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# PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE | LE MAGAZINE DES PSYCHOLOGUES DU CANADA

# Family Violence
# La violence familiale

Kerry Mothersill, PhD, RPsych &
John Pearce, PhD, RPsych
Guest Editors/Rédacteurs en chef invité

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# Message from the CPA President

*Ian R. Nicholson, PhD, CPsych*

This issue of *Psynopsis* focussing on Family Violence describes some of the challenges we encounter with these issues, but also highlights the broad range of important roles provided to our discipline.

First, these articles point to the challenges and opportunities that come from many different levels. International approaches, from organizations such as the World Health Organization and the United Nations; to national initiatives, such as the Bill C-36 Protecting Canada's Seniors Act (2012); to provincial challenges, including the need to advocate for the reintroduction of the Child Advocate Office in Ontario; to local models, such as Child Advocacy Centres; to the front-line clinical work of assessment and treatment of victims of violence. It can be hard to imagine how to tackle issues of such scope and complexity.

The social responses to these issues add to these complexities. Even within a level of government the responses come from various ministries, including health, community and social services, education, and the attorney general. These agencies sometimes duplicate services. More problematic is that they sometimes leave gaps that can affect the most vulnerable.

The issues are made even more complex since there is no one group that are victims of family violence. As the authors in this issue have so clearly demonstrated, small children, intimate partners, and older adults can all experience violence and abuse.

However, the greatest lesson from these articles is that our discipline is uniquely placed to have a role in responding to these issues. Example after example outlines our ability to have an impact on all the different levels where these issues need to be addressed. They demonstrate our ability to influence our governments, at all levels and in all sectors, to respond to the needs of our most vulnerable. They demonstrate our ability to have these impacts across the various groups who are vulnerable—and our ability to do more.

In particular, as is mentioned in some of the articles, the Truth and Reconciliation Commission of Canada provided evidence of the marginalization and oppression of Indigenous Peoples in Canada. The TRC final report describes the abuse and deaths of children in our residential schools across our country for several decades. It is becoming clear to our discipline the impact that this violence has had on generations of children.

We can do more.

Our discipline, through research, education, and practice, can be better.

These articles provide the evidence that we are making advances in research, education, and practice. Important initiatives, such as the VEGA (Violence-Evidence-Guidance-Action) Family Violence Project, are continuing to develop. As we learn, we will continue to develop.

Psychology is uniquely situated to address the broad range of complex issues that underline family violence and our response to it. One of great values of CPA's *Psynopsis* is that it allows for colleagues, such as Kerry Mothersill and John Pearce, to tie together the disparate strands of such a complex issue into a unified overview to assist us in understanding what we have done, where we are now, and what is yet to be done. *Psynopsis* again provides us with invaluable opportunity to learn.

# Message du président de la SCP

*Ian R. Nicholson, Ph. D., C. Psych.*

Le présent numéro de *Psynopsis* consacré à la violence familiale décrit certains des défis que nous rencontrons lorsque nous sommes confrontés à cette problématique, mais met également en lumière la portée du rôle que joue notre discipline à cet égard.

Tout d'abord, les articles qui composent notre numéro spécial soulignent les défis et les possibilités qui émanent de plusieurs échelons différents. Par exemple, à l'échelle internationale, il y a des organismes comme l'Organisation mondiale de la santé et les Nations Unies qui ont des stratégies en matière de violence familiale. À l'échelle nationale, le projet de loi C-36, Loi modifiant le Code criminel (maltraitance des aînés) (2012) est à l'étude; à l'échelle provinciale, l'Ontario milite pour le rétablissement du Bureau de l'intervenant provincial en faveur des enfants; à l'échelle locale, il y a les centres de défense des enfants; et en première ligne, se fait le travail clinique, qui consiste à évaluer et à traiter les victimes de violence. Il peut être difficile d'imaginer comment aborder des questions de cette portée et de cette complexité.

Les réponses sociales à la violence familiale ajoutent à cette complexité. Même au sein d'un même ordre de gouvernement, les réponses proviennent de divers ministères, notamment la santé, les services sociaux et communautaires, l'éducation et le procureur général. Il y a parfois un chevauchement entre les services fournis par ces organismes. Mais ce qui est plus problématique, c'est qu'ils créent parfois des lacunes susceptibles d'affecter les personnes les plus vulnérables.

Les problèmes deviennent encore plus difficiles, car il n'y a pas qu'un seul groupe qui soit victime de violence familiale. Comme les auteurs du numéro spécial le montrent clairement, les enfants en bas âge, les partenaires intimes et les personnes âgées peuvent tous subir de la violence et des abus.

Cependant, la plus grande leçon que nous pouvons tirer de ces articles, c'est que notre discipline est particulièrement bien placée pour s'attaquer à la problématique de la violence familiale. Tous les exemples illustrent comment la psychologie peut intervenir à tous les échelons où ces questions doivent être abordées. Ils montrent notre capacité à influencer nos gouvernements, à tous les échelons et dans tous les secteurs, pour répondre aux besoins des personnes les plus vulnérables du Canada. Ils illustrent notre capacité à agir dans les différentes populations vulnérables, et notre capacité à en faire plus.

En particulier, comme on l'a mentionné dans certains articles, la Commission de vérité et réconciliation du Canada a fourni des preuves de la marginalisation et de l'oppression des peuples autochtones au Canada. Le rapport final de la Commission décrit les décès et les abus subis par les enfants placés pendant des décennies dans les pensionnats indiens de tout le pays. Pour notre discipline, l'impact de cette violence sur des générations d'enfants est de plus en plus évident.

Nous pouvons faire plus.

Notre discipline, par le truchement de la recherche, de l'enseignement et de la pratique, peut faire mieux encore.

Les articles publiés ici fournissent la preuve que nous faisons des progrès dans la recherche, l'éducation et la pratique. Des initiatives importantes, comme le projet VEGA (Violence, Éléments factuels, Guidance, Action) sur la violence familiale, continuent de se développer. Au fur et à mesure que nous apprenons, nous continuerons de progresser.

La psychologie est particulièrement bien placée pour répondre à la vaste gamme de questions complexes qui mettent en évidence la violence familiale et notre réponse à celle-ci. L'une des grandes valeurs de *Psynopsis*, le magazine de la SCP, est qu'il permet à des psychologues, comme Kerry Mothersill et John Pearce, de relier les différents volets d'une question extrêmement complexe pour créer une vue d'ensemble unifiée, qui est à même de nous aider à comprendre ce que nous avons fait, où nous en sommes maintenant, et ce qui reste à faire. Encore une fois, *Psynopsis* nous offre une occasion inestimable d'apprendre.

Family Violence:

# Issues and solutions across the lifespan

***Kerry Mothersill, PhD, RPsych, Psychology Professional Practice Lead, Alberta Health Services and John Pearce, PhD, RPsych, Independent Clinical Consultant, Alberta Children's Services, Calgary Region***

As representatives of the Canadian Psychological Association (CPA), our involvement with the National Guidance and Implementation Committee (NGIC) of the VEGA (Violence-Evidence-Guidance-Action) Family Violence Project (https://vegaproject.mcmaster.ca/), funded by the Public Health Agency of Canada, commenced in 2015. Together with representatives of numerous health care organizations, our contributions to the development of pan-professional educational materials were informed by our clinical experience with victims of family violence. However, over the course of many NGIC meetings, our knowledge was markedly enriched and broadened by the stories and wisdom shared by numerous health professionals with an array of front-line experiences. From the director of a women's shelter who struggled with inadequate resources, to the dental hygienist who observed firsthand evidence of childhood neglect, to the First Nations mid-wife who shared her knowledge of culturally informed practices—our professional silos gave way to the collective task of developing and refining learning materials for all health professionals.

The first article in this issue, *Safe responses to family violence: Clinical update and future research* by McTavish, McKee, and MacMillan, provides an overview of the considered approach VEGA has taken to summarizing the research on intimate partner violence (IPV) and child maltreatment (physical abuse, emotional abuse, sexual abuse, neglect, and exposure to IPV), and to developing educational materials for detecting and safely responding to family violence by front-line practitioners across the health care professional spectrum. The information provided serves as a starting point for practitioners to access the VEGA training and skill-building resources.

The contribution by Romano, *Using a child rights perspective to address family violence in Canada*, provides information on the incidence of child abuse in Canada. Romano brings the United Nations Convention on the Rights of the Child (CRC), ratified by Canada in 1991, into clear view and outlines how psychologists can implement its Articles through their involvement in education, advocacy and clinical services.

Garfinkel describes in *Child advocacy centres in Canada: A coordinated, wrap-around response to child abuse*, how the centres provide physical, mental health, law enforcement and child protection services in an integrated and trauma-informed manner that decreases the stresses on children and their families when reporting instances of child abuse. The role of psychologists and the services they typically provide in the centres are identified.

In *Domestic violence considerations in parenting plan evaluations*, Olszowy, Reif, Saxton and Harris argue for greater domestic violence training and adherence to specific assessment guidelines when preparing parenting plan evaluations. Specific tools that provide a gendered analysis and examination of domestic violence are recommended when conducting multi-informant and method assessments. Evaluators are encouraged to review the 41 risk factors for domestic homicide as identified by the Ontario Domestic Violence Death Review Committee.

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# La violence familiale : problèmes et solutions à toutes les étapes de la vie

*Kerry Mothersill, Ph. D., psychologue agréé, chef du service de psychologie, Alberta Health Services, et John Pearce, Ph. D., R. Psych., psychologue clinique indépendant, Alberta Children's Services, région de Calgary*

À titre de représentants de la Société canadienne de psychologie, notre participation au comité national d'orientation et de mise en œuvre du projet VEGA (Violence, Éléments factuels, Guidance, Action) sur la violence familiale (https://vegaproject.mcmaster.ca/fr-ca/accueil), financé par l'Agence de la santé publique du Canada, a débuté en 2015. Avec des représentants de plusieurs organismes de soins de santé, nous avons contribué à l'élaboration de matériel éducatif à l'intention des professionnels de la santé et des services sociaux, fondé sur notre expérience clinique auprès des victimes de violence familiale. Cependant, au fil des réunions du comité, nos connaissances se sont considérablement enrichies et développées grâce aux histoires, au bagage de connaissances et à l'éventail d'expériences de première ligne des nombreux professionnels de la santé qui y ont pris la parole. Nous avons vu défiler, entre autres, la directrice d'un refuge pour femmes, qui tente de faire son possible malgré le manque de ressources, une hygiéniste dentaire, qui observe des preuves directes de négligence chez les enfants, et une sage-femme des Premières nations, qui a partagé avec nous ses connaissances sur les pratiques adaptées sur le plan culturel; notre cloisonnement professionnel a cédé la place à la mission collective que nous nous sommes donné d'élaborer et de développer des ressources éducatives pour tous les professionnels de la santé.

Le premier article du présent numéro, intitulé *Safe responses to family violence : Clinical update and future research*, de McTavish, McKee et MacMillan, donne un aperçu de l'approche adoptée par le projet VEGA pour faire la synthèse de la recherche sur la violence conjugale et la maltraitance à l'égard des enfants (violence physique, violence psychologique, abus sexuel, négligence et exposition à la violence conjugale) et pour élaborer du matériel éducatif afin d'aider les professionnels de la santé et des services sociaux de première ligne à reconnaître la violence familiale et à y répondre en toute sécurité. Les informations fournies servent de point de départ aux praticiens pour accéder aux ressources de formation et de renforcement des compétences produites par le projet VEGA.

L'article de Romano, *Using a child rights perspective to address family violence in Canada*, fournit des données sur l'incidence des mauvais traitements infligés aux enfants au Canada. Romano présente clairement la Convention des Nations Unies relative aux droits de l'enfant, ratifiée par le Canada en 1991, et décrit comment les psychologues peuvent mettre en œuvre les articles de la Convention par leur participation à l'éducation, à la défense des intérêts et aux services cliniques.

