in the bylaws and Association rules to allow one seat on APA's Board of Educational Affairs (BEA) to be held by an APA High School or Community College Teacher Affiliate member.** An amendment to the APA bylaws to implement the change to the BEA composition will be sent to the membership for a vote this fall.

ADVICE FOR TRANSLATING SCIENCE INTO POLICY

During the February APA Council of Representatives meeting, Council members Kim Gorgens, PhD, Frank Worrell, PhD, Lori Thompson, PhD, and Beth Rom-Rymer, PhD, opened the discussion of how best to support the translation of psychological science into public policy by sharing their experience in working with legislators and other policymakers. APA General Counsel Nathalie Gilfoyle also described the Association's highly successfully *Amicus* Briefs Program.

The collective advice shared with the Council included:

- Speak from the science; don't roam from the data.
- Personalize and humanize the issue. Tell the "story" of how a certain policy initiative can help people or solve a problem.
- Engage all stakeholders.
- Find allies, including reaching for allies beyond the field of psychology.
- Disseminate your findings in accessible language and formats.

BCPA News & Events

• piece of mind @ VPL

JOIN US FOR OPENING EVENT!
6:00PM – 8:30PM Monday May 4, 2015
@ Alice MacKay Room (Lower Level)
Moat Art Gallery (Central Branch).
Vancouver Public Library — 350 West Georgia, Vancouver
The exhibit runs from May 1 to May 15, 2015.

LEARNING TO *Paint* WORKSHOP
6:30PM – 8:30PM Tuesday & Wednesday May 12 & 13, 2015
@ Mount Pleasant Branch — 1 Kingsway, Vancouver

• upcoming workshop

IMPACT THERAPY: A MULTISENSORY APPROACH TO THERAPY (PRACTICAL TOOLS FOR MORE EFFECTIVE THERAPY)
Presented by Dr. Ed Jacobs & Dr. Nina Spadaro
Sponsored by Chuck Jung & Associates
9:00AM – 4:00PM Friday April 24th, 2015
@ University Golf Club

Please find the registration form on page 25 or visit psychologists.bc.ca for more information and registration.

• correction

OF NOTE: The primary author of the Pathological Grief Responses article in the Winter edition of the *BC Psychologist* was Milton Viederman M.D. as well as the secondary author, Dr. Don Hutcheon, R. Psych. Sincerest apologies.

• submit articles

WANT TO WRITE FOR US? We are always looking for writers for the *BC Psychologist* or the BCPA blog. The theme for the upcoming Summer 2015 issue is: resilience. For further details, contact us at: communications@psychologists.bc.ca

WE PUBLISH NOTICES regarding retirement, awards, and deaths of members. Please keep us informed about your career and life milestones. If you want a notice to be included in the publication (approximately 100 words) contact us at: info@psychologists.bc.ca

• weekly e-blast

Our weekly e-blast goes out every Friday and contains updates about upcoming workshops, advocacy activities, and opportunities to get involved with committees as well as job postings. If you would like to be added to the e-blast list or if you would like to advertise, please email us at: communications@psychologists.bc.ca

If you have signed up for the e-blast and are not receiving it, please follow the steps below:

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2. Depending on your email service provider you should also check your spam filter settings and/or your blocked and safe sender list settings. Some email providers also allow you to automatically sort incoming mail. You may need to also check your inbox filter and sort settings. Check the HELP section for your service provider for details.

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Strategies of Governance at the Board Level

DR. DONALD HUTCHEON, C. PSYCHOL. (UK)., R. PSYCH. #1421
Assoc. Fellow of the British Psychological Society
Fellow of the American Psychotherapy Association
Treasurer of the British Columbia Psychological Association (BCPA)

I HAVE BEEN A SUBCOMMITTEE MEMBER, board member and member of the executive of BCPA for several terms since 2003. Over that time I have encountered the typical "ups and downs" of the Board's infrastructure, as influenced by both personality and politics. The following paper discusses the potential power of meta communication development of policy making within a board.

Ask any board member, psychologist or other member of the community about the foibles of being a board member for one or more terms and the following anecdotes will probably be disclosed:

1. Lack of continuity. The shift in membership on an annual basis as terms come up and people come and go precipitate procedures and learning expectations (e.g., Roberts Rules competency) that rarely last. Specifically, new board members tend to be suspicious of the old and want to "make their bones"; retired board members adopt a "wait and see" attitude toward the new brigade etc.,
2. Uneasy Relationships with the Administration (i.e., executive of the board). Often new board members suspect the executive of keeping some issues from total transparency, resulting in mistrust, defensiveness and narrow mindedness (i.e., my/our way or the highway mentality);
3. Political Divisions. The board becomes split — left wing, right-wing — basically in opposition to, or in support of, a decision being made. Often these divisions make it very difficult to get on with the job of policy making or revision, which is a major Board responsibility. If the differences are left unresolved disharmony, misunderstanding and mistrust occur;
4. Special Interests. Most new board members feel that they were elected/nominated on their own private policy platforms, I know I felt this when I was quickly (less than a month) contacted by our current President Douglas Cave in 2008 with identical thinking and agreement on psychopharmacology prescription privileges for psychologists in British Columbia — long overdue in my opinion;
5. Involving the Community. Over my twelve year's association with the BCPA board we often get two kinds of community involvement: apathy when there are no crises; or uninformed criticism when we are perceived as doing something wrong. Strong statements, I know but I would like to see more consistency in continual involvement from our community and I'm not sure at this point late in my career if I have the answer, as in, unlocking the community mind set, hmm what to do;
6. Prioritizing Policy Ventures. Sometimes we find ourselves "snowed under" with demands and policy initiatives prioritizing what to do first, the timing, who should be involved, their strength of political clout to get the job done and at what cost, and the issue is pushed back, and back and then back some more etc.,
7. Perceptions of Procedures. We are often criticized by colleagues and professional associates for being inconsistent in procedures — indeed, even altering procedures to suit our own needs, political or otherwise. The "bottom line" is a challenge of our action or lack thereof causing problems;
8. The Policy Manual. Policy manuals can become so complex that only the initiated can find anything quickly. Colleagues often complain that they find it cumbersome when they attempt to read the document and state "what we need is a policy manual that is concise and easy to use — a set of real guidelines, readily accessible by any board member, psychologist or concerned "third party" citizen".

GUIDELINES — META POLICIES

Problems such as those identified above, and others, have prompted some boards to attempt to establish meta policies — guidelines about how the policy-making process is to unfold, the stages through which it should normally proceed, and who is entitled to be involved, when, and how. Here are some guiding assumptions which come to mind regarding developing a meta policy approach (Downey, 1988):

- It is wise to begin with a comprehensive framework for the policy-making process — but with the understanding that, as circumstances warrant, the framework may be modified or simplified;
- Policies on policy making should address the matter of participation in a very definitive way — to make clear that, although participation is to be encouraged, it is to be programmed in such a way as to leave to the board with the final authority and responsibility to decide;
- Similarly, policies on policy making should address the matter of information and expert advice — for the impression that uninformed opinion can hold sway in the policy-making process is to be discouraged;
- Lastly, though the meta policies themselves may be brief and mere declarations of intent, the procedures that grow out of them must be sufficiently specific to indicate both to the public and to the board exactly how the meta policies are to guide the process. This action is simply good quality control allowing ongoing quality improvement. Specifically, these procedures should indicate:

    a. How the policy process may be initiated and by whom;
    b. How the review process may be initiated and by whom;
    c. How the process, after it is initiated, may be stopped or delayed and by whom;
    d. The roles that information and inclination are to play and how;
    e. How policies will be refined after they are approved in principle;
    f. How policies are to be communicated; and,
    g. How, when, and how often, policies are to be reviewed, and by whom.

