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Hello Members,

There seem to have been a lot of people fully prepared for the world to end in December. I know of at least one young person who dropped out of school because of the pointlessness of attaining a degree (given the end of the world, and all). Perhaps they will be making appointments to see us. Perhaps distress over the continuation of existence will show up as a new disorder in the DSM-5, along with Olfactory Reference Syndrome. We could call it Cancelled Apocalypse Syndrome, or Mistaken Annihilation Disorder (MAD). We invite your suggestions for possible titles. At any rate, I am glad we are still here and able to present you with the latest issue of Psychologica.

In this issue we are inaugurating two columns: one on setting up a private practice in your home and running it efficiently, and another on the messy topic of ethics. We are counting on you to send us questions and suggestions regarding these two topics for future issues.

Also in this issue we have an article on transracial adoption and the controversy around it. Caroline Krupica has been a clinical social worker and psychotherapist for 13 years and the subject is of personal interest to her. She and her husband have 6 biracial children, and as a mixed race couple they have experienced first-hand how the presuppositions of adoption workers can adversely affect the process.

In our opinion column, psychotherapist Daniel Rutley argues that too many therapists try to work within the flawed belief systems of their clients and that this is ultimately detrimental to their progress.

If, like me, you have a number of clients who are taking medications for depression, anxiety, and other conditions, you will be very interested in the article on assessment technologies and why they should be used more often in diagnoses instead of relying on the personal judgment of psychiatrists.

As always we invite your comments. You can email me directly at publications@oaccpp.ca with comments, criticisms, or proposals for future articles and I will personally read all of your emails.

I and my hard-working editorial board wish you an auspicious and interesting year.

Sandra Lewis, M.A., (C) OACCPP
Editor, Psychologica
Dear Colleagues,

This is my first message for Psychologica as President of OACCPP and I want to start by saying it is a great honour and privilege to serve in this capacity. I am looking forward to building on the work that has been done so far and feel very fortunate to have such a strong board of directors to support me.

As most of you know, this year the OACCPP will be celebrating its 35th anniversary. Indeed, we have much to celebrate. I think these landmark events offer opportunities for reflection, hope, review, and change. During the past six years our board’s main effort has been to move from an operational to a policy board and we have essentially achieved that goal. The day-to-day operation of our association is by-and-large carried out by the staff under the management of our Administrative Director.

During the past several months, we have focused most of our activities on matters concerning the regulation of psychotherapy/clinical counselling. However, we always have the interests of our entire membership at heart, including those who won’t be affected by the new College.

For the past three years, our Professional Development Committee has worked on developing training seminars reflecting the very diverse needs of the different divisions of our membership. These seminars will take place at regional sites, through webinars, and at our Annual Conference. Additionally, the newly revised Code of Ethics and Standards of Practice are now on the website. I encourage members to visit our new website, which was introduced at the AGM and went live on November 1, 2012. In particular, I urge you to thoroughly review the above-noted documents.

While the board continues to work hard to develop policies that will benefit our members, committee chairs try to introduce new ideas covering a range of concerns and interests. However, the active participation of our members is crucial in promoting the future direction of the Association. I encourage all of you to send in your suggestions. Tell us what has worked well in our efforts. Tell us what concerns you have and what changes you would like to see.

I wish all of you the very best in 2013!

James Whetstone, M.A., (C) OACCPP, CDRS
President, OACCPP
Re: The Opinion Piece:  
2012: Work, Time, Family. Can We Have It All?

Our colleague Lori Cohen makes an excellent point in her article that in the year 2012, professional women should not be forced to choose between family and career. As a 29 year old mother of two daughters (6 months & 2 years old) and a psychotherapist running a successful private practice, I am facing this very choice with the grandfathering process for the new college. The proposed criterion for grandfathering is based upon hours logged in professional activities in the past 3 years. I have been working as a psychotherapist throughout that time, however I have also had 2 babies in those 3 years. Please don’t penalize me for achieving a balance in which both my family and my practice are thriving.

Madelaine Ahlberg, Psychotherapist

Lori’s article brought out a very good point. I also went back to university in my 40’s and as a single parent. At one point both my daughters (three years age difference) and I were in university. We all attended different universities although we were all in Psychology and Health. Way to go Lori! Thanks for bringing this to our attention as it is happening more and more.

Holly

The title [of this piece] has an infuriating sense of entitlement. For women in the 1970s and who entered the workforce in the 1980s, “having it all” simply meant that women should be able to have both careers and families in the same measure and to the same degree that men do. But today, with so many people having so little and recognition that “men don’t have it all either,” a better and more accurate title for Lori’s article would be Why Working Mothers Need Better Choices to Be Able to Stay in School.

Regarding the whole issue of work-life balance please lay off the staggeringly selfish view that society should be restructured so that your life should be more convenient for you. Work-life balance means managing your overwhelming level of responsibility and workload with enough care so that you do not burn out. It has nothing to do with what you want.

Rob

I can only say that I applaud the author for her forthrightness. I was witness to the exact same situation in my Master’s training program in South Africa, so this isn’t just a Canadian ethic. I feel most especially that students who are parents bring enrichment to their studies due to their own life experience, as so with students over the age of 30, and part-time study should be encouraged.

Thank you for this ‘Opinion piece’.

Allison Cassidy, Psychotherapist

Re: The article on Counselling Chinese-Canadians

I appreciated Jennifer’s article as I recently had a Chinese client. It gave me confidence reading her article and I was able to focus in on what was the client’s experience while being aware of possible cultural differences. I also noticed that the author went to university in my hometown of North Bay!

Holly
This paper documents how the controversial subject of transracial adoption (TRA) unfolded in the United States and looks at some of the recommendations for addressing the best interests of children and families in American and Canadian settings. According to the U.S. Government’s Multiethnic Placement Act (1996), addressing the “best interests of children” means ensuring that they have permanent, safe, stable, and loving homes that will meet their individual needs.

The issue of TRA has been debated strongly in the United States particularly, since the beginning of the 1960s, while changing societal views on the integration of racial relationships were being shaped by the civil rights movement. The controversy had begun planting its roots in the 1940s, when black children in need of families were denied the use of adoption service agencies due to race. Adoption agencies believed that black children would be difficult to place because they were stereotyped as being “special needs” children (Evan B. Donaldson Adoption Institute, 2008).

The first public record of transracial adoption appeared in the United States in 1948, in Minnesota. Four years earlier, in Washington, a white couple had become foster parents to a six-week-old black child. The Johnstons eventually adopted her in 1953 against the advice of placement workers (The Adoption History Project, 2012). Since then, the practice of transracial adoption in the U.S. has mostly increased, but not without resistance.

Problem

The debate was thrust into public view in 1972 when the National Association of Black Social Workers (NABSW) published an opinion paper that delivered a devastating blow to what had become accepted transracial adoption arrangements. To that point, the adoption of black children into white families had become viewed as an increasingly acceptable adoption placement. The NABSW publicly stated its belief that white families should never be allowed to adopt black children (Griffith & Bergeron, 2006). The organization went on to argue strongly that white families would prevent adopted black children from forming a strong racial identity as well as “hindering the development of survival skills that would be necessary to deal with a racist society” (Morrison, 2004).

This position paper sparked immediate debate between opponents of TRA, who suggested that black children were best raised by black families, and supporters of TRA, who believed that being race-neutral and providing a stable, loving home were of paramount importance, irrespective of the race of the family raising the child. There are two questions at the center of this debate: how to serve the best interests of the adopted child, and is it possible for black children to be raised by white parents while developing and accepting their racial self-identity?

In an ideal world, where people of all races and ethnicities would be treated equally, black children placed in the care of the state would be adopted by monoracial parents; that is, two parents who are the same race as the child. However, demographics show that this is not feasible. Recently, black children represented only 15% of the total population of children in the United States, but they accounted for 34% of 510,000 children in foster care (Evan B. Donaldson Adoption Institute, 2008). With a disproportionately small number of black families available to adopt black children, the choices became: (1) having black children remain in foster care for a prolonged period of time and potentially age out of care, or (2) finding a way to make transracial adoption
work more convincingly in the best interests of the child. This paper will present the case that actively nurturing the child's racial identity and integrating experiences of cultural socialization could strengthen the self-identity of black adoptees raised in white families. Furthermore, white parents could provide the love, support and guidance of a family, which the child might miss if left to age out of care within the foster care system.

