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Rapport

Editorial

Dr Ester Cole

At its Fall meeting, the Board of Directors addressed numerous agenda items and revisited its Strategic Plan and Mission Statement on behalf of CHRSP Registrants. Last Spring a continuing education survey was sent out to Registrants, and the Board was pleased with the number of French and English responses. Given heterogeneous practice areas and settings across the country, different topics and continuing education modalities were identified by Registrants, ranging from live workshops, on-line study materials, Webinars and discussion groups. Based on this feedback, CHRSP is in the process of expanding its continuing education programs. This will build on the CE on-line service, which is currently available as part of the agreement with the National Register in the U.S.A. CHRSP Registrants have unlimited access to the on-line CE modules available on the National Register's website.

Given the current issues concerning the proposed changes to the HST/GST made in the last Federal budget, the Board collaborated with APNS and formulated members' questions to be addressed. Once professional clarifications on this issue have been obtained, updated information will be posted on the CHRSP website.

This issue of *Rapport* includes the following:

- "Committed to the Sane Asylum", by Dr. Rosemary Barnes. The paper is a reflection on mental wellness and healing following the publication of her co-authored book
- "Overcoming the Fear of Fear: How to Reduce Anxiety Sensitivity", by Drs. Margo Watt and Sherry Stewart
- "Telepsychology in Canada: A Regulator's Perspective", by Dr. Allan Wilson
- "Reflections on Telehealth", by Dr. Craig Turner
- A short bio of new Board member- Dr. David Pilon
- Helpful Websites, by Dr. Ester Cole

Please continue to submit your English or French papers for future publications in Rapport to ester.cole@sympatico.ca.

Committed to the Sane Asylum

By Rosemary Barnes, PhD, C.Psych, Toronto

Excerpt from introduction to Committed to the Sane Asylum: Narratives on Mental Wellness and Healing by artist Susan Schellenberg and psychologist Rosemary Barnes (Waterloo, Ontario: Wilfrid Laurier University Press, 2009)

Healing was never mentioned when I [Rosemary] began training as a clinical psychologist, about seven years after [my friend] Susan was hospitalized with a psychotic break. Though my graduate studies in psychology had prepared me to become a university professor, scarce employment opportunities forced a career change. In September 1976, I began a post-doctoral fellowship in clinical psychology at a prestigious university-affiliated psychiatric hospital, an apprenticeship of the kind undertaken by students in every health profession both then and now.

Had any one mentioned "healing," which few did in mental health settings, I would have considered the word flowery, quaint or quirky with connotations of primitive or marginal beliefs and practices, as in "faith healing." Had I been challenged, I would have argued that patients improved, so clinical practices must be healing; a poetic word such as "healing" was simply inappropriate in a scientifically grounded professional setting. I would not have recognized clinical constructs and terminology to be obscuring lacunae in theory and practice.

In 1969, as Susan protested through psychosis, I protested by falling in love with one woman, then another. As I had grown up in a conservative religious American family, I understood these experiences to be equivalent to mental illness and deeply shameful. By 1976, I reluctantly reconciled myself to the conclusion that such feelings meant I was lesbian. I met other lesbians and gay men in the 1970s ferment of the gay liberation and feminist movements. Lesbian-feminist groups, new friendships and the electric creativity of the day allowed me for the first time to locate myself with confidence in the larger world. Feminist ideas infused my life with new meanings and possibilities. I learned feminist and anti-psychiatry critiques of mental health care and resolved to do be a better professional than those I read about.

For some years, I had a professional career that I understood and enjoyed. After post-doctoral training, I worked for nine years as staff psychologist at a university-affiliated general hospital and matured as a clinician and researcher. In 1986, I moved to a smaller general hospital as head of the psychology department and moved to address the split between my personal and professional lives by joining a small informal group of hospital professionals working to nurture feminist values in health care. I met Susan when she and I worked in the same political faction during the turbulence surrounding a proposed merger between the small hospital and a larger health care facility.

Then, I became lost. My ability to live with the split between feminist values and professional career commitments eroded as I became increasingly unconvinced that hospital mental health care gave paramount concern to human well-being. I felt cynical, exhausted and angry about my apparently successful career.

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I learned of Susan's experiences with mental health care in 1992 when she exhibited her paintings at Women's College Hospital in Toronto as part of a commemoration for the murders of women staff and engineering students in Montreal, Canada on December 6, 1989. What Susan had to say exceeded the limits of the exhibit and reflected the dilemmas in mental health care that I found persistently troubling. Around the time we agreed to work together, I resigned my hospital position to begin an independent clinical practice. I was relieved to be free of the need to support an institution which I found hostile to my own well being and that of my patients, but felt a failure for abandoning a career path associated with power and prestige.