Hopefully the information provided in the paper provides more clarity about the process of meta communication regarding policy development; from establishment, to implementation, to review. Thank you for your attention in this matter.

REFERENCES

Downey, L.W. (1988). Policy analysis in education. Detselig Enterprises Limited. Calgary, Alberta.

Do Crisis Negotiators Practice What They Preach

MIKE WEBSTER, ED.D., R. PSYCH.
Centurion Consulting Services Ltd. Dr. Webster has practiced as a police psychologist for over 35 years. He specializes in Crisis Management and works with law enforcement agencies both domestically and internationally. He has consulted on a number of high profile crises including Waco Texas, Jordan Montana, Lima Peru, and Gustafsen Lake British Columbia.

HOSTAGE NEGOTIATION RECEIVED its first dose of respectability in the early 1970's following the tragedy at the Munich Olympics, and a couple of disastrous hostage/barricade incidents in New York City attended by the New York City Police Department. As a consequence of these events, Dr. Harvey Schlossberg and Lt. Frank Bolz implemented the strategy of talking with hostage/barricaded subjects rather than simply addressing them with a gradual application of force.

The field received its second dose of respectability during the early 1990's when the Federal Bureau of Investigation asserted that "hostage" negotiation was a misnomer. They explained that most call-outs were not hostage takings but people in crisis, and it followed that those policepersons tasked with talking to the subject should be called "crisis" negotiators. Moreover, they should be taught crisis intervention (or active listening) skills.

In response, those institutions responsible for training crisis negotiators (e.g. FBI Training Academy, Canadian Police College) began to organize their courses around the teaching of active listening skills as the heart of their programs. Today they spend more time discussing, learning, and practicing the skills than on any other topic. Interestingly, I was unable to find any literature questioning the impression that these skills could be generalized from the counseling realm to the hostage/barricade business. Even more interesting to me, because of my roles as a consultant to emergency response teams, and as an instructor of crisis negotiators, was the fact that I was unable to find any evaluative studies that had followed-up on the use of these skills.

I suspected, based upon my observation of crisis negotiators in action (for nearly 30 years), that the skills weren't being used to the degree that many in the business thought they were. It was my expectation, based upon the emphasis placed upon training these skills, and the amount of time spent honing them, that they should be the crisis negotiator's main tool.

What I heard was quite the opposite. It was my impression that the skills were rarely being used, and I found myself continually prompting and reminding crisis negotiators to employ them. More objectively I reminded myself that perhaps due to my own professional development my expectations were too high and my perception was inaccurate. I decided to take a more objective look.

In 2001 I began to collect a sample of audiotapes from crisis negotiators. My intention was to analyze each of these hostage/barricade incidents to determine at what level these active listening skills were being utilized. Early in 2002 I was ready to begin my modest and straightforward project. I had collected tapes from all across Canada — from British Columbia to the maritime provinces — representing the work of 15 separate crisis negotiators. The average length of incident was approximately 3 hours. Twelve of the crisis negotiators were male and three were female. Their average length of experience, as a crisis negotiator, was 6 years. The crisis negotiators represented municipal, provincial, and federal levels of policing. The incidents represented both urban and rural settings. All incidents could be identified as non-hostage (i.e. expressively motivated subjects).

I obtained the audiotapes by outlining my project to a national gathering of Canadian crisis negotiation coordinators. I requested tapes that would allow me to perform an analysis on crisis negotiator communication. When I had all the tapes I thought I would receive, I began my project. I used a research technique called content analysis. This technique is an objective, systematic, and quantitative description of the manifest content of communication (Berelson, 1952). The raw material for the technique may be any form of communication. The form the communication took in my project was audiotaped crisis negotiator communication with a barricaded subject. The analysis entailed a simple classification or tabulation of specific content. I analyzed each crisis negotiator's speaking turn to determine whether it was an active listening skill, or not. (And if it was an active listening skill, which one was it?) I had a very narrow focus. I was not interested in outcome (i.e. success or

failure), but process. I wanted to determine what the level of use of active listening skills was in a reasonably representative sample of trained and experienced Canadian crisis negotiators.

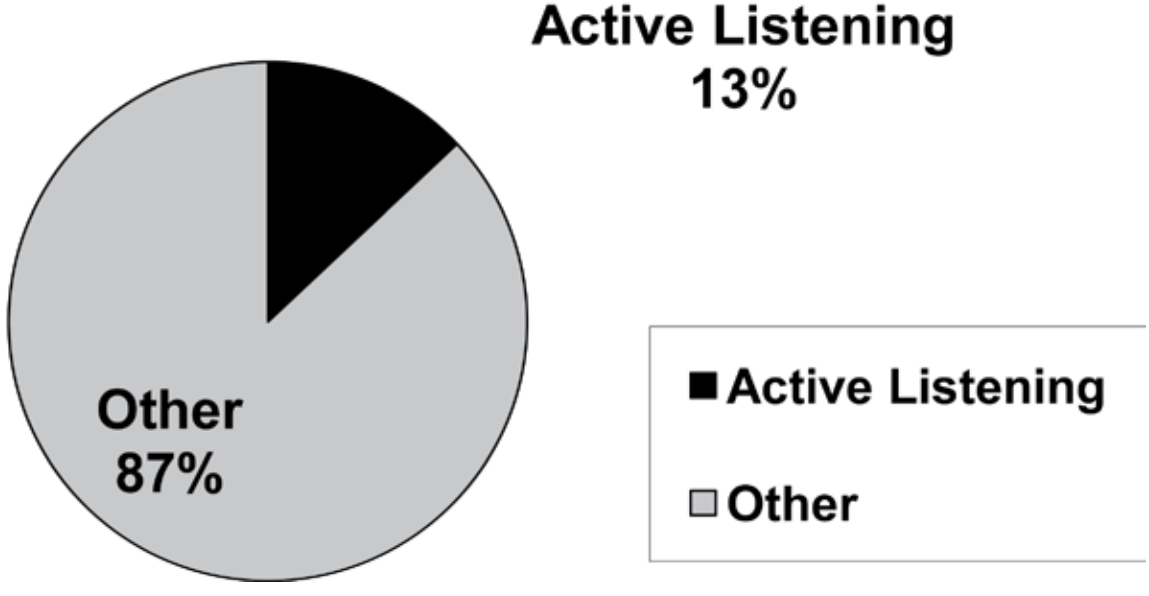
I needed to establish a hypothesis, but I was unable to locate any previous related work that would guide me in doing so. I ended up setting an arbitrary figure that would give me something to prove or disprove. I thought that as these active listening skills are considered to be the heart of crisis negotiator training in North America, and so much time is spent learning and practicing them, they would be used at least 25 percent of the time. That is, 25 percent of crisis negotiator speaking turns would be one of these active listening skills (minimal encouragers, paraphrase, emotion labeling, mirroring, summary) or another. (Silence proved difficult to quantify so "effective pauses" were eliminated). I thought this was a conservative estimate as it left 75 percent of their speaking turns to do all the other things that crisis negotiators do (e.g. calm, reassure, gather intelligence, problem solve).

