

Health Psychology and the Psychology of Health

La santé de la psychologie et la psychologie de la santé



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Health Psychology and the Psychology of Health



Karen R. Cohen Ph.D., C. Psych. CPA CEO

I am very pleased to introduce this special issue of *Psynopsis*. As many researchers and practitioners among the membership can attest, health is something about which Psychology has lots to contribute. Several general and targeted invitations were sent to the membership and its sections inviting contributions to this special issue and the terrific response can be found within these pages!

In creating special issues of *Psynopsis*, we accomplish several things. Two of the most important are that we share information among the readership about initiatives, advances and needs within specialty areas of research and practice. Second, special issues have an advocacy function. We can use them to inform other stakeholders (e.g. the public, government, funders) about the relevance of psychological research and practice to issues of stakeholder concern.

As election polls frequently remind us, health and health care are never far from the thoughts of Canadians. Currently, federal, provincial and territorial governments are focused on their

2004 Health Care Accord which is up for renewal in 2014. In November 2011, CPA was invited to appear before the Standing Senate Committee on Social Affairs, Science and Technology on Canada's 2004 10-Year plan to Strengthen Health Care in Canada. The Panel on which CPA appeared was charged with speaking to health promotion, illness prevention and public health and it was within this context that we were asked to deliver our message.

What follows is the written brief submitted to the Standing Committee, a summary of which was presented to the Committee when Dr. Cohen appeared before them in November. The written brief can also be found at <http://www.cpa.ca/docs/file/Position/CPAbriefSSCommitteeNov2011FINAL.pdf> We will keep the readership updated on any of CPA's further activities on 2014 via the website and *Psynopsis* – those we undertake on our own and those to which we make a contribution as an alliance member (e.g. Health Action Lobby, Canadian Alliance of Mental Illness and Mental Health). For any information, don't hesitate to contact kcohen@cpa.ca at any time.



Canadian Psychological Association. Living Well in Health and with Illness^a

Introduction

The Canadian Psychological Association (CPA) thanks the Standing Committee for its invitation to join in its review and discussions of Canada's health needs, services and supports. The CPA is Canada's largest national professional association of psychologists dedicated to the science, practice and education of psychology in the service of our membership and the public good. There are approximately 18,000 regulated practitioners of psychology in Canada making psychologists the country's largest group of regulated, specialized mental health care providers.

In this brief, we offer our perspective on the implementation of the 2004 Accord. We further focus on the role of psychological factors in health and well-being, the impact of psychological factors on illness, and the costs and needs related to Canada's mental health.

2004 Federal/Provincial/Territorial Accord

The Accord underscores the importance of investing in the supply of Canada's health professionals. Current thinking would call upon government and other stakeholders to think about supply in relation to need. It is not just a question of needing more health care providers but of needing to train more providers to meet the specific health needs of Canadians and to practice in ways that will be maximally cost and clinically effective. As concerns mental health, several emergent needs can be identified that include the chronic conditions attendant upon an aging population and the cognitive and emotional factors that often attend upon these conditions (e.g. the incidence and prevalence of dementia, the role of depression in heart disease).

Increasing the supply of Canada's health human resource (HHR) when it comes to mental health will require an investment in teaching and training our HHR to meet specific needs of the population and to work collaboratively to meet these needs efficiently and effectively. We must invest in the infrastructure that supports a collaborative model of health care service delivery so that, as the 2004 Accord points out, the right person gets the right service, at the right time, in the right place and from the right providers.

The 2004 Accord focuses on reducing wait times and improving access to care but is silent on access issues and opportunities as concerns mental health. The barriers to



Health promotion and illness prevention strategies must deliver the supports and services for people to maintain health and wellbeing. This calls for skills that support success at home and at work.

accessing mental health service that Canadians face are not just related to the supply of providers whose services are funded by our provincial and territorial health insurance plans but also to those providers whose services are not publicly funded. We will speak to this issue later in this brief.

Mental health needs are identified in the 2004 Accord in relation to its home care provisions. Although

community service and crisis response is critical for those dealing with chronic and persistent mental disorders, **it is important to keep in mind that the 1 in 5 Canadians who face a mental disorder will not likely have the kinds of severe and persistent mental disorders that community mental health programs typically serve.** They are most likely to experience depression and anxiety – the disorders which evidence-based psychological treatments and community-based services and supports (inclusive of health promotion and illness prevention programs) can best address.

^a Brief to Standing Senate Committee on Social Affairs, Science and Technology .Canada's 2004 10-Year plan to Strengthen Health Care in Canada. Prepared and delivered by Karen R. Cohen Ph.D., C.Psych. Chief Executive Officer, Canadian Psychological Association. November 3, 2011.



Finally, we would like to underscore the importance of the Accord's continued attention to investing in research when it comes to Canada's mental health. Psychology is a science-based profession and its attention to evidence-based care is a hallmark of practice. It is critical that we support the full range of biopsychosocial inquiry into mental health issues and interventions upon which people's health and wellness depends.

Psychological factors are important to any national discussion of health promotion and illness prevention for three reasons

1. What we think and feel impacts what we do and what we do affects our health.
2. What we think, feel and do affects the course of illness.
3. Disturbances in what and how we think, feel and behave can be health disorders in and of themselves.

Psychological Factors Impact Health. When it comes to health promotion and illness prevention, it is important to create the services and environments that support healthy behaviour (e.g., bicycle paths, recreation centers) but it is equally important to address the factors that impact health behaviour. Building the recreation centre may be easier than getting people to use it. When it comes to health and illness, the role of psychological factors and human behaviour cannot be underestimated.

Good health is correlated with self-worth, peer connectedness, school engagement and parental nurturance as well as with healthy behaviour.¹ Poor health, on the other hand, is often correlated with poor mental health – one seminal longitudinal study found that a pessimistic world view among men at age 25 predicted physical illness decades later².

Psychological Factors Affect Illness. Many chronic diseases, such as heart disease, diabetes and stroke are themselves risk factors for depression.³ Further, there is evidence that the prevalence of coronary heart disease (CHD) is lowest in adults with good mental health and higher among adults with depression or other mental health problems.⁴ Depression is a risk factor for first myocardial infarction and an even stronger predictor of recurrent cardiac events and mortality in patients with known disease⁵. Stress and anger have also been shown to correlate with CHD and increased cholesterol levels⁶. Finally, concomitants of mental and physical illness may be more than additive. When depression and arthritis co-exist, the degree of disability is greater than the sum of disability attached to each condition alone⁷.

The mental health and well-being of Canadians are not being met. Though mental health services and supports at all levels of prevention and treatment are underfunded and under provided, Canada assumes a very large economic burden for its mental health.

Psychological Disorders. In a one year period, 20% of Canadians will experience a mental disorder and the most prevalent among these are anxiety and depression.^{8,9} Mental disorders account for more of the global burden of disease than all cancers combined¹⁰ and by 2020, depression will be second only to heart disease in terms of disability adjusted life years for all age groups and both sexes¹¹.

This prevalence of mental disorders is particularly relevant to youth in that individuals under 20 years are reported to have the highest rate of depressive symptoms and those between the ages of 20 and 29 have the highest rate of anxiety symptoms¹². Further, approximately 70% of mental disorders have their onset in childhood or adolescence¹³. This means that, persons with chronic mental conditions will be less likely to have established the personal and social resources established by those with health conditions that onset later in life.

The cost of psychological disorders. Mood Disorders Society of Canada reports that the costs of disability due to depression are the fastest growing disability costs for Canadian employers¹⁴. The estimated burden of mental illness to the Canadian economy in 2003 was 51 billion dollars¹⁵. It has been reported that in that same year, spending on mental health totaled 6.6 billion, or less than 5% of total health spending¹⁶ – less than that spent by most developed countries¹⁷. This is despite the fact that mental disorders are among the most costly of chronic diseases¹⁸.

Discussions about health care in Canada frequently focus on the unsustainability of health system costs. What these discussions do not frequently mention, however, is that while we are disproportionately underfunding services and supports for Canada's mental health and well-being, we are most certainly overpaying for it.

What we need to do to better when it comes to Canada's mental health and well-being. It is critical to the success of any health promotion and prevention strategy that we attend to the role of psychological factors and conditions that impact how well people live in health and with illness.

When looking at return on investment for services and supports geared to mental health, two key factors must be considered. First, the clinical and cost effectiveness of services and supports may be borne out over time – as much for what they prevent as for what they cure but more often manage. Second, it has been pointed out that the clinical and cost effectiveness of a service and support delivered in one sector (e.g., the school) may be borne out in another (e.g., the workplace)¹⁹.

The strongest evidence for return on investment in mental health involve services and supports that are geared to children and youth that reduce conduct disorders and depression, deliver



parenting skills, provide anti-bullying and anti-stigma education, promote health in schools, and provide screening in primary health care settings for depression and alcohol misuse²⁰. We need to make health promotion and prevention investments upstream, targeting services and supports for children and youth where return on investment appears greatest.

While health promotion and illness prevention efforts can benefit people living without illness, they can also benefit people living with illness. Positive mental health and good health behaviour can help a person to manage a chronic illness and even prevent it from getting worse.

However, there will be those among us who will need treatment services and supports for mental disorders. Psychological services are not funded by provincial health insurance plans. With cuts to the salaried resource of publicly funded institutions like hospitals, schools and correctional facilities, more and more of Canada's psychologists are practicing in the community where their services are inaccessible to Canadians without means or extended health insurance through employment. One in five Canadians will need these services and the public is calling for better access to them²¹.

Psychological treatments are among the best indicated interventions for depression and anxiety, the most commonly experienced psychological disorders among Canadians. Psychological interventions (e.g., cognitive-behavioural therapy) are recommended as the first line of treatment for anxiety disorders and at least part of the treatment (combined with medication) for the treatment of depression. The United Kingdom has recognized the need for, and effectiveness of psychological interventions. Among the deliverables of the UK's mental health strategy is an investment of approximately "...£400 million over four years to make a choice of psychological therapies available for those who need them..."²² Australia has similarly enhanced access to psychological services through its publicly funded health insurance plans. According to the Australian Psychological Society in March 2011, two million people, in high and very high levels of psychological distress, had accessed the program which reportedly is proving to be both cost and clinically effective for Australians²³.

Mental health promotion and illness prevention, yes, but we also need to enhance access to psychological services so that early, appropriate and ongoing intervention can reach the 1 in 5 Canadians who need it. We need to support Canadians living well in health and with illness.

CPA's Recommendations to the Standing Committee for Canada's Health

1. CPA joins other partners and stakeholders in urging the Federal government to **target transfers to the provinces and territories for mental health and that the funds spent on mental health, mental disorders and addic-**

Health promotion and illness prevention does not stop at diagnosis and caring for Canada's mental health does not stop at prevention.

tions are proportionate to the burden of illness in Canada. We need to join in the recognition among other countries that "there is no health without mental health"²⁴.

2. **Health promotion and illness prevention** need be delivered in communities and its efforts should be **upstream with a focus on children and youth.**²⁵
3. **Intervention when necessary for mental health and illness should be collaborative and integrated** across public and private sectors. Collaboration will require the commitment of all stakeholders – inclusive of the governments, employers and insurers that fund services and supports; the institutions and agencies that deliver it; the health care professionals who provide it; and most importantly those of us who receive it.

Successful collaborative practice calls on health care professionals to practice differently but also calls for the changes in principle, policy and procedure, and funding upon which collaborative practice will also depend.

4. We need more **research** into
 - a. the biological, psychological and social determinants of health and illness
 - b. the biological, psychological and social interventions that best help people live well in health and with mental and physical illness.
5. **We are calling on government and other funders to improve access to effective psychological services for mental health problems and disorders.** Services and supports delivered by psychologists may be in the form of program development and evaluation, assessment and diagnosis, treatment and/or supervision of other personnel charged with treatment and service delivery.

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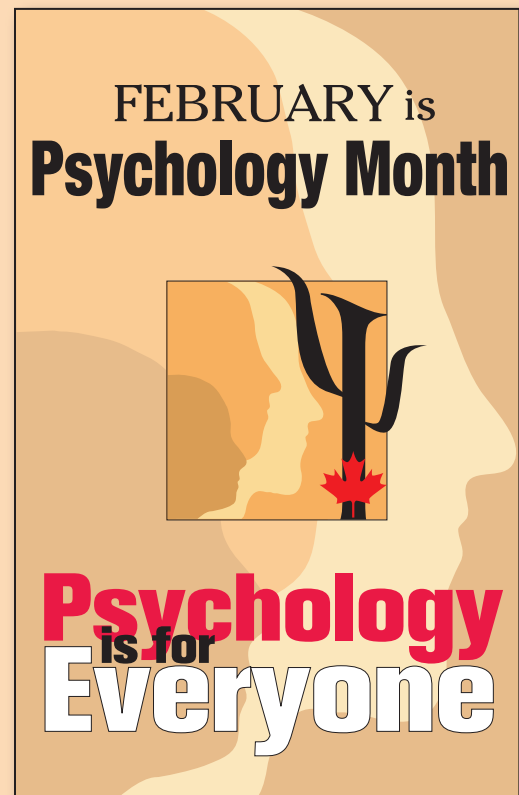
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Psychology Month

February is Psychology Month. We'd love to hear about what you have planned and would like to share it with our community. Email Tyler Stacey-Holmes (publicrelations@cpa.ca) with details of your event and we'll list it on our Psychology Month website.

Mois de la psychologie

Février est le Mois de la psychologie. Nous aimerions entendre ce que vous avez planifié et aimeriez partager avec notre communauté. Faites parvenir un courriel à Tyler Stacey-Holmes (publicrelations@cpa.ca) avec les détails de votre événement et nous allons l'indiquer sur notre site Web du Mois de la psychologie.





La santé de la psychologie et la psychologie de la santé

Karen R. Cohen Ph.D., C. Psych., chef de la direction de la SCP

C'est avec un très grand plaisir que je présente ce numéro spécial de *Psynopsis*. Comme un grand nombre de chercheurs et de praticiens parmi nos membres peuvent en témoigner, la psychologie peut avoir une incidence considérable sur la santé. Un grand nombre d'invitations générales et ciblées ont été envoyées aux membres et à ses sections invitant à présenter des articles pour ce numéro spécial et le présent numéro se veut un reflet de la très bonne réaction que nous avons obtenue!

En créant des numéros spéciaux de *Psynopsis*, nous accomplissons de nombreux objectifs. Deux initiatives que nous croyons les plus importantes sont celles de communiquer l'information à nos lecteurs au sujet de nos initiatives, de nos progrès et des besoins au sein des domaines de spécialité de la recherche et de la pratique. Deuxièmement, les numéros spéciaux ont une fonction de représentation. Nous pouvons les utiliser pour informer d'autres intervenants (p. ex. le public, le gouvernement, les bailleurs de fonds) au sujet de la pertinence de la recherche et la pratique de la psychologie concernant des enjeux qui préoccupent les intervenants.

Comme les sondages en temps d'élection nous le rappellent fréquemment, la santé et les soins de santé ne sont jamais très loin de la pensée des Canadiens. Actuellement, les gouvernements fédéral, provinciaux et territoriaux se concentrent sur l'Accord sur les soins de santé qui doit être renouvelé en 2014. En novembre 2011, la SCP a été invitée à comparaître devant le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie sur le plan décennal pour consolider les soins de santé au Canada. Le groupe d'experts auquel participait la SCP devait aborder la question de la promotion de

la santé, de la prévention de la maladie et de la santé publique et c'était dans ce contexte qu'on nous a demandé de présenter notre point de vue.

Ce qui suit est un mémoire écrit présenté au Comité permanent, un résumé de ce qui aura été présenté au Comité lorsque D^{re} Cohen a comparu en novembre. Le mémoire écrit se trouve à l'adresse suivante <http://www.cpa.ca/docs/file/Position/CPA-briefSSCommitteeNov2011FINAL.pdf> Nous allons tenir les lecteurs au courant de toute autre activité de la SCP relativement à l'accord de 2014 par le site Web et *Psynopsis* – les activités que nous entreprendrons de notre propre chef et celles auxquelles nous contribuons en tant que membre de différentes alliances (p. ex. le Groupe d'intervention action santé (HEAL), Alliance canadienne pour la maladie mentale et la santé mentale). Pour obtenir de l'information, n'hésitez pas à communiquer avec kcohen@cpa.ca à n'importe quel moment.

**Société canadienne de psychologie.
Bien vivre en santé et avec la maladie^a.**

Introduction

La Société canadienne de psychologie (SCP) remercie le Comité permanent de son invitation à nous joindre à son examen et aux discussions entourant les besoins, les services et le soutien en santé au Canada. La SCP est la plus grande association nationale de psychologues professionnels voués à la science, à la pratique et à l'enseignement de la psychologie dans le service à nos membres et au bien public. Il y a environ 18 000 praticiens autorisés de la psychologie au Canada ce qui fait des psychologues le plus grand groupe réglementé de fournisseurs de soins de santé mentale spécialisés au pays.

^a Mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. Plan décennal pour consolider les soins de santé au Canada. Préparé et présenté par Karen R. Cohen Ph.D., C.Psych. Chef de la direction, Société canadienne de psychologie, le 3 novembre 2011.



Dans ce mémoire, nous offrons notre perspective sur la mise en œuvre de l'Accord de 2004. Nous insistons principalement sur le rôle des facteurs psychologiques dans la santé et le bien-être, l'incidence des facteurs psychologiques sur la maladie et les coûts et les besoins en matière de santé mentale au Canada.

Accord fédéral/provincial/territorial de 2004

L'Accord souligne l'importance d'investir dans l'offre de professionnels de la santé au Canada. La pensée actuelle ferait appel au gouvernement et à d'autres intervenants pour penser à l'offre en fonction des besoins. Mais il ne s'agit pas seulement d'une question d'avoir besoin d'un plus grand nombre de fournisseurs de soins de santé, mais aussi de la nécessité de former davantage de fournisseurs dans le but de satisfaire les besoins en santé particuliers des Canadiens et de créer des pratiques optimales tant du point de vue du coût que clinique. En ce qui concerne la santé mentale, de nombreux besoins émergents en pratique peuvent être identifiés, notamment les conditions chroniques qui découlent du vieillissement de la population et les facteurs cognitifs et émotifs qui accompagnent souvent ces états de santé (p. ex. l'incidence et la prévalence de la démence, le rôle de la dépression dans les maladies du cœur).

L'accroissement de l'offre de ressources humaines en santé (RHS) au Canada en ce qui concerne la santé mentale fera appel à un investissement dans l'enseignement et la formation de nos RHS afin de satisfaire les besoins particuliers de la population et il faudra travailler de façon concertée pour satisfaire ces besoins de façon efficace et efficiente. Nous devons investir dans une infrastructure qui vient à l'appui d'un modèle de collaboration de prestation de services de soins de santé de manière à ce que, comme l'indique l'Accord de 2004, la bonne personne obtienne le bon service, au bon moment, au bon endroit et des bons fournisseurs.

L'Accord de 2004 se concentre sur la réduction des temps d'attente et l'amélioration de l'accès aux soins mais passe sous silence les questions et les possibilités d'accès en ce qui concerne la santé mentale. Les obstacles à l'accès au service de santé mentale que les Canadiens doivent surmonter ne sont pas liés seulement à l'offre de fournisseurs dont les services sont financés par nos régimes d'assurance santé provinciaux et territoriaux, mais aussi par les fournisseurs dont les services ne sont pas financés par les deniers publics. Nous aborderons plus tard cet enjeu dans le présent mémoire.

Les besoins de santé mentale sont identifiés dans l'Accord de 2004 par rapport aux dispositions en matière de

soins à domicile. Bien que le service communautaire et les interventions en temps de crise soient essentiels pour ceux aux prises avec des troubles mentaux chroniques et persistants, **il est important de garder à l'esprit que un Canadien sur cinq atteints d'un trouble mental n'aura vraisemblablement pas les genres de troubles mentaux graves et persistants dont s'occupent habituellement les programmes de santé mentale communautaires.** Les Canadiens seront plus vraisemblablement atteints de dépression et d'anxiété – les troubles que les traitements de psychologie fondés sur des données factuelles et les services et les soutiens communautaires (y compris la promotion de la santé et les programmes de prévention de la maladie) peuvent le mieux gérer.

En dernier lieu, nous aimerions souligner l'importance que l'Accord accorde une attention soutenue aux investissements en recherche en matière de santé mentale au Canada. La psychologie est une profession dont les fondements reposent sur la science et l'attention accordée aux soins fondés sur des données factuelles est une marque de commerce de sa pratique. Il est essentiel d'appuyer l'éventail complet des recherches biopsychosociales qui se font

au sujet des problèmes de santé mentale et des interventions dont la santé et le bien-être des personnes sont tributaires.

Il faut tenir compte des facteurs psychologiques dans toutes les discussions nationales concernant la promotion de la santé et la prévention de la maladie pour trois raisons :

1. Ce que nous pensons et ressentons a des incidences sur ce que nous faisons et ce que nous faisons a une incidence sur notre santé.
2. Ce que nous pensons, ressentons et faisons a une incidence sur le cours d'une maladie.
3. Les perturbations dans ce à quoi nous pensons et comment nous pensons, nous nous ressentons et nous comportons peuvent en elles-mêmes être à l'origine de troubles de santé.

Les facteurs psychologiques ont une incidence sur la santé. En ce qui concerne la promotion de la santé et la prévention de la maladie, il est important de créer des services et des contextes qui favorisent un comportement sain (p. ex. des pistes cyclables, des centres récréatifs), mais il est également important de se pencher sur les facteurs qui ont une influence sur les comportements sains. Il pourrait être plus facile de construire le centre récréatif que d'amener les personnes à s'en servir. Lorsqu'il est question de santé et de maladie, le rôle des facteurs psychologiques et du comportement humain ne peut pas être sous-estimé.

La bonne santé entre en corrélation avec l'amour propre, les liens entretenus avec les pairs, l'engagement scolaire et la nurturing parentale ainsi que le comportement sain¹. D'autre part,



la mauvaise santé est souvent corrélaire d'une mauvaise santé mentale – une étude longitudinale fondamentale a révélé qu'une vision du monde pessimiste chez les hommes à 25 ans présageait souvent une maladie physique des décennies plus tard².

Les facteurs psychologiques ont un effet sur la maladie.

Un grand nombre de maladies chroniques, comme la maladie de cœur, le diabète et l'AVC sont en eux-mêmes des facteurs de risque de dépression³. De plus, il y a des preuves que la prévalence de la coronaropathie est plus faible chez les adultes ayant une bonne santé mentale et plus élevée chez les adultes souffrant de dépression ou d'autres problèmes de santé mentale⁴. La dépression est un facteur de risque pour le premier infarctus du myocarde et un prédicteur encore plus grand d'attaques cardiaques récidivantes et de mortalité chez les patients qui connaissent leur maladie⁵. Des études ont également révélé que le stress et la colère entrent en corrélation avec la coronaropathie et des niveaux de cholestérol plus élevés⁶. En dernier lieu, la concomitance de la maladie mentale et physique peut avoir un effet cumulatif. Lorsque la dépression et l'arthrite coexistent, le degré d'invalidité est plus grand que la somme d'invalidité attribuée à chaque condition proprement dite⁷.

Troubles psychologiques. Sur une période d'un an, 20 % des Canadiens éprouveront un trouble mental et l'anxiété et la dépression demeurent les troubles dont la prévalence est la plus élevée^{8,9}. Les troubles mentaux représentent un plus grand fardeau global que tous les cancers combinés¹⁰ et d'ici 2020, la dépression se classera au deuxième rang, tout de suite après la maladie du cœur en termes d'années de vie corrigées du facteur invalidité pour tous les groupes d'âge et les deux sexes¹¹.

La prévalence des troubles mentaux est particulièrement pertinente chez les jeunes selon les études qui révèlent que les individus de moins de 20 ans ont un taux le plus élevé de symptômes de dépression et que ceux entre 20 et 29 ans ont un taux le plus élevé de symptômes d'anxiété¹². De plus, environ 70 % des troubles mentaux font leur apparition au cours de l'enfance ou de l'adolescence¹³. Cela signifie que, les personnes atteintes d'états mentaux chroniques auront moins vraisemblablement établi les ressources personnelles et sociales que celles dont les états de santé se déclarent plus tard dans la vie.

Le coût des troubles psychologiques. La Société pour les troubles de l'humeur du Canada soutient que les coûts de l'invalidité due à des dépressions sont les coûts d'invalidité qui croissent le plus rapidement pour les employeurs canadiens¹⁴. Le fardeau de la maladie mentale estimé pour l'économie canadienne en 2003 était de 51 milliards de dollars¹⁵. Des études

ont révélé qu'au cours de la même année, les dépenses en santé mentale s'élevaient à 6,6 milliards, soit moins de 5 % des dépenses totales en santé¹⁶ – c.-à-d. moins que ce que la plupart des pays développés¹⁷ dépensent et ce malgré le fait que les troubles mentaux se comptent parmi des maladies chroniques les plus coûteuses¹⁸.

Les discussions entourant les soins de santé au pays abordent souvent la question de l'insoutenabilité des coûts du système de soins de santé. Les discussions à ce sujet omettent souvent de mentionner le fait que nous sous-finançons de façon disproportionnée les services et les soutiens pour la santé mentale et le bien-être des Canadiens et que nous payons certainement beaucoup trop cher pour ceux-ci.

Ce que nous devons faire mieux en ce qui concerne la santé mentale et le bien-être des Canadiens. Pour assurer le succès de toute stratégie de promotion de la santé et de prévention de la maladie il est essentiel de se pencher sur le rôle des facteurs et des états psychologiques qui ont une influence sur la manière de vivre en santé et avec la maladie des personnes.

Lorsqu'on examine le rendement de l'investissement dans les services et les soutiens axés sur la santé mentale, il faut accorder l'attention à deux facteurs clés. Tout d'abord, l'efficacité clinique et des coûts des services et des soutiens peuvent être assumés avec le temps – tout autant pour ce qu'ils permettent de prévenir et de guérir, mais le plus souvent pour ce qu'ils permettent de gérer. Deuxièmement, des études révèlent que l'efficacité clinique et le rapport coût-efficacité d'un service et d'un soutien assurés dans un secteur (p. ex. l'école) peuvent être assumés dans un autre contexte (p. ex. le lieu de travail)¹⁹.

La preuve la plus convaincante du rendement de l'investissement en santé mentale est manifeste dans les services et les soutiens axés sur les enfants et les jeunes qui permettent de réduire des troubles du comportement et de la dépression, qui assurent les compétences parentales, donnent de l'information au sujet des façons de contrer l'intimidation et la stigmatisation, encouragent la santé dans les écoles et permettent de faire le dépistage de la dépression et de l'abus d'alcool dans les établissements de soins de santé primaires²⁰. Nous devons

faire des investissements en promotion de la santé et en prévention en amont, tout en ciblant les services et les soutiens aux enfants et aux jeunes où le rendement de l'investissement semble le plus grand.

Alors que les efforts de promotion de la santé et de prévention de la maladie peuvent avoir des bienfaits sur les personnes vivant sans maladie, ils peuvent aussi avoir des bienfaits sur les personnes vivant avec une maladie. Une santé mentale positive et un comportement qui encourage la bonne santé peuvent aider

La santé mentale et le bien-être des Canadiens ne sont pas bien pris en compte. Parce que les services et les soutiens en santé mentale à tous les niveaux de la prévention et du traitement sont sous-financés et qu'ils sont insuffisants, le Canada doit assumer un fardeau économique très lourd au chapitre de la santé mentale.



une personne à gérer une maladie chronique et même prévenir qu'elle ne devienne plus grave.

Cependant, il y a ceux d'entre nous qui auront besoin de services de traitement et de soutiens pour les troubles mentaux. Les services psychologiques ne sont pas financés par les régimes d'assurance santé provinciaux. Compte tenu des compressions de ressources salariées dans les établissements financés par les deniers publics comme les hôpitaux, les écoles et les établissements correctionnels, de plus en plus de psychologues ouvrent des pratiques dans la collectivité, mais leurs services sont inaccessibles pour les Canadiens sans les moyens ou une couverture d'un régime d'assurance-maladie complémentaire offert au travail. Un Canadien sur cinq aura besoin de ces services et le public demande un meilleur accès à ceux-ci²¹.

Les traitements psychologiques font partie des meilleures interventions recommandées pour la dépression et l'anxiété, les troubles psychologiques les plus souvent éprouvés par les Canadiens. Les interventions psychologiques (p. ex. la thérapie cognitivo-comportementale) sont recommandées comme première ligne de traitement pour les troubles d'anxiété et au moins une partie du traitement (combiné avec une pharmacothérapie) pour le traitement de la dépression. Le Royaume-Uni a reconnu la nécessité des interventions psychologiques et leur efficacité. Parmi les produits livrables de la stratégie de santé mentale du Royaume-Uni se trouve un investissement d'environ « 400 millions de livres sur quatre ans pour faire un choix de thérapies psychologiques disponibles offert à ceux qui en ont besoin... »²² Dans le même sens, l'Australie a opté pour une amélioration de l'accès aux services de psychologie par le biais de ses régimes d'assurance santé financés par les deniers publics. Selon l'Australian Psychological Society, en mars 2011, deux millions de personnes, à des niveaux élevés et très élevés de détresse psychologique, ont eu accès au programme qui selon les études s'avère efficace d'un point de vue du coût et d'un point de vue clinique pour les Australiens²³.

