San Gabriel Valley Psychological Association

Analyze This!

The Official Newsletter of the
San Gabriel Valley Psychological Association

www.SGVPA.org AN OFFICIAL CHAPTER OF CALIFORNIA PSYCHOLOGICAL ASSOCIATION January/February 2009

Upcoming Luncheon Meetings

Date: February 6th
Topic: Ancient Explanations for Modern Psychological Maladies: The Therapist's Guide to Evolutionary Psychology
Speaker: Enrico Gnaulati Ph.D.
Date: March 6th
Topic: The Three Dimensions of the Self-Other World: Theoretical and Clinical Considerations
Speaker: Sam Alibrando, Ph.D.

PLEASE RSVP NO LATER THAN THE FIRST MONDAY OF THE MONTH TO SGVPA VOICE MAIL (626)583-3215.
CEU'S available for Psychologists, LCSWs and MFCCs

Monthly luncheons are held the first Friday of the month at the University Club, 175 N. Oakland Avenue, Pasadena, 123:00 p.m. to 1:45 p.m. Lunch $15 members, $20 nonmembers, $5 auditing fee for those who attend without lunch or need CEUs, MCEP units: SGVPA psychologists $15, non-SGVPA member psychologists $25; SGVPA MFT/LCSWs $10, combined $20, non-SGVPA member, MFT/LCSWs $20, combined $30.

PRESIDENT'S MESSAGE

Dear SGVPA Colleagues,

I greet you on a sober note. Professional Psychology is under siege in Sacramento this year. This is not hyperbole, but a sober evaluation of the governor having *re*submitted legislation that would dissolve the Board of Psychology, and create a generic mental health board, overseeing entry level and masters' level psychotherapists as well as psychologists (but not psychiatrists). The effect would be disastrous to the continuation of Psychology as a distinct, doctoral level discipline.

Less abstractly, this legislation would have serious ramifications for our ability to collect fees commensurate with our expertise and training. So I am urging you to join CPA—which is the only voice for organized psychology in the capital—and to contribute your time and money to preserving our profession, and our livelihoods.

Please also remember to renew your SGVPA membership before February 15th, not only to continue receiving this newsletter, using the Listserv, and other benefits of belonging to SGVPA, but to help support our efforts to support Psychology on the local level. Our Governmental Affairs Committee Chair, Dr. Linda Tyrrell, is working hard on local fundraisers and other plans to support policies that promote Psychology and mental health legislation generally. The greater our membership, and the more folks who get involved, the louder our voice and the greater our impact will be.

I hope you enjoy this issue of *Analyze This!* and the thoughtful, informative contributions of several of your colleagues you'll find inside. Some highlights;

- **Analyzing Autistics?** Christina Emmanuel, MFT, explains the value of applying psychoanalytic techniques to the treatment of patients with Autism. (See p. 6)
- **In Praise of Group Therapy!** Dr. Matt Calkins reminds us that this type of treatment is often misunderstood. (See p. 7)
- **Learning More about Learning Disabilities!** Dr. Amanda Han discusses current understanding and clinical insights into working with the learning disabled. (See p.3)

I wish you all success, productivity, happiness, and health in the year ahead!

Suzanne Lake, PsyD
President

Winter Reveling at the Second Annual SGVPA January Jubilee!

Earlier this month, partiers gathered in the magical Chinese courtyard of the Pacific Asia Museum, under star-studded skies and a glowing full moon. Nearly 200 folks enjoyed exotic Asian food, smooth saxophone music, and guided tours of the museum's exquisite galleries.

A highlight was reached when fellow psychologist Judy Chu, current Chair of the State Board of Equalization, addressed us briefly, explaining her concerns for Psychology, and announcing her upcoming run for the newly vacant U.S .Congressional seat vacated by Hilda Solis (who has been nominated to serve as Treasury Secretary by President Obama). Dr. Chu will run in the special elections to be held this March.

Special thanks to JJ co-chairs Drs. Linda Tyrrell and Elisse Blinder, as well as to Membership Committee Chair, Dr. Stephanie Law, and Website Manager, Dr. Amanda Han, for their contributions to this very special event.

To Better Provide Educational Support for Students with Learning Disabilities

By Amanda Han, Psy.D.

