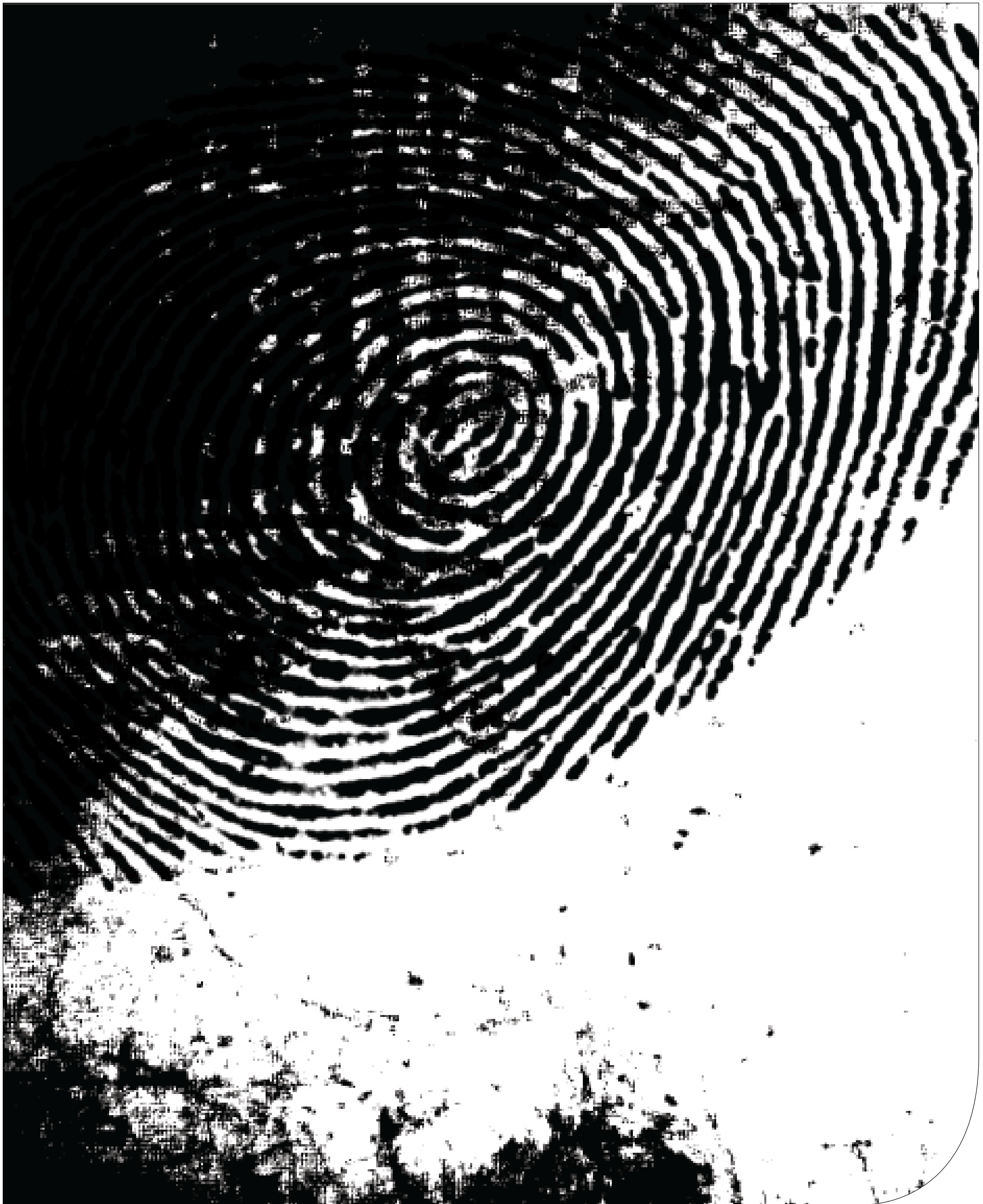


BC PSYCHOLOGIST

Volume 2 / Issue 2
Spring 2013 / Forensic Psychology

09 / ASSESSING CHRISTOPHER DORNER
11 / THE INSANITY OF CHRISTOPHER DORNER?
13 / COUNSELLING PERSPECTIVES FROM BEHIND BARS
15 / PSYCHOGENIC POLYDIPSIA
17 / HOW TO PICK A BOOK FOR CLIENT HOME EXERCISES

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

ADVERTISING RATES

Members and affiliates enjoy discounted rates. For more information about print and web advertising options, please contact us at: communications@psychologists.bc.ca

CONTACT US

#402–1177 West Broadway, Vancouver BC V6H 1G3
604.730.0501 | www.psychologists.bc.ca | info@psychologists.bc.ca

ADVERTISING POLICY

The publication of any notice of events, or advertisement, is neither an endorsement of the advertiser, nor of the products or services advertised. The BCPA is not responsible for any claim(s) made in an advertisement or advertisements mailed with this issue. Advertisers may not, without prior consent, incorporate in a subsequent advertisement, the fact that a product or service had been advertised in the BCPA publication. The acceptability of an advertisement for publication is based upon legal, social, professional, and ethical consideration. BCPA reserves the right to unilaterally reject, omit, or cancel advertising. To view our full advertising policy please visit: www psychologists.bc.ca

DISCLAIMER

The opinions expressed in this publication are those of the authors, and they do not necessarily reflect the views of the *BC Psychologist* or its editors, nor of the BC Psychological Association, its Board of Directors, or its employees.

Canada Post Publications Mail #40882588

COPYRIGHT 2013 © BC PSYCHOLOGICAL ASSOCIATION

EDITOR IN CHIEF
Ted Altar, Ph.D., R. Psych.

ASSISTANT EDITOR
Marian Scholtmeijer, Ph.D.

PUBLISHER
BC Psychological Association

ART DIRECTOR
Inkyung Kang

ADMINISTRATIVE DIRECTORS
Eric Chu
Jeni Campbell

EXECUTIVE ASSISTANT
Rukshana Hassanali

BOARD OF DIRECTORS

PRESIDENT

Ted Altar, Ph.D., R. Psych.

VICE–PRESIDENT

Don Hutcheon, Ed.D., R. Psych.

TREASURER

Marilyn Chotem, Ed.D., R. Psych.

DIRECTORS

Douglas Cave, MSW, RSW, Ph.D., R. Psych., MA, AMP, MCFP.

Michael Mandrusiak, Psy. D., R. Psych.

Yuk Shuen (Sandra) Wong, Ph.D., R. Psych.

