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Inside...

Clinical Section Officers 2002-2003	2
Psychotherapy for abused and neglected children	4
An introduction to the WISC-IV	9
Submissions invited	10
Clinical Section List Serve	11
Therapist self-disclosure	14
Advertising notice	17
Summary of Executive Committee Meeting	18
Appreciations	18
Federal Privacy Legislation	19
On behalf of the Section	19
Newsletter Notice	19
CPA Convention Highlights	20

Message from the Chair

There is an enormous discrepancy between the level of public funding for psychological services in Canada and the documented efficacy of treatments and preventative interventions for emotional and physical disorders (see the Cost-Effectiveness of Psychological Interventions document and the Evidence Based Psychological Therapy Fact Sheet on the Clinical Section web site). It is unfortunate that governments withhold access to these powerful interventions.

The recent hospital psychology department closures and staff reductions in certain areas of the country (including the recent cuts at The Ottawa Hospital) have been alarming. One might be able to understand the parings in an overall context of health budget reductions however, it appears that there it disproportionate lack of awareness on the part of hospital administrators as to the cost-effectiveness of psychological interventions. These events have further reduced access to psychological services and diminished the availability of practicum and internship training. In addition, the budget enhancing recommendations of the Romanow Commission certainly missed the opportunity to bring psychosocial aspects of health care into the mainstream of publicly funded services. As a result, overall cost savings resulting from the implementation of psychological interventions have been ignored.

One example of cost-offset is demonstrated by a recent study which found that six 90-minute sessions of group therapy for women with stage 0 to II breast cancer led to a health care cost reduction. Participants' quality of life improved and they had fewer post-therapy billable services (according to Alberta Health records) as compared to a control group (Simpson, Carlson and Trew, 2001). The cost of the therapy was covered by the savings with \$50 per person left over. Does it get any better?

Funding by governments is poor at best and lobbying efforts of individuals and organizations needs to continue. However, individuals, corporations, the insurance industry and legal systems continue to purchase the services of psychologists in private practice. In my chosen province of Alberta, private enterprise is revered and seen as providing the cure for most economic ills. The government here has led the agenda in enshrining the role of private sector partnering in providing health care and educational services.

So what does the private sector tells us about service provision for problems of emotion and behaviour? The private sector realizes the expertise of psychologists in providing cost-effective services. Why? Clinical psychologists have unparalleled training in behavioral science and assessment/intervention. Research training provides not only knowledge and skills necessary to conduct scientific inquiry, but it also instills a rigorous approach to problem solving and decision-making that is based on a data gathering and hypothesis testing tradition. Psychologists bring a broad skill set (assessment, intervention, research, consultation, supervision, teaching) to human problems. A count of the number of psychologists listed in the yellow pages of any city (195 full and part-time in Calgary, 1 for 4359 citizens) indicates that the private sector is willing to pay for valuable services. The publicly funded health care system should do more of the same.

According to the Canadian Institute for Health Information, private sector spending on health has increased ten-fold since 1976. It would appear that this trend will continue and that psychology will play an important role as consumers take greater responsibility for their health. Unfortunately, those who cannot afford private services will continue to be comparatively disenfranchised.

Continued on Page 2

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From page 1

There is more the profession can do to inform health consumers. We need to ensure that research results (both pure and applied) are not only published in scholarly journals, but also are disseminated to the public through print media, presentations and workshops. There is a growing appetite for this type of information. Articles frequently appear in the press, however often the researcher has not been identified as a psychologist. The profession needs to be recognized as a major contributor. CPA is playing an active role in providing speedy linkages between writers and psychologists.

A newspaper article in March 16, 2003 issue of the *Calgary Herald* was entitled "Canadians spend for peace of mind: Patients increasingly picking up the tab for uninsured diagnostic tests and alternative therapies". The article focused on the cost and proliferation of drugs to treat ADD, sleep disorders, sexual dysfunction, etc. Surprisingly, other professions and pay per CT scans were mentioned but not a word about psychologists or psychotherapy. Why the focus on medications by Romanow and the media, when the data indicate that psychotherapy is more effective than drugs in the treatment of a number of disorders including depression and anxiety? A recent review by Antonuccio, Burns and Danton (2002) entitled "Antidepressants: A triumph of marketing over science" indicated that antidepressants are only as clinically effective as placebos. They suggest that psychotherapy is a more effective and safer alternative. If only our marketing could be as good as our science and practice.

Antonuccio, D. O., Burns, D. D. & Danton, W. G. (2002). Antidepressants: A triumph of marketing over science? *Prevention and Treatment*. Available online at: <http://journals.apa.org/prevention/volume5/pre0050025c.html>

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- Kerry Mothersill, Chair

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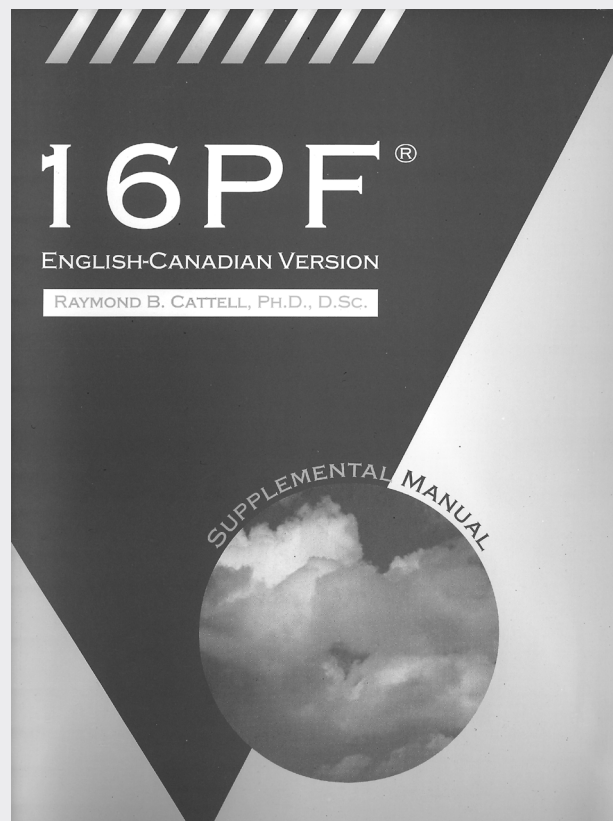
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PSYCHOTHERAPY FOR ABUSED AND NEGLECTED CHILDREN