Johnny Appleseed, a 15 year-old Caucasian male, is a ninth grader at a local high school. Johnny's parents indicated that Johnny put in maximum effort in his classes but received below average results on his tests. His teacher, Ms. Smith, did not understand the reason Johnny continued to fail most of his classes. Ms. Smith reported that Johnny contributed in class regularly, and he appeared to grasp new concepts quickly. However, Johnny consistently did poorly on tests as if he had not learned any of the new concepts. Johnny often complained about headaches and stomachaches throughout the school year. Johnny isolated himself from his peers and family, and he appeared to be quite depressed.

What will you do for Johnny Appleseed and his concerned parents when they come into your office? The first reaction of a savvy clinical psychologist would probably be to explore Johnny's psycho/social/emotional history and find the cause for Johnny's depression. Secondly, a clinical psychologist would also examine issues related to school placement, teachers, and his peers. Was this the right school for Johnny? Did the teachers dislike him? Was Johnny bullied in school? These questions would usually serve as a first and primary approach to address Johnny's difficulties. A psychoeducational evaluation would normally not be conducted unless it was specifically requested.

According to the National Institute for Literacy, there is a 36% increase in the number of students with specific learning disabilities. Of all the students served under the Individuals with Disability Education Act (IDEA), 50.8% had specific learning disabilities. Based on the 27th Annual Report to Congress 2005, 31.6% of children ages 14 and older with specific learning disability dropped out of high school. Of those who did graduate, less than 2% attended and graduated from a four-year college, despite the fact that many were above average in intelligence. Furthermore, 3% of adults age 16 and over reported having a learning disability. The statistics are startling. People with a learning disability do not "outgrow" it: a learning disability is a life-long issue.

PSYCHOEDUCATIONAL EAVALUTION

Licensed professionals such as clinical psychologists and school psychologists are qualified to administer the diagnostic testing for learning disabilities, commonly known as a psychoeducational evaluation. The evaluation generally takes 15-18 hours to complete, and it includes 6 hours of one-on-one test administration. The standardized measurement typically includes, but not limited to, cognitive, achievement, and processing tests. In order for a student to be diagnosed with a learning disability, standardized test scores for academic achievement must be substantially below expectations with regard to the student's chronological age, intelligence, and age-appropriate education.

RECOMMENDATIONS

Once a student has been identified with a specific learning disability, recommendations will be suggested based on the student's functional limitations. Recommendations may include certain accommodations that will allow the student with learning disability to show the knowledge the student has. These accommodations may include, but not be limited to, allowing enlarged print with extended time on tests, extended time on exams, tape-recorded lectures, a scribe, a reader, a calculator, a distraction-reduced environment for tests, and a supervised break. In addition to receiving the necessary support and accommodations from school, it is just as important that the student with learning disability also learns and develops specific coping skills and compensatory strategies to help deal with difficulties.

EDUCATIONAL THERAPY

Who can provide educational support other than the teachers at school? The first person who comes to mind is usually a private tutor. However, a tutor provides educational assistance to individuals without learning disabilities, and the tutor may not understand individual learning differences and their impact on a student's social and emotional development.

In contrast to tutoring, educational therapy is a clinical practice of providing individualized learning strategies to enhance a student's learning outcome. Educational therapists combine educational and therapeutic approaches for evaluation, remediation, case management, and advocacy/communication on behalf of a student with learning disability. The goal in educational therapy is to diminish the discrepancy between the student's academic potential and level of achievement.

(continued on page 4)

Amanda Han *(continued from page 3)*

CONCLUSION

Students with learning disabilities are not "lazy" or "dumb," but they usually have average or above average intelligence. Often, their cognitive abilities fall within the superior range. Their brains just process information differently.

Through extensive training in Learning Disability Assessment in postdoctoral training, I realized how one's academic achievement and learning styles might impact social and emotional development of the student with learning disability. Therefore, I recommend all clinical psychologists extend their expertise and training in psychoeducational evaluation in order to better identity, educate, advocate, recommend, and make appropriate referrals for clients with learning difficulties. That way, we can more effectively serve our clients and meet their needs.

Calling All Movie Buffs!

After a brief hiatus, SGVPA Movie Nights are back!!

Mark your calendar and join other SGVPA *cine-psycho-philes,* where we will munch snacks, and sip soft drinks and wine, as we screen an excellent film selected for your psychoanalyzing pleasure! A discussion of the film will follow.

Date: Friday, January 30, 2009

Time: Please arrive at 6—Screening will begin promptly at 6:30 p.m.