La promotion de la santé mentale et la prévention de la maladie, oui sans hésitation, mais nous avons aussi besoin d'améliorer l'accès aux services de psychologie de manière à ce que les interventions hâtives, appropriées et soutenues puissent se faire auprès d'un Canadien sur cinq qui en ont besoin. Nous devons appuyer les Canadiens à vivre en santé et aussi bien qu'avec une maladie.

Recommandations de la SCP au Comité permanent pour la santé du Canada

1. La SCP se joint à d'autres partenaires et intervenants pour inciter le gouvernement fédéral à **cibler les transferts aux provinces et aux territoires pour la santé mentale et que les fonds dépensés pour la santé mentale, les troubles mentaux et les toxicomanies soient proportionnels**

La promotion de la santé et la prévention de la maladie ne s'arrêtent pas au diagnostic et le soin en santé mentale des Canadiens ne s'arrête pas à la prévention.

au fardeau de la maladie au Canada. Nous devons faire comme d'autres pays et reconnaître « qu'il n'y a pas de santé sans santé mentale »²⁴.

2. **La promotion de la santé et la prévention de la maladie** doivent se faire dans les collectivités et les efforts doivent être **en amont en se concentrant en premier lieu sur les enfants et les jeunes**²⁵.
3. **L'intervention lorsqu'elle est nécessaire pour la santé et la maladie mentales devrait se faire de façon concertée et intégrée** dans les secteurs public et privé. La collaboration fera appel à un engagement de tous les intervenants – y compris les gouvernements, les employeurs et les assureurs qui financent les services et les soutiens, les institutions et les organismes qui assurent la prestation de services, les professionnels de soins de santé qui les fournissent et de façon encore plus importante ceux d'entre nous qui les recevons. Une pratique concertée qui porte fruit exige que les professionnels de soins de santé exercent leur pratique différemment, mais fait aussi appel à des changements dans les principes, les politiques et les procédures et le financement dont la pratique concertée est également tributaire.
4. Nous devons effectuer davantage de **recherche** dans
 - a. les déterminants biologiques, psychologiques et sociaux de la santé et la maladie
 - b. les interventions biologiques, psychologiques et sociales qui aident le mieux les personnes à bien vivre en santé et avec des maladies mentales et physiques.
5. **Nous demandons au gouvernement et aux autres bailleurs de fonds d'améliorer l'accès aux services de psychologie touchant les problèmes et les troubles de santé mentale.** Les services et les soutiens qu'offrent les psychologues peuvent être sous forme d'élaboration et d'évaluation de programmes, d'évaluations et de diagnostics, de traitements et/ou de supervisions d'autres membres du personnel chargés du traitement et de la prestation des services.

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Cost Effective Psychosocial Interventions for Clinical Depression in a Time of Economic Depression

David J. A. Dozois, Ph.D., President

As I write this column, the Brussels leaders' summit is only days away. The leaders from the euro zone countries will meet to develop a comprehensive package that will ideally solve the European debt crisis. Some analysts estimate that the odds of global recession are greater than 50 percent. Times are tough. The dampening of the global economy has forced many countries to rein in their spending and implement various austerity measures. Perhaps these countries should have taken notes from David Chilton's personal finance book, *The Wealthy Barber*, and learned not to spend beyond their means. Now I am not finance-savvy, but I do know that thinking beyond the immediate and planning for the long-term makes a lot of sense financially and otherwise. So where is the fiscal responsibility when it comes to (mental) health care? Where is the long-term planning? Take depression as an example of a problem for which there are cost-effective treatments but poor access to care.

Clinical depression costs. In addition to the tremendous burden to the individual are its costs to society (approximately \$14 billion annually in Canada alone). The World Health Organization estimates that depression will soon be second only to ischemic heart disease in terms of cost to society. Dewa, Chau and Dermer (2010) examined the costs of disability episodes associated with mental health problems and compared them to the costs associated with physical disorders. The average disability episode lasted 33 days (with an average cost of \$9027/episode). Mental/behavioral disorders resulted in the highest disability costs (65-days leave with a mean cost of \$18,000/episode).

Cognitive-behavioral therapy, behavioral therapy and interpersonal psychotherapy are the psychosocial interventions with the most empirical support for the treatment of depression. Of these interventions, cognitive-behavioural therapy (CBT) has been the most actively researched. More than 75 clinical trials and numerous meta-analyses have been published on CBT for unipolar depression (see Butler, Chapman, Forman, & Beck, 2006). CBT is comparable to behaviour therapy, other bona fide

psychological treatments and antidepressant medication for an acute episode of depression, with each producing superior results to placebo control conditions (Beck & Dozois, 2011).

A common misperception is that CBT is effective only for mild and moderate depression. This belief has persisted despite considerable data to the contrary. DeRubeis, Gelfand, Tang and Simons (1999), for instance, conducted a mega-analysis in which they pooled the data from four related trials. These researchers found that CBT was equally effective as antidepressants (tricyclic antidepressants) for the treatment of severe depression. More recent studies that have compared cognitive therapy to SSRIs have also demonstrated that these treatments are equally effective for severe depression (e.g., DeRubeis et al., 2005).

What is particularly interesting, however, is that CBT not only effectively treats an episode of depression but also prevents the occurrence of future episodes (this prophylaxis appears to extend to behavioral activation as well; Dobson et al., 2008). The average risk of relapse following antidepressant medication is more than double the rate following CBT (i.e., 60% compared to 25% based on follow-up periods of 1 to 2 years). Some studies also indicate that patients who receive CBT alone are no more likely to relapse after treatment than are those who receive continuance medication (e.g., Hollon et al., 2005). Hollon et al. successfully treated individuals with depression using antidepressants (paroxetine) or CBT and followed them up over a 12-month period. Following recovery, participants in the antidepressant group were randomly

assigned to continuance medication or shifted to pill placebo. Those individuals who had been treated with CBT were simply followed up (although they were permitted to have up to 3 booster sessions over the course of the year). Both CBT and continuance medication outperformed the placebo control condition. Interestingly, no statistically significant differences were found on relapse rates between CBT and continuance medication (in fact, numerically the CBT group evidenced lower relapse).

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Interventions psychosociales économiques pour soigner la dépression clinique dans une période de dépression économique

David J. A. Dozois, Ph.D., président

Au moment d'écrire la présente rubrique, le sommet des chefs d'État de Bruxelles n'est qu'à quelques jours. Les chefs d'État des pays de la zone euro se rencontreront pour mettre au point un train de mesures exhaustives qui idéalement résoudre la crise de la dette européenne. Certains analystes sont d'avis que les chances d'une récession mondiale sont supérieures à 50 pour cent. Les temps sont durs. Le piétinement de l'économie mondiale a forcé de nombreux pays à sabrer dans leurs dépenses et à mettre en œuvre diverses mesures d'austérité. Ces pays auraient probablement dû prendre note du livre sur les finances personnelles de David Chilton, *The Wealthy Barber*, et apprendre à ne pas dépenser au-delà de leurs moyens. Je ne suis pas un grand financier, mais je sais que de penser au-delà de l'immédiat et la planification à long terme ont beaucoup de sens d'un point de vue financier et autre. Alors où est la responsabilité financière lorsqu'il est question de soins de santé (mentale)? Où est la planification à long terme? Prenons la dépression comme exemple de problème pour lequel il y a des traitements économiques mais un accès médiocre aux soins.

La dépression clinique coûte cher. En plus du fardeau terrible sur l'individu, il faut songer aux coûts pour la société (environ 14 milliards de dollars annuellement au Canada seulement). L'Organisation mondiale de la santé estime que la dépression viendra bientôt au second rang après la cardiopathie ischémique en termes de coût pour la société. Dewa, Chau et Dermer (2010) ont examiné les coûts des épisodes d'invalidité associés aux problèmes de santé mentale et les ont comparés aux coûts associés aux troubles physiques. L'épisode d'invalidité moyenne a duré 33 jours (à un coût moyen de 9 027 \$ par épisode). Les troubles mentaux/comportementaux sont à l'origine des coûts d'invalidité les plus élevés (65 jours de congé à un coût moyen de 18 000 \$/épisode).

La thérapie cognitivo-comportementale, la thérapie comportementale et la psychothérapie interpersonnelle demeurent les interventions psychosociales qui reçoivent le plus de soutien des données empiriques pour le traitement de la dépression. De ces interventions, la thérapie cognitivo-comportementale (TCC) a fait l'objet des recherches les plus actives. Plus de 75 essais cliniques et de nombreuses méta-analyses ont été publiés sur la TCC pour la dépression unipolaire (voir Butler, Chapman, Forman et Beck, 2006). La TCC est comparable à la thérapie du comportement, d'autres traitements psychologiques authentiques et les médicaments antidépresseurs pour un épisode aigu de dépression, chacun produisant des résultats supérieurs aux conditions de contrôle par placebo (Beck et Dozois, 2011).

Une perception erronée commune est que la TCC n'est efficace que pour la dépression légère et modérée. Cette croyance a persisté malgré des données considérables prouvant le contraire. DeRubeis, Gelfand, Tang and Simons (1999), par exemple, ont mené une méga-analyse dans laquelle ils ont rassemblé les données de quatre essais connexes. Ces chercheurs ont trouvé que la TCC était aussi efficace que les antidépresseurs (antidépresseurs tricycliques) pour le traitement de la dépression grave. Des études plus récentes qui ont comparé la thérapie cognitive aux inhibiteurs spécifiques du recaptage de la sérotonine ont également démontré que ces traitements sont également efficaces pour la dépression grave (p. ex. DeRubeis et coll., 2005).

Or, ce qui est particulièrement intéressant est que la TCC n'est pas seulement efficace pour traiter un épisode de dépression, mais aussi pour prévenir l'occurrence d'épisodes futurs (cette prophylaxie semble s'étendre aussi à l'activation comportementale; Dobson et coll., 2008). Le risque moyen de rechute après une médication d'antidépresseurs est plus de deux fois le taux suivant une TCC (c.-à-d. 60 % comparativement à 25 % fondés sur les périodes de suivi d'un à deux ans). Certaines études révèlent aussi que les patients qui suivent une TCC seulement ne sont pas plus à risque d'une rechute après le traitement que ceux qui continuent sur la médication (p. ex. Hollon et coll., 2005). Hollon et coll. ont réussi à traiter les individus souffrant d'une dépression à l'aide d'antidépresseurs (paroxétine) ou la TCC et les ont suivis sur une période de 12 mois. Après leur rétablissement, les participants au groupe auquel on avait administré des antidépresseurs ont été assignés de façon aléatoire à la médication de maintien ou le médicament a été simplement remplacé par un placebo. Ces individus qui avaient été l'objet d'une TCC ont simplement été suivis (bien qu'on ait permis à certains d'entre eux d'avoir trois séances de rappel au cours de l'année). La TCC et la médication de maintien se sont avérées supérieures à la condition de contrôle par placebo. Fait intéressant, aucune différence significative d'un point de vue statistique n'a été trouvée sur les taux de rechute entre la TCC et la médication de maintien (en fait, d'un point de vue numérique le groupe de TCC manifestait moins de rechutes).

Il semblerait que même si la TCC et les antidépresseurs peuvent également changer les symptômes de la dépression et certains aspects (davantage au niveau de la surface) de la pensée négative (comme le traitement de l'information, les pensées automatiques et les attitudes dysfonctionnelles). Cependant, la thérapie cognitive semble modifier davantage certaines des

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structures cognitives « plus profondes » qui peuvent être à l'origine d'une rechute et d'une récurrence (p. ex. Dozois et coll., 2009).

Les analyses de rapport coût-efficacité révèlent aussi que les traitements comme la TCC coûtent moins cher à administrer que la médication. Ne serait-il pas alors financièrement responsable d'assurer que les Canadiens ont accès aux traitements psychologiques les plus efficaces? Ce message à teneur financière a clairement convaincu le Royaume-Uni qui a attribué 170 millions de livres sterling pour accroître l'accès à la TCC (en passant, le président honoraire de la SCP de 2011-2012, Dr David M. Clark, a été l'un des chefs de file dans cette initiative). Au moment où le Canada se penche sur son Accord de soins de santé, c'est un message que nous devons en tant que psychologues aussi envoyer aux décideurs canadiens. Le Canada et les Canadiens méritent l'avenir le plus brillant possible. Lorsqu'il est question de santé mentale, la psychologie peut leur aider à l'avoir.

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It appears as though CBT and antidepressant medication may equally change depressive symptoms and certain (more surface-level) aspects of negative thinking (such as information processing, automatic thoughts and dysfunctional attitudes). However, cognitive therapy appears to further modify some of the "deeper" cognitive structures that may give rise to relapse and recurrence (e.g., Dozois et al., 2009).

Cost-effectiveness analyses also indicate that treatments such as CBT are cheaper to administer than medication. Wouldn't it then seem fiscally responsible to ensure that Canadians have access to such efficacious psychological treatments? This fiscal message spoke clearly to the United Kingdom which allocated £170 million to increase access to CBT (incidentally, CPA's 2011-12 Honorary President, Dr. David M. Clark, has been one of the leaders involved in this initiative). As Canada re-envision its Health Care Accord, it is a message that we as psychologists need to send to Canadian policy-makers as well. Canada and Canadians deserve the brightest future possible. When it comes to mental health, psychology can help give them one.

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In Matters of Health - Psychology Matters

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The first objective of the CPA's Mission and Mandate is to 'improve the health and welfare of all Canadians'. I remember the discussion of this terminology at an annual meeting of the CPA several years ago and the decision to use the word 'health' without the qualifying 'mental' before it.

The importance of psychology to health has been consistently highlighted over the past decade (e.g. Arnett, J., 2001; 2006). Nonetheless, much of the general public views Psychology through a mental health lens, and continues to have difficulty understanding the difference between psychology and psychiatry. The unique contributions of psychology to mental health are not well appreciated, nor is the role of psychology to the larger health mandate. Psychology and psychological factors are critical to the good management of health and illness. An increased understanding of the value of psychological services for health promotion, improving health behaviours, primary and secondary prevention, and the management or adaptation to various health conditions and disabilities, is necessary for the science and practice of Psychology to do its job improving the health and welfare of Canadians. To do this, we need to continue our efforts to help the public, and the institutions and organizations that fund psychological services, understand that psychologists are in the health business, in the broadest possible sense.

The review by Romanow and Marchildon (2003, *Psychological Services and the Future of Health Care in Canada*) highlighted areas where psychological services should be offered because of demonstrated outcomes and cost effectiveness. These were: brain-related disorders; rehabilitation services; end-of-life care; primary care, and cost-effective drugless therapies for depression, anxiety, addictions, as well as conduct, mood and personality disorders. Collectively these affect the health of a large number of Canadians and with 2020 projections for depression, obesity and diabetes, will affect an increasing larger proportion.

As is true of most hospitals, the psychological services provided at The Ottawa Hospital (TOH) are aligned with what Romanow and Marchildon recommended:

- Neuropsychology services across inpatient units such as trauma, neurosurgery, psychiatry and for patients with acquired brain injury, stroke, Alzheimer's, etc.
- Rehabilitation psychology services for people with spinal cord injury, amputation, multiple sclerosis, respiratory disorders, chronic pain, etc.
- Health psychology early intervention and treatment services for patients with cancer, HIV, hepatitis C, cardiac, bariatric surgery, etc.
- Clinical Psychology services for patients with urgent care needs, eating disorders, first episode psychosis, etc.

In spite of substantive contributions of demonstrated value and efficacy, tight hospital budgets and the lack of legislation mandating service, the growth of psychology within publicly funded health care institutions remains challenged. Here is the

'Catch 22': new services are not supported because there is no research demonstrating their value but the value of a non-existent service cannot be demonstrated! Sometimes we are able to inform and educate serendipitously. For example, the psychologist on the Family Health Team at TOH, Dr. Pamela Cooper, is registered in both Clinical and Neuropsychology. While initially hired to provide clinical services, the ability to offer neuropsychology service as well has been important, not only for patient care, but also in demonstrating the importance of the service to both front-line practitioners and administrators. As the value of this contribution is shared, it increases the possibility of neuropsychology services being requested for patients in other primary care settings.

Hospital psychologists have advanced practice through research and research funding. There has been outstanding research done in Academic Health Science Centres and increased partnerships among University and Hospital colleagues around psychological research in health. Evidence demonstrating the contribution of psychological variables in decreasing health care costs or improving outcomes underscores the essential need for continued knowledge transfer. As health budgets tighten, the place of research in health care settings has faced two opposing forces, with scrutiny about cost and direct relevance on one hand and with increased appreciation of program evaluation and outcome and medical cost offset research, on the other. Leveraging additional resources through research is a valued currency to hospital administrators, particularly in Academic Health Science Centres.

It's also important to recognize that Canadian health centres, primarily hospitals, contribute to Psychology. As has been noted by others, most psychologists receive a substantial proportion of their clinical training in hospital settings which provide intern stipends, accreditation fees, opportunity to teach and train and Training Directors' positions. Collectively, hospitals provide the balance of breadth and depth in psychology training associated with acute care (e.g. trauma and oncology) as well as those services associated with regional in- and out-patient programs (e.g., rehabilitation, maternal-fetal medicine, first episode psychosis).

The tag line **In Matters of Health – Psychology Matters**, developed by Dr. Peter Henderson, has been used at TOH on Psychology staff lanyards, mugs, pens, pads, and on the articles written for the TOH Journal during Psychology Month. In spite of the ups and downs and changes in management structures, support for what psychology has to offer is being recognized in some institutions through clinical and leadership roles as well as research, teaching, and training opportunities.

The new Section on Psychology in Hospitals and Health Centres should help us to share, unite, and advance the ways in which psychology matters in matters of health.

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School Psychology:

The Gateway to Psychological Well-Being and Health

By Juanita Mureika, L.Psych., member of the Section of Psychologists in Education and the Canadian Association of School Psychologists

Imagine if you can ... you are a psychologist, with all the knowledge and understanding of the development of cognition, perception, emotions, relationships, psycho-social adjustment, and mind-body connections that your training in psychology has afforded you AND, you are in a position to use those broad skills with a wide audience, at an early age, in a prevention-based model. You have universal access to a population of children, families, and those who influence their development and can make a difference, because you go to them and are with them – they don't have to come to you! You have the ability to both promote emotional health and to forestall future dysfunctions. You are a school psychologist!

The opportunities for health promotion and early intervention that a school psychologist has are huge. No other branch of psychology has such access to such a large population at such an early age. Schools are the first legally mandatory service that a child will encounter, so everyone from 5-18 becomes your client, along with their parents, families, and teachers. Because you work in the system, you are on-call, in the mix, and constantly teaching, coaching and modeling measures to promote positive classroom and school climate, engage in activities to strengthen the community, and help parents and teachers better understand the children in their care.

You have the tools to identify problems, and because you are in the system, that identification can be early enough to allow for prompt intervention, which might avert later problems, academic or emotional/behavioural. Because you are in the system, as well, you reduce the stigma of mental health contact with psychologists by responding promptly to concerns in a positive and pro-active approach in the natural environment. Without this early intervention, problems grow and become chronic and possibly disabling, and then a clinician and more serious involvement is required to turn around what is now interfering with functioning.

The Positive Behaviour Support model (www.pbis.org), which most schools espouse, is a public health model. Efforts are directed primarily towards Universal interventions, creating safe and caring learning environments. Secondary interventions are targeted towards early identification and speedy intervention, both academic and behavioural. Tertiary interventions apply to a small proportion of the school population, and normally involve more intensive assessment and intervention, as well as community liaisons with mental health agencies and practitioners, health professionals, public safety and correctional officers, and social services agencies. The school psych-

ologist is the link to the community for the broader-based planning and intervention that these high needs students and families will need. Lean and Colucci, in their 2010 book, *Barriers to Learning: The Case for Integrated Mental Health Services in Schools*, have argued effectively for the importance of school-based mental health professionals in the promotion and sustaining of positive learning and behaviour in schools.

The role of a school psychologist is unique among psychologists in that it is not pathology-based. We don't need to worry so much about fixing what is broken but in finding strengths and building on them. As Jeff Grimes wrote in the National Association of School Psychologists' *Communique (1997)*, "There needs to be a shift in focus from diagnosing how a learner is *disabled* to diagnosing how a learner can be *enabled*".

With that in mind, the possibilities for intervention are extensive and include wrap-around services in the family, school and community. Some of the most exciting initiatives today are developing bullying prevention programs, leading social skills and stress management sessions, teaching suicide awareness, parenting training and teacher professional development, all of which have wide appeal and far-reaching impacts on the mental health of a school population.

Unfortunately, the school psychologists of today are victims of the success of our predecessors. Psychologists first entered the school system in the 1960s to respond to a need for diagnosis for programming and medical intervention. Those first psychologists were so convincing in their efforts to promote psycho-educational testing as the first requirement for any learning or behavioural challenge that they, in essence, built in a dependency in the system for psychological test data. The testing industry boomed, and demand for psychologists to do the tests grew and grew, unfortunately beyond the supply of psychologists available to do the work. But, since the dependency was there, universities began training teachers in Educational Psychology programs to do the testing that the system believed was required to intervene with kids.

Fast forward to today. Despite the efforts of universities to appropriately train psychologists to work in the schools, there continues to be more demand than supply to meet the needs of the system. The prevention part of the role, which is the most appealing and rewarding part of the job, is eroded by the perceived requirement for test data and diagnosis before educational planning. Title issues, educational levels and a scarcity of CPA accredited programs and internships in school psychology may make the specialty less appealing to many than the more numerous and popular clinical psychology programs. As well, experience and observation tell us that more and more

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Psychology with Technology: Innovations in Sleep Treatment

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Chronic insomnia refers to significant difficulties with falling asleep, staying asleep, or non-restorative sleep coupled with daytime impairment. With one in ten affected, chronic insomnia has been described as an international public health problem (Espie, 2009). Although there are robust treatments for this problem, accessing such care is often problematic. This paper outlines an innovative delivery of a brief treatment for insomnia that combines technology and psychological science in a cost-effective model.

Treatment of Insomnia. Treatment as usual for chronic insomnia is often provided by the primary care physician who offers pharmacotherapy (Hayward, Jordan, & Croft, 2010). Less frequently offered is cognitive behavioral therapy (CBT) which is considered to be the gold standard treatment for insomnia and recommended by the American Academy of Sleep Medicine (Morgenthaler et al., 2006). A review of trials comparing CBT to pharmacotherapy showed that there are comparable short-term outcomes between CBT and sleeping agents, but that CBT has better durability in the long-run (Riemann & Perlis, 2009). Further, research has shown that individuals with insomnia often express a preference for CBT over medication treatments for this problem often due to fears of side-effects and dependency (Vincent & Lionberg, 2001).

Even the most highly effective treatments are of little use if there is insufficient access to such treatment. In the past few years, a Canadian evidence-based computerized program for insomnia has been developed to increase access to service (Vincent & Lewycky, 2009). This 6-week program (*return2sleep.com*) involves users logging onto a website from their homes to enter information about their sleep and to complete modules. The modules include materials related to sleep restriction therapy, stimulus control, cognitive therapy, sleep hygiene, relaxation therapy, mindfulness meditation, and psychoeducation. Housed in a hospital-based psychology-run clinic in Winnipeg, Manitoba, users fill out “sneak peek” questionnaires to assess which aspect of the upcoming module may be most relevant to them. Adherence to weekly sleep homework through “how did I do?” logs is reinforced through text messages and graphics. Graphs provide daily feedback about progress in sleep and a sleep calculator suggests an appropriate bedtime to users given sleep diary information and based on the sleep restriction strategy. Evaluation of data from a randomized controlled trial with 118 outpatients with insomnia showed that



users of *return2sleep.com* reported significant improvements in sleep quality, insomnia severity, daytime fatigue, arousal, and maladaptive attitudes about sleep (Vincent & Lewycky, 2009). A follow-up study with a larger sample size ($n = 228$) showed that treatment effects were maintained, were largely unaffected by comorbidity (either psychiatric or alternative sleep disorder), age, gender, or educational level (Vincent, Walsh, & Lewycky, 2011; under review), and were mediated by sleep locus of control (Hebert, Vincent, Lewycky & Walsh, 2010). *Return2sleep.com* is now being used as a first-line intervention in a stepped care model of service.

Stepped Care. Stepped care involves the provision of the lowest intensity and highest volume intervention followed by the application of more intensive services as needed. It is not only prudent fiscally, but providing patients with treatments of their choice has been associated with better adherence and outcomes (Raue, Schulberg, Heo, Klimstra, & Bruce, 2009). Currently, upon referral, those with insomnia are screened by an online coordinator, and if psychologically stable, they are offered *return2sleep.com*. After completion of the computerized treatment, the individual is offered an in-person consultation with a staff psychologist in the sleep clinic to consider further treatment needs. The addition of the computerized treatment step has resulted in a 50% reduction in the uptake of the in-person consultation due to sleep improvements associated with *return2sleep.com*, and a 66% reduction in the uptake of group treatment due to the impact of the preceding interventions. Numbers of individuals requiring individual care have remained low but static. Flexibility, ease of access, and cost savings associated with *return2sleep.com* and the stepped care model within which it is housed are attractive features that were recognized by a Leading Practice designation by Accreditation Canada (2010). Implications of these developments are that more Canadians with chronic insomnia will be effectively treated regardless of their locale. Combining technology with psychological science presents an opportunity for health psychologists who specialize in sleep to provide Canadians with accessible and evidence-based approaches.

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Your Work, Your Health: The Role of Industrial Organizational Psychology in Health & Health Care in Canada

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For many, the workplace would not be the first place to consider when addressing questions related to health and health care; however, given that the average individual will spend more time at work than any other context (excluding sleepingⁱ), perhaps it should be. Interactions between work and health include (1) the physical tolls of work, (2) the psychological tolls of work and the (3) social dependence on work.

The physical tolls of work have traditionally been those associated with manually laborious and risky work. However, modern working conditions are also riddled with potential physical dangers as they become increasingly sedentary in nature. A vast number of injuries directly related to sedentary work conditions have become more prominent and are hailing greater concern from both health professionals and the general publicⁱⁱ. Increased occurrences of employees being overweight, suffering from poor circulation, carpal-tunnel syndrome, ‘tennis elbow’, wrist tendinitis, and lower-back injury are but a few of the health-related issues that come along with sedentary work.

Not only is work wrought with potential risks to employee physical well-being, there is an increasing body of literature examining the psychological tolls associated with maladaptive working conditions. According to a survey conducted by Statistics Canada in 2004ⁱⁱⁱ, approximately 3,400,000 Canadians were suffering from burnout, and 48% of absenteeism contained a “mental health component”. In addition, the survey found that 49% of men reported difficulty balancing work-life demands, with an even higher proportion of women reporting the same difficulty. Moreover, recent research on workplace violence (active and passive) has found that victims endure psychological (e.g. reduced morale, anxiety), psychosomatic (e.g. sleep apnoea) and social (e.g. family tension) repercussions^{iv,v}.

In addition to the aforementioned tolls, it is also important to address the role of organizations in relation to their employees’ health. In Canada, organizations are not legally bound to provide any form of health care or pension plan, both of which are benefits^{vi}. The extent to which one’s employer provides these benefits has an impact on the health services one can access and thereby on one’s health. In addition, for the most part, organizations make the rules surrounding the number of sick days and access to leaves of absences. These rules can create conditions for *presenteeism* or when an employee goes to work but does not fulfill his or her role or job to the detriment of the employee’s health, productivity, and the health of co-workers. This may result in greater costs to have the person present than absent.

Industrial Organizational (I/O) makes important contributions to employee health. For example, in the field of motivation, a significant amount of attention has been directed toward understanding the motivational underpinnings of employee burnout

and job satisfaction. In regards to selection, research has demonstrated that the proper fit between the individual, the job and the organization can be critical in increasing job satisfaction, and decreasing the risk of excessive stress^{vii}. Additionally, research has also demonstrated that training is central to empowering employees, helping to buffer against stress and cope with workplace demands^{viii}.

A comprehensive understanding of the relationships between employees and the organizations for which they work is critical to an understanding of the health issues and needs of Canadians. Given that approximately 61.6% of the Canadian population is currently employed (2010^{ix}), evidence-based improvements made to the workplace offer an almost unparalleled opportunity to make a dramatic and positive contribution to society and the health and lives of countless Canadians.