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I. A Brief Review of the Problems Associated with Maltreatment

Maltreated children are at significant risk for developing problems in the following areas:

1. Attachment Organization
2. Emotional and Behavioral Self-Regulation
3. Development of Autonomous Self
4. Language Development
5. Cognitive Development and Adaptation to School
6. Peer Relations

Conclusions¹. Despite being at increased risk for psychological and behavioral problems, maltreated children do not demonstrate a uniform response to abuse or neglect. They do not fall neatly into one diagnostic category and do not constitute a homogeneous syndrome that we can label "the maltreated child".

2. There is considerable overlap in the characteristics of children exposed to different subtypes of maltreatment. Some children show no symptoms or transient problems, while others present with long term and chronic difficulties.

The heterogeneity and diversity are revealed when we examine the outcome associated with sexual abuse (Kendall-Tackett et al., 1993):

1. In most studies sexually abused children were found to be more symptomatic than their nonabused peers.
2. When compared to nonabused but clinical groups of children, sexually abused children were actually less symptomatic than the clinical children in the majority of studies.
3. The percentage of children with a particular symptom was mostly between 20 and 30.
4. Many of the symptoms did not occur uniformly across all age groups.
5. 21 to 49 of children who had been sexually abused were asymptomatic (four studies).
6. Abatement of symptoms has been demonstrated in 7 longitudinal studies: 1/2 to 2/3 of all children were less symptomatic 18 months after disclosure, but 10% to 24% became more symptomatic (some of these were children who had no symptoms at the time of the initial assessment).

How can we explain this diversity?

II. Developmental Psychopathology: A Way of Conceptualizing the Impact of Abuse and Neglect

1. Key concepts of developmental psychopathology: Developmental psychopathology maintains that attempts to understand human development from the perspective of just one discipline do an injustice to the complexity of the process. Likewise, an exclusive reliance upon one factor or variable to explain human behavior is overly simplistic and inaccurate.
 - a. Transactional model of human development: The various factors are in dynamic "transaction" (ie, interaction) with one another throughout the lifespan. Child maltreatment is one of a number of variables that may contribute to specific developmental outcomes.
 - b. Stage-salient developmental issues: At each developmental stage, the individual confronts specific developmental tasks that are central to that age. Upon emergence, each remains critical to the child's continual adaptation, although decreasing in salience relative to newly emerging tasks. In optimal development, the child successfully negotiates the attainment of stage-salient tasks and moves through a course of increasing competence and adaptation: later competencies build upon earlier competencies.
 - c. Developmental effects: "Refer to deeper and generalized types of impact, more specific to children, that result when a victimization experience and its related trauma interfere with developmental tasks or dysfunctionally distort their course" (Finkelhor, 1995, p. 184).
 - d. Localized effects: "Those specific to the trauma experience but without the major developmental ramifications ... these symptoms can be called localized not only in the sense that they are short-term, which they often are (Kendall-Tackett et al., 1993), but also in the sense that they primarily affect behavior associated with the victimization experience and similar classes of experience" (Finkelhor, 1995, p. 184).
 - e. Resiliency and moderator variables: A central focus in the study of resiliency has been the attempt to identify those variables that mediate the impact of adverse events. Four broad sets of factors:
 1. Maltreatment factors (eg., frequency/chronicity of the maltreatment, severity)
 2. Individual factors (eg., intellectual functioning, developmental stage)
 3. Family factors (eg., level of support from family post-disclosure)
 4. Environmental factors (eg., reactions of systems to reports of abuse/neglect)

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III. Principles of Therapy

1. Assessment is the foundation of therapy: The notion of pathogenic processes.
"...in other words, the selection of a treatment method hinges on the assessment of the specific pathogenic processes that contribute to the child or adolescent's maladjustment" (Shirk, 1996, p. 73).
2. Treatment must be comprehensive and ecologically based: Never treat the child in isolation.
There are many factors, including ones embedded in the family and larger society that contribute to or moderate a child's response to maltreatment. Although many maltreated children require direct treatment, intervention must occur at the family level to maximize the child's recovery and growth.
3. Treatment must have a developmental focus.
 - a. Treatment must address developmental effects.
 - b. Treatment must be developmentally sequenced - a "family practice" orientation.
 - c. Treatment must be developmentally sensitive.
4. Use directed or non-directed therapy as required.
5. Therapy must be culturally sensitive.
6. Phenomenological orientation of the therapist.

IV. Engagement Phase of Therapy

1. Orient the child to the purpose, process, and structure of therapy sessions.
2. Regularity, consistency, and safety in therapy sessions and therapeutic relationship.
 - a. Promoting predictability and safety.
 - b. Promoting object constancy.
 - c. Dealing with provocative behavior.
 - d. Physical contact with abused and neglected children.
 - e. Countering regressive behavior.
3. Being empathic about the child's affective expression.
4. Role of play in the engagement phase.
5. Teach neglected children how to play.
6. Therapist as a "secure base".

