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SPECIAL ISSUE/ ÉDITION SPÉCIALE

The Role of Psychology in the "Concussion Crisis"

Le rôle de la psychologie dans la « crise des commotions cérébrales »

Chris Friesen, Ph.D., C. Psych, Guest Editor/rédacteur en chef invité

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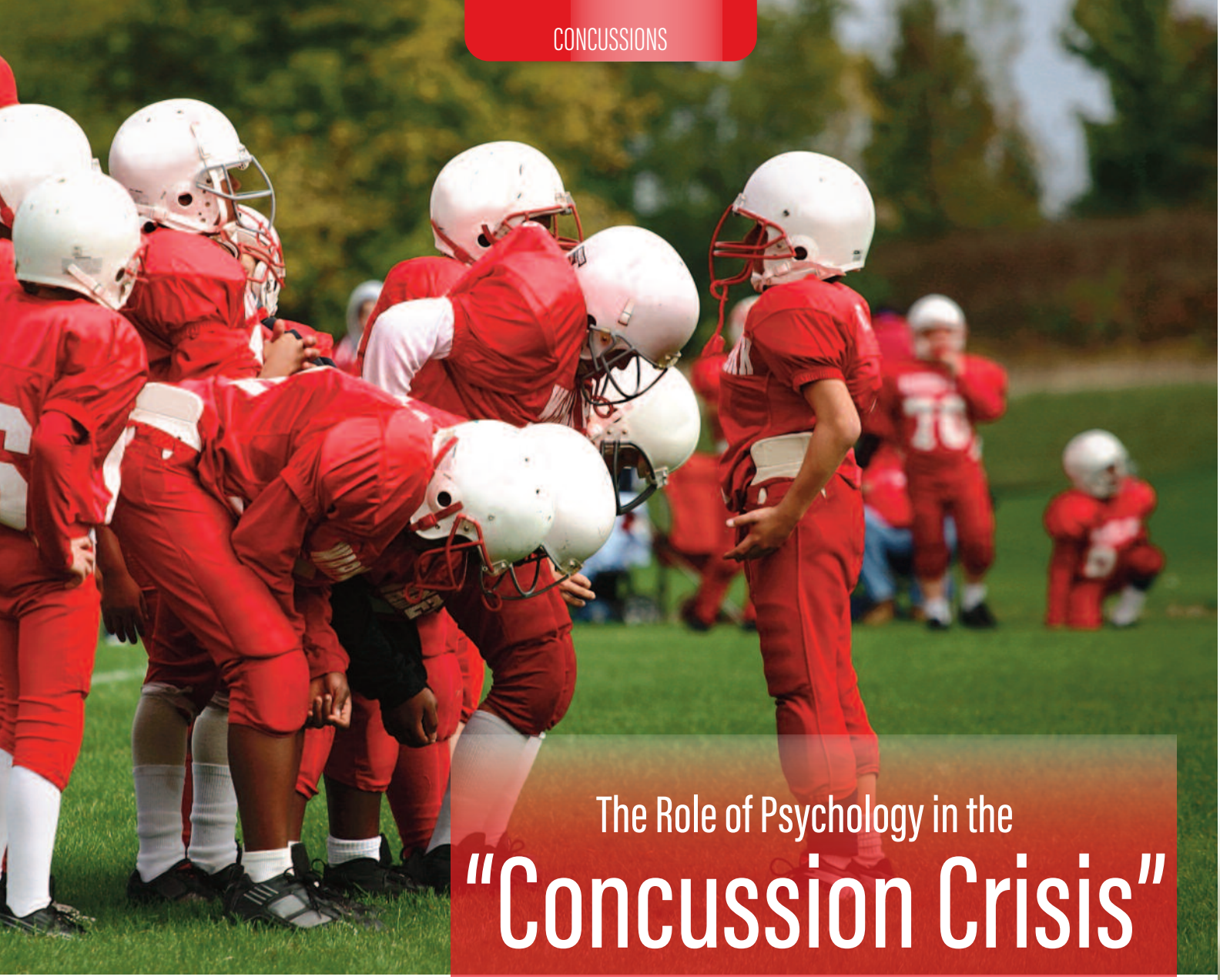

The Role of Psychology in the "Concussion Crisis"

Chris Friesen, Ph.D., C.Psych., Guest Editor

If you pay attention to the news, you may be under the impression that concussion rates are skyrocketing. You may also believe that concussions (aka mild traumatic brain injuries or mTBI) can cause long-term and even permanent problems with cognition (e.g. early senility), emotion (e.g. severe depression), and behaviour (e.g. substance abuse, violence, and even suicide). But are we really in a "*concussion crisis*"[1, 2] as the media seems to suggest?

As media attention on the topic has increased, thankfully so has research on concussions. Health professionals and scientists from various disciplines, especially psychology, have been trying to better understand the effects of concussions. It is my hope that after reading the articles in this special concussion issue, you will have a better understanding of what we do and do not know about them. I also hope that it will be clear just how well suited we are as a profession to deal with the alleged "*concussion crisis*" by nature of our training in research, diagnosis, management, and treatment.

Before exploring the role of psychology in this "*concussion crisis,*" it is important to clearly

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understand what is, and what is not, a concussion. Concussions fall within the broader classification of traumatic brain injuries (TBI) that are caused by a direct blow to the head or body, acceleration-deceleration (e.g. whiplash-type injury without head impact), penetration of the brain by a projectile (e.g. bullet or shrapnel), or blast exposure (e.g. bomb blast).

There are four TBI classifications based on the level of severity. These are determined by what happens immediately following an injury, not the symptoms that develop or endure after the acute phase. These factors include: Glasgow Coma Scale (GCS; a measure of consciousness) ratings at the scene of the injury or in hospital, length of loss of consciousness (LOC), length of alteration of consciousness (e.g. being dazed, confused, incoherent, disoriented, or having significant incoordination), and length of posttraumatic amnesia (PTA; inability to form memories after the injury). See Table 1 for more detailed classification criteria.

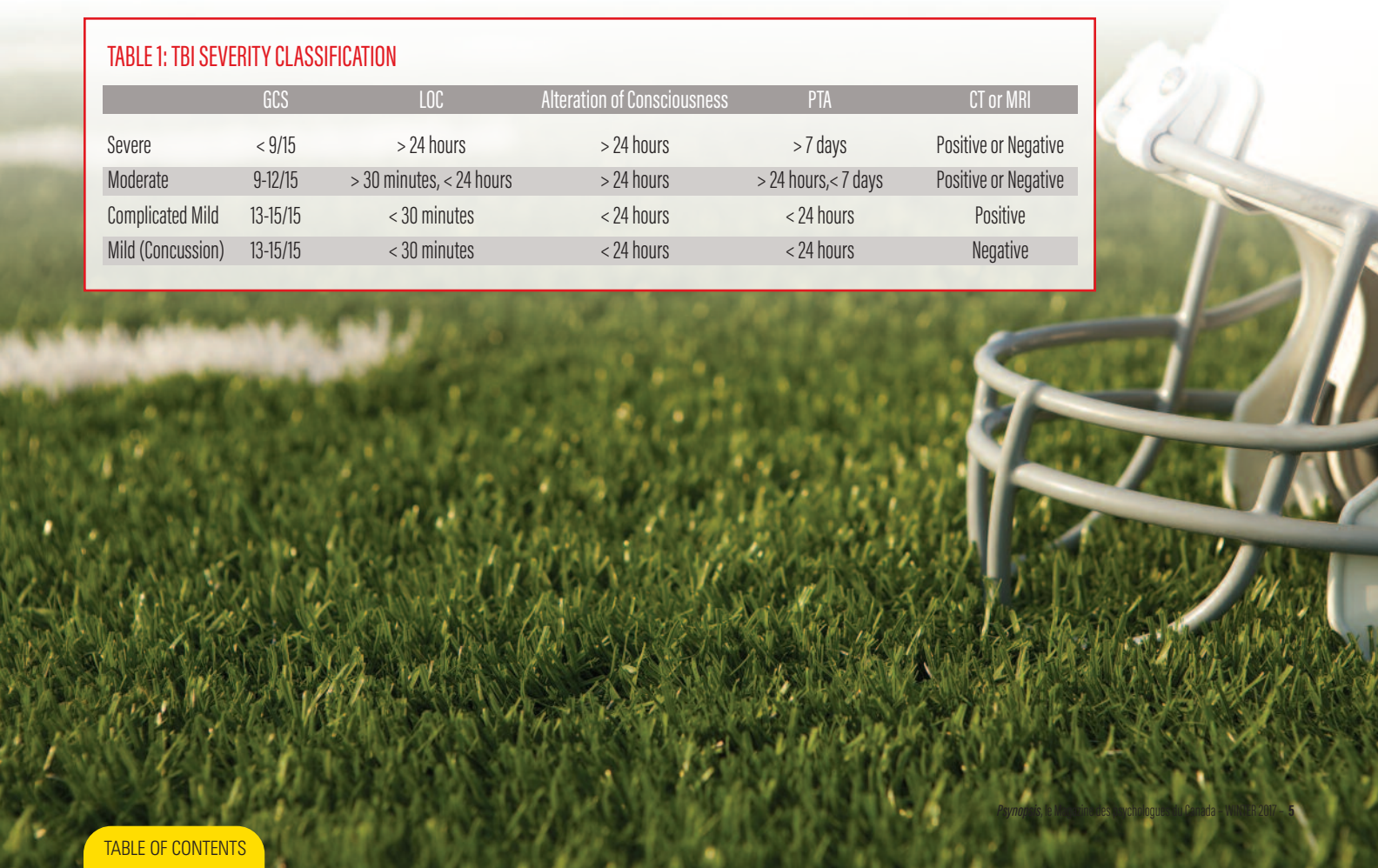
The severity classification is typically a good indicator of expected outcomes. Generally, individuals who suffer a severe TBI have significant and permanent functional deficits. In contrast, though many individuals who suffer a moderate TBI also have some permanent functional deficits, a good percentage of them make significant recovery and go on to lead relatively normal lives. As the name suggests, mTBI is the mildest form of TBI – individuals who experience an uncomplicated mTBI tend to have the best outcomes.[3] Researchers have estimated that more than 80% of all TBI's are categorized as mTBI/concussion.[4]

As seen in Table 1, within mTBI, there are two levels of severity. A complicated mTBI has the same injury characteristics of an mTBI/concussion, except brain imaging (i.e., head CT or MRI) reveals visible structural damage to the brain. In addition, the recovery trajectories of complicated mTBI patients can be more consistent with those of moderate TBI than mTBI/concussions.[5]

For a concussion to occur from a biomechanical perspective, it is estimated that a minimum threshold of approximately 70-100 g of translational acceleration force is required.[6] The force typically required is estimated to be the equivalent of hitting a stationary object, such as a goalpost or another motor vehicle, at 40 kph; however, such force does not always lead to a concussion.

TABLE 1: TBI SEVERITY CLASSIFICATION

	GCS	LOC	Alteration of Consciousness	PTA	CT or MRI
Severe	< 9/15	> 24 hours	> 24 hours	> 7 days	Positive or Negative
Moderate	9-12/15	> 30 minutes, < 24 hours	> 24 hours	> 24 hours,< 7 days	Positive or Negative
Complicated Mild	13-15/15	< 30 minutes	< 24 hours	< 24 hours	Positive
Mild (Concussion)	13-15/15	< 30 minutes	< 24 hours	< 24 hours	Negative



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We often hear about the high-profile concussive injuries of professional athletes, like Sidney Crosby, but what about the effects of concussions in children and adolescents?

Neurophysiologically, in the acute phase, a concussive impact causes a "*neurometabolic cascade*" that essentially results in a mismatch between the brain's increased need for glucose in the presence of decreased cerebral blood flow.[7, 8]

The symptoms following a concussion, or what is commonly referred to as "*postconcussion syndrome*" generally involve a combination of headaches, dizziness, memory loss, poor concentration, anxiety, depression, irritability, sleep problems, fatigue, and noise and light sensitivity. However, as highlighted by a number of authors in this issue, researchers have noted that many of these symptoms are highly non-specific to concussions. They are also commonly reported after other types of injury (e.g. orthopedic injuries)[9, 10] and in "*healthy,*" "*normal,*" or non-injured individuals.[11-17] Contributors to this issue further point out that the measured effects of concussion during the first few days to weeks post-concussion are quite mild and typically resolve within this timeframe in the vast majority of people[18-21].

In this issue, Plourde, Brooks, Kirkwood, and Yeates start us off with a good general overview of psychologists' roles in the assessment and management of concussions and touch on the often forgotten pre- and post-injury variables that can affect the speed of recovery. Longman and Longman then dispel the myths held by lay people and health providers alike related to the diagnosis, treatment, and expected outcomes following a concussion; myths that we, as psychologists, need to be aware of to effectively play our role in tackling the "*concussion crisis.*"

While we now have a better understanding of single mTBI/concussions, the effects of multiple concussions are less clear because the available research in this area is not consistent. It is, however, essential for us, as a society, to better understand these effects so we can make informed decisions on whether to expose children and young adults to sports that place them at high risk for multiple concussions. In this issue, Alfano presents his lab's work on multiple concussions in athletes. His multi-year research highlights just how staggeringly common concussions are in university athletes and brings us one step closer to understanding the effects of multiple concussions by examining whether this is associated with an increased risk of mental health problems. He also provides much-needed concussion guidelines for athletes, sports organizations, and parents.

We often hear about the high-profile concussive injuries of professional athletes, like Sidney Crosby, but what about the effects of concussions in children and adolescents? Williams and Spiegler from the Hospital for Sick Children in Toronto, clearly articulate the indispensable role licensed psychologists play in both properly diagnosing pediatric concussions and treating concomitant issues with Cognitive Behavioural Therapy (CBT). Their case example highlights how such treatment serves to properly educate children and their parents, reversing the damage often caused by some of the concussion myths highlighted throughout this issue.

Readers working in the medical-legal realm have surely witnessed substandard concussion evaluations by other healthcare professionals, including psychologists. Wiseman, a clinical neuropsychologist with extensive clinical experience in the assessment and management of concussion within a medical-legal context, provides a step-by-step overview of how to properly conduct an evidence-based forensic evaluation of concussed individuals. Her article is a must-read for anyone involved in medical-legal and independent evaluations.

Finally, readers with a taste for neuroscience will undoubtedly be intrigued by Davis' article on how an older technology (the EEG) is being revitalized with modern statistical techniques, normative databases, faster computers, and more sophisticated amplifiers to shed light on the effects of concussion on the brain's electrical activity. Neuropsychologist readers will be intrigued not only by the potential to use the EEG to identify concussions, but also the use of EEG biofeedback to treat the early effects of concussions and/or comorbid conditions. The EEG can be a valuable tool in clinical settings, but is often misunderstood and underutilized by our profession. I encourage anyone interested in learning more to check out the CPA's Quantitative Electrophysiology Section.

In this special issue, we have gathered articles from some of the top researchers and clinicians to provide you with up-to-date, evidence-based information on concussions. I hope you will come to see that our extensive training in both the ability to produce, comprehend, and critically evaluate research and to diagnose and treat disorders of the mind and brain places us in a unique and, I would argue, ideal position to help tackle the current "*concussion crisis.*"

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

Le rôle de la psychologie dans la « crise des commotions cérébrales »

Chris Friesen, Ph. D., C.Psych., rédacteur en chef invité

Si vous vous tenez au courant de l'actualité, vous avez peut-être l'impression que le taux de commotions cérébrales explose. Peut-être aussi croyez-vous que les commotions cérébrales (appelées également lésions cérébrales traumatiques légères ou LCTL) peuvent entraîner des problèmes à long terme et permanents sur le plan cognitif (p. ex., la sénilité précoce), émotionnel (p. ex., la dépression sévère) et comportemental (p. ex., la toxicomanie, la violence, voire le suicide). Mais y a-t-il vraiment une *« crise des commotions cérébrales »*[1, 2], comme les médias le laissent entendre?

Comme l'attention des médias sur le sujet a augmenté, il en est heureusement de même de la recherche sur les commotions cérébrales. Les professionnels de la santé et les scientifiques de diverses disciplines, notamment la psychologie, essaient de mieux comprendre les effets des commotions cérébrales. J'espère qu'après avoir lu les articles du présent numéro spécial sur les commotions cérébrales, vous comprendrez mieux ce que nous savons et ce que nous ignorons sur celles-ci. J'espère aussi qu'il deviendra évident pour vous combien la psychologie, comme profession, est bien placée pour faire face à la

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prétendue *« crise des commotions cérébrales »* en raison de la formation des psychologues en recherche, en diagnostic, en prise en charge et en traitement.

Avant d'explorer le rôle de la psychologie dans cette *« crise des commotions cérébrales »,* il est important de bien comprendre ce qu'est, et ce que n'est pas une commotion cérébrale. Les commotions cérébrales font partie de la catégorie générale des lésions cérébrales traumatiques (LCT), qui sont causées par un coup direct à la tête ou au corps, l'accélération-décélération (p. ex., coups de fouet cervicaux sans impact à la tête), la pénétration d'un projectile dans le cerveau (p. ex., balle ou éclats d'obus) ou l'exposition aux explosions (p. ex., explosion d'une bombe).

Les LCT sont classées en quatre catégories, selon le niveau de sévérité. Le niveau de sévérité est déterminé par ce qui se passe immédiatement après la blessure, et non par les symptômes qui se développent ou persistent après la phase aiguë. Les facteurs de sévérité sont, notamment : le score de Glasgow (Glasgow Coma Scale [GCS] : une mesure de l'état de conscience) sur les lieux de l'accident ou à l'hôpital, la durée de la perte de conscience (PC), la durée de l'altération de la conscience (p. ex., être abasourdi, confus, incohérent, désorienté, ou présenter une incoordination importante) et la durée de l'amnésie post-traumatique (APT; incapacité à former des souvenirs après la blessure). Reportez-vous au tableau 1 pour plus de détails sur les critères de classification.

La classification en fonction de la sévérité est généralement un bon indicateur des résultats attendus. En général, les personnes qui souffrent de LCT sévère ont des déficits fonctionnels permanents importants. En revanche, même si de nombreuses personnes qui souffrent d'une LCT modérée ont aussi certains déficits fonctionnels permanents, un bon pourcentage d'entre elles se rétablissent bien et retrouvent une vie relativement normale. Comme son nom l'indique, la LCTL est la forme la plus légère de LCT : les personnes qui subissent une LCTL non complexe ont tendance à avoir les meilleurs résultats[3]. Les chercheurs estiment que plus de 80 % de l'ensemble des LCT font partie de la catégorie des LCTL/commotions cérébrales[4].

Comme le montre le tableau 1, il existe deux niveaux de sévérité parmi les LCTL. La LCTL complexe a les mêmes caractéristiques lésionnelles que la LCTL/commotion cérébrale, à l'exception des dommages structurels visibles au cerveau révélés par l'imagerie cérébrale (c.-à-d. tomodensitométrie de la tête ou IRM). En outre, le processus de rétablissement des patients qui ont subi une LCTL complexe ressemble davantage à celui des patients qui souffrent d'une LCT modérée qu'à celui des patients qui ont subi une LCTL/commotion cérébrale[5].

Du point de vue biomécanique, pour qu'une commotion cérébrale se produise, le seuil minimum de la force d'accélération doit être de 70 à 100 g environ[6]. Généralement, la force nécessaire est l'équivalent d'une collision avec un objet fixe, comme un poteau de but ou un autre véhicule à moteur, à 40 km/h; toutefois, une telle force ne conduit pas toujours à une commotion cérébrale.

Du point de vue neurophysiologique, au cours de la phase aiguë, l'impact qui cause la commotion cérébrale entraîne une *« cascade neurométabolique »*, qui mène à un déséquilibre entre le besoin de glucose accru du cerveau en présence d'une baisse du débit sanguin cérébral[7, 8].

