



# NEWSLETTER

EDITOR:  
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CANADIAN PSYCHOLOGICAL ASSOCIATION

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## MESSAGE FROM THE CHAIR

This issue of the newsletter is a third of volume two. I am sure that you share with me some amazement at the speed with which time passes. However, we have been able to make a number of accomplishments since our last newsletter. We are all set for the Annual Business Meeting, to be held Friday, June 12, from 12:00 - 1:00 p.m., in the Cullen Room. Please check your schedule and try to attend the meeting. In addition to the Business Meeting, two Section activities have been planned. The theme of these activities involves clinical issues associated with the experience and treatment of trauma. First, we have organized a Panel Discussion, which will address cognitive therapy for Post Traumatic Stress Disorder, the training for Critical Incident Stress Management,

and issues in the assessment of trauma. Presentations will be made by John Arnett, David G. Hart, and Janice Howes, and time will be set aside for discussion. This Panel will be chaired by David S. Hart, and will be held Thursday, June 11, 3:00 - 4:30 p.m., in Suite 410. Second, a Conversation Hour, also chaired by David S. Hart, will be held to discuss the formation of the Canadian Trauma Response Network. This will be held Saturday, June 13, 11:00 a.m. - 12:00 p.m., in the Pilot Room. Anyone interested should plan to attend both of these sessions.

Since the last newsletter, we have completed our review of all Section 26 submissions to the conference (Posters, Workshops, Symposia, and Theory Reviews). The CPA Convention Committee has made its final decisions regarding acceptance of individual submissions, and submitters have been informed regarding acceptance/rejection. Section 26 will be involved in two Poster Sessions, one of which is dedicated (Thursday, June 11, 8:30 a.m. - 12:00 p.m., in Place Montcalm); while the second is shared with Section 28 (Family; Saturday, June 13, 8:30 - 10:30 a.m., in Place Montcalm). I would like to thank the Submissions Review Sub-Committee, composed of Chris Bilsbury, Janice Howes, Christine Ellsworth, and Joanne Gusella, for their hard work in reviewing the 122 Section 26 submissions. You will recall that we nominated Sandra Butler and Francis Widiger to be invited speakers at the Convention. However, neither of our nominees were selected, but we can look forward to invited addresses from Tory Higgins (speaking on Self-

Discrepancy Theory) and Merideth Kimball (speaking on Gender Similarities and Differences). Clearly, these addresses are relevant to Clinical Issues. Section members should also be aware that we made preliminary arrangements to have Sandra Butler present on Violence Against Women as a Section activity, but due to financial constraints we were unable to finalize our plans.

In this issue you will find two of three documents that have been prepared by the Executive for your review. Each of these documents will be discussed as an item on the agenda at the Business Meeting, and we will be holding a vote on the adoption of each by the Section. The three documents include: (1) revisions to the By-Laws. These revisions are to make nominations to the executive easier (by reducing the number of endorsements of nomination from three to two). Also, the revisions establish procedures for making nominations and holding an election from the floor during the Business Meeting for positions on the Executive not filled prior to the Meeting. (2) a definition of Clinical Psychology. With this document we hope to proactively define Clinical Psychology and use this definition in our advocacy efforts. Please review this statement carefully. (3) a brochure (to be circulated in a subsequent mailing) describing Clinical Psychology that is intended to be used for public education. If adopted by the Section and approved by the CPA Board of Directors, the brochure will be available to Section Members (at a cost). Any suggested revisions, or comment, on either of these two documents can be directed to me. Please come to the Meeting prepared to vote on these documents. Once approved by the Section, they will be forwarded to the CPA Board of Directors for final approval. Proxy votes regarding the By-Law amendments should be sent to me by

members unable to attend the Business Meeting. While not specified in the By-Laws, I will be making a motion at the Meeting to also accept proxy votes on the Brochure and the Definition of Clinical Psychology.

In closing I would like to mention that two members of the Clinical Section Executive Council are running for CPA office. Keith Dobson is standing for President-Elect and David Hart is standing for Member of the Board of Directors. Good Luck to you both. Let us all remember to vote. I look forward to seeing you in Quebec.

T., Michael Vallis, Ph.D.  
Chair, Section on Clinical Psychology

#### **XXIV Banff Conference on Behavioural Science**

The annual Banff Conference, for the first time co-sponsored by Section 26, was held March 15-19. The focus of the conference was, *The State of the Art of Cognitive-Behavioural Therapy*. Keith Dobson (Section 26 past-Chair) was the co-chair of the Conference, which involved a series of Keynote Addresses, Clinical Workshops, Conversation Hours, and a Poster Session. Topics included Cognitive-Behaviour Therapy for Anxiety Disorders (including Post Traumatic Stress Disorder), Depression, Eating Disorders, Personality Disorders, chronic pain, as well as family and marital dysfunction. A common theme discussed throughout the Conference was the integration of behaviour, cognition, affect, interpersonal relationships, and motivation. The quality of presentations and breath-taking setting combined to result in an excellent learning experience for all attending. The Section was well represented at the conference, with presentations by Keith Dobson (Keynote Address), Janice Howes

(Workshop), Charlotte Johnson (Workshop), and T. Michael Vallis (Workshop). Section members will be interested in the XXVth Conference, which has been tentatively titled, Anxiety and Depression Across the Lifespan. Look for details of the program in a future issue of the newsletter.