I realized gradually that I was working with Susan with the hope of healing this wound within myself. My inability to reconcile my work as a hospital psychologist with my commitment to feminist values and process was a major reason that I left hospital practice. Though I never wished to reverse the decision, I wandered for years, troubled about why the choice and what I might have done differently. Susan's taking responsibility rather than blaming, her introductions to artists and writing on art and her insight into the connection between healing of the person and healing of world all influenced me profoundly. Healing required collecting the disparate and conflicting fragments of my personal and professional experiences and fitting them together to form a new story of my life's work.

We [Susan and Rosemary] write to offer thoughts on a different vision for mental health care. We feel it helpful to talk about healing. Healing is different from "conquering" disease, achieving a "cure" or "managing" a condition; indeed, such concepts and terminology reinforce the discourses of power and transcendence. We think of healing as growth in ability to love and forgive self and other, to cope, to feel pleasure, to engage in meaningful activity and to follow the psyche's inner direction away from addiction and towards greater wholeness. Healing is a creative process relying on an inner capacity neither created nor destroyed by professional care, but amenable to nurturing.

We believe that healing is relational and tied to the earthy specifics of individual and community life. We tell our personal stories together in order to challenge the conventional doctor/patient relationship and to show how this crucial relationship can and should be reorganized. We mean "doctor" broadly to refer to any professional providing patient care, e.g., physician, nurse, psychologist, social worker, physiotherapist, and "patient" to describe individuals seeking care from doctors. In the *realpolitik* of conventional mental health care, the doctor (or nurse, psychologist, social worker, occupational therapist) is seen as the confident, powerful, infallible expert responsible for maintaining order by making quick, accurate diagnoses and providing effective treatment. Patients are seen as weak, distressed, needy, foolish, sometimes threatening, dependents responsible for "getting well" by following the directions of the doctor. Such relationships form a command-and-control system of the type that is being abandoned as ineffective in many areas of commerce and business. Such relationships leave many patients and doctors as exhausted, harmed and frustrated as it left each of us.

We met in the context of local hospital politics, a kind of war zone, have worked together as friends and never been in a doctor/patient relationship. However, our ability to learn from one another, to collaborate, to nurture each other, to appreciate strengths and to balance weaknesses is an example of the honest, mutually respectful, interdependent relationship we see as essential to healing and well being. We believe that such a healing relationship is possible in many contexts, including the doctor/patient relationship. We represent this in the writing ahead as we have above, that is, by passages where we each tell our separate stories, as well as passages where we relate shared conclusions.

We hope that this book shows in practice what we deeply believe, that emotional disturbance – and who among us has not experienced this in some form? – can be best addressed by living with an eye to delight and commitment to the creative, relational, earthy process of healing.

Overcoming the Fear of Fear: How to Reduce Anxiety Sensitivity

By Margo C. Watt[a,b,d] & Sherry H. Stewart[b,c]

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Anxiety sensitivity (AS) refers to the fear of arousal-related somatic sensations associated with anxiety; sensations such as increased heart rate, respiration, and perspiration. This fear arises from the belief that such sensations will be followed by physical harm, cognitive dyscontrol, or social embarrassment and rejection (Reiss & McNally, 1985; Reiss, 1991). For example, high AS individuals might fear that increased heart rate or shortness of breath signifies a heart attack, that the inability to think clearly indicates impending loss of control, or that trembling will elicit public ridicule. In contrast, a low AS individual would perceive such sensations as unpleasant, but transient and harmless consequences of being in an anxious state. Approximately 10 to 20 percent of people in the general population have elevated levels of anxiety sensitivity (Bernstein et al., 2006; Watt & Stewart, 2008)**.**