I relied upon a simple frequency count of the objective variables (i.e. the active listening skills) to support my hypothesis. I listened to every crisis negotiator's speaking turn on every tape I had collected. I marked each speaking turn as either yes (it was an active listening skill; and which skill it was) or no (it was not). When I had all the tapes marked I determined the percentage of active listening skills in the total amount of speaking turns. I did not perform statistical manipulations of the data, as I was not interested in the statistical significance of anything. I just wanted to find out how often active listening skills were used.

I found that crisis negotiators, in my sample, used an active listening skill only 13 percent of the time. That is, these veteran crisis negotiators utilized an active listening skill 13 times in every 100 speaking turns (see fig.1). This outcome failed to support my hypothesis.

Of this 13 percent approximately 66 percent of the active listening skills used could be identified as an attending skill or minimal encourager (e.g. "yes", "I see", "uh-huh"); paraphrasing comprised 12 percent of the total ; emotion labeling comprised 9 percent of the total; summary comprised 7 percent of the total; and mirroring comprised 6 percent of the total (see figure 2). When the minimal encouragers were factored out of the original 13 percent active listening skills total, this left approximately 6 percent of all the speaking turns being an active listening skill (see figure 3). That is, only 6 out of 100 times did the crisis negotiator use paraphrasing, emotion labeling, mirroring, or summary. This is somewhat alarming as empathic communication is thought to be crucial to effective counseling (Rogers, 1951; Truax & Carkhuff, 1967; Gendlin, 1970).

Figure 1 Total Active Listening Skills



I went even further to examine several other variables as factors. Once again, I performed no tests of statistical significance on the data. I simply computed percentages. I also examined crisis negotiator training date experience, gender, and level of policing (municipal, provincial, federal) as factors, and found minimal differences across these factors. Therefore, these contextual variables likely had no mitigating effect on the principal finding of this project.

Figure 2

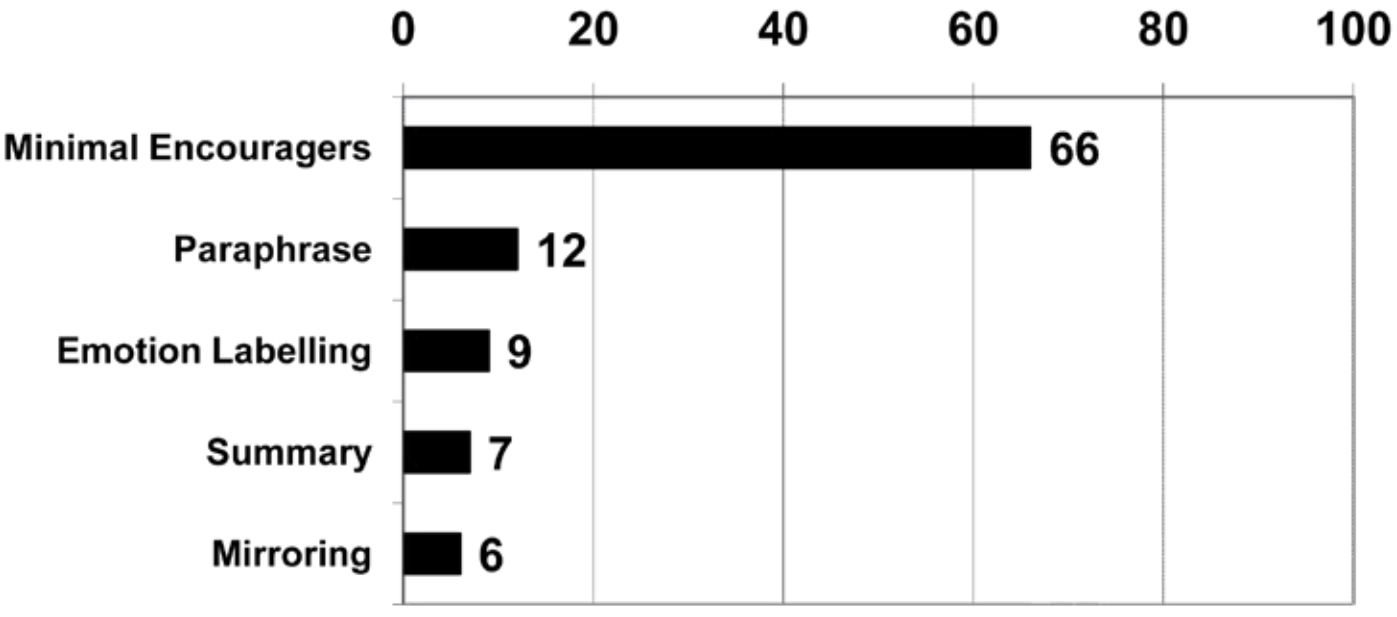
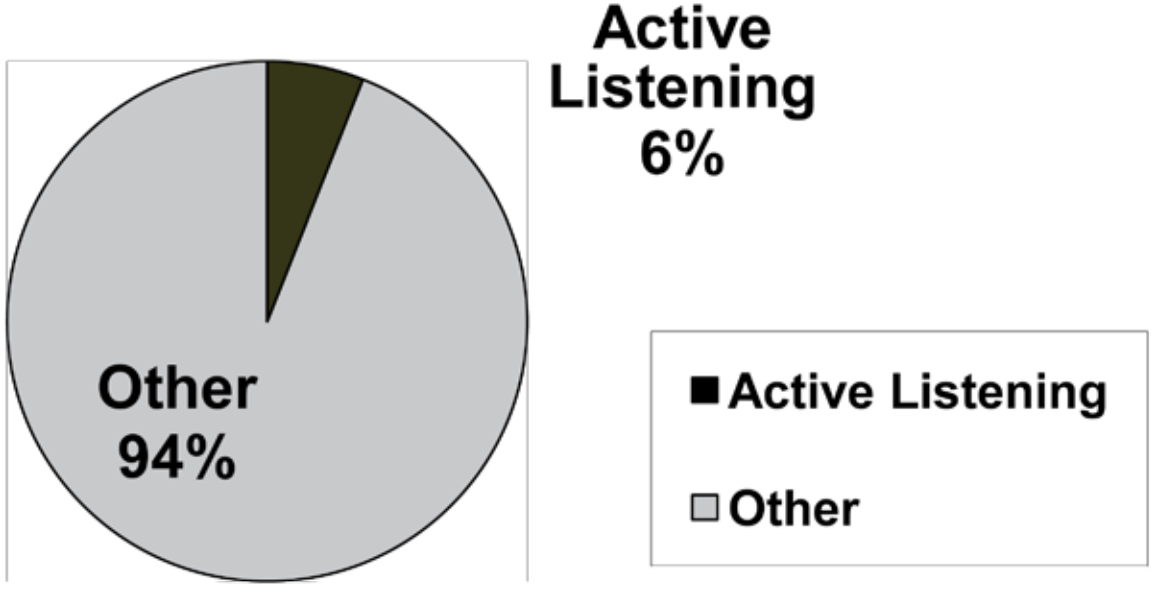


Figure 3 Total Active Listening (Absent Minimal Encouragers)



CONCLUSION

This was a modest project done out of curiosity and not really clean enough to be dignified with the term controlled research. It really raises more questions than it answers. It can (and I'm sure will) be criticized on several levels. The sampling procedure was not strictly random (yet produced a group of those thought to be the best in their field). And, I was both the author of the project and the principal rater of the tapes. Perhaps some neutral raters and the establishment of inter-rater reliability would have increased objectivity.