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Making Room for Positive Psychology in the Field of Bariatrics

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It is hardly breaking news at this point that obesity is on the rise or even that it is associated with numerous significant health risks. Nor is it news that weight-loss diets, even well-developed ones, show only modest results when it comes to sustainable weight loss. Bariatric surgery has emerged as a promising tool for sustainable weight loss and concomitant reduction in health problems. In 2009, the Ontario Bariatric Network was established by the Ministry of Health and Long-Term Care. As a result of this initiative, funding was provided to establish four hospital-based Bariatric Centres of Excellence (CoE) and four Regional Assessment and Treatment Centres (RATCs). Each of these centres incorporates a multidisciplinary healthcare team that comprises physicians, nurses/nurse practitioners, dietitians, social workers, physiotherapists/kinesiologists, and psychologists. A multidisciplinary team approach was recommended in recognition of the fact that bariatric surgery is but one component of a successful weight and health management program, which needs to be accompanied by changes in diet, exercise, and behaviour in order to be maximally effective. Enter the psychologist.

Psychology's role thus far in the field of Bariatrics has focused on assessing patients' psychological status pre-surgery to determine eligibility, as well as researching the role of psychopathology as a predictor of weight loss following bariatric surgery. It was thought that the presence of psychopathology (e.g., anxiety, depression, binge eating, etc.) might negatively impact an individual's ability to make the necessary post-surgical changes in behaviour, thereby interfering with weight loss, and possibly placing them at risk for increased symptoms of mental illness. The results of this research have been equivocal, and more thorough research is needed to determine how psychological status pre-surgery impacts weight loss and other post-surgery outcomes.

Given the above, it has also been suggested that the role of psychologists on a bariatric team needs to shift from primarily assessing pre-surgical eligibility to assessing and treating vulnerabilities pre- and post-surgery with the aim of helping clients successfully manage this challenging, yet hopeful transition. I would argue that we, as a profession, also need to study the relationship between psychological resilience and postsurgical outcomes for bariatric patients. The absence of mental illness does not necessarily imply the presence of mental health. In



other words, just because you don't have a diagnosis of mental illness doesn't mean that you are psychologically resilient. Also, having a mental illness does not preclude you from retaining strengths that can be helpful, even protective factors for individuals during periods of significant life change.

To date, the study of psychological resilience among patients presenting for bariatric surgery has been largely ignored in favour of looking at the impact of psychological illness. The field of Positive Psychology seems well-suited to address this gap. There is a large body of research which shows that characteristics of psychological resilience such as optimism, gratitude, and meaning in life, etc. are related to positive mental and physical health outcomes. It seems plausible, given the results of past research that these same characteristics would be beneficial in making the postsurgical life transition successful. In other words, among patients presenting for bariatric surgery, those who are generally happy, grateful and/or satisfied with life (positive emotion), those who have strong healthy relationships, and those who have a sense of something larger than themselves (meaning), should weather this transition better than those who do not. They may be more likely to adhere to treatment recommendations, experience greater changes in their eating behaviour, greater weight loss or longer maintenance of weight loss, more positive changes in body image and self-esteem, suffer fewer complications, and benefit more from a quality of life perspective. Such a finding could lead to the development of strengths-based psychological interventions designed to maximize well-being prior to surgery for those patients who may not have many of these characteristics for

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The Influence of Fathers' Involvement on Sons' Health

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Psychologists have known for some time that fathers have a significant influence on their sons' psychosocial and emotional development (Lisak, 1994; Richards & Duchkett, 1996). Recently, researchers have been discovering more about the link between healthy fatherhood and men's psychological health (Ball, Moselle, & Pedersen, 2007). The characteristics of the father, the amount of time he spends with his children, and the closeness of the father/child relationship have all consistently predicted male adjustment outcomes in clinical and non-clinical populations (for reviews, see Amato & Gilbreth, 1999; Rohner & Veneziano, 2001).

Traute Klein (1999), in his "Lessons I Learned from my Father," vividly described the powerful influence his father had on his life. Klein (1999) writes, "I have no recollection of why we were there or where we were going. I do not even remember starting on the trek or finishing it. It didn't matter. The only thing that mattered was my little hand in my father's big hand... Without my father's hand to guide me and his voice to encourage me, I would not have dared even to think of crossing that long, long bridge, a bridge with nothing but a rail to hang onto. This seemingly endless trek that my father and I took in the autumn of 1945, through the totally devastated city of Berlin, is one of the post-war scenes that remain firmly engraved in my mind... Throughout all those years my father never needed to preach to us. He taught us by his presence and by his example" (paraphrased from Klein, 1999).

Klein's story of fatherhood and closeness is one that many sons do not share. There are sons today who are haunted by the ruins of alienated relationships with fathers. They are haunted by the transgenerational wounds passed on to them (Biller, 1982; Corneau, 1991). It is difficult to measure the experience of sons who have lived with an alienated relationship with their fathers. Rather than a calming presence, the fathers' presence creates chaos. Instead of bringing security, these fathers bring injury; fear without reassurance, pain without comfort.

How destructive is this path? Researchers reported in a 1994 study that children exhibiting violent misbehaviour in school were 11 times more likely to live without their fathers as were children who did not exhibit violent behaviour (Ko, 1999). In fact, low supervision of adolescents was found to be a greater cause of delinquency than poverty (Sampson & Laub, 1994). The absence of fathers is consistently associated with juvenile emotional disorders, crime, suicide, promiscuity, and later mar-

ital break-up (Rotheisler, 1997). The United States Department of Justice reports that 72% of adolescents who committed murderers, 60% of those who committed acts of rape, and 70% of those who became long-term prisoners grew up in father-absent homes (Ko, 1999). Of these developmental risks, sons are more likely than daughters to commit suicide, to be violent, to abuse substances, and to go to prison.

Strained father/son relationships have significant, weighty implications for men's overall psychological health, but when the relationship between fathers and sons is healthy, the relationship has a profound positive effect on the psychological health of both sons and fathers (Ball et al., 2007). Ball et al. (2007) show that a healthy father/child relationship can militate against violence, delinquency, suicide, and hospital visits. Furthermore, when fathers are close to their children, both are less likely to engage in substance abuse and children are more likely to abstain from substance use. Healthy father/child relationships protect children and predict overall healthier life ecology. Positive father involvement is associated with healthy coping strategies in fathers and children, and it results in lower risk of negative health outcomes for both fathers and children (Ball et al., 2007).

Psychologists researching masculine health issues have found that the changing nature of masculinity in late modernity is creating a health crisis for men (Levant, 1997; Robertson 2007). Their findings support what others have long theorized, gender ideology and masculine identifications are intergenerational transmission processes that are passed from father to son (Dadson, Westwood, & Oliff, in press; Luddy & Thompson 1997; Mussen & Berkele 1959; Robertson 2007). Discovering more about how fathers' alienation specifically affects their sons will give health care practitioners insight into this particular male injury and will help address the health care issues of men who have experienced a failed relationship with their fathers.

Counselling psychologists are working hard to learn more about how to help meet men's health care issues and how to help equip fathers to interrupt the cycle of absence, neglect and abuse. That means we need further conceptual elaboration, more research, and the development of better clinical interventions. This will give health care providers improved tools to help men. Together we can discover new and better ways to help men and enable them to become the kind of fathers who will guide sons through life's dangers even "when all other bridges seem to be destroyed" (Klein 1999).

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Music, Dementia, and the Quality of Life

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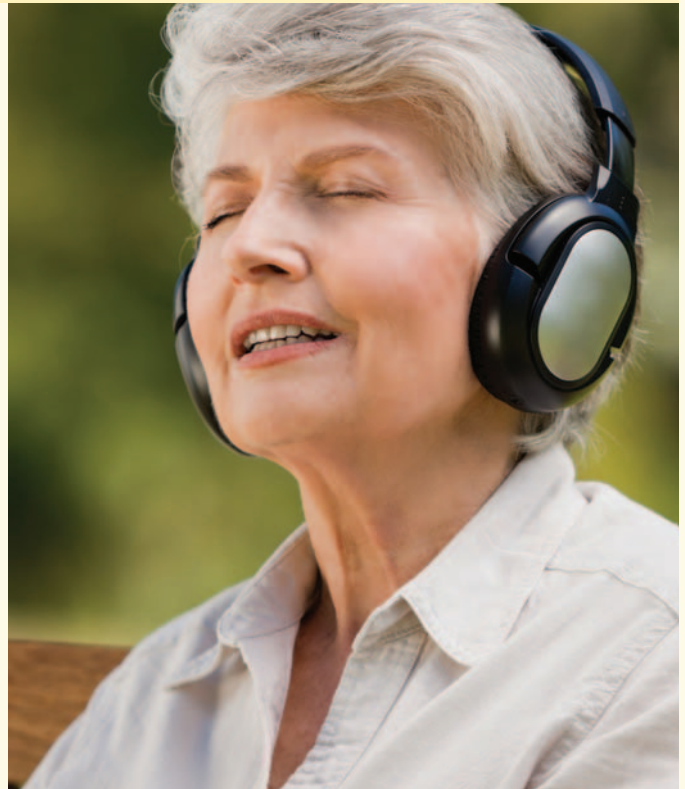
Music is a fascinating resource for studies of dementia and dementia care. Stories and descriptions abound on how music seems to be beneficial for people with dementia. Yet, until a very few years ago, there was very little evidence-based research documenting the perceptions and memories of people with dementia and supporting the development of care services and programs.

The statistics are bleak. Alzheimer Disease (AD)—a progressive neurodegenerative disease for which no effective cure is known—is the most widespread of the dementias and is increasing at an alarming rate worldwide. Almost everyone has experienced the heartbreak of losing a family member or friend to the disease. Over half a million Canadians are affected; this number is expected to double over the next 20 years and the cost of care to escalate to \$153 billion in 2038. Given the strength and visibility of Canadian researchers within in the multidisciplinary field of music psychology, it is timely to consider how we might contribute to this issue of national concern.

Current research does offer hope with progress toward understanding the risk factors, promoting early diagnosis, and developing pharmacological interventions that delay the onset of symptoms. More recently, with specific relevance to psychology and health, there is the added promise of nonpharmacological interventions. Here music can play a central role. I will highlight three research questions and further directions.

Question 1: Do persons with AD remember music? At Queen's University a chance encounter with my colleague J. M. Duffin (Medicine), led us to conduct and publish (2005) an assessment of an 84-year old woman whose severe dementia had not hampered her recollection and enjoyment of music. We played her phrases of familiar or unfamiliar tunes and simply observed her reactions. When (and only when) the tune was familiar, she smiled and sang along, often continuing when the phrase had stopped. Her score was as high as those of our healthy older controls.

Following this case report, our team has now tested over 200 people—young adults, older adults, and people with AD—on a variety of music and cognitive tests. Participants find the music tests easy, simple, and fun. We can say with confidence that musical memories are present for many, if not most, people with dementia. It is not necessary to be a musician to have these musical memories. Musical memories can be tunes from the past that we all tend to have sung or hummed such as Happy Birthday, the Wedding March, Christmas carols, fire-side and camp songs, and so on.



Question 2: Can music be used to help perception and retention of other, nonmusical, information? At the Queen's laboratory, we are now asking whether musical memories evoke other, seemingly forgotten, memories. A team of researchers at the University of Montreal—Isabelle Peretz, Aline Moussard, and Sylvie Belleville, in collaboration with Emmanuel Bigand (University of Bourgogne) is addressing the issues if and how music could be an efficient mnemonic for learning new verbal information. They plan to apply their findings to developing useful strategies for the activities and specific needs of every day life. A postdoctoral fellow at Montreal, Benjamin Zendel, is pursuing the hypothesis that music training may rehabilitate age-related declines in the ability to process acoustic information such as understanding speech in noisy environments.

Question 3: How can music be used in clinical interventions? It is thought, and sometimes reported, that music may aid communication among caregivers, family, and friends, may enhance the sense of a forgotten self, and may reduce behavioural symptoms of AD such as agitation and apathy. These topics are central to care practice but the area itself is vastly under-researched. Lise Gagnon at the University of Sherbrooke and collaborators are taking up the challenge. They have demonstrated that persons with AD retain an affective response to music. Now they want to know whether hearing relaxing music and singing music can diminish agitation among institutionalized patients. Further, they want to explore the specificity and the reliability of such an effect.

In sum, music has tremendous potential for enhancing dementia care and the quality of life for the person with dementia. It invites collaboration among clinical and cognitive psychologists, neuroscientists, health practitioners, and music therapists



to develop rigorously controlled studies leading to highly feasible practices and services. Protocols that can be easily implemented by volunteers or caregivers at home will benefit the person with dementia and will alleviate the demands of care.

L. L. Cuddy is a Fellow of CPA Her research is funded by the Natural Sciences and Engineering Council of Canada, the GRAMMY foundation, and the Alzheimer Society of Canada.

Resources:

Alzheimer Society of Canada, <http://www.alzheimer.ca/>
Cuddy L. L., & Duffin J. M. (2005). Music, memory, and Alzheimer's Disease: Is music recognition spared in dementia, and how can it be assessed? *Medical Hypotheses*, 64, 229-235.
Peretz, I., Halpern, A. R., & Cuddy L. L. (Eds.), (in press). Dementia and music. Special issue of *Music Perception*.

Along with our formal assessment at Queen's University, we have collected stories and anecdotes from caregivers and families. Here are but a few examples:

- "I was so glad to see her express such happiness [with music] - something we don't see much anymore."*
- "[Music was] one of the last ways in which we could make a connection on a more personal, intimate emotional level with him"*
- "My mother has begun to sing many Hebrew and Yiddish tunes, which she hasn't sung in quite some time; they were familiar to her but have only resurfaced since...."*
- "My mom was diagnosed with a mix of AD & vascular dementia at 65 years of age. In the summer of 2007,- she was well advanced by now - she had barely said a word of any kind in months. I had my CD of Hindi songs from the 1950's playing (songs I knew she grew up on, and so I played for her every chance I got). And all of a sudden, this tiny little soft voice was heard - my mom was singing along to the words as best as she could. The memory still brings tears to my eyes."*
- "My best friend who really is a lovely musician came to the house to visit [my father with dementia], and I suggested she play the piano for him. Prior to this he had been glaring at her. She started to play his favorite song.... And he started to smile and hum along... at the very end, he said thank you."*

We are always happy to hear stories;
if you have one to share please email:
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School Psychology

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psychologists are making careers in private practice. For schools, children and their families, that essentially puts psychological intervention very far out of reach, and certainly not timely.

The CPA Board has struck a task force on Publicly Funded Psychology, and schools, along with hospitals and corrections have begun the work of finding answers to work place dilemmas, including supply and demand. The school psychology working group has conducted a national

survey of those working in school psychology positions, and has found that the diversity of educational level, titles, and workplace priorities are about as broad as the number of those who replied. One thing that responders had in common was an enthusiasm and a dedication to the role they can play in schools. The task force is currently developing Standards for School Psychology in Canada which, it is hoped, will define universally recognized standards of training and role definition so that the profession can grow to the stature that it merits in the Canadian psychology family and in schools.

Bariatrics

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reasons related or unrelated to their obesity and its social repercussions. In this way, the role of Psychology becomes one not only of assessment for inclusion or exclusion from bariatric surgery, but rather one of helping clients to transform their mental health as well as their physical health.

Many of these characteristics will be the target of research here at the Health Sciences North Bariatric Assessment and Treatment Centre. We intend to study an entire array of resilience characteristics such as: dispositional optimism, happiness, satisfaction with life, gratitude, autonomy, environmental mastery, growth initiative, self-acceptance, flourishing, meaning in life and mindful awareness. We are particularly interested in understanding their impact on post-surgery outcomes such as changes in weight, physical and emotional quality of life, body image and self-esteem, eating behaviours, etc.

Another aspect of well-being we will be examining is the

amount, type, and quality of social support the patient has while going through this transition. We know that individuals who have someone in their support system that helps them to reinterpret negative life events (called "adaptive inferential feedback") tend to be less likely to become depressed and hopeless. Likewise, when we teach someone to provide this specific type of feedback to a person following a negative event, that person's negative mood begins to improve. Here again, we think that this type of "adaptive inferential feedback" may augment the patient's ability to effect the eating, exercise, and behavioural changes they need to make for successful weight and health management.

We have only just opened the doors to our program, but we are very excited to learn more about bariatric patients' strengths and supports and hopefully to help them recognize and harness their strengths and support systems. We look forward to sharing our results, and anticipate that Psychology will make an important contribution to this healthcare setting.



Mental Health Stigma in Health Psychology

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As psychologists, one of the most troubling issues facing our clients is stigma. For many people with a mental illness, the fear of stigma prevents them from seeking treatment in the first place, because they are afraid of being labeled, judged or discriminated against. In health psychology this fear can be especially pronounced. As a client once told me, “I didn’t want to come and see you, because I thought I’d be labeled a ‘head case.’ Once that happens, no one takes you seriously.”

There is growing evidence that people living with a mental illness will experience disparities in healthcare provision, and that those disparities contribute to poor physical health outcomes. The inequalities are due to a variety of factors, but “healthcare provider issues including the pervasive stigma associated with mental illness,” are one of the barriers (Lawrence & Kisely, 2010, p.61).

When I queried my health psychology colleagues for examples of stigma, both health professional stigma and self-stigma were mentioned. Because of difficulties with depression, a client with diabetes may be labeled as unmotivated to make lifestyle changes and receive less follow-up care. A client with Post-Traumatic Stress Disorder from a work injury feels that he should be able to “just get over it,” and delays seeking help, because he feels weak.

The stigma surrounding mental illness is, of course, entrenched in many systems besides healthcare, and reflects a larger societal issue. For example, 72% of people would be very likely or somewhat likely to disclose a family member’s cancer, while only half would disclose a relative’s mental illness. (Canadian Medical Association, 2008)

Opening Minds, the anti-stigma initiative of the Mental Health Commission of Canada (MHCC), is the largest systematic effort to reduce the stigma of mental illness in Canadian history. It is identifying and evaluating existing anti-stigma programs across the country, determining their effectiveness, and rolling out the successful programs nationally.

Opening Minds is working with 65 partners and 45 projects. More than 25 of the projects are directly aimed at reducing the stigma surrounding mental illness associated with workers in frontline healthcare, including emergency room workers, psychologists, psychiatrists, social workers, etc. This work is par-

ticularly important, because many people with a mental illness say some of the worst stigma they have experienced came from front-line healthcare workers (Out of the Shadows at Last Report, 2006).

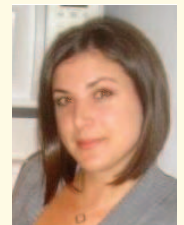
Health psychologists have a unique opportunity to reduce stigma in our healthcare settings. Providing education to clients and other healthcare professionals on mental illness, encouraging your organization to consider a formal mental health education program, and introducing a module specifically on stigma when training upcoming psychologists are all possible avenues. In Saskatchewan, I’ve had the unique opportunity to be part of one of the anti-stigma programs being evaluated, which has been both enlightening and rewarding. You can read more about the anti-stigma programs including those targeted to healthcare professionals by visiting

http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Programs_province_Aug_2011.pdf.

This article is the second in a series on the work of the Mental Health Commission of Canada.



CPA Welcomes new Manager of Government Relations



Meagan Hatch joins CPA as Manager of Government Relations. Before joining the Canadian Psychological Association she worked at the Canadian Psychiatric Association and was responsible for government relations, communications and stakeholder relations. She is also an active member of the government relations committee for the Canadian Alliance on Mental Illness and Mental Health (CAMIMH). Meagan has extensive public sector experience, having worked as a senior consultant lobbyist and served as a legislative aide in two consecutive federal governments. In addition, Meagan holds a strong background in media relations, and developing and implementing local and national communication strategies.



Assessment, Prevention and Intervention The Role of Health Psychologists in Bariatric Surgery Programs

Daniella Sandre, Ph.D., C.Psych., Clinical, Health, and Rehabilitation Psychologist, Bariatric Surgery Program, The Ottawa Hospital

Bariatric surgery programs in Ontario have been in operation since 2009, following initiation of funding through the Ministry of Health and Long-Term Care. Obesity rates are on the rise, with 24% of Canadians reporting a BMI of 30 or higher between 2007-2009 (Statistics Canada, 2011). Obesity has long been recognized as a detriment to health due to frequently occurring obesity-related comorbidities such as diabetes, obstructive sleep apnea, hypertension, dyslipidemia, and cardiac disease.

Health Psychologists involved in the care of bariatric surgery patients contribute to the assessment of factors which can affect surgical candidacy. They also provide education, support, and interventions aimed at improving patient readiness for surgery and helping them develop skills to facilitate implementation and maintenance of lifelong behavioral change. Health psychologists also work with patients to identify the psychosocial and behavioral challenges that might adversely affect adherence to pre and post-operative treatment plans. From a mental health perspective, research in the area of bariatric surgery has found that weight loss surgery candidates have a higher prevalence of mental disorders as compared to other surgical patients and/or those patients who are obese who do not pursue surgery as a weight-loss treatment option (Greenberg, Sogg, & Perna, 2009). Thus, in addition to the above, the role of the health psychologist on bariatric surgery teams is to assist identify patients whose psychiatric disorders are severe enough to contraindicate surgery and to identify as well as the factors that warrant psychosocial intervention to optimize post-surgical outcomes. Addressing these issues pre-operatively is an important strategy to increase the likelihood of successful post-surgical outcomes.

Improving post surgical outcomes is important because, despite the benefits of Weight Loss Surgery (WLS), these procedures are not without risk and post-operative outcomes are variable (Greenberg, Sogg, & Perna, 2009). Experts in the field have been examining psychosocial and behavioral correlates of post-operative outcomes among WLS patients in order to better predict those factors which may help or hinder adherence to post-surgical treatment plans and weight loss. Consequently, many bariatric surgery centers require a comprehensive psychological assessment in order to identify those candidates who

may require additional intervention and/or support in order to improve readiness for surgery. These assessments also aim to identify those individuals for whom surgery is not the ideal treatment option due to the presence of psychosocial contraindications.

Although many patients are required to participate in a psychological evaluation prior to undergoing weight loss surgery, there currently exists no standardized assessment protocol to guide these evaluations. Nevertheless, there are some generally agreed upon areas of focus included in these assessments, such as the presence of unstable mood disorder, substance abuse, eating disorder, psychosis, and personality disorders involving a tendency towards poor impulse control and/or self-harm behavior. These assessments also include assessment of patients' understanding of the procedure and post-operative treatment recommendations as well as their appreciation of the potential risks of surgery.

Given this, the Bariatric Centers of Excellence in Ontario recently have organized a Mental Health Task force aimed at: 1) developing a standardized pre-surgical psychosocial assessment protocol, 2) providing consultation support regarding complex cases, and 3) reviewing developments in such areas as: pain management and substance use in surgical candidates; assessing candidates with developmental disabilities; tobacco use, screening, and surgical candidacy; the bariatric surgery candidate and ADHD; and, adherence to treatment recommendations.

This Task Force is comprised of psychiatrists, psychologists, social workers, and psychosocial researchers from bariatric surgery programs across Ontario, including: Humber River Regional Hospital, University Health Network, Guelph Bariatric Center of Excellence, Hamilton Health Sciences Center, and The Ottawa Hospital.

The development of standard guidelines in the area of psychological service provision for bariatric surgery candidates will enhance the long-term efficacy of weight loss surgery. By becoming more adept at identifying pre-operative psychosocial risk factors, health psychologists will also be able to develop targeted intervention, and ensure surgical access to patients who might otherwise be ruled out. Identification and development of standardized psychosocial practices will improve service delivery and patient care across bariatric surgical centers in Ontario and hopefully across Canada.



Psychology and Medicare: What can we learn from history?

John Conway, Ph.D., CPA Archivist and Historian

In 1974 the Minister of National Health and Welfare, Marc Lalonde, released “*A New Perspective on the Health of Canadians*” on prevention and health promotion that promised to vigorously address the environmental and behavioural lifestyle determinants of health. Having just graduated with a Ph.D. in clinical psychology, I thought the future looked very bright indeed.

“Behavioural medicine” and “health psychology” were launched as specialty areas by the end of the 1970s. Forty years later, health psychology has grown to include clinical, clinical neuropsychology, public, community, critical, and occupational health sub specialities.

Our knowledge about how closely behaviour and health are related has increased greatly. The Canadian Medical Hall of Fame includes four of psychology’s eminent scientists: Brenda Milner, Donald Hebb, Endel Tulving and Ronald Melzack. Research in health psychology is featured frequently in the media which, of course, means it is sometimes distorted.

Despite this progress, psychologists are not utilized nearly as much within our health care delivery system as they might be. We know that tobacco use, poor diet, and insufficient physical activity are key risk factors of cancer, heart disease and diabetes, conditions that together account for about two-thirds of all deaths. If Monsieur Lalonde’s promises about prevention and health promotion had been kept, our health care system today would look quite different and would surely include a great many more psychologists.

Psychology and Medicare

Over the last fifty years CPA, along with provincial associations, has advocated for better recognition of psychology within Medicare. The results have not been encouraging.

John Arnett (2005) pointed to the influence of Medicare as a significant factor in the under use of psychology in our health care system. Medicare’s focus on treating illness, and providing acute care for “medically necessary” services has eclipsed prevention and health promotion.

In 1964, the Royal Commission on Health Services recom-

mended that the “psycho-diagnostic and psycho-therapeutic services rendered by a properly qualified psychologist with special training in these areas” should be included in medical services benefits. In the Medicare Bill, however, “paramedical services,” including psychology, were not included as eligible. Despite an amendment making it possible for each province to include “paramedical services” in its medicare legislation, no such legislation has ever been seriously considered.

In 1980, the report on “*Health Insurance Progress in Canada*” recognized the contributions of psychology, concluding that “the whole area of psychological services should be studied and better utilization made of the valuable services psychology can make in the health field.” The report was filed on the shelf.

In its original form, the Canada Health Act (1984) specified that federal funds could be used for “medical practitioners.” The Act was changed to include “other health care practitioners” where they were included in a provincial medicare plan.

In 2003, there was renewed hope that the Romanow Commission on The Future of Health Care might support an enhanced role for psychology within Medicare. In vigorous lobbying, CPA emphasized the importance of providing

patients with the right service at the right time from the right professional, and argued that psychological services should be made accessible across the full continuum of care. Several potential funding models for psychological services were put forward: a government funded, fee-for-service model like physicians; and variations on public funding such as vouchers to citizens for psychological services; funding for individuals receiving some form of income assistance; and regional health authorities contracting for psychological services from private practitioners.

The Federal government was being squeezed: the growing costs of health care and growing pressure for the expansion of privatization made talk of expanding services a tough sell. CPA rightly argued that psychological services have been shown to result in improved health status and substantial cost savings.

Romanow’s final report relied heavily on the “physical” medical model, and gave little attention to the psychological



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aspects of disease or prevention. Despite calling mental health the “orphan in health care,” the report was a disappointment for psychology and for all those who understand the close relationships between mental and physical health.

Romanow and Marchildon (2003) considered the role of psychology in health care in a lead article in *Canadian Psychology*. They acknowledged that psychological services should be more readily available in a restructured public health care system and that there were viable psychological interventions that were at least as effective as prescription drug therapies for a variety of health problems. They believed there were emerging opportunities for psychology to become more integrated into a reformed primary-care system. Apparently, Romanow got it, but politics-as-usual trumped the evidence. They concluded that as provincial governments struggle to control health spending they were unlikely to add psychologists on a fee-for-service basis to provincial health care plans.

Sadly, the lesson from psychology’s history of advocacy for the inclusion of our services within Medicare: Forget it.

History Lessons from Saskatchewan

What might it take to succeed in having psychology better integrated into our health care systems? Let me offer a couple of examples of transformative change in health care from my home province.

The real birth of Medicare. Saskatchewan-style “Medicare” had its beginnings long before the CCF government of Tommy Douglas came to power in 1944 (Houston & Massie, 2009). In 1915, a small town voted to pay tax money to keep their doctor from moving to a larger town. The next year, the Saskatchewan government changed its Rural Municipality Act to permit the use of land tax money to pay doctor’s salaries or to build a hospital. Saskatchewan had the first municipally-paid doctors in North America.

From this small innovation, four rural municipalities near Swift Current, SK developed comprehensive health coverage without limitations for its residents—full hospitalization and doctor coverage, freedom of choice of doctor, even a children’s dental plan. This locally controlled form of “prepaid health insurance” flourished before the election of Douglas, and it predated Britain’s National Health Service Plan.

The lesson here: Small, local innovations sometimes lead to great things.

Transformation of mental health care. Within three months of its election the Douglas government introduced coverage for hospital care, including for those suffering from mental illness and addictions (Conway, 2008).

At the same time, the government took steps to address the atrocious condition and severe overcrowding of the province’s two mental institutions. From 1963-66, care for the mentally ill was transformed by deinstitutionalization. Saskatchewan’s rate of deinstitutionalization was the highest in the world.