Contents

04 LETTER FROM THE PRESIDENT

09 ASSESING CHRISTOPHER DORNER BY MIKE WEBSTER, ED.D., R. PSYCH.

06 LETTER FROM THE CO-EDITOR

11 THE INSANITY OF CHRISTOPHER DORNER? BY MIKE WEBSTER, ED.D., R. PSYCH.

07 LETTER FROM THE ADMINISTRATIVE DIRECTOR

13 LESSONS FROM THE INSIDE: COUNSELLING PERSPECTIVES FROM BEHIND BARS BY MARGARET DREWLO, MA. & NATALIE DEFREITAS, MA.

08 BCPA NEWS

15 PSYCHOGENIC POLYDIPSIA (EXCESSIVE FLUID SEEKING BEHAVIOUR) BY DONALD HUTCHEON, ED.D., R. PSYCH.

17 THE BIBLIOTHERAPEUTIC MAZE: HOW TO PICK A BOOK FOR CLIENT HOME EXERCISES BY TED ALTAR, PH.D., R. PSYCH.

Letter From The President

TED ALTAR, PH.D., R. PSYCH.
The President of the BC Psychological Association.
Contact for the Board of Directors at board@psychologists.bc.ca

Dear Members,
I trust that you all have had a good Easter break and are looking forward to the warming and brightening of Spring and Summer months. One of the issues that arose with some members was why there occurred a successful motion at our last AGM to increase the recommended rates of Psychologists from $175/hr. to $200/hour. There was concern that we may be out-pricing ourselves with our competition and that many clients will be unable to afford a psychologist. For comparison purposes, note the following rates among the other Provinces:

Province	Rate
British Columbia	$200
Alberta	$180
Saskatchewan	$140
Manitoba	$155
Ontario	$220
Nova Scotia	$150
Quebec	$80 to $130

Clearly, we are asking for the second highest rates in Canada. We all believe in equity of mental health and accessibility for low income people. Unfortunately, this is not yet a reality and the recommended rates published by our Psychological Associations are only recommendations as we are all free to charge what we deem appropriate for our respective client populations or individuals. In my own practice with First Nations and the working class in the economically depressed area of Terrace, I charge only $100/hour and I will still charge even less for those who cannot afford $100/hour. As Mahatma Gandhi once said, *"The world has enough for everyone's need but not enough for everyone's greed"*. Of course, given this over-populated planet, even meeting everyone's needs is difficult. However, to be fair, we must remember that many of our colleagues have exacting specialities in forensic psychology or neuropsychology, specialities that are more technical, incur a greater liability, require heavier and more constant upgrading and therefore arguably deserve a higher rate. Indeed, for such specialities, there is a market capable of bearing such costs. Also, other colleagues work with people of higher incomes who can easily afford the recommended higher rates. The BCPA recommended rate is just that, a "recommended" rate but not a required rate. Each psychologist must in good conscience decide for herself and himself what is a fair rate for her or his practice and client population.

Another issue that arose out of our AGM meeting when the motion for the higher rate was made, debated and passed, was whether such a decision affecting all psychologists should be made only by those that attend our AGMs. This is a good point which this board wants to properly address and we are planning on sending a ballot to the membership on this very question.

I believe that we need to continue to advocate and press government to hire Psychologists and fund Psychological Services through a collaborative care model and maybe one day through MSP. I also believe that we must represent, not just the present, the future of psychology for the next generations of psychologist who are assiduously learning to become Psychologists. To this end, I have chaired the Rx committee for limited psychopharmocology privileges for those psychologists with a post-doctorate masters in psychopharmacology. I accept being President not for the title but to make a difference, which this board has definitely achieved in terms of completing advocacy briefs to be ready for the opportune political moment, restructuring our organization to be more efficient and more focused towards achieving our common purpose.

At the State Leadership Convention in Washington this year, I was pleased to hear that many other associations are opting for small boards of no less than 5 and maybe not more than 8 since smaller boards are more efficient, everyone's voice is more readily heard, and there can be a greater unity than with a larger board. Of course, the disadvantage of a small board would be the risk of a lack of diversity of viewpoints. I am proud of the fact that our members have benefited from a board with a greater geographic, ethnic, cultural, and age diversity than was typical of previous boards. Unfortunately, four of our ten directors resigned this year and we are in the process of finding replacements to preserve both diversity and our unity of purpose.

I personally believe that fair debate and the exchanges of reasoned opinion is always important and with the exercise mutual respect, magnanimity and patience the end result has been an excellent record of this board making the right decisions on some very difficult matters. Certainly, one of the most difficult tasks that any board sometimes has to undertake, and is understandably loathe to address, is that of necessary restructuring to achieve greater cost efficiency, better working conditions and higher staff morale. Determining what needed to be achieved and undertaking the implementation of changes by your vice President and myself consumed over 300 hours of our time. The vice President did not even claim his travel expenses and freely volunteered his time. I also did not claim all of my expenses but took seriously our obligation to volunteer, to responsibly serve and to abide by our code of conduct that all board members were required to sign as a condition of serving. Other board members also volunteered their time. This is the kind of commitment and sacrifice that this board has demonstrated. Due diligence and respectful consideration was exercised. Naturally, with a board of twelve there was going to be some disagreement and any major change personally affecting staff was not going to be avoided or made rashly under my watch and a fair contractual requirement was met that any such decision must pass by a 2/3 majority. That way, key decisions by evident facts and the most rational reasons were going to have to prevail. Peter Drucker once said that *"Management is doing things right; leadership is doing the right things."* The proof that we were right and did the right thing is that I am pleased to report that the restructuring has been accomplished as evident from the fact that staff efficiency, creativity, initiative and morale has improved to a very high level indeed. In addition staff and the board have found a number of ways to cut costs.

The difficult and onerous task that we now face is that of selecting and hiring an Executive Director. Currently, with our excellent staff the office is running very smoothly but we need an ED to help move us further in our cause to promote the individual benefits and public need for psychology. Just as with the restructuring, there was again some board disagreement. Personally, I have advocated that we hire a Registered Psychologist for the following reasons:

1. If you want a professional then of course you hire a professional and if you want someone who can talk psychology and advocate for psychology then hire a psychologist.
2. Communication with professional stakeholders like the CPA, APA, CPBC, Physicians, Social Workers, etc., I believe is best achieved by a Psychologist who can be respected as an equal with our professional stakeholders.
3. The title of "Dr." does carry a recognized and deserved credibility and respect that we would do well to utilize in an arena where we cannot underestimate the degree of competition and competing political interests.
4. We have a notable and unique advantage in talking to politicians and administrators and that is that we can also connect with them on a personal level should they raise any personal psychological questions about themselves, a family member or someone they know. At the SLC workshop on talking to politicians, it was emphasized that one should try to make a personal connection with people. I think we would be foolish to ignore this singular advantage that we can exercise.

Of course, finding the right Psychologist who is highly knowledgeable and who shows political acumen, agreeableness and charm, is certainly a strong goal and maybe we will not immediately find a Psychologist who is suitable both as

a good manager and as a persuasive and charismatic advocate. In this case, intelligence and personality is everything! We will be open to the possibility of hiring the best person even if they are not a psychologist and there are a number of options we can consider. For instance, we can hire a manager part time to manage the office and hire a Psychologist part time for advocacy. Unfortunately, our limited budget does not allow us to hire both full time. We have to make our limited funds work wisely and go far. What we have proven over a five month period in the organization, with the help of our interim director Dr. Ferguson, is that office management can be effectively achieved over three days a week and does not require five days. Indeed, we and the staff have found many other ways to save on costs. I must thank our excellent staff who more or less can run the daily operations on their own. This board will continue, as it has over the last sixteen months, to exercise due care and due diligence and if need be, take our time to find the right person to serve as our advocate to effectively promote Psychology and our profession in this Province.

Respectfully,
Dr. Ted Altar ■

Letter From The Assistant Editor

MARIAN SCHOLTMEIJER, PH.D.
The Co-Editor of the *BC Psychologist* April edition.
University of Northern British Columbia Instructor.

Dear Members of the BCPA,

I have been happy to act as co-editor for this issue of the *BC Psychologist*. This issue contains a diversity of articles on some fascinating topics. On the theme of forensic psychology, we have two thought-provoking articles by Dr. Mike Webster on the most recent shooting spree in the United States and some sound advice from Margaret Drewlo and Natalie DeFreitas based on their experiences with the Canadian jail system. Also on the bill are Dr. Don Hutcheon's highly informative article on psychogenic polydipsia, which is the excessive consumption of water (interesting to learn that one could drink too much water), and Dr. Ted Altar's valuable article on bibliotherapy (an idea I am much inclined to favour).