Definition
For the purpose of this article, the definition of transracial adoption will be that of Griffith & Bergeron (2006), "adoption of black children by white families." This is in contrast to the U.S Children's Bureau (2000) definition, where "the race of the child differs from that of at least one adoptive parent" (as cited in Freundlich, 2004).

History
Children enter the child welfare system for a variety of reasons. Many then become available for adoption through government-funded agencies like the Children's Aid Society. There are also a number of private adoption agencies that engage in TRA; however, their different reporting practices may make it challenging to determine the number of TRAs accurately for research and statistical purposes.

"Private agencies were managing more adoptions of black children than were government-funded agencies due to racism in the American child welfare system…"

In 1971 transracial adoptions increased to a high point in the U.S. when the number of white parents looking to adopt far exceeded the number of white infants available. There were three main reasons for this: the legalization of abortion, increased availability of contraceptives, and increased acceptance of single/teen pregnancies (Evan B. Donaldson Adoption Institute, 2008). Most of the transracial adoptions were being facilitated by private agencies because of what has been characterized as racism within the American child welfare system and also because of cultural differences (Quiroz, 2008). At that time, the amount needed to adopt a child through a private agency ranged from $4,000 to over $40,000 in the United States, which tended to keep the adoption of black children a mainly white middle-to-upper class pursuit (Quiroz, 2008). These figures are consistent across states and are reflective of those associated with private adoption today.

The increased popularity of the TRA strategy gained some negative attention in 1972 when the NABSW published its first opposing position paper. After that paper was distributed, the number of adoptions of black children decreased by 39 percent from 2,574 to 1,569 the following year (Morrison, 2004). In 1985, NABSW President, William T. Merritt went on record at a Senate hearing, stating, "We view the placement of black children in white homes as a hostile act against our community. It is a blatant form of racial and cultural genocide" (as cited in U.S. Commission on Civil Rights, 2010).

In 1977 the Fifth Circuit Court in Fulton County, Georgia suggested that since biological family members look alike, so too should children brought into a constructed home. The court acknowledged that children would acclimate better as a "normal" family if adoptive parents look like they have actually given birth to the child being adopted. It was duly noted, however, that race should not be the only determining factor (Drummond v. Fulton County, 1977; Griffith & Bergeron, 2006). This recommendation presupposed that the physical similarity of children and adoptive parents was critical to the normalcy of the family unit. The position of the Fifth Circuit Court left room for interpretation, and agencies in the United States reverted to historic practices of same-race placement policies (Griffith & Bergeron, 2006).

As supporters and critics of transracial adoption continued to voice their concerns, the wait for black children to be adopted by families of the same race increased. Many adoption workers held beliefs similar to black activists in the NABSW. In 2003, a white child in the U.S. was waiting two years and eight months to be adopted, while a black child was waiting twice as long, and 15-20% reached adulthood without being adopted at all (Courtney & Piliavin, 1998 as cited in Butler-Sweet, 2011). To make matters worse, the problem of longer wait times for black children became exacerbated by their increased chances of entering care. When assessments for child abuse in families of origin were reviewed, there was no significant difference in the prevalence of child
maltreatment within black and white families; however, black children were apprehended and placed in foster care at twice the frequency of children apprehended in the total U.S. child population (U.S. Government Accountability Office, 2007 as cited in Evan B. Donaldson Adoption Institute, 2008).

In relation to the general population of children under the age of 18, data from the 2000 U.S. Census (as cited in Griffith & Bergeron, 2006) showed that 68.6% (49,598,289) were white and 15.1 percent (10,885,696) were black. A greater proportion of black (0.9%) than white children (0.4%) were awaiting adoption in September 2003 (Griffith & Bergeron, 2006). To make matters worse, the problem of longer wait times for black children became exacerbated by their increased chances of entering care. When assessments for child abuse in families of origin were reviewed, there was no significant difference in the prevalence of child maltreatment within black and white families; however, black children were apprehended and placed in foster care at twice the frequency of children apprehended in the total U.S. child population (U.S. Government Accountability Office, 2007 as cited in Evan B. Donaldson Adoption Institute, 2008).

As mentioned earlier, the number of transracial adoptions in the United States dropped significantly after the NABSW's initial position paper was released, and proponents of TRA, mainly adoptive parents, began fighting back in the late 1980s. They argued that the refusal of adoption due to race was a form of reverse discrimination and not in the best interests of children. In 1984, the National Coalition to End Racism in America's Child Care System was formed in Taylor, Michigan by Carol Cocoa and seven other foster parents. It was intended to be both a support and an advocacy group for the acceptance of white parents wanting to adopt black children. The Coalition asserted that children should be placed in homes of parents most qualified to meet their needs, regardless of the race of the parents.

In 1994 and 1996 the Multiethnic Placement Act (MEPA, then MEPA-IEP) attempted to aid in facilitating the rights of white parents to adopt black children, decrease the length of time children were waiting to be adopted, and work toward the recruitment of black adoptive and foster parents (Butler-Sweet, 2011). The original version of MEPA came under intense scrutiny because it continued to allow race-matching policies to play a significant role in the denial of child placements in white families (Vidal de Haymes & Simon, 2003). The language in MEPA's "permissible consideration" provision was amended on August 20, 1996 and Section 1808 (Interethnic Adoption Provisions or IEP) of an unrelated piece of legislation (the Small Business Job Protection Act) was instituted to amend the arbitrary language of the original (1994) version of MEPA. The MEPA had stated previously that consideration of race would be acceptable on a case by case basis if caseworkers could prove it was in the best interests of the child.

Race-matching was intended to be an effective way to integrate a constructed family while meeting the needs of both parents and children. Historically, however, the practice also included matching physical features and temperament of the child, which supported racist beliefs that black children were “impulsive, unstable, prone to insanity and had poor temperaments” (Quiroz, 2008). The impact of race matching on communities effectively encouraged the continued separation of racial groups.

In 1991 the NABSW reasserted its stance that white parents should not be allowed to adopt black children, suggesting that no matter how loving and skilled white parents could be, they would do irreparable harm to the child (Griffith & Bergeron, 2006). The NABSW published a subsequent position paper in 1994 (NABSW, 2003) on the preservation and safeguarding of black families. This latter position paper emphasized the idea that when black children are adopted, priority should be given first to kinship care (relatives or extended family members) and black adoptive families second. However the 1994 paper represented a shift in attitude from the original assertion that white parents never should adopt a black child. The paper allowed that TRA could take place after all appropriate same-race adoption opportunities had been exhausted (Griffith & Bergeron, 2006).

This shift in sentiment appeared to move closer to that of the Child Welfare League of America (CWLA). The CWLA, as the oldest organization for the welfare
of children in the United States, stated that TRA should work in the best interests of the child. If there was a chance that a black child was going to be in foster care for an extended period of time when suitable white parents were available, then the child should be adopted by white parents (Lee, 2003).

“In 2004, Missouri and Kentucky had laws that would enable adoptive parents to return children who come to look like they are racially different from the adoptive family as they get older…”

In May, 2008 the TRA debate was reignited the release of a report by the Evan B. Donaldson Adoption Institute. The report was in response to the MEPA, which had mandated that all federally-funded social service agencies employ a “color blind” approach to processing adoptions. The Donaldson report disagreed, recommending that race should play a role in TRA. The Institute believed that black children need exposure to their racial identity in a way that white parents cannot adequately provide (Butler-Sweet, 2011).

Discussion

The fundamental concern is whether white parents can nurture the child’s ethnic and cultural needs as they relate to self-identity. Concrete descriptions of support that could be put in place to help strengthen the racial identity of black children adopted by white parents have begun to appear in adoption literature from the U.S. (Vonk, 2001) and Canada (Canadian Paediatric Society, 2006; Dwyer & Gidluck, 2012). Vonk (2001) reviewed and condensed a starting list of 176 published recommendations relating to transracial adoption. She suggested a definition of cultural competence based on three constructs: racial awareness, multicultural planning and survival skills (see Table 1) and has co-authored a psychometric test designed to measure cultural competence in prospective TRA parents (Massatti, Vonk & Gregoire, 2004).

A position statement from the Canadian Paediatric Society (2006) contained similar recommendations and included specific ages when children are developmentally ready to understand different aspects of their own identities and the larger implications of TRA. The statement recommended that all children in a family unit be taught about racism and coping strategies, not just the adoptee(s), because siblings in TRA families may also become targets of racist behaviour. It also was recommended that TRA families stay in contact with each other for support.

