



THE CANADIAN CLINICAL PSYCHOLOGIST

NEWSLETTER OF THE CLINICAL SECTION OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION

Message From the Chair

Peter Bieling, Ph.D., C.Psych.

My message focuses on the upcoming convention, especially if you're still on the fence about joining us in Halifax...

The early bird discount rate for registration is open until May 12th, but you can register anytime, right up until the morning of June 13th.

The link for registering is here:

<https://web.cpa.ca/registration/index.php?page=login7>

We're very excited about the pre-convention workshop on Wednesday June 13th -- Dr. Alex Chapman will be presenting "Dialectics in Action: Practical Acceptance and Change Strategies from Dialectical Behaviour Therapy."

Alex is an Associate Professor at Simon Fraser University, and you can read more about his work here:

<http://www.psyc.sfu.ca/people/index.php?topic=finf&id=97>.

Of course, there's a huge need in the field to work with clients who have emotional dysregulation, and this workshop will offer lots of practical nuggets.

We're also excited that Dr. Sherry Stewart is presenting our Section's public lecture on Wednesday June 13th titled *Why Do People Drink Alcohol? Research from the Bench to the Clinic*.

In addition to the workshop and lecture, the conference program itself is dotted with contributions from members of our section too numerous to mention here. But as always, the clinical section had a very large number of excellent submissions for posters, symposia, and workshops. I want to especially highlight the student symposium on Borderline Personality Disorder which takes place on Thursday June 14th in Suite 203, Level 2.

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We're also excited to be offering a reception that follows our annual business meeting this year, and those activities will be in Suite 301, Level 3 beginning at 3pm and ending at 5pm (an hour of mastery activity and one hour of pleasant event).

At our meeting, we hope to present an update on the recent request for proposals around advocacy. Some time ago, the clinical executive had decided to spend \$5000 on advocacy but despite suggestions and numerous conversations hadn't reached a decision. We believe that a competitive and peer-reviewed process will make best use of these funds.

So the next couple of months will be busy for the clinical executive and our section, culminating in Halifax!

CPA Clinical Section Public Lecture

Wednesday, June 13, 2012

Place: Bluenose Room

Why Do People Drink Alcohol? Research from the Bench to the Clinic

Sherry H. Stewart, Ph.D.

Departments of Psychiatry and Psychology, Dalhousie University, Halifax

People drink alcohol for a variety of reasons or "motives". For example, some drink to affiliate with others, and some drink to fit in with a valued peer group. Still others drink for the euphoric feelings alcohol can produce, while some use alcohol to escape from negative emotions. In this talk, Dr. Stewart will present a useful model for understanding the various reasons that people drink alcohol. She will demonstrate how some drinking motives are riskier than others in terms of associations with heavier alcohol consumption levels and/or alcohol-related problems. Dr. Stewart will review work she and her colleagues and students have conducted on this issue using methods as diverse as self-report questionnaires, lab-based experimental methods, and real world daily diaries. She will conclude the lecture with a review of prevention and treatment findings showing that alcohol intervention outcomes can be improved by targeting the maladaptive motives underlying alcohol misuse.



Sherry Stewart

From the Editors' Desk

May 7 – 13, 2012, marks The Canadian Mental Health Association's Mental Health Week. The purpose of this annual national event is to encourage awareness of mental health-related issues. The Psychology Foundation of Canada recently held a video contest entitled "There's No Health Without Mental Health." The intent of these videos was to increase awareness of childhood stress. These are just two examples of many Canadian initiatives on mental health awareness.

Increasing awareness and promotion of mental health is a national objective, particularly because mental illness is a major public health concern. One in every five people in Canada will experience a mental health problem in their lifetime (Health Canada, 2002). Not only is this costly to the individual and his or her family, but also to the community and the health care system.

What role does the clinical psychologist play in the mental health care system, given the demand for services? Currently, psychological services exist across the continuum of care. In terms of supply, the number of active registered psychologists in Canada has steadily increased from 12,676 in the year 2000 to 16,156 in the year 2009 (Health Personnel Database, Canadian Institute for Health Information, 2011).

In March 2008, The CPA Board approved the "CPA Task Force on the Supply of Psychologists in Canada." In October 2010, this task force reported back to the board. The report can be found at the following link:http://www.cpa.ca/docs/file/Task_Forces/CPA_SDTaskForceFinalReport_Oct2010.pdf. This document outlines issues regarding the supply and demand of psychologists, and what this means for future careers in the field. For instance, a large proportion of the psychology workforce is nearing retirement, and services for an aging population will soon be in high demand.

Given these issues regarding the future supply and demand of psychologists, it is important to be aware of the wide-range of opportunities within the field. We are hoping to profile individuals in this newsletter employed in various capacities across the country highlighting universities, hospitals, rehabilitation programs, schools, correctional facilities, community clinics, armed forces, social-welfare agencies, private practice, etc. Consider whether you or someone you know has something to contribute to the Fall 2012 edition of The Canadian Clinical Psychologist.

We hope to see many of you next month in Halifax!

Enjoy your newsletter,

Elizabeth & Andrea



Dr. Elizabeth Levin



Andrea Woznica

Special Thanks to Stacey Kosmerly, Hons. B.A. Psychology from Laurentian University for her assistance in design, layout and putting this newsletter together.

New Section

Lorne Sexton, Joyce D'Eon, Bob McIlwraith and Kerry Mothersill invite you to attend a Town Hall forum followed by an organizational meeting to launch a new Section of CPA: Psychologists in Hospitals and Health Centers. The Forum is scheduled to take place during the CPA Convention in Halifax on: Thursday June 14 from 2:30 to 4:00 and the Section Formation meeting will be held immediately after from 4:00 to 5:00. The formation of this Section was one of the recommendations of the CPA Task Force on the Future of Publically Funded Psychology Services in Canada.