Nonetheless, I think it raises some interesting questions. For example, "What role does active listening actually play in hostage/barricade work?" Someone several decades ago we had the impression that these skills could be borrowed from the counseling context and transplanted to the emergency response context. If it turns out that the present findings are replicated by others, this impression will have to be questioned. The mystery to be solved would be — if the police are so successful at managing hostage/barricade incidents and they aren't using the skills that they are being taught, then what are they doing? In other words, if they only employ an empathic technique 6 percent of the time, then what are they doing the other 94 percent of the time? Are there other equally effective factors that are more directive than responsive in nature? In the present project the 94 percent was made up of leading skills such as questions, explanation, suggestion, advice, I-messages, confrontation, reframing, self disclosure, and warning. Perhaps active listening is best viewed as a small piece of a larger package. It may account for the creation of a working alliance between the crisis negotiator and the subject but not for the solving of problems. The latter may need its own set of skills unrelated to active listening. Or perhaps the effectiveness of problem solving skills is in proportion to the quality of the working alliance established through active listening.

To focus directly on the hypothesis of the present project, "Is there an optimal level of active listening?", perhaps it's more a question of timing than rates. That is, maybe it's not how often the active listening skills are used but when they are used. (Although in the present project scores of, many perfect opportunities were missed and the incidents were managed successfully). Is there even a correlation between the rate of active listening and outcome?

Another interesting direction to pursue is the classification process. Policepersons are selected, in most police services, to undertake general duty police work. Those qualities thought to make the best professional policeperson include tough mindedness, conservatism, dogmatism, achievement orientation, competitiveness, problem solving, and the like. When these individuals are applied to tasks (like crisis negotiator) that require qualities outside the range of their personality, they experience discomfort. It could be that many policepersons don't have the aptitude to learn the skills being taught and they rely on what they know best, and what is easiest for them to do.

This project suggests that there a discrepancy between the amount of time spent training active listening and the amount of time its used. There seems to be a discrepancy between what you think you do and what you actually do. (And my experience as a consultant to American law enforcement, in this area, and an adjunct instructor at the FBI Academy leads me to believe that this discrepancy exists south of the 49th parallel as well). I might be wrong but my impression is, that for all the emphasis that is put on active listening skills, they should be utilized more. Moreover, if you're not using the skills that you are taught, and still meet with success, wouldn't you like to know what accounts for that?

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Learning Disability: Have Psychologists Forgotten How to Think?

ARNOLD FUNK, R. PSYCH.

Born and raised in Manitoba, Arnie completed course requirements for a PhD in clinical psychology at the University of Kansas, but did not finish that degree. He has been a clinical psychologist in a State Hospital in Kansas, psychologist in the psychiatric unit of a general hospital in Saskatchewan (also doing research on LSD), supervisor of two Child Guidance Clinics in Michigan and the agency's consultant to school districts. A school psychologist in BC since 1978, he also joined Central Office in Child & Youth Mental Health Services for 6 years. He has conducted special education audits in 15 school districts in BC, and currently works for the Maple Ridge SD.

THE JOINT STATEMENT (***Evidence-Based Guidelines for Diagnosis of Learning Disabilities: Response to Proposed DSM-5 Criteria for Learning Disabilities***) published by the American Psychological Association and the National Association of School Psychologists has supported the DSM-5 definition of Specific Learning Disorders. Accepting these new diagnostic criteria is problematic for a number of reasons:

1. dismisses the criterion of an ability/achievement discrepancy as a basis for diagnosing LD, proposing instead a vague criterion that a person can be diagnosed with such a disorder if the achievement is below expectations for his/her age level.

2. states that those who do not have an intellectual disability (or sensory, emotional, or neurological impairment, or inadequate instruction, etc.) can be diagnosed with LD if their academic skills are not consistent with their age. Thus, age is the only basis for evaluating a discrepancy with skill levels;

3. has the age/skill discrepancy as not defined, except to say that it "is significantly below expected levels". It offers no guidance as to how the latter can be determined.

4. criticizes ability/achievement models because such diagnoses have not led to enhanced learning even with remediation. Since when is a disability/disorder determined by the effectiveness of the treatments available for it? People suffer physical disabilities all of their lives, but the lack of a cure does not negate the disability, and the lack of response to treatment should not be a criterion for making a diagnosis.

5. criticizes ability/achievement models because such diagnoses have led to social inequities. Surely one can separate a diagnostic criterion from negative social effects. The two phenomena are distinguishable, and should not be melded into a single characteristic.

6. criticizes ability/achievement models because such diagnoses have led to increasing diagnosis rates. Yet, the article proposes many additional bases for the diagnosis of reading disabilities which would surely increase their prevalence.

7. acknowledges that teachers, who work with students on a daily basis, are poor predictors of learning disabilities. Yet, by supporting the DSM-5 diagnosis, the document encourages physicians, who have no experience in teaching children and who may only see them once or twice a year, to make the diagnosis on hearsay evidence. Where is the research that justifies this?

8. By discounting the use of cognitive measures, except to rule out intellectual disabilities, it negates the bell curve that describes the range of most human characteristics. In effect, a student with an IQ of 76 is equated with a student with an IQ of 130, since the only criterion is whether academic skill levels are beyond expectation based on age alone. Cognitive ability is not a gauge in this determination. This is counter-intuitive.

9. There is no statement in the DSM-5 definition that a psychological or psychoeducational assessment is necessary for diagnosing a learning disorder. Only hearsay evidence is referenced in the DSM-5, no direct assessment is required.

10. For reading disabilities, the most common form of identified learning problem, there is no mention of the most intuitively convincing criteria — the significant discrepancy between oral comprehension (aka verbal comprehension or IQ) and reading comprehension. If one is unable to read at the level of one's understanding, surely that qualifies as a reading problem. Yet, this criteria isn't mentioned in either the Joint Statement or the current version of the DSM-5.

11. The shift from the label 'disability' to 'disorder' in the DSM-5 is not explained or justified. 'Disorder' is defined as "to disturb the regular or normal functions of." or "an illness that disrupts normal physical or mental functions...." An inability to read is not best understood as a disturbance of regular or normal functions. It is an inability or disability. The use of the term 'disorder' appears to be an attempt to cast it as a medical illness rather than a disability, placing it more firmly in the realm of medicine.

12. There is no acknowledgement that a definition of learning disorder/disabilities is an arbitrary definition, just as the definition of intellectual disabilities is arbitrarily set. Since these definitions are arbitrary, they are not validated or determined by research evidence. The reference to "evidenced-based guidelines" in the title of the Joint Statement is therefore misleading.

In sum, the psychologists' 7-page Joint Statement, as well as the DSM-5, offers unclear objective criteria for the diagnosis of learning disabilities or disorders. It can be expected to lead to increasing confused diagnoses, individually determined and un-standardized, with a sharp increase in the incidence levels based on their access to physician services. The impact on costs can be great.

This Joint Statement (http://www.apadivisions.org/division-16/news-events/learning-disabilities.pdf) by the APA and NASP, representing 134,000 and 25,000 members respectively who are trained psychologists, is an disservice to the profession. They have ceded the diagnosis of learning disabilities to other professions (physicians and teachers who test kids) who are untrained in the assessment skills necessary to make informed decisions, and who are guided by vague criteria.