Les symptômes qui surviennent après une commotion cérébrale, appelés communément *« syndrome postcommotionnel »*, prennent généralement la forme d'une combinaison de maux de tête, de vertiges, de pertes de mémoire, de problèmes de concentration, d'anxiété, de dépression, d'irritabilité, de troubles du sommeil, de fatigue,

TABLEAU 1 : CLASSIFICATION DE LA LCT SELON LA SÉVÉRITÉ

	GCS	PC	Altération de la conscience	APT	Tomodensitométrie ou IRM
Sévère	< 9/15	> 24 heures	> 24 heures	> 7 jours	Positif ou négatif
Modérée	9-12/15	> 30 minutes, < 24 heures	> 24 heures	> 24 heures< 7 jours	Positif ou négatif
Légère complexe	13-15/15	< 30 minutes	< 24 heures	< 24 heures	Positif
Légère (commotion cérébrale)	13-15/15	< 30 minutes	< 24 heures	< 24 heures	Négatif

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et de sensibilité au bruit et à la lumière. Cependant, comme le soulignent un certain nombre d'auteurs qui collaborent au présent numéro, les chercheurs mentionnent que plusieurs de ces symptômes sont loin d'être spécifiques aux commotions cérébrales. De plus, ces symptômes sont fréquemment signalés après d'autres types de blessures (p. ex., blessures orthopédiques)[9, 10] et chez les personnes en *« bonne santé »*, *« normales »* ou qui n'ont pas subi de blessure[11-17]. En outre, les collaborateurs du présent numéro font remarquer que les effets mesurés d'une commotion cérébrale, enregistrés dans les premiers jours et les premières semaines suivant la survenue de la blessure, sont plutôt légers et se résorbent habituellement pendant cette période chez la grande majorité des personnes[18-21].

Dans le présent numéro, Plourde, Brooks, Kirkwood et Yeates commencent par nous donner un bon aperçu général du rôle que peuvent jouer les psychologues dans l'évaluation et la prise en charge des commotions cérébrales et traitent des variables pré- et post-blessure, souvent oubliées, qui sont susceptibles d'affecter la vitesse de récupération. Ensuite, Longman et Longman détruisent les mythes véhiculés par les profanes et les fournisseurs de soins de santé en ce qui concerne le diagnostic, le traitement et les résultats attendus à la suite d'une commotion cérébrale; si nous voulons jouer efficacement notre rôle, nous devons, à titre de psychologues, être conscients de ces mythes pour faire face à la *« crise des commotions cérébrales »*.

Même si nous comprenons mieux aujourd'hui les effets d'une LCTL/commotion cérébrale isolée, les répercussions des LCTC/commotions cérébrales multiples sont moins claires, car les données de recherche disponibles dans ce domaine ne sont pas cohérentes. Cependant, il est essentiel pour nous, en tant que société, de mieux comprendre ces répercussions, car elles nous permettront de décider de manière éclairée si l'on doit exposer les enfants et les jeunes adultes à des sports qui présentent des risques élevés de commotions multiples. Dans le présent numéro, Alfano présente son travail en laboratoire sur les commotions multiples chez les athlètes. Sa recherche pluriannuelle met en évidence la fréquence incroyablement élevée des commotions cérébrales chez les athlètes universitaires et nous fait comprendre un peu mieux les effets des commotions cérébrales multiples en essayant de déterminer si cela est associé à un risque accru de problèmes de santé mentale. Il fournit également des lignes directrices indispensables sur les commotions cérébrales à l'intention des organisations sportives, des athlètes et des parents.

Nous entendons souvent parler des commotions cérébrales subies par des athlètes professionnels de haut niveau, comme Sidney Crosby, mais qu'en est-il des effets des commotions cérébrales chez les enfants et les adolescents? Williams et Spiegler, de l'Hospital for Sick Children de Toronto, expliquent clairement le rôle indispensable que jouent les psychologues agréés dans l'établissement de diagnostics de commotion cérébrale pédiatrique fiables et le traitement de problèmes concomitants à l'aide de la thérapie cognitivo-comportementale. L'exemple de cas qu'ils utilisent met en lumière l'utilité de ce type de traitement pour éduquer adéquatement les enfants et leurs parents, tout en réparant les dommages causés souvent par certains des mythes sur les commotions cérébrales dont il est question dans le présent numéro.

Les lecteurs qui travaillent dans le domaine médicolégal ont certainement déjà vu des évaluations de commotions cérébrales de piètre qualité, effectuées par des professionnels de la santé, y compris les psychologues. Wiseman, une neuropsychologue clinique qui possède une vaste expérience clinique dans l'évaluation et la prise en charge des commotions cérébrales dans le contexte médicolégal, fournit une vue d'ensemble, étape par étape, de la façon de mener des évaluations médicolégales de qualité, fondées sur des données probantes, auprès de personnes qui ont subi une commotion cérébrale. Son article est un incontournable pour toute personne qui effectue des évaluations médicolégales et indépendantes.

Enfin, les lecteurs qui s'intéressent aux neurosciences seront sans aucun doute intrigués par l'article de Davis, qui traite de la façon dont une technologie ancienne (l'EEG) est en train de renaître grâce aux techniques statistiques modernes, aux bases de données normatives, à des ordinateurs plus rapides et à des amplificateurs plus sophistiqués, pour faire la lumière sur les effets des commotions cérébrales sur l'activité électrique du cerveau. Les neuropsychologues seront intrigués non seulement par la possibilité d'utiliser l'EEG pour identifier les commotions cérébrales, mais aussi par l'utilisation du neurofeedback pour traiter les effets précoces d'une commotion cérébrale ou les troubles comorbides. L'EEG peut s'avérer un outil précieux dans les milieux cliniques, mais il est souvent mal compris et sous-utilisé par notre profession. J'encourage toute personne qui souhaite en apprendre davantage à se renseigner sur la Section d'électrophysiologie quantitative de la SCP.

Dans le présent numéro spécial, nous avons rassemblé des articles de certains des meilleurs chercheurs et cliniciens dans le but de vous fournir des renseignements à jour, fondés sur des données probantes, sur les commotions cérébrales. J'espère que vous serez à même de constater que notre formation approfondie, qui nous rend aptes à produire, comprendre et évaluer la recherche d'un œil critique, et à diagnostiquer et traiter les troubles mentaux et cérébraux, nous place dans une position unique et, je dirais même plus, dans une position idéale pour contribuer à régler la « *crise actuelle des commotions cérébrales* ».

Pour la liste des références, voir www.cpa.ca/psynopsis

The Role of Neuropsychologists and Psychologists in the Care of Concussion

Vickie Plourde, PhD, Cumming School of Medicine, University of Calgary; Brian L. Brooks, PhD, Alberta Children's Hospital and University of Calgary; Michael W. Kirkwood, PhD, University of Colorado School of Medicine and Children's Hospital Colorado; and Keith O. Yeates, PhD, Department of Psychology, University of Calgary

Public awareness of concussion, also called mild traumatic brain injury (mTBI), has increased tremendously in the last few decades. This is in part because of scientific research dedicated to the development and validation of tools measuring the acute effects of concussion, but also because of media attention paid to elite athletes sustaining concussions while playing contact sports. Immediately after sustaining a concussion, people can experience post-concussive symptoms (physical/somatic, such as headaches and pain; sleep disruption and dizziness; cognitive, such as inattention; and emotional, such as irritability) and declines on objective tests of their balance and cognitive functioning (e. g., memory, processing speed, attention).[1]

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What is the time frame to expect for complete recovery after a concussion?

Clinical recovery following a concussion is usually achieved somewhere between 10 days and three months post-injury.[2, 3] Time to recovery varies between individuals based on a number of variables, including the severity of the injury; the number of symptoms experienced immediately post-concussion; pre-injury psychological (e. g., anxiety, depression) or neurodevelopmental (e. g., Attention Deficit/Hyperactivity Disorder, learning difficulties) conditions; the psychosocial environment in which the patient lives; the existence of symptom exaggeration or feigning; and clinical management strategies. Recovery can also take a little longer in children compared to adults.[4] Although most individuals return to their pre-injury functioning within this time frame, a small minority will struggle with persistent post-concussive symptoms that can continue for more than three months, and in some cases for over a year.[5, 6] These individuals are more likely to require long-term medical consultation post-injury for management of some of these symptoms (e.g. post-traumatic headache), as well as neuropsychological and psychological support for recovery.

What is the role of the neuropsychologists and psychologists?

Clinical neuropsychologists and psychologists are involved mainly in providing assessment and intervention services to this population. They can be involved immediately after the concussion to conduct acute assessments, but they usually play a larger role sub-acutely or during the chronic stage post-injury. At these stages, a neuropsychological evaluation tailored to the individual's needs is often recommended if the individual has not yet recovered. This type of evaluation typically includes an initial clinical interview, followed by standardized assessment using population-referenced questionnaires assessing post-concussive and psychological symptoms, as well as tests of cognitive functioning.[7] Validity testing should always be used to assess effort and motivation during the evaluation, as non-credible presentations occur relatively frequently in both adults and children who display persistent post-concussive problems.[8] The neuropsychological evaluation helps to better understand the current functioning of the individual, identify how pre-injury functioning may be influencing the recovery trajectory, and develop recommendations to optimize recovery in multiple life settings, including at home, at school, and at work.[9, 10] Consultation may also be provided, and people involved in patients' care can be steered towards existing resources about concussion, such as the Concussion Awareness Training Tool (http://www.cattonline.com) and the Parachute Canada Organization (parachutecanada.org).

Neuropsychologically-based feedback following the assessment can serve as an effective intervention that promotes concussion recovery. During this session, results of the evaluation are discussed with the individual, as well as with parents when working with children. Education regarding concussion recovery and common symptoms can be provided along with recommendations individualized to patients' needs. The feedback session itself can be beneficial by providing reassurance and increasing knowledge about symptoms and recovery. Other specific, evidence-based interventions can also help to decrease post-concussive symptoms and increase quality of life, such as cognitive behavioural therapy (CBT) for insomnia, anxiety, or depression symptoms. Indeed, because most post-concussive symptoms are not specific to or entirely explained by the concussion, management strategies proposed for other populations presenting with these symptoms may be effective in patients with post-concussive symptoms.

In summary, neuropsychologists and psychologists have a key role in providing care to individuals with concussion who are experiencing persistent symptoms post-injury.[11] However, despite the increasing scientific interest in concussion, more research is needed to continue improving clinical care of these individuals. Neuropsychologists and psychologists will continue to be important players in this arena.

For a complete list of Disclosures, Conflicts of Interest and references, please go to www.cpa.ca/psynopsis

Concussion Myth-Busting: What You Need to Know

R. Stewart Longman, PhD, Alberta Health Services, and Katharina Rach-Longman, PhD, private practice

Concussion, also known as mild traumatic brain injury (mTBI), is the most common type of head injury, with an incidence of 210,000 cases per year in Canada. Given greater reporting and awareness of mTBI, and public concern about long-term consequences, psychologists have an increasingly important role in patient and family assessment, education, treatment, and follow-up. Like other health concerns, the public's knowledge of mTBI consists of a mix of useful information, outdated information, and outright myths that are important to address. Canada has been a leader in early patient education after mTBI,[1] and this information is useful for many psychologists, given the frequency of such injuries.

The following myths about concussions come from our patients, colleagues, and non-expert friends. We debunk them with factual responses.

Diagnosis

MYTH You can diagnose a concussion exclusively by symptoms (as opposed to history).

FACT The criteria for concussion are a force to the head with loss or alteration of consciousness, and symptoms generally start immediately after the injury. The common symptoms of concussion (headache, dizziness, fatigue, light and noise sensitivity, poor concentration, nausea, anxiety) have many causes, and often occur in the absence of brain injury.

MYTH Unconsciousness is necessary for a concussion.

FACT Actually, alteration of awareness (no memory or confused memory for the period immediately after injury) is sufficient for diagnosis.

MYTH Only imaging can confirm a diagnosis of concussion.

FACT Since mTBI is a diagnosis based on history of an event, rather than symptoms, imaging will not confirm a diagnosis of a concussion. However, a proportion of people do show abnormalities on brain imaging (approximately 16% by CT scan, about 33% on MRI),[2] but people with no history of injury may also show abnormalities.

MYTH Concussion can be confirmed by saliva testing/EEG/other techniques.

FACT Although news reports suggest biological tests may help diagnose concussion in the future,[3] mTBI is a diagnosis from history. Without a force to the head, there is no concussion.

Treatment

MYTH Do not sleep after a concussion.

FACT Patients or family might worry about dying in sleep, even weeks after injury. This myth stems from rare catastrophic cases of intracerebral bleeding. Fortunately, gently rousing the individual every few hours in the first night after injury is sufficient. After the first day, they are not at risk.

MYTH Complete physical and mental rest is required. Do not do anything for a week or more after a concussion and stay in a dark, quiet room.

FACT This idea has become popular, but resting for more than about three days is counterproductive.[4] Instead, gradually resuming physical and mental activity, as tolerated, is important. For those who are slow to recover, developing a specific activity plan may help.

MYTH Resume high activity immediately: "Suck it up, don't be a wuss, it's just a concussion."

FACT While gradual increase in activity is helpful, excessive fatigue after concussion can slow recovery. Limiting activity when symptoms are more severe, with gradual increases in physical and mental activity (including social activity and stimulation), appears most helpful.

Expectations

MYTH If you are not better within a week, you will never recover. Or the opposite, a concussion will resolve within 24 hours with no lingering effects.

FACT In media portrayals of concussion, people either recover within minutes, or else never recover. In real life, most athletes recover in days to a week, while non-athletes often need a few weeks, but on average, people appear fully recovered by three months. Most people experience improvement for days or weeks. Tracking improvement, rather than expecting complete recovery within a few days, is helpful for our patients.

MYTH All symptoms following a concussion are attributable to the concussion (i.e. headaches, dizziness, mental lapses, low mood, or pain).

FACT A concussion often occurs with other injuries in a fall, motor vehicle crash, or sports injury, and these also affect recovery. In some people, a vestibular injury can cause persistent dizziness, which can be disabling but effectively treated by our physiotherapy colleagues. Lapses in memory or concentration are common in everyone, but some people become excessively focused on these after concussion. Similarly, pain, anxiety, and medication effects cause distress that should be treated, not just labelled 'postconcussion symptoms.'

MYTH A diagnosis of concussion is a risk for later dementia.

FACT The recent focus on potential long-term consequences in professional athletes has made the term chronic traumatic encephalopathy or CTE, familiar. For those who have one or a few concussions over the course of our lives, there is little evidence for long-term problems. For example, there was no indication of increased dementia in veterans seen up to 50 years after mild brain injury, although there was an increased risk after a severe brain injury.[5] The risk of CTE is still unknown, and epidemiology is just beginning.

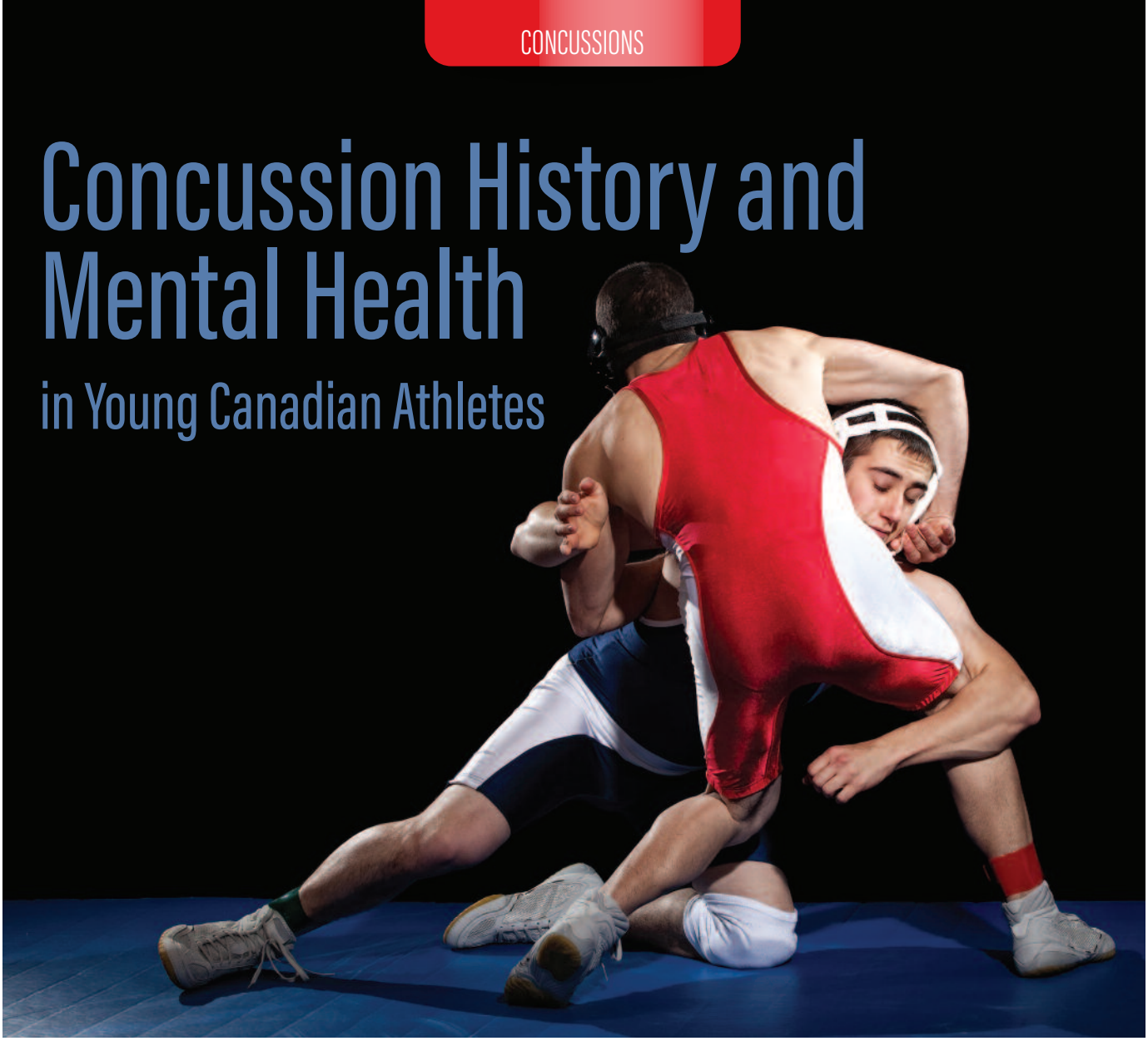
Conclusion

Concussions are common, can be distressing for patients and families when they occur, and myths about common symptoms can increase those worries, thereby exacerbating symptoms. Povіding accurate information, directing patients to appropriate services when necessary, and clarifying misinformation is an important role we have as psychologists in our communities.

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

Concussion History and Mental Health

in Young Canadian Athletes

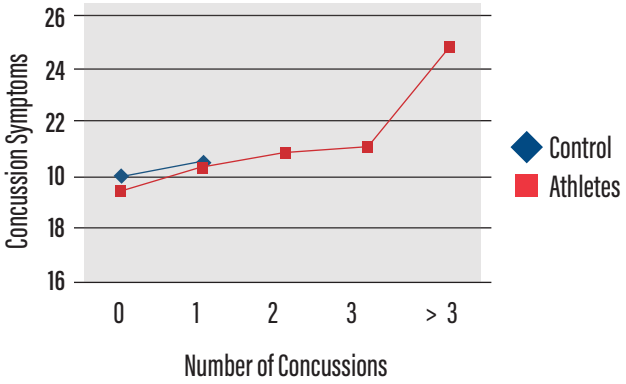


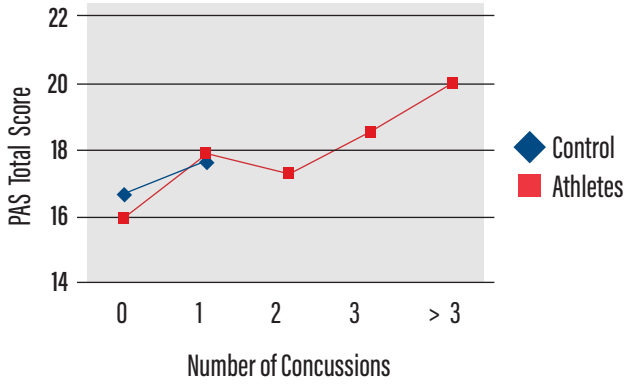
Dennis P. Alfano, Ph.D., C. Psych. (ON), R.D. Psych. (SK)
Fellow, National Academy of Neuropsychology

It seems commonplace these days to hear of another professional athlete who has sustained a concussion and is 'going through the concussion protocol' or who 'passed the concussion test' and is returning to play. The high-profile nature of professional sports has certainly increased public awareness of the significant short and, in some instances, potentially long-term mental health aspects of sports concussion. But just how common is concussion in sports? And to what extent are concerns over concussion-related mental health problems valid? Questions such as these are particularly important to those who value the numerous developmental, social, and health benefits of sports participation but nonetheless recognize the inherent potential for concussive injury, especially with regard to higher risk contact sports, such as ice hockey or football.