Hospitals and other publicly-funded healthcare centres, such as primary care clinics, are where most Canadians obtain their psychological services. Psychology services in these institutions have been under attack in some provinces, while growing and diversifying in other parts of the country. Changes in organizational structures, administrative and clinical accountability lines over the past two decades have been challenging for psychology, at the same time as the private practice sector has expanded significantly. Professional training has been impacted by the changes in hospital psychology departments. The CPA Task Force on Psychology in the Public Sector has examined psychological services in hospitals and healthcare centres, and members of the task force will provide an overview of issues in Canada as well as a progress report on their activities. Psychologists in administrative, practice leader and training roles are particularly invited to attend and speak to the issues that are relevant to their facility. Immediately following this town-hall presentation and discussion, the organizational meeting of the new CPA Section of Psychologists in Hospitals and Health Centers will be held, which will set the agenda for national action by psychologists providing clinical and health psychology services in the public sector. The development of a national perspective on the organization and delivery of psychological services in publically funded health facilities will have a significant effect on the future of the profession on the front line.

The following are some initial areas that will be addressed by the Section:

- Highlighting the distinct roles of psychologists in health care settings
- Supporting psychology leadership in hospitals and health care centres and their advocacy for administrative support for psychology practice and research
- Improving the quality of psychological practice in hospitals and health care settings through establishing and promoting standards of clinical practice and
- promoting practice-based research
- Sharing information among Canadian hospitals and health care settings regarding psychological best practice services and the development and deployment of
- psychologists in health care
- Supporting the development of professional training opportunities in hospitals and other health care settings
- Promoting professional and public awareness of psychology services in hospitals and health care settings
- Assisting in the development of Canadian benchmarks and recommended guidelines for psychological services across conditions

Ten Thoughts for Ten Years: Reflections on a First Decade of Clinical Practice

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In the fall of 2011 I was invited by a former professor to give a seminar to the clinical psychology graduate students at the University of Saskatchewan. In contemplation of the various topics on which I might have spoken, I was struck that the timing of his invitation coincided with the tenth anniversary of my Ph.D. convocation from that same program. My wish in creating that seminar was to provide the students with insights from my first decade of clinical practice. As I told them, these were things which would have been valuable for me to know in 1994 when I started graduate school. I'm happy to share them more broadly here. Without further delay then, ten thoughts for ten years...

1. To thine own self be true (with apologies to the psychoanalysts)

When we train to become psychologists, there can be a sense that in order to find our professional "voice", we have to put on a professional façade or become something other than what we are. I believe that becoming a psychologist means building on what we are rather than negating or dividing it. Rogers (1957) referred to this as genuineness on the part of the therapist. If we are trying to be something we're not, we will come across as anxious or worse, as phony. Lots of people who will become our clients have exquisitely sensitive BS meters, and if we fake it in the clinical setting it's only a matter of time before our clients bust us. Much of what drives psychological distress is what Rogers (1957) termed "incongruence", or the discrepancy between our actual experience and our self-image as it represents that experience. If we're trying to help clients solve incongruence, and we're actively projecting something in the room that we're not, this is terrible modeling and undermines the work we're trying to accomplish.

2. Empathy – the clinician's superfood

We all know what empathy is in an intellectual sense. The challenge is to know it in the experiential sense, with your clients who present in psychological distress. This "knowing" comes differently to each of us. It came to me more as a psychologist than as a graduate student. Empathy deepens trust, the alliance, and thus exploration. Most significantly it conveys acceptance on behalf of the therapist, which facilitates same in the client. Put differently, if we can accept that which causes a client so much upset, the client learns he/she can do likewise. For those who train psychology students, pay close attention to their body language the next time a client begins crying in session. Does the student lean forward thereby closing the physical and psychological space from the client, or lean away? Those who lean forward are closer to what I would call experiential empathy.

3. Interesting vs. Relevant

I would argue that everything a client tells us is interesting, because it's part of their narrative. Not everything they tell us is relevant, however. The degree to which this distinction is understood is directly related, in my experience as a supervisor, to seniority in graduate school. I remember the first time I ever sat across from a "client" (an undergraduate psychology volunteer), in my first assessment class in 1994. Simply getting this person to engage in dialogue with me was a "win". I was so excited to show my supervisor the tape. ("See, she didn't run from the room in hysterical laughter! We talked for a whole hour! Professional psychology, here I come!") My supervisor had other ideas about my performance. Our job as psychologists is to assess that which we need to, based on the referral question, our place of employment, etc. If the client wanders in discourse, we need to use all our skill to focus the interview and get the information we require. I once supervised a student on her first placement, and in a 90-minute semi-structured psychosocial screen she allowed the client to speak about his woodworking hobby for 45 minutes. She reminded me of myself, years before. We had a wonderful hour of supervision afterward.

4. We assess psychological distress, we don't cause it

A number of students I have trained have become visibly uncomfortable when their clients fall to pieces during a psychological assessment. What has come out subsequently in supervision are feelings of culpability by the student for causing the breakdown. I have even had students tell me how awful they felt for making their clients cry. Such moments are ripe for learning, of course. It may be that the student misunderstands his role, which is to assess the psychological status of the client, whatever that may be. It may also be that there is countertransference at play, in that a student who cannot tolerate emotional upset in himself won't be able to tolerate it in his client. In any case, I try to impress upon my students that there are multiple reasons to have a client stay with raw emotional upset. Can they tolerate it or regulate it better than they realized? If so, they need not be so fearful of affect. If not, that is valuable information in making a case formulation. In addition, when we try to move the client past (or "solve") the raw affect too quickly, it teaches the client that those feelings are something to be avoided. By way of analogy, imagine telling your family physician something that had been burdening you for a long time and, in the catharsis of the disclosure you begin to cry. Now imagine your family physician, in response, made no eye contact, got shifty in her chair, and changed the subject. The lesson you would take away is "never tell my doctor the truth of what's troubling me again."