V. Modifying Internal Working Models and Interpersonal Schemata

1. Mechanisms of impact: The influence of internal working models and interpersonal schemata.
Components of internal working models (IWMs):
 - a. Information, expectations, and feelings about other people (whether individuals will be responsive, trustworthy, accessible, and caring versus unresponsive, untrustworthy, inaccessible, and uncaring).
 - b. Corresponding representations of themselves and their own role in these relationships (whether they are worthy and capable of obtaining other's care versus unworthy and incapable). IWMs provide the individual with a basic context for subsequent relationships with other people. If children's experiences of their relationships with care-givers have been characterized by unavailability, uncertainty, insensitivity or overt abuse, they may develop negative expectations of other relationships, and begin to regard themselves as unworthy and incapable of obtaining adequate care (ie. poor self-esteem).
 - c. Unconscious rules for processing attachment-related information and memories. IWMs affect the range of what can be perceived, how perceptions can be interpreted, and how the person behaves in accordance with these models. The child is hardly a passive recipient of experience; rather, he or she is an active constructor of reality who both creates experiences and differentially attends to diverse information in the social world. Although attachment theory emphasizes expectations derived from one type of relational pattern - the caregiver's responsiveness to the child in distress - it's likely that children develop other interpersonal expectations that are derived from different types of recurrent interpersonal patterns. They develop generalized expectations of how others will respond when they are assertive, independent or incompetent. Interpersonal schemata (IS) refer to expectations about others' probable responses to the self. Unlike internal working models, they can refer to a broad range of relational patterns, rather than being tied to the care-giving or care-receiving pattern central to attachment theory. (Shirk, 1998).

Preemptive Processing Model: IS sensitize children to negative aspects of social interactions which, in turn, amplify negative emotional reactions and problematic behavioral responses. This results in biased and deficient patterns of processing social information.

Schema-Triggered Affect Model: Stressful interpersonal events may activate problematic IS which then trigger related emotions.

Characteristics of maladaptive interpersonal schemata:

- a. Overgeneralized and decontextualized.
 - b. Chronically accessible.
 - c. Rigidity.
2. Continuity versus discontinuity in development. The therapeutic relationship as a mechanism of change.

Continue on next page

A basic tenet of attachment theory maintains that earlier relationships influence later ones. Therefore, the child may react to the therapist in ways characteristic of earlier attachment and relational patterns. Psychotherapy, especially the relationship between the child and the therapist can be one opportunity to modify these negative IWMs and IS by introducing some discontinuity into the child's life. The psychotherapeutic relationship, often so different from earlier ones marked by maltreatment and rejection, can counter the child's pessimistic and negative beliefs and expectations of others and self.

Pessimistic model. "These increasingly stable characteristics account for consistency in behavior across time, self-fulfilling prophecy effects, and the failure of intervention in later life (relative to intervention in early life)." (Crick & Dodge, 1994, p. 81).

Optimistic model. "In essence, the therapeutic relationship provides an opportunity for constructing new expectations about how significant others will respond to the self. Therapist's responses to the child that are discrepant from well-developed expectations provide enacted evidence that could potentially disconfirm problematic interpersonal schemata." (Shirk, 1998, p. 12).

Problems with the optimistic model:

1. It presupposes children will engage in therapeutic enactments that are based on underlying IWMs or IS.
2. Are discrepant relationship experiences in therapy sufficiently powerful to promote therapeutic change?
3. Lack of research.

Multiple experiences or relationships that consistently counter these negative beliefs and expectations are necessary. Exclusive reliance upon psychotherapy is insufficient to fully ameliorate maltreated children's difficulties. It is only one part of a comprehensive treatment plan.

Example of psychotherapy with children with an avoidant attachment organization.

- a. Minimal interaction, independent play.
- b. Constricted affective expression.
- c. Therapeutic strategies:

Respect the child's reliance upon the defensive use of avoidance.

Initiate interaction with the child that demonstrates goodwill and a willingness to meet some of the child's emotional and psychological needs. For example, follow through with any promises made to the child.

- d. Gradually try to become more involved and interactive with the child.
- e. Begin to verbalize conflicting feelings about relationships.
- f. Encourage the child to identify and critically examine the negative and unconscious assumptions of IWMs/IS re relationships. Strategies:
 - i. Identify situations that elicit specific expectations.
 - ii. Re-link expectations with the relational context in which they were formed.
 - iii. Differentiate the original context that shaped IWMs/IS from new situations.
 - iv. Identify emotions triggered by IWMs/IS.
 - v. Promote tests of expectations in new situations with careful consideration of both confirming disconfirming evidence to change expectations.

VI. Helping Children Acknowledge the Maltreatment and Express Associated Feelings and Cognitions

1. Play therapy techniques.
 - a. Doll play (eg., Narrative story stems: Bremerton, Ridgeway, & Cassidy, 1990; Buchsbaum, Toth, Clyman, Cicchetti, & Emde, 1992)
 - b. Storytelling and story writing
 - c. Art

VII. Reformulating the Meaning of the Maltreatment

1. Modifying attributions of responsibility.
 - a. Self-statements re responsibility.
 - b. Role-playing.
 - c. Review of the child's history.
2. Modifying stable and global attributions.
 - a. Identify historical and current nonabusive, healthy relationships.
 - b. Identify those aspects of the therapeutic relationship to counter these attributions.