A multi-year project on concussions in young Canadian athletes was a focus of research in my neuropsychology laboratory at the University of Regina. Myself and a cadre of senior undergraduate and graduate research assistants studied a sample of 260 university students made up of 160 athletes from the men's and women's ice hockey teams, the men's and women's wresting teams, and the football team, as well as 100 non-athlete controls, none of whom had ever participated in organized sport. The sample overall had a mean age of 20 years.

Epidemiological data from Thurman shows the estimated median annual incidence of traumatic brain injury in children and youth, up to 20 years of age, from all causes to be 691 per 100,000 population for cases treated in emergency departments, with around 20% of cases (averaged across age





ranges) to be the median proportion due to sports or recreational activities.[1] As incidence figures can be somewhat difficult to appreciate, especially in terms of their application to individual cases, we took an appreciably more tangible perspective, where risk of concussion was expressed as career prevalence based on the data obtained from a structured interview assessing health and injury history. The results revealed that overall, 71% of the athletes reported a history consistent with at least one concussion compared to 19% of the non-athlete controls – a difference that is statistically significant and illustrates the substantial risk of a sports concussion beyond the 'base rate' of concussion evident in the non-athlete controls. The data from the athlete groups revealed the following prevalence figures for a history of at least one concussion in individual cases: men's hockey – 92%; women's hockey – 47%; men's wrestling – 70%; women's wrestling – 71%; football – 72%. Young and otherwise healthy Canadian athletes therefore appear to be at a substantially high risk for sustaining a concussion.

The period of recovery from a sports concussion is generally short-lived and the outcome generally good; however, there are factors associated with a more prolonged recovery, including: age, sex, medical (including psychological or psychiatric) history, history of prior concussions, and the early clinical presentation of the concussion itself. An important, albeit controversial, aspect of sports concussion is the idea that multiple concussions may have a cumulative effect on cognitive and emotional functioning, and may increase the risk for longer-term mental health problems. The results from our sample revealed that overall 43% of the athletes reported a history consistent with multiple concussions compared to 5% of the non-athlete controls, a statistically significant difference. History of multiple concussions in individual cases was: men's hockey – 56%; women's hockey – 28%; men's wrestling – 60%; women's wrestling – 43%; football – 40%.

A Concussion Symptom Scale (CSS) and the Personality Assessment Screener (PAS)[2] were also administered to the research participants. The results revealed that number of concussions correlated significantly with CSS and PAS total scores in the athlete group, but not the non-athlete control group. When concussion history was broken into none, one, two, three, or more than three concussions, the relationship between number of concussions and the CSS and PAS revealed a pattern of generally increasing scores, especially on the PAS where the mean score associated with greater than three concussions was sufficiently high to be associated with a potentially clinically significant psychological profile (see charts). Overall, the findings indicated that a history of multiple concussions in young and otherwise healthy Canadian athletes is common and may be associated with increased risk for mental health problems.

So, what should athletes, sports organizations, and parents do?

- Improve awareness and education on sports concussion, associated risks, and primary prevention.
- Create local procedures to identify suspected cases of concussion and remove athletes from play.
- Develop appropriate protocols to treat concussions and foster a safe return to play.
- Recognize that the impact of sports concussion goes beyond the issue of return to play and encompasses short, and sometimes longer-term, academic and mental health aspects of functioning.
- Be vigilant and trust personal instincts when it comes to sports concussions.

When a concussion occurs (or is suspected) and symptoms seem to linger, if there is a history of multiple concussions, or if other medical or mental health problems are pre-existing (e.g., depression, anxiety, learning disability, ADHD), athletes and parents need to advocate aggressively and seek out health care professionals, such as sports neuropsychologists, with specific expertise in the diagnosis, assessment, and treatment of sports concussions.[3] A goal of appropriate clinical management of sports concussion should ideally be to mitigate the risk of longer-term mental health problems.

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

Diagnosis and Management of Pediatric Concussion

Tricia S. Williams, ABPP-CN and
Brenda J. Spiegler, ABPP-CN, Hospital for Sick Children

Though recent media attention has brought greater awareness to pediatric concussion, ironically it has led to considerable misunderstanding of the concept and its anticipated positive recovery trajectory. Misconceptions lead to inaccurate diagnosis and poor clinical management that can cause prolonged distress among youth and their families. In this article we provide evidence-based information about diagnosis and management of pediatric concussion with the goal of improving clinical outcomes for children, youth and their families. We then offer a case example of how mismanagement and personal predisposing factors can support prolonged symptomatology and illustrate how the cognitive behavioural model is well-suited to treat post-concussion distress and disability.

Diagnosis and Acute Management

In the first hours to days following a concussion, diagnosis and management is best done by physicians, largely so they can rule out something other than, or in addition to, concussion. Bleeding (subdural hematoma) or decompensated hydrocephalus, conditions that involve structural changes to the brain,[1] may occur in addition to concussion but are more serious and require a different management plan, including possible surgical intervention. 'Second impact syndrome' is diffuse brain swelling, which is potentially life-threatening but is exceedingly rare and not necessarily attributable to a second or cumulative concussive event.[2, 3] The potential for serious injury does require assessment by a physician, but it is unfortunate that the media, and even legislation, often confuse or consider these conditions in the same conversation as simple concussion.[4]

Once more serious conditions are ruled out, the recovery trajectory of a single, simple concussion is very positive with the majority of individuals recovering within days to weeks.[5-8] It is essential that this recovery message be delivered within the acute phase with appropriate psychoeducation provided about how/when to return to school/sport, how to manage energy conservation, and the expectation for resolution of symptoms.[9-11] Recommendations to children and their parents following concussions have historically focused on cessation of all physical and mental activity; however, total rest or dark room seclusion can be iatrogenic, increasing symptomatology and hindering recovery in children and adults.[11-13] Another frightening message has been that increases in symptoms are detrimental to recovery or cause actual brain damage.[14] There is no evidence that this is the case.

Another tricky issue in the management of pediatric concussion occurs when a diagnosis is made retrospectively, beyond the acute period of injury. In our experience, this can happen weeks, months, and in some cases years later. This is

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poor practice for several reasons. First, symptoms following a concussion emerge and are most severe within the first 24 hours.[1, 8] Certainly, contextual factors, such the adrenaline associated with competition, may mask symptoms in the initial hours, but new symptoms do not emerge spontaneously in the weeks to months following an injury. Second, the non-specificity of concussion symptoms (i.e., headache, fatigue, irritability) also add to the inaccuracy of making retrospective diagnoses given these issues are quite common in the general population.[15-17] Third, retrospective bias has increasing impact over time. One Canadian study showed that parents increasingly underestimate premorbid symptoms and progressively attribute post-injury symptoms to the concussion.[18]

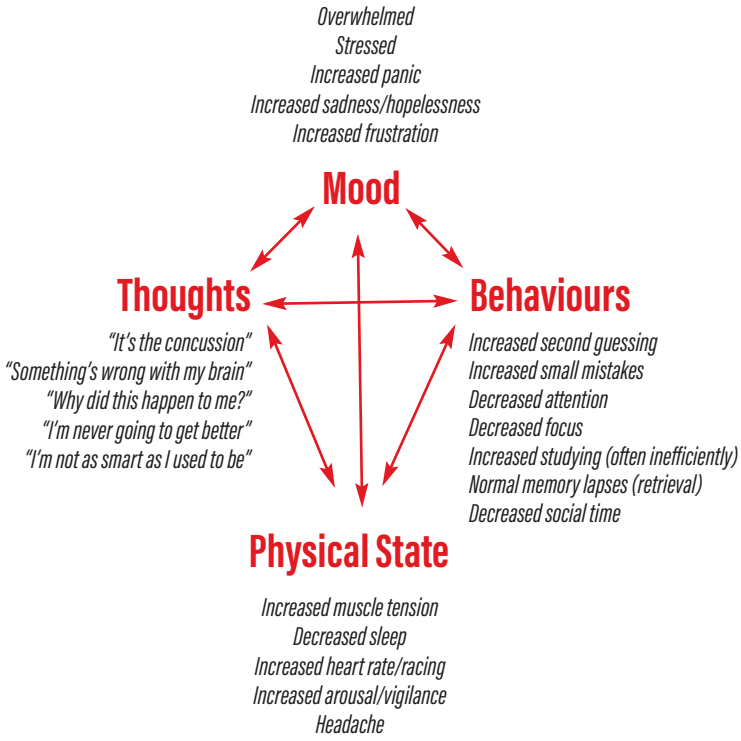
Environmental and individual factors should also be addressed in the management of sub-acute pediatric concussion. The oppressive media attention to the very rare but dramatic cases of catastrophic injury associated with concussion[19] is very worrisome to families. Individual child, parent, and family factors, such as pre-existing anxiety, learning disabilities, and various motivations/secondary gains can influence the experience of concussion and interpretation of even the best delivered messages about recovery.[20-23]

Taken together, knowledge about appropriate diagnosis, the anticipated recovery trajectories, and potential risk factors for prolonged symptomatology places the clinical neuropsychologist in a unique position to manage pediatric concussion beyond the acute phase. Children and youth are often referred for neuropsychological assessments when post-concussive complaints persist beyond typical recovery times with questions about the impact of the concussion on neuropsychological skills such as attention and memory.

Case Example

After three months of missed school following a simple concussion, a 14-year-old, previously well girl was referred for neuropsychological assessment. She and her mother shared the mixed messages they had received from emergency and community-based care including the advice to remain in a dark room with no screen time or social interactions. The young woman described this as "being in jail," which led to increased mental health and cognitive complaints. These, in turn, increased the youth and parent's concern that something serious was "wrong with my/my child's brain." Objective testing and clinical interview reflected strong overall performance but substantial anxiety and attribution of all symptoms to the concussion. The neuropsychologist informed them that her concussion did not cause permanent brain damage and she had likely healed from a concussion perspective.

Following feedback, the teen participated in five one-hour therapy sessions that reviewed cognitive behavioural principles and their application to her association between



performance and concussion (see figure). Session topics included: 1) psychoeducation regarding normal recovery following concussion, 2) introduction to thinking mistakes and thought records as they related to symptoms, 3) connection of thought patterns with mood, 4) review of a personal CBT concussion model, and 5) environmental messaging via media. At the final session, there was substantial reduction in her post-concussion symptoms, and most importantly, none were attributed to her concussion history. The client shared that through the neuropsychological assessment, she learned it was not the concussion that was affecting her, but anxiety that had escalated in its aftermath and that was putting up "walls" and affecting her memory. She learned concussion is not something that is incurable, but something she was able to heal from and return to normalcy.

Summary

This case study offers a poignant example of how important acute diagnosis and appropriate messaging are to recovery following concussion. It highlights the role neuropsychologists can play in assessing and reassuring children and their families following concussion and in guiding them on the path to recovery. Clinical psychologists are encouraged to share this recovery message and not to hesitate to offer treatment for fear that there is something 'neurological' that differentiates these clients and families from others with anxiety or depression that can be effectively addressed by evidenced-based psychological practice.

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

Forensic Assessment of Mild Traumatic Brain Injury (also known as Concussion)

Karen Wiseman, Psy.D., C. Psych., ABPP-CN, Toronto Rehabilitation Institute and independent private practice

Mild traumatic brain injury (mTBI) accounts for 75-85% of all traumatic brain injuries, with an estimated annual incidence of 503 per 100,000.[1] Though they are common, the lasting impact of mTBIs is often overestimated due to misattribution of symptoms. In general, the prognosis for full recovery following a single mTBI is excellent, and any objective evidence of neurocognitive impairment becomes difficult to find as early as 24-48 hours following concussion.[2] Several investigations have also found little evidence of persisting cognitive or emotional difficulty following multiple concussions.[3]

The myth that 10-15% of people with mTBI never recover from mTBI has been disproven by the scientific evidence.[1-3] Furthermore, there are numerous existing well designed studies indicating that "postconcussion syndrome" (PCS) symptoms occur in litigants, injured workers, healthy volunteers, and individuals with chronic pain, depression, anxiety, and orthopaedic injury in the absence of head or brain injury. Some authors even suggest that non-brain injury related factors (i.e. premorbid factors, social and motivational variables, and psychological characteristics) are more probable than brain injury related factors to be responsible for persisting symptoms as early as one month, and certainly by three months post-injury.

Despite this, many healthcare professionals continue to diagnose PCS, implying a causal role of concussion in persisting symptoms.

The following approach to assessment of persisting symptoms following mTBI is suggested to help the evaluating psychologist navigate the morass that concussion/mTBI can become, particularly in a forensic assessment context.

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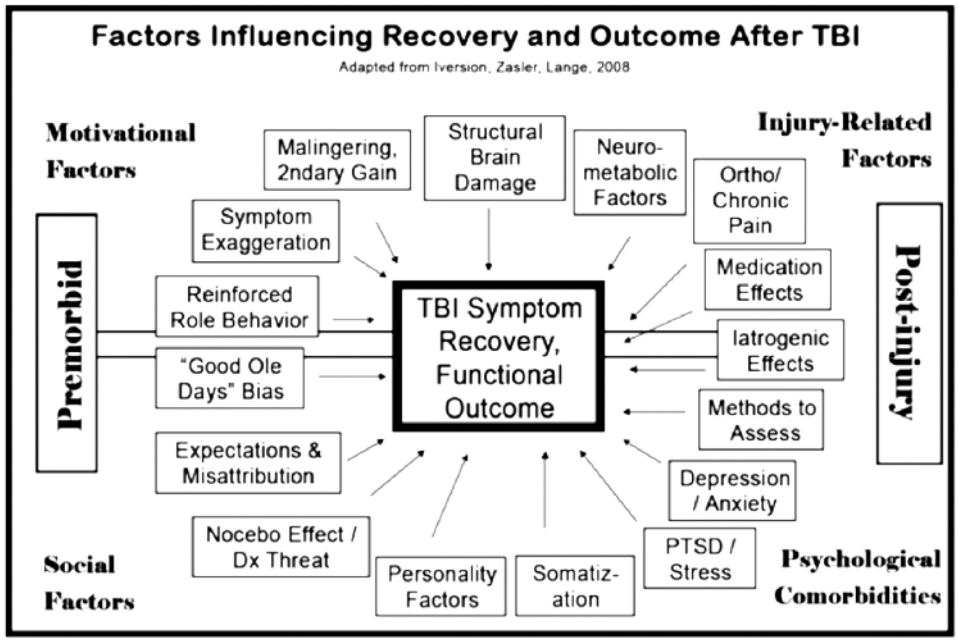
1. Be familiar with the underlying pathophysiology, natural history, and typical outcomes of mTBI. The research regarding mTBI continues to advance, so it is incumbent on any professional working in the field of concussion management to stay abreast of it. The listed references are useful, but not exhaustive.

2. Review any available documentation related to the injury characteristics (e.g., ambulance call reports, ER records, brain imaging reports) to confirm an mTBI did in fact occur before treating someone for persisting symptoms. It is astounding how often the diagnosis of concussion is made due to reported symptoms when there is no evidence to support it.



This figure is useful when evaluating persistent complaints following mTBI.4

3. Request pre-injury records. I am often provided with a host of post-injury records, but it is the pre-injury records that are particularly useful in determining the extent to which premorbid or concurrent psychosocial factors may be responsible for persisting symptoms.

4. Conduct a thorough interview, and a separate collateral interview when appropriate. While gathering information about symptoms is an important component of assessment, diagnosis based exclusively on checklists is not advised because it is well documented that symptoms can be elicited by checklists themselves.[1, 2] A combination of open-ended and specific questions in the context of a diagnostic interview is necessary. This should include a thorough investigation of premorbid and social variables that may be impacting symptoms in the aftermath of mTBI.

5. Evaluate validity through behavioural observation with an eye for consistency, pattern analysis, use of stand-alone or embedded cognitive performance validity indicators, and use of psychological measures with validity scales. Base rates of malingering in mTBI can be as high as 40% in compensation seeking contexts; therefore, no meaningful or defensible conclusions regarding impairment can be drawn in the absence of validity testing. In addition, sometimes statements about injury severity, current function and prognosis can be made even when cognitive or psychological data are invalid.

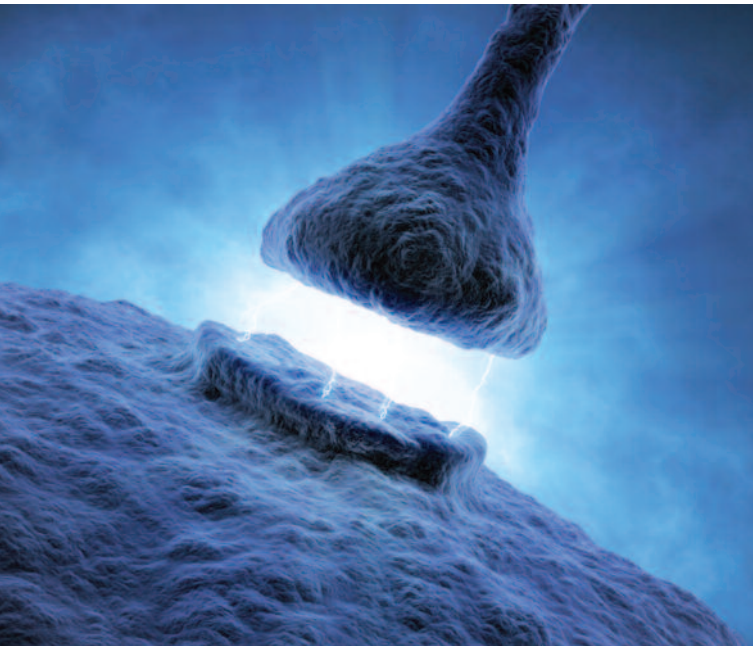
6. Conduct a thorough assessment of cognition, using appropriately validated and normed instruments. Include measures of psychological functioning with validity scales, and in cases of an expected contribution of premorbid learning or developmental difficulties, be sure to include achievement measures and ideally a review of premorbid academic records.

7. When interpreting cognitive data, remember that cognitive deficits are not proof of brain injury. The evidence that a brain injury occurred and the severity of brain injury is found in the acute injury characteristics, not in cognitive data remote from the injury.

8. Consider differential diagnoses. Those most relevant in the context of chronic symptoms following mTBI include Malingering or Factitious Disorder; Somatoform Disorder (including chronic pain); substance use, particularly alcohol abuse; and developmental conditions, including Specific Learning Disorder, Attention-Deficit/ Hyperactivity Disorder, and personality disorders. Accident related Adjustment Disorder, major mood disorders, and anxiety disorders may also be relevant. Be aware of potential medication effects and the impact of litigation on symptom expression as well.

9. Finally, when arriving at a final conclusion, be careful to weigh the potential value of diagnosis against any possible iatrogenic effect of misdiagnosis or over-diagnosis. Sometimes cognitive test results reflect normal intra-individual variability that should not be diagnosed as a neurocognitive disorder, and sometimes an emotional reaction is a normal and adaptive reaction to a change in life circumstance. Diagnostic labels and associated treatment prescriptions can prolong symptoms rather than ameliorate them, particularly in a forensic context.