5. How to make recommendations and influence people

At the conclusion of an assessment interview, whenever possible, I share both my working formulation with my client, and my ideas on treatment. On occasions when I need time to reflect on the case and on potential recommendations, I'll inform my client of this and arrange to follow up whether by phone or in person, again to run my treatment recommendations by the client. This serves two purposes. First, if clients have any questions – and they often do – about what treatment would entail, I can provide details and offer reassurance, which enhances buy-in by clients. It's remarkable how five or ten minutes of time spent in this way can facilitate compliance with our recommendations. Second, some clients will listen politely, and then tell us "thanks for the recommendation, but not in a million years." In these instances, I don't bother making the recommendation as this becomes an academic exercise. However, I *do* indicate in my report that I reviewed with the client what I felt was the most appropriate treatment option, and that the client declined same for reasons known (or perhaps not) to me. This makes for a stronger report.

6. Not all problems are solvable

Learning the limits of our power as psychologists to help other people is a humbling experience, but an absolutely necessary one if we are to avoid professional burnout. There are many reasons why client problems are unsolvable. First, clients may be unready for change. Many excellent books have been devoted to motivational interviewing. Second, in the words of a colleague, "people have the right to self-destruct." Self-destruction can take many forms, suicide being the most final. But as another colleague once told a roomful of peers, "we're in the business of mental illness which cannot be divorced from human mortality." Third, there may be secondary gain at play. Secondary gain can take the form of money ("if I remain disabled the insurance company pays my wage and my mortgage"), attention ("I used to be invisible, now everyone asks me how I'm doing"), or assistance ("my husband never helped with housework before I was sick"). All of these things can be very hard for a client to relinquish, which certainly can undermine change efforts. The point here is not that we have a license not to do our best. The point is that our best sometimes is not enough.

7. Personal disclosure to clients

I have found that personal disclosure, used strategically and timed well, can open up the therapy relationship as it makes us human with our clients. I recall seeing an older woman who had experienced a lifetime of hurt and heartache, but who would not permit herself to feel anger (and she had much to be angry about) as she had learned very early that anger was unsafe. Her father was an angry drunk who beat everyone in the house; her earliest memory was walking in on her father beating her mother, and seeing her mother sit up, covered in blood. Her anger came out in unhealthy ways, particularly hoarding and gambling. In one session I shared with her a personal example of anger, specifically a new co-worker who "gifted" me with a new nickname every day, which he would holler in a booming voice within earshot of fellow staff and clients ("Sheckter the Connector!", "Sheckter the Director!", "Sheckter the Vector!", "Sheckter the Heckler!"). The more this progressed, the angrier I became.

I allowed myself to sit with the anger for a few days, in order to understand it, and to let it guide my behaviour. It told me to respectfully but assertively confront my co-worker, and inform him his behaviour was unacceptable. He actually thanked me, and today we're friends as well as co-workers. After I shared this story with my client, her therapy took off.

8. Eureka! Psychology is a soft science

A science's "hardness" can be understood as the magnitude of its predictive accuracy. Physics, with its many laws, has perfect predictive accuracy and thus represents science at its hardest. The highest level of predictive accuracy psychology has been able to achieve is roughly 50%. I agree wholeheartedly with Howard (1996), who sees this as a cause for celebration, not apology. I reject the idea that we should wring our hands for being stewards of a science which can account for "only" half of the variability in human behavior. Humans aren't robots; we're complex creatures, and our unpredictability is magnified by mental illness which leads us to do all kinds of irrational things. Besides, no other discipline comes close to 50%.

9. What's eating Marc Sheckter (i.e., things that really irritate me)

Herein, the rant portion of my 10 thoughts.

- The notion that those of us who have earned a Ph.D. must produce research to honor our training as scientists is one I reject. We can do this equally well by being diligent consumers of research. The research literature is a living entity, and represents that which so nobly distinguishes psychology from the other helping professions.
- I dislike allegiance to the "purity" of treatment models. The manualized treatment that we learn is illustrated with case studies and excerpts which are culled from hundreds of hours of data. We are reading the best of the best in terms of therapy prototypes. In my experience, real life practice is messier as clients have a habit of going off script. I'm not arguing against the usefulness of empirically validated treatments here (see my previous point). Rather, I'm arguing in favour of clinician flexibility.
- A person should never be equated with his or her mental health. The most important line in DSM-IV-TR comes from its introductory section, where we are reminded that we are not diagnosing people but rather disorders that people have. Equating a person with a mental illness can happen in ways obvious, such as saying someone "is borderline" or "is bipolar" (would we ever say someone "is MS" or "is cancer"?), and subtle such as saying "Mr. X meets criteria for PTSD" when we should say "Mr. X's symptoms meet criteria for PTSD".

10. The learning never stops

August 24, 2001, was the final day of my pre-doctoral residency, and what I consider to be my last day as a graduate student. My training director, in my last hour of formal supervision, asked me if I had any parting questions. I had a biggie. I told him that two months hence I would be walking across the stage and getting my parchment, after which I would be Dr. Sheckter. I would be expected to know what I was talking about, and yet I felt I didn't know anything. What could he tell me? His response was to say "Marc, I know more now that I did a year ago, and I'll know more a year from now than I do currently. The learning never stops." He was dead-on correct. Novices become experts through volume and repetition, and through reflecting on treatment failures in a manner which is honest, intensive, and consultative. Celebrate the good, breathe deeply and accept the bad, and know that wisdom comes.