Location: Home of Dr. Suzanne Lake
875 S. Madison Ave.
Pasadena, Ca 91106

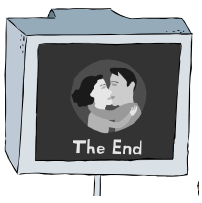
Feature film: "MATCH POINT"

Directed by Woody Allen
Starring Jonathan Rhys-Meyers, Scarlett Johansson, & Emily Mortimer
(2006)

Synopsis:

One-time tennis pro, Chris Wilton (Jonathan Rhys-Meyers) was used to falling just short in his life. But when he befriends wealthy Tom Hewett and marries his sister, Chloe (Emily Mortimer), the doors are opened to the kind of money and success that Chris had once only dreamed of having. Chris should settle for this lucky happiness, but he is tormented by his attraction to Tom's impossibly beautiful and alluring fiancée, Nola (Scarlett Johansson). When attraction turns to obsession, Chris faces a terrible and critical choice. Now everything in his life hinges on whether or not Chris falls short again...and if his luck finally runs out.

Please: Bring a snack or a drink to share,
&
RSVP to Phil Gable, phillipgable@yahoo.com



See you there!!

Psychology and Family Law

By Mark Baer, Esq.

From my friends in psychology, I know that that good communication is at the heart of good relationships. As an attorney, I can tell you that good communication is vital to successful legal proceedings as well. Perhaps nowhere is this more true than in family law. However, in my experience, good communication is all too rare between individuals involved in family proceedings, which leads to a variety of unfortunate consequences.

After years of working in transactional law (that is, writing contracts related to creating business entities, or sometimes dissolving them, as well as creating estate planning documents), I began practicing family law in 1995. In transactional law, there is typically no overt conflict, and my work there focused on helping my clients make good business and contract choices, and otherwise protecting their interests. Family law, on the other hand, is a completely different ballgame. As a transactional attorney, I was typically hired to put something together, to create or renew a certain "relationship." As a family law attorney, I am hired to help clients break a relationship apart. Somewhat ironically, "*family* law" is about dissolving a marriage or non-marital family involving children. Thus, whereas emotions are not typically problematic in transactional law-- where the work is largely about creating or renewing relationships-- painful and conflictual emotions are unfortunately the norm in family law.

Representing my clients as a family law attorney, most of the time, I am working with people who loved each other very much at one time, or who may still love each other, even though the relationship failed. As a result of the pain and anger involved in that failure, the parties very often no longer communicate (constructively) at all any more, and instead leave crucial communications up to their respective attorneys. This can be disastrous on a number of levels.

I believe that the best way I can serve my clients is to help them to make as many of the important decisions in the dissolution of their relationship *outside* of the court system. This demands clear, accurate communication between the parties to a divorce, as well as between their respective attorneys.

Unfortunately, many attorneys make themselves practically unreachable for the purpose of negotiating settlements. I have found that sometimes attorneys run family law mills, and have so many cases that they don't have the time (or make the time) to resolve cases outside of court. In other cases, an attorney sees only the financial incentives involved in dragging out a case, so that it has to go to court again and again. He has little interest in effectuating a timely settlement. (In the current economic climate, fewer people will be able to hire divorce attorneys, and I suspect that some attorneys will be seeking "cash cow" opportunities to meet their own financial goals. Such an attorney may fail to return phone calls and/or fail to respond to letters. Ultimately, the opposing attorney will of necessity resort to attempting to resolve the case through court proceedings, or and/or trial.

A good attorney also manages his or her client's best interests by promoting realistic expectations concerning what they may *want,* versus what they are likely to get in a negociated settlement. For a variety of reasons, attorneys sometimes fail in that regard. They let their clients down by promoting unrealistic expectations, such that the clients want to keep fighting—through litigation, involving skyrocketing legal fees as well as high emotional tolls—for decisions that are unreasonable and ultimately unattainable. Clients who insist on having their "day in court" are often very disappointed with the results—especially considering the expense involved. They completely lose control over the resolution of a matter when they put it in the hands of a judge. A judge, after all, is only human and may have a very different perception from the client's.