Dans son article, *Child advocacy centres in Canada: A coordinated, wrap-around response to child abuse*, Garfinkel décrit comment les centres fournissent des services de santé physique et mentale, ainsi que des services d'application de la loi et de protection de l'enfance, de manière intégrée et qui tient compte des traumatismes. Cette approche réduit les pressions exercées sur les enfants et leurs familles lorsqu'il s'agit de déclarer les cas de maltraitance envers les enfants. Le rôle des psychologues et les services qu'ils fournissent habituellement dans les centres sont recensés.

Dans *Domestic violence considerations in parenting plan evaluations*, Olszowy, Reif, Saxton et Harris plaident pour l'amélioration de la formation sur la violence familiale et le respect des lignes directrices en matière d'évaluation s'appliquant aux évaluations des plans de parentage. Les auteurs recommandent certains outils, qui fournissent une analyse et un examen sexospécifiques de la violence familiale lors de la réalisation des évaluations qui font appel à des sources d'information et des méthodes multiples. Les évaluateurs sont encouragés à examiner les 41 facteurs de risque d'homicide au sein de la famille, établis par le Comité d'étude sur les décès dus à la violence familiale de l'Ontario.

Dans l'article de Wathen, *Identifying intimate partner violence in mental health settings: There's a better way than screening,* on présente les statistiques canadiennes sur la violence conjugale, ainsi que les liens entre les antécédents de traumatismes et de violence et les problèmes de santé mentale. Wathen préconise une approche de recherche de cas plutôt que le dépistage universel, lorsqu'il s'agit d'évaluer la violence conjugale. Il propose des recommandations concrètes pour la communication entre clinicien et client, notamment le protocole LIVES, lorsque vient le temps d'aborder la divulgation de la violence conjugale et d'y répondre.

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## La violence familiale : problèmes et solutions à toutes les étapes de la vie

*Suite de la page 7*

Le dernier article, *Protecting vulnerable older adults from abuse and neglect,* de Konnert, fournit des statistiques troublantes sur la fréquence de la maltraitance envers les aînés au Canada, énumère les facteurs de risque et décrit ce que les psychologues peuvent faire pour en réduire l'incidence, y compris les moyens de réduire la pression des soignants. L'auteure conclut en disant que « la façon dont on traite les personnes les plus vulnérables de la société est le reflet de notre humanité », et que cela s'applique à tous ceux et celles qui subissent de la violence au sein de la famille.

Ce numéro spécial de *Psynopsis* sur la violence familiale témoigne de l'ampleur et de la multiplicité des effets de la violence et des mauvais traitements sur la vie des Canadiens de tous les âges, et de la façon dont ils se manifestent. Les auteurs déterminent ce que peuvent faire les psychologues pour prévenir, détecter, évaluer et traiter la violence familiale. Nous soulignons l'importance d'améliorer la formation des psychologues sur la violence familiale et nous encourageons nos collègues à prendre des mesures actives pour veiller à ce que des changements fondés sur la dynamique de la violence familiale soient apportés aux services que nous fournissons. Nous vous suggérons, en guise de point de départ, de cliquer sur le lien conduisant aux ressources éducatives créées par le projet VEGA, fourni au début de notre article. Le matériel pédagogique multimédia a été soigneusement conçu de manière à en équilibrer la concision et la portée. Nous tenons à remercier la SCP de nous avoir donné l'occasion de parler au nom de la psychologie au comité national d'orientation et de mise en œuvre du projet VEGA ainsi qu'aux autres membres du comité, de qui nous avons énormément appris dans notre effort collectif pour mieux comprendre et combattre la violence familiale.

*John Pearce est un psychologue pour enfants, qui a consacré sa carrière à l'évaluation et au traitement des enfants maltraités et négligés, et leurs familles. Après avoir travaillé pendant 32 ans au programme de lutte contre la maltraitance des enfants de l'Alberta Children's Hospital l'hôpital, il offre désormais des consultations cliniques aux travailleurs sociaux et aux superviseurs de l'Alberta Children's Services.*

*Chef du service de psychologie de l'Alberta Health Services (AHS), région de Calgary, Kerry Mothersill est le coordonnateur du service régional d'évaluation psychologique (AHS) et est professeur adjoint au département de psychologie de l'Université de Calgary. Il offre des services de thérapie cognitivo-comportementale et d'évaluation psychologique en plus d'enseigner, et de faire de la supervision et de la recherche. Il est actuellement le président du College of Alberta Psychologists.*

## Family Violence: Issues and solutions across the lifespan

*Continued from page 6*

In Wathen's article, *Identifying intimate partner violence in mental health settings: There's a better way than screening,* the Canadian statistics on intimate partner violence (IPV) are presented and the connections between trauma/violence history and mental health issues are identified. Wathen argues for a case-finding approach, rather than universal screening, in assessing for IPV. Concrete recommendations for clinician-client communication are provided, including the LIVES Protocol, when addressing and responding to disclosure of IPV.

The final article, *Protecting vulnerable older adults from abuse and neglect,* by Konnert provides disturbing statistics on the frequency of elder abuse in Canada, identifies risk factors, and outlines what psychologists can do to lessen the incidence, including ways to help reduce care-giver strain. Her final point, "the treatment of our most vulnerable is the measure of our humanity" can be applied to all who are subject to family violence.

This special issue of *Psynopsis* on Family Violence speaks to the many significant and unacceptable ways that violence and abuse negatively affects the lives of Canadians of all ages. The authors have identified what psychologists can do to prevent, detect, assess, and treat family violence. We underscore the importance of enhancing the training of psychologists about family violence issues and encourage our colleagues to take active steps to ensure that violence informed changes are made to the services that we provide. A good start would be to click the link to the VEGA materials provided at the beginning of this paper. The multi-media instructional materials were carefully crafted with a balance between brevity and impact. We would like to thank CPA for providing us with the opportunity to be the voice of psychology on the NGIC, and to our colleagues on the committee who taught us so much as we collectively contributed to the VEGA Family Violence Project.

*John Pearce is a child clinical psychologist whose career has focused on the assessment and treatment of abused and neglected children and their families. After working for 32 years in the Child Abuse Program at Alberta Children's Hospital, he now provides clinical consultations to Alberta Children's Services caseworkers and supervisors.*

*Kerry Mothersill is the Alberta Health Services (AHS) Psychology Professional Practice Lead in the Calgary Zone, the Coordinator of the Regional Psychological Assessment Service (AHS) and is an Adjunct Professor, Department of Psychology, University of Calgary. He provides Cognitive Behavioural Therapy and psychological assessment services in addition to teaching, supervision and research. He is the current President of the College of Alberta Psychologists.*

# Safe responses to family violence: Clinical update and future research

*Jill McTavish, PhD, Postdoctoral fellow, Department of Psychiatry and Behavioural Neurosciences, McMaster University; Christine McKee, MA, Program Manager, Department of Psychiatry and Behavioural Neurosciences, McMaster University; and Harriet L. MacMillan, CM, MD, MSc, Distinguished University Professor, Department of Psychiatry and Behavioural Neurosciences and Department of Pediatrics, McMaster University*

Family violence, including intimate partner violence (IPV), child maltreatment (physical abuse, emotional abuse, sexual abuse, neglect, and exposure to IPV), and elder abuse, is a significant public health problem. They are highly prevalent experiences—for example, global estimates suggest that one in three women (30%) have experienced either physical and/or sexual IPV in their lifetime, one in four adults (23%) were physically abused as children, one in nine adults (12%) were sexually abused as children, and one in six older adults (15.7%) have been abused in the past year.[1-3] These types of family violence have significant potential negative mental and physical health impacts across the lifespan. Children of any age, including infants, may show changes in their behaviour, growth, and development related to child maltreatment—for example, developmental delay first seen in infancy; anxiety and mood disorder symptoms and poor peer relationships first seen in childhood; substance use and other risky behaviours often first seen in adolescence; and increased risk for personality and other psychiatric disorders, relationship problems, and maltreatment of one's own children in adulthood.[4–8] Given the prevalence and significant impacts, what does the scientific evidence say will help?

## Current state of family violence research

Research in the area of family violence is complex and evolving. Progress has been made in the epidemiology of family violence, especially in the areas of child maltreatment and intimate partner violence; much less is known about elder abuse.[3] There are significant opportunities in the family violence field in Canada for future research on primary prevention (preventing violence from happening), secondary prevention (detecting violence early and preventing it from getting worse), and tertiary prevention (improving quality of life and reducing symptoms associated with violence exposures). While awaiting future evidence about ways to prevent and reduce family violence, the VEGA (Violence, Evidence, Guidance, Action) Project (see https://vegaproject.mcmaster.ca/whyvegavideo) has created pan-Canadian guidance and educational resources to assist healthcare and social service providers with recognizing and responding safely to those experiencing family violence (see Figure 1).[9]

VEGA has developed online educational resources in consultation with 22 national organizations (including the Canadian Psychological Association) thanks to funding from the Public Health Agency of Canada.[9] As such, it can be considered a project aimed at assisting providers with reducing family violence that is happening, reducing the experience of any associated problems, and preventing further violence. VEGA conducted extensive systematic reviews of the evidence on IPV, child maltreatment, and children's exposure to IPV, in coordination with the World Health Organization (WHO) officials and parallel WHO child maltreatment guidance development



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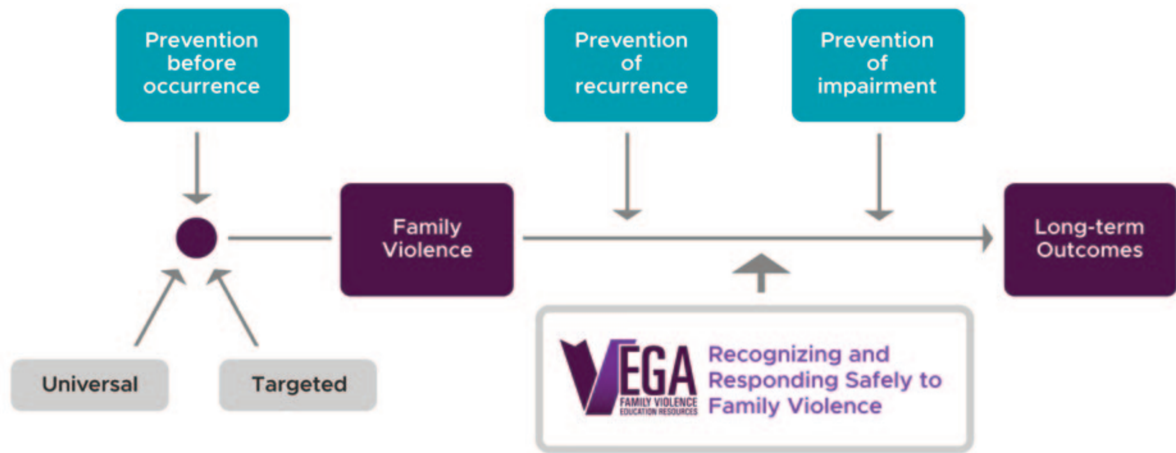
Figure 1. Preventing family violence and associated impairment—Where VEGA fits *(Adapted)*[10]