My field is not psychology. I have a Ph.D. in English (thanks to the influence of my life partner Dr. Ted Altar) and a Bachelor of Laws (thanks to a midlife crisis). In my years as an Instructor and then Professor of English, I have found that writers need a lot of time to ponder their essays. It would be a good idea for the BCPA to post themes of upcoming issues on the website well in advance of the due date for submissions.

I have great respect for a lot of the work done by psychologists. Myself, I have published in the area of the cultural representation of nonhuman animals and am now working on how and where we can get rights for nonhuman animals into the law. I would be delighted to read an issue dedicated to animals and psychology. I am also worried about what has happened to feminism and wonder why people become conservative at middle age. I'm sure that psychologists would make intelligent contributions to these sorts of questions.

Of course, all submissions to the *BC Psychologist* are read with much interest. The journal welcomes all articles on topics that inspire you.

Dr. Marian Scholtmeijer ■

Letter From The Administrative Director

ERIC CHU
The Administrative Director of the BC Psychological Association. Contact: eric.chu@psychologists.bc.ca

As the weather shifts and we see glimpses of spring, I am happy to report that the office staff have shown great initiative, commitment and collaboration. Together with the Board of Directors we are looking closely at ways we can reduce costs, change our work processes and use our resources more efficiently. This in turn will allow us to be more equipped to better serve our members. Some of the highlights from the first few months of 2013 include:

Psychology Month
This national month long campaign encourages organizations and individuals in the psychology community to promote the disciple and to send the message that "Psychology is for everyone". This year's initiatives included:

- Psychology month posters and the updated BCPA brochure were sent to over 300 medical clinics, libraries, universities/colleges and neighbourhood houses throughout BC.
- A free public presentation by Dr. Carla Fry on Raising Children in an Era of Entitlement.
- A free public workshop: From Bondage to Bonding – Enriching your Relationship by Dr. Sara Joy David.
- Pre-movie advertising for the BCPA referral service shown in 24 theatres in Vancouver and Victoria.

Piece of Mind
This project is an initiative of the Community Engagement Committee of BCPA. The aim is to inspire the community through artistic expression to live a psychologically healthy lifestyle. Post secondary students are invited to submit pieces of art to express what psychological health means to them. Prizes include $500 for tuition, a one month art exhibition in the Moat Art Gallery and inclusion in a digital publication. Join us in May for the opening exhibition. More details will be announced in our weekly e-newsletter.

Diversity Health Fair
Once again BCPA participated in the Diversity Health Fair held on March 9th. Over the years the fair has grown and evolved into one of the most dynamic multicultural events in the Lower Mainland attracting more than 3000 people. One of the goals of the fair is to connect newcomers and individuals from diverse background with health and wellness resources. This free and family friendly fair featured over 50 health and wellness organizations. A special thank you goes to Lorraine Bennington, Nancy Prober and Adrienne Wang for volunteering at our booth and interacting with over 200 individuals throughout the day.

Best regards,
Eric Chu ■

BCPA News

UPCOMING EVENTS /

WorkSafeBC WORKSHOP on April 26th

ETHICS SALON
Vancouver and Surrey Ethics Salons on April 30th
Victoria Ethics Salon on May 1st
Please visit http://psychologists.bc.ca for more information and registration.

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 2013 issue is: Addiction. For further details, contact us at: info@psychologists.bc.ca

CONTACT US /

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 (100 words maximum) contact us at: info@psychologists.bc.ca

SOCIAL MEDIA /

JOIN US ONLINE
www.psychologists.bc.ca/blog
www.youtube.com/bcpsychologists
www.twitter.com/bcpsychologists
www.facebook.com/bcpsychologists

ENHANCE YOUR MENTAL HEALTH SERVICES WITH A UBC DOCTORAL PRACTICUM STUDENT!

The PhD program in Counselling at UBC is seeking to enhance connections to service providers in the development of supervised practicum placements.

- Program accredited by the Canadian and American Psychological Associations
- Practicums are flexible in hours, focus and orientation, and the students' work is covered by university insurance

Please contact Dr. Richard Young, Program Director, **richard.young@ubc.ca**, if you are interested in this type of collaboration.

Assessing Christopher Dorner

MIKE WEBSTER, ED. D., R. PSYCH.
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.

Not long ago Christopher Dorner, an ex-LAPD member and former U.S. Navy reservist was charged in connection with a series of shooting attacks on police officers and their families; four people died, including two police officers, and three officers were wounded. This made Mr. Dorner the subject of one of the largest manhunts in LAPD history spanning two U.S. states and Mexico. On February 11, 2013, charges were filed against Mr. Dorner by the Riverside District Attorney for the murder of one police officer and the attempted murder of three others. The following day Mr. Dorner was killed in a stand-off with police at a cabin in the San Bernardino Mountains.

In the aftermath of Christopher Dorner's shooting spree it would be easy to overlook the fascinating peculiarities of his behaviour. The American mainstream media would like us to see him as just another "tragic coupling" of an irrational individual with high-powered weapons. They would like us to view his acts as inexplicable and a reflection of his mental instability. Christopher Dorner has written a letter entitled "Last Resort" and addressed it to "America". The major portion of that letter clearly outlines his grievances, his objectives, and the rationale behind his behaviour. The mainstream media, however, has largely focused its attention on the few ramblings that could be interpreted as "crazy". They would like us to overlook the very real human issues that are at play beneath Christopher Dorner's murderous behaviour.

Christopher Dorner is alleged (I use this word as Mr. Dorner was never found guilty beyond a reasonable doubt in any courtroom) to have killed four people and wounded three. This is not the, now routine, American situation of a random shooting by a right-wing gun-nut pushing back against a government he sees as infringing on his rights. These acts have been committed by a young man who espouses liberal democratic ideals, supports Hilary Clinton, supports stricter gun control, is a former policeman, and a naval reservist. The target of his attack is his former employer (the Los Angeles Police Department), that he accuses of racism, violence and corruption. (It is not my intention in this article, to put the LAPD on trial).

What is of interest to me, in this all-encompassing tragedy, is where we look for answers. As usual, our initial focus has been on Christopher Dorner, his character and his mental status. What is missing, and not likely to be found, on MSNBC or *Entertainment Tonight,* is a long hard look at the context in which he came to embrace such violent tactics.

Much of the study of violent acts, like Christopher Dorner's, are carried out from an individual perspective (e.g. Borum, 1996; Grisso & Tomkins, 1996; Monahan & Steadman; 1996). In this case, that would entail examining his personality, attitudes, values, beliefs, mental status, etc. This approach, though, has proven less than useful and is unable to account for the interactional nature of violence. Why did Christopher Dorner target only certain persons? The individual approach doesn't account for variability over time and place. Why did motivation, context, and precipitating factors equal violence on February 3, 2013 and not before or in other circumstances?