#### NETWORKING

A Letter From Kenya - Gloria Eldridge.

(Editor's Note: This delightful letter is Gloria's response to my invitation to write for us about her unusual application of clinical lore in a very different culture.)

I should probably title this "They Didn't Tell Me in Graduate School that Psychology Would Be Like This." For the past year, I have been wearing two hats: a woolen toque as psychologist in the Anxiety Disorders Clinic at St. Boniface Hospital in Winnipeg, and a safari hat as behavioral consultant in an STD control project in Nairobi. I just started my third 2-month "tour of duty" in Kenya. As I write, I munch on mandazi (addictive little Kenyan donuts) and gaze out the window at Kenyatta National Hospital, throngs of people in Western and traditional dress, fruit sellers, crowded matatus (mini-buses piloted by drivers who would be models for "Type A" research - more hostility and time urgency than I've ever seen), and bougainvillea, hibiscus, and poinsettias. It is the end of the dry season and everything is brown and parched; there are serious water shortages in Nairobi (as well as shortages of milk, butter, rice, cooking gas, and soon, maize).

The Departments of Medical Microbiology at the University of Manitoba and the University of Nairobi have had a productive history

of collaboration on STD research. For this project, they expanded to the Departments of Community Health at both universities, and, for the first time, included a psychologist as a regular member of the research team. This reflects the growing importance of socioeconomic, cultural, and behavioural factors in the STD in HIV epidemics. The project is funded for 5 years by the Canadian International Development Agency (CIDA) to strengthen STD control in Kenya, to reduce the morbidity associated with STDs, and to slow the spread of HIV.

STDs are epidemic in Kenya, resulting in major health complications, particularly for women and infants. Untreated STDs are responsible for infertility, spontaneous abortion, ectopic pregnancy, stillbirth, and respiratory and ocular infections (including blindness) in newborns; tertiary syphilis is responsible for cardiovascular and neurological complications. Alarmingly, many STDs, in particular the genital ulcer diseases, facilitate both HIV transmissibility and susceptibility. The HIV infection statistics in Kenya are dire, although the Kenyan situation is not yet as catastrophic as that of many Central African countries. Current estimates (based on sentinel surveillance of women in antenatal clinics) are that 10 - 15% of the adult urban population are infected with HIV. Rural areas are about half that amount. Approximately half of babies born to infected mothers are infected.

The CIDA STD project has a clinical arm and a community arm. The clinical arm is a demonstration of the impact of reorganizing the STD treatment system and retraining staff in public health clinics in Nairobi and several rural areas. Formerly, STDs were treated in Special Treatment Clinics (STCs) only on referral from a primary care clinic.

In theory, this sounds like a reasonable idea; however, the net impact was delayed and frequently poor (if any) treatment. At STCs, STD patients encountered interminable queues, brief (1 - 2 min) and dehumanizing consultations, stigma, and, as often as not, no antibiotics. Not surprisingly, many elected to get treatment from chemists, private clinics (frequently of dubious reputation), or from drug peddlars at bus stations or markets. Also no surprisingly, the STD epidemic continued to grow.

Reorganizing clinics to treat at first contact and retraining staff in tested treatment algorithms meant faster and better treatment and lower probabilities of further transmission of the STD. Nurses in Antenatal Clinics were trained to identify and treat STDs during antenatal checkups. The new system is a wonderful improvement, except that it is often impossible to get essential supplies, such as antibiotics, syringes and needles, antiseptics, vaginal specula, and rubber gloves - all the essentials Canadians take for granted. There is no shortage of medical supplies in Kenya; there is a shortage of money in the public health system to pay for them. (The CIDA project walks a fine line between supplying enough essentials to keep the demonstration project operating while not making it unsustainable when CIDA funding ends.) Despite these problems, the clinical project is running smoothly. In one clinic in Nairobi, hundreds of patients with STDs (and their partners) are being treated every week, where none were treated before.

The community arm of the project (which has just started) is designed to strengthened STD control by community education (on STD transmission, symptoms, prevention, and treatment) and community mobilization to support changes in sexual behaviour. Kenyan project staff have already started training

peer educators in womens' groups and youth groups. The next step is to include schools, churches, and factories. While basic research is not the mandate of CIDA, the project plans to include research into patterns of sexual behaviour and attitudes toward personal risk and behaviour change. This information is limited or nonexistent in Kenya and necessary for developing effective community interventions.