Regardless of the reason, if one or both attorneys are unable or unwilling to make every effort to assist the clients in settling the matter out of court, the true losers are the parties involved in the divorce. In such cases, the only way that a case can be resolved outside court is by the clients communicating directly with each other and resolving the matter on their own based on the information they each learned in the course of the proceedings. Such resolution is only possible if the clients are ready, willing and able to communicate with each other. This is why I firmly believe that good legal representation involves diffusing powerful emotions and encouraging realistic, if not conciliatory goals in a divorce settlement. As difficult as it may be—and often, a supportive and constructive relationship with a mental health professional is key—the parties involved need to try and keep their emotions under control and maintain good communication with each other. In the end, the positive resolution is more than worth it.

Working Psychoanalytically on the Autism Spectrum

By Christina Emanuel, MFT

"Get out!" I exclaimed, enthusiastically, after my autistic client recounted a marvelous achievement he had accomplished. Rather than basking in the glow of our shared happiness, this client promptly stood up and started to leave. You see, he took my comment literally, not recognizing or remembering that "get out" is an expression that means something like, "Wow! Terrific! Awesome!" Instead he took it as an instruction to get out of my office.

I've worked with individuals on the autism spectrum (particularly young adults) for many years and continue to be stunned by their literal approach to language and people. At the same time, it is typical for autistics to manage certain abstract concepts in ways I could never dream of with my puny little mind, preoccupied as it is with zillions of competing ruminations, many useless and most having to do with sorting out others' social intentions, much like a giant Excel spreadsheet grabbing my attention at all times. As one young man with autism recently told me, "I can grasp the shape, nuances, and meaning of a musical sound, but I can't do the same with people." He regularly misunderstands others' intentions but is a scary-talented student of philosophy and a jazz trumpeter of the highest caliber. These talented minds can focus on highly specific concepts to the exclusion of outside distractions; their understanding of these ideas rivals my empathy with people. (Many admirers of autism object to the movement to "cure" these often gifted minds, but that is a separate article.)

Autism is traditionally characterized by impaired social interaction and communication, along with restricted and repetitive behaviors and perseverative interests. Many autistics are mentally retarded, though this is a separate diagnosis. My autistic patients find it difficult to read non-verbal social cues—including facial expressions, variations in prosody, and language tricks such as irony, sarcasm, jokes, or deceit—yet they are specialists in everything from Pokemon to physics. It is common for them to experience and process sensory data in idiosyncratic ways.

Because of their social ineptness, autistics are regularly maligned as asocial. They are dismissively treated with cognitive-behavioral interventions, as it is not expected that they can work in the transference, self-reflect, or interact intersubjectively. Nothing could be further from the truth. Individuals with autism struggle as much as the next traumatized patient who can't mentalize or offers defenses to relatedness and insight, but most of them *really want to be with another subject and develop their own subjectivity.* They get lonely and want human contact.

It is true that people with autism aren't naturally wired for intersubjectivity. In fact, this is what I understand to be the central deficit in autism. (For a good description see Daniel Stern's *The Present Moment in Psychotherapy and Everyday Life.*) However, this wiring snafu—a true social skills learning disability—doesn't exclude a *desire* to know people and their minds or the ability to work psychoanalytically. I find that individuals with autism respond to frequent and intensive interventions that help translate what they are missing and teach them to become more fluent in human contact. This is experienced as liberation, allowing a patient then more fully to experience a two-person therapeutic relationship. This is similar to how my dyslexic nephew benefits from focused and repetitive practice with an expert who understands the gap between what he is perceiving on the page and what is actually printed, ultimately giving him the freedom to read and learn.

An example of a social skill often lacking in autism is tact (though autistics do not have a monopoly on tactlessness!). Not long ago I was informed (accurately) by one of my clients that my gray roots were showing and that it was time to color my hair. I didn't take (very much) offense at this notification because I recognized that her intention was to speak the truth, not to ream me in the transference. I took that opportunity to show her, using the context of our relationship, that there are other minds that are different from her mind and that are affected by her intentions, a revelation. She then wisely decided that when gray roots appear it's best to clam up. Once we got that out of the way—and after I colored my hair—we talked more about how she experienced me, her fantasies about being my daughter, and how jealous she was of the child I was pregnant with at the time. We analyzed her dreams and poetry. Her emotions became easier to tolerate. Her behaviors settled down. Time stopped being discontinuous for her and took on a more coherent shape.