An excessive focus on Christopher Dorner fails to recognize the contextual and systemic factors at play in his violent behaviour. A broader perspective (e.g. Braverman, 1999) suggests that the genesis of his violent behaviour lies as much within the systems, policies, and procedures of the institutions that he moves through (especially the most meaningful ones, like his employer) in his day-to-day life. In addition to being an individual, Christopher Dorner was a member of a large bureaucracy (the LAPD) that consumed much of his life. Any violence that he may have perpetrated will have been the result of a process too rich and too complex to be explained as solely coming from his individual make-up. When thinking of Christopher Dorner, keep this in mind:

> *"Violence is a process, as well as an act. Violent behaviour does not occur in a vacuum. Careful analysis of violent incidents shows that violent acts often are the culmination of long developing, identifiable trails of problems, conflicts, disputes, and failures" (Fein & Holden, 1995).*

If you regard Christopher Dorner's behaviour as his response to what he viewed as a hopeless situation, then it becomes clear that ***anyone can become violent under the right conditions.*** It has been said (May, 1969) that violence is a potential within all human beings as none of us can stand "the perpetually numbing experience" of our own powerlessness. Imagine being a member of the LAPD and experiencing what Christopher Dorner alleges he experienced. In his "Last Resort" he is telling us that he felt powerless to ensure the satisfaction of some universal and basic, human needs including: identity, recognition, fair play, security, attachment, participation, independence, and understanding. If it were you who suffered the injustice, disrespect, and corruption that he believed he suffered - what would you do? Would you succumb without doing or saying anything? From this perspective Christopher Dorner's violent behaviour can be seen as an attempt to regain his efficacy — to have his needs met. We all have our limits. To truly understand Christopher Dorner's violent actions we must consider the interaction between him, the LAPD's systems, policies and procedures, the problems he had, and the LAPD's response to them. ■

REFERENCES

Borum, R. (1996). Improving the practice of violence risk assessment. *American Psychologist, 51, 945–956.*

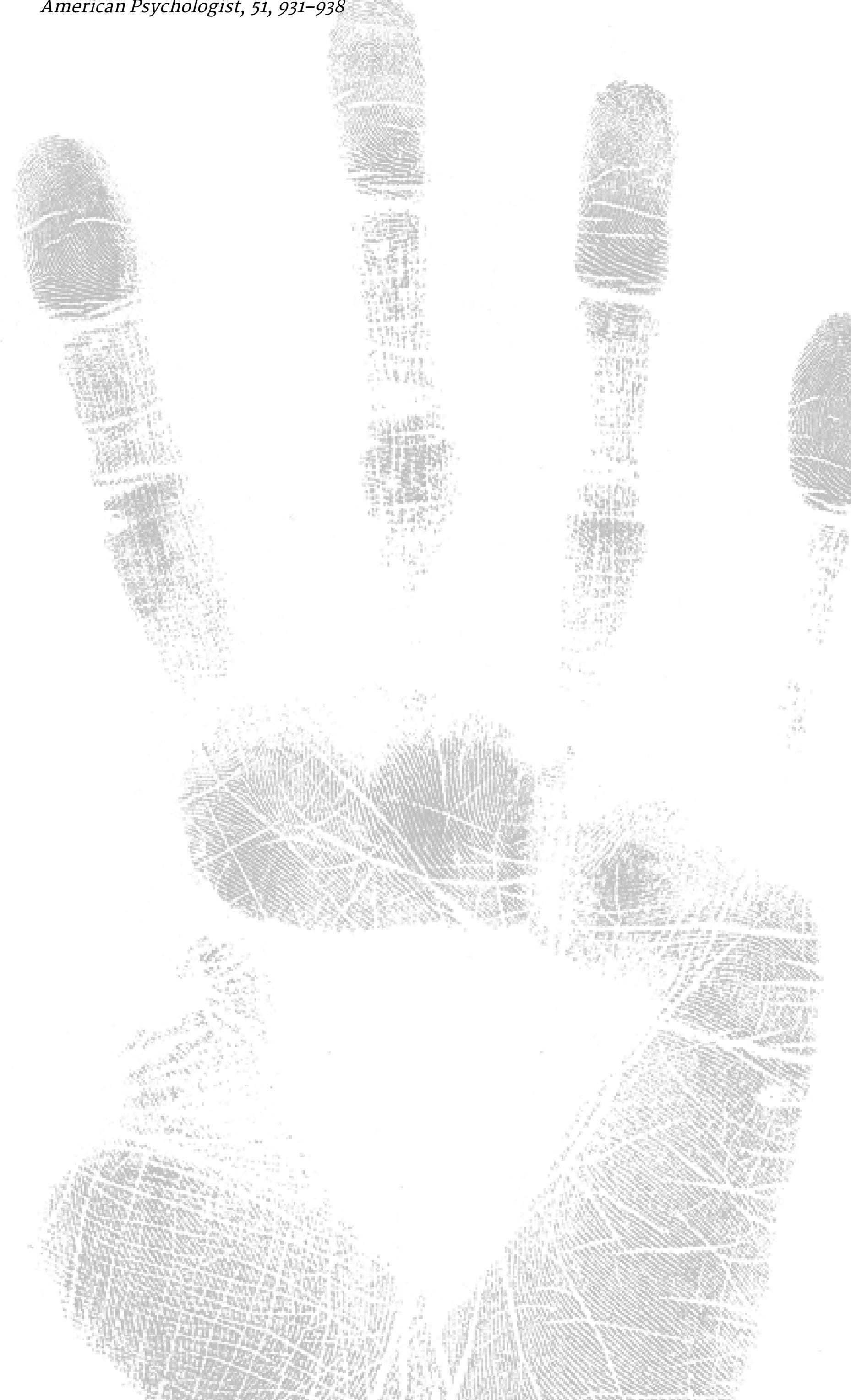
Braverman, M. (1999). Preventing workplace violence: A guide for employers and practitioners. *Thousand Oaks, Sage Publications.*

Fein, R.A. & Holden, G.A. (1995). Protective Intelligence threat assessment investigations: A guide for state and local law enforcement officials *(Research Rep. NJC No. 170612) Washington D.C. U.S. Department of Justice.*

Grisso, T. & Tomkins, A.J. (1996). Communicating violence risk assessments. *American Psychologist, 51, 928–944*

May, R. (1969). Love and will. *New York, NY: Dell Publishing*

Monahan, J. & Steadman, H. (1996). Violent storms and violent people. *American Psychologist, 51, 931–938*



The Insanity of Christopher Dorner?

MIKE WEBSTER, ED. D., R. PSYCH.
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.

No doubt you remember Christopher Dorner; the ex-LAPD police officer and former United States Navy reservist. He was charged in connection with a series of shootings on police officers and their families from February 3 – 12 2013. The attacks left three police officers wounded and, four people dead, including the (civilian) daughter of a former LAPD member. These actions made Christopher Dorner the subject of one of the largest manhunts in LAPD history, involving two U.S. States and Mexico. On February 11, 2013, the Riverside District Attorney filed charges against Mr. Dorner for the murder of a police officer and the attempted murder of three other officers. The following day Mr. Dorner died during a stand-off with local police at a cabin in the San Bernardino Mountains.

Questions regarding Christopher Dorner's mental status and motivation not long ago were being debated from the office water cooler, all the way to CNN. What do you think? Was he insane? How could such a seemingly All-American young man allegedly (I will use this word throughout as Mr. Dorner was never found guilty beyond reasonable doubt in a court of law) have committed such murderous acts? Was he inherently evil? These important and interesting questions regarding human behaviour have been the object of study for social psychologists (e.g. Albert Bandura, 1986) for several decades.

From a social learning perspective, the answer to these questions comes from an understanding of our moral development. As we go through the socialization process we develop a set of guides and deterrents for our behaviour. Once we are old enough to have developed internal controls we attempt to regulate our behaviour. We prefer to engage in actions that are consistent with our morals, as this type of behaviour is satisfying and enhancing of self esteem. We would rather not behave in ways that violate our moral standards, as this would open us to self criticism and self devaluation. Thus, it is our ability to sanction our own behaviour that keeps our actions in line with our morals.