So what does a clinical psychologist do in a project like this one? After my first panicky "now what do I do?" reaction, I realized that psychologists have unique skills to contribute. In the first year of the project, I worked with clinic reorganization and staff training. Training in measurement proved useful in designing procedures to measure clinical practise, knowledge of STDs, and health worker attitudes toward patients with STDs and HIV. We also collected self-report data on previous infections and sexual behaviour from STD clinic attenders (and matched controls). In the hectic first days of clinic reorganization, I often found myself pressganged into service helping nurses or clinical officers who were uncertain about the new procedures or the application of the clinical algorithm. (There were many days when I wondered what an ex-animal behaviour researcher was doing up to her metaphorical elbows in body fluids and ulcers in an STD clinic in East Africa.)

Now, at the start of the second year of the project, I am working with academic staff from the Department of Community Health at the University of Nairobi to design and evaluate peer education programs and community workshops. As the project develops, I hope to branch out into basic research on sexual behaviour and its socioeconomic and cultural context. We would like, in time, to attract graduate students from Psychology or Community Health who



would be interested in research in these areas.

How has it been to work on a project like this one? As is probably true of anyone who works for the first time in a developing country, my initial reaction was to feel stunned by the absence of everything that we take for granted in health care in Canada. And then to feel stunned by the poverty and deprivation and the huge economic disparities within the country. I've developed a certain pessimism about the possibility of enough - and fast enough - change in sexual behaviour to slow the rate of HIV or STDs. When high rates of partner change are rooted in poverty, displaced families, and the lack of power or equality for women, and when STDs and HIV are embedded in a context of minimal health care and education; and poor health, nutrition, and sanitation, it becomes apparent that there are no "simple" solutions.

\* \* \*

**UNLIMITED DEMAND FOR LIMITED SERVICE:  
A STRATEGY FOR MANAGING PSYCHOLOGY  
REFERRALS.** C. Bilsbury, Ph.D.,  
Director of Psychology, Camp Hill  
Medical Centre, Halifax, N.S.

The psychology Department at Camp Hill Medical Centre has, for many years, provided therapeutic services to patients referred directly by family physicians and other specialists in the community. This has become both an expected and an appreciated service for all concerned, and it prevents the unnecessary bureaucracy that would occur if community referrals were detoured through hospital programmes serviced by Psychology. This arrangement carries risks, however. Any hospital psychology department's primary mandate is to provide services to hospital patients. A moderately sized department can be

swamped easily by an unpredictable and uncontrolled number of referrals by the potentially endless number of community-based physicians.

Within Camp Hill Medical Centre, psychology services are delivered through two routes. First, psychologists are involved in hospital-based programmes (e.g., Stroke team, Memory Disability Resource Centre, Hypertension unit, Psychiatry Outpatient Department, Nova Scotia Diabetes Centre). Second, psychologists run their own programmes, such as services for Post-traumatic stress disorder, Anxiety disorders, Cognitive therapy, Stress management, etc. The inherent tension between service demands for hospital-based programmes, psychology-based programmes, and community physicians was identified as a problem in a Quality Assurance review. The primary problem is that community-based referrals were the most difficult to control, since there was no mechanism to discuss referrals and encourage/discourage referrals, before they were made. For instance, in 1989 a total of 55 community-based referrals were received in the Behavioural Services Division of the Department (i.e., four to five patients referred per month, with a range from zero to eight patients referred in any given month). In 1990, 57 community-based referrals were received (i.e. four to five patients referred per month, with a range from 0-15 patients referred within any given month). This is an underestimate of the total number of community referrals received, as it does not include community referrals sent directly to Departmental coordinators for Rehabilitation and Neuropsychology services, or to staff psychologists. However, the data collected through the Behavioural services division amply illustrates the problem.

Therapeutic psychological services are time-consuming. The typical

session is one hour and therapy often involves 15 to 20 sessions, with longer-term cases not being uncommon. Clearly therefore, four to five patients per month places a heavy demand on the services of the Department. For instance, if patients are seen for an average of six months (a reasonable estimate), a caseload of 24-30 community-based referrals would be seen at any one time. Again, these statistics represent an underestimate of the actual caseload.

Aside from the problem of the overall drain upon resources imposed by these community referrals is the matter of the month-to-month fluctuations in the rate of referrals. For instance, in one month alone (January 1990) 15 community-based referrals were received. Given the demands to provide timely psychological services, this caused a significant strain upon resources required for hospital- and department-based programs.

Since it was not possible to handle all of these referrals, and in the absence of a better system, a waiting list developed. Since there was no control over the intake of referrals, the waiting list became excessive. Patients were commonly having to wait between four and seven months for an initial appointment. It is inappropriate for patients in need of psychological services to wait this long while they experience high levels of distress. The lengthy waiting list creates a frustrating expectancy for the patient, deterring them (or their referring physician) from seeking alternate avenues of help. Related to this is the fact that psychological problems can easily become entrenched the longer they are experienced. Furthermore, our initial assessment appointment is to evaluate the patient and to determine the appropriate services required. It is not uncommon for this initial "Assessment for Therapy"

to indicate that our particular psychological services are not appropriate. To have someone wait for several months, only to find that they are unsuitable for the specialized services offered, is counterproductive.

