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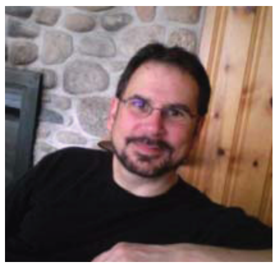
PRESIDENT'S REPORT



Michael Ross, Ph.D.

We have been busy lately. In this column I want to give you an update regarding all the activities we have been involved with of late. It seems the more we do the more we generate. The more people we contact the more it leads to other people to contact. The more e-mails we send the more we get back. The more issues we get involved with we find even more issues to devote our attention to. All, in our opinion, interesting and important.

We have taken on a number of advocacy efforts over the last year and will be increasing our efforts in the near future. As you know, we held a very well attended (in person and via distance) information session about the new Personal Health Information Act (PHIA) and made our concerns clearly known to the provincial government representatives who were there. Drs. Genest, MacGillivray and Service articulated clearly psychology's concerns, apprehensions, and misgivings about the Act. Prior to the Act being passed the APNS helped facilitate the appearance of several media stories about psychologists' concerns about the Act and we submitted a written brief to the Provincial Legislature that was entered into the official record. The Act did pass and we will now attempt to get heard before the regulations committee so that we can influence the way the Act is implemented. Lesley Hartman took the initiative on this project and did a wonderful job of advocacy on our behalf. As a spin-off benefit, we were approached by the Nova Scotia Association of Social Workers who share our concerns and want to collaborate with us on this and potentially other projects of shared interest. We have also begun advocacy efforts to help establish a Psy. D. training program here in Nova Scotia. This initiative is a direct result of the feedback we received from the outreach meetings we held over the last year with the NSBEP regarding the entry level credential issue. The psychologists in attendance at these meetings clearly wanted more opportunities for advanced education regardless of their stand on the credential issue. Quebec, New Brunswick, and Newfoundland have all recently launched programs and we want our members and the public to benefit from having this training opportunity here in Nova Scotia. As a result of these initiatives we have also increased our collaboration with the CPA and its Practice Directorate. With the CPA convention being held in Halifax in June 2012 we hope to work even more closely together. Another major advocacy event is that the APNS executive will be meeting with the chairs of the new provincial mental health strategy commission in March.

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EDITOR'S INTRODUCTION ~ Debra Garland, M.A., Editor

Debra Garland has been in private practice in Dartmouth, Nova Scotia since 1997. She offers services to individuals, families, government agencies and Family Court with a focus on custody access, parental capacity and psychoeducational assessments, as well as parenting and co-parenting interventions. She is a past President of APNS and maintains memberships in CPA, AFCC and CRHSPP.

Happy New Year! It seems as though 2010 flashed by – and here we are January 2011! Aside from after Christmas sales – following through with New Year's resolutions seems to be most folks focus. Television, radio, newspaper, and internet media are promoting and pushing weight loss and the more reputable – good health and fitness which led to the current issue of the *APNS Newsletter*. This quarter's issue focuses on health and well-being from various angles.

Tracey Earle reminds us about the need to make time and effort to take care of the caregiver – something often overlooked. She reminds us that even our relaxation routines can become so regular they become ineffective. Tracey's points are well taken and a prompt to evaluate how and if we take sufficient care to re-energize and recoup from our work.

Brad Peters brings to mind existential questions that plague clients and impact on us as clinicians in our approach to therapy and in response to clients. He notes our need for awareness of existential issues so as clinicians we are "promoting a definition of mental health that is capable of supporting a human life".

Myles Genest provides an article that discusses fee scheduling which may not at first read strike as health related - but can and does impact on the success and thus the health of a practice. He discusses the paucity of training and information about setting up the business side of a private practice and those issues that impact on the 'health' of the practice from a business perspective.

Finally, Robin McGee provides a very personal account of closing her private practice due to her serious illness. She provides the mechanics of how to close a practice, as well as the responses she received from clients.

I hope this issue is enjoyed and the 'health advice' employed whether it is as individual clinicians or for the 'health' of our practice.