Most of the patients discharged were placed in small approved homes located across the province. Community care for the mentally ill was better established in Saskatchewan than it was almost anywhere in North America: outpatient clinics, traveling clinics, psychiatric nurses, and psychiatric wards in general hospitals – all were firsts of their kind in North America.

The first fully funded provincial psychiatric research program in the country was initiated in 1950. Innovative research programs prospered, e.g., the first-ever token economy was designed and evaluated at the Weyburn Psychiatric Hospital by a young psychology intern, Ted Ayllon.

Saskatchewan mental health care in the 1950s and 60s was truly “leading edge,” with jurisdictions across North America adopting Saskatchewan’s policies and practices.

Mental health became a priority in Saskatchewan at this time because a few critical conditions were in place:

1. The government championed the way. Douglas and the CCF were passionately committed; mental health care was included in the transformative agenda to reform health care.
2. The leadership was exceptional. Douglas himself, who was both Premier and Minister of Public Health, was the overall architect of mental health reform. Visionary professionals from across North America came and stayed.
3. The work environment was ideal. The CCF cabinet and its senior bureaucrats provided a unique working environment in which many professionals enjoyed considerable freedom of action.
4. Citizens played perhaps the most critical role of all. It was no accident that the CMHA set up its first provincial branch in Saskatchewan in 1949. At the height of its influence in the late 1950s, CMHA Saskatchewan had a membership of 50,000. Imagine—five percent of citizens advocating for mental health. Among its members were Douglas, his entire cabinet and all of the senior bureaucrats in mental health.

These favourable conditions depend on citizens—the electorate—to embrace the politics of possibility. That’s what it will take to bring psychology to the heart of our health care system.

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Mild Traumatic Brain Injury in Children and Adolescents

Dianne O'Connor, Ed.D., ABSNP, C.Psych.,

Mild Traumatic Brain Injury in children represents a serious public health concern. Unfortunately, it is a common childhood condition. Each year, as many as 500,000 American youths under the age of 15 suffer a Traumatic Brain Injury (TBI) that requires hospital based medical care. The vast majority of these injuries are diagnosed as mild.

Too often we fail to provide these young people with neuropsychological evaluations to help determine the nature and extent of any deficits they have suffered, and how to treat them. We also fail to explore the broad range of deficits they may have suffered, including the cognitive and academic concerns that many of these children will exhibit. These particular deficits often remain hidden at the outset, and when they do surface these injured children may receive a diagnosis of a learning disability or a developmental delay or an emotional or behavioural problem. When this happens they are unlikely to receive appropriate educational and cognitive support. Hence, they are less likely to move forward to realize the full extent of their capabilities, and the best possible outcomes given the extent of their injuries.

Many of these young people will attend at the hospital emergency room and are discharged the same day. The burden falls on emergency room health care providers and those in outpatient care settings to manage mild TBI in children and adolescents. Like many of us, these professionals may lack understanding of mild TBI in children, and how the manifestations of the injury can change and present over time. Many are also unaware of how negative and debilitating the effects of a mild TBI in children can be, and just how long lasting. These effects can extend across all developmental areas, from the social, emotional and behavioural - to the academic and cognitive, and compromise life quality and wellness throughout the life span.

Nowhere, may this be truer than in the school setting. Yet coping in school is one of the biggest challenges the brain injured young person will face, and is reported by survivors as more challenging than any residual physical deficits. Assisting the child, adolescent or young person at school, whether he attends a preschool or daycare setting or an elementary, secondary or post secondary program, is often the most critical and essential piece of any treatment plan. This is true whether the student is returning to or is already in attendance at school.

The child or adolescent spends most of his waking day at school. It is the environment where he must perform successfully across a range of developmental domains. These include the social, emotional, and behavioural domains, as well

as the cognitive and academic areas. He must do so as independently and age appropriately as possible, and to the fullest extent of his capabilities, if he is to succeed not only at school, but move forward to his potential as an adult. Meeting these expectations is often an extreme struggle for the brain injured student, regardless of his age, or the apparent severity of his injury.

Extending the treatment plan to the school may be the most difficult component of the intervention plan to implement, and the one that is most often neglected. Much is involved in ensuring the success of the treatment plan, from planning and training of school support staff and others who work with the student, to assessments and evaluations to establish baseline functioning levels and assist with monitoring and further treatment planning.

There are also additional concerns that inhibit the brain injured child's success at school. School personnel generally lack the support, training and expertise required to assist in accommodating these children, and providing them with appropriate, effective interventions. There are structural and systemic issues as well. Although Canada has compulsory education laws to support the inclusion and accommodation of students with special needs, these do not apply to students with Traumatic Brain Injury. While, some provinces do more than others, Canada's special education policies, unlike many states in the U.S., fail to recognize Acquired Brain Injury as a specific exceptionality that requires accommodation.

Nevertheless, to promote the best possible outcomes in brain injured children it is essential to provide them with individualized programs tailored to their unique deficits, and their often changing nature over time. Without such support these children are less likely to reach the full extent of their potential, both as young people and later as adults.

The Toronto Board of Education has recently adopted initiatives to address the initial screening needs and academic problems that can plague young people who suffer a concussion on the school sports field or playground. Unfortunately, these initiatives fail to address the equally critical and often ongoing and long term needs of the many children and adolescents who suffer acquired brain injuries through other means such as car accidents, falls or lack of oxygen.

It is time to rectify this situation. Appropriately trained psychologists need to provide consultations and school neuropsychological evaluations to increase understanding of TBI in children. School neuropsychological evaluations help to uncover the nature and extent of the deficits a brain injured young person has suffered, and lead to evidence based interventions to promote the best possible outcomes in these children.



Exercise for Mood and Anxiety Disorders

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In this article, we discuss an intervention with strong biological effects, a broad spectrum of efficacy, and targeted mental health effects that rival those obtained by either cognitive-behavior therapy (CBT) or pharmacotherapy. Yet, its application to date has been seriously hindered by relative inattention to the motivational, cognitive, and contextual determinates of its successful application. There is a powerful role that clinicians can play in enhancing treatment outcome and promoting general health by applying exercise interventions for mood.

Exercise has been shown to have dramatic effects on mood. Population based studies indicate that exercise improves well-being; decreases depression, anxiety, and hostility; and offers greater feelings of social connectedness. In controlled clinical trials, programmed exercise can provide depression relief that rivals that provided by antidepressant medication. Indeed, across clinical trials, exercise interventions have shown efficacy for depression or anxiety disorders as a stand-alone intervention, in combination with CBT, and in combination with medications (for patients who have failed to respond adequately to antidepressant medications). In all these applications, programs of moderate exercise involving 4 to 5 weekly exercise sessions of moderate intensity (often walking focused) of 30-40 minutes durations. These same levels of exercise also have

powerful effects on physical health, reducing risk of cardiac and all causes of mortality. Despite these successes, exercise interventions are rarely on the list of clinician's commonly prescribed interventions, and overall leisure time exercise rates remain painfully low in most developed countries. In short, exercise is like a highly efficacious pill that no one takes.

In recent years, we have made efforts to change this reality, first with exercise treatment manuals for clinicians, and, more recently, with our direct-to-the-consumer book, "Exercise for Mood and Anxiety: Proven Strategies for Overcoming Depression and Enhancing Well-Being." Our goal has been to underscore the tremendous benefits of exercise to mental health, and help mental health clinicians feel comfortable with prescribing moderate exercise. To help patients start and maintain exercise programs, clinicians have to intervene with the many time management and motivational challenges brought by regular exercise. Cognitive-behavior therapists are exactly the professionals to lead this effort. Well over half of our exercise book for consumers focuses on motivational issues and exercise. In brief, we teach individuals about the strong influence of context on motivation, helping determine which of an individual's many competing motivations will get behavioral attention at any given moment. Moreover, we attend to the contingency between exercise and outcomes. Unlike exercise for physical fitness, where weeks and months of effort are required to experience palpable gains, exercise for mood can offer

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Health Psychology – Opportunity and Challenge in Interprofessional Practice

Tavis Campbell, Ph.D., R. Psych., University of Calgary & Head, Health Section, CPA, Joshua A. Rash, M.Sc., University of Calgary and Simon L. Bacon, Concordia University

In the last issue of *Psynopsis*, Ian Nicolson, past president of the Canadian Council of Professional Psychology Programs, highlighted evidence that health care is moving in the direction of interprofessional education and training. Within the broad discipline of Psychology, this trend is arguably no more apparent than within the sub discipline of ‘Health Psychology,’ which is largely concerned with understanding how biological, psychological (including behavioral), environmental, and cultural factors are involved in physical health and illness. The development of evidence-based behavioral medicine assessment and intervention methods over the past 30 years has resulted in a major expansion of psychology into routine clinical care within services aimed at treating Canada’s major causes of morbidity and mortality. Clinical Health Psychologists will normally be found working in diverse settings ranging from hypertension and diabetes clinics, to cancer centres, to surgical weight loss clinics. Along with this interest and enthusiasm, however, come some significant challenges for the field that must be addressed if we are to survive and thrive in an interprofessional reality. Based on consultation with the membership of the Health Psychology section at CPA, we have highlighted below two concerns related to interprofessional practice that are regularly raised in our meetings and exchanges.

Training Health Care Providers (HCP’s)

With the growing recognition that most chronic illness is a direct result of longstanding patterns of behavior and lifestyle choices, including sedentary behavior, excessive caloric intake and smoking, there is tremendous interest within mainstream medicine to provide more effective interventions aimed at behavior change. Traditional efforts have involved providing education and advice based on the notion that people will be able to make better choices if they understand the risks and rewards. When it comes to efforts at complex behavior change, however, psychologists know through decades of research that these sorts of appeals (including attempts to induce fear) are unlikely to be sufficient to motivate health behaviors in the long-term. Instead, a variety of HCP’s are being trained by psychologists in more sophisticated models of motivating behavior change, including Motivational Interviewing (MI), which many of you will recognize as a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence (1). For example, the Heart and Stroke Foundation of Canada recommends using MI as a method of initiating be-

havior change for weight management and include MI training in their current hypertension initiative (2). While the interest and application of interventions such as MI in routine clinical care represents an exciting acknowledgment of the importance of psychology in addressing major health care issues, there is at the same time considerable concern that widespread promulgation might be premature. To begin with, the best evidence for effectiveness of MI comes from the addictions literature. In contrast, our group reported in a recent meta-analysis with accompanying systematic review that the use of MI in the context of behavioral weight loss programs was promising but that evidence is limited (3). Further, there exists no consensus regarding how best to train HCP’s in MI or how to assess basic competency. This is of particular concern if we consider that the incorrect or inappropriate application of psychological/behavioral interventions might not be benign and has potential to create harm.

Integration with Public Health Efforts

There are distinct and often opposing approaches to promote health behavior change in the population that might create tension and disagreement between health psychology and public health efforts in Canada. So-called low-reach, high-intensity interventions are characteristic of psychological approaches at the individual level and have received considerable criticism that they might not effectively influence behavior change on a large-scale. On the other hand, high-reach, low-intensity interventions, characteristic of the public health approach, address health behavior change at the societal level and may include efforts such as banning smoking in public settings, raising taxes on unhealthy foods and supplementing gym memberships. Arguably, both population approaches and behavioural approaches targeting individuals may be required in order to effectively manage the health behaviors of Canadians. The mix of behavioural interventions and population interventions depends on the specific circumstances of both the individual and the population.

For example, consider the issue of salt consumption and cardiovascular disease. Diets high in salt are now recognized as one of the leading risks to cardiovascular health in the world as they increase blood pressure in both children and adults. In countries with developed economies like Canada, population-based approaches reducing salt additives to food, supplemented by public education campaigns might need to be the primary means of intervention to ensure that the healthy option is the easiest option – a basic caveat of public health interventions. A

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universal reduction in salt additives during the manufacturing process has a strong potential to reduce health disparities in vulnerable populations while improving overall population health.

While population-based approaches may be most important to ensure the population, and especially policy makers, understand and are supportive of the need to reduce dietary salt, behavioural interventions may continue to be necessary for individuals who are at great personal risk from high salt consumption. Although behavioural interventions, focused on individuals, likely have a smaller impact on a population basis, may be more expensive and not universally accessible (hence potentially adding to health disparities), their offset should not be underestimated. High risk individuals whose behaviour does not change also stand to need expensive medical intervention and, possibly, shortened and decreased quality of life. High risk individuals live with other high risk individuals (i.e. family members) who may stand to benefit from the behavioural health changes made by the currently identified high risk patient – hence offsetting more potential high risk. Population-based approaches reach many but also many of low risk. Individual-based approaches reach few but those for whom high risk comes at great personal and health care cost. These approaches are not alternatives to each other and both have their indications.

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Exercise

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immediate benefit.

Indeed, part of the good news about exercise for mood is that you don't have to struggle through high-intensity workouts to get the benefits. With moderate intensity exercise, you can expect an increase in positive mood within minutes after exercise. Of course, you will also get mood benefits if you pursue high intensity exercise, but the good feelings after exercise may be delayed for a half hour or so. But the larger issue is that high intensity exercise can make people feel bad *during* the exercise. And, not surprisingly, feeling bad during exercise is a prescription for less consistent exercise over time. A 2008 study from Brown Medical School, researchers found that ratings of pleasure taken during a single episode of exercise predicted the degree to which people stayed with their exercise program over time. That is, just a 1-point difference in rated pleasure on an 11-point scale predicted a 40-minute difference in exercise per week performed 6 and 12 months later.

Fortunately, there is an increasing literature on some of the factors that limit pleasure during exercise, with a major review published in the August, 2011, issue of the journal, *Sports Medicine*. One of the consistent predictors of negative affect during exercise was high intensity. During exercise, pleasure ratings plummet around the time that the ventilator threshold is reached – roughly the point when you exert yourself hard enough that you have a hard time talking normally. In addition to the overall level of exercise, self-selection of exercise intensity is important. An increase in intensity of just 10% over an individual's preferred level can lead to a rapid loss of pleasure while exercising. But personal preference is likely to change over time. As a person gets used to exercise, diversifying the exercise routine and/or intensity is important.

But individuals often need additional help getting to their exercise regimen. They need to heed the cognitions that

can derail exercise attempts and rehearse with cognitive restructuring for the different sort of thoughts that can derail exercise attempts in the morning, midday, or in the evening. Individuals also need instruction in regular review of the benefits of exercise, using the mood and attentional benefits from the last exercise experience to guide expectations for the next workout (this is in direct contrast to thinking about only the first few minutes of exercise—a particularly aversive moment in the workout experience—a bad habit that typifies many individuals' exercise planning).

We also emphasize the role of contextual cues and combinations of motivators to aid exercise adherence. For example, use of social support, social cues for exercise, and such everyday strategies such as keeping exercise gear in a visible location. Similarly, we recommend enhancing pleasurable expectations for exercise. Saving music or recorded books for exercise time is one way to combine motivational cues for an exercise session: the exercise shoes sitting out in the hall with your iPod, with a note tucked into a shoe that says, "mood."

In short, in our book on the topic, we have simply applied some of the core principles of CBT, combined with research in motivational science, to help individuals get to and stay with a program of exercise for mood. Cognitive-behavioral therapists are expertly suited to use principles of behavior change not only with traditional CBT interventions, but with helping patients also pursue the mood benefits of exercise. Clinicians of course need to be aware of the physical limitations of their patients, and we always encourage medical clearance before stating an exercise regimen. Cognitive-behavioral providers are at an important point of health care delivery, being exactly the professionals to introduce their patients to the benefits of exercise for mood as part of a more comprehensive treatment program, and having the potential of also offering their patients the dramatic health benefits that a continued program of exercise can offer.



Happy 20th Birthday Health Action Lobby



photo Jean-Marc Carisse

From Left: Dr. Karen Cohen, CEO of CPA and Co-Chair of the Health Action Lobby; Ms. Joy Smith, Member of Parliament and Chair of the House of Commons Standing Committee on Health; Mr. Glenn Brimacombe, President and CEO of ACAHO and Co-Chair of the Health Action Lobby pose for a picture at the 20th anniversary breakfast for HEAL held at the Parliamentary restaurant, Ottawa December 2011.

John Service Ph.D., Director, CPA Practice Directorate

The Health Action Lobby (HEAL) was formed in 1991 out of a real sense of crisis. Its initial intention was to help protect health care from the damaging effects of the reductions in Federal Government transfer payments to the provinces and territories during the significant federal budget reductions of the Chretien Government. These transfers are primarily for fiscal balance (equalization), health care (Canadian Health Transfer) and education and social services (Canadian Social Transfer).

The crisis was real. It was important to reduce the debt and to balance the Federal Government books, of this there is little doubt. However, to do so by seriously reducing funding for healthcare, universities, social welfare programs etc was highly problematic to the viability of said services.

The founding members of Heal were chosen to provide as broad and inclusive a representation of health and health care as possible. The original 7 members included the national associations representing medicine (CMA), nursing (CNA), psychology (CPA), long term care (CLTCA), hospitals and health care facilities (CHA), public health (CPHA) and consumers (CAC)¹. Psychology was an essential component for three reasons: mental and behavioural health, private practice and research. HEAL has grown to 34 national health-related associations dedicated to protecting and strengthening Canada's health system. The coalition represents more than half a million health providers as well as organizations and institutions that provide services and health information.

Over the last two decades, HEAL has been one of the most important health centric advocacy groups in Canada. Many of its documents can be found at <http://www.healthactionlobby.ca/>. HEAL has addressed issues including health system financing and the role of the Federal Government, health human resource planning, accountability in health care and the continuity, accessibility and comprehensiveness of the services Canadians receive every day.

HEAL has successfully bridged the perspectives of payers (public and private), patients and providers both within and outside of publicly funded health services. It advances evidence-informed policy choices.

Dr Karen Cohen, CPA's Chief Executive Officer, is currently the HEAL Co-Chair along with Mr Glenn Brimacombe, CEO of the Association of Canadian Academic Healthcare Organizations (ACAHO), the association that brings together the research and teaching hospitals in Canada.

CMA: Canadian Medical Association

CNA: Canadian Nurses Association

CPA: Canadian Psychological Association

CLTCA: Canadian Long Term Care Association

CHA: Canadian Hospital Association: now the Canadian Healthcare Association

CPHA: Canadian Public Health Association

CAC: Consumers Association of Canada



Hope Foundation of Alberta: A Canadian Centre for Innovation and Research in Counselling Psychology

Denise Larsen, Ph.D., R. Psych., University of Alberta and Hope Foundation of Alberta and Wendy Edey, M.Ed., R. Psych., Hope Foundation of Alberta

At 67 Elizabeth sought counselling for the first time in her life. Specifically, she said that she sought hope. Her psychiatrist had diagnosed her with depression. Home life had become more of a struggle than ever since her husband's recent retirement. Elizabeth described a lifetime of verbal abuse that only seemed to worsen now that her husband was home most days. When gently queried by me, her counselling psychologist, about the possibility of leaving her husband, Elizabeth was adamant. The financial ruin would be devastating, intolerable, and permanent. She wanted hope and would stay in the marriage. Informed by practices innovated at the Hope Foundation of Alberta, I invited Elizabeth to participate in some activities that could help us move forward together.

The Hope Foundation of Alberta is an independent non-profit counselling and educational service with a long-standing commitment to counselling psychology innovation and applied research on hope. It is the practice arm of an innovative community-university partnership and is a center affiliated with the Faculty of Education at the University of Alberta. Hope research in the health and social sciences has grown exponentially over the past twenty years, with over 4000 articles now catalogued on the Hope-Lit Database (<http://www.hope-lit.ualberta.ca/Hope-LitDatabase.html>).

The Hope Foundation has long adhered to a multidimensional understanding of hope, recognizing that hope is a multifaceted experience, which when effectively accessed offers vital energy and resources for client change. Describing how hope influences clients' ability to consider the future, Hope Foundation founder Ronna Jevne (1994) writes, "Hope is the ability to envision a future in which you wish to participate". Lynch (1965) points to the cognition and emotion that underpins hope in his assertion that hope is, "the fundamental knowledge and feeling that there is a way out of difficulty, that things can work out, that we as human persons can somehow handle and manage our internal and external reality". Qualitative research across the health and social sciences now consistently confirms the multidimensional nature of hope experiences (Larsen, Edey, & LeMay, 2007) and the importance of hope in human change processes (Cheavens, Michael, & Snyder, 2005). For example, common factors models suggest that hope accounts for approximately 15% of client change, approximately the same amount for which theoretical orientation is thought to account (Hubble, Duncan, & Miller, 1999).

Returning to the case at the outset of this article, in many ways, Elizabeth's counselling issue was similar to many clients. How can I find a future with which I wish to engage given the realities of my life and my circumstance? Targeting a hope-focused intervention, I invited Elizabeth to create a list of 10 personal hopes using the sentence stem, "I hope ...". Elizabeth was instructed that her hopes could be very small; simple or complex; serious or fun; and focused on the near or distant future. Her hopes could be things over which she had control or not. As we discussed her list, Elizabeth learned that she had more than one hope to live toward. She had briefly glimpsed some futures in which she might wish to participate. She had dabbled with the notion that things might indeed be okay. Of course, psychotherapy with Elizabeth included more than this one intervention, however this small exercise provided Elizabeth with some tangible evidence that hope did still reside in her life.

The program of counselling psychological research at the Hope Foundation of Alberta examines hope in practice. Like the brief example above, we develop practice methods with a hope perspective and study the impact of the practice on clients and therapists. Our research examines a number of practice concerns relative to working with hope in counselling psychology. On many research projects we employ interpersonal process recall, an applied research interview method acclaimed thanks to the work of Canadian psychotherapy researcher, David Rennie (e.g., 1994). We examine questions about hope-in-practice, like the following:

Within individual psychotherapy, do counselling psychologists intentionally address client hope in session? If so, how?

How do clients experience hope in session? Clients often enter therapy demoralized, finding any personal action toward healing difficult. Are there practices or interventions that clients experience as hope supporting?

Therapists encounter numerous client difficulties, including child custody, trauma, suicide, and homicide. Is hope an important factor for counselling psychologists in their work? If so, how do they sustain their own hope in the face of difficult work with clients?

When counselling psychologists encounter client hopes that they do not share, how do they decide to negotiate this challenging ethical terrain in session?

Information about these research projects and publications is available on the Hope Foundation website cited above and on major social science research databases.



Closing the Gap between Research and Practice in Health Psychology: Examples from the Area of Paediatric Pain

Rachel Horton, M.A. and Nicole Racine, M.A., Clinical Developmental Psychology, York University

Arguably one of the greatest challenges in health research is bridging the gap between evidence-based research and primary care. While large bodies of research point to methods and treatments that ameliorate health, the translation of knowledge to practice is often slow and cumbersome. This is no truer than in the field of paediatric pain where it has taken decades to demonstrate that infants feel pain, let alone require treatment for pain. A growing number of health psychology researchers, however, are striving to make changes to the health care system so that infants' pain is acknowledged and ultimately alleviated. As doctoral students in the Opportunities to Understand Childhood Hurt (OUCH) laboratory at York University, under the supervision of Dr. Rebecca Pillai Riddell, we are members of a team of researchers whose goals are to investigate the ways in which infants express pain as well as effective methods to help reduce pain-related distress associated with medical procedures. In the following paragraphs, we illustrate the challenge of knowledge translation using examples from our research in the area of paediatric pain and discuss four strategies that members from our team have undertaken in pursuit of these goals.

Identifying the Problem. It is hard to imagine that people once believed that infants did not feel pain. However, as recently as 30 years ago, the belief that infants could not feel pain, or that pain would not have a negative, long-term impact, was prevalent. Analgesics, even during open heart surgeries, were often avoided for infant patients due to the unknown effects of analgesics on the infant body and the belief that pain would not lead to long-term adverse outcomes. Today, it is well established that the infant in pain is markedly vulnerable. Infants cannot predict, manage, understand or verbalize their pain and are wholly dependent on caregivers (which can include parents, nurses or doctors) to recognize pain signals and to respond to these signals with appropriate care. The emotionally negative experience that infants and parents undergo, as a result of under-managed pain, can lead to maladaptive health behaviours such as avoidance of health care, pre-procedural anxiety, and needle phobias. Research has demonstrated that under-managed pain in infancy (e.g., circumcision without analgesia) is associated with maladaptive mental health outcomes later in life including lower pain thresholds. Despite the known health problems related to under-managed pain in infancy, pain from acute paediatric medical procedures continues to be poorly managed. For example, although infants in Canada receive up to 15 immunizations prior to their second birthday, standards of care do not include the use of analgesia or non-pharmacological strategies to minimize the pain of inoculation.

Assessing the Problem. Prior to endorsing the standard use

of interventions for paediatric pain, a solid foundation of research pertaining to pain expression in healthy, typically-developing infants was needed. Research from our lab and across Canada (e.g., leading experts in the field of infant pain from the University of British Columbia, McGill University, Dalhousie University and the University of Toronto) has shown that the age of the infant (e.g., 2 months versus 12 months) affects the way in which infants express pain, the specific strategies that are effective in managing pain, and the successful timing of implementing these strategies during medical procedures. It has also been well-established that caregivers (parents, in particular) play a key role in soothing infants in distress and in advocating for infants in pain and that caregivers (e.g., nurses versus doctors) interpret infant pain differently.

Evaluating Interventions. We collaborated with others in the field to conduct a broad meta-analysis of non-pharmacological strategies for infant procedural pain. Our team recently published these findings in a Cochrane Review (Pillai Riddell et al., 2011) in which we reviewed 51 randomized controlled trials involving 13 different types of commonly investigated non-pharmacological treatments of infant pain (e.g., rocking/holding the infant) during medical procedures while accounting for infant age and the timing of interventions. We found that kangaroo care (i.e., skin-to-skin contact), sucking-related interventions (e.g., using a pacifier) and swaddling/facilitated tucking were efficacious in relieving both pain reactivity (right after the procedure) and immediate pain-related regulation (at least 30 seconds after the procedure) for preterm infants (i.e., born at 36 weeks gestation or less). For neonates (i.e. infants born at 37 weeks until one month of age), sucking-related interventions were found to be efficacious for pain reactivity and immediate pain-related regulation, while rocking/holding was found to be efficacious for immediate pain-related regulation only. There were no non-pharmacological treatments reviewed that demonstrated sufficient evidence for pain relief in older infants (i.e., over one month to 36 months of age), however, more research is needed for this group. The conclusions from this meta-analysis are important for guiding health-care practitioners on evidence-based interventions for infant pain and when to implement these strategies.

Implementing Evidence-Based Interventions. With the knowledge that parents play a key role in advocating for their infants in pain and in soothing their infants in pain, members of our lab are working within a multidisciplinary team that includes international leaders in infant pain research such as Dr. Anna Taddio (Leslie Dan Faculty of Pharmacy, University of Toronto) and Dr. Moshe Ipp (Division of Paediatric Medicine, The Hospital for Sick Children) to conduct a randomized-con-

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Interprofessional care: What it is, why it matters, and what is needed

Gregory K. Tippin, M.A. Candidate, Clinical Psychology, Lakehead University, and K. Amanda Maranzan, Ph.D., C. Psych., Lakehead University

Contemporary health service delivery

Interprofessional care (IPC) in the delivery of health service is receiving increasing attention from funders, agencies that deliver care and from health professionals themselves. As an example, IPC was recently identified as a strategy for renewal of Ontario's health care system, suggesting that the province is transitioning towards this structure of care. IPC is seen as one response to the shortfall in service in the face of increasing demand. Poised to be more cost and clinically effective, IPC would seem to benefit all stakeholders in health service delivery.

What is interprofessional care?

IPC is one model of a collaborative approach to health service provision. HealthForceOntario views IPC as a client-centered model with a very high degree of communication among providers and the client and one in which health service is coordinated around client's needs and treatment goals. This structure allows for multiple health providers, from varying professions, to combine their expertise to best serve clients. IPC should result in holistic care that is seamlessly organized to eliminate service overlap and where providers respond to changes over the course of treatment.

Why does interprofessional care matter?

In the Fall 2011 issue of *Psynopsis*, Dr. Ian Nicholson described how psychology has much to offer when practicing under the IPC structure. Psychology needs to adapt and integrate itself within this model of care – both to promote the relevance of psychological services to health care in general and to participate in what is being viewed as a more efficient and

effective mechanism of health service delivery. IPC and collaborative care, particularly within primary care, is also consistent with the goals for a reformed Canadian mental health system identified by the Mental Health Commission of Canada. Treatment that is integrated, holistic and client-centred will presumably be more efficient and decrease duplication of service from solo providers. Additionally, IPC is a model well suited to address the psychological factors concomitant with a range of physical disorders. IPC, with its team of providers, allows for a breadth of care that would be difficult to achieve through traditional or solo service delivery.

What is needed?