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



Mild Traumatic Brain Injury and Quantitative EEG

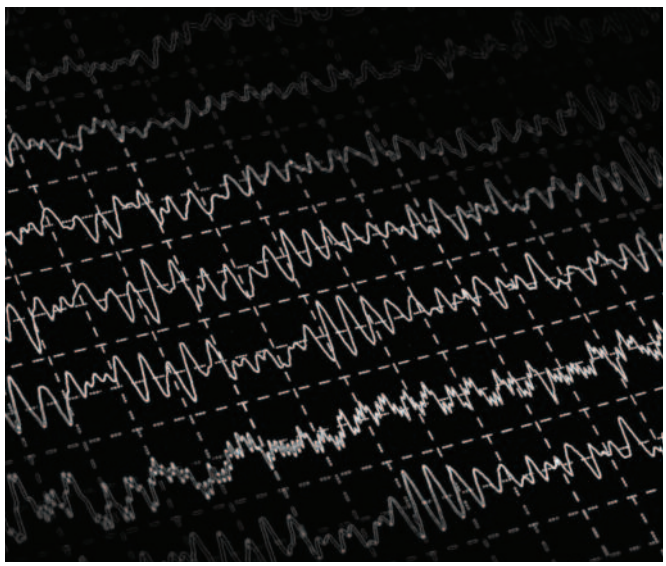
John Davis, Ph.D., C.Psych., ABPP,
Hamilton Health Sciences and McMaster University

Quantitative EEG (qEEG) methods look at how the brain functions by measuring the electrical activity of neurons, the cells in the brain that send information with their electrical impulses. [1, 2, 3] This electrical activity of the brain can be examined in single cells, or in regions made up millions of neurons. The larger groups of neurons produce activity that is organized into voltage waves or oscillations of various speeds, and plays a significant role in perception, thinking, emotional experience, and action. The aim of qEEG methods that study mild traumatic brain injury (mTBI), or concussion, is to see where and how parts of the brain may perform differently than normal after injury, so that effective diagnoses and treatments can be developed and decisions can be made about return to activities.[4]

Conventional EEG assessment examines what looks like a collection of squiggly lines that represent the various frequencies of electrical activity at multiple brain locations as they play out over time. This kind of visual EEG assessment is not done routinely after TBI because of the inconsistent relationship between the EEG findings and post-injury symptoms.[5, 6] In contrast, qEEG assessment converts the "squiggles" of the brain waves into reliable numeric measures that show details of brain function that cannot otherwise be seen.

After mTBI, the most consistent findings are of brain wave slowing, and changes in information coordination or transfer between parts of the brain.[5, 7-20] The slowing of brain wave oscillations can occur throughout the brain or be limited to a more localized area.[17] qEEG findings have also shown abnormal differences in activation between the two sides of the brain or increases in faster brain wave activity. After mTBI, qEEG measures can be highly sensitive to areas of bleeding and help in the rapid identification of patients at risk,[21, 22] and basic scientific research has used qEEG measures to better understand specific types of damage that can occur because of mTBI, such as diffuse axonal injury breakdown of the blood-brain barrier.[13] In addition to such "resting state" qEEG findings, cognitive event-related potentials (ERPs) may also show changes that suggest altered brain reactivity and transmission of information after mTBI.[14, 23]

Research is currently underway on the potential utility of qEEG metrics to help to make decisions about when a person is ready to resume activity or return to competitive sport, with the goal of preventing repeated concussion and poor



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recovery.[24] A recent finding has been that qEEG changes after mTBI last longer than measured changes in thinking and behaviour.[25] Some research also suggests that qEEG findings can be combined with measures of thinking and posture to predict a person's ability to function later in their recovery after mTBI.[26] Although EEG abnormalities that are present soon after mTBI usually resolve within weeks to months, as many as 10% of those who have had an mTBI show ongoing EEG changes.[5, 10]

While qEEG changes do occur after a head injury, they may not be specific to TBI,[5] and may be related to other disorders. Therefore, efforts are under way to develop mathematical combinations of qEEG measures that are uniquely related to TBI.[16, 18, 23, 24] At this time, however, qEEG findings alone are not able to show conclusively that a person has or has not had an mTBI, or whether a person who has had an mTBI is experiencing ongoing symptoms because of persisting changes in their brain due to trauma.

Based on the association of abnormal EEG patterns and problems with thinking, emotion, and behaviour after mTBI, research and clinical practice has begun using qEEG biofeedback to normalize brain wave patterns. This type of biofeedback uses sensors to measure a person's EEG activity, and presents sounds and visual displays to the person based on computer analysis of their EEG activity. Such feedback about their brain activity shows the person when it changes toward the desired goal. The delivery of this instantaneous information reinforces more normal brain activity with the objective of improving thinking, emotional regulation, and behaviour.

EEG biofeedback for ADHD, for example, has shown evidence of improving attention and inhibition, and causing changes in the structure and function of the brain itself.[27, 28] Results with individuals who have sustained a TBI have begun to show similar findings.[29-31] For clinical conditions, EEG biofeedback is usually provided together with conventional treatments by licensed health professionals. As newer EEG measures develop to assess the function of entire brain networks, it may become possible to match individuals with specific qEEG profiles to specific treatments following mTBI.

With a significant amount of basic science and clinical research now underway, qEEG methods show promise for becoming useful tools in the diagnosis and treatment of mTBI when used in combination with other methods. Because of their excellent training in research, assessment, and treatment related to behaviour and its biopsychosocial foundations, psychologists are in a unique position to lead collaborative teams in both academic and clinical settings.

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

CPA HIGHLIGHTS

Karen R. Cohen, Ph.D., C. Psych, Chief Executive Officer and
Lisa Votta-Bleeker, Ph.D., Deputy CEO and Director, Science Directorate

Below is a list of our top activities since the last issue of *Psynopsis*. Be sure to check http://cpa.ca/Psynopsis/ for a complete list of our activities, and 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 Avocacy Win!

In December 2016, we learned the federal government was considering taxing the premiums Canadians pay on the health and dental benefits received through employment. To oppose the tax we: drafted a letter on behalf of the Health Action Lobby (HEAL) calling on the Minister of Finance not to institute this tax; joined a subset of HEAL organizations to give a press conference on Parliament Hill, circulate a joint press release, meet with MPs of all parties, and launch an online letter-writing campaign; and sent our own letter to the Minister of Finance detailing why the proposed tax was a regressive one for mental health services in Canada. Thanks to these efforts and your active support, the prime minister announced in the House of Commons on February 1 that the government would not be implementing the tax!

2 Section Engagement

We are committed to engaging with our sections, on a rotating basis, to discuss ways in which we can work together to bring greater attention to the subject matters our sections address. As part of this commitment, we met with the executive of the Section for Educational and School Psychology and the chair of the Section for Students in November and December 2016, respectively. In 2015, we met with the chairs of the Developmental, Industrial/Organizational, and Social and Personality Sections.

3 Health Accord – Lobbying for Access to Psychological Services Through Proposed Targeted Funds for Mental Health

Over the last months, we have been actively meeting with the federal government to discuss our recommendations for enhancing access to psychological services under the new Health Accord. We have had meetings with the Prime Minister's Office, the Minister of Health and a number of her key staff, senior staff from the Public Health Agency of Canada, and the Liberal Mental Health Caucus to name a few. In December, the provinces and territories all declined to accept the Health Accord offer but 12 provinces and territories have since accepted the Accord bilaterally. We have recommended two options to government, and to our provincial psychology association partners, for the use of the targeted funds: an adaptation of the UK's Improving Access to Psychological Therapies (IAPT) program or the integration of psychologists and psychological services into primary care. More recently we met with our eastern psychological association partners to refine those recommendations into a model that would work in Eastern Canada. We had an excellent meeting and we plan to support the advocacy efforts of the eastern provincial psychological associations promoting the model with governments.

http://www.cpa.ca/docs/File/Government%20Relations/Targeting%20funds%20for%20better%20access%20to%20quality%20mental%20health%20care%20for%20Canadians%20February%202017final.pdf

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4 Fundamental Review of Science in Canada

In late September 2016, the Science Directorate (in consultation with the Scientific Affairs Committee) developed a white paper on issues affecting psychology researchers in Canada. The paper was submitted to a panel convened by Minister of Science, Kirsty Duncan, to look at issues related to fundamental science in Canada. Over 1,250 submissions were made to the panel. We now eagerly await the report, which is currently with the Minister of Science, and are exploring ways to bring the findings of the report to members.

http://cpa.ca/docs/File/News/CPA_ScienceReviewSubmission_Final_30Sept2016.pdf

5 CPA Journals Meet Open Access Requirements

In October 2016, we met with representatives from the American Psychological Association (APA), the Social Sciences and Humanities Research Council, the editors of our three journals, and our director for science and liaison to the Publications Committee to discuss open access. We are in full compliance with the tri-council policy on open access for publicly-funded research – authors can make the pre-publication version of their articles open access via a repository one year following publication in a CPA journal (i.e. green access), or authors can make their articles open access at the time of publication for a publishing fee of $3,000 USD (i.e. gold access). Introductions to special issues are also open access. The APA will revise instructions to authors in order to better promote what is available to support open access.

6 Support from Family Physicians

Dr. Cohen met with the CEO of the College of Family Physicians and Surgeons about developing a joint position on integrating psychologists and mental health services into primary care. This meeting resulted in a joint letter to the Minister of Health advocating for mental health investments in primary care. The letter was developed in consultation with our presidential officers and the chair of our Professional Affairs Committee.

http://cpa.ca/docs/File/Press%20Release/Mental%20Health%20joint%20letter%20Jan%202017%20CFPC%20CPA.pdf

7 Canadian Consortium for Research (CCR)

On January 20, Dr. Votta-Bleeker and the CCR hosted the 5th annual breakfast with the funders at our office with representatives from SSHRC, CFI, NSERC, and Mitacs. Information provided at the breakfast, along with the report from the Fundamental Science Review, will form the basis for the CCR's 2017 advocacy efforts.

8 New Editor of the *Canadian Journal of Behavioural Science*

The Board of Directors is pleased to announce that Dr. E. Kevin Kelloway, CPA Past President, has been named the next Editor for CJBS (2017- 2022). Dr. Kelloway began his term as Editor-Elect in January 2017. The CPA and its Board extends its sincerest thanks to Dr. William Roberts for his service as Editor. Dr. Roberts will serve as outgoing Editor in 2017, with his term ending in December 2017.

9 International Initiative for Mental Health Leadership

Dr. Cohen attended the February 2017 conference of IIMHL in Australia. The theme of the conference was contributing lives, thriving communities. She also met with the CEO of the Australian Psychological Society to discuss Australia's success with its federally-funded improving access to psychologists' program, a leaders' meeting for ICAP 2018, and common association issues. Upon the recommendation of the CEO of the MHCC, Dr. Cohen was asked to join an international clinical leaders table of the IIMHL, which will host its inaugural meeting in Washington in 2017.

10 Mental Health Commission of Canada (MHCC)

Mr. Matt Murdoch has joined MHCC's national collaborative for suicide prevention on behalf of the CPA and attended a meeting of the collaborative in Iqaluit in October 2016. Dr. Cohen continues to sit on the MHCC's advisory committee on e-mental health, which met in November 2016 and, most recently, in January in Vancouver. The meeting included presentations on the tele-psychology work by Drs. Heather Hadjistavropoulos (University of Regina) and Peter Cornish (Memorial University of Newfoundland) who did an outstanding job and were very well received by the delegates.

FAITS SAILLANTS des activités de la SCP

Karen Cohen, Ph. D., C. Psych., chef de la direction, et
Dre Lisa Votta-Bleeker, Ph. D., directrice générale associée et directrice de la Direction générale de la science

Voici la liste des principales activités menées depuis la publication du dernier numéro de *Psynopsis*. Ne manquez pas de visiter le http://cpa.ca/Psynopsisfr/ pour consulter la liste complète de nos activités, et écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique mensuel, *Nouvelles de la SCP*, pour vous tenir au courant de toutes les choses que nous accomplissons pour vous!

1 Victoire de la représentation!

En décembre 2016, nous avons appris que le gouvernement fédéral envisageait d'imposer les cotisations des employeurs aux régimes de soins médicaux et dentaires, ce qui en ferait un revenu imposable pour les Canadiens. Pour nous opposer à cet impôt, nous avons rédigé une lettre au nom du Groupe d'intervention action santé (GIAS), demandant au gouvernement d'abandonner son projet d'instaurer cet impôt et nous nous sommes joints à des organisations membres du GIAS pour donner une conférence de presse sur la Colline du Parlement, faire circuler un communiqué de presse commun, rencontrer les députés de tous les partis et lancer une campagne épistolaire en ligne. Pour finir, nous avons envoyé notre propre lettre au ministre des Finances, dans laquelle nous expliquons pourquoi l'impôt proposé constitue un impôt dégressif pour les services de santé mentale au Canada. Grâce à ces efforts et à votre soutien efficace, le premier ministre a annoncé à la Chambre des communes, le 1er février, que le gouvernement renoncera à mettre en application cet impôt!

2 Participation des sections

Nous nous sommes engagés à rencontrer les sections, à tour de rôle, afin de discuter des façons de travailler ensemble pour attirer l'attention sur les sujets qui intéressent les sections. Dans le cadre de cet engagement, nous avons rencontré le comité de direction de la Section de la psychologie éducationnelle et scolaire et la présidente de la Section des étudiants, en novembre et en décembre 2016, respectivement. En 2015, nous avons rencontré les présidents de la Section du développement, de la Section de la psychologie industrielle/organisationnelle et de la Section de la psychologie sociale et de la personnalité.

3 Accord sur la santé – Lobbying pour l'accès aux services psychologiques au moyen de fonds ciblés destinés à la santé mentale

Au cours des derniers mois, nous avons rencontré à plusieurs reprises le gouvernement fédéral pour discuter de nos recommandations en vue d'améliorer l'accès aux services psychologiques dans le cadre du nouvel Accord sur la santé. Nous avons tenu des réunions avec le Cabinet du Premier ministre, la ministre de la Santé et certains membres clés de son personnel, des hauts fonctionnaires de l'Agence de la santé publique du Canada et le caucus libéral sur la santé mentale, pour ne nommer que ceux-là. En décembre, les provinces et les territoires ont tous refusé d'accepter l'Accord sur la santé proposé, mais depuis, 12 provinces et territoires ont accepté une entente bilatérale sur les transferts en santé. Nous avons recommandé deux options au gouvernement et aux associations provinciales de psychologues en ce qui a trait à l'utilisation de fonds ciblés, à savoir : une adaptation du programme Improved Access to Psychological Therapies (IAPT) du Royaume-Uni ou l'intégration des psychologues et des services psychologiques aux soins primaires. Dernièrement, nous avons rencontré nos associations partenaires de psychologues de l'est du pays pour adapter ces recommandations et en faire un modèle qui pourrait fonctionner dans l'est du Canada. Cette rencontre a été très fructueuse, et nous avons l'intention de soutenir les efforts de représentation des associations provinciales de l'est pour faire la promotion de ce modèle auprès des gouvernements.

http://www.cpa.ca/docs/File/Government%20Relations/Targeting%20funds%20for%20better%20access%20to%20quality%20mental%20health%20care%20for%20Canadians%20February%202017final.pdf

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4 Examen du soutien fédéral à la science fondamentale

À la fin de septembre 2016, la Direction générale de la science (en collaboration avec le Comité des affaires scientifiques) a élaboré un livre blanc sur les problèmes auxquels sont confrontés les chercheurs en psychologie au Canada. Le document a été présenté à un groupe d'experts créé par la ministre des Sciences, Kirsty Duncan, chargé d'examiner les questions liées à la science fondamentale au Canada. Plus de 1 250 mémoires et documents ont été adressés au groupe d'experts. Nous attendons avec impatience le rapport, qui est maintenant entre les mains de la ministre des Sciences, et explorons les moyens que nous pourrions utiliser pour communiquer les conclusions du rapport aux membres.

http://cpa.ca/docs/File/News/CPA_ScienceReviewSubmission_Final_30Sept2016.pdf

5 Les revues de la SCP répondent aux exigences en matière de libre accès

En octobre 2016, nous avons rencontré des représentants de l'American Psychological Association (APA), le Conseil de recherches en sciences humaines (CRSH), les rédacteurs en chef de nos trois revues, ainsi que l'administrateur de la science de la SCP et point de contact avec le Comité des publications, afin de discuter du libre accès. Nous respectons en tous points la politique des trois organismes sur le libre accès à la recherche financée par les fonds publics. En effet, les articles publiés dans une revue de la SCP sont accessibles en libre accès dans leur version finale. Pour ce faire, l'auteur archive son article dans un dépôt (appelé « green access ») ou, s'il choisit l'option « gold access », l'auteur publie son article en libre accès moyennant des frais de 3 000 $ US. Les introductions des numéros spéciaux sont également offertes en libre accès. L'APA révisera les instructions à l'intention des auteurs pour faire mieux connaître les outils et mécanismes qui existent pour appuyer le libre accès.

6 Soutien de la part des médecins de famille

La Dre Cohen a rencontré la directrice générale et chef de la direction du Collège des médecins de famille du Canada afin de discuter de l'élaboration d'une position commune sur l'intégration des psychologues et des services de soins de santé mentale aux soins primaires. Cette réunion a donné lieu à une lettre commune adressée à la ministre de la Santé, qui fait la promotion des investissements en santé mentale dans les soins primaires. La lettre a été rédigée en collaboration avec les présidents de la SCP et le président du Comité des affaires professionnelles.

http://cpa.ca/docs/File/Press%20Release/Mental%20Health%20joint%20letter%20Jan%202017%20CFPC%20CPA.pdf

7 Consortium canadien pour la recherche (CCR)

Le 20 janvier, la Dre Votta-Bleeker et le CCR ont tenu, dans nos locaux, le 5e petit-déjeuner annuel avec les bailleurs de fonds, auquel ont participé des représentants du Conseil de recherches en sciences naturelles et en génie (CRSNG), de la Fondation canadienne pour l'innovation, du CRSH et de Mitacs. L'information fournie au petit-déjeuner, ainsi que les résultats de l'examen du soutien fédéral à la science fondamentale, constituera la base des efforts de représentation que déploiera le CCR en 2017.

8 La *Revue canadienne des sciences du comportement (RCSC)* a un nouveau rédacteur en chef

Le conseil d'administration est heureux d'annoncer que le Dr E. Kevin Kelloway, président sortant de la SCP, a été nommé rédacteur en chef de la RCSC pour la période de 2017 à 2022. Le Dr Kelloway a entamé son mandat de rédacteur en chef désigné en janvier 2017. La SCP et son conseil d'administration offrent ses plus sincères remerciements au Dr William Roberts, pour son travail comme rédacteur en chef de la revue. En 2017, le Dr Roberts occupera la fonction de rédacteur en chef sortant, son mandat se terminant en décembre 2017.

9 International Initiative for Mental Health Leadership (IIMHL)

La Dre Cohen a assisté au congrès de l'IIMHL, en février 2017, en Australie. Le thème de la conférence était « contribuer à la vie, avec des collectivités prospères ». Elle a également rencontré la chef de la direction de l'Australian Psychological Society pour discuter de la réussite du programme financé par le gouvernement pour améliorer l'accès aux psychologues, mis sur pied en Australie, d'une réunion éventuelle avec les dirigeants à l'ICAP 2018 et de questions communes aux deux associations. Sur recommandation de la chef de la direction de la Commission de la santé mentale du Canada (CSMC), la Dre Cohen a été invitée à se joindre au groupe des chefs cliniques internationaux de l'IIMHL, qui tiendra sa première réunion à Washington en 2017.

10 Commission de la santé mentale du Canada (CSMC)

M. Matt Murdoch a rejoint, au nom de la SCP, le Groupe de collaboration national sur la prévention du suicide mis sur pied par la CSMC, et a participé à une réunion du Groupe de collaboration à Iqaluit en octobre 2016. La Dre Cohen continue de siéger au comité consultatif de la CSMC sur la cybersanté mentale, qui s'est réuni en novembre 2016 et, tout récemment, en janvier, à Vancouver. Dans le cadre de cette réunion, les Drs Heather Hadjistavropoulos (Université de Regina) et Peter Cornish (Université Memorial de Terre-Neuve) ont fait des présentations sur le travail de psychologue en ligne. Tous deux ont fait un travail remarquable et ont été très bien reçus par les délégués.

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2017 Elections for the CPA Board of Directors

Instructions for Nominations

As per By-Law 5.06, any CPA member can submit a nomination for election to the Board of Directors for the open positions, **not less than 30 nor more than 65 days prior to the date of the Annual General Meeting of Members (AGM). A call for an advance vote will be issued within 29 days before the AGM.** Advance voting will occur by electronic vote using the same system as in 2016.

In early April 2017, a call for nominations will be issued for the following six positions:

- President-Elect
- Practitioner
- Director representing Section on Students
- Director representing the Council of Professional Associations of Psychologists (CPAP)
- Director representing the Canadian Council of Professional Psychology Programs (CCPPP)
- Director representing the Canadian Society for Brain, Behaviour and Cognitive Science (CSBBCS)

Please take this opportunity to speak with colleagues and friends over the next few months about running for a seat on the CPA Board of Directors. Your association needs you – membership engagement makes for a strong and successful organization!