Dwyer & Gidluck (2010) presented a series of policy recommendations on pre- and post-adoptive TRA services to the Metropolis Centre in Atlantic Canada, a consortium of academic researchers, government representatives and non-governmental organizations. Considerable stakeholder testimony from adoptive parents was quoted in their report, including ways the training of adoption support workers needs to be expanded, and how access to coordinated services could be improved for families.

Some continue to believe that black children raised by white parents will have difficulty as they try to self-identify and accept their racial identity (NABSW, 2003). Others have suggested that being raised in a white-parented family does not negatively impact the racial identity of black adopted children (Griffith & Bergeron, 2006).

Recommendations

At the present time, most of the published recommendations intended to provide support for adoptive families, adoptees and workers with whom they interact have been derived from expert opinion and family consultation. Best practices among TRA support interventions will need to be determined by well-designed research that examines longer-term impacts on outcomes of interest for transracial adoptees and their families. Longitudinal studies could be particularly useful in understanding variables such as adoptees’ experiences of racial and self-identity over the life span.

The impact of specific training programs for families and workers in social services also could be examined. For example, placement preparation programs (PPP) can teach pre-adoptive white parents about issues commonly associated with raising a child of a different race. Such programs can help parents learn unfamiliar aspects of personal hygiene (e.g., skin and hair care) and to experience, as closely as possible, real-life situations in which children may experience feelings of oppression. For instance, it is important for caseworkers to be informed about
conditions like Mongolian blue spots, which are birthmarks mistaken for bruising and evidence of physical abuse, on or near, the back and buttocks.

“The discord among organizations that play an important role in the transracial adoption process leaves much of the responsibility for approving adoptions with front-line workers…”

Conclusion

The discord among organizations that play an important role in the transracial adoption process leaves much of the responsibility for approving adoptions with front-line workers who may not have the background or training to make the right decision.

Carbon Krupica MSW, RSW has been a clinical social worker and psychotherapist for over 13 years. She holds certificates in Parenting Capacity Assessment and CBT, and is completing her final (fourth) year in the Toronto Child Psychoanalytic Program. Caroline and her husband are proud parents of six biracial children. In presenting this history of transracial adoption, Caroline recalled a variety of interactions she and her husband had as a mixed race couple considering adoption. She has experienced presuppositions held by some adoption workers, and ways that race matching in the adoption of black and biracial infants might be influenced by them.

References

Drummond v. Fulton County Department of Family and Children’s Services et al., 563 F.2d 1200 (5th Cir.1977).
Table 1. Recommendations for stakeholders of transracial adoption, excerpted and combined under three constructs of cultural competence (after Vonk, 2001).

**Racial Awareness**

Self-awareness about:

- the influence of my own cultural background on my thoughts, speech and actions
- my feelings and attitudes about my child’s race and birth culture and the need to examine and change my own stereotypes, preconceived notions and racial prejudice
- my feelings about interracial dating and marriage
- my motivation to adopt outside of my race and culture
- my extra responsibilities as a parent

**Multicultural Planning**

Providing my child regular contact with his/her birth culture:

- in daily life, school and community services
- including sustained contact with good role models such as friends, skilled teachers and other adults and families
- via language, music and visiting the community and/or country of the child’s cultural heritage

**Survival Skills**

Parental learning and teaching:

- how, where and why children may encounter the reality of racism and preparing children for exposure
- coping strategies for children to manage themselves and others when exposed to racism or discrimination
- family strategies to manage insensitive questions and remarks by strangers
- seeking peer support and guidance for all family members via contact with other multiracial families
- validating a child’s hurt and anger, while assuring the child that others’ behaviour does not result from, or reflect, personal shortcomings of the child
- how to anticipate and manage attempts by the child to alter his/her physical appearance
I believe there is a significant and qualitative difference between helping a client get better versus helping them feel better. Further, I believe therapists sometimes encourage or allow irrational and/or magical thinking at the expense of long-term emotional health. Therapists justify this approach as “working within the client’s belief system.” The question then becomes: is it a good idea to work within the client’s belief system?

I would like to argue that most of the time, the answer is an emphatic “No!”

An example of working with belief systems would be telling deeply religious clients that there ARE guardian angels protecting them from harm, in an effort to calm their anxiety. Many therapists may do this because they also believe in the protection of angels or any of myriad unconfirmed claims. However, would you want your family physician to provide anti-spell medication for those patients who believe in voodoo?

It seems fundamental that part of providing good therapy is teaching the client to minimize future psychological, emotional, or behavioural pitfalls and to help the client avoid repeating past mistakes. Teaching clients to think rationally and live in accordance with reality is protective. While not always fun or comforting, it is functional.

I believe it is usually the clients’ belief system that has driven them to your office in the first place. Whether they believe they are worthless, or they can’t succeed because they have lost a job, or that they are unlovable because they have been rejected, it is a flawed belief system that is the primary, and maybe the only controllable source of their distress.

More often than not, some aspect of the client’s thinking is illogical, irrational, unrealistic, or problematic. If a client is fearful because he lost his lucky rabbit’s foot, the therapist could provide a quick and easy solution: buy another rabbit’s foot. What’s the harm if it resolves the anxiety issue?

When Steve Jobs, the late co-founder and CEO of Apple Inc., was diagnosed with cancer, he initially refused medical treatment believing that eating properly, vitamins, positive thinking, and meditation would cure him. His type of cancer has a 95% cure rate and some doctors have suggested his decision not to get treatment led to an untimely and early death.

Far too often clients make off-handed comments, such as denying climate change, believing in Bigfoot, alien abductions, past lives, psychic healing, and ghosts. These beliefs very often go unchallenged by therapists who may even share the beliefs. This kind of thinking on the part of the client suggests a poor reasoning process and poor reasoning tends to produce flawed choices.

Sloppy, irrational, or superstitious thinking is often simply a bad habit and if left unaddressed may produce future emotional or behavioural problems. By teaching clients the basics of rational, skeptical, and scientific thinking, the therapist can help them...
begin to analyze and therefore make better judgments in new or novel situations. Charles Darwin said, “To kill an error is as good a service as, and sometimes even better than, the establishing of a new truth or fact.” It seems to me that good therapists actively seek out “cognitive dragons” to slay. This is protective for the client.

For more than two decades, I’ve asked clients to keep an open mind, to explore and seek out the truth, to remember that our thinking can be flawed, that we can be misled, and that we can misperceive, misunderstand, and misinterpret. We can easily come to wrong conclusions. It’s important to be vigilant about our thinking process by challenging assumptions and claims that we or others make.

As therapists we would be wise to take this advice as well as to provide it to our clients: Take nothing on faith. While scientific research does not explain everything, I feel it is prudent to use what we know to be true while investigating what is still unknown. Carl Sagan, astrophysicist and Nobel Prize winner said, “For me, it is far better to grasp the Universe as it really is than to persist in delusion, however satisfying and reassuring.”

It is my position that we, in this honourable profession, need to elevate the level of discourse and call on each other to find ways of challenging our client’s irrational and unscientific thinking, as well as our own.

**Ed. Note:** The opinions expressed in this column are not the official position of the OACCPP. If you would like to comment immediately on this article, [CLICK HERE](#) and we will use some of your comments in the next issue.
What does it mean to be ethical? When we are being ethical, we are operating in a way that attempts to consider all relevant perspectives (e.g., client, client’s family, therapist, employer, society) and to weigh these perspectives morally, in a principled and balanced way. It is not by accident that we say being ethical, because ethical practice is a process, a way of being, rather than something that someone does.

This new ethics column is being offered to readers of Psychologica with three main intentions:

1. to stimulate mindful self-reflection by members on ethical practice;
2. to provoke discussion, including on the OACCPP web site, about practical ways that members are handling some of these issues; and
3. to encourage continuing exploration of complex ethical issues that challenge and stretch us in our work.

E-therapy: What’s to Consider?

Introduction

Technology has been one of the most pervasive social influences of the past decade. As various forms of technology have infiltrated our lives, including our professional practices, they have forced us to take a stand on how to perceive and use these advances rather than to question if we are to use them, as if there were a clear-cut “yes” or “no” to their inclusion. The increased availability of smart phones, laptop computers, tablet devices and wireless Internet access has allowed more of our time than ever before to be spent online. Increased online use has brought issues and questions to our professional doorsteps that cannot be ignored, for to do so could be unethical. In this article which launches the new “Practical Ethics” column, we will examine some of the issues attached to what many may consider to be the embodiment of technology’s impact on therapy and counselling: e-therapy.