Despite the view that IPC results in more efficient and effective care, and despite the fact that there has been uptake of this model, there is a surprising paucity of research into its outcomes and benefits. The evidence often cited in support of IPC has some significant shortcomings; most notably, its methodologies are poorly described and its use of terminology inaccurate. Although this is a model that has obvious intuitive appeal, there is a clear need for research into clients' treatment outcomes from IPC. More specifically, we need randomized control trials to demonstrate treatment efficacy and efficiency over traditional models of care and research into the practice-based effectiveness of the model.

Despite the need for more research, IPC is being promoted and practiced. However, health professionals continue to train for practice in silos rather than collaboratively. What is needed for the practice of psychology, and indeed for all of the health care professions, is education and training in interprofessional practice. The development of common standards and curricula for collaborative practice will not only prepare us to practice collaboratively, they may also facilitate examination of the model's use as a strategy to improve health care.

Paediatric Pain

Continued from page 34

trolled trial of pharmacological and non-pharmacological interventions for the management of infant pain in a community context. The aim of this trial is to involve numerous stakeholders (e.g., parents, paediatricians) and to provide definitive evidence with regards to which pain interventions should become part of the standards of care for immunizations across Canada.

Like many health psychology trainees, the overarching aim of our research is that it will lead to advances in health care practices that will ultimately improve the health of Canadians. Researchers have made great strides towards alleviating the distress and pain that infants experience as a result of medical procedures. Our efforts in translating knowledge to practice, however, are far from over. With progress towards the identification of effective strategies for managing infant pain, numerous knowledge translation strategies

will need to be undertaken to ensure that pain management is the rule rather than exception for Canadian infants.

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Promoting Post-Secondary Student Wellness

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Increasingly, post-secondary health services are transitioning to a wellness model to more effectively and efficiently meet the diverse needs of students. The World Health Organization (2010) defines health and wellness as “a state of complete physical, mental and social well-being, and not merely the absence of disease.” Wellness is: 1) a choice – a conscious decision to assume responsibility for the quality of one’s life, starting with a decision to shape a healthy lifestyle; 2) a way of life – a lifestyle designed to achieve one’s highest potential for well-being; and 3) a process – movement towards the integration of mind, body, and spirit to create greater quality of life. According to Herman (2005), holistic wellness models are consistent with post-secondary student development models and the philosophy that student development is an essential purpose of higher education.

The era of budget cuts and financial restrictions calls for innovative strategies for service-provision within student services. The rise of wellness centres on campuses across North America provides a valuable opportunity to integrate services to more efficiently meet student needs. However, the typical conceptualization of “wellness” focuses almost exclusively on physical and mental aspects of wellness. Further, these facets of wellness are often addressed in a parallel rather than integrated manner (Herman, 2005).

The wellness model requires interprofessional collaboration (IPC) to meet the mandate of integrating mind, body, and spirit. IPC refers to different professionals working together collaboratively, not just side-by-side, to meet the needs of the target

population. Barr et al. (2005) defined IPC as “learning with, from and about each other to improve collaboration and the quality of care” (p. 31). Many post-secondary health services aim to practice interprofessionally; however, few resources are available to guide the development of integrated services.

Workshop Experience

A series of five wellness workshops was collaboratively developed by representatives from counselling services, health services, and chaplaincy services at a Canadian university. The final product from this collaborative process was a series entitled *Be the Best You Can Be*. Each workshop was 90-minutes in length and all five workshops were offered three times during a Spring semester. Workshops were free to students. Attendance at the workshops exceeded expectations, drawing in six to eleven participants per group, with total participation ranging from 17 in the Spiritual wellness workshop to 48 in the Mental wellness workshop. A drop-in format was implemented to draw in participants, often doubling or tripling the workshop pre-enrolment. Following is a summary of the goals for each of these workshops.

Good Connections: Your Best Social Self. The goal of this workshop was to provide skills and strategies for developing healthy relationships and social connections. Key factors present in healthy relationships with friends, partners, and families were identified. We discussed ways to talk about issues that really matter to students, how to create healthy boundaries, and how to balance the students’ rights with those of others through assertive communication.

Good Body: Your Best Physical Self. The goal of this workshop was to help students make their body work for them. Stu-

dents learned about elements necessary for enhancing their health and building their resilience, ranging from stretching to healthy eating, to sexual health. The importance of physical wellness for managing the stress of university was emphasized.

Good Feelings: Your Best Emotional Self. In this workshop, we aimed to help students learn to become better observers of their feelings, to accept and value them, and to attend to emotions' signals. The relevance of building emotional wellness was associated with building students' capacity to enjoy life, cope with stress, and focus on important personal priorities.

Good Heart: Best Spiritual Self. This workshop was designed to use experiential exercises to help students become more attuned to themselves and their personal sense of spirituality. Strategies implemented included drumming (grounding), a labyrinth walk (centering), and focusing (self-care).

Workshop Evaluation. Program evaluation is critical to provision of any new service as it provides information about achievement of learning goals or aims of the service. Evaluations were created in a post-pre format, scored on a 5-point likert scale, based on the specific learning goals identified for each workshop. This format helped us gain an understanding of students' previous knowledge and/or skill prior to the workshop. In addition, it provides insight into students' perceptions of the knowledge and/or skill development in relation to the learning goals. Results demonstrated a statistically significant change in knowledge and skill development in the positive direction. Pre-

assessment responses ranged from Strongly Disagree to Strongly Agree, with the majority of responses occurring between Disagree and Agree. Post-assessment responses ranged from Disagree to Strongly Agree, with the majority of responses occurring between Agree and Strongly Agree.

Feedback from students

"...I just wanted to let you know that I really enjoyed these wellness workshops...it was one of my favourite university experiences"

"In combination with [the other workshops] this has been extremely useful in contributing to my overall wellness."

Providing opportunities for students to develop a balanced sense of wellness is critical to their academic success, ongoing personal development, and overall health and wellness. Students coming for counselling at post-secondary counselling centres are presenting with greater severity and complexity of concerns than ever before (Cairns, Massfeller, & Deeth, 2010). Psychology plays a very important role in providing preventative services, such as these wellness workshops, which has the potential to improve wellness of students and minimize future strain on national health resources.

Special thanks to: Ann Laverty, Kathryn Sherwin, and Tim Nethercott

CPA Membership Survey

Help us shape the future of the Canadian Psychological Association

Thank you to the nearly 1,300 CPA members who have taken the time to complete the Membership Survey. We would still like to collect responses from our members, but also, we are eager to receive more responses from psychological professionals who are not currently members of CPA. Please consider forwarding the survey to your colleagues, students, co-workers and friends within the psychological community. Your responses will help us shape a better future for CPA and its growing membership.

Please take ten to fifteen minutes to answer some questions which will help CPA grow and improve. Thank you!

www.cpa.ca/membershipsurvey

You Could Win \$250 By Completing This Survey!

By completing the survey, you may enter your name into a random draw to win one of four \$250 prizes. 1 (one) winner will be randomly selected from each of the following categories:

- Psychologist, CPA Member
- Psychologist, Non-Member
- Student, CPA Member
- Student, Non-Member

We encourage you to refer colleagues to complete the survey.

For every Non-Member you refer, and who fully completes the survey and names you as the referrer, you will be given an extra chance of winning one of three \$250 prizes.

Questions or comments about the survey can be directed to Tyler Stacey-Holmes at publicrelations@cpa.ca.



Karen R. Cohen Ph.D., Chief Executive Officer
Ashley Ronson M.Sc., Manager Science Directorate
John Service Ph.D., Director, Practice Directorate
Melissa Tiessen Ph.D., Director, Education Directorate

What follows is an update of science, practice and educational activity undertaken by Head Office staff since our last update in the Fall 2011 issue of *Psynopsis*. For any further information about any of the activities described please feel free to be in touch with us. We want to hear what you think. Unless otherwise indicated, please contact Karen Cohen (kcohen@cpa.ca) on national activities for science and practice. Contact Ashley Ronson on science activity (arsonson@cpa.ca). Contact John Service (jcservice@cpa.ca) on activity related to provincial/territorial practice. Contact Melissa Tiessen (mtiessen@cpa.ca) on matters pertaining to accreditation and continuing education.



Social Science and Humanities Research Council of Canada. As discussed in the Fall issue of *Psynopsis*, recent conversations with the leadership of SSHRC lead us to understand their view that higher education needs to be based on evidenced-based models of learning. CPA is pulling together a summary of psychological research demonstrating how new insights into learning lead to new pedagogies and improved learning outcomes. Once this summary is complete, we will make it available to the membership.



Canadian Institute Health Research. Ashley Ronson, in concert with the Scientific Affairs Committee is developing a fact-sheet highlighting psychological research relevant to each of the 13 institutes of CIHR, with the ultimate goal of raising the profile of psychological contributions to health research. This fact sheet will also be made available to the membership once done.



Standards and Guidelines. As announced earlier, CPA has launched a psychology in public practice task force for 2011/12 with each of three sub – forces: publicly funded health care organizations, schools and correctional facilities. CPA Head Office is working with the task forces and, currently helping the hospital force to collect service delivery guidelines and helping the criminal justice task force in its public policy objectives.



CPA policy and public statements: In November 2011, CPA partnered with the Association for the Treatment of Sexual Abuse on a statement about the role of psychological factors

and treatment in sexual abuse. http://www.cpa.ca/docs/file/Press%20Release/Press%20Release%20-%20ATSA_CPA_PressRelease_Nov1_11.pdf CPA Head Office is also working with the Criminal Justice subtask force on psychology in public practice in the development of a series of statements related to criminal justice and mental health. These are planned for release in early 2012.

At their November meeting, CPA's Board of Directors spent some time reviewing the structure and function of CPA's Public Policy Committee. Meagan Hatch (CPA's Manager of Government Relations starting with CPA in January 2012) presented to the Board on government relations and Tyler Stacey-Homes (Manager of Association Development, Membership and Public Relations) presented on communication. Following the presentations, Board voted to endorse a new structure which includes a Public Policy Committee that assumes a proactive policy role. The Committee will develop an annual a strategic policy plan to recommend to the Board and then provide oversight to task forces appointed to carry out specific policy work. CPA's leadership (CEO and President) will work with our Managers of Government Relations and Public Relations to fulfill the more reactive policy function demanded of associations. If your area or research or practice has a public policy implication to which you would like to contribute, please contact Dr. Cohen at kcohen@cpa.ca.

Publications: CPA's Publication Committee met in November 2011 with two objectives – some strategic planning for the journals and review and revision of the journals operating policies. Currently each journal is consulting their respective Editorial Boards about content in relation to the journal mandates going forward in the context of member and readership needs and demands.



Final report released on the practice of psychology in Canada. CPA's contribution agreement with the Public Health Agency of Canada (PHAC) was completed in September 2011. Readers will recall that this project enabled CPA to develop its electronic surveillance survey tools and database of psychologists' practice activity. CPA has developed 4 Surveys with which it has collected information about the clinical and demographic characteristics of the clients psychologists treat and the demographic and practice characteristics of the psychologists themselves. The final survey report has been posted on CPA's website [http://cpa.ca/docs/file/MHSP/Final_Report\(1\).pdf](http://cpa.ca/docs/file/MHSP/Final_Report(1).pdf) A series of articles and brochures on the project's findings are also under preparation with the key participation of Dr. John Hunsley at the University of Ottawa. For more information about the practice of psychology in Canada, contact the project's manager, Ashley Ronson at aronson@cpa.ca



National call to action on suicide. In October 2011, the CPA joined in a press conference on Parliament Hill calling for attention to suicide. CPA issued a statement and press release <http://cpa.ca/docs/file/Media/National%20Suicide%20Strategy%20Motion%202011FINAL.pdf> and had the opportunity to watch the motion presented in the House of Commons. The motion called for collaboration among government and stakeholders to make action on suicide a health and public policy priority. Both the motion, made by the Honorable Bob Rae, Acting Leader of the Liberal Party of Canada, and private members bills by Conservative MP Harold Albrecht and NDP MP Meagan Leslie, called for a National Suicide Prevention Strategy. The Motion passed in the House 271 to 3.

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Standing Senate Committee on Social Affairs, Science and Technology. Canada's 2004 10-Year plan to Strengthen Health Care in Canada. CPA was invited and presented a brief to the Standing Committee charged with renewal of the 2004 federal/provincial/territorial health care accord that is set to expire in 2014. Mental health certainly appeared to figure prominently among the Standing Committee's concerns, particularly as concerns children and youth and health promotion and illness prevention investments upstream. See Karen Cohen's introduction to the winter issue for a copy of the brief she presented on behalf of CPA to the Standing Committee.

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Health Action Lobby (HEAL): HEAL celebrated its 20th anniversary in a breakfast on Parliament Hill. Attendees included representatives of the health professional and health care organizations which form the membership of HEAL as well as invited guests in the professional community. Several MPs were in attendance and welcome and remarks were given by Ms. Joy Smith, Chair of the Standing Committee on Health. As Co-Chair of HEAL, Dr. Cohen had the opportunity to thank the guests and say a few words about HEAL's plans for 2012. These include its position on Canada's health human resource and on health renewal for 2014. HEAL will very shortly be issuing a commissioned report on the federal role in health care at which time we will alert the CPA membership.

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Canadian Alliance of Mental Illness and Mental Health (CAMIMH): With new members of its Management Committee, CAMIMH is poised to take on more advocacy activity on behalf of Canada's mental health in 2012. CAMIMH has struck several subcommittees (government relations, communications) through which it will chart its activities and messaging. CPA will Chair CAMIMH's 2012 Mental Illness Awareness Week (MIAW) which will be celebrated by a Champions Awards dinner on October 3rd in Ottawa. Calls for nominations for mental

health champions will be made early in 2012. More information will be available via the CAMIMH <http://camimh.ca/> and CPA's websites.

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Mental Health Commission of Canada (MHCC): CPA sits on the advisory committee of CHEER which convened in October and December 2011. CHEER is charged with knowledge exchange and transfer of best practice in addressing mental health through primary care. In December, CHEER brought together a group of researchers for the purposes of putting together a research proposal on the delivery and evaluation of mental health intervention in primary care. For more information, please contact Dr. Cohen at kcohen@cpa.ca.

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American Psychological Association. CPA continues to work with the APA on several files:

- The CPA Board and the APA Council of Representatives has approved the agreement on mutual recognition between the APA and CPA. The First Street Accord as it has been called (its details were developed by the CPA and APA at the APA's offices on First Street in Washington) is being signed and will be posted on the CPA website once done. A celebration of the Accord, and a presentation on its provisions and future is being planned for the CPA convention 2012.
- The membership will recall that in 2010, APA let CPA know that it intended to rescind all its dues agreements, including the one it has with CPA. In February 2011, the CPA was successful in getting the APA to maintain, at least temporarily, the historic CPA/APA dues agreement. The agreement, affording CPA members residing in Canada a 50% reduction in APA membership dues (and vice versa), will remain in effect through 2012. Another consultation of the 1100 CPA members who are also members in the APA is underway. CPA will use the feedback from this consultation to direct further discussion with APA on the future of the dues agreement beyond 2012.

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Psynopsis. Psynopsis' themes over the next several issues are as follows: Spring (submission deadline March 1st) focus on empirically-supported practice and Summer (submission deadline June 1st) focus on knowledge transfer and translation. Submissions on these themes are enthusiastically invited. Send 900 words or less to Tyler Stacey-Holmes at styler@cpa.ca

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Elections 2011: As mentioned in the Fall issue of Psynopsis, on the CPA website and via CPA news, CPA was very



pleased to support the 6 provincial/territorial elections with the use of Advocacy Online service. Table 1 shows the uptake by jurisdiction. Note that the SK election was ongoing when this data was pulled. As can be seen from the Table, more people looked at the page than sent a letter to their candidates (actions). Registration means those who entered their information in preparation to sending a letter but did not follow through on the action.

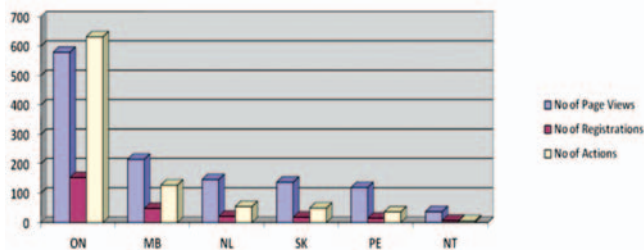


Table 1: Provincial and Territorial Elections October/November 2011



Practice Directorate. The Directorate commissioned a survey of the Canadian public on their views and needs when it comes to psychological services. Survey results, nationally and by province/territory can be found at <http://www.cpa.ca/polls/>. The survey launches the Directorates access to service campaign for 2011/12.

News from Alberta: The School Psychology Committee of PAA has developed *The pivotal role of Alberta school psychology services: A response to Alberta Education's setting the direction.*, The Committee Chair, Dr Coranne Johnson is reaching out to other associations and organizations to find out what important events in school psychology are occurring in other jurisdictions and what can be done collectively. The Committee has been in touch with the CPA task force on school psychology. Coranne can be contacted at schoolpsychology@psychologistsassociation.ab.ca and the document link is http://www.psychologistsassociation.ab.ca/site/paa_school_psychology.

Dr Martin Drapeau, the incoming editor of Canadian Psychology, a faculty member at McGill and the Vice President of L'Ordre des psychologues du Québec, has approached the Practice Directorate enquiring about the possibility of the Directorate adopting service delivery standards (e.g. the number of psychologists recommended for a Bariatric Surgery unit). The PD Chair, Dr Andrea Piotrowski, and the PD Director, Dr. John Service, will be following up on this recommendation in preparation for the PD meeting in early 2012.



Education Directorate. In October 2011, Melissa Tiessen and Karen Cohen attended the 50th anniversary meeting of the Association for State and Provincial Psychology Boards

(ASPPB) in Chicago. Key issues of discussion at this meeting were the importance of communication and collaboration among stakeholders in accreditation, education and training, and regulation and the role and responsibilities of each body in regards to addressing the internship imbalance/crisis. It was also evident at this meeting that while there are education and training issues that are common across Canada and the United States, there are also some important differences and unique opportunities that are present in our smaller Canadian context. (stay tuned for more on this at Convention 2012).



The **Accreditation Panel** met in October 2011 at which time one new programme was accredited, and 8 existing programmes were granted re-accreditation. An up-to-date listing of all CPA accredited programmes is available on the CPA website at: <http://www.cpa.ca/education/accreditation/CPAaccreditedprograms/>

The Accreditation Panel invites nominations! Members serve 3 year terms, with a commitment to attend two meetings in Ottawa each year (around the end of April and the end of October, travel expenses covered); the majority of the work of Panel members is limited to the 2 weeks leading up to each meeting. For more information or to express your interest, contact Melissa Tiessen mtiessen@cpa.ca

In December 2011, Melissa Tiessen attended the bi-annual meeting of the Association of Accrediting Agencies of Canada (AAAC) in Ottawa. The AAAC is an organization comprised of higher education accrediting organizations across various disciplines, with the common goal of supporting quality accreditation practices. Key issues of discussion at this meeting included best practices in training site visitors, appealing to various types of learners, especially the 'millennial' generation, and electronic document storage policies and procedures.

Upcoming events of interest: An internship development session is being planned for Convention 2012, to assist in identifying and disseminating ways that our Canadian Psychological community can help to redress the current internship imbalance. A recent issue of Training and Education in Professional Psychology (2011, volume 5, issue 4, November: <http://psycnet.apa.org/index.cfm?fa=browsePA.volumes&jcode=tep>) also includes some interesting articles on the issue and steps various American organizations are taking to attempt to address this situation.

The newly revised Accreditation Standards and Procedures manual is now in print, and can be accessed from the CPA website: <http://www.cpa.ca/education/accreditation/>. A French translation is in progress. On the site you can also find two 'quick guides' to the changes from the old (2002) to the new (2011) standards.

Finally, additional 'travelling' site visitor workshops are being planned – dates will be posted on the CPA website once confirmed. As well, feel free to contact Melissa Tiessen for more information.



Karen R. Cohen Ph.D., chef de la direction
Ashley Ronson M.Sc., gestionnaire, Direction générale de la science
John Service Ph.D., directeur, Direction générale de la pratique
Melissa Tiessen Ph.D., directrice, Direction générale de l'éducation

Ce qui suit représente une mise à jour des activités en science, en pratique et en éducation mise de l'avant par le personnel du siège social depuis notre dernière mise à jour dans le numéro d'automne 2011 de *Psynopsis*. Pour tout autre renseignement au sujet des activités décrites n'hésitez pas à communiquer avec nous. Nous sommes toujours intéressés à entendre ce que vous pensez. À moins d'indication contraire, veuillez communiquer avec Karen Cohen (kcohen@cpa.ca) au sujet des activités à l'échelle nationale qui concernent la science et la pratique. Communiquez avec Ashley Ronson au sujet des activités en science (arsonson@cpa.ca). Communiquez avec John Service (jcservice@cpa.ca) au sujet de ce qui touche les activités liées à la pratique au niveau provincial ou territorial. Communiquez avec Melissa Tiessen (mtiessen@cpa.ca) au sujet de toute question concernant l'agrément et l'éducation permanente.



Conseil de recherches en sciences humaines du Canada. Tel que décrit dans le numéro d'automne de *Psynopsis*, des conversations récentes avec la direction du CRSH nous ont amené à comprendre leur point de vue que l'éducation supérieure doit être fondée sur des modèles d'apprentissage empiriques. La SCP est en train de produire un résumé de la recherche en psychologie qui démontre comment les nouvelles perspectives dans l'apprentissage donnent lieu à de nouvelles pédagogies et à des résultats d'apprentissage améliorés. Une fois ce sommaire terminé, nous le mettrons à la disposition des membres.



Instituts canadiens de la recherche en santé. Ashley Ronson, de concert avec le Comité des affaires scientifiques est en voie d'élaborer un feuillet d'information mettant en lumière la recherche en psychologie pertinente dans chacun des 13 instituts des IRSC, dans le but ultime d'augmenter la visibilité des contributions psychologiques à la recherche en santé. Ce feuillet d'information sera aussi mis à la disposition des membres dès qu'il sera terminé.



Normes et lignes directrices. Tel qu'annoncé précédemment, la SCP a lancé un groupe de travail sur la pratique publique en 2011-2012 pour chacun des trois sous-groupes : organisations de soins de santé financées par les deniers publics, écoles et établissements correctionnels. Le bureau du siège social travaille avec les sous-groupes et aide actuellement le groupe se penchant sur les hôpitaux à recueillir des lignes directrices en matière de prestation de services et aide le groupe de travail sur la justice pénale à réaliser ses objectifs en matière de politique publique.



Politique de la SCP et déclarations publiques : En novembre 2011, la SCP s'est jointe à l'Association for the Treatment of Sexual Abuse pour une déclaration au sujet du rôle des facteurs psychologiques et le traitement de l'abus sexuel. <http://www.cpa.ca/>

[docs/file/Press%20Release/Press%20Release%20-%20ATSA_CPA_PressRelease_Nov1_11.pdf](#) Le bureau du siège social travaille aussi avec le sous-groupe de travail sur la justice pénale qui se penche sur la psychologie dans la pratique publique dans l'élaboration d'une série de déclarations liées à la justice pénale et la santé mentale. Ces déclarations devraient être publiées au début de 2012.

À sa réunion de novembre, le conseil d'administration de la SCP s'est penché sur la structure et la fonction du Comité de politique publique de la SCP. Meagan Hatch (gestionnaire des relations gouvernementales de la SCP qui entrera à la SCP en janvier 2012) a fait une présentation au conseil d'administration sur les relations gouvernementales et Tyler Stacey-Homes (directeur du développement de la Société, des membres et des relations publiques) a fait une présentation sur les communications. Suivant les présentations, le conseil d'administration a décidé de donner son aval à une nouvelle structure qui inclut un Comité de politique publique afin d'assumer un rôle proactif en matière de politique. Le Comité élaborera un plan de politique stratégique annuel qu'il recommandera au conseil d'administration et assurera ensuite la surveillance des groupes de travail désignés pour s'acquitter d'initiatives particulières en matière de politique. La direction de la SCP (la chef de la direction et le président) travaillera avec les gestionnaires des relations gouvernementales et des relations publiques afin de remplir une fonction plus proactive en matière de politique exigée des associations. Si votre domaine de recherche ou de pratique a des conséquences sur la politique publique auquel vous aimeriez contribuer, veuillez communiquer avec D^{re} Cohen à l'adresse kcohen@cpa.ca.



Publications : Le Comité des publications de la SCP s'est réuni en novembre 2011 afin de faire de la planification stratégique pour les revues et examiner et réviser les politiques opérationnelles des revues. Actuellement la rédaction de chaque revue consulte leur Comité de rédaction respectif au sujet du contenu en regard de leurs prochains mandats dans le contexte des besoins et des demandes des membres et des lecteurs.



Le rapport final sur la pratique de la psychologie au Canada est publié. L'accord de contribution de la SCP avec l'Agence de la santé publique du Canada (ASPC) a été terminé en septembre 2011. Les lecteurs se souviendront que ce projet a permis à la SCP de développer ses outils et sa base de données d'enquête de surveillance électronique et les activités de la pratique des psychologues. La SCP a créé quatre questionnaires qui lui ont permis de recueillir de l'information au sujet des caractéristiques cliniques et démographiques des clients que les psychologues traitent et les caractéristiques démographiques et de la pratique des psychologues proprement dits. Le rapport d'enquête final a été affiché sur le site Web de la SCP à l'adresse [http://cpa.ca/docs/file/MHSP/Final_Report\(1\).pdf](http://cpa.ca/docs/file/MHSP/Final_Report(1).pdf) Une série d'articles et de brochures sur les conclusions du projet sont en préparation avec la participation très importante de D^r John Hunsley de l'Université d'Ottawa. Pour plus d'information au sujet de la pratique de la psychologie au Canada, communiquez avec la gestionnaire de projet, Ashley Ronson à l'adresse aronson@cpa.ca



Appel national à l'action contre le suicide. Le 2 octobre 2011, la SCP a participé à une conférence de presse sur la Colline parlementaire dans le but d'attirer une plus grande attention au problème du suicide. La SCP a émis une déclaration et un communiqué de presse <http://cpa.ca/docs/file/Media/National%20Suicide%20Strategy%20Motion%202011FINAL.pdf> et a eu l'occasion d'assister à la motion présentée à la Chambre des communes. La motion proposait une collaboration entre le gouvernement et les intervenants pour faire de l'action contre le suicide une priorité en santé et en politique publique. La motion présentée par l'honorable Bob Rae, chef intérimaire du Parti libéral du Canada, et les projets de loi d'initiative parlementaire présentés par le député conservateur Harold Albrecht et la députée du NPD Meagan Leslie, demandaient une stratégie de prévention du suicide à l'échelle nationale. La motion a été votée à la Chambre des communes à 271 contre 3.



Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. Plan décennal pour consolider les soins de santé au Canada. La SCP a été invitée à présenter un mémoire au Comité permanent chargé de renouveler l'accord de soins de santé fédéral/provincial/territorial qui prend fin en 2014. La santé mentale semblait certainement parmi les sujets en tête de liste des préoccupations du Comité permanent, particulièrement en ce qui touche les enfants et les jeunes et la promotion de la santé et les investissements en matière de prévention de la maladie en amont. Reportez-vous à l'introduction de Karen Cohen dans le numéro d'hiver pour une copie du mémoire présenté au Comité permanent au nom de la SCP.



Groupe Action santé (HEAL) : HEAL a célébré son 20^e anniversaire par un déjeuner sur la Colline parlementaire. Des représentants des professionnels de la santé et des organisations de soins de santé qui constituent les membres de HEAL ainsi que des invités dans la communauté professionnelle étaient au nombre des invités. Plusieurs députés assistaient et le mot de bienvenue et les remarques ont été prononcés par M^{me} Joy Smith, présidente du Comité permanent sur la santé. À titre de coprésidente de HEAL, D^{re} Cohen a eu l'occasion de remercier les invités et de dire quelques mots au sujet des plans de HEAL pour 2012. Elle a entre autres mentionné la position du groupe sur les ressources humaines en santé et le renouvellement de l'accord de santé en 2014. Sous peu HEAL publiera un rapport mandaté sur le rôle fédéral dans les soins de santé et nous en ferons part immédiatement aux membres de la SCP.



Alliance canadienne pour la maladie mentale et la santé mentale (ACMMSM) : Avec de nouveaux membres qui siègent à son Comité de gestion, l'ACMMSM entend entreprendre un plus grand nombre d'activités de représentation au nom de la santé mentale du Canada en 2012. L'ACMMSM a mis sur pied plusieurs sous-comités (relations gouvernementales, communications) par lesquels elle entend canaliser ses activités et ses messages. La SCP présidera la Semaine de sensibilisation à la maladie mentale (SSMM) de 2012 de l'ACMMSM qui sera célébrée par un souper

de remise des prix aux champions le 3 octobre à Ottawa. Les appels de nominations pour les champions de la santé mentale seront faits tôt en 2012. De plus amples renseignements seront disponibles par les sites Web de l'ACMMSM <http://camimh.ca/> et de la SCP.