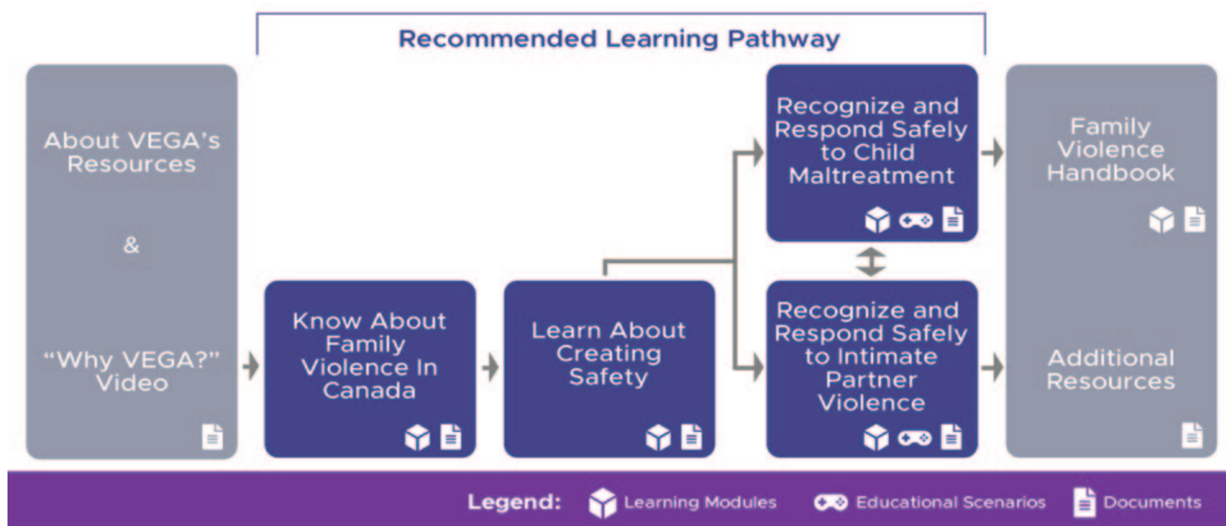



processes.[9,11] While the VEGA mandate did not include elder abuse, some of the principles for recognizing and responding safely are relevant to providers working with older persons experiencing abuse. VEGA seeks to provide a common approach to these forms of violence, as well as a platform for evidence-based guidance and an accreditable curriculum comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios, and a handbook to better equip providers (including students) across a range of settings to provide safe and effective care to those who may have experienced family violence (see Figures 2 and 3).[9]

## Safe recognition through being alert to signs of family violence (case-finding)

Based on systematic reviews of available evidence, and similar to guidance from WHO, VEGA guidance concludes there is no evidence that screening for child maltreatment or IPV benefits the well-being of those experiencing family violence or decreases their future experiences of violence.[9] Instead, providers are advised to be alert to signs of family violence and to inquire about these signs when it is safe to do so. For example, the National Institute of Health and Care Excellence has summarized over 70 potential indicators of child maltreatment.[12] Many of these indicators—for example, a marked

Figure 2. Recommended learning pathway for VEGA educational resources[9]



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change in behaviour or emotional state—may lead a provider to consider (but not yet suspect) maltreatment as one possible explanation for a child's presentation. In the VEGA materials, providers are offered examples of questions to inquire about the child's presentation and ways of responding safely (e.g., provider has sufficient training to provide a safe response, child is seen separately from the caregiver, referral pathways are in place). Common challenges to asking and responding safely are addressed through videos, such as what to do if a caregiver refuses to separate from a child so that the provider can inquire about maltreatment safely or how to make a report to child protection services. In this way, VEGA summarizes the current state of the evidence but also goes beyond it by providing guidance on safe actions that providers can take in their practice.

## Safe responses to family violence

It is perhaps in the area of safe responses to those experiencing family violence where the greatest need for high quality research exists. For example, similar to WHO recommendations,[11,13,14] a VEGA guideline development panel recommended:

- cognitive behavioral therapy (CBT) with a trauma focus for children experiencing sexual abuse or for children exposed to IPV who have posttraumatic stress disorder (PTSD) symptoms
- parent-child interaction therapy for children experiencing physical abuse or neglect who have externalizing symptoms
- advocacy services for women who disclose IPV and their children, and
- CBT or eye movement desensitization and reprocessing (EMDR) for adults with experiences of IPV who have PTSD symptoms.[9]

However, many interventions are considered promising and need further research (e.g., child-parent psychotherapy). In addition, many interventions need rigorous evaluation to identify what works for whom and under what conditions. For example, VEGA had a guideline development panel review 17 randomized controlled trials evaluating what are commonly referred to as "batterer intervention programs," but found there was insufficient evidence to recommend either for or against these interventions.[9] These inconclusive results parallel the findings of other systematic reviews.[15] Researchers are increasingly investigating motivational interviewing techniques for those who use violence in their relationships, although it is too early to give conclusive recommendations on these interventions. In addition, while most of the research reviewed by VEGA examined violence used by men against women, it is increasingly recognized that men experience IPV too, and that, like women, gender non-binary and trans individuals can experience the most severe forms of IPV in their relationships. Practitioners with expertise in these areas are encouraged to partner with researchers in developing and evaluating new and promising interventions.

Figure 3. Educational scenario example: Intimate partner violence[9]

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While there are many fruitful research pursuits in the area of family violence, safe practice in family violence requires an ethical imperative to balance the interplay of macro forces (e.g., current limitations of child protection services, relationships between poverty and violence) and micro skills (e.g., attuning, truly listening, respecting the pace of clients) in relationships between providers and patients/clients. Balancing this micro-macro tension involves acknowledgement of the impact of systemic violence on certain populations, such as the impact of colonialization on Indigenous populations, how racialized youth in the child welfare system are at an increased risk for further re-victimization, or how boys are less likely to disclose experiences of maltreatment to due prevailing gender norms. VEGA's Environment, Approach, Response model (EAR)[9] offers some practical strategies that take into account perspectives of gender-based violence, cultural safety, and trauma- and violence-informed care. Trauma- and violence-informed care extends the trauma-informed care framework with the addition of violence to emphasize the association between trauma and violence. Both research and practice in addressing family violence will continue to benefit from collaboration among providers, students, researchers, and policymakers. This includes a recognition of family violence as a major public health problem and commitment to the belief that everyone deserves a life free from violence.

We would like to thank Dr. Kerry Mothersill and Dr. John Pearce for their contributions to VEGA. We would also like to thank Dr. Karen Cohen for supporting the involvement of the Canadian Psychological Association in the VEGA Family Violence Project.

*For a complete list of references, please go to www.cpa.ca/psynopsis*

# Using a child rights perspective to address family violence in Canada

*Elisa Romano, PhD, CPsych, School of Psychology, University of Ottawa*

Statistics on the exposure of children and youth to family violence in Canada are alarming and continue to highlight the urgent need for greater prevention and intervention efforts that reach all affected families and communities. A recent paper by Hamel and colleagues[1] reviewed rates of family violence in Canada, based on police and child welfare records as well as on nationally representative retrospective studies. Across the various findings, the take-home messages are as follows:

- Most instances of violence against children and youth are perpetrated by a parent figure
- Children under the age of 6 years are especially vulnerable
- Children and youth who experience violence tend to suffer multiple forms of violence
- Approximately 1 in 3 Canadian adults reports a history of physical abuse, sexual abuse, or exposure to intimate partner violence (other forms of family violence were not examined)
- All these statistics represent the tip of the iceberg since violence against children and youth is significantly under-disclosed and underreported.

As a country, we have a responsibility to do much better to ensure the healthy development of children and to attain the 16th Sustainable Developmental Goal of the United Nations that commits to ending all forms of violence (including child sexual, physical, and emotional abuse and neglect within the family) by 2030.[2]

One important, but often overlooked, strategy for effectively responding to and preventing all forms of family violence is through our individual and collective commitment to the United



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Nations Convention on the Rights of the Child (CRC). The CRC came into being 30 years ago on November 20, 1989 and is the most widely ratified human rights treaty. In 1991, Canada ratified the CRC and, as such, committed to uphold its 54 articles that emphasize children's rights to provision of the basic necessities of life and healthy development, protection from all forms of violence, and participation in all matters that affect them.[3] Article 19 of the CRC is especially relevant to the issue of family violence because it states that children and youth need to be protected "from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."[3]

How do we use the CRC to address family violence in our role as psychologists—be it at the clinical, academic, and/or research level? Below are several ideas intended to start the conversation. They are overlapping in nature and are by no means exhaustive.

## Education

In terms of education, we need to commit to continual learning about children's rights and to teaching about children's rights through such activities as undergraduate/graduate courses and clinical supervision. It is also important to include material on the CRC in textbooks that we author (especially on such topics as clinical psychology, child development, developmental psychopathology, family psychology, school psychology, and youth forensic psychology) and to weave the material throughout the textbook content to highlight its applied significance. Knowledge is powerful in changing the manner in which we, as a society, view children and their rights to provision, protection, and participation. For example, our recent study of undergraduate students found that more favourable attitudes toward children's rights were associated with less favourable attitudes toward spanking, and greater knowledge of children's rights strengthened this association.[4] Children's rights should also be fully incorporated into the curriculum at the elementary, secondary, and post-secondary level so that all stakeholders can become advocates for the upholding of children's rights.[5] In fact, Article 42 of the CRC states that efforts must be undertaken to "make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike."[3]

## Advocacy and civic responsibility

Turning to advocacy and civic responsibility, it is important for us, as psychologists, to play active roles in organizations that work to promote the rights of children and youth, as well as in initiatives aimed at holding our elected officials accountable to implementing the CRC. In fact, Principle IV in the Canadian Code of Ethics for Psychologists emphasizes our responsibility to society and to promoting the welfare of all individuals.[6] We can become members of the Canadian Coalition for the Rights of Children[7] that monitors Canada's implementation of the various CRC articles. We can also continue to pressure our federal government to uphold its stated commitment to address all 94 calls to action from the report of the Truth and Reconciliation Commission.[8] This report is highly significant in bringing to light the residential school violence and trauma experienced by Indigenous children and families and to redressing these impacts within such sectors as child welfare, health, education, and criminal justice. Moreover, the 6th call to action specifically indicates repealing Section 43 of the Criminal Code of Canada, which still gives parents the right to use "reasonable" force for correcting children's behaviours (www.repeal43.org). Finally, we can lobby for the re-establishment of the provincial Child Advocate Office in Ontario, which was dismantled by the Ford government; for the establishment of a national Children's Commissioner to advocate for the rights of children and youth; and for the incorporation of the CRC into law so that norms, values, and practices around children's rights are legally binding.[1,5] The Canadian Psychological Association has provided an excellent example of ways in which we can become better engaged in advocacy efforts. There are resources that provide guidance around greater political participation, as well as position papers on such topics as the Truth and Reconciliation Commission report available at www.cpa.ca/advocacy/resources.

## Clinical services

Finally, regarding our clinical services, it is critical to keep children and youth at the forefront in all aspects of our clinical work (e.g., assessment, intervention, consultation with other service sectors). We need to actively ensure that their rights are upheld as they pertain to experiencing safety from all forms of violence and having their needs for healthy development and well-being met. Additionally, the voices of children and youth must be represented and heard in all matters that affect them. As an example of protection from all forms of violence, we in the field of psychology need to prioritize strengthening families and providing support to caregivers so that they can effectively undertake their critical parenting responsibilities.[1] In working with caregivers, I would argue for the implementation of strategies and programs that are consistent with a child rights perspective. As such, interventions that focus primarily on behaviour management (e.g., time outs, removal of privileges, ignoring) should be replaced with those that advocate for emotion coaching, empathic responding, and positive discipline.[9-12] Such efforts would not only be effective but would also highlight our commitment to promoting family well-being (and decreasing family violence) in a way that puts respect for a child's unique personhood at the centre of all our work.