The following system was put in place to address the problem. In order to guide our revisions to the handling of the community-based referrals, the following list of priorities for the provision of psychological services within the CHMC Department of Psychology was adopted: Priority 1 Hospital-based programs, Psychology-based programs; Priority 2 Hospital In-patient and Ambulatory Care Referrals; Priority 3 Community-based physicians.

With these priorities clarified, the next step involved placing a limit on the amount of psychological resources devoted to community-based referrals. This was done by pre-determining how many community-based patients each psychologist would follow at any given time. Within the Department there are six registered psychologists who provide general psychological services to community-based referrals. Each psychologist agreed to follow at least two patients, with two psychologists agreeing to follow up to four patients. This is essentially a "slot" system; having two community patients means having available two hourly slots per week. If appropriate, the slots can be used to carry four patients on a bi-weekly schedule of appointments. In this way, based on a careful review of the service demands of the Department, we agreed to limit the number of community-based patients followed at any one time within the Department of between 14-17. This is approximately one half of the caseload managed in 198-90.

In order to operate this current system, we adopted the following procedures. First, the community-based referring physicians were

informed of our problems with an excessive waiting list, and of our new procedure for managing referrals. Second, all psychologists involved in providing services to community-based patients agreed to meet on a weekly basis to discuss incoming referrals. In this way we also manage any new community referrals that may have been received directly by a specific psychologist. Third, we agreed that if no one within the Department could schedule an appointment for a patient within six to eight weeks of the time that the referral was received, we could not accept the referral. When a referral is received that can be picked up by one of the Department psychologists, an appointment time is given immediately to the patient. If a referral cannot be accommodated into an available slot, the referral is returned immediately with a cover letter to the physician. If possible, advice on appropriate alternative services is provided.

After using the system for 18 months we believe that this is an improved system for four reasons. First, it limits the amount of service devoted to community-based referrals. Second, it protects the more highly prioritized hospital-based and department-based programmes from intrusion by community referrals. Third, it reduces the waiting list to reasonable proportions (patients do not mind waiting six to eight weeks, but times in excess of four to six months, which have been our previous pattern, was clearly unacceptable). Fourth, the new system has been easily understood and accepted by referring physicians.

Monitoring this system is a continuing Quality Improvement activity for the Department. The considerable "grass roots" involvement in its design and operation is in the spirit of the new Canadian Council for Health Facilities Accreditation guidelines

for Psychology services and ensures the commitment of all participants.

\* \* \*

Duty to Protect - Derek Truscott,  
Workers' Compensation Board of  
Alberta, Edmonton.

It is not news to say that psychologists practicing today can no longer content themselves with merely following the standards set down by our governing bodies. Legal regulations are increasingly encroaching upon the delivery of psychological services. Such regulations can be difficult to translate into practice, however, and it is not uncommon for concern and confusion to be aroused in the minds' of practitioners (Wise, 1978).

A case in point is the 1991 Albert decision of *Wenden v. Trikha, Royal Alexandra Hospital and Yaltho* (Truscott, 1992). The *Wenden* decision marks the first time in which the psychotherapists' duty to protect the victims of their clients' violent behavior was applied in a Canadian court of law. This duty to protect was established in the (in)famous California Supreme Court decision regarding *Tarasoff v. Regents of the University of California* (1976).

The *Wenden* decision holds that psychiatrists must take reasonable steps to protect the well-being of a third party if (a) the danger is of a serious nature, (b) the nature can or should reasonably have been anticipated and (c) the victim can or should reasonably have been identified.

This decision presents a number of difficulties for the practicing psychologist. Firstly, does the duty to protect apply to psychologists? Secondly, what does "reasonably should have" mean? And thirdly, how serious must the danger be?

Although Canadian psychologists

were not addressed directly in the *Wenden* case, Justice Murray's decision does imply that psychologists will be bound by this duty to the extent that they have control over the behavior of their clients. This means that if we fail to provide adequate psychological care to a client, and this failure results in a client behaving in a manner which causes serious harm to a third party, then we will be held liable for damages. Stated proactively, we must provide psychological services in accordance with the standards of a normal, prudent psychologist practicing at the same time and in the same geographical area.

The legal concept of "reasonable" is somewhat frustrating for the practitioner in that it does not specifically detail how we must act, but rather represents the degree of skill, care, and knowledge possessed and exercised by the average psychologist (*Critis v. Sylvester*, 1956). This means that if a typical Canadian psychologist would have foreseen the danger and been able to identify the victim, so will we be expected to. This is why consultation with colleagues is so important. Consultation provides us with access to professional consensus about possible actions taken and to a greater number of therapeutic options. Additionally, I would argue that all practicing psychologists should read the guidelines of Monahan (1981, 1985) and be familiar with them.

The last question is actually the most difficult to answer. It will only be through further Canadian decisions that we can say with an degree of certainty how serious the danger must be before the duty to protect will be evoked. At this point we can only rely on U.S. and a few Canadian decisions, which have involved damages ranging from arson (*Hendrick v. DeMarsh*, 1984; Stone, 1986) to bodily harm (*Stewart v.*

*Extencicare Ltd.*, 1986) and murder, and conclude that a serious threat of physical harm will give rise to a duty to protect.