Information about nomination requirements and procedures will be communicated via CPA News and posted on our website. For more information about elections at any time, please contact Cara Bernard at cbernard@cpa.ca.

Current Board Representation

The current balance of the Board and its voting membership is as follows:

- **President**
  David Dozois, University of Western Ontario, London, ON, Clinical Psychology (term ending in June 2018)
- **Past-President**
  Kevin Kelloway, Saint Mary's University, Halifax, NS, Industrial/Organizational Psychology (term ending in June 2017)
- **President-Elect**
  Patrick Baillie, Alberta Health Services, Calgary, AB, Clinical and Forensic Psychology (term ending in June 2019)

Directors with Terms Ending in June 2017

- **Practitioner**
  Samuel Mikail, Sun Life Assurance, Aurora, ON, Clinical Psychology
- **Director representing Section on Students**
  Zarina Giannone, University of British Columbia, BC, Counselling Psychology
- **Director representing CPAP**
  Andrea Piotrowski, University of Manitoba, Winnipeg, MB, Clinical Health Psychology
- **Director representing CCPPP**
  Rupal Bonli, Royal University Hospital, Saskatoon, SK, Clinical Health Psychology
- **Director representing CSBBCS**
  Jean Saint-Aubin, Université de Moncton, Brain and Cognitive Science

Directors with Terms Ending in June 2019

- **Scientist**
  Douglas Mewhort, Queen's University, Kingston, ON, Brain and Cognitive Science
- **Scientist-Practitioner**
  Kimberly Corace, University of Ottawa, Ottawa, ON, Clinical Health Psychology
- **At-large**
  Fern Stockdale Winder, Saskatoon Health Region, Saskatoon, SK, Clinical Health Psychology
- **At-large reserved for a Francophone**
  David Bourgeois, Saint Mary's University, Halifax, NS, Social Psychology
- **At-large reserved for a Masters level member**
  Milena Meneghetti, Calgary, AB, Counselling/Clinical Psychology
- **Director representing CCDP**
  Valerie Thompson, University of Saskatchewan, SK, Brain and Cognitive Science

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Élection des membres du conseil d'administration de la SCP de 2017

Instructions relatives aux mises en candidature

Conformément au paragraphe 5.06 des règlements administratifs, les membres peuvent présenter une candidature aux postes ouverts au conseil d'administration, **au moins 30 jours et pas plus de 65 jours avant la date de l'assemblée générale annuelle des membres (AGA). L'annonce du vote par anticipation sera publiée dans les 29 jours précédant l'AGA.** Le vote par anticipation se fera par voie électronique à l'aide du même système que celui utilisé en 2016.

Au début d'avril 2017, les six postes suivants seront officiellement mis en candidature :

- Président désigné
- Praticien
- Administrateur représentant la Section des étudiants
- Administrateur représentant le Conseil des sociétés professionnelles de psychologues (CSPP)
- Administrateur représentant le Conseil canadien des programmes de psychologie professionnelle (CCPPP)
- Administrateur représentant la Société canadienne pour le cerveau, le comportement et les sciences cognitives (SCCCSC)

Nous vous invitons donc, au cours des prochains mois, à encourager vos collègues et vos amis à envisager de siéger au conseil d'administration de la SCP. Votre association a besoin de vous. Le dynamisme et la réussite de l'organisation dépendent de l'engagement de ses membres!

Des renseignements sur les exigences et la procédure de mise en candidature vous seront communiqués via les Nouvelles de la SCP, et affichés sur notre site Web. Pour plus d'informations sur les élections, vous pouvez communiquer, en tout temps, avec Cara Bernard, à cbernard@cpa.ca.

Composition actuelle du conseil d'administration

Voici la composition du conseil d'administration et les membres votants qui y siègent actuellement.

- **Président**
  David Dozois, Université Western, London, Ontario, psychologie clinique (mandat prenant fin en juin 2018)
- **Président sortant**
  Kevin Kelloway, Université Saint Mary's, Halifax, Nouvelle-Écosse, psychologie industrielle/organisationnelle (mandat prenant fin en 2017)
- **Président désigné**
  Patrick Baillie, Alberta Health Services, Calgary, Alberta, psychologie clinique et judiciaire (mandat prenant fin en juin 2019)

Administrateurs dont le mandat se termine en juin 2017

- **Praticien**
  Samuel Mikail, Sun Life Assurance, Aurora, Ontario, psychologie clinique
- **Administrateur représentant la Section des étudiants**
  Zarina Giannone, Université de la Colombie-Britannique, Colombie-Britannique, psychologie du counseling
- **Administrateur représentant la CSPP**
  Andrea Piotrowski, Université du Manitoba, Winnipeg, Manitoba, psychologie clinique de la santé
- **Administrateur représentant le CCPPP**
  Bonli Rupal, Royal University Hospital, Saskatoon, Saskatchewan, psychologie clinique de la santé
- **Administrateur représentant la SCCCSC**
  Jean Saint-Aubin, Université de Moncton, Nouveau-Brunswick, cerveau et sciences cognitives

Administrateurs dont le mandat se termine en juin 2019

- **Administrateur – scientifique**
  Douglas Mewhort, Université Queen's, Kingston, Ontario, cerveau et sciences cognitives
- **Administrateur – scientifique-praticien**
  Kimberly Corace, Université d'Ottawa, Ottawa, Ontario, psychologie clinique de la santé
- **Administrateur non désigné**
  Fern Stockdale Winder, Saskatoon Health Region, Saskatoon, Saskatchewan, psychologie clinique de la santé
- **Administrateur non désigné représentant les francophones**
  David Bourgeois, Université Saint Mary's, Halifax, Nouvelle-Écosse, psychologie sociale
- **Administrateur non désigné représentant les psychologues au niveau de la maîtrise**
  Milena Meneghetti, Calgary, Alberta, psychologie clinique/counseling
- **Administrateur représentant le CCDP**
  Valerie Thompson, Université de la Saskatchewan, Saskatchewan, cerveau et sciences cognitives

2017 CPA National Convention

Our 2017 National Convention is fast approaching! Here's what you need to know to start planning your trip.

Where and When

Fairmont Royal York, Toronto, Ontario, Canada
Thursday June 8, 2017 – Saturday June 10, 2017

Getting There

Flying with WestJet or Air Canada? Use the following booking codes to get your discounted rate!

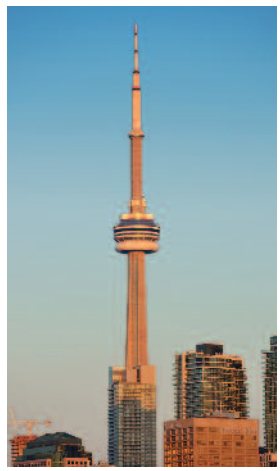
– WestJet flight booking code: NLYPGGT
– WestJet travel agent web use only promo code: YYZOI
– Air Canada flight booking code: TBTF4TE1

Where to Stay

The Fairmont Royal York is a historic Toronto luxury hotel recognized as one of the 2016 Top Hotels in Canada by Condé Nast Traveler readers. It is located in the center of downtown Toronto, minutes away from the city's biggest attractions.

We've secured a block of rooms starting at $235.00 per night. All rooms in the block are available on a first come, first serve basis. Visit https://aws.passkey.com/go/cpaannualconvention2017 or call Fairmont's Global Reservations Centre at 1-800-441-1414 to book your room today! Be sure to mention that you are attending the CPA Convention in June 2017.

What to Do



Toronto is a dynamic and lively city with lots to see and do. Make the most of your trip and check out some of what Toronto has to offer! Here's a few ideas:

- Looking for daring adventure? Try the **CN Tower EdgeWalk** and circle the 356 meter high tower roof! Red jumpsuits and harnesses not you thing? Take the elevator up to the top of the tower to take in amazing city views and to stand on the glass floor.
- Head under the sea at the new **Ripley's Aquarium of Canada**. The Aquarium features North America's longest underwater viewing tunnel with more than 5.7 million litres of water and over 100 interactive opportunities.

- Check out a show! Watch the National Ballet of Canada perform Neumeier's ballet version of ***A Streetcar Named Desire*** at the Four Seasons Centre for the Performing Arts or listen to hills come alive at the new production of ***The Sound of Music***, directed by Tony Award winner Jack O'Brien, at the Ed Mirvish Theatre.

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- Show your pride! The annual **Pride Toronto festival** has become a major Canadian arts and cultural event and the largest Pride celebration in North America. Check out some of the many events happening throughout the month of June.

- Learn about the hockey greats; go one-on-one against life-sized, animated versions of today's greatest goalies and shooters; and get your close up with Lord Stanley's cup at the **Hockey Hall of Fame**! Home to the largest collection of hockey memorabilia in the world, the museum is a must see for any hockey fan.

Must See Convention Keynotes

Reality TV Meets Psychology

Presenters:
Erin Brock, Executive Producer & Supervising Producer, Big Brother Canada
Arisa Cox, Host, Big Brother Canada
Former Houseguest #1 (TBC), Big Brother Canada
Former Houseguest #2 (TBC), Big Brother Canada
Steven Stein, Psychologist, Big Brother Canada

The influence of reality TV has become increasingly prominent over the past decade. Big Brother, one of the earliest and more popular reality shows, is now produced in over 40 countries, and Big Brother Canada gets over one million Canadian viewers glued to their screens every week! What is it that attracts us to these shows? Many bear a small resemblance to psychology experiments of the 1960's and 1970's, such as the famous Zimbardo prison experiment.

In Big Brother Canada a selection of houseguests live together for up to 10 weeks, facing a constant series of challenges, both physical and mental. Each week the houseguests vote out one of their members until there is a winner at the end, requiring a unique set of social skills to survive.

This session will look at the importance of psychology in these shows. Topics will include the effects of the experience on participants, impact on viewers, public education on mental health issues, precautions taken for participants, psychological screening in casting, and more. Perspectives will be presented from the show's producer, its on-air host, former participants, and the show's psychologist.

Presidential Address

Dr. David Dozois

Dr. David Dozois is a Professor in the Department of Psychology at the University of Western Ontario. He is also a member of the Clinical Psychology area, and cross-appointed with the Department of Psychiatry and is currently serving as the Director of the Clinical Psychology Graduate Program. He received his Ph.D. in Clinical Psychology from the University of Calgary (1999). His predoctoral internship training was completed at the Queen Elizabeth II Health Sciences Centre in Halifax, Nova Scotia. He is a former Beck Scholar and he had the opportunity to participate in a one-year training program at the Beck Institute for Cognitive Therapy and Research (2003-2004). He is a Fellow of the Academy of Cognitive Therapy and a certified cognitive therapist.

Honorary President's Address

Dr. Pim Cuijpers

Dr. Pim Cuijpers is professor of Clinical Psychology at the Vrije Universiteit Amsterdam and head of the Department of Clinical Psychology. He is also vice-director of the EMGO Institute of Health and Care Research of the VU University and the VU University Medical Center. Pim Cuijpers has published about 350 peer reviewed papers, chapters, reports and professional publications on the epidemiology, etiology, prevention and (early) treatment of depression, and on guided self-help for depression. He is also involved in a series of meta-analytic studies on psychotherapy for adult depression (www.evidencebasedpsychotherapies.org).

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Congrès national de la SCP de 2017

Notre congrès national de 2017 approche à grands pas! Voici ce que vous devez savoir pour commencer à planifier votre voyage.

Où et quand

Fairmont Royal York de Toronto, en Ontario
Jeudi 8 juin 2017 – Samedi 10 juin 2017

Pour s'y rendre

Vous volez avec WestJet ou Air Canada? Utilisez les codes de réservation ci-dessous pour obtenir votre rabais.

- Code de réservation des vols de WestJet : NLYPGGT
- Pour les réservations effectuées sur le site pour agents de voyage de WestJet, utilisez le code promotionnel : YYZOI
- Code de réservation des vols d'Air Canada : TBTF4TE1

Où sejourner

L'hôtel Fairmont Royal York est un hôtel historique luxueux de Toronto, reconnu en 2016 comme l'un des meilleurs hôtels du Canada par les lecteurs du magazine *Condé Nast Traveler*. Il est situé au centre-ville de Toronto, à quelques minutes des principales attractions de la ville.

Nous avons réservé un bloc de chambres au tarif de 235 $ la nuitée et plus. Toutes les chambres mises à la disposition des déléguées sont disponibles selon le principe du premier arrivé, premier servi. Visitez le https://aws.passkey.com/go/cpaannualconvention2017 ou appelez le Centre mondial des réservations des hôtels Fairmont au 1-800-441-1414 pour réserver votre chambre dès aujourd'hui! N'oubliez pas de mentionner que vous assistez au « congrès de la SCP », qui se tient en juin 2017.

Quoi faire à Toronto

Toronto est une ville dynamique et animée, qui recèle de choses à voir et à faire. Profitez de votre séjour et découvrez ce que Toronto a à offrir au visiteur! Voici quelques idées :

- Vous voulez vivre une aventure audacieuse? Essayez **L'HAUT-DA CIEUX** de la tour CN et faites le tour de l'observatoire de la Tour, à 356 m dans les airs! Les combinaisons rouges et les harnais ne sont pas votre truc? Prenez l'ascenseur jusqu'au sommet de la tour pour admirer des vues saisissantes de la ville et faites quelques pas sur le plancher de verre.

- Plongez sous la mer au nouvel **Aquarium Ripley du Canada**. L'Aquarium possède le plus long tunnel sous-marin d'observation en Amérique du Nord, qui vous fait traverser plus de 5,7 millions de litres d'eau et vous propose plus de 100 activités interactives.
- Allez voir un spectacle! Voyez le Ballet national du Canada exécuter l'adaptation pour le ballet, réalisée par Neumeier, de la pièce ***A Streetcar Named Desire***, au Four Seasons Centre for the Performing Arts; ou encore, venez entendre les collines prendre vie, dans la nouvelle production de ***The Sound of Music***, dirigée par le gagnant du Tony Award, Jack O'Brien, au Ed Mirvish Theatre.
- Affichez votre fierté! Le festival annuel de la **Fierté gaie de Toronto** est devenu un événement artistique et culturel d'envergure et la plus grande célébration de la fierté en Amérique du Nord. Informez-vous sur les nombreux événements qui se dérouleront tout au long du mois de juin.

- Découvrez les grands noms du hockey, mesurez-vous aux versions animées grandeur nature des meilleurs gardiens de but et marqueurs de notre époque et venez voir de près la coupe de Lord Stanley au **Temple de la renommée du hockey**! Avec la plus grande collection de souvenirs de hockey du monde entier, le musée est un incontournable pour tous les amateurs de hockey.

Des conferences à ne pas manquer

La téléréalité rencontre la psychologie

Présentée par :
Erin Brock, directrice et superviseure de la production, Big Brother Canada
Arisa Cox, animatrice, Big Brother Canada
Ancien invité nº 1 (à confirmer), Big Brother Canada
Ancien invité nº 2 (à confirmer), Big Brother Canada
Steven Stein, psychologue, Big Brother Canada

Au cours de la dernière décennie, l'influence de la téléréalité est devenue de plus en plus grande. Big Brother, l'une des plus anciennes et plus populaires émissions de téléréalité, est produit aujourd'hui dans plus de 40 pays, et Big Brother Canada rassemble, chaque semaine, plus d'un million de téléspectateurs canadiens, rivés à leur écran. Mais qu'est-ce qui nous attire dans ces programmes? Plusieurs téléréalités présentent certaines similitudes avec des expériences psychologiques menées dans les années 1960 et 1970, comme la célèbre expérience de Stanford, de Zimbardo.

Dans Big Brother Canada, des invités sélectionnés vivent ensemble jusqu'à 10 semaines, au cours desquelles ils doivent surmonter une série de défis successifs, à la fois physiques et mentaux. Chaque semaine, les invités votent pour exclure l'un de leurs membres jusqu'à ce qu'il ne reste qu'une personne, qui devient le gagnant de la téléréalité. Pour survivre, les candidats doivent posséder un ensemble unique d'aptitudes sociales.

Pendant la conférence, les présentateurs examineront l'importance de la psychologie dans ces émissions. Ils aborderont différents sujets, comme les effets de l'expérience sur les participants, les répercussions sur les téléspectateurs, la sensibilisation du public sur les problèmes de santé mentale, les précautions prises pour protéger les participants, l'évaluation psychologique des candidats potentiels pour faire le choix des participants, et plus encore. Les points de vue de la productrice, de l'animatrice, d'anciens participants et du psychologue de l'émission seront présentés.

Allocution du président

Dr David Dozois

Le Dr David Dozois est professeur au département de psychologie de l'Université Western. Il est également membre du volet de la psychologie clinique. Nommé conjointement par le département de psychiatrie, il est actuellement le directeur du programme d'études supérieures en psychologie clinique. Il a obtenu son doctorat en psychologie clinique de l'Université de Calgary (1999). Il a effectué son stage prédoctoral au Queen Elizabeth II Health Sciences Centre, à Halifax, en Nouvelle-Écosse. Ancien récipiendaire d'une bourse d'études du Beck Institute, il a eu la chance de participer à un programme de formation d'un an au Beck Institute for Cognitive Therapy and Research (2003-2004). Il est un fellow de l'Academy of Cognitive Therapy et un psychologue spécialisé en thérapie cognitive certifié.

Allocution du président honoraire

Dr Pim Cuijpers

Le Dr Pim Cuijpers est professeur de psychologie clinique à l'université libre d'Amsterdam et chef du département de psychologie clinique. Il est également le vice-directeur de l'EMGO Institute of Health and Care Research et du centre médical universitaire de la même université. Pim Cuijpers a publié environ 350 articles évalués par les pairs, chapitres, rapports et publications professionnelles sur l'épidémiologie, l'étiologie, la prévention et le traitement (précoce) de la dépression, ainsi que sur les stratégies d'autosoins guidés pour soigner la dépression. Il a également participé à une série de méta-analyses sur la psychothérapie pour le traitement de la dépression chez l'adulte (www.evidencebasedpsychotherapies.org).

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Call for Journal Editors

Canadian Journal of Experimental Psychology

Call for Nominations
Editor:2018-2022

The Board of Directors of the Canadian Psychological Association (CPA) has opened nominations for the editorship of *Canadian Journal of Experimental Psychology* for the years 2018-2022. Candidates should be available to start receiving manuscripts in 2018, to prepare for issues to be published in 2019.

The *Canadian Journal of Experimental Psychology* is published in collaboration with the Canadian Society for Brain, Behaviour and Cognitive Science (CSBBCS) within a printing agreement with the American Psychological Association (APA).

Editors are members of both the CPA and BBCS. To nominate candidates (or to self-nominate), prepare a brief statement of approximately one page in support of each nomination.

Nominations, accompanied by the nominee's vitae, should be submitted before April 1, 2017 to:

Dr. Lisa Votta-Bleeker
ATTENTION: Chair, CPA Publications Committee
Canadian Psychological Association
Email: executiveoffice@cpa.ca

Interested individuals may obtain more information directly from the Editor, Dr. Penny Pexman, via email at pexman@ucalgary.ca.

Revue Canadienne de psychologie expérimentale

Demande de mises en candidature
Rédacteur en chef : 2018 - 2022

Le Conseil d'administration de la Société canadienne de psychologie (SCP) sollicite des mises en candidature pour le poste de rédacteur en chef de la *Revue canadienne de psychologie expérimentale* pour la période 2018-2022. Les candidats doivent être disposés à recevoir des manuscrits dès 2018 afin de préparer les numéros qui paraîtront en 2019.

La *Revue canadienne de psychologie expérimentale* est publiée en collaboration avec la Société canadienne des sciences du cerveau, du comportement et de la cognition (SCSCCC) dans le cadre d'une entente d'impression avec l'American Psychological Association (APA).

Les rédacteurs sont à la fois membres de la SCP et de la SCSCCC. Pour proposer un candidat (ou pour poser votre candidature), vous devez présenter un énoncé d'environ une page, appuyant chaque candidature.