Autism does not preclude making the unconscious conscious. My patients do come to think and work symbolically and metaphorically despite being wired for a concrete and literal cognitive style. They produce rich and meaningful dreams and art. They form significant therapeutic and personal relationships. They recognize their own subjectivity and that of others. They develop. As a student of psychoanalysis I am hell-bent on applying psychoanalytic principles to the fascinating brain-wiring arrangement found in autism.

Christina Emanuel practices in Pasadena and is a psychoanalytic candidate at The Institute of Contemporary Psychoanalysis. She can be reached at (626) 396-9798 or christinaemanuel@sbcglobal.net.

Consider Group Psychotherapy

By Matthew Calkins, PsyD

As a group therapist, and a person who has been a member of groups, I believe that a well-facilitated psychotherapy group can accelerate the pace and augment the depth of change in individual psychotherapy. The group can be a place for the adult to develop curiosity about and play with the vital, human feelings so often pushed to the margins of experience: Attraction, anger, hunger, need and so on. As a group grows, develops and becomes a healthy community, it can disconfirm errant beliefs, interrupt cognitive distortions, heal wounds.

How does the psychotherapy group accomplish all of this? Group operates through the forces of a community – cultural norms, guidelines, rules. The group therapist's most valuable interventions involve creating and modeling norms with the goal of empowering the group to take care of itself. Healthy norms uphold safety, encourage honesty and ultimately work to create a context for growth and change. For instance, the group leader may model and outline three norms by making the following statement: "The group seems hesitant to talk about anger. I wonder if there is something about anger and other negative feelings that the group might want to avoid." Specifically, the group leader is modeling the use of first person communication, the value of curiosity, and the importance of acknowledging the full spectrum of affect. The group leader also speaks to destructive norms as they emerge, such as scapegoating, acting out, and secrets. With continued work on these levels, the group develops the capacity to uphold healthy norms, to self-monitor and ultimately requires less intervention by the group leader. In other words, the group no longer needs a parent to be in charge. As an agent of change, very few contexts rival a mature, working psychotherapy group.

So why are fewer psychotherapy groups being facilitated now? Managed care and insurance policies likely plays a role. Perhaps the greatest source of hesitation is the fact that a group acts as a kind of lightning rod for fears and fantasies. This is the case not just for the client, but perhaps, for therapists as well. For the therapist, the fear of losing clients (perhaps even more intense in difficult financial times) to group, the fear of the individual therapist being undermined by an unethical group therapist, and a protective impulse for a client could all contribute in the hesitation to refer. While it is true that some groups and group leaders can 'do damage,' that some act unethically, and that some poach clients, the majority choose to work with individual therapists towards the common goal of helping the shared client. Whatever the case, group seems to be an oft misunderstood form of treatment.

Another reason for the decline in group psychotherapy may in fact be the rise in self-help groups and single-subject support groups. The support group tends to maintain a level of restriction to particular content areas. Such groups tend to be more homogenous, and group leaders commonly stress sameness and similarity with the goal of assisting coping with specific issues, or alleviating symptoms. Consider, though, the value of tension and difference in terms of growth and development. While the support group can be the ideal referral for specific problems, don't discount the depth and richness offered by the psychotherapy group.

For those considering referring into group, here are a few tips. Consider the ideal type of group for your client. Interview group leaders about their approach, their policies, the groups they currently run, and their set of beliefs about change. You'll want to consider such things as support vs. psychotherapy, mixed gender vs. men's/women's, co-led v. single leader. Also, you'll want to know that the group therapist will partner with you, and work collaboratively. Be mindful of the possibility that your clients will naturally experience anxiety regarding joining a group, particularly with another professional. Pace your discussions regarding group therapy over time, and test the client's level of comfort.

On a final note, I want to add that running groups in your practice can be very professionally fulfilling. While difficult to start, groups challenge the therapist in unique and powerful ways – due mostly to the fact that the group is always more powerful than any one person (including the leader!). I have always felt that I learn more about being a therapist from the groups I lead.

If you have further questions or are interested in group therapy, or if you'd like to start a group and would like guidance, I encourage you to visit the website for the American Group Psychotherapy Association (AGPA) at www.AGPA.org or its local affiliate, the Los Angeles Group Psychotherapy Association (LAGPS) at www.LAGPS.org.

Obsessive Ruminations

A Psychodynamic Train Wreck: The Natural History of a Counter-transference Enactment

By Alan Karbelnig, Ph.D.