These and other implications of the *Wenden* decision will be the subject of a symposium at the 1992 Annual Meeting of CPA in Quebec City. The symposium is being presented by myself, Diane Birch of Queen's University, Jean Pettifor of the University of Calgary, and Ken Crook of the law firm of Alexander, Holburn, Beaudin & Lang in Vancouver. The title of the symposium is **The psychotherapist's duty to protect and Canadian law.**

\* \* \*

**Trauma Response Network.** We have circulated a draft directory, a number of our newsletter, *Traumanews*, are expecting membership dues from our presumed members to pay our bills, and we are a part of two events on the CPA Quebec program. (1) The Clinical Section is sponsoring a Panel Discussion on Trauma Response, Thursday, June 11, 1500 - 1630, in Suite 410. Janice Howes will talk about cognitive therapy with PTSD, David G. Hart will discuss training for critical incident stress management, and Bob Arnett will present some ideas about use of common assessment measures. David S. Hart will chair the session which is intended to elicit an interchange among psychologists interested in the effects of psychological trauma and their amelioration. (2) A meeting to organise the Canadian Trauma Response Network is scheduled for Saturday, 13 June, 1100 - 1200 in the Pilot Room. Please come if you are interested in this Special Interest Group. An agenda will be circulated in the May number of *Traumanews*. If you wish to be put on our subscription list, send \$10.00 to David G. Hart, Suite 222, 8 Parkdale Crescent NW, Calgary T2N 3T8.

## ANNOUNCEMENTS

### AMERICAN PSYCHOLOGICAL ASSOCIATION ISSUES PAMPHLET ON DOMESTIC VIOLENCE

The American Psychological Association has published a new pamphlet, Violence at Home, designed to help persons who are being beaten by their partners or spouses. The document underscores that violence in a relationship is never okay and never justified, and that violence between partners happens in all groups in society.

The tips offered for victims of partner violence include:

- (1) Begin to plan for your safety and happiness; waiting for abusers to change will not work.
- (2) Find out what resources are available in your area for victims of partner abuse.
- (3) If you think you are in immediate danger, you probably are; flee at once to a safe location or call the police.

The pamphlet also offers advice for batterers and for friends or family members of persons involved in violent relationships.

The pamphlet may be reproduced without further permission of the American Psychological Association, as it may be included in newsletters and other community education materials.

For a free copy of Violence at Home, send a self-addressed, stamped envelope to: Public Interest Initiatives, APA, 1200 Seventeenth Street NW, Washington, DC 20036.

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### National Conference on Applied/Professional Psychology

At the fall meeting of the Board of Directors of the Canadian Psychological Association, a motion was passed supporting in principle the convening of a national conference on applied/professional psychology. As this conference is scheduled for the fall of 1993, this notice is simply to bring this event to the attention of Section 26 members.

The rationale for the conference is that much has happened both within and without psychology that affects professional issues and practices. As the last national conference that addressed issues related to psychology was the 1984 Opinion II State of the Discipline review, it appears timely to take stock of issues and to begin to proactively chart a course on issues of relevance to applied and professional psychology. As such, this conference is not envisioned as a review of the current situation in applied and professional psychology, but rather as an exercise in targeting focused areas for discussion and the formation of action plans.

In order to determine the most profitable areas for focused discussions, a series of planning steps are being contemplated for the shorter term. In the first step, all members of CPA will be invited to suggest topics and resource people for this planning effort. The second phase of the planning will be to assemble the (hopefully large) number of suggestions, and to derive common ideas and themes. These ideas will be then involved in a Delphi poll of identified resource people and experts to judge the relative importance of these topics. From this poll a select number of topics will survive, which will then become the focus of the third stage of focussed conference planning.



Members of Section 26 are invited to suggest issues for national attention. These ideas can be sent to either of the conference co-chairs, listed below. Alternatively, watch for the January and subsequent issues of Psynopsis for the development of this conference.

Keith S. Dobson, Ph.D.  
Department of Psychology  
University of Calgary  
Calgary, Alberta  
T2N 1N4

Mike King, Ph.D.  
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\* \* \*

#### Continuing Education - What would you like?

As you are aware, continuing education is a major concern for CPA. The Section has been asked by CPA's Continuing Education Committee (Prem Fry, Chair), to identify member's needs, and concerns, regarding future CE activities. This is our opportunity to let the CE Committee know what we would like to see. Please forward a list of your ideas to T. Michael Vallis (Chair, Section 26, c/o Department of Psychology, Camp Hill Medical Centre, 1763 Robie St., Halifax, Nova Scotia, B3H 3G2). We have been asked to contribute our ideas in advance of the Annual CE Committee Business Meeting June 14, so please send, call, or fax any ideas as soon as possible. Key concerns and interest in CE activities will be an agenda item at the Section 26 Business Meeting.