PRESIDENT'S REPORT *(continued from page 1)*

As you know, we have circulated a survey to members to help us determine the key points we want to bring to this committee to help better plan the delivery of mental services in Nova Scotia and the role of psychologists in the system. These advocacy efforts have taken up the most time, yet generated the most enthusiasm among our executive team and we look forward to doing and learning more about how to do so effectively.

We have also been involved with a host of other issues. We have completed a survey regarding fees charged for psychological services and we will inform everyone of the results and our recommendations shortly. We are undertaking a review of our "office manager position" by conducting a job analysis and salary review profile to help us better determine and define the job, the title, the salary and also to improve the performance appraisal process. I would like to thank Natasha Scott and Sonya Stevens (who share our student representative position) for their initiative and expertise on these projects. The early career committee held its' first meeting recently and I would like to thank Chimène Jewer for agreeing to be the first chair of this committee and for attending the upcoming APA conference for early career psychologists. Please consider becoming part of this committee if you are a new or relatively new graduate. We have increased our funding support to the Healthy Workplace Awards and Conference which helps to highlight the importance of psychological issues in the workplace and in workers' lives.

The entry level credential committee has completed its' consultation and review process and is in the final stages of completing its' report to the NSBEP. The APNS participated in this process and along with the other committee members helped to ensure that the

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SELF-CARE: A REQUIREMENT NOT AN OPTION ~ Tracey L. Earle, M.A.

Tracey Earle has been in private practice in Halifax since 2000 and works with adults and couples. Outside of her practice, she enjoys her many pets, gardening, cooking, and textile arts.

Even though it is fairly clearly laid out in our Code of Ethics as something we must do, many of us seem to struggle with taking care of ourselves as well as we care for our clients. Responsible caring and protecting the well-being of our clients is a major component of the second principle in our Code of Ethics that drives our everyday actions as psychologist, but self-care for the psychologist is in there too. As there never seems to be a shortage of work or client needs, it is often a judgment call where limits are set regarding work demands versus self-care. Many of us seem to treat self-care as optional, something we do if there is time and energy left, which can leave us vulnerable to illness and burn-out.

The request to write this article came at a time when I was stepping back to revamp my own self-care activities and to find a better work-life balance. From my casual observation, some psychologists seem to take care of themselves fairly well: many exercise regularly, eat healthily, and have outside interests. What I couldn't discern from observation was whether those activities have been sufficient to help them feel like life is "in balance", because similar strategies *alone* were not enough for me to feel so. Good self-care, for me, is more than taking care of my physical health; it involves having a creative outlet that allows for "play" and new learning (outside of psychological topics).

I was intrigued to read that some authors find novel tasks, as well as creative endeavours, such as art and music, to be particularly activating to the right hemisphere of the brain, and activities that favour that brain hemisphere are more conducive to the relaxation response. Could this be key to optimising self-care?

We can all list many factors that promote physical and emotional health, but simply doing these activities does not necessarily deliver a sense of well-being and a balanced life. These latter ideals are what I strive for in good self-care, however elusive they might be. With careers that are filled with clinical obligations, deadlines, loads of paperwork, meetings and professional development opportunities, having reasonable exercise, eating, sleeping, and social routines seem to be factors that are necessary to just function daily. In my experience, and in treating many health professionals, self care for the care-giver seems to require more than the "basics" to feel well and have a balanced life. "Balance" is a dynamic concept, not static. Therefore, what worked once to give a sense of well-being may not continue to be effective as home, family, and work demands change. So, perhaps the first point to consider in appraising our self-care is that our self-care routines should not become too routine, both to deliver optimal benefits and to maintain our interest and motivation.

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broad spectrum of opinions that were expressed were taken into account and that individual members were given opportunities to express their thoughts, opinion, and concerns. Another major initiative by the NSBEP will be the introduction of a continuing competency program for psychologists in Nova Scotia. The NSBEP has developed a program and it is being pilot tested by the NSBEP executive members and the APNS executive members. We also offered our assistance in rolling out the program to psychologists and in providing educational support if needed.
We will continue to host our ethics workshops and outreach meetings (in collaboration with the NSBEP) in locations throughout the province. We are even anticipating having a meeting in Halifax this year. We have received very good feedback about the value of these meetings and workshops. We have also met recently with the chairs of most of our association's committees and we continue to discuss ways to keep our committees active and relevant. The contributions of our committees are essential to the well functioning of the association. We have four positions coming open this year on the executive. We encourage you to think about becoming more involved in this active, rewarding and vibrant association.