Bottom-Up: What Psychology Can Do To Empty Jail Cells
The Reverse Dialectic

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INTRODUCTION

Here I go "preaching to the choir" again. But it does get frustrating when we have so much to bring to the table and sometimes it is therapeutic to share dismay. In the Swingle Clinic's outreach programs, we have experienced tear jerking turnarounds with the homeless and life changing rescues of children just simply caught in the bureaucratic whingeing of functionaries also trapped in dysfunctional systems. The difficulties faced by those trying to implement change are all bureaucratic, never technological, whether soft or hard. And as I listen to the frustration of those trying to implement these changes I am always reminded of the statement made to me by my most sagacious professor "Paul, remember it is never science, it is always politics."

The thrust of this minor rant is to reify that maybe we should push to have our talents implemented early rather than later. In other words, keep people out-of-jail rather than applying our collective considerable talents at what to do when people are snagged in the legal system.

So, if I may be permitted the liberty of reversing the context, let us have a brief look at what we know about keeping kids out of trouble in the first place and what we know about helping at risk kids to get back on board. We could look at many such applications but for the present I will restrict this to the "low lying fruit" areas of ADHD and Bullying.

The Co-Morbidities of Missed Opportunities
The Attention Disorders

As shown in Table 1, the data are quite clear. Untreated ADHD (DSM criteria) and related attention/hyperkinetic disorders (ICD-10 criteria) in childhood are associated with lifetime comorbidity rates estimated as high as 80% (Adler and Cohen, 2004). Incarcerated young males are routinely found about 50% with diagnosable ADHD, conduct disorders again about 50% and all SUDs including alcoholism as high as 85% (see Goodman, 2007; Rosler et al, 2004; Kessler et al, 2006; Young et al, 2002; Swingle, in press A for reviews of these data).

TABLE 1: Sample studies of adult populations with untreated ADHD conditions

ADHD ASSOCIATED RISKS

EMOTIONAL/ADDICTION PROBLEMS
Alcoholism and/or drug addiction 50%
Mood or anxiety disorder 60%

CRIMINAL BEHAVIOR
Percent greater than the General Population (GP)
Arrested 95.0% > GP
Convicted of a criminal offense 154.5% > GP
Imprisoned 800.0% > GP

Now we can identify these conditions quite readily in children. I'm not suggesting a George Bush approach of test them all but more sensible approach that has been tried in a few pilot projects of having an assessment as a resource room activity. That is, kids sent to resource room for help receive pro-forma assessment. We can quibble about how to treat these conditions but identifying them for help is obviously the most critical first step.

Such assessments can be automated tests of attention (e.g., Connors, TOVA), rating scales, or my favorite the limited, Clinical data based QEEG. As detailed in Susan Olding's book, *Pathologies*, the 6 minute Clinical QEEG is remarkably efficient for this purpose. She writes, "One by one he read the (*brainwave ratios*), (*identifying*) my daughter's (*condition*) — more quickly, more accurately than any professional I'd yet encountered" (Olding, 2008, italics added). The latter is based on about 6 minutes of recording time and other systems such as the TOVA can accomplish this in about the same time frame.

So if we can get a simple evaluation program in place that is not Bush type Draconian then many of these children can be rescued and we have many technologies to help these clients. But as my sagacious old prof also told me "Paul, you can't treat them if they ain't there" meaning a lot of effort has to go into getting kids into position to benefit from our many intervention possibilities.

Dr. Mary Jo Sabo, consultant for Yonkers New York School Board, developed a spin-off of this with her "safe rooms." A disruptive child normally negatively consequenced in some standard fashion, such as standing in the hall or being sent to the Principal's office, goes to a resource room area where therapeutic sounds are used to help quiet the child. They can return to class once under self-regulatory control. Data from some other schools for very troubled teens has shown reductions in both number of required visits to the safe-room and amount of time required in the safe-room.

BULLYING

Data from a number of Canadian studies indicate that in 4 – 11 year-old school children samples, about 15 percent of boys and about 10 percent of girls admit to having bullied another child although schoolyard observational studies indicate that the frequency between males and females is quite similar. About 5 percent of boys and about 7 percent of girls report having been bullied and a large number admit to being bystanders when bullying is occurring. Interesting data on bullying in Canada can be obtained from the publicsafety.gc.ca website.

Table 2 shows the data from the Avon Longitudinal study of 6437 early adolescent (average age 12.9 years) children (Lewis et al, 2009). Parents completed regular questionnaires about their child's health and development since birth and yearly physical and psychological assessment from the age of 7 years.

TABLE 2 : Bullied Kids More Likely to Become Psychotic Preteens

- Children who are bullied are more likely to develop psychotic symptoms in early adolescence. Repeated bullying associated with greater risk.
- The odds ratio for psychotic symptoms was 1.94 among victims of bullying at ages 8 and/or 10 years and jumped to 4.60 for repeated or severe victimization.
- Victims often less socially skilled and have no or few friends to protect them.
- Monozygotic twin studies: Victimized twin is more likely to develop depression.

Children with past and current bullying are most at risk for worse physical and mental health, followed by those children with only present bullying (Bogart et al, 2014). In particular, these children show greater depression symptoms, a classic condition often misdiagnosed as ADHD and unsuccessfully treated (Swingle, in press A). Bullies and victims and those that are both also have higher frequencies of being victims and/or perpetrators of criminal activity.

In a study of almost 19,000 adolescents, almost 20% had experienced cyberbullying in the past year. Of that number almost 20% reported depression; almost 5% reported suicide attempts; and about 6% prescription drug abuse. However, these children were also asked "how many days a week they had evening meals with their family" with range of 0 to 7. This study (Elgar et al, 2014) found that the link between cyberbullying and mental health and substance abuse problems was weaker among teens who reported having more family dinners. Family dinner ratings are used as a proxy for family contact and communication suggesting that positive family emotional climate supporting more open emotional communication offers protection for the victimized child. It is also obvious that the parental rule "no cell phones at the dinner table" is sacrosanct!

And yes, we can identify children who may be experiencing bullying. They show markers for exposure to emotional stress (Swingle, 2013), emotional volatility (Swingle, in press B) and reactive depression (Henriques &Davidson, 1991) on the limited QEEG evaluation that can be accomplished as a Resource Room activity. Other procedures can do this as well.

CONCLUSIONS

I have been preaching to the choir about how we can identify and treat children who are at risk. The problems we face in trying to invert the psychology — law relationship are not those of technology, skills, dedication or finances. The problems are overwhelmingly bureaucratic in nature and are supported by lethargy and special interests in maintaining the present state of affairs. Psychology has huge benefits to offer in many of these contests, of which two were briefly discussed. Maybe the BCPA can catalyze? &

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Reflections on 30 Years of Working with Individuals Who Sexually Abuse Others

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Dr. Daria Shewchuk is an educator and clinician in private practice, with a focus on treating individuals who have experienced trauma. As part of her practice (since 1985), she has worked with people who sexually abuse others. She is passionate about her therapy work.

SEXUAL ABUSE IS A MASSIVE SOCIETAL PROBLEM, involving a smaller number of abusers who abuse a much larger number of victims, resulting in very serious (and well documented) consequences for those victims.