Les candidatures, ainsi que le curriculum vitae du candidat proposé, doivent être transmises avant le 1er avril 2017 à :

Dre Lisa Votta-Bleeker
ATTENTION : Présidente, Comité des publications de la SCP
Société canadienne de psychologie
Courriel : executiveoffice@cpa.ca

Les personnes intéressées peuvent obtenir des renseignements complémentaires en communiquant par courriel avec la rédactrice en chef de la revue, la Dre Penny Pexman, l'adresse suivante : pexman@ucalgary.ca.

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Canadian Psychology

Call for Nominations
Editor: 2018 through 2022

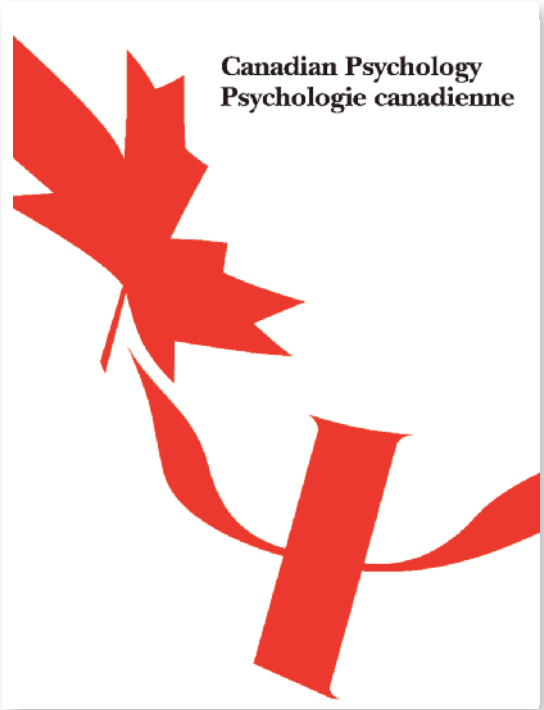
The Board of Directors of the Canadian Psychological Association (CPA) has opened nominations for the editorship of *Canadian Psychology* for the years 2018 through 2022.

Candidates must be members of the CPA and should be available to start receiving manuscripts January 1, 2018 to prepare for issues to be published in 2019.

To nominate candidates (or to self-nominate), prepare a brief statement of approximately one page in support of each nomination. Nominations, accompanied by the nominee's vitae, should be submitted before April 1, 2017 to:

Dr. Lisa Votta-Bleeker
Chair, CPA Publications Committee
Email: executiveoffice@cpa.ca

Interested individuals may obtain more information directly from the Editor, Dr. Martin Drapeau via email at martin.drapeau@mcgill.ca.



Psychologie canadienne

Demande de mises en candidature
Rédacteur en chef : 2018 – 2022

Le conseil d'administration de la Société canadienne de psychologie (SCP) sollicite des candidatures pour le poste de rédacteur en chef de *Psychologie canadienne* pour la période de 2018 à 2022.

Les candidats doivent être membres de la SCP et être disposés à recevoir les manuscrits à compter du 1er janvier 2018 afin de préparer les numéros qui paraîtront en 2019.

Pour proposer un candidat (ou pour poser votre candidature), vous devez présenter un énoncé d'environ une page, appuyant chaque candidature. Les candidatures, ainsi que le curriculum vitæ du candidat proposé, doivent être transmises avant le 1er avril 2017 à :

Dre Lisa Votta-Bleeker
Présidente, Comité des publications de la SCP
Courriel : executiveoffice@cpa.ca

Les personnes intéressées peuvent obtenir des renseignements supplémentaires en communiquant par courriel avec le rédacteur en chef de la revue, le Dr Martin Drapeau, à l'adresse suivante : martin.drapeau@mcgill.ca.

A Gathering of Psychologists in Japan for Two Conferences

IACCP president Patricia Greenfield and Minoru Karasawa the chair of the organizing committee formally opened the conference with a Japanese drum beat.

Five-story pagoda of the Koshoji temple, Nagoya.

Gira Bhatt, Ph.D., Secretary and Member of the CPA's International Relations Committee

In the summer of 2016, the Land of the Rising Sun was the venue for two major international conferences that brought together psychologists from all over the world to share research, expertise, and knowledge gathered from diverse contexts and populations.

The 31st International Congress of Psychology (ICP), which took place in Yokohama, was attended by nearly 8,000 participants, representing 95 countries. Asia had the greatest presence (65%), followed by Europe (9%) and North America (9%), the Pacific region (2.5%), Africa (2%), the Middle East (2%), and Latin America and the Caribbean (2%). The president of the organizing committee, Kazuo Shigemasu, along with his team of 103 members, ensured that the program followed the conference theme of "*Diversity in Harmony: Insights from Psychology*" and pervaded across 63 topic categories.

Princess Akishino Kiko, who has a degree in psychology, gave a welcoming speech during the opening ceremony. She also attended the dinner reception that was organized for the invited speakers of the ICP congress. The opening lecture was delivered by Hiroshi Ishiguro (Osaka U) on *Adaptation to Teleoperate Robots*.

The scientific program included an invited address on "*Globalization and terrorism – finding more effective approaches to preventing violence and promoting peace around the world*" by Canadian psychologist, Janel Gauthier, President of the International Association of Applied Psychology and Chair of the CPA International Relations Committee. David Dozois, President of the CPA was also among the 129 invited speakers. The event featured 120 invited symposia organizers, eight of which were Canadian scholars, including one invited symposium that was organized

by Saba Safdar, President of the next congress of the International Association for Cross-Cultural Psychology (IACCP) to be hosted in Canada in 2018. Consistent with the theme of the ICP congress, the symposium focused on "*The problems and possibilities of diversity*" in different regions of the world, including Canada. The next ICP will be hosted in Prague, Czech Republic from July 25-29, 2020.

The other exciting psychology event held in Japan was the 23rd Congress of the International Association for Cross-Cultural Psychology (IACCP), which was held in Nagoya. Keeping with the city's unique characteristic of being both modern and traditional, the theme of this congress was "*Honoring Traditions and Creating the Future.*"

There were two pre-congress workshops. The first, "Teaching cultural psychology: Course Design and Learning Activities" was hosted by Beth Morling (USA) and Benjamin Cheung (Canada). It was highly interactive and provided very helpful teaching tips. The second, "Cultural Neuroscience: Accomplishments so far and Future Directions" was organized by Shinobu Kitayama (USA), Shihui Han (China), Michele Gelfand (USA) and Yan Mu (USA). It focused on the cutting edge research on brain and culture.

The congress, which was attended by 1,031 delegates from 56 countries, began with an opening ceremony at the Nagoya university campus where the IACCP president Patricia Greenfield, the Congress organizing committee chair Minoru Karasawa (Japan), and the chair of the scientific program Masaki Yuki beat a traditional Japanese drum to proclaim the official start of the congress. The congress also featured several cultural and social events. A cultural tour of the Koshoji temple introduced visitors to Zazen Buddhist meditation led by the temple monk. This calming session was followed by a very traditional tea ceremony in the beautiful tea house, where visitors were greeted by kimono-clad hostesses who served the tea while explaining the significance of the ritual. A day tour of Kyoto was organized for delegates who wished to experience the cultural heart of Japan.

These two congresses provided an excellent platform for psychologists from across the world to mingle and to find common grounds amidst different perspectives through face to face meetings, international networking opportunities, and collegial bonding. Both ICP and IACCP were a testimony to harmony.

The next IACCP will be hosted in Guelph, Canada from July 1-5, 2018, on the heels of the 29th International Congress of Applied Psychology, which will be hosted by the CPA June 26-30, 2018. The CPA looks forward to welcoming delegates from around the world to beautiful Montreal, Canada to explore the link between research and practice through the theme "Psychology: Connecting Science to Solutions."

A lighter moment at IACCP dinner event: Masaki Yuki, chair of the scientific program show-casing his body-builder-wannabe self.

Photography by Thaddeus Pope, IAFOR Media.

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Canadian Code of Ethics for Psychologists, Fourth Edition: Completed and Approved

Carole Sinclair, Ph.D., Chair, CPA Committee on Ethics

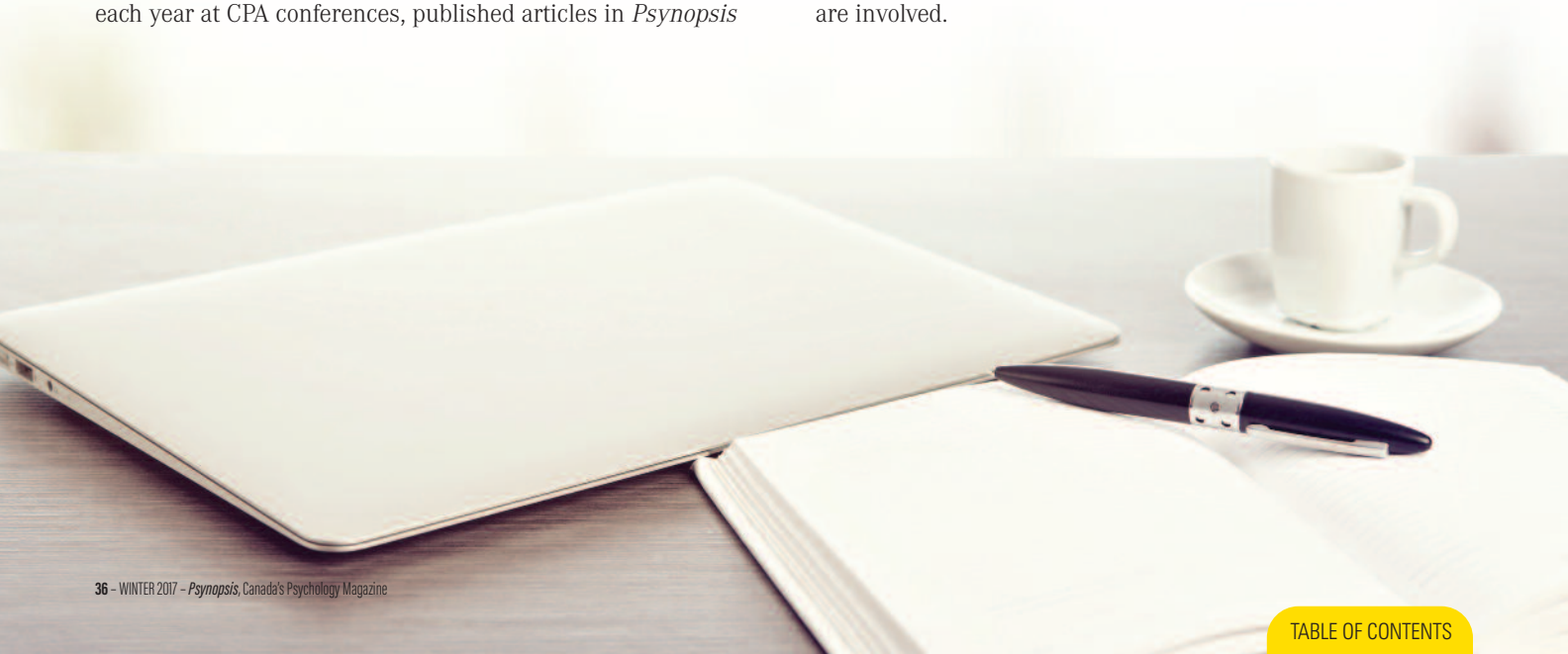
The Committee on Ethics is delighted to report that the *Fourth Edition* of the *Canadian Code of Ethics for Psychologists* was approved unanimously by the Canadian Psychological Association (CPA) Board of Directors on January 30, 2017.

The first edition of the *Canadian Code* was adopted by CPA in 1986, with revisions in 1991 and 2000. A review of the 2000 *Code* was launched in 2010 and, as with previous revisions, the process included: (a) a review of all comments/inquiries regarding the *Code* since 2000; (b) a review of international and interdisciplinary ethics literature since 2000, with identification of new issues, areas of activity, and events related to ethics; and (c) multiple rounds of consultation with various stakeholders, including CPA members, Canadian psychology organizations, Canadian psychology programs, and members of the public.

In addition to surveying CPA members and Canadian psychology organizations regarding what they believed to be the strengths and weaknesses of the *Code* and what they thought needed to be added, updated, or clarified, the CPA Committee on Ethics gave presentations and held discussions each year at CPA conferences, published articles in *Psynopsis* summarizing the feedback received, and widely circulated two complete drafts of the proposed *Fourth Edition* of the *Code* in 2015 and 2016, with invitations to comment and provide feedback.

The feedback indicated strong endorsement of the following features of the *Code*: (a) its emphasis on ethical decision making, including provision of a model for decision making; (b) the aspirational and flexible nature of the *Code*; (c) the four ethical principles and the organization of the *Code* around these principles; and (d) the ordering of the principles. These have all been preserved in the *Fourth Edition*.

However, the review process also indicated five core areas that that needed to be clarified, updated, enhanced, or added, namely: (a) newer ideas regarding ethical decision making and education and training in ethics; (b) rapid growth in the development and use of electronic and digital technologies; (c) rapid increase in collaborative/interdisciplinary relationships and approaches; (d) diversity and the impact of globalization; and (e) the need for more guidance in sorting out responsibilities to different parties when third parties are involved.



The following is a brief summary of some of the major changes in the *Fourth Edition* as they relate to the above core areas:

- **In response to the core area of ethical decision making:** (a) former sections "When Principles Conflict" and "The Ethical Decision Making Process" have been combined into a single section called "Ethical Decision Making;" (b) more emphasis has been added in the ethical decision-making steps on the need for consideration of context, including personal and cultural context; and (c) more emphasis has been placed on personal character in ensuring ethical behaviour (e.g., the following statement regarding responsibilities of the individual psychologist was added: "Engage in ongoing development and maintenance of their ethical sensitivity and commitment, ethical knowledge, and ethical decision-making skills").

- **In response to the core area regarding technologies:** (a) a statement was added to the introduction clarifying that the ethical principles and values apply regardless of the modality of activity, including use of electronic/digital technologies; and (b) reference to electronic/digital technologies has been added to the examples throughout the *Code*. (The 2000 *Code* contained no such examples.)

- **In response to the core area of collaborative/ interdisciplinary activities:** The words "collaborate," "interdisciplinary," and "team" have been incorporated into all sections of the *Code* (Definitions, Values Statements, Ethical Standards), with an emphasis on responsibilities to clients, research participants, and those with whom psychologists collaborate. (These words now appear a total of 36 times. They appeared a total of only three times in the 2000 *Code*.)

- **In response to the core area of diversity and globalization:** (a) in line with CPA's endorsement of the *Universal Declaration of Ethical Principles for Psychologists* in 1998, and after much consultation, discussion, and deliberation, the name of Principle I in the *Code* has been changed to "Respect for the Dignity of Persons and Peoples" and the term "peoples" has been added throughout the *Code*; (b) references to "culture" have been increased throughout the *Code* (doubling the number of times it was used in the 2000 *Code*); and (c) Principle III regarding boundaries as they relate to cultural context has been clarified, including the idea that multiple relationships can sometimes be beneficial in such contexts.

- **In response to the core area of sorting out responsibilities to different parties:** (a) addition/changes have been made to definitions of different types of clients, including "primary client," "contract examinee," "retaining party," and differential use of these terms in the *Code*; (b) more differentiation has been made between "interests" and "best interests," including adding a definition of "best interests;" (c) greater emphasis has been made on the need to "balance the potential harms and benefits" and to take into account the "degree and moral legitimacy of conflicting interests."

In addition to responding to the above five core areas, the *Fourth Edition* of the *Code* also contains many other changes, including:

- Updates consistent with changes to the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.
- Updates to the *Code*'s section on "Care of Animals" (Principle II) consistent with the thinking reflected in recent national and international documents on this topic.
- Change of the phrase "serious physical harm or death" to "imminent serious bodily harm" in response to changes in thinking and laws regarding harm and end-of-life decision making, and in line with the way other major psychology ethics codes are dealing with the topic (e.g., British Psychological Society, Australian Psychological Society, European Federation of Psychologists' Associations). (Note: Canadian law includes psychological harm as well as physical harm in the definition of "bodily harm.")
- Changes to the first Ethical Standard under the Principle II value of *Maximize benefit*, that increase the *Code*'s emphasis on the importance of psychological services being based on the best available evidence.
- Additional definitions of several terms (e.g., best available evidence, community, discipline of psychology, group, just laws, organization, persons, peoples, society, and vulnerable), and more consistency in the use of all terms.

The *Companion Manual to the Canadian Code of Ethics for Psychologists* and CPA's web-based course "Being an Ethical Psychologist" are now being revised to reflect the changes in the *Fourth Edition*. However, the current versions of each of these will remain available until the updated versions are released.

The Committee on Ethics wishes to thank all those who took the time to contribute their thoughts, ideas, and suggestions during the review and revision process. The *Fourth Edition* would not have been possible without your help.

Le *Code canadien de déontologie professionnelle des psychologues, quatrième édition :* terminé et approuvé

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

Le Comité de déontologie est heureux de vous annoncer que la *quatrième édition* du *Code canadien de déontologie professionnelle des psychologues* a été approuvée à l'unanimité par le conseil d'administration de la Société canadienne de psychologie (SCP) le 30 janvier 2017.

La première édition du *Code*, adoptée par la SCP en 1986, a été révisée en 1991 et en 2000. La révision de la version du *Code* de 2000 a été lancée en 2010 et, comme ce fut le cas des révisions précédentes, le Comité de déontologie a procédé comme suit : (a) examen de tous les commentaires/questions sur le *Code* transmis depuis 2000; (b) revue de la littérature internationale et interdisciplinaire sur l'éthique parue depuis 2000, et identification des questions, domaines d'activités et événements nouveaux liés à la déontologie; (c) tenue de plusieurs séries de consultations auprès de divers intervenants, y compris les membres de la SCP, les organisations de psychologie au Canada, les programmes de psychologie au Canada et les membres du public.

En plus de sonder les membres de la SCP et les organisations de psychologie au Canada sur ce qu'ils considéraient comme les forces et les faiblesses du *Code* et sur les points qui, à leur avis, devaient être ajoutés, mis à jour ou clarifiés, le Comité de déontologie de la SCP a donné des présentations et tenu des discussions, chaque année, au congrès de la SPC, a publié des articles dans *Psynopsis*, qui résumaient les commentaires reçus, et a largement diffusé, en 2015 et 2016, deux ébauches de révision complètes de la *quatrième édition* du *Code*, en plus de solliciter les commentaires sur les projets de révision proposés.

Les commentaires reçus révèlent que les personnes et les organisations consultées appuient fortement les aspects suivants du *Code* : (a) l'accent mis sur la prise de décisions éthiques, y compris le modèle de processus décisionnel fourni; (b) la nature ambitieuse et souple du *Code*; (c) les quatre principes déontologiques et la structure du *Code* basée sur ces principes; (d) l'ordre des principes. Ces éléments sont tous maintenus dans la *quatrième édition*.

Cependant, le processus de révision a également mis en évidence cinq domaines clés qui méritent d'être clarifiés, mis à jour, améliorés ou ajoutés, à savoir : (a) l'émergence d'idées nouvelles au sujet de la prise de décisions éthiques, et de l'enseignement et la formation en éthique; (b) la croissance rapide du développement et de l'utilisation des technologies électroniques/numériques; c) l'augmentation rapide des relations et des approches de collaboration/interdisciplinaires; (d) la diversité et l'impact de la mondialisation; (e) la nécessité d'orientations plus précises sur la répartition des responsabilités des différentes parties lorsque des tierces parties sont impliquées.

Voici un résumé de certains des principaux changements apportés à la *quatrième édition* en ce qui a trait aux domaines clés dont il est question ci-dessus :

- **En ce qui concerne la prise de décisions éthiques :** (a) les anciens articles « Conflits entre les principes » et « Le processus de prise de décision éthique » ont été regroupés en un seul article intitulé « La prise de décisions éthiques »; (b) un accent accru est mis sur les étapes à suivre pour prendre des décisions éthiques, dont celle exigeant de prendre en considération le contexte, y

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compris le contexte personnel et le contexte culturel; (c) un accent accru est mis sur les caractéristiques personnelles dans l'observation de comportements éthiques (p. ex., un énoncé concernant les responsabilités du psychologue est ajouté, à savoir : « se livrer à une démarche continue de développement et de maintien de sa sensibilité et de son engagement à l'égard de l'éthique, de ses connaissances sur l'éthique et de ses compétences en matière de prise de décisions éthiques »).