References:

- Howard, G. S. (1996). Understanding human nature: An owner's manual. Notre Dame, IN: Academic Publications.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21(2), 95-103.

The newsletter welcomes opinion pieces. The views expressed are those of the authors and do not necessarily reflect the views of the editors or Clinical Psychology Section.

Book Summary

Eating-Related and Weight-Related Disorders

Collaborative Research, Advocacy, and Policy Change

Gail McVey, editor, Michael Levine, editor, Niva Piran, editor, and H. Bruce Ferguson, editor

This book presents a collection of writings by expert researchers from Canada, the United States, and Australia who are committed to finding common cause and common ground in the prevention of eating disorders and obesity. The ten chapters in this book seek to create a new public health approach to the prevention of weight-related disorders, one that counters the confusion and frustration from public policies, messages, and programs that recipients of prevention efforts often experience.

The first section looks at prevention from a public health perspective, and the second section highlights theories from risk and resilience research that can inform the prevention of weight-related disorders. The contributions are varied in their theories and models, but woven throughout is the theme of collaboration in changing public institutions and social systems that promotes universal prevention and fosters mental health and resilience. Unique methods of linking systems and fostering partnerships across sectors and disciplines are highlighted, and readers are exposed to innovative ideas of how to move the field of prevention science forward to reduce the onset of negative body image, unhealthy weight management, eating disorders, and disordered eating.

Preventing Eating-Related and Weight-Related Disorders is the second in a series of titles from The Community Health Systems Resource Group at The Hospital for Sick Children. This series will educate researchers, policy-makers, students, practitioners, and interested stakeholders on such topics as early intervention in psychosis, aggressive behaviour problems, eating-related disorders, and marginalized youth in educational contexts.

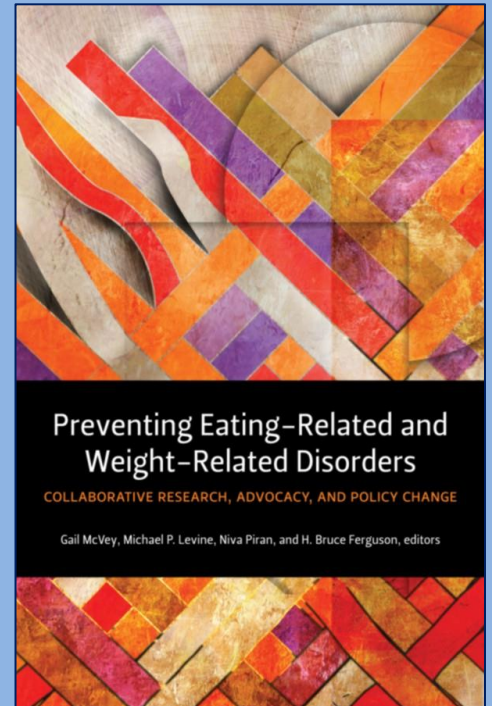
About Gail McVey, Michael Levine, Niva Piran, & H. Bruce Ferguson

Gail McVey is a psychologist and health systems scientist in the Community Health Systems Resource Group at the Hospital for Sick Children, director of the Ontario Community Outreach Program for Eating Disorders, and an associate professor in the Dalla Lana School of Public Health at the University of Toronto.

Michael P. Levine is Samuel B. Cummings Jr. Professor of Psychology at Kenyon College in Gambier, Ohio. He studies disordered eating, sociocultural factors, and prevention.

Niva Piran is a professor in the Faculty of Education of the University of Toronto, a clinical psychologist, and a school consultant in the area of body image.

H. Bruce Ferguson is the director of the Community Health Systems Resource Group at the Hospital for Sick Children and a professor in the departments of Psychiatry and Psychology and the Dalla Lana School of Public Health at the University of Toronto.



Preventing Eating-Related and Weight-Related Disorders

COLLABORATIVE RESEARCH, ADVOCACY, AND POLICY CHANGE

Gail McVey, Michael P. Levine, Niva Piran, and H. Bruce Ferguson, editors

Do you have any comments or suggestions about the Clinical Section Newsletter? We'd love to hear them.

Email Dr. Elizabeth Levin at elevin@laurentian.ca or Andrea Woznica at awoznica@psych.ryerson.ca.

Threats To The Validity of Independent Psychological Assessments: Feedback to whom and when?¹

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One of the psychologists in our practice was recently threatened with a lawsuit if, after the assessment, she were so much as to speak on the telephone to the assessed individual. The examinee was planning to call to provide the psychologist with information about medication, which he did not have initially. When the rehabilitation company that arranged the assessment heard of this, it reacted with shrill and insistent protest, which quickly escalated into the company's threatening legal action.

This was only one recent and extreme example of what seems to be a trend by insurers, agencies who act on their behalf, and lawyers to exert increased control over assessments, raising issues of responsibilities to those whom we see, to those who pay for our work, and to the law, as well as issues of confidentiality.

Who "Owns" the Information?

Ethical responsibility for feedback

Who does "own" and who has a right to the information from a psychological assessment? Paragraph 15 of Principle III of the CPA Code of Ethics states that psychologists provide feedback to those whom they assess: *[Psychologists] provide suitable information about the results of assessments, evaluations, or research findings to the persons involved, if appropriate and if asked.*

"Persons involved" would include at least the individual who is assessed, but could also be read to include the party who contracted for the assessment.