Commission de la santé mentale du Canada (CSMC) : La SCP siège au comité consultatif du CHEER qui s'est réuni en octobre et en décembre 2011. CHEER est chargé de l'échange des connaissances et du transfert de pratiques exemplaires pour s'attaquer aux problèmes de santé mentale par les soins primaires. En décembre, CHEER a rassemblé un groupe de chercheurs aux fins de rédiger une proposition de recherche sur la prestation et l'évaluation des interventions en santé mentale aux soins primaires. Pour plus d'information, veuillez communiquer avec D^{re} Cohen à l'adresse kcohen@cpa.ca.



American Psychological Association. La SCP continue de travailler avec l'APA dans plusieurs dossiers:

- Le conseil d'administration de la SCP et le Conseil des représentants de l'APA ont approuvé l'accord sur la reconnaissance mutuelle APA-SCP. L'Accord de First Street comme elle a été appelée (les dispositions de l'accord ont été élaborées par la SCP et l'APA dans les bureaux de l'APA sur First Street à Washington) est en voie d'être conclu et sera affiché sur le site Web de la SCP une fois que ce sera fait. Une célébration de l'Accord, et une présentation sur ses dispositions et son avenir est planifiée pour le congrès de la SCP en 2012.
- Les membres se rappelleront qu'en 2010, l'APA a laissé entendre à la SCP qu'elle n'avait pas l'intention de reconduire ses ententes de cotisations, y compris celle avec la SCP. En février 2011, la SCP a réussi à obtenir de l'APA qu'elle maintienne, à tout le moins temporairement, les ententes de cotisations historiques entre la SCP et l'APA. L'accord, qui consentait aux membres de la SCP qui résident au Canada une réduction de 50 % des cotisations à l'APA (et inversement), restera en vigueur jusqu'à 2012. Une autre consultation des 1 100 membres de la SCP qui sont également membres de l'APA est en cours. La SCP utilisera la rétroaction de cette consultation pour entreprendre d'autres discussions avec l'APA sur l'avenir de l'entente de cotisations au-delà de 2012.



Psynopsis. Les thèmes de Psynopsis au cours des prochains numéros sont les suivants : printemps (date limite de soumission des articles le 1^{er} mars) porte sur la pratique empirique et le numéro de l'été (date limite de soumission des articles le 1^{er} juin) se concentre sur le transfert et la traduction des connaissances. Des articles sur ces thèmes sont grandement souhaités. Faites parvenir vos articles de 900 mots ou moins à Tyler Stacey-Holmes à l'adresse tyler@cpa.ca



Élections 2011 : Comme il a été mentionné dans le numéro d'automne de Psynopsis, sur le site Web de la SCP et par le biais du bulletin de la SCP, la SCP a été très heureuse d'appuyer l'utilisation du service de Advocacy Online au cours des six élections



provinciales/territoriales. Le tableau 1 indique l'achalandage par administration. Notez que l'élection en Saskatchewan était en cours lorsque les données ont été compilées. Comme on peut le voir à partir du tableau, davantage de personnes ont regardé la page qu'envoyer une lettre à leurs candidats (actions). L'inscription signifie ceux qui ont entré leurs coordonnées en vue de pouvoir envoyer une lettre, mais qui ne l'ont pas fait.

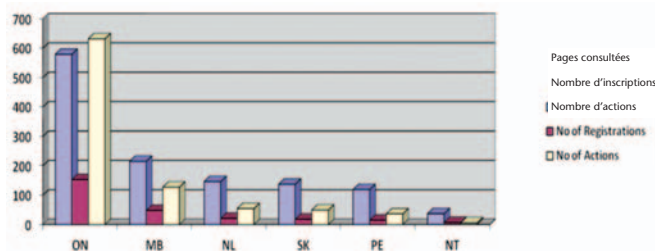


Tableau 1 : Élections provinciales et territoriales octobre/novembre 2011



Direction générale de la pratique. La Direction générale de la pratique a commandé une enquête auprès du public canadien sur leurs points de vue et leurs besoins en ce qui concerne les services de psychologie. Les résultats de l'enquête, à l'échelle nationale et par province/territoire se trouvent à l'adresse <http://www.cpa.ca/polls/>. L'enquête lance la campagne pour un plus grand accès aux services qui sera entreprise par les directions générales en 2011-2012.

Nouvelles de l'Alberta : Le School Psychology Committee of PAA a rédigé le document *The pivotal role of Alberta school psychology services: A response to Alberta Education's setting the direction*. La présidente du Comité, D^{re} Coranne Johnson tend la main à d'autres associations et organisations afin de déterminer les événements importants en psychologie scolaire qui se produisent dans d'autres administrations et déterminer ce qui pourrait être fait de façon concertée. Le Comité est entré en communication avec le groupe de travail sur la psychologie scolaire de la SCP. On peut communiquer avec Coranne à l'adresse schoolpsychology@psychologistsassociation.ab.ca et le lien au document est le suivant http://www.psychologistsassociation.ab.ca/site/paa_school_psychology.

D^r Martin Drapeau, rédacteur en chef de la revue *Psychologie canadienne*, membre de la faculté de McGill et vice-président de L'Ordre des psychologues du Québec, est entré en communication avec la Direction générale de la pratique pour demander des renseignements sur la possibilité que la direction générale adopte des normes de prestation de services (p. ex. le nombre de psychologues recommandés pour une unité de chirurgie bariatrique). La présidente de la DGP, D^{re} Andrea Piotrowski et le directeur de la DGP, D^r John Service assureront le suivi quant à cette recommandation en préparation pour la réunion de la DGP au début de 2012.



Direction générale de l'éducation. En octobre 2011, Melissa Tiessen et Karen Cohen ont assisté à la réunion du 50^e anniversaire de l'Association for State and Provincial Psychology Boards (ASPPB) à Chicago. Les principaux points de discussion à

cette réunion étaient l'importance de la communication et la collaboration entre les intervenants dans le domaine de l'agrément, de l'éducation et de la formation et la réglementation et le rôle et les responsabilités de chaque organisme en ce qui concerne le déséquilibre/crise dans l'internat. Il était évident à cette réunion que même si les problèmes d'éducation et de formation qui sont communs aux deux pays, il existe certaines différences importantes et des occasions uniques qui se présentent dans notre contexte canadien plus petit. (Gardez l'écoute pour plus d'information à ce sujet au congrès de 2012.)



Le Jury d'agrément s'est réuni en octobre 2011 au moment où un nouveau programme avait été agréé, et huit programmes existants ont été reconduits. Une liste à jour des programmes agréés par la SCP se trouve sur le site Web de la SCP à l'adresse suivante : <http://www.cpa.ca/education/accreditation/CPAaccreditedprograms/>

Le Jury d'agrément invite les nominations! Les membres assument un mandat de trois ans, avec un engagement d'assister à deux réunions à Ottawa chaque année (autour de la fin du mois d'avril et à la fin d'octobre, les dépenses de voyage sont assumées par la SCP); le gros du travail des membres du jury est limitée à deux semaines avant chaque réunion. Pour plus d'information ou pour exprimer votre intérêt, communiquez avec Melissa Tiessen à l'adresse mtiessen@cpa.ca

En décembre 2011, Melissa Tiessen a assisté à la réunion biannuelle de l'Association des agences d'agrément du Canada (AAAC) à Ottawa. L'AAAC est une organisation constituée des organismes d'agrément en enseignement supérieur dans diverses disciplines, dans le but commun d'appuyer les pratiques d'agrément de qualité. Les pratiques exemplaires dans la formation des visiteurs d'installations, l'appel à divers types d'apprenants, particulièrement la génération du « millénium » et les politiques et procédures d'archivage des documents électroniques étaient au nombre des principaux points de discussion.

Événements d'intérêt à venir : une séance de développement d'internat est prévue pour le congrès de 2012, afin d'aider à identifier et à diffuser des façons où notre communauté de la psychologie canadienne peut aider à redresser le déséquilibre actuel dans les internats. Un numéro récent de *Training and Education in Professional Psychology* (2011, volume 5, numéro 4, novembre : <http://psycnet.apa.org/index.cfm?fa=browsePA.volumes&jcode=tep>) contient aussi des articles intéressants sur les problèmes et les étapes que divers organismes américains prennent pour tenter de corriger la situation.

Le manuel des normes et procédures d'agrément nouvellement révisé a maintenant été imprimé, et on peut maintenant y accéder sur le site Web de la SCP : <http://www.cpa.ca/education/accreditation/>. La traduction française est en cours. Sur le site vous pouvez également trouver deux « guides rapides » qui indiquent les changements apportés aux nouvelles normes (2011) en regard des anciennes normes (2002)

En dernier lieu, d'autres ateliers de visiteurs d'installations « qui voyagent » additionnels sont prévus – les dates seront affichées sur le site Web de la SCP lorsqu'elles auront été confirmées. Aussi, n'hésitez pas à communiquer avec Melissa Tiessen pour de plus amples informations.



HALIFAX 2012

PRE-CONVENTION WORKSHOP

Date: Wednesday, June 13, 2012

Location: Delta Halifax – 1990 Barrington Street,
Halifax, Nova Scotia, B3J 1P2

Attend CPA Pre-Convention Workshops and earn continuing education credits upon successful completion. All workshops are presented in the language in which they are described.

Deadline for workshop registration: May 13, 2012.

Please note: Pre-Convention Workshops can be cancelled due to low registration up until May 14, 2012.

Those who register for a pre-convention workshop are eligible for a reduced convention fee only until May 13, 2012.

ATELIERS PRÉCONGRÈS

Date : mercredi 13 juin 2012

Lieu : Delta Halifax – 1990 Barrington Street,
Halifax (Nouvelle-Écosse) B3J 1P2

Assistez aux ateliers précongrès et obtenez des crédits d'éducation permanente si terminés avec succès. Tous les ateliers sont décrits dans la langue de la communication.

La date limite pour les inscriptions aux ateliers : le 13 mai 2012.

Veillez noter que les ateliers précongrès peuvent être annulés dû à un manque d'inscription et ce, jusqu'au 14 mai 2012

Les personnes qui s'inscrivent à un atelier précongrès sont admissibles à des frais réduits pour assister au congrès et elles doivent s'inscrire au plus tard le 13 mai 2012.

**Please register online at www.cpa.ca/convention/registration/
Veillez vous inscrire en ligne au www.cpa.ca/congres/fraisinscription/**

WORKSHOP # 1 CE CREDITS 6.0

ADVOCACY WORKSHOP: HOW TO ENGAGE AND INFLUENCE DECISION MAKERS AND THE PUBLIC

Presented by:

John Service, Ph.D., Director of CPA's Practice Directorate
Tyler Stacey-Holmes, CPA's Manager of Association Development, Membership and Public Relations
Meagan Hatch, CPA's Manager of Government Relations

Sponsored by: Canadian Psychological Association

Duration: 9:00am – 4:30pm (6.0 instructional hours)
(Morning and afternoon coffee provided)

CPA/APNS Members:

\$100.00 + \$15.00 HST = \$115.00

Student Affiliates and Student Non-Affiliates:

\$50.00 + \$7.50 HST = \$57.50

Non-Members:

\$150.00 + \$22.50 HST = \$172.50

Promoting science, practice and education in psychology is core to CPA's mandate and critical to the successful impact of the discipline and the profession. Support for research facilitates the creation and dissemination of knowledge and support for practice helps to ensure that people receive the services they need. Many of CPA's and Canadian psychology's constituencies recognize the need for training in advocacy and how to impact public policy. Advocacy can vary in its focus and its target audience. We advocate for funding, policy and legislation, and health services just to name a few. We advocate to granting councils, politicians at the federal, provincial and municipal levels, to health care administrators and the public. This workshop, facilitated by Dr. John Service, Director of CPA's Practice Directorate, Tyler Stacey-Holmes (CPA's Manager of Association Development, Membership and Public Relations) and Meagan Hatch (CPA's Manager of Government Relations) will provide participants with an understanding of how, what, when where and why's of advocacy. The session will begin with an overview of advocacy, focusing on how government works and bills are passed and then on the how to's of communication both within and outside the discipline and profession. Participants will then break out into sessions – depending on the interests and needs of the group, one will focus on advocating for science and another for practice. The break out sessions will provide some hands-on training on how to take an issue from concept to strategy to "ask". Participants will come together in a closing section to share their learnings from the break out sessions.

**WORKSHOP # 2** CE CREDITS 65.5***DIALECTICS IN ACTION: AN INTRODUCTION TO PRACTICAL ACCEPTANCE AND CHANGE STRATEGIES FROM DIALECTICAL BEHAVIOR THERAPY*****Presented by:**

Alexander Chapman, Ph. D., Simon Fraser University,
Department of Psychology

Sponsored by: Clinical Psychology Section

Duration: 9:00am - 4:00pm (5.5 instructional hours)
(Morning and afternoon coffee provided)

CPA/APNS Members:

\$175.00 + \$26.25 HST = \$201.25

Student Affiliates and Student Non-Affiliates:

\$75.00 + \$11.25 HST = \$86.25

Non-Members:

\$225.00 + \$33.75 HST = \$258.75

Describe the dialectical theory underlying DBT and some dialectical strategies. Describe and use in practice some of the core DBT acceptance interventions. Describe and use in practice some of the core DBT change-based interventions.

Dr. Alex Chapman is an Associate Professor and Associate Chair (Graduate) in the Department of Psychology at Simon Fraser University (SFU) and President of the DBT Centre of Vancouver. Dr. Chapman received his B.A. (psychology) from the University of B.C. and his M.S. and Ph.D. in clinical psychology from Idaho State University. After his internship at Duke University Medical Center, Dr. Chapman completed a post-doctoral fellowship with Dr. Marsha Linehan, who developed DBT at the University of Washington. He has given numerous workshops and talks on the treatment of BPD, consults with and trains mental health professionals, and supervises clinical psychology students. Dr. Chapman directs the Personality and Emotion Research Laboratory at SFU, where he studies the role of emotions in BPD and related problems (e.g., self-injury). He has published extensively and has major grants for his research. He has received the *Young Investigator's Award* of the National Education Alliance for Borderline Personality Disorder (2007), the *Canadian Psychological Association's (CPA) Clinical Section Early Career Scientist Practitioner Award* (2011), and an 8-year *Career Investigator Award* from the Michael Smith Foundation for Health Research. He has co-authored four books, including *The Borderline Personality Disorder Survival Guide*.

WORKSHOP # 3 CE CREDITS 3.5***CCPPP - BEST PRACTICE FOR ASSESSING AND GIVING FEEDBACK ABOUT PROFESSIONAL COMPETENCIES FOR TRAINEES*****Presented by:**

George Hurley, Ph.D., Memorial University of Newfoundland
Olga Heath, Ph.D., Memorial University of Newfoundland
Pierre L.-J. Ritchie, Ph.D., University of Ottawa

Sponsored by: CCPPP

(Canadian Council of Professional Psychology Programs)

Duration: 9:00am - 1:00pm (3.5 instructional hours)

Continental Breakfast 8:30am - 9:00am

Coffee Break 10:30am - 11:00am

Lunch 1:00pm - 2:30pm

(Included in workshop price)

CCPPP AGM 2:30pm - 5:00pm

Wine and Cheese Reception 5:00pm - 6:00pm

CPA/APNS/CCPPP Members:

\$75.00 + \$11.25 HST = \$86.25

Student Affiliates and Student Non-Affiliates:

\$50.00 + \$7.50 HST = \$57.50

Non-CPA/APNS/CCPPP Members:

\$100.00 + \$15.00 HST = \$115.00

This half day workshop is intended to give participants an overview of recent work on competency assessment in professional psychology including competencies in interprofessional collaboration. In addition, the workshop will address how to provide feedback about competency progress to trainees. Attention will also be given to methods for dealing with students who are not meeting competency criteria.

George Hurley, Ph.D, RPsych, Professor and Residency Training Director, Registered Psychologist (NL)

Dr. Hurley has been on the centre's faculty since 1980 and is interested in program development, supervision, and outreach/consultation to the university and the community at large. His theoretical orientation is based on an integrationist model. Among other professional activities, Dr. Hurley is a past president of the Canadian Register of Health Service Providers in Psychology (CRHSPP), the US based National Register of Health Service Providers in Psychology (NR) and a past chair of the Section on Counselling Psychology, CPA. He holds cross-appointments to the Discipline of Family Practice, Faculty of Medicine and the Department of Psychology. Dr. Hurley is a Fellow of the American Psychological Association. He is a registered psychologist (Newfoundland and Labrador) and is listed in the Canadian and National Registers of Health Service Providers in Psychology. Dr. Hurley is currently president-elect of the Canadian Council of Professional Psychology Programmes.

Olga Heath, Ph.D., Memorial University of Newfoundland Associate Professor, Faculty Scholar and Co-Director, Centre for Collaborative Health Professional Education, Registered Psychologist (NL)

Dr. Heath joined the faculty of the University Counselling Centre and the Faculty of Medicine in the fall of 2006 and has been involved in a variety of interprofessional education initiatives at the undergraduate and early practitioner level as well as with licensed practitioners from a number of health professions. She is cross appointed to Eastern Health Regional Health Authority to provide guidance and leadership in program development and research in the area of her clinical expertise, Eating Disorders. As a Registered Psychologist, Dr. Heath has more than 20 years of experience working with adults with Eating Disorders. She has been involved in professional activities at both the provincial and national level. As Past-President of the Association of Psychology in Newfoundland Labrador, Dr. Heath has become involved in national and provincial advocacy for psychology services.

Pierre L.-J. Ritchie, Ph.D., University of Ottawa, Professor

Dr. Ritchie is a full professor at the University of Ottawa where he is responsible for clinical training in the School of Psychology. He is Secretary-General of the International Union of Psychological Science and Psychology's Main Representative to the World Health Organization. Dr. Ritchie is also Executive Director of the Canadian Register of Health Service Providers in Psychology. He received his PhD in Clinical Psychology from Duke University.

Dr. Ritchie's career embodies his identity as a clinical / health community psychologist. His scholarly and professional interests address health policy and innovations in primary care as well as ethics in health practice, research and clinical teaching. He has presented and published widely on these subjects. He has been extensively involved in national and international professional and scientific organizations. For over 30 years, he has regularly provided psychological consultation in remote areas. In the international arena, he is passionately committed to capacity-building in the Global South, particularly through strengthening psychology's scientific and service missions.

Dr. Ritchie has received numerous honours and awards (examples: Award for Distinguished Contributions to the International Advancement of Psychology, Canadian Psychological Association; Award for Excellence in Professional Training, Canadian Council of Professional Psychology Programs; Presidential Citation for Distinguished Contributions to International Psychology, American Psychological Association as well as the Award of Merit from both the Ontario Psychological Association and the Ordre des psychologues du Québec).

WORKSHOP # 4 CE CREDITS 6.5**PROCESS MADE SIMPLER: A BEHAVIOURAL GUIDE TO THE THERAPEUTIC ALLIANCE****Presented by:**

Randy Paterson, Ph.D., Changeways Clinic,
Vancouver, British Columbia

Duration: 9:00am – 5:00pm (6.5 instructional hours)
(Morning and afternoon refreshments provided)

CPA/APNS Members:

\$150.000 + \$22.50 HST = \$172.50

Student Affiliates and Student Non-Affiliates:

\$100.00 + \$15.00 HST = \$115.00

Non-Members:

\$175.00 + \$26.25 HST = \$201.25

“Be empathetic,” they say. “Be warm. Build up an effective working alliance.” But we seldom hear exactly HOW these mysterious tasks are to be accomplished. The so-called non-specific factors in therapy are acknowledged to account for the lion's share of variability in psychotherapy outcome, but they are seldom made explicit. Whether one adopts a therapy model believed to work entirely through the alliance, or a technique-focussed model such as cognitive behaviour therapy, an effective working relationship between clinician and client is a prerequisite for change. This workshop presents specific, behavioural practices designed to maximize therapeutic progress. Topics covered include: orienting clients to therapy, marking the transition from assessment to treatment, getting on the same page with regard to the goal of therapy, creating an effective session from waiting room to farewell, therapist nonverbal behaviour, microcommunication strategies (closed-ended questions can be a very good thing), macrocom-

munication strategies (selective validation, self-disclosure, shifting the focus from pathology to strength, and the careful use of honesty), techniques for marking out your most important points, coping with client resistance and noncompliance, and dealing with breakdowns in the alliance. The emphasis throughout is on specific strategies rather than generalities.

Dr. Paterson is the owner and Director of Changeways Clinic, a multiple-provider psychological private practice in Vancouver BC specializing in cognitive behaviour therapy for depression, anxiety, and related concerns. He is the author of *Private Practice Made Simple*, *Your Depression Map*, and *The Assertiveness Workbook* (all from New Harbinger Publications), and numerous treatment guides and therapy resources published through Changeways Clinic. He coordinates the monthly PsychologySalon talk series in Vancouver and writes a blog on psychology and therapy at www.psychologysalon.com. He has provided psychotherapy supervision for many years, and offers regular professional training workshops on topics including communication skills training, the treatment of depression and anxiety disorders, diversity awareness, cognitive behaviour therapy, and private practice management.

WORKSHOP # 5 CE CREDITS 7.0**SEX IS NATURAL, SEX IS FUN: GIRLS' AND WOMEN'S SEXUAL WELL-BEING****Presented by:**

The Keynote Speaker in this day-long Institute is Lucia O'Sullivan, Ph.D., University of New Brunswick

Sponsored by: CPA Section on Women and Psychology (SWAP)

Duration: 9:00am - 5:30pm (7.0 hours of instructional hours)
(Morning and afternoon refreshments provided)

CPA/APNS Members:

\$175.00 + \$26.25 HST = \$201.25

Student Affiliates and Student Non-Affiliates:

\$75.00 + \$ 11.25 HST = \$ 86.25

Non-Members:

\$185.00 + \$27.75 HST = \$212.75

Participants will be introduced to the EFTT approach to treating complex interpersonal trauma, including the theoretical and research underpinnings of the approach, and the interventions used in the therapy. Most prominently, the workshop will present intervention guidelines and strategies for helping clients confront trauma feelings and memories (exposure) and a step-by-step process for resolving attachment injuries with particular perpetrators. In addition, we will present guidelines for cultivating an effective therapeutic relationship and strategies for promoting client self-development — including reducing fear and avoidance of emotional experience, and transforming shame and self-blame. Videotaped examples will illustrate key therapy processes.

Sandra Paivio received her PhD in psychology from York University in 1993 where she studied with Les Greenberg. She is one of the developers of emotion-focused therapy particularly applied to complex relational trauma (EFTT). Dr. Paivio currently is a practicing clinical psychologist, Head of the Psychology Department, and Director of the Psychotherapy Research Centre at the University of Windsor. She is an internationally recognized scholar and therapist with more than



20 years of experience. Dr. Paivio is an invited member of the American Psychological Association (APA, Division 56) committee to develop treatment/best practice guidelines for complex trauma. Dr. Paivio is author of numerous publications and conference presentations on psychotherapy and problems related to trauma. She is co-author (with Les Greenberg) of *Working with Emotion in Psychotherapy* and author (with Antonio Pascual-Leone) of a recent book, *Emotion-Focused Therapy for Complex Trauma*, published by APA (2010).

Antonio Pascual-Leone is a clinical psychologist and an associate professor of psychology at the University of Windsor. He completed his early graduate training in France and his Ph.D. with Les Greenberg at York University. He has published several papers on the process and outcome of psychotherapy, with a focus on the role of emotion. Dr. Pascual-Leone has co-authored (with Sandra Paivio) a book on Emotion Focused Therapy for Complex Trauma, which was published by APA in 2010. He has also completed an outcome study on an emotion focused treatment for domestically violent men as well as several papers on psychotherapy skills training. In 2009, he received the Young Researcher Award from the international Society for the Exploration of Psychotherapy Integrations and Division 29 of the American Psychological Association honored him with a Distinguished Publication Award for, "Best empirical research article of 2009." He runs the Emotion and Intervention Research Lab at the University of Windsor, where he also teaches emotion focused therapy (EFT) and integrative approaches to psychotherapy.

those with high resistance with primarily distancing behaviours, and those with high resistance with depression/somatization. The main emphasis will be on the use of videotape segments to highlight unconscious operations, evaluation of these operations and working with the client to address what is learned through specific, timed interventions.

Dr. Allan Abbass is Professor of Psychiatry and Psychology, Director of Psychiatric Education and founding Director of the Centre for Emotions and Health at Dalhousie University. He completed medicine at Dalhousie, Family Medicine at McGill University and Psychiatry residency at University of Toronto. He is a leading teacher and researcher in the area of Short-term Psychodynamic Psychotherapy with over 100 publications in this area. He is on the editorial board of 3 journals including the APA journal *Psychotherapy*. He has received a number of teaching awards including a national teaching award in Psychiatry. His recent research includes several meta-analyses of short-term psychotherapy including the Cochrane Review of Short-term Psychodynamic Psychotherapy for common mental disorders. He is sought out to provide training programs to International audiences in the areas of anxiety, depression, somatic disorders and personality disorders. He provides ongoing training to groups of psychologists in Denmark, Norway, UK, Poland, Italy and Canada. He has been honored with visiting professorships at institutions in the US, UK, Italy and Poland.