So far, so good. You might be thinking, based upon the foregoing, that Christopher Dorner's socialization process went awry and he ended up with a different set of morals than those of more pro-social individuals, who profess revulsion at what he is alleged to have done. But there's a catch — our moral standards do not run constantly, on automatic pilot. In order for our self-regulatory mechanisms to function we must activate them; and the flip side of that coin is that humans have several psychological tactics they can use to interfere with that process and disengage their morals from their behaviour. This means that people who share the same moral standards can behave in polar opposite ways. Those who behave pro-socially have activated their morals and those who don't have not. Moreover, this suggests that Christopher Dorner could have held pro-social morals and acted in an antisocial manner; all he would have needed to do is disengage his morals from his behaviour. We have several mechanisms of moral disengagement that we use routinely to break the linkage between what we value (or profess to believe) and what we do.

There are several of these mechanisms that we humans deploy whenever we behave in ways that further our own ends but injure others; they include moral justifications, displacing responsibility, disregarding, minimizing, or misrepresenting the damage we have done, or blaming the victim.

In the interest of being brief, I have chosen only two of these mechanisms to examine, that may have been at play in Christopher Dorner's alleged behaviour. The first involves our ability to reconstrue the moral value of the reprehensible behaviour we commit. People do not usually engage in antisocial, or egocentric, forms of behaviour unless they can justify the morality of their actions. So if Christopher Dorner could find a moral purpose for his

alleged murderous behaviour, he could have convinced himself that what was previously culpable had now become honourable. His alleged behaviour would have become more personally and socially acceptable because it was committed under the influence of a moral imperative. Was it not made clear in Christopher Dorner's "Last Resort", written to "America", that he saw himself as following a code of honour in opposition to the LAPD that he believed had ruined his good name and his life? In his writing he revealed to us his self image — an African American, an "honest officer", a conscientious worker, a veteran — all in juxtaposition to what he saw as a corrupt and abusive organization. Do you think Christopher Dorner disengaged his morals from his behaviour by providing a moral imperative? In other words, had he convinced himself that under the circumstances he was morally justified in doing what he did?

The second mechanism of moral disengagement that Christopher Dorner appeared to use repeatedly was to dehumanize his alleged victims. Whereas the previous mechanism focused on his view of his injurious behaviour, this one involves his view of the target of his actions. If we view others as similar to ourselves it is much easier to identify with their joys and sufferings and more difficult to treat them in reprehensible ways. However, we are able to decrease similarity by making others sub-human and thus easier to victimize. (The most obvious example of this is the use of racial slurs). When we have reduced others to something less than human it only makes sense that they would be insensitive to the cruelest of behaviours. In removing others' human qualities Christopher Dorner would have been able to avoid self condemnation for his alleged violent acts, and even more so been able to rationalize them based upon his victims' lesser status. Throughout his "Last Resort" Christopher Dorner refers to his alleged victims as "enemy combatants" rather than members of the LAPD, or the law enforcement community. He made a list of various victims, and added: "You are a high value target"; an inanimate object. Finally he cautions the residents of Los Angeles, "...don't honour these fallen... dirtbags"; a filthy inanimate object. You may find his alleged killing of the female civilian inconsistent with my presentation. In response I will suggest that Christopher Dorner was a rational individual. You don't need to be irrational (insane) to commit murder. Moreover, the woman was the daughter of an investigator that Mr. Dorner believed had done a poor job of investigating his complaints of harassment. Mr. Dorner tells us, "When your family members die, they [the LAPD] just see you as extra overtime at a crime scene... Why would you value their lives when they clearly don't value yours or your family member's lives?" Tit for tat? Do you think Christopher Dorner disengaged his morals from his behaviour by dehumanizing his alleged victims? In other words, had he convinced himself that his alleged victims were something less than human and deserved to be killed?

I asked you at the outset of this brief piece what you thought of Christopher Dorner's mental status and motivation. Knowing what you now know, about how we humans can be equipped with pro-social morals but override them in certain circumstances, was he evil, was he insane? Or was he a rational human being who simply justified his violent behaviour based upon what he believed had been done to him? Before you answer, consider something Christopher Dorner said in his letter to "America":

> "Ask yourselves what would cause somebody to take these drastic measures like I did. That's what is important". ■

REFERENCES

Bandura, A. (1986). Social Foundations of Thought and Action: A social Cognitive Theory. *Englewood Cliffs, N.J.: Prentice Hall*

Lessons from the Inside: Counselling Perspectives from Behind Bars

Margaret Drewlo and Natalie DeFreitas have 15 years experience between them, working in provincial or federal institutions and with the justice system.

Due to the segregated nature of prisons, the experiences of working inside a prison are unique and largely unknown to the general public. Margaret and Natalie discovered their shared history during rare quiet moments while working in a university-counselling centre. What follows is their conversation about their most important acquired wisdom from working in the secret world of prisons.

Margaret: When I saw the theme for this issue, I immediately thought of your recent TEDxVancouver talk on restorative justice and our coffee room talks about our experiences working in the justice system.

Natalie: *I also appreciate that in our work environment we connect with colleagues from different areas of expertise and the TEDx talk was an opportunity for me to share my experience with a broader audience outside of the mental health or justice networks.*

Choosing the work

Margaret: I was completely naïve coming to work in the jail system for the first time. I was working in retail at the time — feeling stuck and under employed. The opportunity came up to facilitate substance abuse education groups for youth in the provincial jail system and I jumped at the chance. I gradually expanded my work to include working in adult jails. I thought I would last a few months. I stayed for seven years.

Natalie: *While completing my undergraduate degree at Queen's University, I volunteered with a non-profit literacy organization in 5 federal, adult penitentiaries in Kingston, Ontario. Subsequently, I worked with a restorative justice non-profit in Toronto, Ontario with youth both in and out of prisons. Through these experiences, I gained an intricate understanding of the contributing factors to criminal behaviours — namely the role of mental health concerns, poverty, trauma/abuse and illiteracy/educational influencers. This understanding shaped my decision to pursue a career in mental health.*

What others should know when considering work in the prison system

Margaret: When working in the prison system, it helps to be open-minded and it is imperative to have good personal boundaries. Open-mindedness is beneficial when coming to terms with the reality of the lives of much of the incarcerated population. They have lived in poverty, they have mental health conditions, and often they come to their first incarceration with a history of abuse and trauma. Boundaries are vital to maintain your own physical and psychological safety and ensure the safety of other staff and inmates. Because prisons are largely sealed off from the outside, interpersonal dynamics are intense. How one interacts with staff and clients in such a setting can have a surprisingly large impact — for the good, or not.

MARGARET DREWLO, MA.

Margaret Drewlo has an M.A. in psychology. She is a clinical psychology doctoral student at Antioch University in Seattle--a school with a strong social justice focus. Margaret is currently competing her pre-doctoral internship at the University of British Columbia.

NATALIE DEFREITAS, MA.

Natalie DeFreitas has an M.A. in psychology from the Adler School of Professional Psychology. Natalie currently works as a Registered Clinical Counsellor at the University of British Columbia and as a justice consultant within her private practice.

Natalie: *There is an opportunity for huge positive impact, but not without acknowledging one's position in the environment. Extra attention to honing self-awareness, practicing complex empath, and challenging biases is imperative. Consideration*

must be given to how the systemic structure of the environment will affect you and your client personally and professionally. I learned quickly to confront aspects of my own identity as an educated, privileged, woman, coming into an environment where the vast majority of my clients would not share this same demographic. It helps to be cognizant of the uniquely damaging stigmas that incarcerated clients experience in order to avoid perpetuating them.

The importance of self-care

Margaret: Self-care helps maintain a balanced life in the face of the tremendous stress of forensic work that partners, family and friends may not understand. Vicarious trauma is something that everyone working inside a prison will encounter. A person who has lost his or her freedom is experiencing a trauma, regardless of how that person has acted out in society. Most people in prison have experienced a lifetime of trauma even before they are sentenced and incarcerated. Then there are those incarcerated individuals who have brought tremendous trauma to their victims and the families of their victims. One certainty about working in a prison setting — you need to be ready to confront trauma and look after your self in the process.