Further discussion of this principle in the CPA Code suggests that there may be instances in which such feedback might not be provided: *Fully open and straightforward disclosure might not be needed or desired by others and, in some circumstances, might be a risk to their dignity or well-being, or considered culturally inappropriate.*

If full disclosure is not provided, the code is clear that the individual must be informed of this beforehand and that the withholding of information is not undertaken lightly: *In such circumstances, however, psychologists have a responsibility to ensure that their decision not to be fully open or straightforward is justified by higher-order values and does not invalidate any informed consent procedures.*

Because the Canadian legal system, which is primarily adversarial, includes the principle of legal privilege, psychological information that is available to some parties may not be available to others, except through legal channels. In some instances it is up to the court to determine what information *must* and what *may not* be shared among parties, and the psychologist who is carrying out an assessment that may contribute to decisions of the courts has an obligation to adhere to normal legal process. If a party has a right to commission an assessment, it may therefore also have the right to prevent the results from being communicated even to the person who is assessed, and it is not up to the psychologist to override that privilege.

The College of Psychologists of British Columbia recognizes the existence of situations in which feedback to the individual who is assessed may be withheld by the psychologist². The Standards of the Nova Scotia Board of Examiners in Psychology also bear on the issue: *To the extent advisable and not contraindicated, a psychologist shall properly inform a person who has undergone an assessment or his/her legal representative of the conclusions, opinions and recommendations issuing from the assessment within a reasonable time. (NSBEP Standards of Professional Conduct)*

¹A version of this piece previously appeared in the *Nova Scotia Psychologist*. This version has been edited by the Clinical Newsletter editors for length

²Macartney-Filgate, M. S., & Snow, W. B. (2011). The practitioner as expert witness. In D. R. Evans (Ed.), *The law, standards, and ethics in the practice of psychology*, (3rd Ed., pp. 493-517).

The qualifiers, “to the extent advisable and not contraindicated,” obviously permit exceptions to providing feedback. The phrase would appear to relate to the possibility that feedback may have the potential for harm, which could contra-indicate and override the responsibility for full disclosure of information in relatively rare instances.

The APA code of ethics (2002) is, as usual, more direct and prescriptive. It clearly provides for some situations in which direct feedback may not be provided, including in “forensic evaluations”. But consistent with the Canadian Code’s requirement that such withholding be part of the informed consent, it also says that we have to explain this beforehand:

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance. (APA, 2002)

Note that “forensic” applies broadly to all evaluations in which the courts may be involved, both criminal, as well as civil, such as assessments related to contested disability claims.

Following the principles from the codes and standards, psychologists have a responsibility to provide information about the findings of an assessment to the individual who is assessed, but that responsibility may be superseded by a higher-order responsibility to protect the individual, should the feedback be deemed potential harmful. Secondly, that responsibility may be set aside in instances in which a third party has commissioned the assessment and requires that feedback *not* be provided to the individual who was assessed.

Federal privacy legislation

There is a complication. Federal legislation, in the form of the *Personal Information Protection and Electronic Documents Act (PIPEDA)*, applies to health records that are collected by private practitioners. The following sections are from Schedule 1 of the Act:

4.9 Principle 9 — Individual Access

Upon request, an individual shall be informed of the existence, use, and disclosure of his or her personal information and shall be given access to that information. An individual shall be able to challenge the accuracy and completeness of the information and have it amended as appropriate....

4.9.4

An organization shall respond to an individual’s request within a reasonable time and at minimal or no cost to the individual. The requested information shall be provided or made available in a form that is generally understandable. For example, if the organization uses abbreviations or codes to record information, an explanation shall be provided.³

Except in some carefully prescribed circumstances, there is no provision in this legislation for a health professional to refrain from providing full disclosure. It is likely the force of this legislation that led the College of Physicians and Surgeons of Nova Scotia to provide direction for its members regarding third party reports and patient access to medical records (Guidelines for Medical Record-Keeping, 2008) which appears simply to be an acknowledgment of the legal requirement that is provided by PIPEDA. As far as I am aware, psychologists do not yet have a formal statement to this effect from their regulatory body.

³ (A useful guide to PIPEDA can be found on the website of the Office of the Privacy Commissioner of Canada, at http://www.priv.gc.ca/information/guide_e.cfm#010.)

9.4 Third Party Reports

Patients should be informed of the purpose of the examination and the way it will be conducted. The patient must be advised in advance that the prepared report will be disclosed to the third party requesting the report as well as to the patient if so requested by the patient. ...

In terms of patient access to medical records, reports prepared or records relating to examinations conducted at the request of a third party are considered the same as any other medical records. The physician must allow the patient access to these reports if requested, subject to the same conditions applicable to other medical records. This does not apply to situations where the physician has no patient contact and offers an opinion based on pre-existing records.

When Is There a Responsibility Not To Release To the Examinee?

Macartney-Filgate and Snow (2011) have noted, “Generally, in the forensic context, **a health care relationship does not exist**⁴, the purposes of the assessment are legal in nature, and there are significant potential complications if direct feedback to the examinee is provided.” They further explain: “There is, consequently, no duty to provide feedback to an examinee, and indeed it is difficult to envision a circumstance in which this would be appropriate” (p. 508).