WORKSHOP # 6 CE CREDITS 6.0

INTRODUCTION TO INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY: A VIDEOTAPE WORKSHOP

Presented by:

Allan Abbass, MD FRCPC, Dalhousie University

Sponsored by: CPA Section on Psychoanalytic and Psychodynamic Psychology

Duration: 9:00am - 4:30pm (6.0 hours of instructional hours) (Morning and afternoon refreshments provided)

CPA/APNS Members:

\$200.00 + \$30.00 HST = \$230.00

Student Affiliates and Student Non-Affiliates:

\$100.00 + \$15.00 HST = \$115.00

Non-Members:

\$300.00 + \$45.00 HST = \$345.00

Intensive Short-term Dynamic Psychotherapy now has a building evidence base with over 20 published outcome studies including clients with personality disorder, panic disorder, treatment resistant depression and a range of somatoform disorders. Several studies show it to be cost effective, resulting in reduced medical service use, hospital costs, medication costs and disability costs. This videotape-based workshop will review the current state of evidence for short-term psychodynamic psychotherapy methods and then will focus on Davanloo's Intensive Short-term Dynamic Psychotherapy as developed at McGill University. Videotapes will be used to present evaluative and treatment processes of this method across the spectra of suitable patients for this approach. Such cases include patients with no personality disorder, with severe personality disorders with dissociation,



CPA PRESIDENTIAL ADDRESS / ALLOCUTION PRÉSIDENTIELLE
Psychological Treatments: Putting Evidence into Practice and Practice into Evidence
David Dozois, Ph.D., CPA President



HONORARY PRESIDENT'S ADDRESS / ALLOCUTION DU PRÉSIDENT D'HONNEUR
Developing and Disseminating Effective Psychological Treatments: Science, Practice and Economics
David M Clark, DPhil., King's College London, University of London



THE FAMILY OF PSYCHOLOGY KEYNOTE ADDRESSE / CONFÉRENCE "LA FAMILLE DE LA PSYCHOLOGIE »
Pain, Social Communication, Empathy and Prosocial Behaviour... in the Laboratory Mouse
Jeffrey S. Mogil, Ph.D., McGill University



SCIENCE AND APPLICATIONS KEYNOTE ADDRESS / CONFÉRENCE "SCIENCE & APPLICATIONS"
Challenges in Conceptualizing, Assessing, Diagnosing and Treating Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder (ADHD)
Rosemary Tannock, Ph.D., University of Toronto

CPA INVITED SPEAKERS /
CONFÉRENCIERS INVITÉS PAR LA SCP



Attention in Space and Time
Raymond M Klein, Ph.D., Dalhousie University



**Ethnocultural Diversity
in Psychological Trauma**
Nnamdi Pole, Ph.D., Smith College



**The Socio-Cultural Underpinnings
of Terrorist Psychology**
Jerrold M Post, Ph.D.,
The Elliot School of International Affairs,
The George Washington University



**Psychologists Role in Rural/Northern and
Urban-Based Collaborative Care Models**
Pierre Ritchie, Ph.D., University of Ottawa

CPA/SECTION INVITED SPEAKERS
CONFÉRENCIERS INVITÉS PAR
LA SCP ET LES SECTIONS



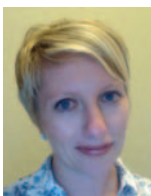
**Leaders' Mental Health and
their Leadership Behaviors**
Julian Barling, Ph.D., Queen's University



**Understanding
Terrorist Psychology**
Randy Borum, Ph.D.,
University of South Florida



**Prosocial Incentives Increase Employee
Satisfaction and Team Performance**
Michael I Norton, Ph.D., Harvard Business School



**Let's give them something to Talk about: 100
Perspectives on Feminism and Psychology**
Alexandra Rutherford, Ph.D., York University



**The Efficacy of Psychodynamic Psychotherapy:
Talk Therapy in the Era of Prozac, Managed
Care, and Evidence Based Practice**
Jonathan Shedler, Ph.D.,
University of Colorado School of Medicine

CPA SECTIONS RELATED PROGRAM
PROGRAMME LIÉ AUX SECTIONS DE LA SCP

Aboriginal Psychology / Psychologie autochtone
Reception / Réception
Annual Meeting / Réunion annuelle

**Adult Development and Aging /
Développement adulte et vieillissement**
Annual Meeting / Réunion annuelle

Brain and Cognitive Science / Cerveau et science cognitive
CPA Invited Speaker / Conférencier invité de la SCP
"Attention in Space and Time"
Raymond Klein, Dalhousie University
Annual Meeting / Réunion annuelle

Clinical Psychology / Psychologie Clinique
CPA Invited Speaker / Conférencier invité de la SCP
*"Psychologists Role in Rural/Northern and
Urban-Based Collaborative Care Models"
Pierre Ritchie, University of Ottawa
Reception / Réception
Annual Meeting / Réunion annuelle

Clinical Neuropsychology / Neuropsychologie clinique
Reception / Réception
Annual Meeting / Réunion annuelle

Community Psychology / Psychologie communautaire
Annual Meeting / Réunion annuelle

Counselling Psychology / Psychologie du counseling
Section Keynote Speaker / Conférencière invitée par la section
"Counselling Psychology Section Keynote"
Sharon Robertson, University of Calgary
Reception / Réception
Annual Meeting / Réunion annuelle

Criminal Justice Psychology / Psychologie et justice pénale
Section Keynote Speaker / Conférencier invité par la section
"Dr. James Ogloff's Criminal Justice Section Career Contribution
Award Keynote"
James Ogloff, Monash University and Victorian Institute
of Forensic Mental Health
Annual Meeting / Réunion annuelle

Developmental Psychology / Psychologie du développement
Annual Meeting / Réunion annuelle

Environmental Psychology / Psychologie de l'environnement
Section Keynote Speaker / Conférencier invité par la section
"What Canadians Value about Urban Forests, and Why that Matters"
Peter Duinker, Dalhousie University
Annual Meeting / Réunion annuelle

Extremism and Terrorism / Extrémisme et terrorisme
CPA Invited Speaker / Conférencier invité de la SCP
"The Socio-Cultural Underpinnings of Terrorist Psychology"
Jerrold Post, Washington University
CPA/Section Invited Speaker / Conférencier invité (SCP / Section)
"Understanding Terrorist Psychology"
Randy Borum, University of South Florida
Section Keynote Speaker / Conférencier invité par la section
"Using Thematic Content Analysis to Distinguish Terrorist from
Non-Terrorist Extremist Groups"
Peter Suedfeld, University of British Columbia
Reception / Réception
Annual Meeting / Réunion annuelle

**Family of Psychology / Psychologie de la famille**

Annual Meeting / Réunion annuelle

Health Psychology / Psychologie de la santé

CPA Invited Speaker / Conférencier invité de la SCP

**“Psychologists Role in Rural/Northern and Urban-Based Collaborative Care Models”*

Pierre Ritchie, University of Ottawa

Annual Meeting / Réunion annuelle

History and Philosophy of Psychology / Histoire et philosophie de la psychologie

Section Keynote Speaker / Conférencier invité par la section

“The Skin of Memory and our Journey through the Disassembled Past”

Scott Greer, University of Prince Edward Island

Annual Meeting / Réunion annuelle

Industrial and Organizational Psychology / Psychologie Industrielle et Organisationnelle

CPA/Section Invited Speakers / Conférenciers invités (SCP/ Section)

“Leaders’ Mental health and their Leadership Behaviors”

Julian Barling, Queen’s University

**“Prosocial Incentives Increase Employee Satisfaction and Team Performance”*

Michael Norton, Harvard Business School

Annual Meeting / Réunion annuelle

International and Cross-Cultural Psychology / Psychologie internationale et interculturelle

CPA Invited Speaker / Conférencier invité de la SCP

“Ethnocultural Diversity in Psychological Trauma”

Nnamdi Pole, Smith College

Annual Meeting / Réunion annuelle

Psychoanalytic and Psychodynamic Psychology / Psychologie Psychoanalytique et Psychodynamique

CPA/Section Invited Speaker / Conférencier invité (SCP/ Section)

“The Efficacy of Psychodynamic Psychotherapy: Talk Therapy in the Era of Prozac, Managed Care, and Evidence Based Practice”

Jonathan Shedler, University of Colorado School of Medicine

Annual Meeting / Réunion annuelle

Psychologists in Education / Psychologues en éducation

Section Keynote Speaker / Conférencière invitée par la section

“Waking up to the Consequences of Inadequate Sleep in Children”

Penny Corkum, Dalhousie University

Reception / Réception

Annual Meeting / Réunion annuelle

Psychology in the Military / Psychologie du milieu militaire

Annual Meeting / Réunion annuelle

Psychopharmacology / Psychopharmacologie

Annual Meeting / Réunion annuelle

Psychology and Religion / Psychologie et religion

Annual Meeting / Réunion annuelle

Rural and Northern Psychology / Psychologie des communautés rurales et nordiques

CPA Invited Speaker / Conférencier invité de la SCP

**“Psychologists Role in Rural/Northern and Urban-Based Collaborative Care Models”*

Pierre Ritchie, University of Ottawa

Section Keynote Speaker / Conférencière invitée par la section

“Helping People Help Themselves-Self-Directed Treatments in Rural Settings”

Elizabeth Church, Mount Saint Vincent University

Reception / Réception

Annual Meeting / Réunion annuelle

Sexual Orientation and Gender Identity Issues / Orientation sexuelle et identité sexuelle

Annual Meeting / Réunion annuelle

Social and Personality Psychology / Psychologie sociale et de la personnalité

CPA/Section Invited Speaker / Conférencier invité (SCP/ Section)

**“Prosocial Incentives Increase Employee Satisfaction and Team Performance”*

Michael Norton, Harvard Business School

Annual Meeting / Réunion annuelle

Sport & Exercise Psychology / Psychologie du sport et de l'exercice

Reception / Réception

Annual Meeting / Réunion annuelle

Students in Psychology / Étudiants en psychologie

Section Keynote Speaker / Conférencier invité par la section

Arla Day, Saint Mary's University

Reception / Réception

Annual Meeting / Réunion annuelle

Teaching of Psychology / Enseignement de la psychologie

Section Keynote Speaker / Conférencière invitée par la section

“Music Psychology in the 21st Century: Theory and Teaching”

Annabel J. Cohen, University of Prince Edward Island

Annual Meeting / Réunion annuelle

Traumatic Stress / Stress traumatique

Section Keynote Speaker / Conférencière invitée par la section

“Suggestion, Fantasy, and Intolerable Reality in the Narration of Trauma”

Constance Dalenberg, Alliant International University

Reception / Réception

Annual Meeting / Réunion annuelle

Women and Psychology / Femmes et psychologie

CPA/Section Invited Speaker / Conférencière invitée (SCP/ Section)

“Let’s Give them Something to Talk About: 100 Perspectives on Feminism and Psychology”

Alexandra Rutherford, York University

Reception / Réception

Annual Meeting / Réunion annuelle

* **Speaker nominated by multiple sections**

ACCOMMODATIONS

DELTA HALIFAX HOTEL (Downtown Halifax)

1990 Barrington Street
Halifax, Nova Scotia, B3J 3L6
Group Code (online): GHGAL
Group Code (Telephone/email): **HGALAN**

DELTA BARRINGTON (Downtown Halifax)

1875 Barrington Street
Halifax, Nova Scotia, B3J 3L6
Group Code (online): GPSYC
Group Code (Telephone/email): **BGPSYC**

Reservations for both Delta's

Telephone: 1-888-423-3582 or
E-mail: hal.reservations@deltahotels.com
Online: Delta Barrington or Delta Halifax
(<http://www.cpa.ca/convention/traveltips/accommodations>)

Group rate is available until May 14, 2012.

Subject to availability.

Here is a little incentive to book early... Book your hotel accommodation at the Delta Halifax or Delta Barrington before April 1st, 2012. Your name will be entered in a draw to win 1 night's accommodation during the convention dates at the Single/Double Guest Room rate.

You can access the site and learn more about the event and to book, modify, or cancel a reservation up until June 11, 2012.

Room Single / Double Occupancy:

Single/Double Guest Room \$ 229.00 (Plus applicable taxes)
Junior/Signature Suites \$ 279.00 (Plus applicable taxes)

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Student Rate: \$31.00/night for single room
Tourist Rate: \$47.00/night for single room
Student Rate: \$56.00/night for double room
Tourist Rate: \$74.00/night for double room
Rates include: Destination Halifax marketing levy, 15% HST, linen, towels & regular membership privileges to Dalplex Athletic Facility.

Visit Dalhousie University
(<http://www.ancillaries.dal.ca/default.asp?mn=1.5>) to reserve online. Use special rate code "Canadian Psychological Association" on your Reservation Form. Rooms are currently being held in the Risley and Howe Hall. Book by April 1, 2012.

Note to the membership on accommodation for convention 2012...

We are really looking forward to welcoming you to convention 2012 in Halifax. The Delta Halifax and the Delta Barrington are our convention hotels. They are centrally located in downtown Halifax and large enough to accommodate the many delegates we expect to join us. We would like to encourage you to consider staying at the Delta Halifax or the Delta Barrington while you attend the convention. Convention costs are tied to guest room uptake. If we reserve too few guest rooms in our block, some convention delegates are disappointed to have to stay elsewhere. If we reserve too many, CPA (and ultimately its members) pay attrition costs for not meeting our room block as well as face more expensive meeting room costs (because meeting room costs are tied to guest room uptake). Many thanks for your support. For more information, feel free to contact the convention office convention@cpa.ca.

HÉBERGEMENT

HÔTEL DELTA HALIFAX (centre-ville d'Halifax)

1990, rue Barrington
Halifax, Nouvelle-Écosse B3J 3L6
Code de groupe (en ligne) : GHGAL
Code de groupe (téléphone/courriel) : **HGALAN**

DELTA BARRINGTON (centre-ville d'Halifax)

1875, rue Barrington
Halifax, Nouvelle-Écosse B3J 3L6
Code de groupe (en ligne) : GPSYC
Code de groupe (téléphone/courriel) : **BGPSYC**

Réservations pour les deux Delta

Téléphone : 1-888-423-3582 ou
Courriel : hal.reservations@deltahotels.com ou
En ligne : Delta Barrington ou Delta Halifax
(<http://www.cpa.ca/convention/traveltips/accommodations>)

Le tarif de groupe est offert jusqu'au 14 mai 2012. Nombre limité de chambres.

Voici un petit incitatif pour réserver tôt... Réservez votre chambre d'hôtel au Delta Halifax ou au Delta Barrington avant le 1^{er} avril 2012. Votre nom sera entré pour le tirage au sort d'une nuitée au cours des dates du congrès au tarif des chambres pour une ou deux personnes. Vous pouvez accéder au site et en apprendre davantage au sujet de l'événement et pour réserver, modifier ou annuler une réservation jusqu'au 11 juin 2012.

Chambre pour une personne / deux personnes :

Chambre pour une/deux personnes 229 \$ (plus les taxes)
Chambre salon/signature 279 \$ (plus les taxes)

UNIVERSITÉ DALHOUSIE

Une très belle résidence d'été située sur le campus de l'Université Dalhousie.
étudiant : 31,00 \$/nuitée - chambre pour une personne
Tarif touriste : 47,00 \$/nuitée - chambre pour une personne
Tarif étudiant : 56,00 \$/nuitée - chambre pour 2 personnes
Tarif touriste : 74,00 \$/nuitée - chambre pour 2 personnes
Le tarif inclut : la taxe à la commercialisation à destination d'Halifax, 15 % TVH, literie, serviettes et privilèges des membres réguliers à l'installation de conditionnement physique Dalplex.

Visitez le site (<http://www.ancillaries.dal.ca/default.asp?mn=1.5>) de l'Université Dalhousie pour réserver en ligne. Utilisez le code de tarif spécial « CPA2012 » sur votre formulaire de réservation. Les chambres sont actuellement retenues au Risley Hall et au Howe Hall. Réservez avant le 1^{er} avril 2012.

Remarque à l'intention des membres au sujet de l'hébergement au congrès de 2012...

Nous avons vraiment hâte de vous souhaiter la bienvenue au congrès de 2012 à Halifax. Le Delta Halifax et le Delta Barrington sont les hôtels où se déroulera le congrès. Ils se situent au centre-ville d'Halifax et sont suffisamment grands pour accueillir le très grand nombre de délégués attendus. Nous aimerions vous encourager à considérer de séjourner au Delta Halifax ou au Delta Barrington lorsque vous assisterez au congrès. Les coûts du congrès sont liés au nombre de chambres réservées. Si nous réservons un trop petit nombre de chambres dans notre bloc, certains délégués au congrès seront déçus d'avoir à séjourner ailleurs. Si nous en réservons un trop grand nombre, la SCP (et ultimement ses membres) paie des frais pour ne pas avoir respecté le bloc de chambres qui a été réservé et les coûts seront plus élevés pour les salles de réunion (parce que les coûts des salles de réunion sont liés au nombre de chambres occupées). Merci beaucoup de votre soutien. Pour de plus amples renseignements, n'hésitez pas à communiquer avec le bureau du congrès à l'adresse suivante convention@cpa.ca.



Lobsterfest



at/chez Murphy's The Cable Wharf!! *

Join us in celebrating the *best* of the Maritimes! Enjoy a bagpiper-led processional from the convention hotel to one of Halifax's premiere seafood establishments. You'll be entertained by a live East Coast band as you enjoy your succulent lobster dinner (1 1/4 lb) served with all the fixin's (dessert and non-alcoholic beverages included). *Alternate meals: Chicken or Vegetarian.

Don't know how to eat a lobster? **No problem!** There will be a live demonstration on how to crack open your ruby-shelled crustacean! *See you on the wharf!!*

Friday, June 15th, 2012

Murphy's The Cable Wharf (Murphy's On the Water)
1751 Lower Water Street, Halifax

**7:30 pm - Bagpiper-led processional from the Delta Halifax
\$75.00 taxes and gratuities included**

More details to come – tickets must be purchased in advance at the time of your online Convention Registration (Limited seating)



Joignez-vous à nous pour célébrer ce qu'il y a de *meilleur* dans les Maritimes! Appéciez une procession dirigée par un joueur de cornemuse depuis l'hôtel du congrès jusqu'à l'un des meilleurs établissements de fruits de mer d'Halifax. Vous serez charmés par un orchestre de la côte Est en mangeant votre succulent souper de homard (1 ¼ lb) servi avec tous les accompagnements (dessert et breuvages non alcoolisés inclus). * Repas de poulet ou végétarien aussi disponible.

Vous ne savez pas comment manger un homard? **Pas de problème!** Il y aura une démonstration en personne sur la façon d'ouvrir ce crustacé à la carapace rubis!

Au plaisir de vous voir sur le quai!!

Vendredi 15 juin 2012

Murphy's The Cable Wharf (Murphy's On the Water)
1751, rue Lower Water, Halifax

**19 h 30 - Procession dirigée par un joueur
de cornemuse à partir de Delta Halifax
75 \$ taxes et pourboires compris**

Il y aura plus de détails à venir – les billets doivent être achetés à l'avance au moment de votre inscription au congrès en ligne (nombre de places limitées)





Getting a handle on science policy: Report on the 2011 Canadian Science Policy Conference

Ashley Ronson, M.Sc., Manager, CPA Science Directorate;
Aimée Surprenant, Ph.D., Chair, CPA Scientific Affairs Committee

From November 16th to 18th, 2011, the 3rd annual Canadian Science Policy Conference was held in Ottawa, Ontario. Hundreds of representatives from government, academia, private industry, and not for profit organizations participated in the numerous informative sessions in the course of the three-day event. Topics included discussions on science culture in Canada, enabling private sector innovation, reflections on northern science policy, and major issues in Canadian science policy. Although many of the presentations did not directly address policy issues in *psychological* science, we were able to pull information from each attended session that could help shape future policy directives of CPA's Science Directorate.

The "Science Policy 101" workshop on the first day of the conference proved to be especially valuable in providing a road map for exploring science policy initiatives. A brief tutorial with a case example is available on the science pages of the CPA website. Conference sessions also provided useful information on knowledge translation, education and training of doctoral-level scientists, social innovation, and science culture. Highlights of what we learned are described below.

KNOWLEDGE TRANSLATION. The purpose of the knowledge translation, mobilization, and brokering (K*) session was to illustrate some successful examples of translating scientific findings to stakeholders — including educators, public policy makers, and the general public. Too often our results do not get to those who need it. One reason for this is that researchers generally do not have the time, the training, or sometimes the inclination to describe their findings in simple, easy-to-understand messages. However, there are many intermediaries already available to help disseminate research findings widely and there are individuals who know how to translate science. Sometimes all that is needed is to put the person who has the knowledge in contact with the person who needs it.

One example of such a resource is the Knowledge Network for Applied Education Research (KNAER; www.knaer-recrae.ca) that supports the strengthening of links between research, policy, and practice in education in Ontario. The projects they fund include partnerships among school districts, universities, colleges, federations, media, and health services. Another example showcased in the session was Research Impact (www.researchimpact.ca), run out of York University. This is a program that serves as an intermediary and connects university research with users across Canada so that research can help to inform decision-making in public policy and professional practice. One lesson that was emphasized in the session was that structures for doing K* are often already available so all that is

needed is to identify those that exist and make a connection. A perfect example is the Science Directorate at CPA: The directorate is already present in your national organization and is willing to help find ways to disseminate research in psychological science to assist policy makers and others to make informed decisions based on empirical data. The Science Directorate has many resources that members can access including a research hub, advocacy for science and, most recently, membership in the Science Media Centre of Canada. Thus, we are positioned as a knowledgeable intermediary that can connect the results of research in psychological science with decision-makers throughout Canada.

EDUCATION AND TRAINING OF DOCTORAL-LEVEL SCIENTISTS. A panel discussion focused on the education and training of scientists. As Dr. Angela Crawley, the Vice-Chair of Operations of the Canadian Association of Post-doctoral Scholars noted, fewer than 25% of new science PhDs will actually get academic jobs. Thus, one might ask, "Are we producing too many PhD's?" Panelists including Olga Stachova, CEO of MITACS, Dr. Alan Bernstein, Founding President of CIHR, and Dr. Suzanne Fortier, President of NSERC felt that the question should be reframed **to ask whether we are training the PhDs for the opportunities that are available**. The feeling was that we still need to train new scientists but that the new generation of scientists will have to be more active in creating their own opportunities and perhaps even inventing new ways of contributing to science outside of a university setting. One problem identified is that the average academic has little experience in training students to succeed outside of academia.

One possible solution to the problem is to form industry-academia partnerships that include internship opportunities to help students get industry and/or research-related job experience and mentorship. There are a handful of programs aimed at exactly that. For example, MITACS (www.mitacs.ca) provides both pre- and post-doctoral research internships in collaboration with business, industry and community organizations. In addition, SSHRC's Talent program supports the development of the next generation of researchers and leaders across society. It is currently being restructured and they are seeking feedback from the scientific community (http://www.sshrc-crsh.gc.ca/funding-financement/umbrella_programme_programme_cadre/talent-consultation-eng.aspx).

SOCIAL INNOVATION. Innovation does not just involve basic sciences and technology; more and more, we are finding ways to be *socially* innovative. What might this look like? There are organizations, such as the Ontario Centre for Excellence, that bridge communication between non-profit organizations and industry and academic partners. The goal is to



facilitate working relationships on mutually beneficial projects that lead to new products and services and address social challenges.

SCIENCE CULTURE. Throughout the conference, we really got the sense that it was not only important to promote science in policy, but also to develop science as a culture more prominently. Slowly but surely, CPA has taken steps to develop its own *psychological* science culture. The Science Directorate formed in 2009 and with that Dr. Lisa Votta-Bleeker (as the Director of the Science Directorate) and the Scientific Affairs Committee have taken charge to make a name for psychology in science culture. The Science Directorate has been involved in many advocacy and policy initiatives (particularly surrounding funding for psychology research), but also has started two new initiatives at CPA: the Recruit Research Participants Portal (R²P²; a useful tool to help researchers find participants of all kinds among the CPA membership) and the Research Hub (a search database to help CPA members find other researchers with similar or different research interests for collaboration or mentorship). Last year as President of CPA, Dr. Peter Graf inaugurated the high school psychology science fair, which is a very important step to increasing the reach of psychological science and passing on the torch to younger generations of scientists and psychologists. See the Head Office Update for news on other of CPA's 2012 Science initiatives.

Attending this conference sparked ideas to help advance psychology in science even further, to see what more we could be doing. It would be useful to benchmark our science activities with other countries. What good things in science promotion are we accomplishing? What could we be doing better? What are other countries doing that might be useful for us to accomplish as well? We could also do more as a psychological science community to encourage psychologists and researchers to get involved in leadership roles and to participate on advisory boards in our society. For example, CPA currently sits on the Steering Committee of the Canadian Consortium of Research (CCR). The CCR is an umbrella organization that concerns itself with the funding of research of all sectors and support for post-secondary education. As a national organization for psychology in Canada, CPA is ideally positioned to continue showcasing psychology's contributions to science and to push forward in making psychology a leader in science culture.

Special CPA Member Discount to APA's PsycNET® GOLD package

Starting January 1st 2012, CPA members may purchase a 1-year subscription to the **APA's PsycNET® GOLD** package*, at a cost of **\$175.00 CAD** plus applicable GST/HST, which will give the subscriber access to the package for the calendar year. A half-year subscription can be purchased after July 1st 2012 at the cost of \$87.50 CAD plus applicable GST/HST for access to the package for the remainder of the calendar year.

Information and rates to join CPA can be found at web.cpa.ca/media.

**see website for details*

Rabais consenti aux membres de la SCP pour le logiciel PsycNET® GOLD de l'APA

À compter du 1^{er} janvier 2012, les membres de la SCP peuvent acheter un abonnement d'une année au logiciel* **PsycNET® GOLD** de l'APA, à un coût de **175 \$ CA** plus la TPS/TVH en vigueur, qui donnera à l'abonné l'accès au logiciel pour l'année civile. Un abonnement de six mois peut être acheté après le 1^{er} juillet 2012 au coût de 87,50 \$ CA plus la TPS/TVH en vigueur pour l'accès au logiciel pour le reste de l'année civile.

L'information et les taux pour se joindre à la SCP se trouvent à l'adresse web.cpa.ca/media.

**voir les détails sur le site Web*



Cutting Edge Training in Child and Play Therapy

The Canadian Association for Child and Play Therapy (CACPT) offers cutting-edge training in Child and Play Therapy. Sign up for one-day courses or apply to the six-week Play Therapy Certificate Program and obtain 180 educational units, which is one of the steps needed to become a Certified Child Psychotherapist & Play Therapist. Courses are offered in London in May and June and in Toronto in July. The application deadline for the Play Therapy Certificate Program is March 15 (for London) and May 15 (for Toronto) so apply soon! If you just want to attend an individual workshop, there is no deadline but limited space is available so you are encouraged to register early.

For further information on courses or on getting certified as a Child Psychotherapist & Play Therapist please visit our webpage at www.cacpt.com or call CACPT at **519-827-1506**.



Psychological services trusted by Canadians: Poll results

John Service Ph.D., Director, Practice Directorate

The results of Canada's first national opinion poll of Canadians' knowledge of and attitudes towards psychological services show that Canadians have confidence in psychological services. Psychologists were ranked with family physicians and psychiatrists as the most trusted mental and behavioural health professionals.

Respondents indicated confidence with psychology: very confident (17%), confident (42%) and somewhat confident (35%) with 4% indicating they had no confidence and only 2% having no opinion. It is very positive that the no confidence and no response categories were so low. It is disappointing that the very confident category received a 17% response rate. It is not known what percentage of respondents had first hand experience with psychological services upon which to base their ratings.

The profession received high effectiveness ratings in the areas of depression and anxiety (above 70%) and stress related to cancer or other health problems (63%). On the other hand, the majority of respondents were not as aware of psychologists' important contributions to learning disabilities (44%) and dementia (38%). Teachers were seen as the first choice for learning disabilities by a large margin (32%) over family physicians (14%) and psychologists (13%). In terms of addictions, fifty four percent of respondents thought psychology could do a good job but indicated that their first choice in this area was family physicians (28%) followed by counsellors (19%) and psychologists (12%).

In terms of access barriers to psychological services, respondents ranked the five options as follows: too costly (80%); not covered by provincial/territorial medicare plans (75%); lack of coverage by employers' benefits (67%); long waiting lists

(67%); preference for dealing with problems oneself (50%) and stigma (39%). Eighty five percent supported increased coverage through publically funded services.

It is important to note that stigma in terms of psychological services is likely lower than expected and yet still high. This is hard to judge, however, until we know what the stigma thresholds are for other categories such as cancer or heart disease and other professional services. In some cases the results are dramatically different province to province and when an individual jurisdiction is compared to the nationally combined data. The national, provincial and territorial results are available at <http://www.cpa.ca/practitioners/practicedirectorate/>.

The Practice Directorate has been working with Delta Media, an Ottawa based communications firm, to develop a coordinated national advocacy strategy so all governments (provincial, territorial, national) hear the same messages in the same language. The goal is to use our collective strength to make progress on a select number of issues we all share. An example of one such issue is psychology's links to primary care.

The survey is part of a national advocacy strategy. Ekos Research Associates, a well respected national polling company, conducted the poll. A total of 2,832 people were surveyed. This is considered to be a very strong sample size for a national survey. The confidence limits are +/- 2%, 19 times out of 20. All the provincial associations and the Northwest Territories participated in the survey as members of the Practice Directorate Council.

CPA funded the survey and each provincial association and the Northwest Territories contributed additional funds to increase the number of respondents in their jurisdiction.

For more information visit

<http://www.cpa.ca/practitioners/practicedirectorate/>.

Call for Psynopsis Submissions 2012



Submissions are invited to Psynopsis for 2012. Articles must be no more than 900 words and relevant to the issue's theme. Themes for 2012 are:

Spring 2012: Evidence-based practice, submission deadline March 1st.

Summer 2012: Knowledge Transfer and Translation, submission deadline June 1st.

For more information, contact Dr. Cohen at kcohen@cpa.ca

Appel de propositions d'articles pour Psynopsis en 2012

Nous vous invitons à faire des propositions d'articles qui seront publiées dans la revue Psynopsis en 2012. Les articles ne doivent pas compter plus de 900 mots et ils doivent être pertinents à la thématique du numéro. Les thématiques en 2012 sont les suivantes :

Printemps 2012 : Pratique fondée sur les données probantes - date limite de proposition d'article le 1^{er} mars

Été 2012 : Transfert et traduction des connaissances, date limite de proposition d'article le 1^{er} juin.

Pour de plus amples renseignements, communiquez avec D^{re} Cohen à kcohen@cpa.ca

The International Society of Political Psychology: Connecting Psychology and Politics

Peter Suedfeld, Ph.D., University of British Columbia
Member of the CPA International Relations Committee

Do psychological characteristics of political leaders such as Stephen Harper and Barack Obama change as their time in office accumulates? What is the relationship between voters' knowledge of the issues and their voting preferences? Why is democratization such a difficult process in many countries but not all? Can we predict whether an international confrontation will end peacefully or lead to war? These and many other important questions are among those addressed by political psychologists.

Political psychology is a cross-disciplinary pursuit. Its original and largest component derives from social and personality psychology. Addressing the issues related to political events and behaviors, political psychologists can generalize, transfer, and apply theories and methods from most areas of psychology, as well as from political science, history, sociology, and a host of other disciplines.

Among the currently "hot" topics in the field are political ideology, voter choices, the formation of national and ethnic identity, the assessment at a distance of political leaders' personality and decision-making, the connection between neuropsychology and politics, cultural factors in political processes, and the making of war and peace.

Some psychologists confuse political psychology with psychobiography and psychohistory. The latter labels make such confusion easy; but those two fields, although they can be subsumed within the more general category of political psychology, are mostly characterized by the use of depth psychology to address political and historical topics. This approach represents only a small segment of political psychology.

Although most political psychologists identify with their home disciplines and belong to the appropriate organizations, they also have a shared home in the *International Society of Political Psychology* (ISPP). ISPP was founded in 1978 and now has about a thousand members, drawn from all of the disciplines listed above as well as from applied areas such as strategic analysis and diplomacy. Although the single largest group is from the United States, members live in many countries and every continent except Antarctica. The core publication venue for their work is the journal, *Political Psychology*, published

by Wiley-Blackwell. The work of political psychologists has also appeared in major journals in political science (the American Political Science Association has a Political Psychology section), social psychology, personality, etc., and in many books including two editions of a *Handbook of Political Psychology*.