What do we mean by e-therapy? There are many published definitions, and many are accompanied by an acknowledgment that what we mean by e-therapy is still evolving with ongoing professional debate and developments in both technology and the law. Even the way we refer to the practice has many synonyms, e.g., electronic practice, Internet-based psychotherapy, telemental health, behavioural telehealth, and so forth. Table 1 contains some recent attempts to define, describe, and delineate the practice of e-therapy, including our own version from the OACCPP Standards of Practice (2012). Because there are differences in what people include or exclude under the heading of e-therapy, discussions about the associated benefits, risks, effectiveness, legalities and other issues, including ethical issues, must also be qualified. As a further caveat, some authors and investigators derive financial benefit from software applications used in e-therapy, so the author disclosures and funding sources should be examined carefully when reading reports about specific applications of e-therapy.

In this article, we will emphasize forms of e-therapy where a trained mental health practitioner is directly involved with the client(s), whether in real time (synchronously, as in chats, videoconferences, and virtual reality programs) or within an agreed-upon time frame (asynchronously, as in providing an e-mail reply within 48 hours). Computer-mediated applications intended to be carried out without interaction with a therapist will be mentioned secondarily, although many have been shown to be helpful in assessment or as adjuncts to traditional face-to-face therapy.
History

To locate the Internet within the much longer history of mental health interventions, research within the U.S. Department of Defense in 1969 has been cited as the progenitor of the Internet we know and use today (Childress & Asamen, 1998).

Possibly only the most visionary developers could have imagined the scope of Internet-mediated applications we now consider necessary. Interestingly, even the potential usefulness of telephone technology was lost on some industry insiders who were distracted by their own vested interests at the time they first encountered it. When Alexander Graham Bell offered the idea of his telephone device to Chauncey M. DePew, president of the Telegraph Company, DePew’s committee-informed response was that it was “idiotic,” “extravagant,” and “impractical” and would never replace the telegraph. By 1925, there were 12 million business and home telephones in operation (Grayson, n.d.).

Attempts to use computers in psychotherapy have been described as reflecting four waves of psychotherapeutic thought: client-centered, behavioural, psycho-educational, and cognitive and cognitive-behavioural. Applications within the waves, respectively, have included: (1) therapist-client dialogue simulation; (2) exposure or desensitization plus training; (3) cognitive restructuring, problem solving, and coping; and (4) a combination of methods used in cognitive behavioural therapy (CBT) via multimedia (Cavanagh, Zack, Shapiro, & Wright, 2003, as cited in Cavanagh & Shapiro, 2004).

Applications and Disorders

At the time of their review of the use of computers and the Internet for psychological treatment, Tate and Zabinski (2003) concluded that most applications were cognitive-behavioural or purely behavioural. They categorized the existing applications in three ways: (1) little or no therapist contact, (2) communication with providers (synchronous or asynchronous), and (3) as adjuncts to standard face-to-face therapy. In another review of Internet-based mental health interventions, Ybarra and Eaton (2005) noted that there was symptom alleviation with both self-directed and therapist-led interventions and recommended research methods that are needed to study these modalities. Emmelkamp (2005) reviewed Internet use in mental health, including computerized assessment tools and both stand-alone computer interventions and those with a therapist. Table 2 contains a summary of the e-therapy interventions that were used to treat various disorders and some of the reviewers’ commentary about effectiveness.

Issues Related to E-therapy

Our own Standards of Practice (OACCPP, 2012) highlight some of the issues that need attention when we consider participation in aspects of e-therapy. Verifying client identity (initially and for each exchange), age (age of majority in Ontario is 18) and the capacity to consent to the terms of treatment (e.g., non-crisis) are fundamental among therapist responsibilities. Maintaining the security and privacy of client material may require ongoing, creative diligence on the part of the therapist. At the same time, the reasonable limitations to protecting information transmitted over the Internet must be explained to the client as part of the informed consent process. The Standards of Practice prohibit providing services to clients living in a jurisdiction that requires a license not held by the OACCPP member. Practice standards are described for aspects that are unique to the provision of e-therapy services (managing the terms of payment and asynchronous communication) and are the same as when providing face-to-face services (i.e., record keeping and the need for continuing education to ensure competence). Finally, members are advised to check directly with providers of their malpractice insurance to be clear on their coverage for specific forms of electronic practice.

A variety of other issues have been highlighted in published discussions of e-therapy. These can be grouped under the following headings: benefits and risks, therapeutic relationship, technological/technical aspects, and emergencies.
Benefits and Risks

Rochlen, Zack, and Speyer (2004) summarized some of the benefits and challenges of e-therapy. There may be increased convenience for therapists and clients and for people with limited mobility or limited local access to mental health professionals and services. Likewise, people’s willingness to access mental health services may increase when feelings of stigma and shame are not intensified by visibility in the community or during face-to-face contact. E-therapy clients may be willing to share sensitive material earlier than when face-to-face. Communicating by writing instead of speaking may have a similar effect for some clients. When the messaging is asynchronous, there is more time for reflection and carefully thought-out expression than real-time conversation allows. In fact, many forms of more traditional psychotherapy utilize the therapeutic benefits (e.g., greater client ownership) of expressive writing via means such as journaling, writing assignments, and therapeutic letters. The therapist also may benefit from having some increased time to reflect on how to reply to the client, and the potential to use multimedia may enhance the power of expression for both parties. Finally, mutual online access allows the therapist to work from an almost limitless bank of supplementary resources that the client can access and use with a few clicks.

Under the heading of challenges associated with e-therapy, the same authors (Rochlen et al., 2004) identified some potential limitations to e-therapy approaches. Exchanges based on only text or virtual reality may be more difficult for both clients and therapists to interpret accurately due to the absence of nonverbal cues (although there may be some substitute cues, e.g., choice of avatar and use of emoticons). Communication media involving voice can add dimensions of expression even when there is no video component, but they are most like face-to-face therapy when there is both audio and video, providing the quality of transmission is sufficient for “telepresence” (the feeling of being in someone’s presence without sharing any physical space). Clients with poor ego strength, paranoid tendencies, or poorly developed facility with the written word may fail to connect in e-therapy despite the quality of transmission or earnestness of the therapist. The onus is on the therapist to continually assess if the medium of e-therapy is appropriate for the goals of therapy with particular clients. While the time delay of asynchronous exchanges can be beneficial, it can feed misinterpretations by either party in the absence of other cues, especially in light of potential crisis conditions. Finally, e-therapy can complicate developing an accurate and nuanced sense of a person’s identity, and it has been recommended to build in security steps (e.g., codes and screening questions) that verify the client’s true identity with each exchange, as well as collecting intake information that will facilitate cultural competence and knowledge of basic personal details (Quackenbush & Krasner, 2012).

Therapeutic Relationship

Although there is a widely accepted body of evidence that the quality of the therapeutic relationship has high importance to the outcomes of face-to-face therapy, its importance relative to other factors (e.g., model of change) has not been established yet for e-therapy. Likewise, we have an insufficient understanding of which other factors may support or hinder effectiveness in e-therapy environments. Direct and transferential relationships have been described in case reports (Quackenbush & Krasner, 2012) and reviewed (Rochlen et al., 2004) along with other process aspects between the therapist and client, such as interpretation, self-disclosure, confrontation, homework compliance and counter-transference.

Jerome and Zaylor (2000, p. 478-9) described ways that human communication in interactive televideo applications is experienced “quite differently” than it is in face-to-face interactions. Their commentary extended beyond characteristics of the single psychotherapist-client dyad to online family and group interventions, as well as to non-psychological applications in telehealth. They noted that even in televideo communications, participants in different
locations experience “two separate environments” and cropped ones at that. Some subtleties of face-to-face conversation and informal communication (e.g., glances and side conversations) were less likely to occur in televideo exchanges, and the effects of altered sensory cues on therapeutic process have not been worked out yet. Artifacts (e.g., delay, distortion) in audio and video transmission might obscure these cues even further. The authors made an interesting proposal that maybe we shouldn’t overvalue the collective attributes of our gold standard of face-to-face transmission. Maybe, they suggested, there are hidden advantages to discover among what we may now see as artifacts of televideo communication. Likewise, proxemics were important in the two-dimensional medium of televideo, but they operated differently, with movements (especially movement toward or away from the camera and zoom-ins with the camera or microphone) creating different effects remotely than they did in person. Brightness of ambient light created different effects between the televideo and in-person experience. As a final human factor, clients experienced a reduced power differential with the therapist in a televideo exchange compared to a face-to-face experience, and this might have resulted in greater relaxation and candor.