The issue is that direct feedback to the assessed party “carries a risk of contaminating, biasing or even invalidating future assessments” (p. 507) and it may therefore impede a legal process, not facilitate it. The situation is less clear in situations in which the request for the assessment comes from an insurer. In such circumstances, there is a legal question pending, viz., do the contractual conditions apply for entitled benefits, but the matter may not yet be legally contested. Nonetheless, the psychologist has to be aware that the examination may ultimately be brought forward as evidence, and he or she may be asked for an opinion as an expert in court. As a result, the same cautions apply, although it is possible that the records may be considered part of an individual’s health record and therefore ultimately accessible by the individual. I am not aware of any cases that have made this distinction completely clear

Thus, there may be a conflict between, on the one hand, the expectation and/or request from insurers, lawyers, and other agencies that we must not release information about the assessment to the individual who is assessed, and on the other hand, the possibility of challenge under our privacy legislation. It may also be, however, that in individual cases there are other laws governing release that would take precedence over PIPEDA. The privacy act does allow for exceptions to disclosure in the case of solicitor-client privilege, or information generated in the course of a formal dispute-resolution process, or “when required by law.” Some assessments may fall under these exceptions. It would be helpful to psychologists if our regulatory boards were to clarify these circumstances for us. Does an independent examination that is conducted for the purpose of assisting an insurer in evaluating the contractual conditions for disability constitute an exception to the requirement to provide feedback?

External Influence on Outcomes

Obvious and subtle threats

Rehabilitation agencies who are hired by insurers to co-ordinate assessment and treatment of clients commonly ask for electronic copies of reports, and to provide our reports on their letterhead, and sometimes attempt to influence, if not dictate, how our findings are worded or our conclusions. An agency once composed a letter over the name of one of our psychologists and provided it to her with a request for her signature. In another, an agency attempted to prevent me from even mentioning a current, published reference work and required a prior, outdated edition because the law governing that entitlement required use of the outdated resource, even though it been acknowledged by the professional community as inappropriate. Such intrusive practices may be surprising, but at least they are fairly readily recognized and can easily be successfully countered.

⁴emphasis added

Less obvious influences have more potential for harm simply because the threats they pose may not immediately be evident. For example, lawyers who commission assessments may request that the psychologist communicate with them “after you have examined the plaintiff and before you prepare your report.” The intention is to obtain a preview of the assessment’s results, with a view to discontinuing the process, precluding the completion of a report if it is deemed not to be in the client’s interest or to advance the client’s cause. Lawyers who make this request may appear quite puzzled when one declines their invitation for a telephone consultation after seeing the client but before completing the report.

If, following a discussion between the psychologist and counsel, there is a possibility that the assessment process will be terminated, then the assessment is not truly independent, but is partly contingent upon the lawyer. Counsel wants to retain the possibility that only certain opinions may be expressed; others may be filtered out. Lawyers argue that they do not wish to interfere with the process nor to determine the outcome, but that if it is clear that the assessment is not going to assist their client’s case, they do not wish to spend the funds required to complete the work involved. This is exactly the problem for the psychologist. In effect, the lawyer is saying, “I will not interfere, as long as it is going to be of use to my client,” which means that all other possible outcomes are excluded. Lawyers also argue that other professionals, including specialist physicians, routinely engage in this pre-report consultation with them concerning their “independent assessments.” It may be that psychologists are more acutely attuned to subtle influence than are some other professionals, which is why our standards of practice are relatively uncompromising.

Assessment or consultation—not both

A similar problem prevails when lawyers request that the psychologist examines the existing medical records, and then consults with them before proceeding. It is legitimate for a lawyer to hire a psychologist as a consultant, to offer advice to counsel concerning the psychological aspects of a case, including assisting the lawyer in preparing for cross-examination of an expert witness, or helping to decide how to proceed in light of the psychological dimensions that are evident from the documents filed in a case. If a psychologist undertakes this consulting role, however, he or she may not then proceed to act as an independent assessor. The independence is lost by having consulted, and if an assessment is required, it needs to be carried out by someone else.

Psychologists ought not to cross from playing the role of an independent assessor to offering partisan opinions or advice. There are several ethical principles and guidelines that are relevant to these issues. Offering a psychological opinion on the basis solely of available records may violate the APA Ethical Principles of Psychologists and Code Of Conduct (2002):

9. Assessment / 9.01 Bases for Assessments

- (a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)*
- (b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.*
- (c) The Code allows for a record review or consultation, but the resulting opinion should not usually concern the individual's psychological functioning or characteristics, but should confine itself to the records themselves (adequacy of assessment procedures, etc.).⁵*

⁵The Canadian Code governs Canadian psychologists' decision-making in instances of ethical dilemmas, and we are also subject to the APA Code in terms of guidance and minimum standards of practice that would be expected by a court.

Kirk Heilbrun is one of the authorities in this work (co-author of *Foundations of forensic mental health assessment*, 2009):

The request for a “preliminary” opinion following a few hours of document review is troubling for obvious reasons. I routinely decline to give “preliminary” opinions even after I have seen the individual, until everything is scored, all records reviewed, all collaterals contacted, and everything is thought through....Perhaps the best way to describe my objection to preliminary opinions are that they constitute (as the attorney is well aware) the camel’s nose in the tent. It’s much harder to conclude that the news is mostly bad for an attorney if you have indicated, even on a preliminary basis, that it is (or may be) good. Even more, once you have committed yourself (even preliminarily), I believe you are no longer impartial in your evaluation of findings. Instead, you are inclined to look for what supports the preliminary opinion and to deemphasize what does not. It’s a subtle but insidious process. (Heilbrun, personal communication.)

Maintaining Independence

In 1997, Paul Lees-Haley wrote an article entitled, *Attorneys influence expert evidence in forensic psychological and neuropsychological cases*⁶, in which he warned about “a growing threat to the validity of psychological and neuropsychological evaluations in forensic matters” (p. 321). His purpose in writing was “to alert psychologists and neuropsychologists of a serious threats to validity in forensic cases. To the extent that our data are colored by an unseen hand, our conclusions may be speculative, or worse, misleading” (p. 324). Lees-Haley did not see clear solutions, but said that his goal was to draw attention to the problem and encourage further enquiry. He also noted that although in seminars throughout the US and Canada, attorneys were studying how psychologists collect data and formulate opinions, “almost none of the continuing education programs of psychologists are teaching us how attorneys are applying this information in their role as a zealous advocate.”