*For a complete list of references, please go to www.cpa.ca/psynopsis*

# Child advocacy centres in Canada: A coordinated, wrap-around response to child abuse

*Daniel Garfinkel, PhD, RPsych, The Treehouse Vancouver Child and Youth Advocacy Centre*

Child abuse has profound and far-reaching individual, societal, and economic impacts. Sadly, child abuse is not uncommon. In a nationally representative sample of adults in Canada, 26.1% reported childhood experiences of physical abuse, 10.1% reported sexual abuse, and 7.9% reported exposure to intimate partner violence.[1]

A child's disclosure of abuse activates multiple systems with a mandate to respond, including law enforcement, child protection, health care, and victim services. Traditionally these systems have operated largely independently and from within their organizational silos, thereby creating a confusing, fragmented response that placed additional strain on children and families who had to navigate these complex systems during a period of overwhelming distress. Children underwent forensic interviews in police stations, an intimidating and stressful setting for children and their parents. In addition, children were required to tell their story multiple times over a series of interviews with different professionals, potentially causing re-traumatization and complicating legal proceedings. Moreover, interviewers lacked knowledge about aspects of children's development relevant to forensic interviewing, particularly involving language and memory development and how children respond to repetitive questions about their experience.[2] Services such as medical exams, victim support, and therapy likely occurred at different locations and required separate referral processes with little coordination between them. Sharing of information between systems was limited and inefficient, and vulnerable children fell through the cracks.[3]

Over the past 30 years in the United States and, more recently, in Canada during the past decade, Child Advocacy Centres (CACs) have provided an innovative and effective model for supporting children who disclose abuse by co-locating law enforcement, child protection, mental health, and medical and victim advocacy professionals under one roof–sometimes referred to as a "one-stop shop" for victims of child abuse. CACs may differ in their structure and scope of services, but they remain consistent in their overarching goal of coordination across disciplines in a welcoming, developmentally appropriate, and trauma-informed facility.[4]

Compared to communities that do not have a CAC, children served by CACs have increased access to forensic medical exams and mental health services; investigations are more coordinated, collaborative, and multidisciplinary; and there is faster decision making in laying criminal charges.[5] The CAC model is intended to help moderate the negative impact of abuse by reducing stress experienced by children in the aftermath of their disclosure. For instance, most children will undergo only one investigative interview, led by investigators who specialize in child forensic interviewing.[6] CACs also provide a range of services to enhance parent and caregiver sensitivity and responsiveness to the needs of their child.[7] CACs strive to raise

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# Domestic violence considerations in parenting plan evaluations

***Laura Olszowy, Katherine Reif, and Michael Saxton, PhD Candidates and Residents at the London Family Court Clinic; and Kimberly Harris, PhD, CPsych, Assistant Executive Director, London Family Court Clinic***

Over the past 20 years, legal and mental health professionals have recognized that domestic violence (DV) is a relevant factor when determining appropriate parenting time and responsibilities. More recently, there has been increased public scrutiny and a call for accountability by mental health professionals to conduct fair and balanced parenting plan evaluations. It is important to recognize that only a minority of separating and divorcing families will reach an impasse and require a parenting plan evaluation; however, when required, the presence of DV increases the complexity of these already challenging assessments. This article highlights the current best practices for parenting plan evaluations in the context of DV. This article also serves as a timely reminder that professionals require advanced skills to handle these cases with due diligence and care.

A lack of specific, assessment-related directives for parenting plan evaluations from provincial governing bodies and differences in provincial legislation can contribute to variability in practice.[1,2] Best practice guidelines recommend multiple interviews with parents, obtaining the views and preferences of the child(ren) where developmentally appropriate, observations of parent-child interactions, and collateral information and objective tests and measures.[3,4] DV further increases the complexity of parenting plan evaluations. Unfortunately, research has found assessors may lack specialized DV training, place an overreliance on limited sources of information, and underutilize specialized DV measures.[5] This is especially concerning given that courts place significant weight on the recommendations stemming from parenting plan evaluations.[6]

DV is a child protection concern, given the elevated co-occurrence of DV and child abuse and the negative effects of exposure to DV on children.[7,8] Although separation has been a crucial step toward safety for some victims, research has shown that for some high-risk cases separation is a significant risk factor for lethality,[9,10] which also extends to child homicides[11]. Accordingly, it is recommended that one consider children to be at potential risk if their mother is also at-risk.[12] Planning for safety in the assessment process is important from the outset. For example, ensuring that assessment sessions with each parent do not overlap and implementing procedures that prevent the sharing of contact information or appointment times between parties. It is equally important to prioritize safety in the parenting plan recommendations since coercive control dynamics can extend for years beyond separation. In some cases, the judicial system can be misused as a tool for continued power and control over a victim, such as prolonging the court process to increase contact and unnecessary financial burdens.[6, 13,14]

In order to provide a safe parenting plan evaluation, adequate screening and a comprehensive risk assessment should be undertaken.[15,16] Measures typically used in assessments do not offer a gendered analysis or examine the nuances of DV. Specific DV psychometric tools (e.g., Danger Assessment[17]; Brief Spousal Assault Form for the Evaluation of Risk [B-SAFER][18]; Mediator's

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## Domestic violence considerations in parenting plan evaluations

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Assessment of Safety Issues and Concerns [MASIC][19]; Abusive Behaviours Observations Checklist [ABOC][20]) that examine the perpetrators' patterns of coercive control, their degree of accountability, and the impact of the violence on the victim and children, among other factors, are most relevant. [21]

The child's perspective is also of importance when making recommendations.[22] If DV is identified, evaluators should seek to understand the risk of lethal or severe violence in order to provide an appropriate parenting plan. However, DV can also have significant impacts on day-to-day parenting.[11] For example, many perpetrators have a tendency toward harsh and rigid discipline and their use of coercive control can undermine the parenting of the victim.[6] Comprehensive observations of parent-child interactions, combined with objective measures of parenting attitudes and beliefs, can aid in examining the impact of DV on parenting. Current best practices emphasize the importance of the goodness-of-fit between parenting functional skills and abilities and the psychological and developmental needs of the child(ren). Therefore, attention should be placed on parenting plans that appropriately assess and address the unique needs of each child in the family.[3]

An evaluator must be aware of and account for the multitude of risk factors that can present in these cases. The Ontario Domestic Violence Death Review Committee (DVDRC) provides a detailed list of 41 risk factors for domestic homicide that can be considered when conducting assessments.[10] The Battered Women's Justice Project also provides suggestions on effective responses to DV.[23] Risk management strategies may include supervised access or temporary suspension of access pending successful completion of a batterer intervention program and a program focused on parenting[24] (see caringdads.org). Assessors should be mindful that vital information about risk is often held by various collateral sources.[11] In other words, many people hold pieces of the puzzle and the assessor may well need to collect data from neighbours, friends, extended family, and service providers to gain a complete picture of risk. Additionally, there are cultural dynamics requiring consideration including for newcomer and refugee populations (see CDHPI.ca) and collectivist cultures.[25]

In summary, carefully conducted multi-informant, multi-method assessments by psychologists and other adequately trained mental health professionals are crucial to assess risk and form the basis for appropriate parenting plans. Failing to recognize and appropriately respond to risk and offer/recommend plans that adequately protect victims and their children can lead to adverse outcomes for families. Parenting plan evaluations where DV is identified require more time and effort for assessors to ensure the best interests of children.

*For a complete list of references, please go to www.cpa.ca/psynopsis*

## Child advocacy centres in Canada: A coordinated, wrap-around response to child abuse

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awareness of the issue of child abuse in their communities by developing and disseminating educational tools to promote effective responses when abuse is disclosed or suspected. CACs have successfully advocated for children to be accompanied by facility dogs when they testify in court and they provide psychoeducational court preparation programs that lower children's anxiety by demystifying the court process.

Through co-location and collaboration across multiple agencies, CACs offer several advantages to the professionals who work within them, such as:

- more timely access to relevant case information to help with decision making and service provision
- the sharing of multidisciplinary perspectives on the circumstances of child abuse victims and their families
- shared responsibility and mutual accountability in prioritizing the best interests of children with respect to their safety and well-being, and
- mutual support among professionals in managing particularly complex or upsetting files.

Psychologists are represented within the multidisciplinary CAC model, particularly in providing psychological assessment and evidence-based therapeutic intervention to children and their caregivers (as well as supervising graduate-level psychology practicum students and pre-doctoral residents in this domain); conducting program development and evaluation; and providing clinical leadership, case consultation, and training to the multidisciplinary team. Moreover, psychologists with a forensic specialization conduct forensic interviews and train law enforcement and child protection workers in the science of child interviewing.

CACs offer an effective approach to serving vulnerable children and families impacted by child abuse. The range of disciplines represented and services provided in one facility enables CACs to support children and families over the course of their involvement with the criminal justice system. There are now over 800 CACs in the United States. A commitment of seed funding in 2010 from Justice Canada's Victims Fund led to expansion of the model in Canada. Over 35 CACs now exist in various stages of development across Canada. A National Network of Canadian CACs, chaired by Justice Canada, is finalizing national practice guidelines for Canadian CACs. A draft of these guidelines was published in 2015.[8] The draft guidelines emphasize the importance of providing services that are inclusive and sensitive to the range of diversity present in the community in which the CAC is located; including, but not limited to: culture, ethnicity, language, religion, socioeconomic status, disability, gender, and sexual orientation. Some Canadian CACs have also formed partnerships with Indigenous bands or nations and with delegated child welfare agencies. In the coming years, expansion of the CAC model throughout Canada is anticipated.

*For a complete list of references, please go to www.cpa.ca/psynopsis*

# Identifying intimate partner violence in mental health settings: There's a better way than screening

*C. Nadine Wathen, PhD, Professor and Canada Research Chair in Mobilizing Knowledge on Gender Based Violence, Western University*

A woman or girl is killed every 2.5 days in Canada. For one of the most prevalent types of violence against women—intimate partner violence (IPV)—it's every 6 days. The numbers are not improving.[1]

IPV refers to "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours".[2] IPV is prevalent—about a third of Canadian women experience it in their lifetime, and all genders experience various forms of IPV. Figure 1 highlights key Canadian data; women are more than twice as likely (34%) as men (16%) to experience the most extreme forms of IPV (sexual assault, beating, strangulation or threats with a gun or knife) and are more likely to report long-term psychological effects (22%) than male victims (9%).[3] New national data coming in 2020[4] will help us better understand gendered IPV patterns, including among LGBTQI2S+ people, and how they relate to key mental health outcomes.

To help understand the causes of IPV, the World Health Organization's (WHO) socio-ecological model is useful, outlining how the causes of violence occur across a continuum from individual factors to societal structures. The one risk indicator that cuts across all ecological levels is beliefs about gender norms and roles that devalue women and girls, minimize (and even glorify) the effects of violence, and fail to hold perpetrators to account. Preventing these forms of violence requires attending to root causes.

Figure 1. IPV in Canada

*Source for statistics: The Chief Public Health Officer's Report on the State of Public Health in Canada 2016 - A Focus on Family Violence in Canada[3]; graphic by J. MacGregor.*



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## Why identify IPV?

For mental health care providers, knowledge of a person's trauma and violence history is a key factor to help understand their current mental health status and their pathways to changing the violence in their lives. Given the established relationships between experiences of IPV and depression, anxiety, post-traumatic stress and suicide,[3,5] most national and international guidelines advocate assessment of violence experiences during intake in mental health settings, and subsequently as required. However, what most guidelines do not advocate is routine, universal screening of all women presenting for health care; evidence from multiple experimental studies shows no benefit of this approach.[6]

## How (and how not) to ask

The first consideration when opening space for a discussion about IPV experiences is to ensure the person's emotional, cultural, and physical safety. Years of qualitative research with abused women tells us that making decisions about IPV, including whether or not to talk to someone, is a process. Our research group has synthesized this research in a short graphic document,[7] whose key takeaways are:

- Becoming aware that you are in an abusive relationship is a complex and difficult process and knowing what to do to ensure your own safety, and that of any children, takes time and requires weighing many factors, especially various risks, including immediate danger. Each woman and each situation are unique and there's no "one-size-fits-all" approach.
- Abusive relationships are complex. Providers need to understand that women are often committed to the relationship and love their partner—they want the abuse to end but might not want the relationship to end.
- Even once an abusive relationship "ends" (i.e., someone leaves), the abuse often continues and can escalate—the time of separation is one of highest risk of serious outcomes, including death.[1] "Leaving" should not be positioned as the only or primary goal; providers are encouraged to refrain from thinking or asking "why doesn't she just leave?" or judging women who choose not to do so.

In sum, the role of formal and informal helpers is to develop a rapport with the woman such that the care encounter is seen as a safe place to discuss options, if she wishes to do so.