The potential for meaningful therapeutic (and other) relationship formation has been explored in detail by Gorini, Gaggioli, Vigna, and Riva (2008) in their detailed treatment of shared three-dimensional virtual reality as a means of delivering Internet-based mental health service. They described their experiences with the Second Life© program as “tailored immersive e-therapy whose key factor is interreality,” which they defined as “creation of a hybrid augmented experience merging physical and virtual worlds.” The authors proposed that the co-experience of 3-D virtual worlds may have been superior to more conventional applications like e-mail, chatrooms and videoconferences in terms of greater feelings of presence, facilitated clinical communication, trust between therapists and clients, and greater cohesiveness in group-based therapies. The potential for addiction to virtual world relationships at the expense of in-world relating was noted as one of a number of caveats associated with the influence of the virtual reality format.

Technical and Technological Aspects

It is clear, especially from the aforementioned descriptions of using the Second Life© virtual reality software for e-therapy, that therapists will require considerable technical competence to both leverage the benefits and minimize the hazards associated with its use. In a case report, Quackenbush and Krasner (2012) explored the nature of experience and decision making within a single therapist-client dyad. In the broader treatment of ways that the medium of online virtual reality can be used in e-therapy, Gorini et al. (2008) described methods to create specific media, e.g., targeted psychoeducation for specific disorders (called “islands”). Some existing islands within Second Life© were mentioned for people with Asperger’s syndrome, other forms of autism, cerebral palsy, and agoraphobia. The authors described developing their own island for the prevention and treatment of addiction, along with some of the associated design collaborations and expenses that are required to create and maintain such features. In addition to the technical sophistication of this latter paper, there was obvious energy invested in describing ways to connect virtual experience with useful improvements in lived experience. Likewise, clear respect for all of the stakeholders of virtual reality e-therapy was obvious throughout their discussion of ethical practice. This paper is a worthwhile and fascinating read for its discussion of applications within telehealth, even for practitioners with no active plans to participate in e-therapy. [The full text is accessible via pasting the doi into your browser of choice.]

Emergencies and Safety

Computer-based interfaces with clients pose risks for both clients and therapists, partly due to the added complexity of verifying that one is interacting with the correct person in a known location, as well as limiting
access to the interaction by unintended others (e.g., fraudulent therapists or questionably intentioned people, both known and unknown to either party).

While it has been recommended to explain as part of the informed consent process that e-therapy is not appropriate as crisis therapy, some authors also recommend routinely applying further safeguards. For example, the therapist may provide the client with information about locally accessible crisis management resources and personnel, and offer to facilitate a referral, should the need arise, for protection from self- or other-directed harm (Manhal-Baugus, 2001; Childress & Asamen, 1998).

**Ethical Guidelines and Codes Relating to E-therapy**

Since at least the mid-1990s, people have considered the ethical implications of providing mental health services supported by, or conducted exclusively via, electronic devices. While some authors (Humphreys, Winzelberg, & Klaw, 2000; Koocher & Morray, 2000) have noted that developments in technology and its applications tend to outstrip development of ethical guidelines, there is a significant bank of published codes to guide our professional practice beyond the content of the OACCPP’s Code of Ethics (2012) and Standards of Practice (2012), and all of these continue to evolve. They are too extensive to summarize here, but readers might be interested in sources that contain commentary on existing or developing ethical guidelines of professional bodies (Manhal-Baugus, 2001; Hsiung, 2001; and Serafini, Damianakis, & Marziali, 2007) or that offer their own set of guidelines or perspectives to inform them (Hauptman, 1996; Myers & Miller, 1996; Dever Fitzgerald et al., 2010; Childress & Asamen, 1998; and Koocher & Morray, 2000). In addition to keyword-guided literature searches, readers can access existing ethical codes and practice standards concerning e-therapy by searching the web pages of most mental health organizations and associations.

In this article, we have tried to serve up more of a thought starter than an exhaustive review of the ethical and other issues facing us as we consider our evolving relationships with e-therapy. Studies and reports on new applications from 2012 alone make for a large, rapidly moving, and fascinating body of work.

**Questions to seed discussion:**

1. What aspects of e-therapy are you currently practicing?
2. What is the most common or most problematic ethical issue you encounter in this work?
3. How are you managing this issue and what informs you in managing it?

If you would like to comment immediately on this article, [CLICK HERE](http://www.oaccpp.ca) and we will use some of your comments in the next issue.
References


<table>
<thead>
<tr>
<th>Definition and Commentary</th>
<th>Source</th>
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<tbody>
<tr>
<td>The provision of mental health services (assessment, treatment, or other intervention) via electronic means rather than standard in-person methods.</td>
<td>OACCPP (2012)</td>
</tr>
<tr>
<td>Delivery may be synchronous [i.e., in real time] or asynchronous, used as adjuncts to face-to-face interactions or as the sole means of providing mental health services.</td>
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<td>Includes: telephone; teleconferencing; e-mail; text messaging; Internet-based voice, video, instant messaging, or videoconferencing (including Voice Over Internet Protocol - VoIP); social media; or other media.</td>
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<td>The same standards of practice and ethical guidelines should be observed as for in-person mental health services. There are some additional considerations connected with electronic practice.</td>
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<td>A computer-based environment that can simulate physical presence in places in the real world, as well as in imaginary worlds.</td>
<td>Quackenbush &amp; Krasner (2012)</td>
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<td>Therapy was typically provided in a virtual office, just as it would have been had it taken place in the physical world. [This is a case report of psychotherapy conducted within a virtual reality program called Second Life ©. The therapist and client communicated via avatars, primarily using text messaging, with telephone and Skype added near the end of therapeutic contact.]</td>
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<tr>
<td>Internet-based psychotherapy provided through web pages and, self-help materials.</td>
<td>Dever Fitzgerald, Hunter, Hadjistavropoulos, &amp; Koocher (2010)</td>
</tr>
<tr>
<td>Involves varying degrees of therapist contact (e.g., via e-mail, videoconferencing and telephone).</td>
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<td>The use of electronic communications technology to eliminate or reduce geographic barriers to receiving psychiatric and other mental health services.</td>
<td>Hailey, Roine, &amp; Ohinmaa (2008)</td>
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<tr>
<td>Includes the use of any form of communication technology.</td>
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<td>Applied to services for management of alcohol and substance abuse, eating disorders, and smoking prevention.</td>
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<tr>
<td>All forms of electronic mental health services delivered over the Internet, including informational and educational products as well as direct services offered by professionals.</td>
<td>Ybarra &amp; Eaton (2005)</td>
</tr>
<tr>
<td>Online interventions range from passive (e.g., informational web sites) to active (e.g., therapist-moderated cognitive behavioral therapy).</td>
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<tr>
<td>Any type of professional therapeutic interaction that makes use of the Internet to connect qualified mental health professionals and their clients.</td>
<td>Rochlen, Zack, &amp; Speyer (2004)</td>
</tr>
<tr>
<td>An online therapist is defined as any qualified mental health professional that uses the Internet as a medium for practice.</td>
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<tr>
<td>The process of interacting with a therapist online in ongoing conversations over time when the client and counselor are in separate or remote locations and utilize electronic means to communicate with each other.</td>
<td>Manhal-Baugus (2001)</td>
</tr>
<tr>
<td>E-therapy is flexible enough to also address many difficulties that clients present to the online therapist. As in other types of therapy, such as bibliotherapy, occupational therapy, and rehabilitation therapy, e-therapy does assist a person in addressing specific concerns with specific skills.</td>
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</table>
- E-therapists are very different from the “one question,” “information,” or “advice” services. E-therapy is about forming a relationship with a trained counselor.

- Bulletin boards, chat rooms, news and discussion groups operated within health-related web pages, listservs, and other electronic forums focused on social, health, and psychological issues. Humphreys, Winzelberg, & Klaw (2000)

- Some are unstructured discussion groups, others have a professional facilitator and an “ask the expert” format, while others are self-help groups led by an individual (usually a nonprofessional) who shares the problem that the group addresses.