SELF-CARE: A REQUIREMENT NOT AN OPTION ~ Tracey L. Earle, M.A. (from page 3)

As psychologists, although we have knowledge about making behaviour changes, being that psychologist may be an impediment to good self-care in several ways. First, we likely have no one who checks up on our self-care practices as we do for our clients. Feeling accountable to someone is a very helpful support tool for many people; but I really don't think that is the answer in why we may struggle with self-care.

Second, as a profession, we are used to focusing on the needs of others first and keeping our own needs in the background.
Third, we may perceive ourselves as the "expert" and fail to use the structure and methods to enable lasting behaviour change that we would implement for a client (e.g., appropriate and realistic goals that have measurable outcomes to track benefits for our efforts).

A fourth obstacle could be underlying beliefs and attitudes. There is a stereotype that many psychologists have some perfectionistic tendencies, (high self-expectations, the push to excel, and to make sure all details are correct.) While such tendencies have real benefits in the sphere of professional practice, for self care such attitudes may make the process burdensome instead of a release or another obligation to fulfill (a "should" instead of a pleasure).

If we have not begun self-care practices at all, it could mean we have unrealistic expectations of how to start or how progress will go. If we take our self-care too seriously, or try to do it perfectly, it may not be as beneficial a counterbalance to daily stress if the process is seen as one more goal to achieve or if we feel inadequate.

In October 2010, two clinical psychologists in the US, Ann Dunnewold and Diane Sanford, launched a web-based 21-day challenge which asked women to take 15 minutes daily to implement various simple self-care tips and then to blog about their experiences.
http://www.livingselfcare.com

The tips are not new self-care ideas to most psychologists: abdominal breathing, exercise, read something that connects with personal interests or values, soak in a tub, simplify expectations, etc. However, the challenge showed that sustaining daily self-care was difficult for most women. Because of dramatic drop out in participants, the challenge itself had to be simplified from a daily tip to a weekly tip in the first weeks of delivery. It is likely a safe generalization to say that many care-givers, regardless of gender or professional status, struggle with maintaining and prioritizing self-care and we should be careful not to expect too much too quickly when trying to change.

Dunnewold and Sanford's first tip in the self-care challenge was to take two minutes to just breathe and to repeat: "It is not selfish; it is self-preservation." Because self-care is usually preventive and not reactive, there is the perception that skipping or scrimping on it for a while may not be so bad. There may be no immediate noticeable ill-effects of doing so. As care-givers, although we know this not ideal I think we need to be wary of falling into this trap.

A 2006 poll by Expedia regarding vacation time and use, suggested that "medical professionals and caregivers top the list of most vacation deprived professionals." Similar polls across the world repeatedly find Canada near the bottom of the list of economically developed nations with respect to number of vacation days and fully utilizing those days (only the USA and China are lower). Our North American attitudes to work and leisure do not seem to value leisure as much as other countries do. Up to 25% of survey respondents said they do not use all of their available vacation days, usually because of work related reasons. Simply put, it seems work comes first for many people. It is not just the amount of time away from work that is part of self-care and a balanced life, but highly valuing something other than our professional accomplishments. I believe we need to more highly value our hobbies, social, and leisure pursuits; we need to see the importance of play beyond childhood. Let 2011 be the year you expand and vary your self-care practices to include all aspects of well-being, value self-care more highly, and care for yourself as well as you do for clients and family.

In closing, I would like to share a quote that I have had been posted in my office for years. "It is utterly false and cruelly arbitrary to put all of the play and learning into childhood, all the work into middle age and all the regrets into old age." - *Margaret Mead.*

EXISTENTIAL THEMES IN THERAPY ~ Brad Peters, M.Sc.