Reiss and McNally (1985) originally suggested that AS could arise from either genetic factors and/or learning experiences. Subsequent research has found evidence for both pathways. Stein, Jang, and Livesley (1999) found that AS had a strong heritable component with nearly half of the variance in anxiety sensitivity levels (h^2 = .45) accounted for by genetic factors. Several studies also have implicated childhood experiences in the development of AS. For example, we found that high AS young adults reported more instances where they were rewarded by parents for displaying sick role behaviour in response to childhood anxiety symptoms than controls, as well as more instances where their parents modeled fear reactions to anxiety symptoms, and/or verbally transmitted their beliefs about the harmfulness of such symptoms (Watt, Stewart, & Cox, 1998). We replicated these findings in two subsequent studies (i.e., Stewart et al., 2001; Watt & Stewart, 2000). We have also found retrospective reports of parental problem drinking to be associated with elevated levels of AS in the adult child (MacPherson, Stewart, & McWilliams, 2001; Watt & Stewart, 2003). In addition to genetics and learning history, interpersonal factors, such as attachment characteristics, have been linked to the development of elevated AS. Weems, Berman, Silverman, and Rodriquez (2002) found that individuals with insecure attachment, especially preoccupied and fearful attachment styles, reported significantly higher levels of AS than securely attached individuals. These findings were later replicated by Watt, McWilliams, and Campbell (2005).

High AS has been linked to the development and maintenance of a variety of mental and physical health concerns. These concerns include panic disorder (reviewed in Olatunji & Wolitzky-Taylor, 2009); substance use problems (Stewart, Samoluk, & MacDonald, 1999); chronic-pain-related disability (McCracken & Keogh, 2009); recurrent depression (Taylor, Koch, Woody, & McLean, 1996); borderline personality disorder (Lillienfield & Penna, 2001); exercise avoidance (Sabourin, Hilchey, Lefaivre, Watt, & Stewart, 2011), and obesity (McWilliams & Asmundson, 2001). Many of these health concerns tend to co-occur rendering high AS a good target for transdiagnostic intervention. Transdiagnostic interventions assume that mental health problems are manifestations of shared risk factors or core processes (e.g., high neuroticism). Treatments that target these underlying factors/processes hold the promise of reducing symptoms across a range of disorders and, perhaps, preventing symptoms from becoming full-blown disorders (Barlow et al., 2011)

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After several years of research, in 2008, we published a self-help book based on our findings with a brief cognitive behavioural therapy (CBT) specifically designed to reduce AS. The brief CBT follows a treatment manual, adapted from earlier interventions (Conrod et al., 2000; Harrington & Telch, 1994), and consists of three components: (1) psychoeducation, (2) cognitive restructuring, and (3) interoceptive exposure (i.e., running).

(1) Psychoeducation

The psychoeducation component of the brief CBT includes two steps. First, participants learn about AS and about the association between AS and the development of anxiety disorders and other mental and physical health disorders. Participants learn how exposure to anxiety-related sensations (stressful situations) can trigger negative cognitions (e.g., catastrophizing) about potentially hazardous outcomes (illness, embarrassment) in high AS individuals. Participants also learn how to parse their anxiety into its constituent parts – physical sensations, emotions, thoughts, and actions – and to understand the connections between each of these four parts. Second, participants are encouraged to consider how AS might explain some of their own mental and physical health symptoms and how reducing AS levels could have broader implications for their mental and physical well-being.

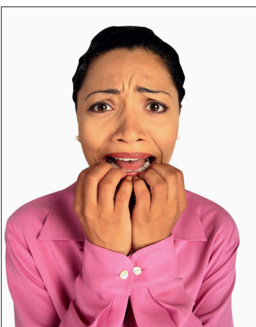
(2) Cognitive Restructuring

In this component, participants learn how what they think can impact how they feel and what they do when they are anxious. Participants learn how to identify their own thoughts, particularly dysfunctional automatic thoughts. They are taught that the most common types of thinking errors associated with high AS are *catastrophic thinking* (i.e., expecting the worst case scenario) and *probability overestimation* (overestimating the likelihood of that scenario ensuing). Participants are then taught how to reduce their AS by challenging these dysfunctional automatic thoughts. Participants learn how to collect evidence and logically analyze their thoughts by asking themselves a series of four questions. (1*) "What's the worst thing that could happen?" (2) "What are the chances X will happen?" (3) "What if X does happen?" "So what?"* (4) *"What else might happen?"* or *"If X is unlikely to happen and/or you are quite sure you could handle it even if X did happen, then what else might you think about now instead of focusing on X?"* Participants then are taught how to replace their negative automatic thoughts with more reasonable and realistic thoughts so as not to resume old patterns of distorted thinking.