- Members or individuals simply come and go as they please, without their presence or identification being monitored in any way.

**Table 2**

*Reviews of Internet-Based Mental Health Interventions with Commentary on Effectiveness.*

<table>
<thead>
<tr>
<th>Application Type with Disorder or Indication</th>
<th>Outcomes</th>
<th>Reviewers*</th>
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<tr>
<td>Self-help: Headache, depression, anxiety, physical activity promotion</td>
<td>Authors concluded that evidence for the effectiveness of internet use was strongest for: 1. clients submitting behavioural assignments, 2. getting social support from peers, and 3. getting education, feedback and support from the therapist. Client disengagement could be a problem with automated, strictly psychoeducational sites, especially when not tailored to the client’s situation by interactive exchange. Interactivity with a web site also can allow for stepped care, matching the intensity of support needed with that provided. Asynchronous communication interventions “...have shown positive effects across multiple disorders and populations.” Synchronous communication interventions “...can be very helpful in achieving therapeutic goals,” although slow typists may be at a disadvantage, especially in a group setting. Clients reported positive effects associated with having internet contact as an adjunct to face-to-face therapy; they felt they had more access to the therapist, and felt more accountable to do their self-monitoring.</td>
<td>Tate &amp; Zabinski (2003)</td>
</tr>
<tr>
<td>Asynchronous (peers or therapist): Sexual abuse, suicide, depression, cancer, disabilities, eating disorders, elder cognitive and mood disorders</td>
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<tr>
<td>Asynchronous (therapist): Weight loss and maintenance, posttraumatic stress, grief</td>
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<tr>
<td>Synchronous (peers or therapist): Eating disorder-related body image</td>
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<td>Periodic behavioural self-assessments used as adjuncts to standard face-to-face therapy: Binge eating, anxiety (phobias, social phobia, panic), exposure and desensitization (PTSD, combat trauma)</td>
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<tr>
<td>Educational websites, screening tools: Depression, suicidal ideation</td>
<td>There has been alleviation of symptoms with both self-directed and therapist-led interventions. Authors recommended: 1. greater overall utilization of the internet in mental health; 2. study design guidelines for research into internet interventions;</td>
<td>Ybarra &amp; Eaton (2005)</td>
</tr>
<tr>
<td>Online support groups: Depression, anxiety, suicide</td>
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</tr>
<tr>
<td>Individual therapy: PTSD$^b$ and other disorders</td>
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</tbody>
</table>
- Group therapy: Eating disorders
- Computerized screening vs. in-person paper testing: Panic attacks, anxiety, depression, substance abuse
- Computerized screening vs. structured interviewing: Anxiety disorders, major depression, substance abuse
- Stand-alone computer treatment (program determines and delivers feedback to client): Phobias, panic, depression, OCD, anxiety, problem drinking
- Psychoeducation and e-mail or writing assignments: PTSD, burnout, work-related stress
- Virtual reality modified by therapist in real time: Anxiety disorders, specific phobias, social phobia, PTSD
- Virtual reality exposure: Eating disorders, obesity, male sexual dysfunction, nicotine addiction, opioid dependence, management of: pain, palliative care, rehabilitation, dementia, ADHD

A number of studies, including some RCTs, have shown comparable effectiveness between face-to-face therapy and both stand-alone computer treatment and interactive virtual reality for many, but not all disorders. Particularly, virtual reality technology for exposure has been effective in treatment of specific phobias.

Online assessment has been shown to have comparable psychometric properties, and may have several advantages over clinician-administered tests and interviews conducted in person.

Use of the internet can offer clients more tailor-made treatment, including feedback from therapists.

Effectiveness criteria are needed that are more rigorous than client self-report to assess comparative effectiveness of different treatment modalities.

Author opines that the greatest resistance to therapy delivered via the internet and virtual reality comes from clinicians, and that “most” clients find computer interaction highly acceptable, although the early dropout rates may be higher than for face-to-face therapy.

Emmelkamp (2005)

See the full text reviews for the specific studies describing these interventions.

PTSD (posttraumatic stress disorder), OCD (obsessive-compulsive disorder), and ADHD (attention-deficit hyperactivity disorder)

RCTs (randomized controlled trials)

If you would like to review a book for Psychologica (we may be able to provide you with a complimentary copy) or get your book reviewed, let us know.

E-mail publications@oaccpp.ca
A Pathway to the Use of MRIs in the Diagnosis of Psychiatric Disorders
by Sebastiano Fazzari, Ph.D.
Thoppil Abraham, M.D.
Sean Robb, Graduate Student

Introduction
When people seek treatment with a psychiatrist, more often than not they have been referred by a family physician. The referring clinician may assume that the psychiatrist will use various tests to make a diagnosis and determine a treatment plan. These tests might include blood tests, EEGs, imaging, standardized instruments, or other instruments that are more accessible to a specialist compared to a generalist.

The psychiatrist also may be operating from the assumption that the referring agent has made use of tests that would warrant a referral to a specialist. When clinicians operate under these assumptions, the patient/client may not receive the most appropriate diagnosis and treatment.

The author’s hope, using a diagnosis of depression as an example, to present a better and more consistent approach to treatment when more than one clinician is involved.

Assessment
If an individual is being referred for a psycho-educational assessment the clinician will follow a certain standardized process that includes (Groth-Marnat, 2003):

- evaluating the nature and extent of an individual’s learning difficulties;
- measuring intellectual strengths and weaknesses;
- assessing behavioural difficulties;
- creating an educational plan that is sensitive to the individual’s ability, personality, and the characteristics of the environment;
- estimating an individual’s responsiveness to intervention; and
- recommending changes in an individual’s program or placement.

On the other hand, if an individual is being referred for a psychological assessment, it is understood that the following parameters are used (Groth-Marnat, 2003):

- the use of clinical checklists;
- a semi-structured clinical interview;
- a cognitive assessment using standardized instruments;
- a personality assessment using standardized instruments;
- estimating the individual’s responsiveness to intervention; and
- a recommended treatment modality that will address issues identified

If an individual is referred for a neuropsychological evaluation, the following steps seem to be an accepted process (Lezak, Howieson, Bigler, & Tranel, 2012):

- Based on the referral question, the patient’s social history and present life circumstances would be examined, including behavioural observations.
- There would be an investigation and examination of medical history and current medical status.
- The clinician would then identify, select and administer appropriate neuropsychological batteries, score and interpret the results, and provide recommendations for treatment.

Some individuals are referred for medical reasons. Studies indicate that approximately 25 to 50% of individuals with medical problems show comorbidity with emotional/psychiatric disorders. In these cases, the following procedures are generally used (Groth-Marnat, 2003):

- identification of an underlying psychological disorder or possible emotional factors associated with medical complaints;
• assessment of neuropsychological deficits;
• if applicable, a psychological assessment for chronic pain or chemical dependency;
• laboratory screening to rule out thyroid and adrenal dysfunctions, electrolyte imbalances, B-12 and folate deficiencies, prolactin, testosterone, progesterone, and estrogen imbalances; and
• based on findings, identification of treatment that addresses psychosocial difficulties and any underlying psychological or neuropathology.

Even when there are procedures for establishing diagnoses, the assessing clinicians often arrive at different conclusions. Some possible reasons for this discrepancy include:

• different assessment methodologies,
• heterogeneity of the symptoms presented, including the variability and the appearance of the symptoms as well as the course they follow;
• bias of the assessing clinician;
• the motives of the individual being assessed, (some individuals seek assessment due to secondary gains and may either feign symptoms or exaggerate them); and
• false positive and false negative results which can lead to over- or under-diagnosing.

Until recently, psychiatrists would conduct an assessment using a clinical interview. Based on the clinical interview, a psychiatrist would then communicate a diagnosis and would prescribe psychopharmacological treatments based on best practice guidelines. Often psychiatrists conducting these assessments are “under the gun.” They may find themselves in environments without any resources or with insufficient time to use state-of-the-art technology or modalities. There also may be financial restraints that prevent a psychiatrist from using state-of-the-art technology.

“…while other branches of medicine use biomarkers to determine a diagnosis, psychiatrists have relied mostly on their clinical skills and judgments, often prescribing medications that affect brain functioning.”