Brad Peters works as a part-time professor at Saint Mary's University and is a clinical psychologist (cand. reg.) and co-owner of Cornerstone Psychological Services. Brad considers himself a theoretical integrationist, both academically and in his clinical practice where he works with children (8+), adolescents, and families.

Existentialism is an area of thought or study related to concerns about existence. Most of us, and many of our clients, will at some time reflect on what it means to be human: What is the meaning or purpose of this life? If we all just die anyway, how can there be a point to it all? How am I to live a 'good' life? On some level, it would seem that we are all existentialists. Human beings have the unique capacity to think about abstract concepts and think in terms of time and space. As a species, these capabilities have helped us to survive and to thrive, but like an unfortunate side effect, they also enable us to reflect on our own mortality and provoke difficult questions related to our very existence.

Freud (1927), Becker (1973), and Yalom (1980), have all observed that individuals and societies tend to avoid uncomfortable existentially-themed thoughts and feelings by engaging in defense mechanisms that generally take the form of denial, repression, or intellectualization. More contemporary social scientists (i.e. Greenberg et al., 2004) have experimentally tested and found empirical support for the existence of these defense mechanisms – and therapists may not be immune to them. What might we do, for example, when a client with terminal illness wants to talk with us about fears and anxieties related to their dying? Or when a client is having a crisis of religious belief or meaning?

When a therapist cannot see or understand the underlying cause or central issue, they risk getting caught up in symptom management. But our therapeutic approaches in these situations may do more harm than good, such as when we over-utilize CBT to the extent that it becomes a defense mechanism - helping someone intellectually detach from an underlying feeling or fear that prevents them from confronting it. Avoidance and engagement in defense mechanisms lead to rigid restriction of thought, feeling, and behavior – which can be a workable definition of mental illness. We may alternatively rationalize that the above issues are outside the scope of what therapy can offer, and choose to refer our client to a life coach, religious shaman, or priest. But I believe the therapist has a role here – especially when these issues cause the symptoms we were asked to address.

The first therapeutic challenge involves becoming sensitive to existential issues arising in therapy. Existential anxieties are shared by all humans, and while the feelings and fears are usually suppressed during our day-to-day lives, certain life experiences or stages of development can provoke them. These issues are likely to arise, for example, during adolescence, mid -life transition, and near the end of life. They may also surface when someone close to us dies, which can cause us to reflect on our own mortality, and that of other people important to us.

Crises of meaning can also present themselves in therapy after the client and therapist have explored and deconstructed unhealthy beliefs or assumptions upon which the client has based their life. While they might have been in ways self-defeating or unhealthy, they nonetheless served as a template from which the client extracted their sense of worth, purpose, and meaning. With the false structure or dysfunctional belief system now ejected, the client often has a disquieting sense of having been uprooted, accompanied by an unsettling feeling of groundlessness. A client may begin to anxiously re-evaluate their life; they take inventory of the time they have left and desperately seek new ways of defining their worth and attaining meaning. From an existential perspective, this is only natural. And if we therapists pay attention and grasp the significance of these moments, we can seize them as opportunities to encourage meaningful personal growth.

Unfortunately, professional training in existential theory is almost unheard of in today's graduate schools. With many of our clinical training programs focused on so

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EXISTENTIAL THEMES IN THERAPY ~ Brad Peters, M.Sc. *(from page 5)*

called 'empirically based treatments,' the enterprise of therapy threatens to become nothing more than a process of symptom management, through use of superficial therapeutic gimmicks and band-aid solutions. Our psychologists risk becoming co-conspirators of our culture's consumer-driven desire for quick fixes and instant cures which allow clients to continue on with a minimal level of functioning without need for self-exploration or personal growth. Our training does not teach us otherwise, so our clients are seldom given an option.