(3) Interoceptive Exposure

High AS individuals often rely on maladaptive behaviours in order to manage their anxiety. Some individuals may rely on distraction, others on avoiding potentially anxiety-provoking situations and situations that might provoke anxiety-related physiological sensations (e.g., physical exercise). Still others may rely on alcohol and drugs to reduce the tension associated with anxiety. Whereas these solutions may be effective in the short-term, they only serve to perpetuate the anxiety cycle in the long-term. Participants are introduced to the idea of learning "to be in anxiety" rather than escaping from anxiety; running toward rather than running away from anxiety. Here, we introduce the client to interoceptive exposure (IE) – repeated exposure to feared physical sensations as a means of reducing the fear of those sensations and learning how to cope more effectively with anxiety. Participants learn how IE activities are intended to direct their attention to their feared sensations, to provide them an opportunity to challenge their catastrophic thoughts about these sensations, and to encourage their habituation to these sensations so they no longer provoke panic or avoidance behaviours. At this point, participants are introduced to a number of different interoceptive exposure activities, including running. Physical exercise is chosen because it induces similar arousal-related sensations to anxiety and is also more real-life than some of the other prescribed IE activities such as spinning (i.e., spin around while standing or in an office chair) and straw breathing (i.e., breathing through a narrow drinking straw). Participants are asked to run three times a week for 10 minutes each time over the next eight weeks. They are provided with a heart rate monitor and exercise tracking sheets to monitor their physical exercise. In addition, they are taught how to identify the thoughts and feelings triggered by running and to relate these thoughts and feelings back to their anxious experiences.

Originally, the brief CBT was designed to be delivered in three sessions over three consecutive days to young adult women. We began with this particular population because young women tend to report higher levels of AS and are at greater risk for high AS-related disorders than young men. Moreover, high AS young women self-report engaging in less physical exercise and perceive themselves as less physically fit than their low AS counterparts. At this point, however, the brief CBT has been delivered to both non-clinical and clinical samples, including young and older adults, both men and women, in both individual and small group formats. In a recent trial of delivering the brief CBT by distance (i.e., telephone), the sessions were expanded to be conducted over eight weeks (Olthuis, Watt, Mackinnon, & Stewart, under review); nonetheless, the same three core elements are still well represented in the treatment (psychoeducation, cognitive restructuring, and interoceptive exposure). A number of randomized controlled trials (RCTs) have demonstrated the efficacy and effectiveness of the brief CBT in reducing AS levels but also pain anxiety (Watt, Stewart, Lefaivre, & Uman, 2006); problematic alcohol use (Watt, Stewart, Birch, & Bernier, 2006); symptoms of stress, depression, and anxiety (Sabourin, Hilchey, Lefaivre, Watt, & Stewart, 2011; Sabourin, Stewart, Watt, & Krigolson, 2013). The recent tele-delivery of the intervention over eight weeks resulted in reductions in AS, as well as symptoms of panic, social phobia, and posttraumatic stress, as well as the number of DSM-IV diagnoses per participant, when compared to a waiting list control. These gains were maintained at 12 week and 20 week follow-ups. Together, this exciting set of intervention studies suggests that our AS-targeted intervention may have implications for helping a broad range of clients; clients with various mental and physical health conditions for which AS may operate as a common risk or maintenance factor.



Recommended Readings

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Olthuis, J. V., Watt, M. C., Mackinnon, S., & Stewart, S. H. (submitted). Telephone-delivered CBT for high anxiety sensitivity: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*

Sabourin, B. C., Hilchey, C. A., Lefaivre, M-j., Watt, M. C., & Stewart, S. H. (2011). Why do they exercise less? Barriers to exercise in high anxiety sensitive women. *Cognitive Behaviour Therapy, 40*, 206-216.

Sabourin, B., Stewart, S. H., Watt, M. C., & Krigolson, O. (Under revision). Running as interoceptive exposure for decreasing anxiety sensitivity: Replication and extension. *Behavior Therapy.*

Sabourin, B. C., Stewart, S. H., Watt, M. C., & Krigolson, O. E. (Under revision). Two interventions involving physical exercise decrease anxiety sensitivity and distress among high anxiety sensitive women. *Behaviour Research and Therapy*.

Watt, M. C., Birch, C. D., Stewart, S. H., & Bernier, D. B. (2006). Brief CBT for high anxiety sensitivity decreases drinking and drinking problems: Evidence from a randomized controlled trial. *Journal of Mental Health, 15*, 683-695.

Watt, M. C. & Stewart, S.H. (2008). *Overcoming your fear of fear: How to reduce your anxiety sensitivity.* Oakland, CA: New Harbinger Publications, Inc.