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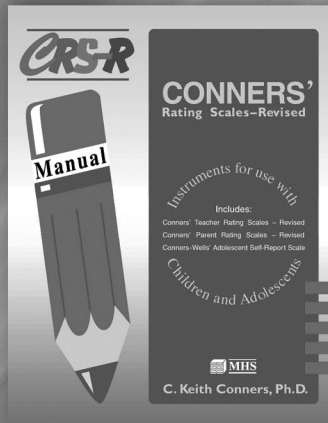
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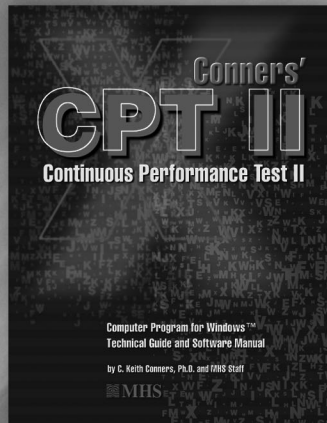


ADHD Across the Lifespan

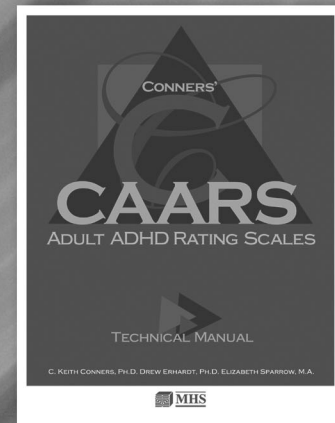
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An Introduction to the WISC-IV

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The WISC-IV is the latest revision of the well-known and well-respected Wechsler Intelligence Scale for Children. Though popular and widely used, the WISC-III has been updated to reflect changes in the norms and the normative population, as well as to enhance the test structure and to include the new subtests that have proven reliable and valid on the recent editions of the WAIS and WPPSI.

The development team for the WISC-IV had a number of revision goals in mind based on recent developments in the field of cognition and intelligence as well as clinical utility and feedback from practitioners:

1. Improving Assessment of Fluid Reasoning, Working Memory and Processing Speed:

The first revision goal was to advance assessments of fluid reasoning, working memory and processing speed. Fluid reasoning has been enhanced by the introduction of new subtests on both the verbal and non-verbal scale including Matrix Reasoning, Picture Concepts and Word Reasoning. While Matrix Reasoning may be familiar to many people, Picture Concepts and Word Reasoning are new subtests initially introduced in the WPPSI-III. Picture Concepts is designed to measure abstract and categorical reasoning and as the difficulty levels of items progress, the demand for more abstract reasoning increases. Word Reasoning is a verbal subtest that requires the child to listen and respond to an increasingly specific list of clues and provide a response that is reasonable based on the verbal clues. Something of a riddle type activity, this subtest is fun and interesting for the children and assesses their ability to generate, integrate and synthesize verbal information.

The subtests that had been labeled Freedom From Distractibility on the WISC-III, are now part of the Working Memory Index and this has been enhanced by the inclusion of the Letter-Number Sequencing subtest, an adaptation of the version first introduced on the WAIS-III. In Letter-Number sequencing, the child is asked to listen to strings of letters and digits, manipulate the information and repeat back in the sequence requested by the examiner. This task is differentiated from the Digits Forward task by its requirement to mentally manipulate and reorganize the information presented and from Digits Backward by its inclusion of numbers and letters presented alternately by the examiner.

The Processing Speed Index has also been enhanced by the inclusion of the new Cancellation subtest.

Cancellation requires the child to scan a page and identify animals among a series of pictures that includes foils such as furniture, fruit and other objects common for all young children. There are two conditions to Cancellation, the first is a random condition in which the all the pictures, including the foils, are randomly placed on the page. The second condition is a structured condition in which the animals and foils are organized in straight lines on the page. The random condition is administered first, followed by the structured condition. In addition to providing valuable information regarding processing speed, there is also additional clinically valuable information available by making comparisons between performance on the random and structured components. Finally, there are additional procedures for the Coding subtest including a Free Recall, Digit Cued Recall, Symbol Cued Recall and a copying task. Each of these recall procedures gives the examiner a wealth of clinical data regarding performance not just on the Coding task but on processing skills in general. The Coding Copy task allows the examiner to determine whether poor performance is primarily due to motor skills or whether there are true processing speed deficits. All of these alternate procedures originally appeared on the WISC-III PI (Process Instrument) but have now become standard on the WISC-IV.

In addition to specifically improving the assessment of fluid reasoning, working memory and processing speed, these changes also serve to strengthen the four-factor model and aid in the interpretation and profile analysis for individuals.

2. Enhancing Clinical Utility:

The second goal was to enhance the clinical utility of the WISC-IV. In part this was addressed through the enhancements addressed in the previous paragraph but also through increased clinical studies that took place throughout the standardization data collection. Validity studies for the WISC-IV took place with fifteen different clinical groups including: learning disabled (Reading, Writing and Math), receptive and expressive language disorders, mild and moderate mental retardation, Autism and Autism spectrum disorders, hearing impaired, motor impaired, traumatic brain injuries, attention deficit disorders and gifted children. These clinical studies allow us to examine the effectiveness of the instrument with these populations. Since the Wechsler scales are primarily used with referred populations, clinical utility is at least as important as strong normative data. Included in the technical manual are tables that report the performance of all of these clinical validity groups, information that allows the clinician to interpret the clients' performance in relation to their diagnostic group.

Continued on page 10

From page 9

3. Linking with WIAT-II:

The use of ability/achievement discrepancies in the assessment of learning disabilities is common practice in most parts of North America. To allow the clinician the opportunity to perform these discrepancy analyses, the WISC-IV is linked with the WIAT-II and the manual contains all the tables and information you will need to complete the ability achievement discrepancies using both the simple and predicted difference methods.

4. Improving the Psychometric Properties:

The final goal was to improve the psychometric properties of the batteries. Already recognized as some of the most psychometrically sound assessment instruments, the WISC-IV sets the new gold standard for reliability and validity of subtests, scales and indices. Attention was also paid to removing cultural/racial bias in items and ensuring that the items and artwork are reflective of current social and cultural contexts.

Of course to make these improvements and meet the revision goals, some things were removed. With the WISC-IV you will notice the omission of some subtests that you may have grown to either love or dislike. No longer included are Picture Arrangement, Object Assembly and Mazes. While these tests have become a familiar part of the Wechsler scales, they were removed for a number of reasons, including, lack of clinical utility, relatively weak psychometric properties and user friendliness.