Bolstered by Soren Kirkegaard's lament that "ours is a paltry age because it lacks passion," Dr. Alan Karbelnig writes this regular column to provoke thoughtful reaction from his SGVPA colleagues. He has been a member of SGVPA since 1988, and served as its president in the early 1990s; he has chaired the SGVPA Ethics Committee for 14 years. Alan is a Training and Supervising psychoanalyst at the New Center for Psychoanalysis and the Newport Psychoanalytic Institute. He practices psychoanalytic psychotherapy and forensic psychology in South Pasadena.

Simply put, psychoanalytic psychotherapists enter into intimate but bounded relationships with the persons consulting them, become embroiled in their internal dramas, and then interpret rather than enact them. Ideally, the process unfolds with both emotion and containment, facilitating a helpful shift in personality. But this requires tremendous self-discipline. Much of the training, personal psychotherapy and continuing education of psychodynamic psychotherapists serves to help them manage these highly intense encounters.

Last Spring, I provided a brief course of psychotherapy during which this dramatic re-enactment process unhappily derailed. I offer this brief and fictionalized recounting in the hope that you can avoid a similar fate. At that time, a gay attorney named Joey consulted me weekly for help breaking a pattern of aborted intimate relationships. He was in his young 40s, and had been in three significant romantic relationships, each lasting more than five years, and each ending in the same way. He would begin the relationship highly idealizing his partners– usually for their occupational achievement as doctor, lawyer, or celebrity actor – and then end with a gradual devaluation of them leading to his termination of the relationship.

By the end of the first session, I was already wondering how and when this pattern would repeat itself in the transference relationship. I actually interpreted this early on. Joey initially rejected the possibility that this idealization-devaluation cycle could be repeated in our work, citing the "outward signs" of my occupational success.

Approximately three months later, and just as I was beginning to experience the excruciating back pain that ultimately led to my diagnosis of endocarditis, Joey left me an angry message immediately after a session. He felt criticized at my having mentioned that he appeared sad. He was furious that I'd made him so aware of his appearance. I had no hint of his having reacted this way during the session. My recollection was that I had offered the observation with great empathy and sensitivity.

Perhaps because of my own vulnerability, I reacted strongly, and with intense concern. I immediately called him, acknowledged that I'd received the message, and invited him to come in before his usual weekly appointment to discuss what had occurred. Over the next few days, as we exchanged messages looking for a suitable extra session time, I felt increasingly anxious myself. Could I have been too aggressive in the way I pointed out the sad facial expression? Could I have been more critical than I remembered? I felt increasingly vulnerable and inadequate myself.

With each message that I left offering alternative meeting times, Joey's negative responses escalated. This set of interchanges culminated in his ending the brief course of treatment by voicemail message. I left a final message offering a termination session to at least review what had occurred. I never heard back from him.

Now having the benefit of more than six months of retrospection, I view the experience as a painful but enlightening example of transference-countertransference run amok. If I had it to do over again, I would have simply left one message of acknowledgment with an invitation to come in sooner to discuss what occurred. I believed instead – real or imagined – that Joey needed the contact, that he needed a more overt invitation from me. In doing so I may well have initiated the same cycle that had led to his seeking help in the first place. The more vulnerable I became, the more he devalued me, finally leading him to terminate the treatment in much the same way that he'd ended many romantic relationships in the past.

So what lessons can be taken from this sad tale? Never forget the power of the drama of the person consulting you or of your own personal vulnerability to become negatively embroiled in it. Perhaps most significantly, remember the crucial importance – more than maintaining an observing ego, more than carefully managing boundaries, more than remaining emotionally attuned – of this commonsensical trait:

Patience.

ETHICS BRIEF: Confidentiality and Suicide

By Ethics Committee Alan Karbelnig, PhD, Chair
Linda Bortell, PsyD, Isabel Green, PhD, Don Hoagland, PhD, Toni Cavanagh Johnson, PhD, Phillip Pannell, PhD

This is part of a series of bi-monthly articles written by the SGVPA Ethics Eommittee. The articles reflect research from a variety of sources, including Ethical Principles of Psychologists and Code of Conduct from the American Psychological Association and other sources. These articles are intended to provide education, not actual legal advice.