Watt, M. C., Stewart, S., Lefaivre, M-j, & Uman, L. A (2006). Brief cognitive-behavioural approach to reducing anxiety sensitivity decreases anxiety related to pain. Cognitive *Behaviour Therapy, 35*, 248-256

Telepsychology in Canada: A Regulator's Perspective

By Allan R. Wilson, Ph.D.
Registrar, Nova Scotia Board of Examiners in Psychology

There have been major advances in communication technology in recent decades. These advances have created new opportunities for psychologists and new challenges for the regulators of psychological services.

The Association of Canadian Psychology Regulatory Organizations (ACPRO) has defined telepsychology as "the use of information and communications technology to deliver psychological services and information over large and small distances". Telepsychology might be used to deliver health services within a Canadian jurisdiction, or from one jurisdiction to another.

In virtually every jurisdiction in Canada there are regions where residents have very limited access to face-to-face psychological services. One of the promises of telepsychology is that it may improve access to psychological services for residents who currently do not have readily available in-person services. Likewise, residents may wish to use this modality to access more specialized services that otherwise would not be available in their region. This has created a new opportunity for psychologists who wish to grow their practice by responding to the unmet needs in another region.

Where are psychological services being provided?

It is clear where psychological services are being provided, when these services are being delivered in the traditional face-to-face manner. The services are being provided where the psychologist and the client are located. The answer to this question is less clear when, in essence, the services are being transmitted through the air between a psychologist who is located in one Canadian jurisdiction and a client who resides in another Canadian jurisdiction. Are the psychological services being provided where the psychologist is located, or where the client is located?

Most, but not all, jurisdictions in Canada have adopted the position that psychological services delivered via telepsychology are deemed to occur where the client resides. One of the advantages of this position is that it makes it easier for the client to contact the local regulatory body if difficulties arise that warrant a complaint. The client does not have to track down and communicate with the regulatory body of the psychologist's home jurisdiction.

Do I need to be licensed/registered in the jurisdiction where the client resides in order to provide psychological services via telepsychology?

The primary role of a regulatory body is to ensure the delivery of competent and ethical psychological services by licensed/ registered practitioners. Most, but not all, jurisdictions in Canada have adopted the position that a psychologist providing telepsychology to the residents of their jurisdiction must be licensed/registered in the jurisdiction. For most, it is not sufficient to be licensed/registered in another Canadian jurisdiction.

Are there standards or guidelines specific to the practice of telepsychology?

Regardless of the modality used for service delivery, all psychologists are expected to adhere to the Canadian Code of Ethics for Psychologists (3rd Ed.) or the code de deontologie (Quebec), professional standards within their home jurisdiction, and to local laws and regulations. Some have argued, as well, that there is a need for guidelines and standards specific to the practice of telepsychology

The Association of Canadian Psychology Regulatory Organizations (ACPRO) has adopted Model Standards for Telepsychology Service Delivery (June 2011). Many of its member organizations have since adopted these standards (check the website of your regulatory body).

A Joint Task Force of the American Psychological Association (APA), the Association of State and Provincial Psychology Boards (ASPPB) and the American Psychological Association Insurance Trust (APAIT) have developed ….

"Guidelines for the Practice of Telepsychology":

Guideline 1: Psychologists who provide telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees or other professionals.

Guideline 2: Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

Guideline 3: Psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide. When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements that govern informed consent in this area.

Guideline 4: Psychologists who provide telepsychology services make reasonable effort to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks to loss of confidentiality inherent in the use of the telecommunication technologies, if any.

Guideline 5: Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.

Guideline 6: Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.

Guideline 7: Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.

Guideline 8: Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to client/patients across jurisdictions and international borders.

A document outlining the rationale and application of each of these guidelines is available on the ASPPB website.

Like Guideline 8 of the APA/ASPPB/APAIT Guidelines, the ACPRO Model Standards states that: "Psychologists delivering telepsychology services outside their home jurisdiction will ensure they are legally entitled to do so". As noted above, the laws governing telepsychology are not uniform across the country. You are encouraged to contact the appropriate regulatory body before engaging in telepsychology outside your home jurisdiction.

Reflections on Telehealth

By Craig Turner, Ph. D., C. Psych., Winnipeg

This writer reviewed two National Register Online CE telehealth articles for Rapport. The articles differ in that one provides feedback on the use of videoconferencing counselling with military personnel while the other article provides an overview and commentary about the various issues and challenges involved in Telehealth. The articles were: The Role of Telehealth in Treating Military Personnel by Dr. Raymond Folen et al and Trends in Telehealth by Dr. Morgan Sammons.