## A better way to ask and respond

The WHO has prepared the LIVES Protocol[6] to support these discussions (Figure 2). Along with a trauma- and violence-informed care (TVIC)[8] approach, this means identification and response that is strengths-based, person-centred and prioritizes safety above all else.

Figure 2. WHO LIVES Protocol

| | |
|---|---|
| LISTEN | Listen closely, with empathy and without judging. |
| INQUIRE ABOUT NEEDS & CONCERNS | Assess and respond to specific needs and concerns – emotional, physical, social and practical (e.g., childcare). |
| VALIDATE | Show that you understand and believe.<br>Assure them that they are not to blame. |
| ENHANCE SAFETY | Discuss a plan for protection in case further harm occurs. |
| SUPPORT | Support them by helping connect them to information, services and social support. |

## Bottom line

Mental health care providers should understand the prevalence and impacts of violence among those they serve generally and, when interacting with individual clients or patients, be aware of their experiences of violence that may influence current mental health status and treatment plans. For example, women in coercively controlling relationships[9] may not have choices about how they spend common financial resources, and may not be able to attend treatment sessions, or buy and take medications, without putting themselves at increased risk. It is important to understand that ongoing violence is not only related to mental health, but also to the choices that those experiencing it may have. When discussing treatment options, the principles of TVIC[8] guide us to offer real choices and build on the strengths that survivors bring. After all, most women will have found ways to keep themselves, and any children, safe. Starting with what has worked, and building this into treatment strategies, respects their resilience while also offering more realistic, and safe, care plans.

Awareness about IPV as an important mental health indicator; knowing how best to engage in discussions about IPV; and developing person-centred, trauma- and violence-informed strategies to promote safe treatment plans are important considerations for mental health care providers. Above all, the person's safety, autonomy, dignity, and well-being should guide all decisions about how, when, and whether to ask about IPV, and what to do next.

## Online education for health care providers

- Women's College Hospital (Toronto): http://vaw.dveducation.ca/
- World Health Organization: https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/

*For a complete list of references, please go to www.cpa.ca/psynopsis*

# Protecting vulnerable older adults from abuse and neglect

*Candace Konnert, PhD, RPsych, Director of Training Clinical Psychology Program, University of Calgary*

Often when we think about family violence, we forget that it can occur at any age and stage of life. However, abuse and neglect prey on the most vulnerable in our society, including older adults. The Canadian population is aging rapidly and increasing age is associated with greater levels of dependence on both formal systems of care and informal caregivers, most often family members.[1]

Collecting epidemiological data on elder abuse has been hampered by a lack of consensus on the definition and measurement of elder abuse.[2,3] In general, mistreatment of older adults refers to action or inaction that causes harm within a trusting relationship and includes both abuse and neglect.[4] The 12-month prevalence rate of elder abuse in Canada has been estimated at 7.5%, including psychological abuse (2.7%), physical abuse (2.2%), sexual abuse (1.6%), and financial abuse (2.6%).[4] There is evidence that rates of elder abuse are increasing. From 2009 to 2017, the rates of police-reported family violence against older adults increased by 6%, while the rates decreased among child and youth victims (-7%) and partner victims (-14%). These data represent a year-over-year increase, with family violence against older adults rising 4% from 2016 to 2017.[5] Importantly, abuse of older adults is chronically under-reported. Potential barriers to detection include social isolation, dependence on family members for care, embarrassment and reluctance to report abuse, limited professional knowledge and training, lack of screening and detection protocols, fear of liability, and lack of community resources for supporting older victims. In the absence of a gold standard measure, evaluations of suspected abuse should include informal questions (e.g., "Are you afraid of anyone?"), attention to the physical and psychological signs of abuse, and the evaluation of risk factors in both victims and perpetrators. Psychologists should keep in mind that physical (e.g., balance problems leading to falls) and psychological conditions (e.g., mood disorders) can mimic abuse. When possible, interviewing clients and caregivers separately is paramount and home visits can provide incremental information about potential abuse, neglect, and safety in the home.[6]

Risk factors with unanimous or near-unanimous support include a shared living situation, social isolation and poor social networks, dementia (for physical abuse), and, among the perpetrators, mental health problems (primarily depression), hostility, alcohol abuse, and dependency on the mistreated older adult (for a review, see NICE, 2015[4]). Interestingly, there is evidence that elder abuse is a life-long process, since having been abused as a child, youth, or middle-aged adult emerged as the second strongest risk factor in a representative sample of 8,163 Canadians 55 years of age and older.[4]

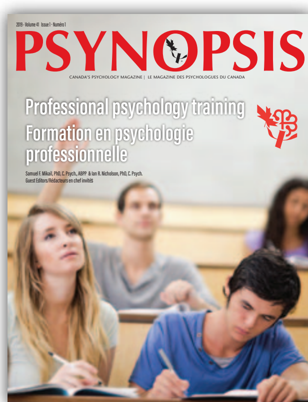
Mandatory reporting laws for elder abuse do not exist in Canada, beyond legislation designed to protect those who receive provincially funded care or support services (e.g., Alberta's Protection for Persons in Care Act). Instead, Bill C-36, Protecting Canada's Seniors Act, was passed in 2012. Described as a largely symbolic piece of legislation, it addresses only the most egregious forms of abuse, overlooks the hidden nature of elder abuse, fails to acknowledge that victims are often dependent and do not want their relatives locked up, and neglects the systemic issues that can lead to elder abuse (e.g., lack of support for caregivers[7]).

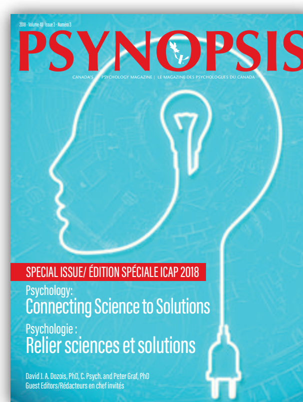
Given the lack of attention to this growing problem, what can we do? First, psychologists should be familiar with referral resources in their communities such as geriatric outreach services or elder abuse teams. Second, psychology training programs need to provide education about abuse across the lifespan. The National Institute for the Care of the Elderly provides helpful assessment and intervention resources for curriculum development on this topic (http://www.nicenet.ca/tools-elder-abuse). Third, psychologists need to recognize symptoms related to caregiver burden and support family caregivers with the appropriate resources. Many caregivers who engage in abuse are not necessarily bad people but are people caught in very difficult circumstances.[8] Nearly half (46%) of Canadians have provided care to a family member or friend with a long-term health condition, disability, or aging need.[1] The majority were helping older parents and over half felt worried or anxious (55%), tired (51%), short-tempered or irritable (36%), overwhelmed (35%), or had disturbed sleep (34%).[1] These symptoms, particularly in combination with difficult family relationships, place older adults at risk for abuse. Adding to this cumulative stress, employed caregivers are faced with work and caregiving responsibilities. It is estimated that Canada loses 558,000 full-time employees annually due to their inability to meet the demands of caregiving and work.[9] In addition to recognizing and treating caregiver burden, psychologists can help family caregivers navigate complex and fragmented health and social service systems and access resources; for example, the Compassionate Care Benefit, a job-protected leave for caregivers, and support for out of pocket expenses. A recent Canadian poll indicated that 43% of caregivers were not familiar with available tax credits, and only 12% had used them.[10] Psychologists should also familiarize themselves with organizations that provide resources to caregivers (e.g., Ontario Caregiver Coalition, Alzheimer's associations) and should know how to navigate long-term care systems that are unique to each province. For example, home care and respite care may provide caregivers with much-needed relief from caregiving. Unfortunately, caregivers are often reluctant to reach out for help and, in these instances, psychologists can reinforce the need for self-care. Finally, research on abuse needs to take a life course perspective and acknowledge the trajectory of abuse over time. Early childhood adversity has received considerable attention in the literature and it may exert its strongest influence in very late life, when difficult life events, troubled family relationships, and loss increase vulnerability. Clinically, childhood abuse may be an important risk factor for detecting abuse among older adults.

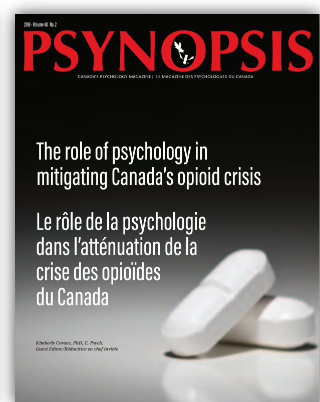
Practice in this area is a delicate balance between protecting older clients and honouring their needs for self-determination. As with all age groups, psychologists must strive to protect the therapeutic relationship while addressing the needs of vulnerable clients. To paraphrase the sentiments of many people, the treatment of our most vulnerable is the measure of our humanity. Let's include older adults in that vulnerable group and provide a comprehensive approach to preventing abuse in later life.

*For a complete list of references, please go to www.cpa.ca/psynopsis*


# Have an idea for our upcoming issues?



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# Diane Hiebert-Murphy

*"The skills students learn in the Couples Counselling Project equip them to identify family violence issues regardless of the setting and intervene using principles of best practice. This is Diane's legacy, and the legacy of the project itself."*

Throughout 1994, Roy Lavoie terrorized his wife, Rhonda. He was twice charged with offences against her, including assault and abduction. Both times he was released on bail. On January 19th, 1995, Rhonda filed for divorce; the next day, she and Roy were found dead in a van near Gimli.

The murder-suicide shocked Manitoba, and a Commission of Inquiry was established. The Lavoie Inquiry was tasked with, among other things, reviewing the systems in place for dealing with domestic violence and exploring the development of interventions for individuals experiencing high conflict and abusive behaviour in their intimate partner relationships. In June of 1997, 91 recommendations were submitted to the Manitoba legislature.

In response to the Inquiry's recommendations, the Government of Manitoba provided funding to expand services to address family violence. In 1998, this included the launch of the Couples Counselling Project under the supervision of Dr. Diane Hiebert-Murphy, a professor in the Faculty of Social Work and the Psychological Service Centre at the University of Manitoba.

Diane recognized the need in the community for intervention at a couple's level. She recognized that many women who experience violence in relationships want the abuse to end, but do not want to terminate the relationship. The Couples Counselling Project was created as a service, training, and research project to provide couples therapy for those who have experienced physical and/or psychological abuse in their relationship. Located in a University of Manitoba community-based facility in the inner city, it was set up to help couples committed to working toward a violence- and abuse-free relationship.

Twenty-two years later, it is still doing exactly that. An example of the important research that has come out of the Couples Counselling Project are studies on power dynamics in couples who experience conflict, as well as the external factors that affect those dynamics, such as housing and poverty. Research has also been done with women seeking services from domestic violence shelters, trying to understand how they make sense of their relationships while experiencing violence, in some cases significant physical violence; what they are looking for in relationships; and how practitioners can better support them as they make choices to increase their safety and well-being.

But for Diane, the real legacy of the Couples Counselling Project lies in the training portion of its mandate. Graduate students in clinical psychology and social work complete practicum training that helps them develop knowledge and skills for working with couples who are experiencing high conflict and abuse. They learn how to screen couples to determine the appropriateness of conjoint treatment (a critical element) and, when couples therapy is appropriate, to help couples move toward safety and greater relationship satisfaction. They learn how to assess risk and how to help couples separate when that is in the best interests of safety.

Having developed this expertise, students go on to work in a wide variety of fields, often in a setting that does not explicitly focus on treatment for family violence. But the skills they learn in the Couples Counselling Project equip them to identify family violence issues regardless of the setting and intervene using principles of best practice.

This is Diane's legacy, and the legacy of the project itself. There are practitioners working all over Canada in not-for-profit community agencies, in child welfare, in publicly funded institutions, and in private practice who have been trained under her guidance. Sadly, it is too late for the Lavoies. But, thanks to Dr. Hiebert-Murphy and to the Couples Counselling Project, there are competent psychologists and social workers who can intervene when couples experience conflict and abuse, and hopefully prevent similar tragedies in the future.