#### MEMBER NEWS

**A Legal Handbook for the Helping Professional**, David Turner, LL.B., Dip.S.W. & Max R. Uhlemann, Ph.D., Editors. This handbook of original contributions was written to provide helping professionals from a variety of disciplines with easy access to legal information that has implications for daily practice. Each chapter summarizes key legal information in a specific area and includes a section on answers to questions most frequently asked by helping professionals. Chapters relating to provincial law present primarily a British Columbia focus. A resource list of additional reading material is included at the end of each chapter for those interested in more information. (The editors are professors in Social Work and Counselling Psychology, respectively, at the University of Victoria, and the contributors are primarily lawyers expert in their fields. Development of the handbook was sponsored by The Law Foundation of British Columbia. Proceeds from sales will be used for continued legal education of helping professionals.)

Contents: 1. Legal knowledge for Helping Professionals. 2. The Charter and Human Rights. 3. Child Protection and the Legal Process. 4. Native Indian Self-Determination and Child Protection Law. 5. Adoptions. 6. Family Law. 7. Family Violence and the Criminal Court System. 8. Youth Justice and the Legal Process. 9. Mental Health: Disorder and Incapacity. 10. Rights of Persons with Physical and Mental Disabilities. 11. Legal Liability. 12. Informed Consent, Confidentiality and Access to Information. 13. Implications for the Future.

220 pages, 8-1/2 x 11, perfect bound.  
\$15.00 plus \$3.00 postage and handling for one copy. Add \$.75

postage for each additional copy. Payment by cheque or money order must accompany orders from individuals. Remittance payable to: The Sedgewick Society.

Mailing Address: c/o Dr. Max R. Uhlemann, Dept. of Psychological Foundations in Education, P.O. Box 3010, University of Victoria, Victoria, B.C. V8W 3N4

\* \* \*

## **WORKING DEFINITION OF CLINICAL PSYCHOLOGY**

### **General Principles**

Clinical Psychology is a broad field within the discipline of Psychology, dealing with the application of psychological

principles to the prevention, amelioration, and rehabilitation of psychological distress, disability, dysfunctional behaviour, and health-risk behaviour (medical as well as mental health risk).

Clinical Psychology involves both scientific research, primarily involving a nomothetic approach, and clinical service, primarily involving an idiographic approach.

Clinical Psychology involves a broad approach to human problems (both individual and interpersonal) consisting of assessment, diagnosis, consultation, treatment, program development, administration, and research with regard to children, adolescents, adults, the elderly, families, groups, and the disadvantaged.

Clinical Psychology is devoted to the principles of human welfare and professional conduct as outlined in the Canadian Psychological Associations's Canadian Code of Ethics. According to this code the activities of Clinical Psychologists are directed toward: respect for the dignity of persons, responsible caring, integrity in relationships, responsibility to society.

### **Importance of Ethical Standards**

The conduct of psychological activities in a highly ethical manner is an essential aspect of the behaviour of Clinical Psychologists. The Canadian Psychological Association has specified the principles involved in ethical behaviour, and the standards to be followed to ensure proper behaviour. All Clinical Psychologists, by requirements of their provincial/territorial registration, are required to be familiar with the ethical standards relevant to their activities, and to follow these standards at all times. The following is a list of the relevant documents guiding the ethical behaviour of Clinical Psychologists:

A Canadian Code of Ethics for Psychologists, Standards of Professional Conduct, Standards for the Development of Psychological Tests, Guidelines for Providers of Psychological Service, Guidelines for Therapy and Counselling of Women, Guidelines for the Elimination of Sexual Harassment, Guidelines for Assessing Sex Bias and Sex Fairness in Career Interest Inventories, Guidelines for the Use of Animals in Research and Instruction in Psychology, Standards for the Employment of Para-Professionals and Psychological Assistants, Short Checklist for Nonsexist Research.

### **Activities of Clinical Psychologists**

Clinical Psychology is an active and evolving field of practice. Due to the nature of the training of most Clinical Psychologists (i.e., academic doctoral level training) there is a great deal of ongoing development of knowledge and service in new areas of relevance to Clinical Psychologists. The doctoral level training well equips Clinical Psychologists to develop new knowledge. By the same token, it makes it difficult to provide a

comprehensive listing of the activities of Clinical Psychologists. However, common activities can be identified, which, while not exhaustive, are representative.

#### **Population Seen**

Clinical Psychologists work with a broad range of populations, including the following: individuals (infants, children, adolescents, adults, the elderly), couples (regardless of gender composition), families (multi-generational and blended families, as well as traditional), groups, organizations, systems.

#### **Service Settings**

Clinical Psychologists are found in a number of service settings, including the following: General Hospitals and Medical Clinics, Mental Health Clinics and Psychiatric Hospitals, Rehabilitation Hospitals and Clinics, Community Service Agencies, Private Practice, Universities and Colleges, Industry, Military, Prisons and Correctional Facilities, Private and Governmental Research Agencies, Schools.

#### **Services Provided**

The typical services provided by Clinical Psychologists include the following: Assessment and Measurement, Diagnosis, Treatment, Consultation, Teaching and Supervision, Policy Planning, Research, Administration.