The WISC-IV is scheduled to publish in the summer of 2003. We encourage all of those who are interested in learning more about this product to contact your Clinical Measurement Consultant Paul David Leger. Currently, we are collecting data for Canadian norms. We have received terrific support from clinicians across Canada in response to the Canadian norms project but always appreciate additional support. If you are interested in becoming a part of this project, please contact Jenni Pitkanen at 1 800 387 7278 ext 515.

Submissions Invited

This newsletter, the Canadian Clinical Psychologist/ Psychologue Clinicien Canadien invites submissions from Section members and students.

Brief articles, conference or symposia overviews, and opinion pieces, are all welcome. The thoughts and views of contributors belong strictly to the author(s), and do not necessarily reflect the position of the Section, the Canadian Psychological Association, or any of its officers or directors.

Please send your submission, in English or French, directly to the editors, preferably either on disk or via e-mail attachment to either of the editors.

The newsletter is published twice per year. Submission deadlines are as follows: September 15th (October issue) and March 15th (April issue).

Editors:

Deborah & Keith Dobson
ddobson@ucalgary.ca
keith.dobson@ucalgary.ca



Clinical Section List Serve

The CPA Section on Clinical Psychology initiated its list server, in August 2001, in order to inform members about important news and events, and to disseminate information generated from the Executive of the Section.

It is not the Executive's intention to use the list serve as an open forum for discussion nor to advertise on behalf of members of the Section. The list serve will simply be used for Section news. We intend to operate in the best interests of our members, and your email addresses will be protected and kept completely confidential.

Every member of the Section (who provided CPA with their email addresses) were placed automatically on the list server.

Ideally, all Section members will be active on the list server. If you have not already received information through the list server, please send your email address to Dr. David Dozois at didois@uwo.ca, and type "Subscribe" in the subject heading (please ensure that your email address is correct). To access information about the listserver, type <http://lists.cpa.ca/mailman/listinfo/cpa>.

The Executive Committee of the Section on Clinical Psychology anticipates that the list server will be an effective means of communicating with its members and we hope that you will take this opportunity to join the list. We would again like to acknowledge CPA for its generous support in providing this service at no cost to the section.

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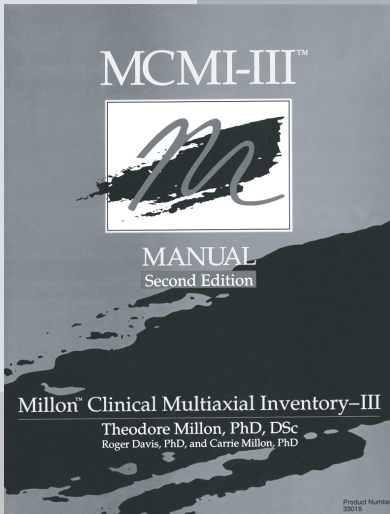
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Therapist Self-Disclosure: Theoretical Perspectives, Research and Recommendations

Kerry Mothersill, Ph.D.

Some therapists propose that therapy should be focused almost exclusively on the client's experience. Introduction of information concerning the therapist is a distraction at best and it may interfere in the process of dealing with current and past issues. Others rarely hesitate to share frank reactions with clients. They believe that clients are tough and that "even brutal honesty can advance the therapeutic cause" (Efran, 2002). The range of perspectives on this form of therapist behaviour is wide, as can be seen from the following brief theoretical review.

Theoretical Differences

Psychodynamic theorists have traditionally argued that therapist self-disclosure interferes with the therapeutic process, shifts the focus away from the client, disrupts transference, and potentially undermines the client's trust in the therapist through exposure of weaknesses (Curtis, 1981, 1982; Greenson, 1967). Lane and Hull (1990) have suggested that "a willingness to share one's past or present experience with the patient does not make the analyst more genuine or humane". They give the opinion that "It is naïve to believe that self-disclosure will bind analyst and patient together in an 'exchange of intimacies'".

In contrast, Fisher (1990) suggests that revealing countertransference in a timely and appropriate way sets the stage for a psychology of "shared experience" which "undoes the malignancy of early developmental secrets between child and parent". Mutual self-disclosure is necessary for intimacy to take place. Coltart (1986) notes that a rigid following of the "sacred rules of the True Analyst" may negatively affect the patient and the therapy process. Wachtel (2000) suggests that "If the therapist can skillfully maintain the proper balance of engagement and reflection, such immersion in the patient's interpersonal world can be a primary medium for understanding the patient's experience and the sources of his difficulties".

Humanistic theorists (e.g. Jourard, 1971; Derlega et al. 1991) suggest that self-disclosure elicits greater disclosure by the client, enhances client self-exploration, fosters an atmosphere of honesty and understanding and enhances the therapeutic relationship. It is argued that "The essential process of self-disclosure in psychotherapy occurs pre-reflectively and at a nonverbal level and is expressed in the enduring emotional ambience in which treatment transpires" (Josephs, 1990). Overall, humanistic-experiential therapists tend to self-disclose more frequently than analytic therapists (Simon, 1990).

Rational-Emotive Therapy follows a coping model of self-disclosure where the therapist indicates that s/he has experienced similar distress/disturbance in the past but has

been able to overcome them with RET methods (Dryden, 1990). It is suggested that self-disclosure should not take place indiscriminately, too early in the therapy process or when such information could be used to discredit the therapist. Therapists from this perspective also are encouraged to disclose their feelings and reactions to client behavior in the sessions though this must be done tactfully in the context of good clinical judgment.

Feminist therapists use the self-disclosure of values so that they can be known, scrutinized and discussed in therapy (Brown & Walker, 1990). It is one of the methods used to rebalance the power differential in therapy. In addition, the therapist must disclose how hypotheses are arrived at, what theories are referenced and how certain diagnostic ideas are included or excluded. Self-disclosure also facilitates the therapist's serving as a role model. Sharing one's personal vulnerabilities and solutions validates the client's reality and lets her know that she is not alone. However, it is important that the client not become the therapist's confidant, that the therapist not over generalize from her own experience and that the therapist be sensitive to sociodemographic differences.