- **En ce qui concerne les technologies :** (a) un énoncé est ajouté à l'introduction qui précise que les principes et les valeurs éthiques s'appliquent indépendamment de la modalité de l'activité, y compris l'utilisation des technologies électroniques/numériques; (b) la référence aux technologies électroniques/numériques est ajoutée à tous les exemples donnés dans le *Code*. (Le *Code* de 2000 ne contenait aucun exemple.)

- **En ce qui concerne les activités en collaboration et les interventions interdisciplinaires :** les mots « collaborer », « interdisciplinaire » et « équipe » sont intégrés à tous les articles du *Code* (Définitions, Énoncés de valeurs, Normes de déontologie), en mettant l'accent sur les responsabilités envers les clients, les participants à la recherche et les personnes avec lesquelles les psychologues collaborent. (Ces mots apparaissent désormais 36 fois. Ils n'étaient mentionnés que trois fois dans la version du *Code* de 2000.)

- **En ce qui concerne la diversité et la mondialisation :** (a) conformément à la *déclaration universelle des principes de déontologie pour les psychologues*, approuvée en 1998 par la SCP, et après plusieurs consultations, discussions et délibérations, le nom du Principe I du *Code* devient « Respect de la dignité des personnes et des peuples » et le terme « peuples » est ajouté dans l'ensemble du *Code*; (b) les références à la « culture » sont plus nombreuses dans l'ensemble du *Code* (ce terme est utilisé deux fois plus souvent que dans le *Code* de 2000); (c) le Principe III concernant les frontières dans le contexte culturel est clarifié; on y inclut, notamment, l'idée que les relations multiples sont parfois bénéfiques dans de tels contextes.

- **En ce qui concerne la répartition des responsabilités entre les différentes parties :** (a) des ajouts/modifications sont apportés aux définitions des différents types de clientèle, y compris le « client principal », la « personne évaluée », la « partie qui demande l'évaluation » et les différentes utilisations de ces termes dans le *Code*; (b) une plus grande différenciation entre les « intérêts » et les « intérêts supérieurs », y compris l'ajout de la définition des « intérêts supérieurs »; (c) accent accru mis sur la nécessité d'« équilibrer les avantages et les inconvénients possibles » et de prendre en compte le « degré et la légitimité morale des intérêts contradictoires ».

En plus de donner suite aux cinq domaines clés portés à l'attention du Comité de déontologie, la *quatrième édition* du *Code* contient plusieurs autres modifications, parmi lesquelles :

- Mises à jour conformes aux changements apportés à l'*Énoncé de politique des trois Conseils Éthique de la recherche avec des êtres humains*.
- Mise à jour de l'article du *Code* portant sur les *« Soins des animaux »* (Principe II) afin de rendre celui-ci conforme aux opinions exprimées dans les documents nationaux et internationaux récents sur le sujet.
- Remplacement de l'expression « dommages physiques graves ou mort » par l'expression « dommages corporels graves et imminents » en réponse aux opinions et aux lois relatives aux préjudices dans le contexte de la prise de décisions de fin de vie, et conformément à la façon dont d'autres grands codes de déontologie en psychologie envisagent cette question (p. ex., British Psychological Society, Australian Psychological Society, Fédération européenne des associations de psychologues). (Note : dans la législation canadienne, les préjudices psychologiques et les dommages corporels sont considérés comme des « lésions corporelles ».)
- Modifications apportées à la norme de déontologie rattachée à la valeur du Principe II *Maximiser les autres bénéfices*, qui met un accent accru, dans le *Code*, sur l'importance de fonder les services psychologiques sur les meilleures données probantes.
- Définition de plusieurs termes utilisés (p. ex., meilleures données probantes, collectivité, discipline de la psychologie, groupe, lois justes, organisation, personnes, peuples, société et vulnérable) et uniformisation des termes utilisés.

Le *Companion Manual to the Canadian Code of Ethics for Psychologists* et le cours en ligne de la SCP, intitulé « Being an Ethical Psychologist », sont en cours de révision afin de tenir compte des changements apportés à la *quatrième édition*. Cependant, les versions actuelles du *Companion Manual* et du cours en ligne seront disponibles en attendant que la version à jour soit publiée.

Le Comité de déontologie tient à remercier toutes les personnes qui ont pris le temps de lui faire part de leurs réflexions, leurs idées et leurs suggestions au cours de l'examen et de la révision. La *quatrième édition* n'aurait pas été possible sans votre aide.

#ItDoesntHaveToHurt

Partners with Twitter Canada to Engage with Parents about Children's Pain

Christine Chambers, PhD, Canada Research Chair in Children's Pain, Dalhousie University & IWK Health Centre, @drcchambers

For the last year, we have been partnering with Erica Ehm's YummyMummyClub.ca (YMC) to bring parents #ItDoesntHaveToHurt, a social media initiative that aims to improve parents' awareness and use of evidence-based information about children's pain, including a range of psychological, physical, and pharmacological management strategies. #ItDoesntHaveToHurt translates scientific knowledge about children's pain management into blog posts, YouTube videos, Twitter parties, Facebook polls, and Instagram images, all posted and promoted on the YMC website and on social media. Since its launch in September 2015, #ItDoesntHaveToHurt has generated over 130 million impressions (i.e., possible content views); has won multiple awards including, most recently, Best Online Campaign at the Canadian Online Publishers Awards; and was a Finalist for Best Branded Content at the DIGI awards, which recognize the best in Canadian digital media.

#ItDoesntHaveToHurt marked its first anniversary with a special knowledge translation event at Twitter Canada headquarters in Toronto on September 15, 2016. The event brought together all the scientists, parents, members of the health community, content creators, and digital influencers who have partnered to develop, implement, and evaluate #ItDoesntHaveToHurt. The live event was complemented by a one hour online Twitter party that allowed parents and scientists to discuss various topics in children's pain in real time. In addition to allowing us to base our event at their headquarters, Twitter Canada allowed us to use their proprietary Q&A video app to answer parents' questions live over video. This was the first time the app, which had previously only been used by high profile individuals and celebrities (e.g., Prime Minister Justin Trudeau, athlete Jose Bautista), was used to engage with the public about health information.

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The Twitter party generated more than 7,000 tweets about children's pain, with over 350 participants and had a reach of over 6 million people. There were over 3,000 views of the videotaped answers to parents' questions about pain, and #ItDoesntHaveToHurt trended #1 on social media that evening.

To date, #ItDoesntHaveToHurt has been primarily funded by a Knowledge to Action operating grant from the Canadian Institutes of Health Research. Partners include: the Nova Scotia Health Research Foundation, the Canadian Pain Coalition, and the Canadian Association of Paediatric Health Centres of Canada. The IWK Health Centre recently announced that they will be funding a continuation of the initiative into 2017. We are optimistic that our innovative science-media partnership can serve as a model for more effective knowledge translation to parents on a variety of topics.

More information about the event with Twitter Canada can be found in these media articles:
Chronicle Herald - http://thechronicleherald.ca/artslife/1396852-child-pain-researchers-team-up-with-twitter
Marketing Mag - http://www.marketingmag.ca/media/twitter-party-spreads-research-on-pediatric-pain-management-183502?rss=yes

Summaries of the tweets sent during the event at Twitter Canada and during the online Twitter Party (including videotaped responses to parents) can be found at:
https://storify.com/DrCChambers/itdoesnthavetohurt-partners-with-twitter-canada
https://storify.com/DrCChambers/itdoesnthavetohurt-twitter-party-2

More information about #ItDoesntHaveToHurt is available at: http://itdoesnthavetohurt.ca/
And all of our #ItDoesntHaveToHurt content for parents is archived at: http://pediatric-pain.ca/ItDoesntHaveToHurtInitiative

Allan Urho Paivio (1925-2016)

Albert Katz, Ph.D., Western University

Allan (Al) Paivio was born to Finnish immigrants, Aku Paivio and Ida Hanninen, in Northern Ontario in what is now Thunder Bay; an area of Canada where Finnish was more frequently spoken than English at the time. His father was a poet, playwright, and radical socialist journalist who wrote for Finnish-language newspapers and whose left wing orientation Al adopted throughout his life. Aku's most famous poem was "To my son is Spain", about his fears for, and pride in, Al's older brother Jules who joined the Canadian contingent of the International brigade to fight Fascism during the Spanish civil war and was the last living member of the MacKenzie-Papineau brigade when he died in 2013.

In 1928, Al's family briefly lived in Sudbury, Ontario, where his father worked on a paper called *Vapaus* (Finnish for "freedom"), before moving to a somewhat rustic 240-acre land grant at Tilton Lake outside the city. The young Al Paivio, who in winter often had to ski miles to school, was noted for his athletic prowess and his passion for a healthy lifestyle, traits that he maintained throughout his life. After serving in the Canadian Navy for the last two years of World War II, Al moved to Montreal with his wife, and high school sweetheart, Kathleen (Kay), to whom he was married for 50 years.

In Montreal, Al earned a B.Sc. in Physical Education from McGill University (1949) and opened one of the first gym and health studios in Montreal. Active as a body builder, he was awarded the title of "Mr. Canada" in 1948, an achievement he rarely discussed until later in his academic career because of his belief that such activities were denigrated by academics and would distract from his scholarly

achievements. Having launched a successful business, Al decided to pursue his love of psychology and applied to graduate school at McGill. Working under the supervision of Wallace Lambert, Al earned his Ph.D. studying "stage fright." Leaving McGill, Al went on to complete a post doc at Cornell University. He then took up his first academic position at the University of New Brunswick (UNB) before being lured to the University of Western Ontario by Mary Wright in 1963, much to the chagrin of the president of UNB and the glee of the president of Western. Al stayed at Western until his retirement.

Although Al published on a variety of topics, he is best known for his seminal research and theorizing on issues dealing with the representation and properties of mental images and verbal associative structures. While a graduate student at McGill, Al had started examining linguistic factors in learning, noting that concrete words served as better retrieval cues than abstract words in paired associate learning. He postulated that this effect was due to the fact that concrete words easily engaged mental imagery and, thus, better served as "conceptual pegs." This finding and subsequent work culminated in a classic paper in *Psychological Review* (1969) and the elaboration of his well-known dual coding theory, presented in his book *"Imagery and Verbal Processes (1971*).

Dual-coding theory proposes that mental imagery and verbal processes are separable but inter-connected representational systems, each with their own testable properties. To convince the behaviourist sceptics of the day, Al initially approached the study of mental imagery from a strict operational perspective, arguing the only way to convince the scholars of the day of the psychological reality of mental imagery was to be a rigorous experimentalist and use the methodology with which they were familiar. He forcefully made this point in his 1975 CPA presidential address (in which he presented parts in French, passionate that the association must embrace both Canada's official languages).Though dual-coding theory has often been simplified as merely a theory of mental imagery, ignoring its larger representational context, one cannot underestimate the importance of this influential work or of his later research on the analog and embodied nature of mental imagery.

Al was among the most cited psychologists in the world during the 1970s for his research that, along with that of a few others, once again made mental imagery (and cognition) a respectable field of study after its banishment during the behaviourist interregnum. Over his career Al published about 200 empirical articles and chapters, and five books. Among his many awards and recognitions, Allan was appointed a Fellow of the Royal Society of Canada and was the third recipient of the CPA's "Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science." Even in retirement, he continued to be an active scholar, publishing papers and books until near his passing.

Allan Paivio was a true gentleman, a loving family man, and a wise mentor. He is survived by his second wife Delores, and four of his five children.

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Disclosures and Conflicts of Interest

Brian Brooks receives royalties for tests published by Psychological Assessment Resources, Inc. [Child and Adolescent Memory Profile (ChAMP, Sherman and Brooks, 2015), Memory Validity Profile (MVP, Sherman and Brooks, 2015), and Multidimensional Everyday Memory Ratings for Youth (MEMRY, Sherman and Brooks, 2017)], has previously received in-kind support from another test publisher (CNS Vital Signs), and receives royalties from a book that addresses traumatic brain injury in children [Sherman and Brooks (2012), Pediatric Forensic Neuropsychology, New York: Oxford University Press]. Michael Kirkwood receives royalties for books published by Guilford Press and Oxford University Press. Keith Yeates receives royalties for books published by Guilford Press, Cambridge University Press, and Taylor & Francis.

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CPA ACTIVITY UPDATE

Karen R. Cohen, Ph.D., C. Psych, Chief Executive Officer and
Lisa Votta-Bleeker, Ph.D., Deputy CEO and Director, Science Directorate

The following is an update of the CPA's activities since our last issue. For further information about any of the activities described below or to provide feedback, please contact us.

Unless otherwise indicated, please contact:

- Dr. Karen R. Cohen (kcohen@cpa.ca) - practice
- Dr. Lisa Votta-Bleeker (lvottableeker@cpa.ca) – science
- Dr. Stewart Madon (smadon@cpa.ca) – accreditation and ethics
- executiveoffice@cpa.ca – public affairs and government relations, continuing professional development
- membership@cpa.ca – membership and benefits

PERSONNEL

We have had a number of staff changes in the last months...

- Practice Directorate - Dr. Andrea Lee, a local psychologist also in private practice, is filling the role of Director of the Practice Directorate while Dr. Rozen Alex is on maternity leave.
- Administration and Accreditation - Ms. Krista Hembruff, Administration Assistant, and Mr. Anas Choukri, Administration and Accreditation Assistant are filling the role of Ms. Sarah Fletcher while she is on maternity leave.
- Membership and Events - After a six month leave, Ms. Kathy Lachapelle-Petrin returned to convention duties in January on a part-time basis. Ms. Agnieszka Arkuszewski, Associate of Membership, Events, and Association Development, and Ms. Olivia Provost-Walker, Membership Data and Service Coordinator, have also joined the department.
- Public Affairs and Communications - Ms. Meagan Hatch, Director of Public Affairs and Communications, returned from maternity leave in March 2017.

EDUCATION AND TRAINING

Accreditation. The *Fourth Edition* of the *Canadian Code of Ethics for Psychologists* was approved unanimously by the Board of Directors on January 30. The Companion Manual to the Canadian Code of Ethics for Psychologists and CPA's web-based course "Being an Ethical Psychologist" are now being revised to reflect the changes in the Fourth Edition.

MEMBERSHIP

Member Renewals. Membership renewals were sent in November 2016. Members who have not yet renewed their membership are encouraged to do so online at http://www.cpa.ca/membership/renewal.

Member Benefits. We recently partnered with Mercedes-Benz Canada to offer members the most competitive incentives on new Mercedes-Benz, AMG and smart vehicles. Check out our www.mercedes-benz.ca/psychologist for more details!

Section Engagement. We are committed to engaging with our sections, on a rotating basis, to discuss ways in which we can work together to bring greater attention to the subject matters our sections address. To this end, we met with the executive of the Section for Educational and School Psychology and the chair of the Section for Students in November and December 2016, respectively. These meetings were preceded by meetings with the chairs of the Developmental, Industrial/Organizational, and Social and Personality Sections in December 2015.

KNOWLEDGE TRANSFER AND EXCHANGE

***Psynopsis* – Call for Submissions**. The spring 2017 issue of *Psynopsis Magazine* will be devoted to advocacy. We are now accepting submissions on advocacy campaigns, strategies, and successes. Submissions of 400-900 words can be made to psynopsis@cpa.ca before April 2. Please note that all submissions must follow the editorial guidelines on our website and may be edited with the author's consent. If you have ideas for themes for future issues of *Psynopsis*, please contact the Editor-in-Chief, Dr. Karen R. Cohen (kcohen@cpa.ca).

Fact Sheets. We recently published a new fact sheet on physical activity, mental health, and motivation. Fact sheets on a number of topics are currently in development, including but not limited to: concussions, aging well, caregiver burden, and Seasonal Affective Disorder. Members wishing to develop a fact sheet are encouraged to email factsheets@cpa.ca.

Journals and Publications. The Board of Directors is pleased to announce that Dr. E. Kevin Kelloway, CPA Past President, has been named the next Editor for CJBS (2017- 2022). Dr. Kelloway began his term as Editor-Elect in January. The CPA and its Board extends its sincerest thanks to Dr. William Roberts for his service as Editor. Dr. Roberts will serve as outgoing Editor in 2017, with his term ending in December 2017.

In January, the Board of Directors issued a call for Editors for both the Canadian Journal of Experimental Psychology (CJEP) and Canadian Psychology (CP). Terms for these editor positions will begin January 2018 and end December 2022. Current editorial terms for Drs. Pexman and Drapeau will end December 2018.

CPA Journals Meet Open Access Requirements. In October 2016, we met with representatives from the American Psychological Association (APA), the Social Sciences and Humanities Research Council, the editors of our three journals, and our director for science and liaison to the Publications Committee to discuss open access. We are in full compliance with the tri-council policy on open access for publicly-funded research – authors can make the pre-publication version of their articles open access via a repository one year following publication in a CPA journal (i.e. green access), or authors can make their articles open access at the time of publication for a publishing fee of $3,000 USD (i.e. gold access). Introductions to special issues are also open access. The APA will revise instructions to authors in order to better promote what is available to support open access.

International Congress of Applied Psychology (ICAP) 2018. Planning continues for ICAP 2018 (Montreal, QC from June 26-30, 2018). In January, we met with MCI and executives from the International Association of Applied Psychology (IAAP) to review planning for the congress. Calls for abstracts, section programming, and registration will open in September 2017. Our annual national convention, including section business meetings and programming, will take place within the ICAP schedule. We look forward to making this an amazing experience for CPA members and non-members alike. Be sure to follow ICAP 2018 on social media and via www.icap2018.com.

GOVERNMENT RELATIONS, ADVOCACY, AND OUTREACH

Chief Science Officer. On December 5, 2016, the Honorable Kristy Duncan, Minister of Science, delivered on a key mandate commitment by launching the search for a Chief Science Advisor for Canada. The Chief Science Advisor will be responsible for providing scientific advice to the Prime Minister, the Minister of Science, and members of Cabinet. This individual will also advise on how to ensure that government science is open to the public, federal scientists are able to speak freely about their work, and science is effectively communicated across government. The application process closed January 27.

Fundamental Review of Science in Canada. In late September 2016, the Science Directorate (in consultation with the Scientific Affairs Committee) developed a white paper on issues affecting psychology researchers in Canada, which is available on our website. The paper was submitted to a panel convened by Minister of Science, Kirsty Duncan, to look at issues related to fundamental science in Canada. Over 1250 submissions were made to the panel. We now eagerly await the report, which is currently with the Minister of Science, and are exploring ways to bring the findings of the report to members.

http://cpa.ca/docs/File/News/CPA_ScienceReviewSubmission_Final_30Sept2016.pdf

Health Accord. Over the last months, we have been actively meeting with the federal government to discuss our recommendations for enhancing access to psychological services under the new Health Accord. We have had meetings with the Prime Minister's Office, the Minister of Health and a number of her key staff, senior staff from the Public Health Agency of Canada, and the Liberal Mental Health Caucus to name a few. In December, the provinces and territories all declined to accept the Health Accord offer but 12 provinces and territories have since accepted the Accord bilaterally. We have recommended two options to government, and to our provincial psychology association partners, for the use of the targeted funds: an adaptation of the UK's Improving Access to Psychological Therapies (IAPT) program or the integration of psychologists and psychological services into primary care. More recently we met with our eastern psychological association partners to refine those recommendations into a

model that would work in Eastern Canada. We had an excellent meeting and we plan to support the advocacy efforts of the eastern provincial psychological associations promoting the model with governments.

http://www.cpa.ca/docs/File/Government%20Relations/Targeting%20funds%20for%20better%20access%20to%20quality%20mental%20health%20care%20for%20Canadians%20February%202017final.pdf

Taxing Health and Dental Benefit Premiums. In December 2016, we and others learned that the federal government was considering taxing the premiums Canadians pay on the health and dental benefits they receive through employment. This would have made psychological services less, rather than more available to Canadians. We drafted a letter on behalf of the Health Action Lobby (HEAL) calling on the Minister of Finance not to institute this tax. We then joined with a subset of HEAL organizations to give a press conference on Parliament Hill, circulate a joint press release, meet with MPs of all parties, and launch an online letter-writing campaign. We also sent our own letter to the Minister of Finance detailing why the proposed tax was a regressive one for mental health services in Canada. Thanks to these efforts, the prime minister announced in the House of Commons on February 1 that the government would not be implementing the tax!