Working from an existentially-informed approach involves asking more from ourselves and our clients. It requires being aware of existential issues when they arise in therapy and having a framework for helping clients navigate through them. It means at times being open to challenging our views of reality and especially our culture, which in many ways defines that reality. How often, for example, do we allow ourselves, and in turn allow our clients, to question the beliefs, values, and assumptions that are implicit within our Capitalistic and consumer-driven North American culture? When our clients claim that they want to be *happy*, how often will we *assume* what they mean, rather than question its implication and maybe even its validity? Doing so would involve comfortably questioning *our own* definitions of happiness and ways that we satisfy our human need for meaning, in all its finitudes and even its absurdities.

Existential concerns, including those related to our own mortality and impermanence, have the potential to cause great discomfort for many people, including our clients. But while these existentially-flavored questions are often bitter to the taste, they are full of sustenance – if we can help our clients digest them. Though it is obvious that some of these difficult topics do not have easy answers, the process of asking the questions and the stand one takes toward them can be healing. The therapeutic goal is therefore to broaden a person's conscious awareness; their capacities to think, feel, and act; it is concerned not only about alleviating mental illness and suffering, but in promoting a definition of mental health that is capable of supporting a human life.

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SETTING FEES IN PRIVATE PRACTICE ~ Myles Genest, Ph.D.

Dr. Myles Genest is Chief Psychologist with Genest MacGillivray Psychologists (GMP), in Halifax. He works with individuals, couples and groups, combining clinical expertise with 20 years of experience in research and teaching. The author of numerous chapters, papers, and books concerned with therapy, assessment, and professional issues, Dr. Genest is sought as a consultant by other health professionals.

Last year, the Editor of the *Nova Scotia Psychologist* asked me to write something about fees in private practice. While I was working on this, the Nova Scotia Government EAP sent a communication to some psychologists, which included the following:

> *Starting January 1, 2011 … the NS Government EAP … will be initiating a capped fee for service of $100 per one hour session...for the first 4 one hour EAP sessions.*

Prior to that, Nova Scotia Government EAP would provide a total of $400 in coverage annually, but each psychologist could bill at his or her usual rate. This change means that the psychologist has to make a choice: Either provides four sessions at a $100 rate; or bill the excess to the client directly, or, if possible, to his or her extended insurance plan. If the psychologist's normal fee is $155, and services were provided at the $100 rate, there is a shortfall of $220 over just four sessions (a shortfall of over 35%).

I called Kim Purcell, Coordinator of the EAP, who sent the memo, to ask her about the intention of this change in the plan. She said it is an attempt to provide more services for their employees without costing more to the program.

The only way that this new NS Government EAP plan would work they way they intend it to is if psychologists were to "absorb" the shortfall. Is this a reasonable request? What are the implications of such arrangements? In the broader picture, the situation raises questions about how we determine what fee to charge, and when we should vary from our usual policies?

I have been meeting with clinical interns and graduate students to offer a brief seminar on private practice for over 10 years, and it never fails that participants raise concerns about setting and collecting fees. Although it is evident that psychologists are becoming more comfortable with the business side of psychological practice, it is still one of the least emphasized aspects of our education, and an area in which even many who have been practising for years continue to feel insecure.

What do psychological services offer?

For most users of private psychological services, the question about the value of services is not whether they will benefit–most people, though not all, assume they will profit from the encounter – it is a question of the *relative* value of seeing a psychologist rather than another, less expensive, mental-health practitioner, or someone in the publicly funded health-care system.

On their website, the Ottawa practice, Gilmore Psychological Services[1], directly address the question of why one would pay more for private psychological services, when it is possible to obtain services from a psychiatrist, whose services are covered by the provincial health-care plan, or to see a counsellor or social worker, whose services might not be covered but who charge less per session than private psychologists do. Gilmore makes the point that "Clinical psychologists have more mental health and psychotherapeutic training and experience than any other health profession." They then review the extensive education and supervision that psychologists receive, and note that as members of a legally regulated profession, psychologists must meet educational and supervision requirements and adhere to ethical standards set by the regulatory body. There is recourse to the regulatory body in the case of complaints, and third-party insurers may reimburse psychologists' fees but not those of unregulated professionals, such as "therapists". Finally, Gilmore writes, "Many people do not want to see a psychiatrist because they do not want a medical approach to their problems. Many (but not all) psychiatrists are very biomedical and believe that moods are the result of biochemical imbalances that should mainly be treated by pills. This is like saying your tension headache always requires an aspirin and

[1] http://ottawa-psychologists.com/questions.php

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couldn't be cured by relaxation, a massage or some problem solving."