Just like other members, *group therapists* may openly share their thoughts and feelings in a sensitive manner, respond to others authentically and acknowledge motives and feelings (Vinogradov and Yalom, (1990). Therapist transparency is seen to counteract irrational responses to the group leader, help members see the therapist as a real person in the here and now and model sharing and honesty. When group leaders reveal the process guiding their therapy interventions, the members are able to see how the questions, thoughts and conclusions are derived from interactions within the group. Group therapists are encouraged to ask themselves questions prior to using therapist transparency, including "Am I facilitating transference resolution, creating therapeutic norms, assisting the interpersonal learning of members, working on their relationship with me and accepting members through my self-disclosure?" (Vinogradov and Yalom, (1990). Dealing with the group's feedback about what has been said is also part of the interpersonal process. It is suggested that group therapists self-disclose more than individual therapists in order to model responsible personal and profession transparency.

Cognitive therapists have also contributed to the debate on self-disclosure. In general, this approach to therapy takes a cautious stance on the issue. Judy Beck (1995) has suggested that "Appropriate and judicious self-disclosure by the therapist can help some patients view their problems or beliefs in a different way." Beck, Rush, Shaw and Emery (1979) indicated that some emotional sharing by experienced therapists can have a beneficial effect on the therapeutic relationship, although the therapist should not use the sessions for self-treatment. In addition, they suggest

Continued on page 15

that caution must be exercised in the therapist expressing her/his own emotions in therapy with depressed clients due to a tendency to distort information. Therapists' disclosure of their own problems may "feed the pessimism of the depressed patient". Bedrosian and Bozicas (1994) suggest that therapist's attempts to normalize client's thoughts, feelings and behavior through self-disclosure often fails to achieve its intended purpose. They argue that clients tend to focus more on differences than similarities in comparing themselves with therapists. It is suggested that the therapist ask themselves the following questions, otherwise clients may be placed at risk if self-disclosure is routinely used as a treatment strategy:

- What were the therapist's cognitions and emotional responses prior to and during the self-disclosure?
- Were there signs that the therapist might have acted impulsively, perhaps because of his or her own discomfort?
- Who was more affectively involved in the exchange, the therapist or the client?
- How did the therapist's posture change during and after the self-disclosure? Were such changes consistent with the overall treatment plan?
- What is it about the particular client that stimulates self-disclosure by the clinician, either in terms of the client's issues, the therapist's issues, or, as is most likely, a combination of the two?
- Were there reasons, particularly in the therapist's nonprofessional life, why he or she would be thinking of the personal material in question at this particular time? On balance, was the therapist dealing with his or her own material or with the client's?
- Did the client truly benefit from the information, or did he or she discount it somehow because it involved the therapist?
- Was the level of self-disclosure appropriate with the particular client, particularly in light of any boundary problems he or she might have in relationships?
- How will the therapist feel and respond if the client wants to discuss the topic again?
- What other interventions might the therapist have attempted instead of the self-disclosure, either directed at the same point or addressing related areas of content?
- Could the therapist's material have been used more effectively if it had been reworked into an anecdote about a third party?

Beck and Freeman (1990) indicated that considerable judgment is required in expressing emotional reactions to client's information and expressions. Although disclosure by the therapist may increase intimacy, it may be threatening to the client. However, denial of the affect that is apparent to the client through nonverbal reactions may decrease trust and encourage fear.

Self-Disclosure Process

There are two general types of therapist self-disclosure. The first involves a response to a client's question and the second occurs when the therapist volunteers unprompted information. The content of the client's question or the therapist's volunteered information typically includes: 1) the therapist's reaction to the topic being discussed or to what the client has said in therapy, 2) a detail of the therapist's life, 3) a therapists' personal belief or perspective and/or the 4) the process of doing therapy. Therapists' disclosure can include their reactions to something about what the client has said or done as well as the introduction of material about their own life that is either relevant to or independent from the therapeutic topic or process.

It is recognized that verbal disclosure by therapists occurs in an ongoing context of non-verbal reactions that occur with varying degrees of therapist awareness and congruence with verbal behaviour.

Why do Therapists Self-Disclose?

Therapists report that they self-disclose in order to increase the perceived similarity between themselves and their clients, to model appropriate behaviour, to foster the therapeutic alliance, to validate and normalize client experiences, to offer alternative ways of thinking and acting, to increase a patient's sense of self and to satisfy clients who want therapist disclosure (Hill & Knox, 2001; Simon, 1990). Therapists who disclose more frequently see the process as a way to communicate care, respect and equality with their patients.

What are the Effects of Therapist Self-Disclosure?

Clients have reported that therapist self-disclosures can be helpful and tend to increase their affective level in therapy (Hill et al. 1988). In addition, disclosure can lead to client insight, make the therapist seem more real and human, improve the therapeutic relationship and increase openness and honesty in therapy (Knox, 1997). Reassuring disclosures tend to be more helpful than challenging disclosures (Hill et al, 1998). In general, clients perceive therapists as warm and friendly when they self-disclosure (Dies, 1973; May & Thompson, 1973; Murphy & Strong, 1972).

Six studies that used correlational methods (with vague definitions and methods of assessing disclosure) found no relationship between frequency of disclosure and client, observer and therapist ratings of treatment outcome (Hill & Knox, 2001). However, a client survey rated disclosures as having a positive effect on therapy (Ramsdell & Ramsdell, 1993).

Continued on page 16

In a well-controlled study by Barrett and Berman (2001), clients who receive more frequent congruent therapist self-disclosures following their own disclosures liked their therapists more and had less symptom distress following four sessions of treatment. In this study, therapists disclosures were relatively infrequent (maximum 5 per session in contrast with a mean of more than 60 client disclosures per session) and brief (averaging less than 15 s in length).