#### **Clinical Psychology and the Law**

It is necessary for Clinical Psychologists to be aware of the legal aspects of their practice. The practice of Psychology is regulated by each province and territory through a Psychology Act(s), which include the legally binding methods for registration and discipline, as well as the limits of practice and the structures and powers of provincial/territorial Psychological Associations.

In addition, it is important that Clinical Psychologists be knowledgeable of the Criminal Code of Canada and the Young Offenders Act,

as well as legal precedents as they relate to the practice of psychology (e.g., the duty to warn; the reporting of child abuse). It is especially important for Clinical Psychologists providing psycho-legal services (e.g., child custody assessment, forensic assessment, expert witness) to be knowledgeable of the law and legal requirements for their areas of practice, including proper preparation of reports, testimony in court, etc.

#### **Knowledge Base**

##### **General**

The training of Clinical Psychologists involves learning, through course work, practical experience, and research, of biological, social, cognitive, and affective bases of behaviour, as well as of individual differences, statistics, and research methodology. These areas of Psychological knowledge are not unique to Clinical Psychology, but are generic, and overlap with other disciplines, such as sociology and biology.

##### **Specific**

The knowledge base specific to Clinical Psychology is obtained through undergraduate and graduate training, consisting of course work, supervised experience, and research activities. Knowledge of personality, development, p s y c h o p a t h o l o g y , assessment/diagnosis, and intervention define the field of Clinical Psychology. As well, knowledge of ethical principles, their application and enforcement, as well as the ability to develop and manage a helping relationship with clients (individuals, couples, groups, organizations, and systems) is an integral part of the knowledge base of Clinical Psychology.

The knowledge base within Clinical Psychology is extremely broad and varied, so much so that no individual Clinical Psychologist can become competent in all areas of Clinical

Psychology. As a result, Clinical Psychologists function within the specific limits of their competence (i.e., knowledge and expertise), and are expected to publicly acknowledge their limits. Clinical Psychologists are responsible for enforcing these limits by referring to others (either within or outside of the area of Clinical Psychology) when they are faced with a task outside of their limits of knowledge and skill.

### **Training Required**

#### **Entrance Level Requirements**

Given the nature of the complex tasks facing Clinical Psychologists, and the growing need for Clinical Psychologists trained at a level to expand the knowledge of the profession, Section 26 of the Canadian Psychological Association recommends the Doctoral degree in Clinical Psychology, including a one-year pre-doctoral internship, followed by provincial/territorial registration, as the minimum entry level requirement into the profession. Doctoral level training is necessary to provide Clinical Psychologists with the sophistication to ensure competent continuing education throughout their careers and also to produce Clinical Psychologists with competency in multiple models of service delivery. Competence in multiple models of functioning is necessary in order to ensure sufficient skill to make informed decisions as to which form of assessment or intervention is most appropriate for the individual. Further, Doctoral level training involves extensive supervised clinical experience, especially in light of the movement by Academic Programs toward the required completion of a one-year Pre-Doctoral internship. Less extensive training may be sufficient for the acquisition of the basic clinical skills (interviewing, limited assessment and diagnosis, very limited treatment) but it is insufficient to ensure the

acquisition of high level clinical skills.

#### **Practica/Internship Training**

In order to ensure sufficient training in the requisite skills of Clinical Psychology, and sufficient exposure to clinical tasks and roles, Section 26 recommends that the full-year Pre-Doctoral Internship be a necessary part of the training of Clinical Psychologists. The Internship should be preceded by Practicum training. The Accreditation Committee of the Canadian Psychological Association recommends that at least 600 hours of supervised Practicum training be completed prior to the Pre-Doctoral Internship, and Section 26 endorses this recommendation.

#### **Accreditation**

In order to ensure uniformity in training across the various Doctoral Level training Programs in Canada Section 26 strongly recommends that Academic Programs and Clinical Internship setting seek Accreditation of their Programs from the Canadian Psychological Association. The Canadian Psychological Association's Accreditation Committee has established clear guidelines for the development and running of Clinical training Programs.

### **Professional Skills of Clinical Psychology**

The fundamental skills areas that are essential for competent functioning as a Clinical Psychologist include the following:

#### **Assessment**

There are a number of methods employed in assessment, including interviewing, systematic observation, and psychometric testing, both of the client, and significant others, as well as groups, the environment, and organizations/systems. Multiple assessment methods are often utilized, and Clinical Psychologists must be sufficiently trained so as to be able to choose the most appropriate method or instrument from

among the many available.

Assessment of an individual's development, behaviour, intellect, interests, personality, cognitive processes, emotional functioning, and social functioning are also performed by Clinical Psychologists, as are assessment activities directed toward couples, families, and groups. Interpretation of assessment results, and integration of these results with other information available, in a way that is sensitive to special populations, is an essential skill of Clinical Psychologists.