Early in my career, I realized that we, as a society, cannot address sexual abuse by just treating victims, as more victims would spring up that could possibly be treated. As a society, we must also address the supply side of the problem, that is, the problem of the person who abuses others. Ideally, we can do this in a way which is respectful and in collaboration with the abuser by assisting them to learn about themselves, their behavior and its impact on others and on themselves, as well as helping them learn how to take full responsibility for, and change, their behavior.

My mentor was a forensic psychologist who specialized in working with sex offenders, and the cases he presented were fascinating to me. I subsequently chose to do a practicum (at that time as a social worker), at one of only two residentially-based treatment programs for sex offenders in Canada at that time (in 1985). During this practicum, I saw the impact, on my colleagues, of working exclusively with individuals who offend. It was then that I decided that I needed to work with victims as well as offenders. Since that time (until I moved to BC approximately 6 years ago), I have focused primarily on providing treatment and working with victims, and those who engaged in sexual abuse. The following are my reflections based on my own research (i.e., Dann (Shewchuk), 1987) and experience, as well as the current literature in the field.

In my private practice, I made a point of screening out individuals who are on the psychopathic end of the spectrum, as they are a special group requiring different approaches. I provide treatment to individuals who have either gone through the court system or who are "voluntary" clients unlikely to have charges pressed against them (i.e., who are not coming because of pending charges, although they may be coming because the family/victim coerced them).

I have yet to meet anyone who aspires to grow up to be a "sex offender". Most people (psychopaths sometimes being the exception) would prefer not to have this title. Some people who abuse others don't even understand what their problem is. They may experience their behaviour as "occurring" without really understanding how they arrived at this point in their life. Sometimes, they feel traumatized by their own abusive behavior. Often they do not really understand what is wrong with them, what is sexually "normal", and how they can help themselves. Many are in what Prochaska & DiClemente (1983) call the 'pre-contemplation stage of change'. They have a vague idea that something is not quite right with them, but aren't really sure of how people without their type of problem experience a 'normal' sexual relationship.

Their sexually abusive behavior typically unfolded over time and in specific contexts. It often has distinct phases or milestones. Therefore, conducting a developmental assessment of the client's sexuality and sexually abusive behaviors and patterns can be very helpful. In addition, every problem has an "architecture" to it, so we can best help our clients if we understand the "architecture" of their problem.

Research on therapeutic outcomes for this population tends to be divided into two groups:

1. research on the common factors to therapy, and
2. research on what is relevant to addressing a particular problem.

Researchers such as Scott Miller study the factors that are common to all therapies, such as good therapeutic rapport. Although many common factors have been identified, they are not the only active ingredients of therapy. Duncan and Miller (2000) note: "Many therapists have made the disappointing discovery that any given model that purports to ameliorate human suffering is limited. One size does not fit all". (p. 169)

For me, as a therapist, I see the common factors as necessary but often insufficient in treating this

population. When I worked on my Master's thesis, I became familiar with Doshay's (1943) longitudinal research study which examined the files of 256 juvenile male sex offenders (ages 7 – 16) treated in a New York Court Clinic between June 1928 and June 1934. Doshay's study (1943) is significant for at least four reasons. First, it suggests that pre-pubescents receiving treatment do much better in later years than post-pubescents. This confirms the findings of modern researchers that young people who sexually abuse others should be treated as early as possible. Second, Doshay counsels against traditional psychoanalytic methods in treating sexual offenders, as they did not work. Rather, the study advocates that the sexual act be addressed directly, within the context of the child's total personality and his family situation. Third, Doshay advocates for the universal teaching of "sex hygiene" (sex education and information), and the promotion of awareness in schools as one of the most important preventative approaches. Fourth, Doshay's study reveals that adult "sex failures", that is, those who were found to have re-offended at follow-up, had repeated the same acts they had engaged in during their adolescence.

In the writer's opinion, Doshay's work covered the basics, which most current research has supported. Since then some work has been added around typologies and the architecture of sexual offending (i.e., different types of offender dynamics), with perhaps more information about the development of sexuality in relation to subsequent sexually abusive behavior and treatment approaches. We also have a great deal more information as to "what works" in treating people who sexually offend.

Assessing and addressing these variables helps the therapist to learn the structure/architecture of sexual abuse. For example, if I was suffering from anxiety, I would likely want to see a therapist who is familiar with what anxiety is, how the client may experience it, and what may help. However, learning the structure/ architecture of sexual abuse is challenging for a number of reasons Specifically, people who offend sexually are a very diverse group. Additionally, sexual offenders can be motivated by many different variables. In action, the actual abuse can be perpetrated in many different ways. Nonetheless, the more we understand the contributors to sexual offences and how the client may personally experience them, the more we can help the client.

A respectful and helpful approach paired with a functional assessment that provides an analysis of criminogenic needs (the principle of selecting appropriate targets for treatment) and which is matched with the approaches and learning styles of the offenders does reduce recidivism. It is important for the therapist to understand sexual development, and to be able to assess for sexual developmental deficits or developmental quirks. The nature of these developmental quirks/sexual deviance is important to understand, as is the architecture of the sexual development of an individual and their sexual behavior patterns.

The questions which need to be asked here are: Which variables (including sexual variables) may be changeable and which ones may not? Which patterns of sexual deviance tend to cluster together? Does the whole cluster need to be addressed at the same time or can certain variables be singled out? Which variables should be targeted in treatment? Once the relevant variables have been ascertained, the focus of treatment should be on what was going on inside the offender "at the time" of the offending behavior and what will the offender respond to therapeutically.

Responsivity is a variable that refers to the need for the type and style of service to reflect offender characteristics. For example, many offenders are more responsive to cognitive/behavioural or social learning approaches. Research warns against some types and styles of service for the offender population. There is much documentation, for example, of the failure of unstructured approaches with offenders. They also warn against the use of traditional psychodynamic and nondirective client-centred therapies with offenders. They note that these therapies are designed to free people from the personally inhibiting controls of 'super-ego' and 'society', but neurotic misery and over-control are not criminogenic problems for the majority of offenders.

Shame is another variable that the therapist needs to be able to work with. Offenders who feel shame may hide from their victims and people who know about their past. The offenders also tend to use psychological defense mechanisms to protect themselves from their inner shame.

It would be obvious to any clinician that the above variables would constellate themselves into different individuals in unique ways. Treatment should directly stem from the assessment of relevant variables. For example, once the therapist and client are able to identify a pattern or cycle of behavior, they can then start working towards interrupting the cycle before the acting-out behavior re-occurs. I have unfortunately seen the situation where a person who offended sexually was thoroughly assessed, and referred for treatment, however the treatment program had a set curriculum, which did not fit the offender's patterns and dynamics. This ultimately led to failure.

Following Marshall's (2011) strengths-based approach, I advocate for therapists to use the "common elements" research as a guide in building good working relationships with these clients. In addition, therapists should be familiar with: the possible dynamics of people who abuse others and the variables to assess for; research on "what works" in this population, and; use their skills in a technically eclectic and integrated way, taking into account the abusers' learning style and approaching the abuser in way that is developmentally appropriate for that client.

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This 6-day Certificate Training Course, taught by Canadian Psychologist and Art Therapist Judy Weiser (considered the world authority on "PhotoTherapy Techniques") is **an intensive training experience for advanced mental health professionals (*only*)** to learn how to use clients' own personal snapshots and family photographs (and interactions with these) to improve their therapy or counseling practice.