Natalie: *It was difficult for me to witness the injustices that came with the territory, either through my clients' personal lived trauma, the trauma inflicted as a result of my clients' actions or traumas inflicted by the "system" itself. I learned that I needed to do my small part to break the cycle. In order to create rich and meaningful encounters for my clients, I needed to ensure I did the same in my personal life. Additionally, I really learned to appreciate humour and opportunities to laugh with my support network. As simple as it sounds, it helps balance tough work experiences.*

A client who changed us or informed our future practice

Margaret: I had many life changing experiences while working in the jail system including hearing details of violent assaults and murders and seeing young and adult men trying to make a positive change in their lives. The memory that is the most sustaining is one that still makes me laugh. I was working in a secure custody wilderness camp for adolescent boys. The setting was quite beautiful, the childhoods of most of the boys and young men quite tragic. One day before a discussion group started, the boys seemed unusually excited. After a few moments, I discovered that they put a small garter snake in my art supply case and hoped for a big reaction. Luckily for me, I was not afraid of snakes. In seeing those mirthful faces in front of me I encountered the healing miracle of laughter.

Natalie: *I feel privileged for my time working within the correctional system. I am so grateful to my clients for allowing me to be part of their journey. I remember working with a group of male youth at a remand facility. Initially they tested me, and refused to participate during group sessions. One session, much to everyone's surprise, we bonded over our shared appreciation of hip-hop music. After witnessing many of the kids parallel their own experiences with lyrics in rap songs, we collaboratively decided to incorporate music writing into our group work as a way of processing difficult emotions. At the end of our work together, a client shared that for the first time in his life he felt he "had a voice." I consistently reflect on my time working in prisons, how it has contributed to my growth, and find myself humbled and inspired by the experiences I've had.*

Our varied experiences in the prison system shaped us, ultimately for the better. We bring the insight from those years into our current work with clients and find that our lessons from "behind bars" ultimately have made us more skilled practitioners. ■

Psychogenic Polydipsia (Exessive Fluid Seeking Behaviour)

DONALD "DON" HUTCHEON, ED.D., C. PSYCHOL. (UK)., R. PSYCH.
The Vice-President of the BC Psychological Association.

Psychogenic polydipsia is, on a continuum, the compulsion to seek out and over drink any/all fluids and is a type of polydipsia exhibited by patients with mental illness and/or the developmentally disabled. It is also present in a subset of schizophrenics. These individuals, often chronic schizophrenics with a long history of mental illness, frequently exhibit enlarged ventricles and shrunken cortex on MRI, making the physiological mechanism difficult to isolate from the psychogenic. Psychogenic polydipsia is a serious disorder that often leads to institutionalization as it can be very difficult to manage outside the inpatient setting. It should be taken very seriously and can be life-threatening, as serum sodium is diluted to an extent that seizures and cardiac arrest can occur. Those individuals afflicted have been known to seek fluids from any source possible.

The clinical presentation is as follows: the client drinks large amounts of any/all fluids, which raises the pressure of the extracellular medium. As a side effect, the antidiuretic hormone level is lowered. The urine produced by these clients will have a low electrolyte concentration, and it will be produced in large quantities (i.e., polyuria). If the individual is institutionalized, close monitoring by staff is necessary to control fluid intake. In extreme episodes, the client's kidneys will be unable to deal with fluid overload and weight gain will be noted (Gibson, WikiDoc Resources, 2010).

Polydipsia is increased thirst and excessive fluid intake, greater than 3L per day. As many as 20% of schizophrenics are polydipsic and approximately 3.5% – 5% of all schizophrenic clients develop a more serious symptom of self-induced water intoxication (i.e., SIWI). Individuals diagnosed with "psychogenic polydipsia" — of which 80% are diagnosed with schizophrenia — have a fluid intake that is usually 4 – 10L/day, some drink up to 22L/day! Hyponatremia is a low serum sodium level below 130mmol/L (normal range 135 – 145 mmol/L). Polyuria is urine output in excess of 3L/day. In the psychiatric population, polyuria exists as a compensatory mechanism for polydipsia; 25% of polydipsia patients have acute development of hyponatremia where there is a precipitous drop in serum sodium. This occurs sporadically and unpredictably and results in the syndrome of water intoxication (i.e., SIWI).

Clozapine is an atypical antipsychotic medication, which, in low doses, is the most common pharmacological intervention in the treatment of self-induced water intoxication (i.e., SIWI). The restriction of fluid intake appears to have little or no influence on the excessive urge to drink by clients diagnosed with psychogenic polydipsia. As a result, investigators have turned to pharmacological interventions to treat either the polydipsia itself or the hyponatremia. Of note: clozapine has well-known side effects, including orthostatic hypotension, lowering of seizure threshold, anti-cholinergic toxicity, and significant incidence of agranulocytosis (1% – 2%). Many clients with polydipsia or hyponatremia may have multiple physical illnesses that could preclude the use of clozapine (Verghese, deLeon & Josiassen, 1996).

Behavioural strategies include limiting the daily water intake when indicated, initiating fluid restriction when there is a significant weight increase, taking a "serum sodium levels" count if signs and symptoms of intoxication start to appear, providing constant attention for the patient which can include locking the individual in seclusion for their own safety. Behavioral management programs should be mandatory.

Psychosocial rehabilitation (PSR) programs for individuals diagnosed with psychogenic polydipsia, requiring tertiary care, should be guided by the principles of psychosocial rehabilitation, with sophisticated medication management and behavioural interventions. The PSR approach to service delivery is based upon fundamental and interconnected concepts (Canadian Code of Ethics, PSR, 2010):

1. PSR programs emphasize the need for individually tailored interventions;
2. PSR programs emphasize a flexibility, either the individual's capacities be adapted to environmental realities or the environment be changed to suit the capacities of the person;
3. PSR programs are oriented to exploitation of people's strengths;
4. PSR programs aim at the restoration of hope;
5. PSR programs emphasize the vocational potential of mentally ill individuals;
6. PSR programs extend beyond work activities to encompass a full array of social and recreational life concerns;
7. Recipients of PSR programs are actively involved in their own care;
8. The PSR program is an ongoing process.

Client Care Requirements

Tertiary care is generally provided to persons with severe and persistent mental illness (SPMI). These clients exhibit conditions and problem behaviours that require services well above those provided with the secondary care level (Wasylenki, Goering, Cochrane, Simon & Wirth-Couchon, 2000). This enriched type of treatment should require referral from secondary care for those individuals with problems that are complex and refractory to primary and secondary care. Criteria for success usually includes the need for higher levels of management and security, staff expertise, and staffing program resources, all in conjunction with more detailed and specialized assessment and treatment.

During the past 10 years, psychiatric service delivery research and expert opinion has successfully promoted community-based services providing tertiary care, to reduce reliance on traditional hospital-based tertiary care (Wasylenki et al, 2000). In contrast to past reliance on traditional inpatient settings for tertiary care, it is possible to employ flexible strategies to maximize time in the least restrictive settings. Level of staff expertise is a critical element of tertiary care. Tertiary care providers have generally advanced training and a commitment to service the population of clients with psychogenic polydipsia. Many long-term residents diagnosed with psychogenic polydipsia who reside in a provincial or state psychiatric hospital, can graduate from inpatient tertiary care services to a community resource, if the funding allows for an appropriate staffing model. More specifically, hospital patients who have complex but stable conditions can be supported in community settings with access to tertiary services Hutcheon, 2012).