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# CPA HIGHLIGHTS

*Below is a list of our top activities since the last issue of Psynopsis. Be sure to contact membership@cpa.ca to sign up for our monthly CPA News e-newsletter to stay abreast of all the things we are doing for you!*

## 1 New page on COVID-19

As the impact of COVID-19 is being felt worldwide, we recognize the pressure this evolving crisis is placing on educators, teachers, supervisors, and practitioners of psychology throughout Canada. On behalf of the CPA, we extend our gratitude for the leadership roles so many of you are playing in your communities and your efforts to address the needs of your colleagues, students and patients. To support your efforts, and to inform the public, we have compiled and created a variety of resources. We are also working with our partners and other associations to advocate not only on behalf of our members, but also for members of the Canadian public. These resources and up-to-date information on COVID-19 are available on the CPA website.

## 2 Seven new COVID-19 fact sheets

Seven Psychology Works fact sheets have been created for the COVID-19 crisis. Dr. Steven Taylor, Dr. Kim Lavoie, and Chair of the CPA's Health Psychology and Behavioural Medicine Section, Dr. Justin Presseau created "Coping with and Preventing COVID-19"; Dr. Stewart Madon, Accreditation Registrar and Ethics Officer at the CPA prepared "Working From Home With and Without Children"; "Psychological Impacts of the Coronavirus" and "Helping Teens Cope with the Impacts of and Restrictions related to COVID-19" were prepared by Dr. Lisa Votta- Bleeker, CPA Deputy CEO; "Psychological Practice and COVID" was prepared by the CPA's CEO, Dr. Karen Cohen; "Emotional and Psychological Challenges faced by Frontline Health Care Providers during the COVID-19 Pandemic" was created by Dr. Anita Gupta; and "Student Wellness and COVID" was a joint collaboration between the CPA and the Canadian Federation for Students. The "Psychological Impacts of the Coronavirus" Fact Sheet was also digitized into a video.

## 3 Call for pro-bono assistance for front-line workers

Canadians with COVID-19 depend on the expertise of our health providers. The health and well-being of those health providers are critical to them being able to deliver their expertise. The Canadian Psychological Association wanted to help and called on all registered psychology practitioners to consider donating some of their time to provide psychological services to front line health care providers who may be feeling stressed, overwhelmed, or distressed by being on the front lines of this health crisis. To sign up, please complete the registration form : https://web2.cpa.ca/membersurveys/index.php/451688

## 4 CPA's 81st Annual National Convention is going virtual!

Following continuous monitoring of the evolving issues related to the COVID-19 situation in Canada and abroad, inclusive of federal and provincial government decisions taken in the service of community safety to prohibit large gatherings of people, the CPA's Board of Directors made the necessary decision to cancel our in-person 81st CPA Annual National Convention in Montreal, QC, scheduled for May 28-30, 2020, inclusive of all pre-convention workshops scheduled for May 27th. Individuals who had registered for a pre-convention workshop or the convention have received a full refund. Since taking this decision, the CPA's Convention staff, committee and Board of Directors have been exploring as quickly as possible all options to virtualize our event, and are pleased to announce that we will be moving our annual in-person convention to a virtual event over the months of July and August. All individuals accepted to present at the CPA's in-person convention are encouraged to participate in the virtual event; check your inbox for an email outlining some preliminary information regarding how to participate. Please check the CPA's convention website regularly for information on the virtual event; we hope you'll be able to participate and take in some of the numerous sessions that were accepted for inclusion in this year's scientific program.



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## 5 National ban on conversion therapy

In 2015, the CPA released a policy statement on conversion therapy, opposing any therapy with the goal of repairing or converting an individual's sexual orientation, regardless of age. This statement has been shared by many media outlets since then and has contributed significantly to the federal government's March 9th decision to ban the practice of conversion therapy across Canada.

## 6 MHCC and CAMIMH discussion on inter-organizational alignment

On February 6, senior leadership from the Mental Health Commission of Canada (MHCC) and members of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), including the CPA, met to discuss opportunities for inter-organizational alignment in the context of a new federal government. Mental health has been identified as an important priority for the Minister of Health. CAMIMH and the MHCC collaboratively support better access to care for mental health problems and conditions. CPA has contributed to an MHCC network whose focus is on calling on government and other stakeholders to expand access to psychotherapy within public health systems.

## 7 Addressing service gaps in PEI

The CPA joined the Psychological Association of PEI in offering assistance to the Department of Health and Wellness in order to help address acute service gaps in mental health across the province. A joint press release was issued and resulted in broad media coverage across the province.

## 8 Psychology Month

Throughout February, we celebrated Psychology Month by highlighting psychology graduates working outside clinical practice and academia. We profiled PhDs working in aviation, banking, publishing, advertising and video game design, and many other areas. These profiles are still available to read on our website at https://cpa.ca/careers/psychology-profiles/. We are hoping to continue profiling psychology graduates who work in fields outside academia and clinical practice. If you or someone you know fits this bill, please email our communications officer Eric at ebollman@cpa.ca.

## 9 8th Annual CCR breakfast with the funders

In early March, the CCR (Canadian Consortium for Research), for which the CPA's Deputy CEO, Dr. Lisa Votta-Bleeker serves as Chair, hosted its 8th annual breakfast with the funders. Representatives from CIHR, SSHRC, NSERC, CFI, and Mitacs were all in attendance. This annual event provides both CCR members and the funders a great opportunity to meet directly to discuss issues impacting research in Canada.

## 10 New fact sheet "Anxiety Related to Food Allergy in Children"

In March, the CPA published a new Psychology Works fact sheet concerning anxiety related to food allergies in children. The fact sheet was prepared by Dr. Joanne Gillespie, IWK Health Centre, and reviewed by Food Allergy Canada.

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CPA ONLINE COURSES

# FAITS SAILLANTS des activités de la SCP

*Voici la liste des principales activités menées depuis la publication du dernier numéro de Psynopsis. Écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique mensuel, Les Nouvelles de la SCP. Vous serez ainsi au courant de tout ce que nous accomplissons pour vous!*

## 1 Nouvelle page sur la COVID-19

À mesure que l'impact de la COVID-19 se fait sentir dans le monde entier, nous reconnaissons la pression que met la crise actuelle, et en constante évolution, sur les éducateurs, les enseignants, les superviseurs et les praticiens du domaine de la psychologie de partout au Canada. Au nom de la SCP, nous exprimons notre gratitude au grand nombre d'entre vous, qui jouez un rôle de leadership dans leurs collectivités, et qui s'efforcent de répondre aux besoins de leurs collègues, leurs étudiants et leurs patients. Pour appuyer vos efforts et informer le public, nous avons compilé et créé diverses ressources. Nous travaillons aussi avec nos partenaires et d'autres associations pour appuyer, non seulement nos membres, mais aussi toute la population canadienne. Ces ressources et ces renseignements à jour sur la COVID-19 sont accessibles sur le site Web de la SCP.

## 2 Sept nouvelles fiches d'information sur la COVID-19

Sept fiches d'information de la série « La psychologie peut vous aider » ont été élaborées dans le contexte de la crise de la COVID-19. Le Dr Steven Taylor, la D[re] Kim Lavoie et le président de la Section de psychologie de la santé et de médecine comportementale, le Dr Justin Presseau, ont créé « Faire face au coronavirus et prévenir la COVID-19 »; le Dr Stewart Madon, registraire et agent d'éthique de la SCP, a préparé « Travailler à domicile pendant la pandémie de coronavirus, avec et sans enfants à la maison »; « L'impact psychologique de la pandémie de coronavirus (COVID-19) » et « Aider les adolescents à faire face aux impacts et aux restrictions liés à la COVID-19 » ont été préparées par la D[re] Lisa Votta-Bleeker, directrice générale associée de la SCP; « La pratique de la psychologie et le coronavirus (COVID-19) » a été préparée par la D[re] Karen Cohen, chef de la direction de la SCP; « Emotional and Psychological Challenges faced by Frontline Health Care Providers during the COVID-19 Pandemic » a été élaborée par la D[re] Anita Gupta, tandis que « Le bien-être psychologique des étudiants et la COVID-19 » était une collaboration entre la SCP et la Fédération canadienne des étudiantes et étudiants. La fiche d'information « L'impact psychologique de la pandémie de coronavirus (COVID-19) » a également été numérisée en vidéo.

## 3 Invitation aux psychologues à offrir des services gratuits aux travailleurs de première ligne

Les Canadiens atteints de la COVID-19 dépendent de l'expertise de nos fournisseurs de services de santé. Mais pour que le personnel de la santé soit en mesure de mettre son expertise au service des malades, il faut en prendre soin. La Société canadienne de psychologie aimerait y contribuer. La SCP voulait aider et a demandé à tous les psychologues agréés d'envisager de donner un peu de leur temps pour fournir des services psychologiques aux fournisseurs de soins de santé de première ligne, qui peuvent se sentir stressés, débordés ou angoissés du fait de leur position sur la ligne de front de cette crise sanitaire. Pour vous inscrire, veuillez remplir le formulaire d'inscription qui se trouve à l'adresse https://web2.cpa.ca/membersurveys/index.php/451688.

## 4 Le 81e congrès national annuel de la SCP passe en mode virtuel!

Le 81e congrès national annuel de la SCP passe en mode virtuel! Après avoir effectué un examen continu de la situation de la COVID-19 au Canada et à l'étranger, et au vu des décisions prises par les gouvernements fédéral et provinciaux pour protéger les collectivités et interdisant les grands rassemblements, le conseil d'administration de la SCP a pris la décision d'annuler son 81e congrès national annuel, qui devait se tenir à Montréal, au Québec, du 28 au 30 mai 2020, ainsi que tous les ateliers précongrès prévus le 27 mai. Les personnes qui s'étaient inscrites à un atelier précongrès ou au congrès ont reçu un remboursement complet de leur inscription. Depuis que cette décision a été prise, le personnel,

le comité du congrès et le conseil d'administration de la SCP se sont mis rapidement à étudier toutes les options possibles pour transformer le congrès en événement virtuel et sont heureux d'annoncer que cette année, notre congrès se tiendra, non pas en personne, mais de manière virtuelle, au cours des mois de juillet et août. Toutes les personnes qui devaient présenter une communication au congrès sont invitées à participer à l'événement virtuel; vérifiez votre boîte de réception pour voir si vous avez reçu un courriel contenant quelques informations préliminaires sur les modalités de participation. Veuillez consulter régulièrement le site Web du congrès de la SCP pour obtenir de l'information sur l'événement virtuel. Nous espérons que vous pourrez participer à certaines des nombreuses séances qui figurent dans le programme scientifique de cette année.

## 5 Interdiction nationale de la thérapie de conversion

En 2015, la Société canadienne de psychologie a publié un énoncé de position sur la thérapie de conversion, dans lequel elle s'oppose à toute thérapie dont l'objectif est de « soigner » l'homosexualité ou de modifier l'orientation sexuelle d'une personne, quel que soit son âge. Depuis sa publication, cet énoncé de position a été envoyé à de nombreux médias et a contribué de façon importante à la décision du gouvernement fédéral, rendue le 9 mars, d'interdire la pratique de la thérapie de conversion à l'échelle du Canada.

## 6 Discussion de la CSMC et de l'ACMMSM sur l'harmonisation interorganisationnelle

Le 6 février 2020, des dirigeants de la Commission de la santé mentale du Canada (CCSM) et des membres de l'Alliance canadienne pour la maladie mentale et la santé mentale (ACMMSM), dont la SCP fait partie, se sont réunis pour discuter des possibilités d'harmonisation interorganisationnelle dans le contexte d'un nouveau gouvernement fédéral. La santé mentale a été définie comme une priorité importante pour la ministre de la Santé. L'ACMMSM et la CSMC réclament de concert un meilleur accès aux soins pour traiter les personnes qui souffrent de problèmes de santé mentale et de troubles mentaux. La SCP a travaillé avec un réseau de la CSMC, dont l'objectif est de demander au gouvernement et à d'autres intervenants d'élargir l'accès à la psychothérapie dans le système public de la santé.