Experience for yourself how the emotional information that "lives inside" personal and family snapshots (and pictures taken by others), is much more important than the visual details shown on their surfaces — and how this knowledge can be used to help clients in powerful yet safe ways that words (or inner self-reflection) alone simply cannot do.

Be trained in the skills that help clients benefit from exploring the "why" of the photographs they take, appear in, pose for, remember, imagine, or choose to keep (or not!).

Learn through slide- and video-illustrated presentations (including case-illustrations), demonstration role-plays and numerous experiential practice sessions with your own (and other people's) photos — *under Weiser's direct supervision* -- exploring how photos create meaning, evoke feelings, create thoughts, hold secrets, trigger memories, create personal and family narratives, illustrate family systems dynamics, project inner values, reflect judgments and expectations, and share information, while telling their own stories *their* way — and how to effectively and successfully incorporate both active and reflective photo-based techniques into your own therapeutic practice.

Important:

Workshop purpose is for professional training of advanced-level Mental Health Professionals, and is not intended for personal therapy processing!

Prior experience with cameras or photographic art is not required

CEU/CEC Credits will have been applied for from CPA (Canada) and NBCC (USA)

MORE INFORMATION:
jweiser@phototherapy-centre.com

CSCH Canadian Society of Clinical Hypnosis BC Div

THE POWER OF VISUALIZATION
FEATURING: DR. LEE PULOS, PHD, ABPP
MAY 23rd 2015

Vancouver Masonic Centre

Many psychologists are now recognizing imagery and visualization as among the most powerful tools in cognitive psychology.
The earliest visualization techniques ever recorded are from over 4,000 years ago. This workshop will open the mind's eye to the rich inner world of our imagination, integrating ancient and modern techniques for creating and achieving goals, optimizing health, identifying subconscious road blocks, developing intuition and creating our most optimal healthy and fulfilling future possible.

Open to healthcare professionals and to the public.

For more details visit **www.hypnosis.bc.ca**
Or call **604 688 1714**

British Columbia School of Professional Psychology

406-1168 Hamilton Street • Vancouver, B.C. • V6B 2S2 • (604)682-1909 • Fax (604) 682-8262 • email: wilensky@interchange.ubc.ca

The British Columbia School of Professional Psychology is presenting Basic Training in Eye Movement Desensitization and Reprocessing (EMDR). This course is approved by the Eye Movement Desensitization and Reprocessing International Association (EMDRIA).

Participants will learn to use EMDR appropriately and effectively in a variety of applications. Such use is based on understanding the theoretical basis of EMDR, safety issues, integration with a treatment plan, and supervised practice. Part One / Level I EMDR training is usually sufficient for work with uncomplicated Posttraumatic Stress Disorder in most clients. Part two / Level II is necessary for working effectively with more complex cases, special populations and more severe, longstanding or complicated psychopathology.

Qualified applicants will have a minimum of Masters level training in a mental health discipline and must belong to a professional organization with a code of ethics or be a Graduate student in practicum/internship with appropriate supervision.

Instructor: Marshall Wilensky, Ph.D., R. Psych., EMDRIA Approved Instructor
Format: Lecture, discussion, demonstration, video – 20 hours. Supervised practice (during training weekends) – 20 hours
Consultation by group meetings or online discussion forum – 10 hours
Dates: Weekend One: September 11 – 13, 2015; Weekend Two: November 27 – 29, 2015
Times: Friday 9:00 a.m. – 5:00 p.m.; Saturday and Sunday 9:00 a.m. – 4:30 p.m.
Consultations: October 19, November 16, 2015 and January 18, 2016 6:30 p.m. – 9:30 p.m.
Location: Peretz Centre (6184 Ash St., Vancouver)
Tuition: Full Course: $1,850 (before July 29, 2015) $1,950 (after July 29, 2015)
Previously trained EMDR clinicians can get updated for half price
Registration: Online at www.emdrtraining.com (>>Basic Training >>Vancouver page)

For more information please contact: Alivia Maric, Ph.D., R. Psych. 604 251-7275 amarica@shaw.ca

BRITISH COLUMBIA PSYCHOLOGICAL ASSOCIATION

Sponsored by Chuck Jung Associates
Psychological and Counselling Services

Impact Therapy: A Multisensory Approach to Therapy (Practical Tools for more Effective Tharpy)

WORKSHOP PRESENTED BY
DR. ED JACOBS & DR. NINA SPADARO


Dr. Ed Jacobs


Dr. Nina Spadaro

Friday April 24th, 2015
9:00AM – 4:00PM @ University Golf Club
5185 University Blvd. Vancouver, BC V6T 1X5

Continuing Education Credits: 6

About the Workshop
This workshop promises to give you new ideas regarding how to work with all kinds of clients. More than 25 creative techniques will be demonstrated with many other ideas briefly presented. Impact Therapy is an active, creative multisensory approach to counseling based on the idea that the brain likes novelty. Therapy is about the art of engagement and this workshop offers many engaging strategies and skills. Presenters will show creative ways to use counseling theories that make sessions more interesting and beneficial. The majority of the workshop will be brief demonstrations.

Learning Objectives
1. Participants will learn ways to use props in helpful ways in therapy.
2. Participants will learn valuable ways to use the whiteboard in therapy.
3. Participants will learn creative ways to use counseling theories.
4. Participants will learn simple, effective ways to have more impact.

About the Presenter – Ed E. Jacobs, Ph.D., LPC
Ed Jacobs is the coordinator of the Masters' program in the Counseling, Psychology, and Rehabilitation Department at West Virginia University. He received his MA in psychology from the University of Texas at Austin and his Ph.D. in Counselor Education from Florida State University. Professional publications include 30 articles in books and journals as well as six books on counseling techniques: *Impact Therapy, Creative Counseling Techniques: An Illustrated Guide; Group Counseling in Correctional Settings;* and *Group Counseling: Strategies and Skills,* which is now in the 7th edition, and his two latest books, *Impact Therapy: The Courage to Counsel* and *How to Select and Apply Change Strategies in Groups (Group Work Practice Kit).*

Ed is the founder and director of Impact Therapy Associates. He is a licensed professional counselor in West Virginia and has been in private practice for over 25 years. Ed has presented throughout the United States, and Canada and in Turkey, Indonesia, Australia, and New Zealand over 400 workshops on Impact Therapy and group counseling for agencies, school districts, and organizations. Ed is known for his practical, down-to-earth style in both his presentations and his books. Each summer, Ed conducts training institutes on Impact Therapy.

Ed has been recognized for his outstanding teaching and contribution to the field. In 2006, he was given the Outstanding Teacher Award in his college. Also in 2006 he was given the Innovator of the Year Award by the Association for Creativity in Counseling. In the past he was recognized for his contributions in group work by being given the Professional Advancement Award and selected as a Fellow in the Association for Specialists in Group Work. Ed is on the advisory board for the National Association for Cognitive-Behavioral Therapists.