Maintaining independence in conducting an assessment is difficult. There are many threats to its integrity. Other parties who have a vested interest in the outcome of the assessment may present ostensibly harmless requests to the psychologist. Our best defence against violating our own principles is to hesitate before agreeing to any requests, to consult with knowledgeable colleagues, and to maintain whatever protocol is required to remain unbiased in fact and in appearance.

⁶Lees-Haley, P. (1997). Attorneys influence expert evidence in forensic psychological and neuropsychological cases. *Assessment*, 4, 321-324.

REQUEST FOR PROPOSALS: CPA Clinical Section Advocacy Grant

The Clinical Section of CPA would like to support an advocacy project related to the science and practice of clinical psychology in Canada. A maximum of \$5000 funding is available. Proposals must be led by a member of the Clinical Section and/or student affiliates, but may include other professionals or partner organizations. For the purpose of this grant, advocacy projects will be considered in broad terms, and can be internal or external to the field of clinical psychology. Examples could include grassroots campaigns, informing and educating the public, government, or health care sector, branding of clinical psychology, and empowering others to advocate for mental health issues.

Proposals will be peer reviewed and criteria to be evaluated will include: (1) impact on audience and breadth of target audience, (2) soundness of methodology, and (3) track record of the applicant team. The application must be limited to 3 pages including a 150 word summary, 2 pages for a brief description of the audience, approach, expected outcome, and team. 1 page should be reserved for a detailed budget.

Proposals should be forwarded via e-mail by May 4, 2012 to the Chair of the Clinical Section of CPA, Peter Bieling, at: pbieling@stjosham.on.ca



Executive Committee Meeting Minutes

January 21, 2012, 9:00am - 4:00pm EST, Ryerson University, Toronto

(Attendees: Patricia Furer, Peter Bieling, Margo Watt, Jennifer Garinger, Emma MacDonald, Elizabeth Nilsen)

1. Approval of Agenda:

Trish moved, Jennifer seconded

2. Approval of Minutes – September 21, 2011 Executive Committee Meeting Teleconference

Peter and Margo approved in November (newsletter deadline)

3. Report from Chair

Advocacy project- Task force on EBP: (\$5000)

i. Ideas for spending the advocacy money were reviewed. Consensus was to put out a request for proposals. Criteria for the RFP and timeline were discussed.

Clarify criteria for CS Fellow status

i. Committee reviewed current description and decided the current criteria were fine. Committee discussed ways to solicit new candidates (newsletter, listserve, website, etc.)

Early Career Scientist-Practitioner award – nomination and selection process

i. Margo (as Chair-elect) receives applications (deadline April 15), previous applicants who are still eligible are re-considered. Applicants need to be members of the section to be considered.

Approval of April executive meeting minutes

i. Approved by Trish, seconded by Emma

4. Membership and financial report

Membership – as of January 18, 2012 (total: 584), numbers likely lower due to lapsed membership Financial report: on January 18, 2012 the financial statement indicated there was \$16,070.27 in the chequing account; 12,022.68 in the 5-year stepper GIC; total assets: \$28,092.95.

5. Student Report

Ken Bowers award

i. Submission deadline: May 2, 2012 (applications sent to Margo); applicants must be clinical section member
Student Travel awards

i. Submission deadline: May 1, 2012 (applications sent to Emma)

ii. Advertised through listserves and as students apply to CPA convention

Student Educational Activity Grant

i. Reviews by 1 executive member; 2 external reviewers (6 applications)

ii. Changes to advertisement for next year: indicate applicants need to be clinical section member; indicate that only core application considered (supplemental information does not need to be sent).

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Student symposium for CPA 2012

- i. Abstract submitted to CPA, if not already members, all presenters will register as clinical section member prior to convention

Other:

- i. 2012 Convention: students from local universities will be contacted to see if they can help with pre-convention workshop (will be able to attend workshop without charge).

6. Past-Chair Report

Executive Nominations for 2012-2013

- i. Chair- elect: call has gone out in listserve and newsletter: (deadline March 25, 2012)
 - ii. Student representative
- Emma agreed to remain on committee for one more year

7. Communications

Website / Listserve

- i. Will update the calls for applications/nominations on website

8. CPA 2012 Conference

Pre-convention workshop

- i. Alex Chapman scheduled to provide workshop on DBT/BPD
- Public lecture
- i. Sherry Stewart agreed to speak (location not yet determined)

Public lecture advertising

- i. Committee reviewed ideas for advertising

Review process of submissions to Clinical section (176 submitted, 168 accepted)

- i. Process improvement issues: provide reviewers with information on poster requirements; make sure reviewers only review assigned numbers; emphasize guidelines about needing data before submitting

ABM & reception

- i. Will try to schedule together; advertise through newsletter and listserve advertisement

9. New Business

- o Psychology month- February
- o Clinical section stance on Bill C10?
- o Fact sheet on clinical psychology
- o Comments on CPA's definition of evidence-based practice of psychological treatments & sources of

10. Spring teleconference: scheduled for April 23, 11 – 1 EST

Adjournment

Liz motion to adjourn, Trish seconded

What do you want to see in the Clinical Section Newsletter? We'd love to hear from you. Email Dr. Elizabeth Levin at elevin@laurentian.ca or Andrea Woznica at awoznica@psych.ryerson.ca.

Book Summary

New Directions in Sex Therapy: Innovations and Alternatives

Dr. Peggy Kleinplatz

Focuses on critiques of, and alternatives to conventional approaches to sex therapy. With each passing year the treatment of sexual problems seems to emphasize more medical and pharmacological interventions. There is correspondingly less interest in the experiences of the individuals or couples involved. I hope that this book expands the definition of the field. It is replete with helpful new clinical illustrations from master therapists across the spectrum of theoretical orientations to demonstrate these approaches in action.