Confidentiality is an integral part of the Ethics Code for Psychologists. As psychologists we are to maintain the confidentiality of our clients. In our Informed Consent we make clients aware of the limits of confidentiality. Many psychologists believe that we are legally required to breach confidentiality when a client is a danger to himself. This is not the case. In California law, there are several exceptions to the confidentiality between a psychotherapist and client. One of the exceptions is when there is a reasonable suspicion of a client engaging in suicide. Therefore, California law allows the psychologist to legally breach confidentiality when the psychologist believes the client is a threat to himself/herself, but it does not require a psychologist to do so. "There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." (Evidence Code § 1024.) Likewise, the Code of Ethics of Psychologists does not require a psychologist to breach the confidentiality of a client when the psychologist is aware of the client's desire to terminate his/her life. This leaves the psychologist with potentially very weighty decisions.

There are at least three situations in which a client could take their life when in therapy with a psychologist. 1) An individual is in therapy but there is no reason to suspect suicide. If the person were questioned about suicide, there would be no indication of suicidality, yet the client takes his/her own life; 2) An individual is in therapy, there is reason to suspect suicidal intent but the clinician does not respond/assess effectively/sufficiently. In some cases of this kind, it is only after the client takes his/her life that the clinician recognizes that the signs were present but overlooked. 3) A client indicates his/her choice is to end life on this earth. The psychologist evaluates the client to determine if he or she is competent to make the decision and does not breach confidentiality. The client finds a way to terminate his/her own life.

In the first two types of suicide, the psychologist has not been faced with an ethical dilemma regarding confidentiality. In the third situation, the dilemma may be formidable to the psychologist. Ethical dilemmas abound for clinicians, yet when it comes to the death of his/her client, the challenge of confidentiality is extreme. The Code of Ethics does not direct us about how to navigate this dilemma. The General Principles of the Code of Ethics of Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity and Justice are to what psychologists should aspire. As psychologists we are to do our best for each client, do no harm, and establish relationships of trust, honesty, truthfulness and integrity. We are to take precautions that our personal biases do not get in the way of sound judgment. These General Principles may only confound the dilemma of psychologists who have to make the decision about what to do when a client who is competent to make the decision, discusses his/her plan to suicide.

This situation is likely to become more difficult with the advent of "assisted suicide" laws. Oregon has a law allowing "physician-assisted suicide." This is called the Oregon Death With Dignity Act passed in 1994. In Oregon, after proper screening and deliberation, an individual can make the decision to terminate his/her life with medical assistance. Since l980, right-to-die groups have tried to change the laws in Washington State, California, Michigan, Maine, Hawaii, and Vermont, so far without success. Thus, in the USA, Oregon stands alone.

A Dutch Treat Networking Lunch Meeting!

How many times have you asked yourself "who does what" among our colleagues?

How confident are you that other SGVPA members really know what you do?

This new program is designed to provide additional opportunities for SGVPA members to get to know one another, to feel comfortable sharing cases and to discover resources among their professional colleagues.

Our next meeting will be
Tuesday, February 10th
from 12:15 to 2:00 p.m.
at
Sitar Indian Restaurant
(located on the south side of Colorado Blvd
between El Molino and Madison, with free parking in back)

Bring plenty of business cards!
RSVP by the Tuesday before each luncheon to
Dr. Elisse Blinder
at dreblinder@charter.net

MONTHLY PROGRAM SCHEDULE
2008 -2009

Date: April 4th

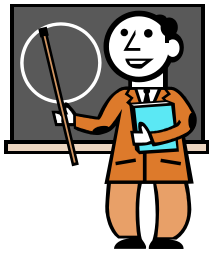
Topic: Transference and Countertransference Issues Concerning Victims of Violent Crime and Other Traumatic Incidents of Adulthood

Speaker: Carl H. Shubs Ph.D.

Date: May 1st

Topic: Spiritually Traumatized Patients: Patience for the Process

Speakers: Stephanie Law Psy.D. and Lisa Carruthers Psy.D.



WELCOME NEW MEMBERS!

LICENSED

Joshua Cornell, Psy.D.
Alison Johnson, Psy.D.

STUDENTS

Luke Anderson
Lisa Finlay, MA
Migum Gweon
Esther Lee
Lina Ponder
Lydia Wang
Amy Welch

ASSOCIATE

Norma Encarnacion, MFT
Patricia Luehrs, LCSW, Psy.D.
Erika Robertson, LEP
Mark Tinley, MFT Intern

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11:00 AM – 2:00 PM

SPEAKER: Elizabeth Trawick, M.D.
"Framework for Thinking: Psychoanalytic Perspectives on Early States of Mind"

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