In sum, excessive fluid drinking may occur in almost any psychiatric disorder (e.g., Histrionic Personality Disorder). However, most cases (about 80%) of psychogenic polydipsia with self-induced water intoxication, occur with clients with a psychotic illness, usually of the schizophrenic type. The prevalence of compulsive water drinking in state psychiatric hospitals in the United States has been estimated between 7% – 18% (Jose & Perez-Cruet, 1979), and about half of this population suffer from the complications of SIWI (Hariprasad, Eisinger & Naider, 1988). The cause of polydipsia remains unclear. Although there is some agreement in common areas of diagnosis and treatment interventions (i.e., Clozapine, behaviour modification, psychosocial rehabilitation), a consistent treatment approach throughout the years has emphasized PSR strategies such as psycho — education, which has been implemented in various tertiary care settings. Thank you for your attention in this matter, and when working in an inpatient psychiatric setting, be vigilant for this threat to patient well-being.

Dr. Donald "Don" Hutcheon C.Psych. (UK)., R.Psych. Associate Fellow of the British Psychological Society Fellow of the American Psychotherapy Association ■

REFERENCES

Psychosocial Rehabilitation (PSR) (2010). Principles of Psychosocial Rehabilitation (PSR). *Canadian Code of Ethics,* 109–118.

Gibson, M.C (2010). Psychogenic polydipsia. WikiDoc Resources.

Harisprasad, M,K., Eisinger, R.P., & Nadler, R.M et al. (1988). Hyponatremia in psychogenic polydipsia. *Archives of Internal Medicine,* 140, 1639–1642.

Hutcheon, D. (2012). *Psychogenic Polydipsia: Treatment Strategies and Housing Options.* ACFEI Media, Springfield, MO and Paul H. Brookes Publishing Co., Inc. Baltimore.

Jose, C., & Perez-Cruet, J. (1979). Incidence and morbidity of self-induced water intoxication in state hospital patients. *American Journal of Psychiatry.* 136(2). 221–222.

Vieweg, W.V.R., David, J.J., Rowe, W.T., Wampler, G.J., Burns, W.J., & Spradlin, W.W. (1985). Death from self-induced water intoxication among patients with schizophrenic disorders. *Journal of Nervous and Mental Disease,* 173, 161–165.

Wasylenki, D., Goering, P., Cochrane, J., Simon, L.J., & Wirth-Cauchon, J.L. (2000). Tertiary mental health services: I.Key concepts. *Canadian Journal of Psychiatry,* 45, 179–184.

The Bibliotherapeutic Maze: How to Pick a Book for Client Home Exercises

TED ALTAR, PH.D., R. PSYCH.
The President of the BC Psychological Association. Contact for the Board of Directors at board@psychologists.bc.ca

Be careful about reading health books. You may die of a misprint. — Mark Twain

The selection of a good client self-help book or workbook is now both easier with internet and also more difficult given the proliferation of titles now available. Although most are probably worthless, the American Psychological Association (Jacobs, 2009) estimated that some 2000 self-help books each year are published! Indeed, there is a pseudo psychology or pop psychology genre of books written by those of doubtful credentials, as for example the books of marriage guru John Gray, PhD, which are to be viewed with scepticism since his PhD was via correspondence through "Columbia Pacific U" (an unaccredited institution closed down in 2000 by Court order). Other pop psychology books flatter with empty promises of hidden potentials, beguile with shallow bromides and banalities, or even promote advice that is outright harmful.

In spite of the proliferation of humbuggery, there are some very good and helpful self-help books. In fact, self-help books have been popular for two centuries and available for a much longer period starting with the literature of the ancient Greek and Roman Stoic philosophers like Epictetus. William James was one of the first Philosopher/Psychologists to offer practical self-help in his published lectures to teachers and students on psychology (James, 1899). Another book that became popular and also came from the Psychological community was Karl Menninger's book, *"The human mind"* published in 1945 that was perhaps one of the first more respectable books from the Psychological community at the time to have been popular for dealing with emotional problems.

The attraction to the public of self-prescribed and self-administered help has probably never been greater in what Philip Rief criticized as the *"triumph of the therapeutic"* in modern society: Whatever the unique social conditions for this hunger for self-improvement and personal meaning, the more sound self-help books, as opposed to pop-psychology books of psychobabble, do address in a practical manner some very real problems for suffering individuals. The better genre of self-help has evolved to now include respectable self-help manuals which can be a great adjunct for psychological treatment. One survey indicated that 85% of psychologists have reported recommending a self-help book to some of their clients (Norcross et al., 2000). Indeed, the proper client treatment manual can be a substantial cost benefit to clients who cannot afford to see a Psychologist as frequently as recommended.

The advantages of having clients work on their problems outside of their therapy sessions in their real life settings would seem to be self-evident. There is unfortunately a lack of research on the therapeutic efficacy of particular materials although there are some exceptions like David Burns' *Feeling Good Handbook*. Meta-analysis of the studies that have been conducted on a few books has shown bibliotherapy to be effective with effect sizes ranging from 0.5 to 1.1 (Richard, E., 2008). Nevertheless, we need to keep in mind that not all clients are amenable to having an additional burden of "homework," and choosing the right book for a particular client can be daunting. Many clients suffer from negative self-attitudes and such clients can conceivably be made to feel worse by particular statements in a book that they read when the Psychologist is not present to correct or explain. A depressed client may feel even more depressed if he or she doesn't complete the "homework" and have to report the failure to the therapist at the next session. Clearly, how one presents the option of some homework is important and it is probably best not to call it homework

but use some other term like *"exercises"* or *"helpful readings"* that a client may wish to try out but not feel obliged to complete. Whether one assigns the whole book or a specific chapter each week seems to make no difference (Carlbring, 2011).

The question becomes which ones to recommend and by what criteria. Obviously you cannot depend on book covers or even a quick skimming of the book, not if you want to avoid books that could be potentially harmful or employ disreputable methods and half-baked, pretentious advice. We now know that thought stopping and distraction techniques for certain problems have been shown to be ineffective and may even make symptoms worse (Richards & Farrand, 2010). Given the plethora of materials to choose from, what are we to do? Maybe a more reliable method is to depend on the opinion of trusted colleagues or accept the word of a general survey of many psychologists like that found in Narcross (2003) who surveyed some 3500 psychologists for their personal ratings of self-help books.

Of course, our scientific training demands that we seek evidence for the bibliotherapeutic materials we may want to use and indeed there are some efficacy studies on a few books for depression (Songprakun, 2012) and anxiety. There are even some recent studies on problems like occupational stress (Kilfedder, 2010), child sexual abuse (Ginns-Gruenberg, 2012), hoarding (Muroff, 2012), low sexual desire (Mintz, 2012). tinnitus distress (Malouff, 2010), and community psychology applications such as ACT for grade twelve students (Jeffcoat, 2012).

Unfortunately, studies of efficacy are too few and far between. A final method would be to rely on the systematic and considered judgement of experts in the speciality of concern. For example, Richard Redding and colleagues (2008) actually reviewed and rated 50 of the top best selling self-help books for depression, anxiety and trauma related disorders. The four expert psychologists prominent in their respective fields served as raters, used a consistent inter-judge rating scale, checked for consistency and rank ordered the fifty books in terms of depending on psychological science, stating reasonable expectations, providing general guidance and being useful overall, and hopefully providing some warning of possible iatrogenic effects. In table 1 are the top 10 from that list.