## 7 Combler les lacunes des services à l'Î.-P.-É.

La SCP s'est jointe à la Psychological Association of Prince Edward Island pour offrir de l'aide au ministère de la Santé et du mieux-être dans le but de combler les graves lacunes en matière de services de santé mentale qui subsistent dans l'ensemble de la province. Un communiqué de presse conjoint a été publié et a bénéficié d'une large couverture médiatique dans toute la province.

## 8 Le Mois de la psychologie

Tout au long du mois de février, nous avons célébré le Mois de la psychologie en présentant des diplômés en psychologie qui travaillent hors des milieux cliniques et universitaires. Nous avons fait le portrait de titulaires d'un doctorat qui travaillent dans l'aviation, le secteur bancaire, l'édition, la publicité et la conception de jeux vidéo, entre autres domaines. Leurs portraits sont toujours disponibles sur notre site Web à l'adresse https://cpa.ca/careers/psychology-profiles/. Nous espérons continuer de faire connaître les diplômés en psychologie qui travaillent dans des domaines autres que le milieu universitaire et la pratique clinique. Si vous ou une personne que vous connaissez êtes de ceux-là, veuillez écrire à notre agent des communications, Eric, à ebollman@cpa.ca.

## 9 Huitième petit-déjeuner de travail du CCR avec les organismes subventionnaires

Au début de mars, le CCR (Consortium canadien pour la recherche), que préside la directrice générale associée de la SCP, la D^re^ Lisa Votta-Bleeker, a tenu son 8e petit-déjeuner annuel avec les bailleurs de fonds. Des représentants des IRSC, du CRSNG, du CRSH et de Mitacs étaient présents. Cet événement annuel offre aux membres du CCR et aux organismes subventionnaires une excellente occasion de se rencontrer en personne pour aborder des questions ayant une incidence sur la recherche au Canada.

## 10 Nouvelle fiche d'information : « L'anxiété liée aux allergies alimentaires chez les enfants »

En mars, la SCP a publié une nouvelle fiche d'information, qui s'ajoute à la série « La psychologie peut vous aider », sur l'anxiété liée aux allergies alimentaires chez les enfants. La fiche d'information a été rédigée par la D^re^ Joanne Gillespie, du Centre de soins de santé IWK, et révisée par Allergies Alimentaires Canada.

# Being an ethical psychologist:
## Updated web-based ethics course now available

*Carole Sinclair, PhD, RPsych, Chair, CPA Committee on Ethics*

One of the major functions of the CPA Committee on Ethics is to develop and provide educational resources on ethics for members. Activities of the committee with respect to this function have included articles in *Psynopsis*, ethics symposia at each annual convention, establishment of the Jean Pettifor Distinguished Lecture in Ethics, and a resource guide, *Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration*. In addition, the committee has overseen four editions of the *Companion Manual to the Canadian Code of Ethics for Psychologists* (1988, 1992, 2001, 2017).

In 2007, the committee added a web-based course, "Being an Ethical Psychologist" to its educational activities. The course was based on the third edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2000); however, with the release of the fourth edition of the *Code* (CPA, 2017), there has been a need to update the course to include the new concepts and language. We are pleased to report that the updated course is now available.

The course is divided into seven units, with topics including the ancient and modern history of ethics codes; the development of ethics codes for psychologists; ethical issues and standards related to the four ethical principles of the *Canadian Code* (Respect for the Dignity of Persons and Peoples, Responsible Caring, Integrity in Relationships, Responsibility to Society); and ethical decision making. The content is relevant to, and draws examples from, all the major areas of psychological activities—research, practice, teaching, and administration—ranging from such matters as academic freedom, cultural differences in obtaining informed consent, the use of disparaging comments with students, and business practices. Lectures and 31 interactive case studies are employed to outline and demonstrate ethical expectations, issues, and problem solving.

The primary perspective of the course is that being an ethical psychologist requires more than knowledge and adherence to ethical rules. It requires a personal commitment to act as ethically as possible in all situations, sensitivity to ethical issues, and the ability to think through and respond to everyday ethical problems. To understand and appreciate that ethics codes are more than simply lists of "rules," the first unit addresses the history and purposes of codes of ethics. It traces early efforts to write codes of ethics for psychologists, and the relationship of ethics codes to the concept of "profession." Unit 1 ends with information about the development of the *Canadian Code of Ethics for Psychologists* (the code that provides the framework for the next units in the course), covering both why and how the *Code* was developed.

Units 2 to 6 provide us with a "walk-through" of the *Code*. Unit 2 takes us through (a) the idea of a social contract; (b) the responsibilities of psychologists in helping to fulfill the social contract; (c) tools for ethical decision making; and (d) the relationship of the *Code* to personal behaviour, regulatory bodies, and codes of conduct. Units 3 to 6 cover the four ethical principles of the *Code.* Each of these units starts with the Values Statement of the ethical principle, explaining the values associated with the principle (e.g., informed consent, competence and self-knowledge, avoidance of conflict of interest, development of knowledge). The main messages of each associated value are reviewed, followed by the specific ethical standards for the value. We are then asked to look at a case study related to the value and respond to questions about the case study.

The final unit explores the process of ethical decision making. It outlines different levels of ethical decision, followed by a review of each of the ten steps in the *Code*'s ethical decision-making model. We then are introduced to a complex ethical dilemma; using the dilemma, we are helped to work through each of the ten steps.

The course is designed to be used for continuing education or as a component of graduate training in psychological ethics. A certificate of completion is generated for those who complete the course with a 75% success rate on the progress quizzes incorporated into the units, and the course has been approved for 15 hours of continuing education. If you or someone you know is interested in the course, further information can be found at https://cpa.ca/professionaldevelopment/webcourses/.

*Please feel free to send your comments about this article or any ideas you have regarding topics for future Ethics Corner articles to ethicscttee@cpa.ca.*

# « Being an ethical psychologist » :

## la version actualisée du cours sur l'éthique est maintenant disponible

*Carole Sinclair, Ph. D., psychologue agréée, présidente,*
*Comité de déontologie de la SCP*

L'une des principales fonctions du Comité de déontologie de la SCP est d'élaborer et de fournir aux membres des ressources éducatives sur l'éthique. Dans cet objectif, le comité a présenté des articles dans *Psynopsis*, organisé des symposiums sur l'éthique à chaque congrès annuel, créé la série de conférences émérites sur l'éthique Jean Pettifor et rédigé un guide de ressources, ayant pour titre *Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice, and Administration*. De plus, le comité a supervisé quatre éditions du *Companion Manual to the Canadian Code of Ethics for Psychologists* (1988, 1992, 2001, 2017).

En 2007, le comité a ajouté à ses activités éducatives un cours sur le Web intitulé « Being an Ethical Psychologist ». Le cours était fondé sur la troisième édition du *Code canadien de déontologie professionnelle des psychologues* (SCP, 2000); cependant, avec la publication de la quatrième édition du *Code* (SCP, 2017), il devenait nécessaire de mettre à jour le cours afin d'inclure les nouveaux concepts et la nouvelle terminologie. Nous sommes heureux de vous informer que la nouvelle version du cours est désormais disponible.

Le cours est divisé en sept modules, portant entre autres sur les sujets suivants : l'histoire ancienne et moderne des codes d'éthique; l'élaboration de codes d'éthique pour les psychologues; questions et normes éthiques liées aux quatre principes éthiques du *Code* canadien (respect de la dignité des personnes et des peuples, soins responsables, intégrité dans les relations, responsabilité envers la société); prise de décisions éthiques. Le contenu s'applique aux principaux champs d'activité des psychologiques, à savoir la recherche, la pratique, l'enseignement et l'administration, et en tire des exemples. La liberté universitaire, les différences culturelles ayant une incidence sur l'obtention du consentement éclairé, l'utilisation de commentaires désobligeants envers les étudiants et les pratiques commerciales sont quelques-unes des questions explorées. Le cours comprend des conférences et 31 études de cas interactives, qui servent à décrire et à illustrer les attentes sur le plan éthique, ainsi que les problèmes et la résolution de problèmes d'ordre éthique.

Le cours part du principe que, pour travailler de manière éthique, posséder des connaissances et respecter des règles déontologiques ne suffisent pas. Les psychologues doivent s'engager personnellement à agir de la manière la plus éthique possible, et ce, dans toutes les situations; ils doivent être sensibles aux questions d'éthique et être capables d'analyser et de solutionner les problèmes éthiques rencontrés au quotidien. Pour comprendre et montrer que les codes de déontologie ne sont pas simplement des listes de « règles », le premier module du cours traite de l'histoire et des objectifs des codes de déontologie. Il décrit les étapes qui ont conduit à la rédaction des premiers codes d'éthique destinés aux psychologues et la relation entre les codes d'éthique et le concept de « profession ». Le module 1 se termine par des informations sur l'élaboration du *Code canadien de déontologie professionnelle des psychologues* (le code qui fournit le cadre des prochains modules du cours), y compris les raisons de sa création et la façon dont il a été élaboré.

Les modules 2 à 6 nous font parcourir le *Code*. Le module 2 nous fait découvrir (a) l'idée d'un contrat social; (b) les responsabilités des psychologues pour aider à remplir le contrat social; (c) les outils de prise de décision éthique; (d) la relation entre le *Code* et le comportement personnel, les organismes de réglementation et les codes de conduite. Les modules 3 à 6 couvrent les quatre principes éthiques du *Code*. Chacun de ces modules commence par l'énoncé de valeurs du principe éthique, en expliquant les valeurs associées au principe (p. ex., consentement éclairé, compétence et connaissance de soi, éviter les conflits d'intérêts, développement des connaissances). Les principaux messages de chaque valeur associée sont examinés, suivis des normes éthiques se rapportant à cette valeur. Nous sommes ensuite invités à examiner une étude de cas liée à la valeur et à répondre aux questions sur l'étude de cas.

Le dernier module explore le processus de prise de décision éthique. On y décrit différents niveaux de décision éthique, suivis d'un examen de chacune des 10 étapes du *modèle de prise de décision éthique du Code*. On nous présente ensuite un dilemme éthique complexe; en utilisant ce dilemme, on nous aide à parcourir chacune des 10 étapes.

Le cours est conçu pour être utilisé pour la formation continue ou comme une composante de la formation des diplômés portant sur l'éthique de la psychologie. Un certificat de réussite est produit pour les personnes qui obtiennent la note de 75 % aux tests d'avancement intégrés aux modules, et le cours équivaut à 15 heures de formation continue accréditées. Les personnes qui souhaitent suivre le cours trouveront de plus amples renseignements à l'adresse https://cpa.ca/fr/professional development/webcourses/.

*N'hésitez pas à envoyer vos commentaires sur le présent article ou à nous faire part de vos idées de thèmes pour la rubrique « L'Espace éthique » en écrivant à ethicscttee@cpa.ca.*

# Opportunity for insight into the state of mental health in Canadian agriculture

*Cynthia Beck, BA (Hons)*

The Canadian Psychological Association (CPA) was invited to attend the Advancing Women in Agriculture Conference East 2019 held in Niagara Falls, ON from October 27th to 29th (https://www.advancingwomenconference.ca/). Over 400 women working in diverse aspects of agriculture production from across Canada came together to network, to share ideas, and to build new skills. Conference organizer and host, Iris Meck, who grew up farming, recognized the importance of including mental health aspects in the conference. She recruited a variety of speakers who addressed financial management, leadership, talking about mental illness, and strategies for farming with family. The conference also included workshops on how to deal with stress, self-care, and maintaining mental health while working in agriculture. The CPA invited Cynthia Beck, a University of Regina clinical psychology master's student and a mixed farm operator, to person the CPA Mental Health information booth at the conference. Attendees stopped by to gather information pamphlets and to ask questions about mental health resources in their regions. Cynthia's background as a farmer was appreciated, and attendees mentioned the importance of mental health care professionals having an understanding of their farming culture and way of life.