There is also the possibility that conditioning may influence a psychiatrist to use a particular methodology in assessing individuals. On the positive side, familiarity with a methodology can reduce or eliminate errors. On the negative side, familiarity may cause one to stop looking beyond a certain threshold.

In completing an evaluation, it is preferable that clinicians rule out organic causes first. Neither psychiatry nor psychology has made it standard practice to utilize technology available to them to look at potential organic causes. There seems to be a preference to see the issues as “psychological” in nature. Therefore, while other branches of medicine use biomarkers to determine a diagnosis, psychiatrists have relied mostly on their clinical skills and judgments, often prescribing medications that affect brain functioning. Why would anyone want to follow this practice without supportive biomarkers?

Protocols Revisited

A clinician would be wise to make use of readily available checklists and standardized instruments that purport to assess cognitive and conative issues. The better instruments such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Personality Assessment Inventory (PAI) have scales that address severity of syndromes. They also address the issue of prognosis. Given that a number of major meta-analyses indicate that psychopharmacological compounds are not warranted in mild and moderate cases of depression (Fournier et al., 2010; Naudel, Maria, & Falissard, 2011), it would be wise to use standardized instruments to determine the level of depression and not simply rely on professional clinical opinion.

“These alarming statistics suggest that approximately 20% of individuals diagnosed with major depression do not respond to any psychiatric treatment provided…”

In addition, a number of empirical studies, including a major multi-centre, randomized control longitudinal study, called Sequenced Treatment Alternative To Relieve Depression (STAR*D), with over 4000 patients suggests that remission rates (50% or greater reduction in symptoms from baseline) following non-psychotic major depressive episodes is between 40-50% using either a first line psychopharmacological compound or a depression-targeted psychotherapy technique (Perlis et al., 2005; Rush et al., 2004). These same studies indicate that a further 20-30% will respond to treatment, but still have underlying residual debilitating symptoms (Fava & Davidson, 1996; Rush et al., 2004).

These alarming statistics suggest that approximately 20% of individuals diagnosed with major depression do not respond to any psychiatric treatment provided (Nemeroff, 2007). Perhaps other neurological/organic etiologies may account for some individuals who report depressive symptomatology, a confound within the literature that is often left unaddressed.
The proposed protocol is designed to assist clinicians in differentiating other medical etiologies from psychiatric etiologies for psychiatric complaints as well as more accurately characterizing psychopathology severity so that treatment can follow accordingly.

Based on the referral questions, a multidisciplinary team would adhere to the administration of the following instruments:

1. age-appropriate problems checklists;
2. personal history and developmental history checklist;
3. age-appropriate mental status checklists;
4. age-appropriate health problems checklists;
5. self-report questionnaire designed to screen for the DSM-IV Axis I disorders most commonly encountered in medical and outpatient mental health settings;
6. instrument assessing cognitive functioning (i.e., executive function, attention, memory);
7. instrument assessing normal and abnormal personality;
8. instrument assessing psychopathology (phenomenology);
9. quick neurological screening test;
10. semi-structured interview;
11. if warranted, use of electroencephalograms (EEGs); and
12. if warranted, use of Magnetic Resonance Imaging (MRI).

The Organic Correlates of Depression

A variety of disorders are accompanied by depressive symptoms. Much of the literature has illustrated that depressive symptoms are often an early presenting complaint of individuals with underlying demyelinating diseases (e.g., multiple sclerosis; Feinstein, 2011), neurodegenerative disorders (e.g., Parkinson’s disease, Alzheimer’s disease, Dementia with Lewy bodies, Huntington’s disease, and frontotemporal dementia; Riedel et al., 2010; Wuwongse et al., 2010); carcinomas/paraneoplastic syndromes such as brain tumors, small-cell lung cancer, and pancreatic cancer (Benros, Lauresen, Dalton, & Mortensen, 2009); and endocrinological disorder (e.g., hypothalamus, pituitary, adrenal [HPA Axis], thyroid, parathyroid, and reproductive organs).

The physical symptoms of depression involve what is referred to in the literature as the vegetative signs of depression: sleep problems, appetite problems, and lack of energy and drive (Morey, 2003). Usually, the individual presents with a diminished level of physical functioning, a disturbance in sleep patterns, a decrease in energy and level of sexual interest, and a loss of appetite and/or weight. The individual also may present with a slowing of psychomotor activity. The lack of energy may explain the difficulty in overcoming the inertia which is obstructing participation in most activities (Morey, 2003). Since elevations in depression scales could reflect distress secondary to other conditions such as anxiety disorders, posttraumatic stress disorder, somatoform disorder, post-partum disorder, substance abuse, and schizophrenia, it is imperative that the specialist clinician use instruments to rule out these other disorders.

Use of proper instruments allows the specialist clinician to arrive at a more precise diagnosis and consequently at a more precise treatment regimen. For example, if the DEP-C subscale on the PAI is elevated it suggests that the individual is likely to be experiencing distorted thoughts surrounding his/her self-efficacy (Morey, 2003); targeting this form of depression with cognitive therapy would be an appropriate intervention. However, if the DEP-P subscale is elevated indicating a vegetative state, a more responsive treatment would be second generation antidepressant medication and/or second generation mood stabilizers.

One way of ruling out organic/neurological etiology of depression from social-emotional causes is with the use of structural neuroimaging, which encompasses a wide variety of techniques, including computed axial tomography (CT) and magnetic resonance imaging (MRI). While the specifics of these methodologies are discussed elsewhere (see Atlas, 2009 for full review), structural imaging techniques, and particularly that of MRI and more modern MR techniques such as diffusion tensor imaging (DTI) have provided substantial insight into the underlying morphological correlates of psychopathology (Atlas, 2009; Ellison-Wright & Bullmore, 2008; Lorenzetti, Allen, Fornito, & Yucel, 2009; Soares & Mann, 1998). Unfortunately, this insight has not yet been translated into clinically reliable biomarkers for psychopathology at the individual level (First et al., 2012). Despite current limitations within neuroimaging methodology, MR techniques are able to provide clinicians with the capacity to exclude a number of gross morphological etiologies for presenting psychiatric symptoms, such as hematomas, hydrocephalus, neoplasms, cerebrovascular diseases and neural atrophy (First et al., 2012). Many of the conditions described (i.e., demyelinating or neurodegenerative diseases) often remain...
undiagnosed until they are accompanied by additional more prototypical sequelae, signaling advancement of the condition and consequently reduced treatment efficacy. Utilization of MR technology could rule out other organic/medical etiological considerations for depressive symptoms.

Functional Neuroimaging

Recently, the advent of functional neuroimaging has brought in a whole new way of examining the brain, by examining the functional activity of cells within the central nervous system as a means of identifying etiological contributions to psychopathology. Functional imaging methodologies include a variety of techniques, including positron emission tomography (PET), magnetoencephalography (MEG) and functional MRI (fMRI). Similar to structural imaging techniques, these technologies have not yet translated into clinically reliable biomarkers for diagnostic purposes of psychopathology at the individual level, despite providing substantial insight into diseases/disorders at the group level of analysis (First et al., 2012).

While functional imaging techniques have not illustrated clinical utility in diagnostics, its utilization in the prediction of individuals who will and will not respond to psychopharmacological treatment in depression has been reported in a number of studies (Ebert et al., 1994; Mayberg et al., 1997; Mulert et al., 2007). It was found that higher resting metabolic rates within the anterior cingulate cortex (ACC) were associated with increased response to antidepressant medication, particularly that of selective-serotonin re-uptake inhibitors (SSRIs; Mayberg et al., 1997; Mulert et al., 2007). The cingulate cortex typically is differentiated anatomically and functionally into a number of different regions (Kolb & Whishaw, 2009). While dorsal portions of this structure have been implicated in a number of cognitive functions, such as performance monitoring (i.e., the self-identification of errors, etc.; Devinsky, Morrell, & Vogt, 1995), anterior portions of the cingulate cortex have been implicated highly in emotional regulation, assigning emotional states to internal and external stimuli, as well as assessing motivational content (Devinsky et al., 1995; Mulert et al., 2007). Consequently, this structure has been particularly implicated in the pathophysiology of depression (Ebert & Ebmeier, 1996; Mulert et al., 2007), and increased resting state activation may reflect an underlying neurocorrelate that is susceptible to psychopharmacological intervention (Mulert et al., 2007).