Part I highlights the major problems and criticisms facing sex therapy and furnishes a rationale for new directions. Included in this new edition are critiques of "sexual addiction" nomenclature, the neglect of the ethical dimension in sex therapy and there is a call to expand our vision of what sex therapy can attain.

Part II demonstrates new approaches to dealing with traditional sex therapy concerns, including lack of desire and erectile dysfunction as well as innovative goals, such as integrating sexual medicine with sex therapy; using client feedback to customize therapy; promoting relationship growth and transcending sexual function/dysfunction to optimize erotic intimacy in long-term couples.

Workshop Announcement

"An Introduction to Mindfulness-Based Cognitive Therapy for the Prevention of Depression Relapse"

A 4-day professional retreat training being offered at Hollyhock Educational Retreat Center, Manson's Landing, Cortes Island, BC Canada, July 5-8, 2012 by Susan Woods, MSW, LCSW (www.slwoods.com) and Mark Lau, PhD, RPsych (www.vancouvercbt.ca/dr_lau.html).

This didactic and experiential training is for mental health professionals interested in Mindfulness-Based Cognitive Therapy (MBCT). MBCT is an empirically validated group treatment program that is specifically designed to address the problem of the re-occurring nature of depression. Part of this training will include periods of silence in which you will have the opportunity to practice mindfulness. A certificate of attendance will be provided.

For more details on this workshop and how to register, please go to <http://www.hollyhock.ca/cms/Mindfulness-Based-Cognitive-Therapy.html>.

REMINDER

There will be a reception that follows our annual business meeting this year at the Convention. Activities will be held in Suite 301, Level 3 beginning at 3pm and ending at 5pm.

Student Section

Letter from the Student Executive

Emma MacDonald, M.A.

Hello fellow Clinical Section members,

I hope that the past few months have been enjoyable and productive ones, and that the weather is starting to get warmer wherever you may be!

The 73rd Annual CPA convention is rapidly approaching, and the Clinical Section has planned many interesting and informative symposia, workshops, and poster sessions. I hope that many of you will be able to attend the convention in the beautiful city of Halifax.

I am happy to report that we will have our third annual Clinical Section student symposium at the convention. This year's symposium is entitled "Understanding features of borderline personality disorder: A focus on graduate student contributions to the research literature". Dr. Alexander Chapman of Simon Fraser University will serve as the discussant. As always, we received many excellent submissions and our reviewers had the difficult task of narrowing it down to four presentations. I am really looking forward to moderating the session and hearing about research on topics such as non-suicidal self-injury and emotion dysregulation. I hope to see many of our section members at the symposium!

Once again, the Clinical Section Educational Activity Student Grant continues to be a popular enterprise. We received six superb applications this year from students across Canada, and the reviewers commented on the high quality of the submissions. I am very pleased to announce that Suzanne Chomycz from Lakehead University was awarded this year's grant, for her submission titled "Innovative Treatment Options: Providing Services to Rural and Northern Communities". This full-day event includes a workshop and presentations from a panel of experts. We can look forward to a summary of the workshop in an upcoming edition of the newsletter.

Please feel free to contact me with any questions, comments, or concerns regarding the Clinical Section.

See you in Halifax!

Emma MacDonald, M.A.
Clinical Section Student Representative
emacdonald@psych.ryerson.ca

Students, what are you looking to see in the Student Section of this Newsletter? Tell us what you think.



The Psychotherapy Practice Research Network (PPRNet)

Giorgio A. Tasca, Ph.D., C.Psych.
 Research Chair in Psychotherapy Research
 University of Ottawa and The Ottawa Hospital

Many Canadians (i.e., over 1 million) turn to psychotherapy to reduce their suffering and improve their quality of life.¹ Rates of psychotherapy use have not diminished in over a decade despite the dramatic rise in the prescription of antidepressant medication during the same period.² There is a large body of research that consistently demonstrates positive outcomes of psychotherapy for a wide variety of disorders³, but psychotherapy research is not always translated into clinical practice.⁴

One can identify at least three barriers to translating psychotherapy research into clinical practice. *First*, clinicians may perceive that randomized controlled trials of psychotherapies are not representative of their clinical practice or relevant to their patients.⁵ *Second*, is a lack of communication between clinicians and researchers resulting in a translational gap between clinical trials and clinical practice.⁶ The *third* barrier is related to the professional diversity of psychotherapy practitioners resulting in few opportunities for cross-disciplinary dialogue, and little apparent cohesion among the communities of practitioners.

A novel intervention to overcome these barriers involves conducting psychotherapy research in applied settings in which clinicians are full partners who inform research areas important to them and their patients. A **Psychotherapy Practice Research Network (PPRNet)** is one means of achieving this goal. In a PPRNet, community-based practitioners actively partner with researchers to define research questions, design research protocols, and implement studies.

Our Canada-wide multidisciplinary team recently was awarded a CIHR grant to launch a PPRNet. We will start by engaging clinicians, knowledge user groups, educators, and researchers in a collaborative psychotherapy research priority setting process. The first phase will involve a PPRNet Conference held on November 17, 2012 in Ottawa that will include 100 participants: multidisciplinary clinicians, knowledge users, educators, and researchers. Research priorities identified through this process will form the basis for future practice-based research conducted in PPRNet members' clinical practices.

We invite you to attend this conference and be part of the process to develop this exciting new psychotherapy practice-based research initiative. For more information please go to: www.pprnet.ca or email pprnet@toh.on.ca.

References

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