In contrast with the volume of theoretical debate, there has been little in the way of high quality research, particularly addressing the effects of therapist self-disclosure on therapy outcome. This is surprising given the range and strength of diverse perspectives and the finding that self-disclosure appears to be a common activity at least for some therapists.

Questionable Therapist Self-Disclosure

The literature indicates that certain forms of self-disclosure are potential harmful for clients.

1. Details of therapist's current and significant problems or stressors, personal fantasies or dreams, and social, sexual or financial circumstances should be avoided.
2. Inappropriate self-disclosure leads to a gradual erosion of treatment boundaries and is the most common factor that precedes therapist-client inappropriate behaviour (Smith & Fitzpatrick, 1995).
3. The therapist's communication can be interfering when it burdens the client with the therapist's problems or issues.
4. Self-disclosure is inappropriate when it represents "acting out" of something that is more for the therapist's benefit than for the client.
5. A review by Hill & Knox (2001) indicated that therapists feel that it is not appropriate to self-disclose on a frequent basis, when it was for their own needs, when it would move the focus away from the client to the therapist, would interfere with the client's flow of material, would burden, confuse or be intrusive for the client, would blur the boundaries between the client and the therapist, would over stimulate the client or interfere with the transference. Overall, the review suggested that therapist self-disclosure is a risky business.

Required Therapist Self-Disclosure

Questions concerning a therapist's credentials and qualifications, such as place of training, amount of training, experience with a patient's problems, and general orientation to therapy are appropriate areas for therapist response.

Recommendations

My review of the literature suggests that verbal disclosures of therapists have a greater potential for positive impact when they are limited and preceded by a conscious review as to the purpose and expected effect on the process and

outcome of therapy. Therapists should carefully observe how clients respond to their disclosures, ask about reactions and determine the impact. Inquiries as to what was learned from the disclosure may assist in clarifying any misconceptions. This information can be employed to assist in forming and revising conceptualizations of clients and in planning subsequent interventions. In addition, inquiring about the client's preference for or against such disclosure may assist in guiding the therapist's use of this risky but potentially helpful therapeutic tool.

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Summary of Executive Committee Meeting: January 25, 2003

CPA 2003 Conference

- For the upcoming conference, there were 70 poster submissions, 5 symposia, 2 conversation sessions, 6 theory reviews, and 4 workshops. Ten posters were redirected to symposia and 2 symposia were created (i. e., Aspects of eating disorders, and Treatment interventions with children and adolescents).
- The reviewers were Drs. S. Currie, M. Dugas, D. Dobson, K. Dobson, S. Graham, R. Mendelson, and K. Von Ranson.
- The deadline for student submissions for the Ken Bowers' Awards is March 28, 2003. A message will be sent to the listserve reminding students that they may submit their papers for an award.
- There was some discussion regarding the length of the submission requirements (i.e., up to 10 pages). It was decided that the requirements will remain the same.
- The information regarding the Clinical Section sponsored presentations will be sent to the membership via the listserve. Registration will be paid for the keynote speaker and the individuals doing the mini-workshops.
- Section Program Introduction of Speakers was discussed and confirmed.

Section Action Activities

- The names of possible nominees for the Section executive positions were presented. D. Dozois has agreed to serve as Chair-Elect.
- The call for fellows was advertised in the newsletter and there has so far been no response. The committee will wait to see what nominations come in.
- The committee has decided to make it policy that we contact all nominees for the status of fellow to determine their availability to attend the conference.

Section Projects

- The current membership of the Clinical Section is 553 (379 full members; 174 student members). There are presently 327 individuals who have subscribed to the listserve. Discussion about the pros and cons of using the listserve to advertise clinical or academic job postings. Feedback will be solicited from the membership.
- It was decided not to print the clinical section brochure again. There was, however, interest in producing this brochure as a PDF file so that members could print it off for their clinics.
- Most members felt that the definition of clinical psychology should remain the same. One question is whether we should update it and, if so, what we should use it for. The definition statement on the web site will be removed. Our web page will be included in search engines.
- A number of fact sheets have already been completed. More people will be contacted to write some of the fact sheets for topics that have been approved. There might be a way to ensure that the fact sheets are updated (e. g., every 5 years), like by placing a date in the posting list.
- The new member recruitment ad was discussed and revised. The revisions will be submitted to Ivan at CPA for Psynopsis and to Michael Coons to distribute to the Student section.

Strategic Planning

- Last year we had discussed the idea of becoming more active in lobbying. We were also interested in possibly pursuing a public lecture in conjunction with the conference as well as putting on master clinician series.
- It was mentioned that we should try to obtain a local person to help set things up for the annual meetings. This person could be arranged at the fall teleconference and could participate via teleconferencing at the winter meeting.

On behalf of the Section, appreciation is extended to....

Shawn Currie
Michel Dugas
Deborah Dobson
Keith Dobson
Susan Graham
Roslyn Mendelson
Kristen Von Ranson

For reviewing submissions to the Clinical Section- 2003 CPA Convention in Hamilton.

Federal Privacy Legislation

Ian Nicholson, Ph.D.
Psychology Professional Practice Leader
London Health Sciences Centre

In April 2001, the federal parliament passed the *Personal Information Protection and Electronics Documents Act*. The aim of this legislation was to regulate the collection, use or disclosure of personal information. Most important for psychology is that it will apply to all commercial activities as of January 1, 2004.

The federal government recognized, however, that many industries and professions are provincial responsibilities. Therefore, the federal government has stated that if a province has substantially similar legislation in place by January 1, 2004, then the provincial law would apply instead of the federal legislation. In the event that a province does not have legislation in place, then the federal legislation will take effect on January 1, 2004.