#### **Diagnosis**

Clinical Psychologists are trained to make specific diagnoses regarding intellectual level, cognitive, emotional, social, and behavioural functioning, as well as mental and psychological disorder. Diagnoses may be made formally, using widely accepted criteria, such as the criteria for evaluating intellectual level or psychiatric diagnosis using the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III-R), or informally, such as diagnosis of family dynamics using a particular theoretical model.

#### **Intervention**

A major activity of Clinical Psychologists is to conduct intervention or treatment. All psychological intervention rests on the ability to develop and maintain functional working relationships with those receiving the intervention (as well as with associated individuals). This is an important skill, as often those seen by Clinical Psychologists are highly distressed and sensitive.

There is an extremely wide range of interventions available, and most Clinical Psychologists are trained in a limited number of models of intervention. Clinical Psychologists are responsible for selecting clients for whom their intervention skills are appropriate, and referring others on to colleagues who have the

requisite skills. All interventions require skill in the following tasks: conceptualization of the problem (involving assessment, diagnosis, and interpretation); formulation of a treatment plan; implementation of the treatment plan; and evaluation of the accuracy and completeness of the conceptualization, formulation, and implementation, as well as the outcome of the intervention.

#### **Research**

Among the health care professionals, Clinical Psychology is one of the few to provide extensive research training. Thus, Clinical Psychologists are ideally suited to design, implement, and evaluation research and program evaluation/quality assurance programs as part of their activities. Research can be of a basic science nature, or more applied in nature.

#### **Consultation/Program Development**

Finally, Clinical Psychologists almost always work with other professional, either directly or indirectly, who are also involved with the client. As such, Clinical Psychologists must be skilled in interacting with other professionals in a respectful and helpful manner. Further, Clinical Psychologists are often asked to contribute to the development of Programs, and require supervised experience in such activities during their training.

\* \* \*

#### **Proposed By-Law Amendment**

**Purpose:** To amend the by-laws so as to allow for nominations and an election to be held at the Annual Business Meeting for vacancies on the Executive not filled by existing procedures for nominations and elections. As well, to make it easier for Section members to be nominated, we wish to reduce the number of Section members needed to



endorse a nomination from three to two.

**Amendment:** (1) Article IV. Officers, Section C. Nominations, Subsection 3.6 b., Change from: "A letter of nomination signed by at least three members or fellows of the Section". Change to: (Change): "A letter of nomination signed by at least two members or fellows of the Section".

(2) Article IV. Officers, Section C. Nominations. Change: Add a new subsection, numbered 6, as follows: In the event that two calls for nominations, published in two consecutive newsletters, do not generate nominees, members may nominate individuals at the Annual Business Meeting, provided that such nominees attest, by written statement or verbally if in attendance at the meeting, that they agree to stand for the position.

(3) Article IV. Officers, Section D. Elections. Change: To add a new subsection, numbered 6, as follows: 6. In the event that two calls for nominations, published in two consecutive newsletters, do not generate nominees, an election for vacant offices shall take place at the Annual Business Meeting. The election will involve a majority vote by members in attendance. The voting will be by a show of hands, unless the majority of members at the meeting prefer a secret ballot.

## CALL FOR NOMINATIONS - SECTION FELLOWS

In accordance with the by-laws for CPA sections, Section 26 is called for nominations from its members for Fellows in Clinical Psychology. Criteria for fellowship are outstanding contribution to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Some examples are: (1) Creation and documentation of innovative programs; (2) service to professional organisations at national, provincial, or local level; (3) Leadership on clinical issues that relate to broad social issues; (4) service outside one's own place of work; (5) Clinical supervision should be equated with research supervision.

In order for nominees to be considered for Fellow status by the executive council, nominations must be endorsed by at least three members or Fellows of the Section, and supportive evidence of the nominee's contribution to clinical psychology must accompany the nomination.

Nominations should be forwarded to:

Dr. Rhona Steinberg  
Chair, Fellows and Awards Committee  
Counselling Service  
TC 2000  
Simon Fraser University  
Burnaby, BC V5A 1S6

## CALL FOR NOMINATIONS FOR SECTION 26 STUDENT AWARD

An award for outstanding student presentation in clinical psychology will be made at the forthcoming annual CPA meeting. This will be an annual award and the recipient will be chosen based on his/her paper submission to CPA. In the case of multiple author papers, the student must be the senior author. Interested students or their faculty

advisors are encouraged to submit abstracts for consideration of the Award to the Chair of the Awards Committee. Up to five outstanding presentations will be selected and these students will be asked to submit their complete papers. The Award will then be selected from this group. This Award will consist of a \$250 cash award plus a certificate of recognition.

Please forward submissions to:

Dr. Rhona Steinberg  
Chair, Awards Committee  
Counselling Service  
TC 2000  
Simon Fraser University  
Burnaby, BC V5A 1S6

#### NEWSLETTER SCHEDULE

The SECTION 26 NEWSLETTER will circulate three times per year: August, November, and March (or late February).

AT QUEBEC CPA  
CLINICAL SECTION MEETING  
THURSDAY, JUNE 11, 2:30  
BOARDROOM



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