Publication Information and Total Quality Score of Books
Ranking/Book title/Primary author/Year/Publisher/Total quality score

rank	Author, (date), Title, Publisher	Score*
1	Hyman, B.M. (1999). *The OCD Workbook.* New Harbinger	94
2	Markway, B. (1992). *Dying of Embarrassment.* New Harbinger	92
3	Antony, M. M. (2000). *The Shyness & Social Anxiety Workbook* New Harbinger	92
4	Neziroglu, F. (2004). *Overcoming Compulsive Hoarding.* New Harbinger	90
5	Foa, E. B. (2001). Stop Obsessing. Bantam Books	90
6	Prentiss, P. (2004). The Cyclothymia Workbook. New Harbinger	88
7	Castle, L. R. (2003). *Bipolar Disorder Demystified.* Marlowe	84
8	Burns, D. D. (2000). Feeling Good. Avon Books	83
9	Hyman, B. M. (2004). Overcoming Compulsive Checking New Harbinger	82
10	Penzel, F. (2000). Obsessive-Compulsive Disorders Oxford University Press	81

*The last number is the over-all score based on whether the book was based on sound science, provides specific guidance, realistic expectations, warnings of potential iatrogenic effects and overall usefulness.

With respect to the above list, I personally use Burn's *Feeling Good Handbook* (1999) for some of my clients suffering depression and or anxiety since it is a better buy for clients, with more coverage and more useful tools and exercises for clients to utilize.

Of course, *caveat emptor* here applies as for example, Redding et al (ibid) found that of the 50 popular self-help books they reviewed, at least 18% could be deemed potentially iatrogenic! Other books may not be iatrogenic but would be of unproven worth and may be useless. Also, not all populations of clients, such as the subthreshold depressed elderly (Joling, 2011), will necessarily benefit from bibliotherapy.

It is to be noted that the best rated books, like the ones listed above, were books addressing a specific problem written by professionals with a doctoral degree that advocate cognitive behavioural interventions. In the end, whatever means you employ to find and select bibliotherapeutic materials, professional psychologists are responsible for what they recommend to their clients.

The man who does not read good books has no advantage over the man who can't read them. — Mark Twain ■

REFERENCES

Carlbring, Per Maurin (2011). All at once or one at a time? A randomized controlled trial comparing two ways to deliver bibliotherapy for panic disorder.; *Cognitive Behaviour Therapy,* Vol 40(3), Sep, 2011. pp. 228–235.

Ginns-Gruenberg, D. (2012) Effectively incorporating bibliotherapy into treatment for child sexual abuse. In the *Handbook of child sexual abuse: Identification, assessment, and treatment.* Goodyear-Brown, Paris (Ed.); pp. 377–398. John Wiley & Sons Inc.

Jacobs, N. (2009). Bibliotherapy utilizing CBT.; In: *General principles and empirically supported techniques of cognitive behavior therapy.* Ed by O'Donohue, W. et al. John Wiley & Sons Inc, pp. 158–165.

James, William (1899). *Talks to Teachers on Psychology: and to Students on Some of Life's Ideals.* Dover Publications 2001.

Jeffcoat, T. & Hayes, S. (teven C2012). A randomized trial of ACT bibliotherapy on the mental health of K-12 teachers and staff. Behaviour Research and Therapy, Vol 50(9), Sep,. pp. 571–579.

Joling, K., et al. (2011). How effective is bibliotherapy for very old adults with subthreshold depression? A randomized controlled trial. *The Amer. J. of Geriatric Psychiatry, Vol 19(3),* Mar, 2011. pp. 256–265.

Kilfedder, C. et al. (2010). A randomized trial of face-to-face counselling versus telephone counselling versus bibliotherapy for occupational stress.; *Psych. & Psychotherapy: Theory, Res. & Pract.,* v. 83, pp. 223–242.

Malouff, J. et al. (2010). The effectiveness of bibliotherapy in alleviating tinnitus-related distress. *Journal of Psychosomatic Research, Vol 68(3),* p. 245–251.

Mintz, Laurie B. Balzer, Alexandra M. Zhao, Xinting Bush, Hannah E.; (2012). Bibliotherapy for low sexual desire: Evidence for effectiveness. *Journal of Counseling Psychology, Vol 59(3),*. pp. 471–478.

Muroff, J. et al. (2012). Group cognitive and behavioral therapy and bibliotherapy for hoarding: A pilot trial. Depression and Anxiety, *Vol 29(7), Jul, 2012.* pp. 597–604.

Norcross, J. et al. (2003). Authoritative guide to self-help resources in mental health (2nd ed.). N.Y.: Guilford Pr.

Redding, R., Herbert, J., & Forman, E. (2008). Popular self-help books for anxiety, depression, and trauma: How scientifically grounded and useful are they? *Professional Pschology, Res. & Practice. v. 39(5),* pp. 537-45.

Richard E., James D. Herbert and Evan M. Forman(2008). Popular Self-Help Books for Anxiety, Depression, and Trauma: How Scientifically Grounded and Useful Are They? *Professional Psychology: Research and Practice, Vol. 39,* No. 5, 537–545

Richardson, R.,l Richards, D., & Barkham, M. (2010). *Self-help books for people with depression: The role of the therapeutic relationship.* Behavioural and Cognitive Psychotherapy, Vol 38(1), 67–87.

Richards, D. & Farrand, P. (2010). Choosing self-help books wisely: Sorting the wheat from the chaff.Detail; In: *Oxford guide to low intensity CBT interventions.* Bennett-Levy, James (Ed.) et al. Oxford University Press, pp. 201–207.

Rief, Philip (1966). *The Triumph of the Therapeutic: Uses of Faith after Freud.* Haper Torchbooks.

Songprakun, Wallapa et al. (2012). Evaluation of a bibliotherapy manual for reducing psychological distress in people with depression: A randomized controlled trial. *Journal of Advanced Nursing, Vol 68(12),*. pp. 2674–2684.

EXECUTIVE DIRECTOR OF THE BRITISH COLUMBIA PSYCHOLOGICAL ASSOCAITON (BCPA)

BCPA is the advocacy organization for all Psychologists in BC and promotes the profession within the province.

The Executive Director (ED) plans, manages, and oversees the operations of the BCPA at the direction of the Board. This involves managing office staff and budget, lobbying on behalf of psychologists with politicians, liaising with relevant organizations (including, but not limited to, Canadian Psychological Association, American Psychological Association, College of Psychologists of BC, and BC Medical Association), and promoting the profession with non-governmental agencies, such as insurance companies.

DEADLINE: MAY 15, 2013.

PREFERENCE WILL BE GIVEN TO A PSYCHOLOGIST.
The position requires significant interpersonal skills, depth of knowledge of the profession of psychology, and ability to accurately and articulately speak about a range of issues involving psychologists. Candidates should be informed of public policy trends and provincial realities impacting the profession, and committed to lobbying on behalf of psychologists so that psychology is appropriately and effectively positioned in BC.

THIS IS A PERMANENT POSITION.
The position requires a minimum of 25 hours weekly. Accommodation on the number of hours can be made for the ideal candidate. Preference will be given to candidates who are interested in long-term employment. Salary will depend on qualifications and agreed upon schedule.

Please send Curriculum Vitae to: HR@PSYCHOLOGISTS.BC.CA
BCPA #402-1177 West Broadway Vancouver, BC V6H 1G3
For more information, **PHONE 604-730-0501**

ADVERTISE WITH BCPA

EMAIL/WEB POSTING/PRINT

DISCOUNTS FOR MEMBERS

PRINT AD COMES WITH FREE WEB POSTING

VOLUME DISCOUNTS AVAILABLE

communications@psychologists.bc.ca