In addition to the use of functional neuroimaging as a means of differentiating responders from non-responders in the psychopharmacological treatment of major depression, the use of loudness-dependent auditory-evoked potentials have also shown considerable predictive capacity (Mulert et al., 2007). These evoked potentials are EEG phenomena that follow increasingly loud auditory tones, and this electrical response has been related inversely to serotonergic activity; that is, the larger the amplitude of this evoked potential, the lower the serotonergic activity. These findings have been illustrated both within the experimental animal literature as well as the correlational human literature (Juckel, Hegerl, Molnar, Csepe, & Karmos, 1999; Hegerl & Juckel, 1993). This may provide insight into the degree that the serotonergic system is implicated in the pathophysiology of an individual’s depressive symptoms, and consequently how efficacious antidepressants that target these systems will be in a given situation. Mulert et al. (2007) have suggested that utilization of both these predictive techniques together would provide considerable information to clinicians about patient prognosis and how aggressive treatment should be. While this finding requires additional replication, it provides preliminary evidence for the utilization of both fMRI and event related potentials within the clinical environment.

The authors are not suggesting that what has been done in the past to diagnose depression is to be forgotten or eliminated. For example, the dexamethasone suppression test which was very popular in the 1970s to differentiate clinical depression from non-clinical depression is presently underutilized. This test also enables the clinician to assess HPA Axis dysfunctions. We are, however, strongly suggesting that technology has been greatly underutilized and that whenever pharmacological
agents are being prescribed, which implies that major depressive symptoms are present at a clinically high range, MRIs could be used to rule out other causes for these symptoms.

**Diagnosis**

We recognize that psychiatry and psychology are inexact sciences; hence a diagnosis based on symptomatology alone is not evidence based. In addition, symptoms alone do not manifest a specific psychopathology. For example, insomnia and a change in appetite are not solely symptoms of depression.

In order to arrive at a diagnosis, clinicians are encouraged to examine the results from the criteria listed under the Protocol Revisited section. Arriving at a diagnostic statement is a process that is both complex and time consuming.

Adequate history taking should include:

- presenting symptoms,
- history of the present illness,
- past psychiatric history,
- past medical history,
- personal history,
- premorbid personality style, and
- a mental status examination.

A traditional mental status examination would consider general appearance, attitude, speech, mood and affect, behaviour, thought process, delusions and hallucinations, suicidal ideations along with any previous history of suicide attempts, insights, motivations and judgments.

The clinician is encouraged to have a descriptive formulation, an etiological formulation, and a diagnostic formulation using DSM-IV TR criteria or ICD criteria. Usually, a diagnosis of Major Depression is given when an individual is experiencing one of the following: (a) a feeling of depression or sadness most of the day; or (b) a loss of interest or an inability to experience pleasure from the activities or most of the activities that were previously considered enjoyable. In addition, four of the following symptoms need also to be present for at least a two-week period in a manner that differs from the usual way of functioning (American Psychiatric Association, 2000):

- Significant weight loss when not dieting; or weight gain; or a decrease or increase in appetite nearly every day.
- Difficulty sleeping through the night or the need to sleep more during the day.
- A noticeable slowing down or noticeable agitation throughout the day.
- A feeling of being fatigued or a loss of energy nearly every day.
- Feelings of worthlessness, hopelessness, and helplessness or extreme or inappropriate feelings of guilt.
- Difficulties concentrating or having an inability to think or an inability to make decisions.
- Recurring thoughts of death or ideas about suicide with or without a specific plan or a suicide attempt.

Fifty years ago, on average, an individual first became afflicted with depression at around forty or fifty years of age. These days depression is often seen in the mid-twenties and, in some cases, in late childhood or adolescence. In addition, 50% of individuals with depression find that it returns, despite what appeared to have been a full recovery. Furthermore, after a second or third episode, the risk of recurrence rises to 80-90% (Williams, Teasdale, Segal, & Kabat-Zinn, 2007). Interestingly, approximately 5% of the population suffers from a major depressive episode at any given time. Sometimes, depression persists—15 to 39% of cases—even one year after the onset of symptoms; 22% of the cases remain depressed two years later. Each episode of depression increases the chances that the individual will experience another episode by 16% (Williams et al., 2007).

**Treatment Considerations**

Given that the disorders are multi-factorial, meaning that they have a bio-psycho-social etiology, the authors recommend an interdisciplinary approach. Understandably, the treatment will depend on the etiology, the pathophysiology, and psychopathology (phenomenology). For example, should demyelinating or white matter lesions be found on the MRI, which is indicative of MS, treatment would likely consist of interferon therapy. If this patient also
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**References**


PRACTICE MADE PERFECT: ADVICE FOR THE SELF-EMPLOYED
An ongoing column hosted by a local practitioner

WHAT ARE SOME OF THE PROS AND CONS OF OPERATING A HOME OFFICE?

PROS

- **Enhanced Trust.** Despite many clinical studies on home office and client trust, none have been conclusive. In my opinion, a home office where clients attend counselling sessions is more conducive to quickly developing a therapeutic relationship than a clinical setting. You are trusting the client by sharing some of your personal life at the outset. This heightens their trust toward you and it can begin often at the first counselling session. I have had many clients mention how comfortable they feel. Many first-timers have noted that the counselling session wasn’t as “bad” as they thought it would be and credit this to my comfortable home office.

- **Domestic Upkeep.** A secondary benefit to a home office is the opportunity for increased productivity in-between sessions. My wife, who is domestically challenged, appreciates that she has very few domestic duties due to my working from home. And if you are just starting out in practice, you may have quite a lot of time between clients!

- **Historical precedent.** Freud, Jung, Mahler and Winnicott all practiced from their homes.

- **Low Cost.** Working from home means you do not have to pay rent and do not have additional costs for computers, office support or commuting.

- **Other benefits include:**
  - No line ups for coffee
  - No idle chatter with colleagues
  - No office politics
  - No office romances (except with your partner)
  - No conspiracies to get you fired
  - No company Christmas parties or secret Santa

CONS:

- **Potential Safety Issue.** It’s advisable to get Prevention and Management of Aggressive Behaviour training prior to opening a home office or be selective in the type of client you take (avoid booking clients involved in a high conflict divorce, for instance). When I was offered a contract to counsel people on probation or parole, I insisted that an office be provided due to the nature of the clientele.

- **Orderliness.** The therapy room and the surrounding area must be presentable at all times, and preferably free of personal items. If you aren’t inclined this way, it could be an issue for you.

- **Separate work and home life.** Ideally your work space is completely separate from your living space. My office is the sitting room, to the right of the centre hallway, in a 103 year old Victorian home. The room where you see clients should only be used for clients or for related work such as reports and assessments. Make sure it is only the office and not used in your non-work life. Be sure to have a separate phone line for your business. I stress keeping your home and office lives separate. Blending can be hazardous to your mental health.

- **Restrictions on when you see clients.** It can be tempting to work at all hours of the day and night when you have an office in your home. However, keep to specific hours (Monday to Friday) regardless of clients’
requests/demands. I tell clients who request appointments on the weekend that if I saw clients then I would be seeking marriage counselling. You can also be restricted by the schedules of other family members. I don’t recommend seeing clients when a family member is home, as clients can feel that their conversations are not truly confidential and noises from elsewhere in the house can be distracting both to you and the client.

- **Limited numbers of clients.** I allow for a half-hour between clients to avoid clients meeting each other. I don’t use my living room as a waiting room.

- **Isolation.** During the day all you see are clients, without the socializing benefits of colleagues, co-workers or peers. Be careful not to satisfy some of your social needs with the clients. You cannot become friends with them. During a long day try to check your emails/phone messages and respond to the social ones to create a sense of connection. Call a friend or a partner and debrief after a challenging session. Go outside and chat with a neighbour.

- **Other thoughts.** Don’t claim a portion of your mortgage or property taxes as an office expense. When you sell your home any increase in the value will be taxed as capital gains based on the percentage that you claimed. Do claim heat and hydro, maintenance, supplies, phone, and furniture, but not rent.

It may seem as though there are far more cons than pros to operating a private practice from home. However, I would not have it any other way.

For further information on offering therapy in a home office check [http://www.zurinstitute.com/homeoffice_clinicalupdate.html](http://www.zurinstitute.com/homeoffice_clinicalupdate.html)

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If you would like to comment on this article, [CLICK HERE](http://www.zurinstitute.com/homeoffice_clinicalupdate.html)

If you have questions you would like answered in future issues, please email publications@oaccpp.ca

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