It is becoming apparent that not all provincial jurisdictions will likely have their legislations passed by that time (e.g., Ontario). As a result, psychologists in many parts of the country need to start becoming familiar with the new federal legislation.

The federal legislation applies to any "organization" and this would apply to organizations that hire psychologists (e.g., hospitals) but also to an individual psychologist's private practice. The "commercial activity" that this legislation would cover would also include a psychologist's private practice.

The primary obligation is to collect, use, and disclose the

personal information of an individual only with the consent of the person to whom it relates. The psychologist must identify where the information is being collected. Any secondary use of any information, such as quality assurance or program evaluation, must be identified. Consent must be obtained before use but may be obtained after data collection. Also, data collection must be limited to the amount and type of personal information that is necessary for the identified purpose.

A new "wrinkle" in the federal legislation is that psychologists in private practice and in organizations will be required to develop formal policies and procedures for retaining and destroying personal information. These procedures include, but are not limited to, consent procedures, methods of file destruction, retention policies, procedures on how to gain access to one's own information, procedures for the correction of erroneous material, security procedures, etc. These policies and procedures will have to be publicly available to all patients and must include the name (or title) of the person in the organization responsible for the policies and procedures.

An organization must also develop simple, accessible complaint procedures for non-compliance with the legislation. All organizations are responsible that individuals are made aware of this information. Once again, while this may seem understandable for larger organizations, it will also apply to individual private practices. This will result in many psychologists having to develop the type of policies and procedures that they would expect to see in institutional settings.

For more information on this legislation, interested psychologists are advised to go to:

<http://laws.justice.gc.ca/en/P-8.6/index.html>

On behalf of the Section:

Congratulations are extended to Dr. Ian Nicholson, of the London Health Science Centre, in London, Ontario. Ian recently received the Ontario Psychological Association's **Award of Merit**, as well as the **Health Psychologist of the Year Award** from the Hospital Psychology Association.

Newsletter Notice:

The Executive of the Clinical Section made a decision at the recent midwinter meeting in Calgary to begin circulating the newsletter primarily through electronic means. The listserv that has been developed and operating (currently by Dr. David Dozois) will serve as the means to send future newsletters. It will also be posted on the Clinical Section Web site. The reasons for this change include reducing printing and mailing costs, ease of communication and member preference.

Members who are not currently part of the listserv or do not have access to e-mail will receive a paper copy through the mail service. If you are not part of the listserv and would

prefer to receive an electronic copy, please contact Dr. David Dozois or one of the co-editors of the newsletter.

If you have not yet provided your email address to the listserv, this may be a great time to do so. Unlike some other listservs, this one does not include regular communication, but is only used by the Executive to disseminate information. It is also likely that if this method for delivering the newsletter is positively received, the paper copy will be phased out.

Your feedback on this issue is more than welcome. Please send any comments you have to the current Chair, Dr. Kerry Mothersill.

CPA CONVENTION 2003

Hamilton, Ontario

CLINICAL SECTION SPONSORED EVENTS**Pre-Convention Workshop: Interpersonal Therapy of Depression (ITP)****Laurie A. Gillies, Ph.D., C.Psych**Wednesday June 11th, 9:00 AM – 4:30PM

CPA Clinical Section Members	\$96.30
CPA Members	\$117.70
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CPA Student Members	\$58.85
Student non-members	\$64.20
Non-Members	\$139.10

**Note:** Refreshments for two breaks are included in the workshop fee. Fee includes GST.

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Other Program Highlights:**Thursday June 12th**

10:00 – 12:50	Clinical Poster Session	
11:00-12:55	Primary Care Psychology (Sy)	Graham Reid, Moderator
1:00-2:55	Treatment Interventions with Children and Adolescents	Susan Graham, moderator
1:00 – 2:55	Cognitive Processes in Depression (Sy)	Keith Dobson, moderator
3:00 – 4:55	Aspects of Eating Disorders (Sy)	Alexis Kennedy, moderator
4:00-5:55	Errorless Approaches to the Treatment of Childhood Disorders (Sy)	J. DuCharme, moderator
4:30 – 4:55	Constructionism, emotion, and meaning-making in psychotherapy (Tr)	
5:00 – 5:25	Borderline personality structure and trauma (Tr)	Rejeanne Dupuis
5:30 – 5:55	Treating Attachment Pathology (Tr)	Jon Mills

Friday June 13th

8:00 – 8:55	<u>Clinical Section Business</u> Meeting (with coffee and muffins)	
10:00-10:55	Ethical Dilemmas and Decision-making in 21 st Century Health-care: A consultative session (Cs)	Ian Nicholson and Keith Dobson
11:00-11:55	Applying for Internship: Perspectives from an Internship and Academic Director (Cs)	John Pearce
11:00 – 12:55	Laughter is not always the best medicine (Sy)	Rob Martin, Moderator
12:30 – 1:25	Preventing Abuse in adolescent dating relationships Keynote address	David A. Wolfe
2:00 – 2:55	How to cope with stress (Cs)	E. Ogus and I. Valentin
3:00-4:55	Enhancing motivation for treatment in eating disorders (Wk)	Randi McCabe
4:00-4:55	Transfer of knowledge from the classroom to the clinical setting: The journey of the clinical student (Cs)	M. Coons, L. Bourque

Saturday June 14th

10:00 – 11:55	Current research on the costs associated with psychological disorders: Implications for policy in Canada (Sy)	N. Koerner, moderator
11:30-1:25	Parent assessments: An overview (Wk)	T. Pezzot-Pearce
12:00 – 12:25	Insurers' perceptions of psychologists: A collision of values? (Tr)	L. Greer
2:00 – 3:55	Parent Abuse: Adolescent children who abuse their parents (Wk)	M. Drebot, P. Robinson

(Wk) Workshop, (Cs) Conversation Session, (Sy) Symposium, (Tr) Theory Review

For more information, go to www.cpa.ca**See you in Hamilton!**