About the Presenter – Nina Spadaro, Ed.D.
Dr. Nina Spadaro wanted to be a psychologist from the time she was eight years old if a report she wrote in second grade is to be believed. After earning her bachelor's degree from Fordham University in Psychology, she studied under Dr. Ed Jacobs at West Virginia University, completing both her Masters in Rehabilitation Counseling, and her Doctorate in Counseling & Guidance in 1983, and then earned her licensure as a psychologist in 1987. Dr. Spadaro incorporates the Impact Therapy approach over a variety of clinical experiences, including counseling psychology at a federal prison, clinical consultation for a Veterans Outreach Center, clinical work in community counseling, and over thirty years of part-time private practice with individuals, couples and families. She also teaches the Impact Therapy Approach in presentations and as a counselor educator. Currently Dr. Spadaro is a core faculty member at Walden University in their Master's in Clinical Mental Health Counseling Program. She moved to the Pacific Northwest in 2013 and has a small private practice in Bellingham, Washington which integrates martial arts, yoga and tai chi with counseling.

How to register for this workshop

- Mail this form to: BC Psychological Association
  402 – 1177 West Broadway Vancouver BC V6H 1G3
- Fax this form to 604 – 730 – 0502
- Go online: http://psychologists.bc.ca

Cancellation Policy: Cancellations must be received in writing by April 17th, 2015. A 20% administration fee will be deducted from all refunds. No refunds will be given after April 17th, 2015.

Free Parking Available.
Go Green: http://tripplanning.translink.ca/

Regular Registration (March 3rd – April 20th, 2015)

- ❑ Regular price $270.90 (incl. GST)
- ❑ BCPA Members and Affiliates $197.40 (incl. GST)

Meal requirements

- ❑ Regular meal
- ❑ Vegetarian meal
- ❑ Special needs or allergies (please include details below)

- ❑ **I will attend Impact Therapy Workshop (required)**
- ❑ **I agree to the Cancellation Policy (required)**

Name: _____

Address: _____

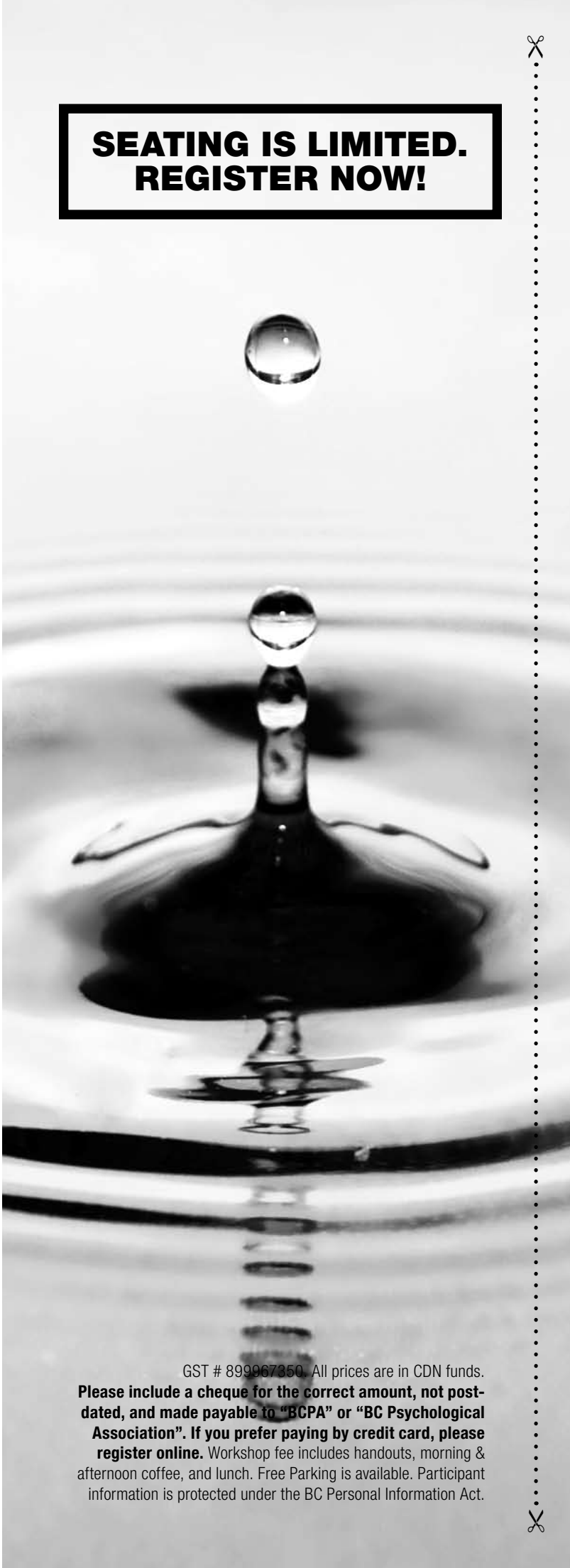
City: _____

Postal Code: _____

Phone: _____

Email: _____

SEATING IS LIMITED. REGISTER NOW!



GST # 899967350. All prices are in CDN funds.
Please include a cheque for the correct amount, not post-dated, and made payable to "BCPA" or "BC Psychological Association". If you prefer paying by credit card, please register online. Workshop fee includes handouts, morning & afternoon coffee, and lunch. Free Parking is available. Participant information is protected under the BC Personal Information Act.

For your peace of mind

Since 1998, Johnston Meier Insurance and the policy insurer Intact Insurance have been providing members of the British Columbia Psychological Association with peace of mind by ensuring the things that matter most to them are well protected.

As our valued customers, you can rest assured that our team of experts will offer you competitive products at competitive rates. For this reason, Johnston Meier has become, for many, the company they choose to manage their insurance needs.

We care about the things that matter to you and welcome the opportunity to be of service to you.

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This professional Liability Program is exclusive to BCPA Members covering the investigation and defense against any civil action brought against you arising out of rendering or failure to render professional services
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(The Professional Office Package placed in conjunction with the Professional Liability Insurance provides comprehensive coverage)

$275.00 for the basic policy (each one can be fine-tuned to your needs for a nominal cost)
$40,000 contents - All Risk coverage
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Accounts Receivable; Extra Expense; Valuable Papers & Records; EDP Equipment • Each coverage up to $25,000
$2 million Commercial General Liability
$500,000 Tenants Legal Liability

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Chuck Jung Associates

Psychological and Counselling Services

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Dr. Elsie Cheung, R. Psych.
Dr. Ken Lum, R. Psych.
Dr. Sharon Jeyakumar, R. Psych.
Dr. Marlo Gal, R. Psych.
Dr. Spencer Wade, R. Psych.
Dr. Robinder (Rob) Bedi, R. Psych.
Dr. Derrick Klaassen, R. Psych.
Dr. Iris Sharir, R. Psych.
Dr. Tara Learn, R. Psych.
Dr. Carey Penner, R. Psych.
Mr. Tacky Chan, M. Ed., RCC
Dr. Tigerson Young, R. Psych.
Dr. Jamie Patel, R. Psych.
Dr. Jim Browning, R. Psych.
Dr. Michelle McBride, R. Psych.
Dr. Kausar (Kay) Suhail, R. Psych.
Dr. Laura Klubben, RCC

ICBC REFERRALS ACCEPTED

Chuck Jung Associates is entering its 20th year of providing treatment services for clients recovering from motor vehicle accidents.

Counselling is also provided in: Punjabi, Urdu, Mandarin and Cantonese.

Services provided in Vancouver, Richmond, North Shore, Tri-City Area, Langley, Surrey, Abbotsford, and Chilliwack.

For more information, contact our Vancouver head office at: 604-874-6754 or visit us at www.chuckjung.com