PARTNERSHIPS AND STAKEHOLDER ENGAGEMENT

Canadian Consortium for Research (CCR). On January 20, Dr. Votta-Bleeker and the CCR hosted the 5th annual breakfast with the funders at our office with representatives from SSHRC, CFI, NSERC, and Mitacs. Information provided at the breakfast along with the report from the Fundamental Science Review will form the basis for the CCR's 2017 advocacy efforts.

Mental Health Commission of Canada. Mr. Matt Murdoch has joined MHCC's national collaborative for suicide prevention on behalf of the CPA and attended a meeting of the collaborative in Iqaluit in October 2016. Dr. Cohen continues to sit on the MHCC's advisory committee on e-mental health, which met in November 2016 and, most recently, in January in Vancouver. The meeting included presentations on the tele-psychology work by Drs. Heather Hadjistavropoulos (University of Regina) and Peter Cornish (Memorial University of Newfoundland) who did an outstanding job and were very well received by the delegates.

Canadian Alliance of Mental Illness and Mental Health (CAMIMH). Dr. Cohen has joined CAMIMH's Management Committee and continues to work with the group to advocate for the recommendations of their report calling for mental health action (which includes adapting the UK's IAPT model).

Canadian Life and Health Insurance Association (CLHIA). Dr. Cohen travelled to Montreal in November 2016 to present to the CLHIA member associations' disability claims managers on solutions to addressing the mental health problems of Canadians, in the workplace and for employees. We are now looking into developing continuing professional development for psychologists on working with insurers and anticipate having a session on the topic at our upcoming convention.

College of Family Physicians (CFPC). Dr. Cohen met with the CEO of the College of Family Physicians and Surgeons about developing a joint position on integrating psychologists and mental health services into primary care. This meeting resulted in a joint letter to the Minister of Health advocating for mental health investments in primary care. The letter, developed in consultation with our presidential officers and the chair of our Professional Affairs Committee, is available online. http://cpa.ca/docs/File/Press%20Release/Mental%20Health%20joint%20letter%20Jan%202017%20CFPC%20CPA.pdf

Health Canada Vega Project (Violence, Evidence, Guidance, Action). The National Guidance and Implementation Committee for the development of Pan Canadian Guidance on Family Violence continues its work. Dr. Kerry Mothersill and Dr. John Pearce attended the committee meeting in November 2016.

Veteran's Affairs Mental Health Advisory Committee. Dr. Cohen attended a committee meeting in November 2016 and has been contributing to its development of a document detailing a centre of excellence to address the mental health needs of the military.

Association of Canadian Psychology Regulatory Organizations (ACPRO). Dr. Cohen attended a meeting of ACPRO in November 2016 to discuss the CPA's role in the development and maintenance of a common dataset among regulatory bodies. Minasu, the company which manages CPA's databases, virtually attended the meeting and is costing out a model to support the regulatory bodies in data collection. It is our intention to come up with a proposal that is based on cost recovery, as well as access to the CPA of the anonymized data for the purposes of advocacy.

International Initiative for Mental Health Leadership. Dr. Cohen attended the February 2017 conference of IIMHL in Australia. The theme of the conference was contributing lives, thriving communities. She also met with the CEO of the Australian Psychological Society to discuss Australia's success with its federally-funded improving access to psychologists' program, some leaders' meeting for ICAP 2018, and common association issues. Upon the recommendation of the CEO of the MHCC, Dr. Cohen was asked to join an international clinical leaders table of the IIMHL, which will host its inaugural meeting in Washington in 2017.

MISE À JOUR DES ACTIVITÉS DE LA SCP

Karen Cohen, Ph. D., C. Psych., chef de la direction, et Lisa Votta-Bleeker, Ph. D., directrice générale associée et directrice de la Direction générale de la science

Voici une mise à jour des activités menées par la SCP depuis le dernier numéro. Pour avoir des renseignements supplémentaires sur les activités décrites ci-dessous ou pour nous faire part de vos commentaires, veuillez communiquer avec nous.

À moins d'indication contraire, veuillez communiquer avec :

- Dre Karen Cohen (kcohen@cpa.ca) – activités touchant la pratique
- Dre Lisa Votta-Bleeker (lvottableeker@cpa.ca) – activités touchant la science
- Dr Stewart Madon (smadon@cpa.ca) – agrément et éthique
- executiveoffice@cpa.ca – affaires publiques et relations avec le gouvernement, perfectionnement professionnel continu
- membership@cpa.ca – adhésion et avantages aux membres

COMPOSITION DU PERSONNEL

Plusieurs changements ont été apportés à notre effectif au cours des derniers mois.

- Direction générale de la pratique – La Dre Andrea Lee, une psychologue locale qui exerce en cabinet privé, assume la fonction de directrice de la Direction générale de la pratique pendant le congé de maternité de la Dre Alex Rozen.
- Administration et agrément – Mme Krista Hembruff, adjointe administrative, et M. Anas Choukri, adjoint, administration et agrément, occupent le poste de Mme Sarah Fletcher pendant le congé de maternité de cette dernière.
- Adhésion et événements – Après un congé de six mois, Mme Kathy Lachapelle-Petrin a repris son travail à l'organisation du congrès en janvier, à temps partiel. Mme Agnieszka Arkuszewski, associée aux services aux membres, aux événements et au développement des activités, et Mme Olivia Provost-Walker, coordonnatrice des services aux membres et des données sur les membres, ont également rejoint les services aux membres.
- Affaires publiques et communications – Mme Meagan Hatch, directrice des affaires publiques et des communications, est revenue de son congé de maternité en mars.

ÉDUCATION ET FORMATION

Éthique. La *quatrième édition du Code canadien de déontologie professionnelle des psychologues* a été approuvée à l'unanimité par le conseil d'administration le 30 janvier. Le *Companion Manual to the Canadian Code of Ethics for Psychologists* et le cours en ligne de la SCP, intitulé « Being an Ethical Psychologist », sont en cours de révision afin d'inclure les nouveautés de la quatrième édition.

ADHÉSION

Renouvellement de l'adhésion. Les avis de renouvellement de l'adhésion ont été envoyés en novembre 2016. Les membres qui n'ont pas encore renouvelé leur adhésion sont invités à le faire en ligne à l'adresse http://www.cpa.ca/adhesion/renewalfr/.

Avantages pour les membres. La SCP s'est associée récemment à Mercedes-Benz Canada afin d'offrir aux membres des rabais hautement compétitifs sur les véhicules Mercedes-Benz, AMG et Smart. Visitez le http://www.mercedes-benz.ca/psychologist pour plus de détails.

Participation des sections. Nous nous sommes engagés à rencontrer les sections, à tour de rôle, afin de discuter des façons de travailler ensemble pour attirer l'attention sur les

sujets qui intéressent les sections. Dans le cadre de cet engagement, nous avons rencontré le comité de direction de la Section de la psychologie éducationnelle et scolaire et la présidente de la Section des étudiants, en novembre et en décembre 2016, respectivement. En 2015, nous avons rencontré les présidents de la Section du développement, de la Section de la psychologie industrielle/organisationnelle et de la Section de la psychologie sociale et de la personnalité.

TRANSFERT ET ÉCHANGE DE CONNAISSANCES

Appel d'articles pour *Psynopsis*. Le numéro du printemps 2017 du *magazine Psynopsis* sera consacré à la défense des intérêts. Nous acceptons présentement les propositions d'article portant sur les campagnes et les stratégies de représentation, et les réussites des efforts de représentation. Veuillez envoyer votre article (de 400 à 900 mots) à psynopsis@cpa.ca avant le 2 avril. Veuillez noter que tous les articles proposés doivent suivre les consignes éditoriales, qui se trouvent sur notre site Web, et peuvent être modifiés avec le consentement de l'auteur. Si vous avez des idées de thèmes pour les prochains numéros de *Psynopsis*, communiquez avec la rédactrice en chef, la Dre Karen Cohen (kcohen@cpa.ca).

Fiches d'information. Nous venons de publier une nouvelle fiche d'information, qui porte sur l'activité physique, la santé mentale et la motivation. D'autres fiches d'information traitant de différents sujets, notamment, les commotions cérébrales, vieillir en santé, le fardeau des aidants naturels et le trouble affectif saisonnier, sont en préparation. Les membres qui veulent élaborer une fiche d'information sont invités à écrire à factsheets@cpa.ca.

Revues et publications. Le conseil d'administration est heureux d'annoncer que le Dr E. Kevin Kelloway, président sortant de la SCP, a été nommé rédacteur en chef de la RCSC pour la période de 2017 à 2022. Le Dr Kelloway a entamé son mandat de rédacteur en chef désigné en janvier. La SCP et son conseil d'administration offrent ses plus sincères remerciements au Dr William Roberts, pour son travail comme rédacteur en chef de la revue. En 2017, le Dr Roberts occupera la fonction de rédacteur en chef sortant, son mandat se terminant en décembre 2017.

En janvier, le conseil d'administration a lancé un appel de mises en candidature pour les postes de rédacteur en chef de la *Revue canadienne de psychologie expérimentale* (CJEP) et *Psychologie canadienne* (PC). Le mandat des deux rédacteurs en chef commence en janvier 2018 et se termine en décembre 2022. Le mandat des Drs Pexman et Drapeau prend fin en décembre 2018.

Les revues de la SCP répondent aux exigences en matière de libre accès. En octobre 2016, nous avons rencontré des représentants de l'American Psychological Association (APA), le Conseil de recherches en sciences humaines (CRSH), les rédacteurs en chef de nos trois revues, ainsi que l'administrateur de la science de la SCP et point de contact avec le Comité des publications, afin de discuter du libre accès. Nous respectons en tous points la politique des trois organismes sur le libre accès à la recherche financée par les fonds publics. En effet, les articles publiés dans une revue de la SCP sont accessibles en libre accès dans leur version finale. Pour ce faire, l'auteur archive son article dans un dépôt (appelé « green access ») ou, s'il choisit l'option « gold access », l'auteur publie son article en libre accès moyennant des frais de 3 000 $ US. Les introductions des numéros spéciaux sont également offertes en libre accès. L'APA révisera les instructions à l'intention des auteurs pour faire mieux connaître les outils et mécanismes qui existent pour appuyer le libre accès.

International Congress of Applied Psychology (ICAP) 2018. La planification de l'ICAP 2018, qui se tiendra à Montréal, au Québec, du 26 au 30 juin 2018, se poursuit. En janvier, nous avons rencontré MCI et les dirigeants de l'International Congress of Applied Psychology dans le but d'examiner la planification du congrès. Les demandes de communications, la programmation des sections et l'inscription au congrès seront disponibles dès septembre 2017. Notre congrès national annuel, y compris les assemblées générales annuelles des sections et la programmation, aura lieu comme d'habitude, et ne sera pas affecté par l'organisation de l'ICAP. Nous avons hâte de faire vivre aux membres de la SCP et aux non-membres une expérience extraordinaire. Suivez l'ICAP 2018 sur les médias sociaux et sur le www.icap2018.com.

RELATIONS AVEC LE GOUVERNEMENT, REPRÉSENTATION ET SENSIBILISATION

Conseiller scientifique en chef. Le 5 décembre 2016, l'honorable Kristy Duncan, ministre des Sciences, a donné suite à un des principaux engagements de son mandat en lançant la recherche d'un conseiller scientifique en chef pour le Canada. Le conseiller scientifique en chef sera chargé de donner des conseils au premier ministre, à la ministre des Sciences et aux membres du Cabinet. Il donnera aussi des conseils sur les moyens à prendre pour veiller à ce que les travaux scientifiques menés au sein du gouvernement soient accessibles à la population, à ce que les scientifiques soient en mesure de parler librement de leurs travaux et à ce que les travaux scientifiques soient diffusés efficacement dans l'ensemble du gouvernement. Le processus de mise en candidature a pris fin le 27 janvier.

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Examen du soutien fédéral à la science fondamentale. À la fin de septembre 2016, la Direction générale de la science (en collaboration avec le Comité des affaires scientifiques) a élaboré un livre blanc sur les problèmes auxquels sont confrontés les chercheurs en psychologie au Canada. Le document a été présenté à un groupe d'experts créé par la ministre des Sciences, Kirsty Duncan, chargé d'examiner les questions liées à la science fondamentale au Canada. Plus de 1 250 mémoires et documents ont été adressés au groupe d'experts. Nous attendons avec impatience le rapport, qui est maintenant entre les mains de la ministre des Sciences, et explorons les moyens que nous pourrions utiliser pour communiquer les conclusions du rapport aux membres.

http://cpa.ca/docs/File/News/CPA_ScienceReviewSubmission_Final_30Sept2016.pdf

Accord sur la santé. Au cours des derniers mois, nous avons rencontré à plusieurs reprises le gouvernement fédéral pour discuter de nos recommandations en vue d'améliorer l'accès aux services psychologiques dans le cadre du nouvel Accord sur la santé. Nous avons tenu des réunions avec le Cabinet du Premier ministre, la ministre de la Santé et certains membres clés de son personnel, des hauts fonctionnaires de l'Agence de la santé publique du Canada et le caucus libéral sur la santé mentale, pour ne nommer que ceux-là. En décembre, les provinces et les territoires ont tous refusé d'accepter l'Accord sur la santé proposé, mais depuis, 12 provinces et territoires ont accepté une entente bilatérale sur les transferts en santé. Nous avons recommandé deux options au gouvernement et aux associations provinciales de psychologues en ce qui a trait à l'utilisation de fonds ciblés, à savoir : une adaptation du programme Improved Access to Psychological Therapies (IAPT) du Royaume-Uni ou l'intégration des psychologues et des services psychologiques aux soins primaires. Dernièrement, nous avons rencontré nos associations partenaires de psychologues de l'est du pays pour adapter ces recommandations et en faire un modèle qui pourrait fonctionner dans l'est du Canada. Cette rencontre a été très fructueuse, et nous avons l'intention de soutenir les efforts de représentation des associations provinciales de l'est pour faire la promotion de ce modèle auprès des gouvernements.

http://www.cpa.ca/docs/File/Government%20Relations/Targeting%20funds%20for%20better%20access%20to%20quality%20mental%20health%20care%20for%20Canadians%20February%202017final.pdf

Projet de taxe sur les prestations d'assurance.
En décembre 2016, nous avons appris que le gouvernement fédéral envisageait d'imposer les cotisations des employeurs aux régimes de soins médicaux et dentaires, ce qui en ferait un revenu imposable pour les Canadiens. Pour nous opposer à cet impôt, nous avons rédigé une lettre au nom du Groupe d'intervention action santé (GIAS), demandant au gouvernement d'abandonner son projet d'instaurer cet impôt et nous nous sommes joints à des organisations membres du GIAS pour donner une conférence de presse sur la Colline du Parlement, faire circuler un communiqué de presse commun, rencontrer les députés de tous les partis et lancer une campagne épistolaire en ligne. Pour finir, nous avons envoyé notre propre lettre au ministre des Finances, dans laquelle nous expliquons pourquoi l'impôt proposé constitue un impôt dégressif pour les services de santé mentale au Canada. Grâce à ces efforts et à votre soutien efficace, le premier ministre a annoncé à la Chambre des communes, le 1er février, que le gouvernement renoncera à mettre en application cet impôt!

PARTENARIATS ET ENGAGEMENT DES INTERVENANTS

Consortium canadien pour la recherche (CCR). Le 20 janvier, la Dre Votta-Bleeker et le CCR ont tenu, dans nos locaux, le 5e petit-déjeuner annuel avec les bailleurs de fonds, auquel ont participé des représentants du Conseil de recherches en sciences naturelles et en génie (CRSNG), de la Fondation canadienne pour l'innovation, du CRSH et de Mitacs. L'information fournie au petit-déjeuner, ainsi que les résultats de l'examen du soutien fédéral à la science fondamentale, constituera la base des efforts de représentation que déploiera le CCR en 2017.

Commission de la santé mentale du Canada (CSMC). M. Matt Murdoch a rejoint, au nom de la SCP, le Groupe de collaboration national sur la prévention du suicide mis sur pied par la CSMC, et a participé à une réunion du Groupe de collaboration à Iqaluit en octobre 2016. La Dre Cohen continue de siéger au comité consultatif de la CSMC sur la cybersanté mentale, qui s'est réuni en novembre 2016 et, tout récemment, en janvier, à Vancouver. Dans le cadre de cette réunion, les Drs Heather Hadjistavropoulos (Université de Regina) et Peter Cornish (Université Memorial de Terre-Neuve) ont fait des présentations sur le travail de psychologue en ligne. Tous deux ont fait un travail remarquable et ont été très bien reçus par les délégués.

Alliance canadienne pour la maladie mentale et la santé mentale (ACMMSM). La Dre Cohen a rejoint le comité de direction de l'ACMMSM et continue de travailler avec le groupe chargé de promouvoir les recommandations de son rapport, qui réclame des mesures concrètes en matière de santé mentale (y compris l'adaptation du programme Improved Access to Psychological Therapies [IAPT] du Royaume-Uni).

Association canadienne des compagnies d'assurances de personnes (ACCAP). La Dre Cohen s'est rendue à Montréal en novembre pour faire une présentation aux gestionnaires de demandes de prestation d'invalidité des associations membres de l'ACCAP sur les solutions à préconiser pour résoudre les problèmes de santé mentale des Canadiens, dans le milieu de travail et pour les employés. Nous envisageons d'élaborer une formation de perfectionnement professionnel continu à l'intention des psychologues qui travaillent avec les assureurs et nous projetons d'organiser une séance sur le sujet lors de notre prochain congrès.

Collège des médecins de famille du Canada (CMFC). La Dre Cohen a rencontré la directrice générale et chef de la direction du Collège des médecins de famille du Canada afin de discuter de l'élaboration d'une position commune sur l'intégration des psychologues et des services de soins de santé mentale aux soins primaires. Cette réunion a donné lieu à une lettre commune adressée à la ministre de la Santé, qui fait la promotion des investissements en santé mentale dans les soins primaires. La lettre a été rédigée en collaboration avec les présidents de la SCP et le président du Comité des affaires professionnelles.

http://cpa.ca/docs/File/Press%20Release/Mental%20Health%20joint%20letter%20Jan%202017%20CFPC%20CPA.pdf

VEGA (Violence, Evidence, Guidance and Action) Project, Santé Canada. Le comité de mise en œuvre et d'orientation nationales pour l'élaboration d'une orientation pancanadienne sur la violence familiale se poursuit. Le Dr Kerry Mothersill et le Dr John Pearce ont assisté à la réunion du comité en novembre 2016.

Comité consultatif sur la santé mentale d'Anciens Combattants. La Dre Cohen a participé à une réunion du comité en novembre 2016 et a collaboré à l'élaboration d'un document décrivant un projet de centre d'excellence, dont la vocation sera de répondre aux besoins en santé mentale des militaires.

Association des organisations canadiennes de réglementation en psychologie (AOCRP). La Dre Cohen a participé à une réunion de l'ACPRO en novembre pour examiner le rôle de la SCP dans le développement et la gestion d'un ensemble de données communes, mis à la disposition des organismes de réglementation. Minasu, l'entreprise qui gère les bases de données de la SCP, a participé à la réunion à distance et s'affaire présentement à évaluer les coûts d'un modèle visant à appuyer les organismes de réglementation dans la collecte de données. Nous avons l'intention de faire une proposition, qui est basée sur le recouvrement des coûts, et sur l'accès de la SCP aux données anonymes aux fins de représentation.

International Initiative for Mental Health Leadership (IIMHL). La Dre Cohen a assisté au congrès de l'IIMHL en février 2017, en Australie. Le thème de la conférence était « contribuer à la vie, avec des collectivités prospères ». Elle a également rencontré la chef de la direction de l'Australian Psychological Society pour discuter de la réussite du programme financé par le gouvernement pour améliorer l'accès aux psychologues, mis sur pied en Australie, d'une réunion éventuelle avec les dirigeants à l'ICAP 2018 et de questions communes aux deux associations. Sur recommandation de la chef de la direction de la Commission de la santé mentale du Canada (CSMC), la Dre Cohen a été invitée à se joindre au groupe des chefs cliniques internationaux de l'IIMHL, qui tiendra sa première réunion à Washington en 2017.