ISPP holds an annual conference, each of which has a core theme but is also open to a wide variety of topics, presentations, and posters from around the world. The conference is held in North America about half of the time; the other half is divided between Europe and elsewhere. The 2009 meeting was held in Dublin, 2010 in San Francisco, 2011 in Istanbul, and the 2012 meeting will be in Chicago. Vancouver hosted it in 1996. The conferences provide opportunities to meet colleagues representing a highly diverse group in every way and to exchange information, suggestions, and ideas.

The theme of the 2011 meeting, "Cooperation and Human Societies: Towards a Multidisciplinary Political Psychology" is built on the geography of Turkey – spanning Europe and Asia. As well, its religious and ethnic diversity and rich history – ancient Greek, Roman, Byzantine, Ottoman – are included to examine patterns of imperial expansion and contraction, war and peace, the treatment of minority populations and so on.

Although political psychology has not established a widely-known identity in Canada, there are a number of researchers working here whose choice of questions and topics fit within the field. A review of their work was published in 2004 by Paul Nesbitt-Larking, who at the most recent

conference presented a paper entitled *Narratives of Religion: Canadian Muslims and the Politics of Engagement*. There were over a dozen other Canadian participants at the 2011 conference as well, discussing research on topics such as the media's depictions of the Toronto G20 demonstrations, how observers react to ambiguous cues of discrimination, empathy as a factor in international cooperation, the Kurdish question in Turkish politics, aspects of voting behaviour, the effect of translation on textual analysis, and issues concerning genocide.

Given that the next annual meeting will be held in our neighborhood, it might be a good opportunity for Canadian scholars interested in seeing the connection between their work and politics to discover whether they would benefit from finding out more about ISPP and its activities.

Political psychology is a cross-disciplinary pursuit. Its original and largest component derives from social and personality psychology. Addressing the issues related to political events and behaviors, political psychologists can generalize, transfer, and apply theories and methods from most areas of psychology, as well as from political science, history, sociology, and a host of other disciplines.



L'École de psychologie de l'Université Laval



Vue aérienne partielle du campus. Source: Université Laval.

Vickie Plourde, candidate au doctorat, recherche et intervention (orientation clinique)

En 1663, l'Université Laval est la première université francophone à naître en Amérique. Des cours en psychologie y sont offerts depuis 1945 et la psychologie est devenue une discipline autonome en 1961. L'École de psychologie rayonne de par l'excellence de sa formation universitaire, le savoir-faire du corps professoral, la diversité d'expertises en enseignement, en recherche et en clinique et de par la présence de ressources académiques complètes et aidantes. Plusieurs programmes sont offerts : certificat, baccalauréat et doctorat.

Quatre différents programmes de doctorat sont offerts. Il y a d'abord le doctorat en psychologie (Ph.D. recherche), axé sur la formation en recherche fondamentale ou appliquée. Le doctorat en psychologie (D.Psy), axé sur la pratique professionnelle et agréé par la Société Canadienne en psychologie (SCP), est aussi offert. Il y a également le doctorat en psychologie, recherche et intervention (Ph.D. orientation clinique), agréé par la SCP et le doctorat en psychologie, recherche et intervention (Ph.D. orientation communautaire) qui conjuguent la recherche empirique à la pratique.

Permettant d'accéder au titre de psychologue, les trois derniers programmes proposent une formation pratique exemplaire sous la supervision de professeurs et de professionnels qualifiés, dans des milieux de stage variés (clinique, scolaire, réadaptation

et communautaire), à l'externe ou à l'interne. Le Service de consultation de l'École de psychologie (SCEP) présente plusieurs possibilités de stages cliniques avec les enfants, adultes, personnes âgées et couples.

En ce qui concerne la recherche, l'École de psychologie reçoit des fonds d'organismes subventionnaires publics et privés, qui lui permet de demeurer actif dans plusieurs champs de recherche. Les étudiants peuvent compter sur plusieurs autres ressources et services, dont un service d'aide à la recherche et le centre de documentation, qui met à leur disposition des salles d'études, une salle d'informatique et le prêt de tests psychométriques.

Quant à la vie étudiante, il existe entre autres un groupe étudiant, la Connexion interétudiante, qui met en place des rencontres et des ressources de soutien aux étudiants. Il existe aussi deux associations étudiantes (premier et troisième cycle) qui veillent aux intérêts des étudiants et qui organisent des activités divertissantes. De plus, la ville de Québec éblouit par sa beauté et son charme. Avec ses espaces verts tel que les plaines d'Abraham et la promenade Samuel-De Champlain longeant le fleuve Saint-Laurent, son festival d'été et son Carnaval d'hiver, ses cafés, restos et sa vie nocturne animée, vous n'aurez pas le temps de vous ennuyer.

Pour plus d'informations concernant l'Université Laval et l'École de psychologie, veuillez visiter les sites web <http://www2.ulaval.ca/> et <http://www.psy.ulaval.ca/>.



L'École de psychologie de l'Université Laval

*Vickie Plourde, Clinical Psychology Ph.D
(research and intervention) Student*

Founded in 1663, Quebec City's Université Laval was the first french-speaking university in America. The university started offering psychology classes in 1945 and Psychology became an independent discipline in 1961. The School of Psychology provides students with a high-quality education, experienced professors in various areas of psychology and helpful academic resources. Many programs are offered: a certificate, a bachelor's degree and doctorates.

Four different doctorate programs are offered. The Research Psychology Ph.D. is centered on fundamental or applied psychology research training. Another offered program is the Clinical Psychology Doctorate (Psy. D.), which is accredited by the Canadian Psychological Association (CPA) and offers professional training in psychology. The university also offers the Clinical Psychology Ph.D., research and intervention, accredited by the CPA and the Community Psychology Ph.D., research and intervention, which combines research and professional training.

Giving students access to licensed practice, these last three programs propose an exemplary practical training in psychology. Students are supervised by qualified professors and professionals, which offer a diversity of training opportunities

(clinic, school, community, readaptation), on and off campus. The university's Psychology Clinic offers many clinical opportunities with couples, children, adolescents, adults and elderly clients.

The School of Psychology receives funds from public and private granting agencies, which contribute to the active involvement of researchers and students in different areas. Students can also count on other resources and services to obtain help. For instance, the Research help service and the Documentation center, offering a computer room, study rooms and a psychometric test library, are available for students.

There are also many student-developed committees. The "interstudent connexion" is a group of psychology students which organizes meetings between students and support resources. Additionally, two students associations organize social activities and make sure that students' interests are heard and respected. Finally, Quebec City is charming. With the majestic Plains of Abraham and Promenade Samuel-de Champlain along the St. Lawrence River, Summer festival and Winter Carnival, numerous coffeehouses, restaurants and exciting nightlife, there is always something interesting to do in Quebec City.

For more information about Université Laval and the School of Psychology, visit the following web sites: <http://www2.ulaval.ca/> and <http://www.psy.ulaval.ca/>.

Sondage auprès des membres de la SCP Aidez-nous à façonner l'avenir de la Société canadienne de psychologie

Nous tenons à remercier les quelques 1 300 membres de la SCP qui ont pris le temps de remplir le sondage auprès des membres. Nous aimerions encore recueillir les réponses de nos membres, mais nous souhaitons ardemment recevoir davantage de réponses des professionnels de la psychologie qui ne sont pas actuellement membres de la SCP. N'hésitez donc pas à faire parvenir le sondage à vos collègues, aux étudiants, à vos co-travailleurs et amis au sein de la communauté de la psychologie. Vos réponses nous aideront à façonner un meilleur avenir pour la SCP et ses membres qui sont de plus en plus nombreux.

Nous vous demandons de dix à quinze minutes pour répondre aux questions qui aideront la SCP à grandir et à s'améliorer. Merci!

www.cpa.ca/membershipsurvey

Courez la chance de gagner 250 \$ en remplissant ce sondage!

Merci d'avoir participé au sondage sur l'adhésion à la Société canadienne de psychologie (SCP). En ayant complété le sondage, vous pouvez inscrire votre nom pour participation à un tirage de quatre prix de 250 \$. Un (1) gagnant sera choisi aléatoirement pour chacune des catégories suivantes :

- Psychologue, membre de la SCP
- Psychologue, n'étant pas présentement membre de la SCP
- étudiant, membre de la SCP
- étudiant, n'étant pas présentement membre de la SCP

Nous vous encourageons à acheminer ce sondage à vos collègues qui ne sont pas membres de la SCP. A chaque fois qu'un de vos collègues remplit le sondage et vous a identifié comme source de référence, vous courez la chance de gagner un des trois prix d'une valeur de 250\$.

Toutes questions ou commentaires reliés au sondage ou au tirage peuvent être acheminés à Tyler Stacey-Holmes, publicrelations@cpa.ca.



What's New?

A Section of Psychologists in Hospitals and Health Centers

Joyce D'Eon, Ph.D., Chief of Psychology, The Ottawa Hospital and Bob McIlwraith, Professor and Head, Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba.

At the last CPA Board meeting, the Board approved a motion by Jennifer Frain to form a new “Section of Psychologists in Hospitals and Health Centers”. The motion, developed in collaboration between Jennifer Frain and Lorne Sexton, was endorsed by CPA members in this sector across Canada.

This follows from the work of the CPA Task Force on the Future of Publicly Funded Psychology Services in Canada, led by Lorne Sexton. The Task Force consists of three sub-groups: Corrections (Chair, Mark Olver); School (Chair, Juanita Mureika) and Hospital (Chairs, Bob McIlwraith and Joyce D'Eon).

The consensus of the Hospital Psychology sub-group of the Task Force was that this area would benefit from the support of a CPA Section, like the Psychologists in Education and Criminal Justice Sections. Their key objectives moving forward for a Section of Psychologists in Hospitals and Health Centers, as discussed with members over a series of telephone conversations and CPA convention meetings, include supporting hospital and other health centers to develop professional practice structures that support the full scope of practice of psychologists and developing organizational guidelines that highlight psychological evidence and practices that lead to improved health care outcomes and improved health.

The Section aims to achieve these goals through:

- 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 (from the Motion, October, 2011).

Despite the challenges Psychology faces in some facilities and regions, there are pockets of outstanding Psychology practice in hospitals, across competency areas, in many new programs, as well as substantive research contributions across the country. The availability of national – rather than provincial – benchmarks for psychological services would help support and strengthen patient care proposals in areas where development is needed. For example, The Ottawa Hospital recently opened a Bariatric Surgery Program (see article by Daniella Sandre, this issue) with a part-time psychology position and now has an additional full-time Health Psychology position. The initial funding for this service was justified and supported because of Bariatric Surgery guidelines, developed 20 years ago at the 1991 National Institutes of Health Consensus Development Conference on Gastrointestinal Surgery for Severe Obesity, which recommended that psychological services be provided to patients being considered for surgery. The development of Canadian benchmarks and recommended guidelines for psychological services across conditions will contribute substantially to patient care and outcomes.

The next steps in formation of the Section will take place at an organizational meeting during the CPA Convention in Halifax in June 2012, at which time the section by-laws will be adopted and officers nominated and elected. For more information about the organizational meeting and the formation of the new section, contact Kerry Mothersill in the Alberta Health Services (Calgary) at: Kerry.Mothersill@albertahealthservices.ca

The dedication and support of Lorne Sexton in carrying this work forward is gratefully acknowledged and much appreciated.



CPA 2012 Elections



NOTE: The election ballots will be mailed separately along with instructions for online voting. Each ballot has a code personalized for each member in the upper right hand corner

Wolfgang Linden, Ph.D.
President-elect position
Elected by Acclamation



It was flattering to receive the encouragement of senior colleagues to let my name stand for the role of President-Elect. Although I sometimes say that throughout my career I have been wearing three different hats, I truly believe that these are actually just one, but ... each with its own look and vantage point.

Born and raised up to the Master's degree in Germany, I can add the perspective of immigrant and English-as-a second language. After completion of my doctorate at McGill, I accepted a 1982 offer from out West and been here ever since. Six years in Montreal also helped to beef up my poor School French.

Probably the largest, and likely the most visible role, is that of academic clinical psychologist in our CPA and APA accredited clinical training program at UBC. Together with two colleagues I was instrumental in seeking our first accreditation, and served for two terms as Director of Clinical Training, always with an eye toward integration of clinical practice and research foundation.

In terms of research, my interests have been fairly broad, at the interface of the behavioral sciences and chronic illness (with focus on cardiovascular disease and, more recently cancer). The type of work done by my team integrates theory-driven ex-

perimental research on negative emotions and health with more applied research using clinical, cardiac and cancer populations; covering experimental studies, systematic review and clinical trials. The work itself has appeared via 140 peer-reviewed journal articles and book chapters and 7 books, including a just released undergraduate textbook in Clinical Psychology. More recently, I have joined ranks with colleagues at the provincial Cancer Control Agency. What began as research into distress screening has become clinical routine, and is now implemented as system-wide distress screening, and is gradually growing into a survivorship care plan: translation at work!

Probably the least visible hat is my almost 30 year involvement with health care lobbying and professional involvement. I joined the Canadian Mental Health Association as a volunteer trying to support efforts at better patient care, to and advocate with the Provincial government for a new mental health plan. As a part of these efforts, I was the primary author of a BC submission about the cost-effectiveness of psychological care for to the Romanow Commission. I am also familiar with Association work through my earlier role as Board member of the BC Psychological Association and as former President of BCPA.

In terms of mission or a agenda, I seek to first and foremost nourish and support the traditions and efforts of my predecessors, to actively work on raising our profile in the public eye, assure continuity between science and practice and vice versa, and help prepare our profession and younger colleagues for a possibly difficult future.



Élections SCP 2012



**NOTE : Les bulletins de vote seront postés séparément avec les directives pour voter en ligne.
Chaque bulletin de vote à son code personnalisé pour chaque membre. Le code apparaît en haut à droite sur le bulletin.**

Wolfgang Linden, Ph.D.
Poste de président désigné
Élu par acclamation



Il était flatteur de recevoir l'encouragement des collègues de la haute direction à poser ma candidature pour le rôle de président désigné. Même si je dis parfois que dans toute ma carrière j'ai porté trois chapeaux différents, je crois sincèrement que ces chapeaux forment en réalité un tout, mais... chacun avec sa couleur et son point d'observation propres.

Né en Allemagne où j'ai étudié jusqu'à la maîtrise, je peux ajouter la perspective de l'immigrant et de l'anglais en tant que langue seconde. Après avoir terminé mon doctorat à l'Université McGill, j'ai accepté en 1982 une offre de l'ouest et j'y suis depuis lors. Six années à Montréal m'ont aussi aidé à parfaire mes maigres connaissances en français acquises sur les bancs d'école.

Sans doute mon rôle le plus grand et vraisemblablement le plus visible est celui de psychologue clinique universitaire dans notre programme de formation clinique agréé par la SCP et l'APA à l'Université de Colombie-Britannique. Ensemble avec deux collègues j'ai participé à chercher à obtenir notre premier agrément et j'ai servi pendant deux mandats à titre de directeur de la formation clinique, gardant toujours à l'esprit l'intégration de la pratique clinique et la fondation de recherche.

Sur le plan de la recherche, mes intérêts ont été assez vastes, à l'interface des sciences comportementales et de la maladie chronique (avec un point de mire sur la maladie cardiovasculaire et, plus récemment, le cancer). Ce type de travail que j'ai effectué avec mon équipe intègre la recherche expérimentale motivée par la théorie sur les émotions négatives et la santé avec une re-

cherche davantage appliquée à partir de populations cliniques, cardiaques et cancéreuses, couvrant les études expérimentales, les examens systématiques et les essais cliniques. Le travail proprement dit a été publié dans 140 articles et chapitres de livres évalués par des pairs et sept livres, y compris un manuel pour les étudiants de premier cycle qui vient d'être publié en psychologie clinique. Plus récemment, je me suis joint à des collègues au Cancer Control Agency provincial. Ce qui a débuté comme la recherche dans le dépistage de la détresse est devenu une routine clinique et est maintenant mis en œuvre en tant que dépistage de détresse à l'échelle du système et évolue graduellement en un plan de soins de survie : la traduction en cours!

Le chapeau qui est probablement le moins visible est celui de mon engagement de 30 ans dans la représentation des soins pour les soins de santé et mon engagement professionnel. J'ai gagné les rangs de l'Association canadienne pour la santé mentale à titre de bénévole essayant d'appuyer les efforts pour de meilleurs soins au patient et faire des représentations auprès du gouvernement provincial pour un nouveau régime de soins de santé mentale. Dans le cadre de ces efforts, j'ai été l'auteur principal d'une présentation en Colombie-Britannique au sujet de la rentabilité des soins de psychologie à la Commission Romanow. Je connais aussi le travail d'association pour avoir déjà siégé au conseil d'administration de l'Association de psychologie de Colombie-Britannique et en tant qu'ancien président de la BCPA.

En termes de mission ou de programme, je tiens tout d'abord à alimenter et appuyer les traditions et les efforts de mes prédécesseurs, de travailler activement de nous faire mieux connaître par le public, d'assurer la continuité entre la science et la pratique et inversement et aider à préparer notre profession et les collègues plus jeunes à un avenir qui pourrait être plus difficile.



Anne Parent, Ph.D.

Candidate for the position of Director-at-large reserved for a Francophone



Dr. Anne Parent studied at Laval University in Québec City where she obtained a bachelor's degree in Education, a license in School and Career Counseling, a master's in Experimental Psychology and a doctorate in Developmental Psychology. She began her career at the National Research Council Canada in Ottawa where she received a Canada Award for Excellence. At NRC, she first worked in the area of Artificial Intelligence and later Virtual Reality. In the area of Artificial Intelligence, Dr. Parent mainly worked on the development of a dialogue management system. In the area of Virtual Reality, she developed various tools contributing to the creation of virtual environments.

Since 2000, Dr. Parent works in private practice using a Cognitive-Behavioral Approach. She was on the executive committee of the Ottawa Academy of Psychology and was given a Merit Award in 2006 for the French translation of the Academy website. For further information on her research or more currently her private practice, please see her website at www.ottawapsych.ca.

Marie-Hélène Pelletier, Ph.D., MBA

Candidate for the position of Director-at-large reserved for a Francophone



Marie-Hélène Pelletier is a practitioner, researcher, and senior manager who combines advanced training and expertise in psychology and business, in French and English. Her doctoral research was supported by multiple fellowships including the Killam Trust and she received a best dissertation award from CPA. Dr. Pelletier has authored multiple publications.

Dr. Pelletier received her BA and MPs from Laval University, and earned her PhD and MBA from UBC. For over 15 years, she worked with Homewood Human Solutions (formerly Wilson Banwell), ultimately as Chief Professional Services Officer. She recently opened her private practice, focused on executive counselling and consulting. She has been involved with various professional organizations, including CPA, and as a professional services provider in both BC and Québec. She is also committed to services which enhance the community, including serving as chair of the board of Dress for Success Vancouver. She is considered an effective communicator both in French and English, with French being her maternal language. Dr. Pelletier's contributions to the CPA board would include knowledge and enthusiasm about research and practice in psychology, and about administration and governance. Dr. Pelletier is highly committed to working with all CPA members in strengthening CPA's position as a national and international leader in the field of psychology.

Anne Parent, Ph.D.

Candidate au poste de directeur non désigné réservé pour un ou une psychologue francophone

Madame Anne Parent a fait ses études à l'Université Laval de Québec, plus spécifiquement un baccalauréat en éducation, une licence en orientation scolaire et professionnelle, une maîtrise en psychologie expérimentale et un doctorat en psychologie du développement. Elle a commencé sa carrière au Conseil nationale de recherche Canada à Ottawa, où elle obtint un prix d'excellence du Canada. Elle y œuvra d'abord au sein d'un groupe de recherche en intelligence artificielle puis au laboratoire de réalité virtuelle. Dans le domaine de l'intelligence artificielle, ses travaux ont porté sur le développement d'un système de gestion du dialogue. Dans le domaine de la réalité virtuelle, Madame Parent élabora plusieurs outils contribuant à la conception d'environnements virtuels.

Depuis l'an 2000, elle travaille en cabinet privé selon une approche cognitivo-comportemental. Elle a fait partie du conseil exécutif de l'Académie de psychologie d'Ottawa. En 2006, l'Académie lui a remis un certificat en guise de reconnaissance pour la traduction française de son site internet. Pour de plus amples informations sur ses recherches ou plus récemment son cabinet, veuillez bien consulter son site internet au www.ottawapsych.ca.

Marie-Hélène Pelletier, Ph.D., MBA

Candidate au poste de directeur non désigné réservé pour un ou une psychologue francophone

Marie-Hélène Pelletier est une praticienne, chercheuse et gestionnaire dotée d'une formation avancée et d'expérience en psychologie et en affaires, tant en français qu'en anglais. Sa recherche doctorale a été appuyée par de nombreuses bourses, y compris celle des fiducies Killam, et elle a reçu un prix d'excellence académique de la SCP. Madame Pelletier a signé de nombreuses publications.

Madame Pelletier a complété son baccalauréat et sa maîtrise à l'Université Laval et elle a obtenu son doctorat et MBA à UBC. Pendant plus de 15 ans, elle a œuvré au sein de Homewood Solutions Humaines (précédemment Wilson Banwell), ultimement comme Chef des Services Professionnels. Elle a récemment démarré sa pratique privée, spécialisée en counselling pour gestionnaires et en consultation. Elle a été impliquée dans divers organismes professionnels, y compris la SCP, et en tant que fournisseur de services professionnels en C.-B. et au Québec. Elle s'implique dans des services communautaires, notamment en tant que présidente du conseil d'administration de Dress for Success Vancouver. Madame Pelletier apporterait au conseil d'administration de la SCP ses connaissances et son enthousiasme pour la recherche et la pratique en psychologie ainsi que pour l'administration et la gouvernance. Madame Pelletier est grandement engagée à travailler avec tous les membres de la SCP pour renforcer la position de la SCP en tant que chef de file national et international dans le domaine de la psychologie.

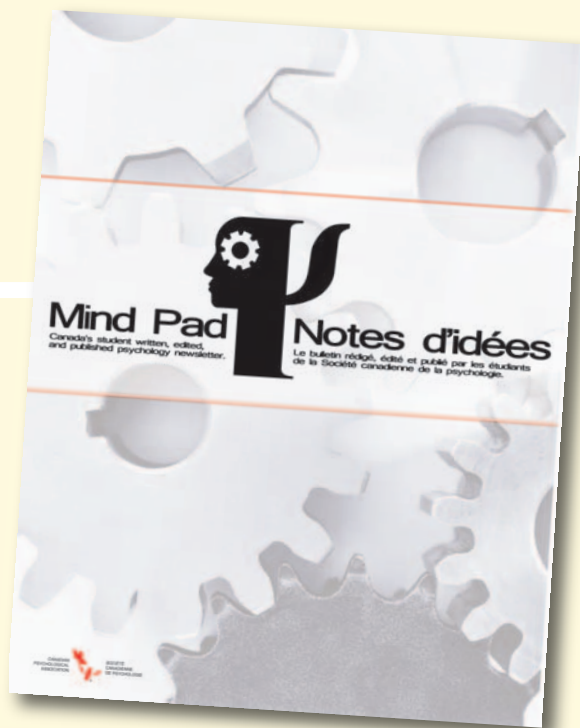
Dear students and psychology faculty,

The CPA student section is proud to present *MindPad*, the Student Sections' latest endeavour! It is a student written and reviewed newsletter. *MindPad* aims to publish material that is of interest to all who are practicing and studying psychology, but targets students in particular. **Our first issue is now available at www.cpa.ca/students/MindPad.** You will find articles as diverse as our students. Topics explored are those of language comprehension impairments and psychosis, an examination of cross-cultural gender counselling and the role of psychologists in an aging Canadian population.

MindPad offers students the opportunity to experience both the writing and the formal reviewing process that every psychologist (and psychologist in training!) must navigate. *MindPad* is a platform for discussion and learning. I encourage you to support our section and students by submitting your comments to the articles or by your sending in your own submission! For more information on *MindPad* and the submission process, please visit www.cpa.ca/students/MindPad.

The next deadline for submissions is February 17th, 2012.

Rana Pishva MSc.
Editor
rana.pishva@gmail.com



À tous les étudiants et professeurs de psychologie

La section des étudiants de la SCP est fière de vous présenter *Notes d'idées*, la dernière entreprise de la section des étudiants! Il s'agit d'un bulletin écrit et révisé par les étudiants. *Notes d'idées* vise à publier du matériel qui intéresse tous ceux qui pratiquent et étudient la psychologie, mais cible tout particulièrement les étudiants. **Vous pouvez maintenant trouver notre premier numéro à l'adresse www.cpa.ca/students/MindPad.** Vous trouverez des articles d'une diversité aussi grande que celle de nos étudiants. Les sujets explorés sont ceux des déficiences dans la compréhension du langage et les psychoses, un examen du counseling des genres interculturels et le rôle des psychologues dans la population vieillissante canadienne.

Notes d'idées offre aux étudiants la possibilité de s'exercer à la rédaction et de se frotter au processus de révision officiel comme le font tous les psychologues (et les psychologues en formation!). *Notes d'idées* est une tribune pour la discussion et l'apprentissage. Je vous encourage à appuyer notre section et les étudiants en présentant vos commentaires sur les articles ou en nous faisant parvenir vos propres articles! Pour plus d'information sur *Notes d'idées* et le processus de présentation d'articles, veuillez vous rendre à l'adresse www.cpa.ca/students/MindPad.

Rana Pishva MSc.
Rédactrice en chef
rana.pishva@gmail.com



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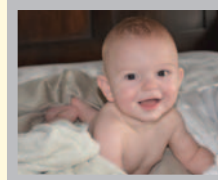
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To find out more and to apply:
jobs.vch.ca/mentalhealth

Dr. Jon Mills recipient of a Gradiva Award

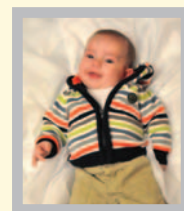
Dr. Jon Mills, Professor of Psychology & Psychoanalysis at the Adler Graduate Professional School in Toronto and Director of Mills Psychology, was recently given a Gradiva Award for best book by the National Association for the Advancement of Psychoanalysis in New York City for *Origins: On the Genesis of Psychic Reality* (McGill-Queens University Press, 2010). See <http://mqup.mcgill.ca/book.php?bookid=2476> His book was also the award recipient of a 2009 grant by the Aid to Scholarly Publications Program, Canadian Federation for the Humanities and Social Sciences, Canada Research Council. The book is currently being translated into French and will be published by Editions Liber in Montreal. Dr. Mills is in full-time private practice and runs a mental health corporation in Ontario.

CPA's is delighted to announce the 2011 additions to the families of CPA's Head Office staff and leadership!



April 1st, 2011. Noah Bleeker was born to Dr. Lisa Votta-Bleeker, CPA's Deputy CEO and Director Science, and her husband Tim Bleeker

August 3rd, 2011 Nicholas Levesque was born to Catherine McNeely Levesque, CPA's Manager of Executive Office and her husband Sebastien Levesque.



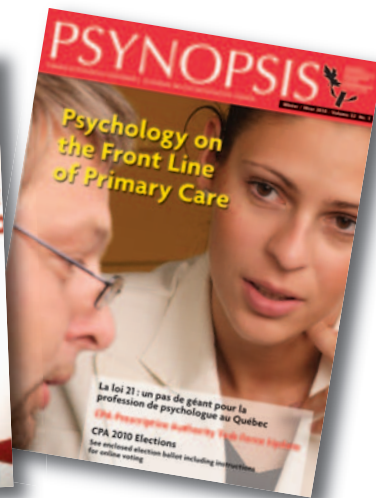
November 2nd, 2011. Zoé was born to Dr. Sylvie Bourgeois, CPA Director-at-large, and her husband Sébastien Huard.

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Psynopsis est également publié sur le site Web de la Société canadienne de psychologie, l'un des outils de commercialisation le plus puissant disponible.

En 2010, la conception, l'aspect et la convivialité de l'édition en ligne de Psynopsis ont changé à pas de géant! Rendez-vous compte par vous-même, visitez <http://www.cpa.ca/adhesion/avantagesdemembresdelascp/psynopsis/>

Grâce à des options de mise en page flexibles et la possibilité d'afficher vos annonces en noir et blanc ou en couleur, tirez avantage de nos rabais en achetant des placements publicitaires répétés qui peuvent s'étaler sur quelques parutions. Pour voir nos tarifs rendez-vous à <http://www.cpa.ca/adhesion/avantagesdemembresdelascp/psynopsis/publicite/>

Pour proposer votre annonce pour fins de publication, communiquez avec le siège social de la SCP à l'adresse publicrelations@cpa.ca.