Dr. Folen and his colleague's article gave examples of specific telehealth (i.e. videoconferencing) work they have been conducting out of Tripler Army Medical Centre (TAMC), located in Oahu. They noted that, since Hawaii is eight major islands separated by water, prior to their use of telehealth, it would often require TAMC to fly patients into Honolulu for several weeks of assessment and treatment. Exorbitant costs, removing from their surroundings, family and friends motivated TAMC to become an early adopter of telemedicine for behavioural health and medical speciality care.

The authors described their first intense use of telehealth came with TAMC staff developing a biofeedback system that would allow biofeedback sessions to be conducted remotely. They reported how they were able to treat a number of soldiers for migraines and other psychophysiologic conditions with good success and substantial cost savings to the government.

The authors then described how they compared face to face treatment versus videoconferencing treatment with the use of their lifestyle management program, LE3AN, for overweight soldiers. Their research found that the treatments were equally effective.

The authors noted that as a training facility TAMC found that telehealth was an effective tool for consultation and supervision for trainees assigned to remote areas.

Interestingly the authors talked about their initial experience with using videoconferencing and/or webcam for clinical assessment or treatment specific to the issue telehealth sessions was that they were so tiring. Initially their providers, who would normally manage eight (i.e. traditional) sessions a day would often report fatigue after only 3-4 videoconference sessions. Over time the authors noted that as the providers became more comfortable with videoconferencing they reported less and less fatigue.

The article by Dr. Sammons provides an overview of the telehealth literature. Dr. Sammons references numerous articles and concludes that there are only a few good outcome studies and most published reports are case studies. Dr. Sammons concluded that there are limits to how much we can generalize on issues such as cost savings and practitioners' liability and that the balance between potential savings and cost of such services remains largely unknown. He adds that positive regulatory action and reimbursement issues are important issues to be dealt with before distance mental health services are fully utilized. Dr. Sammons noted a survey of 29 Canadian university-based telehealth programs 70% of respondents listed funding as a major factor negatively affecting growth of their programs.

Dr. Sammons concluded in his review of the literature to date that for mental health services it is essential that better outcome data and cost effectiveness analysis be developed and that patient acceptance and provider satisfaction are key variables that need to show positive results before administrators and third party payers will be willing to endorse. Dr. Sammons opined that telehealth will never replace traditional face to face provision of services except perhaps in extremely remote areas but that it has great potential to augment currently available services and possibly to improve access and reduce the cost of traditional mental health care.

This writer is already aware of a number of CRHSP psychologists who are using telehealth technology in some form in their practices and it is this writer's opinion that it is only going to increase. For those who are already using the technology and for those who are contemplating I would recommend that you access the National Register's Online CE section and read the full articles for valuable information.

(To find the articles go to www.e-psychologist.org; Register by inserting your last name and your CRHSP Certificate/Registrant number; then go to section titled 'Areas of Expertise'; these articles are in Modules #19 and #14 respectively)

References:

Raymond A. Folen, Stephen L. Jones, Melba C. Stetz, Brenda Edmonds, and Judy Carlson (2010), The Role of Telehealth in Treating Military Personnel

Morgan T. Sammons (2002), Trends in Telehealth

CRHSP Board Members Bios

David J. Pilon, Ph.D.

Dr. David Pilon is a Psychologist from Halifax, Nova Scotia. He began his training in psychology as an undergraduate at Dalhousie University and from there pursued his clinical psychology doctoral studies at the University of Waterloo. He has practiced as a psychologist since 1990 and has been affiliated with the Eating Disorder Clinic of the Queen Elizabeth II Health Sciences Centre in Halifax since then. He is cross-appointed to the faculty of medicine in psychiatry at Dalhousie University. Dr. Pilon is a founding board member of the Eating Disorder Association of Canada and currently serves as its Past President. At Capital Health, he is Program Leader for all of the District's Specialty Mental Health Services. He has been very active in the governance of psychological associations throughout his career. Dr. Pilon has provided psychological consultation in his private practice since 1994.

Helpful Websites

www.ncld.org/types-learning-disabilities, provides information about learning disabilities resources across age groups. The site, created by the US National Center for Learning Disabilities, includes types of LD; answers to common questions; videos; podcasts; easy-to-use checklists and worksheets.

www.veterans.gc.ca, developed by Veterans Affairs Canada,
provides a new free (Android App) resource- PTSD Coach Canada.
Together with professional treatment, it allows users to learn about and manage stress/trauma related symptoms.
It includes tools for screening, and links to supports.

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CRHSP Canadian Register of Health Service Psychologists
RCPOSS Répertoire canadien des psychologues offrant des services de santé