As highlighted by Votta-Bleeker and Cohen (2014), rural Canadians lack access to psychological services.[1] Included in the rural areas are agriculture producers, who face additional barriers to seeking mental health care on top of a lack of access to services.[2,3] Recent research on the mental health of Canadian agriculture producers highlights the critical need for accessible interventions for the farming population.[2] In fact, the mental health of Canadian agriculture producers has been identified as a priority by Canada's House of Commons agricultural committee.[3] In order to provide effective mental health services to rural and agriculture producer populations, it is important for those who work in mental health care to take advantage of opportunities to learn about the unique needs of agriculture producers and their way of life. Attending agricultural events, such as the Advancing Women in Agriculture Conference, is a great way for psychologists to gain insight into the population who feeds us.

*For a complete list of references, please go to www.cpa.ca/psynopsis*

# Remembering
## Marta Yolande Young (1963-2019)

*Written by Patrick Orchard; submitted to Psynopsis by Gira Bhatt, Secretary, International Relations Committee and Maya A. Yampolsky, Chair, International & Cross-Cultural Psychology Section*

University of Ottawa associate professor Dr. Marta Young died on Thursday, September 26, 2019 at the Civic Hospital. She was 56. She was born on May 18, 1963 in London, England. At age three, she began her world travels that never ceased. She lived in British Guyana, Columbia, and Guatemala, with short stints in Paris and Quebec City. At age nine she moved to Paris. At 16, she won a scholarship to attend the first United World College, Atlantic College, in Wales. By 22 she had completed her Master's in Psychology at Western University following a degree in Psychology from Queens University. By age 28 she held a PhD in Psychology. After a few years in private practice, she started her career with the University of Ottawa.

Marta's childhood experience as a minority—being the only white child in her class in Guatemala—informed her entire career. Her research focused on assimilation of refugees and their progeny. She also maintained a private practice through which she assessed refugees to support applications to the Immigration and Refugee Board of Canada. Often her reports were cited as the key reason a refugee was granted protection. She will be missed by that community.

Marta was an ardent feminist and cared deeply about the plight of marginalized people. In her personal relationships she focused on attachment and strove for ever deeper connections with those she loved. She was an excellent French cook and travelled all over the world. She collected art, had an out-of-control pottery obsession, adored folk festivals, and often enjoyed modern dance at the National Art Centre.

As a long-standing member of CPA for over two decades, Marta contributed substantially to both scholarly activities and to administrative tasks. She was a regular presenter at CPA's annual conventions along with her undergraduate honors students and graduate students. She was a member of the International Relations Committee and also served as the chair of the International & Cross-cultural Psychology section for several terms. She was a delegate from Canada to the International Union of Psychological Science. Always the "life of the party", she brought laughter and her personal warmth to after-conference gatherings. Her colleagues and students will miss her greatly.

Marta is survived by her two children, Katya (18) and Nicolas (21); her partner, Patrick Orchard; mother, Maureen Campbell; her brother, Philippe; and her two step-children, Sean (26) and Kimberly Orchard Hayes (28).

Marta was a private person. Few knew that she was terminally ill. She fell and injured her head. A cascading series of complications led to her death. Perhaps the fall was a blessing as it saved her from protracted suffering.

She will be greatly missed.

# An affectionate farewell
## Ronald Melzack (1929-2019)

*Mary Ellen Jeans, CM, MScN, PhD, President and CEO, ME Jeans & Associates, Health Policy and Research Consulting; and Kenneth D. Craig, OC, PhD, FCAHS LLD (Hon), Professor Emeritus of Psychology University of British Columbia*

December 22, 2019 saw the passing of Dr. Ronald Melzack, a widely admired scientist, humanitarian, and leader in the field of pain and an international giant as a psychologist.

Montreal was his home. He was born July 19, 1929 and grew up there, receiving his education primarily at McGill University where he earned his BSc, MSc, and PhD (1954), enjoying the opportunity to have Donald O. Hebb as his doctoral research supervisor. Following Fellowships at the University of Chicago, the University of Oregon Medical School, and the Institute of Physiology, University of Pisa in Italy, he had short faculty appointments at University College, University of London, England, and at the Massachusetts Institute of Technology in Boston. The McGill Department of Psychology became his academic home in 1963 and he remained there, as E.P. Taylor Professor of Pain Studies between 1986 and 1999, ultimately becoming a Professor Emeritus. He also was a devoted Canadian. Unquestionably, Canadian leadership in the field of pain, both in basic science and clinical innovation, was inspired and motivated by his enthusiasm, but in reality his work was international in scope.

While he identified strongly as a psychologist, his contributions saw no disciplinary boundary. He valued any approach that led to a better understanding and control of unnecessary pain and he was as respected in medicine as in psychology. Anybody with an interest in pain, whether scientist, practitioner, patient, or member of the public, has benefited from understanding or the application of Ronald Melzack's contributions.

Only a brief outline of his contributions to science, practice, and professional leadership can be managed here. But these are best considered in the context of the affection extended to Ron by his colleagues, students, and friends. And this in large measure was matched by Ron's kindness, generosity, and warmth in his relationships with others. While brilliant and well-schooled in critical analysis, he took a great interest in other disciplines and their contributions and respected and trusted other people.

His huge influence on pain research and management were founded upon brilliant scientific contributions. Most widely recognized would be the gate control theory of pain (GCT) from "Pain Mechanisms: A New Theory", published in 1965 in *Science* with his friend and colleague, the late British neurophysiologist, Patrick Wall. The paper appears in Garfield's list of Citation Classics. The innovative, evidence-based, conceptual formulation revolutionized how people understood fundamental neuroregulatory mechanisms of pain, inspired a dramatic escalation of research on pain in all disciplines, and provided a basis for the development of novel biomedical and psychosocial interventions for the control of pain.

On the one hand, Ron Melzack's work as a visionary neuroscientist on the GCT captured the brain's capacity for integration of peripheral and central regulatory activity in neuromodulation of the experience of pain. Ultimately, this led to his neuro-matrix model of pain, a formulation supported by current brain imaging research establishing the intricate parallel and serial networks in the brain of regulatory systems. His range of interests was broad and one can find his fascinating papers on such diverse topics as labour pain, pain in people who are elderly, phantom limb pain, beliefs about pain, palliative care and central neuroplasticity. He had a remarkably productive lab, representing a host of highly valued graduate students and an expanding network of scientists throughout Canada, the United States, and globally, all of whom extended research initiated with Ron.

On the other hand, as an insightful psychologist, the GCT promoted understanding of pain as a very complex subjective experience requiring novel measurement approaches to capture this complexity. Working closely with colleagues and students, pain experience was conceptualized as multidimensional, including affective/motivational, cognitive/appraisal, and sensory/discriminative features, and research on the language of pain led to development of the McGill Pain Questionnaire, now a widely used clinical and research tool.

In the early 1970s, recognizing the importance of intensive pain management by clinicians trained in the speciality, Ron, Mary Ellen Jeans and Joe Stafford founded the McGill-Montreal General Hospital Pain Centre, among the first pain clinics in Canada (now the Alan Edwards Pain Management Unit). Serving as the clinic's Research Director, he promoted and bridged both basic and applied research, often bringing basic pain science students to participate in pain clinic activities and ensuring participation of different disciplines (e.g., anaesthetics, nursing, psychology, psychiatry, physiotherapy, dentistry). He was interested in them all, recognizing they made unique contributions to the puzzle of pain.

There were and remain vast ripple effects of Ron's life work. He was tremendously important to his students; he attracted gifted colleagues from around the world; his research was translated into major assessment and treatment tools for people suffering from pain; and, most of all, he contributed to relief from suffering and pain. But he also recognized, in his words, that there was considerable "needless suffering" that needed to be challenged. While Ron's legacy is enormous, he would immediately tell us "the work is not yet fininshed." Those of us who continue to be intrigued by the complexities and mysteries of the human body and mind have benefitted from his joy of curiosity and learning as well as his respect for the discipline of science. It is our obligation and responsibility to continue the path of discovery to ultimately improve the quality of life for our fellow humankind. Ron will remain a guiding light and we will always remember him with affection and admiration.

Ron also saw that his impact would be extended through support of organizations. He generously devoted himself to scientific and professional organizations in Canada and served in leadership roles around the world. Early in his career, he was a Fellow and member of the Board of Directors of the Canadian Psychological Association and in 1988-89 he became its Honorary President. He was a founder of the International Association for the Study of Pain, President between 1984 and 1987, and served on its governing council between 1978 and 1990. In this role and as a brilliant speaker, Ron travelled extensively and delivered many honorary lectures around the world, extending his influence. He also served extensively for other governmental and not-for-profit organizations.

Ron's personal story was also widely known and appreciated by the public. His profile appeared in numerous magazines, including *Saturday Night, Psychology Today, MacLean's, L'Actualite, Equinox, The New Yorker,* and *Reader's Digest*. He also was involved in numerous television interviews and lectures that informed the general public about the nature of pain. This ultimately inspired the Chronic Pain Association of Canada, founded and led by patients.

It is pleasing to note that Ron was recognized in his time with major honours and awards, including being invested as a Laureate in the Canadian Medical Hall of Fame; an appointment as an Officer of the Order of Canada; the Prix du Quebec and the Prix Marie-Victorin, awarded by the Government of Quebec; honorary degrees from the University of Waterloo and Dalhousie University; appointment as a Fellow of the Royal Society of Canada; appointment as an Officer of the Ordre national du Quebec; and recipient of the Queen's Golden Jubilee Medal. He received the Molson Prize "for outstanding contributions to the arts, humanities or social sciences" awarded by the Canada Council; the Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science from the Canadian Psychological Association; the VIth World Congress on Pain Medal; the Award for Distinguished Contribution to Pain Research and Management in Canada, presented by the Canadian Pain Society; the Killam Prize awarded by the Canada Council for the Arts; the Prix Adrien Pinard awarded by the Societe Quebecoise pour la Recherche en Psychologie; and the Canadian Psychological Association Gold Medal for distinguished and enduring lifetime contributions to Canadian psychology. Thus, his brilliant career was richly rewarded.

But most of the aforementioned awards ignore Ron's relationships with other people. It isn't easy deciding whether the affection people had for Ron was stronger than his affection for other people. He was intellectually generous, shared ideas with everybody, wanted to help others, enjoyed a good discussion, and debated with enthusiasm. It always was a great pleasure to spend time with Ron in the company of his wife Lucy, whom he adored and cared for immensely. Our deepest sympathies go to Lucy and their children, Lauren and Joel.

As a hobby, he wrote children's books, mostly focused on the beliefs of the Indigenous peoples of Canada. These included *The Day Tuk Became a Hunter; Raven, Creator of the World*; and *Why the Man in the Moon is Happy.* It is no surprise that these appeared on many best lists of the year, that CBC produced and broadcast *Raven, Creator of the World,* as a three-part series, and that an animated series based on this book was award-winning.

Ron always was a great story teller. One poignant tale comes to mind. In a conversation in which the enormous respect he enjoyed was mentioned, he described a student expressing surprise that he was still alive—famous people in their experience had departed this mortal coil. We had a good laugh. Sadly, the story now requires revision.

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As the impact of COVID-19 is being felt worldwide, we recognize the pressure this evolving crisis is placing on practitioners, researchers, educators, students, employers, families and the public throughout Canada.

On behalf of the CPA, we extend our gratitude for the leadership roles so many are playing in their communities and applaud their efforts to address the needs of their colleagues, students and patients. To support these efforts, and to inform the public, we have compiled and created a variety of resources. In addition, we are working with our partners and other associations to advocate for, not only our members but, members of the Canadian public.

**Compiled and Created Resources Include:**

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We can see the medical and physical impact COVID-19 is having around the world, but the full extent of the psychological impact is not yet known. The discipline and profession have much to contribute.

**Thank you to all for your efforts.**

Be well and stay safe.

Any questions or concerns, please contact executiveoffice@cpa.ca.

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