Although some of the specifics in Nova Scotia differ from those in Ontario, the main points that Gilmore makes are relevant.

Considerations in setting fees

Most clinical graduate students receive little exposure to or education concerning the practice of a business. They are therefore lost when dealing with the exigencies of business and simply hope to absorb the necessary principles and skills from experience. Most who enter private practice also anticipate that there will be some conflicts between operating a business for profit and the ethical principles to which psychologists are committed.

Successful practitioners must negotiate these difficulties, so that the ethical commitment to clients is not sacrificed and the needs of a sustainable, independent business are met. The ethical training that psychologists receive makes clear the consequences of failing to satisfy one's responsibilities to clients. The consequences of failure to provide for the needs of the business are equally dire, for if the operation is not profitable, it will fail, and then of course, clients' needs will definitely not be met, and the psychologists in the practice will have to seek alternative employment. And if psychologists as a group are unable to operate successfully, their expertise is denied to those whom they might serve.

Wilson and Pelletier (1997) noted, "To remain viable, businesses must be profitable. Working to be profitable can often be in conflict with the notion of providing services for free or donating to the common good. Very few businesses target as consumers those members of society who are indigent or in extremis. And it is rare indeed that businesses would price their services or products according to any particular consumer's ability to pay" (p. 87). Wilson and Pelletier continued, "Failure to acknowledge that one's activities [in psychological practice] follow the principles of business can lead to such poor management practices that the professional him or herself becomes the person in extremis. It is difficult to understand the moral principle which would have the talents of society forced to their knees" (p. 88).

The principles of business practice require that fees for services are established not solely upon the basis of an individual's ability to pay, but upon well-considered decisions concerning all the elements that enter into providing a service and being sustainable. An illustration: If services are provided at lower rates to some clients, then in essence, the other clients of the practice are providing subsidies. If the psychologist offers *pro bono* services to some, it is the fees paid by the other clients who are providing the psychologist with sufficient income that he or she can afford not to charge the same to all clients. In the same way that a retail sales business makes "allowance" for the "loss" of some merchandise to those who do not pay for it by setting prices that permit a profit despite these losses, the psychologist offering reduced fees to some clients has set fees for other clients that are sufficient to account for this time that is "lost" to income-generation.

The space between the failure and success of a practice as a business is the area of "profit", what is left after you deduct expenses from gross income. This is what provides the personal income of the psychologists in private practice. Psychologists are relatively anomalous in their tendency to expect low income levels, compared to other professionals who have completed similarly rigorous and lengthy education. And psychologists tend to give scant consideration to the hidden costs of the years of education they have pursued at their own expense, when they are setting expectations for a reasonable income in succeeding years.

The intersection of public and private sectors

For the 20-odd years that I was a faculty member in various university departments, I had a part-time private practice. Particularly in Canada, and perhaps disproportionately in Nova Scotia, many psychologists who work in institutional or educational settings offer services on a part-time basis, while their primary

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responsibilities and source of income are in the public sector.

Of course, under those circumstances, I would have been able to "afford" to charge very low fees, since I was not dependent upon this peripheral practice as my major source of income. At times, and with the full knowledge of the institution, I even had the space and other resources of a university setting within which to see clients, with no direct cost to me. Obviously, in business terms, this provided me with a competitive advantage in setting fees.

Very early in my career as an academic, however, university administrators who were sensitive to the potential of town - gown conflict pointed out to the psychologists and other professionals within the institution (engineers, lawyers, business consultants, etc.) that for those of us in the University to charge fees lower than those of our full-time colleagues in the private sector would unfairly and unethically disadvantage them. It would constitute, and be seen as, the misuse of public funding in the support of an individual's private enterprise.

For those of us in such circumstances, the *costs* side of the business equation is distorted, so that to establish reasonable fees, one must therefore look to examples set by the private sector. The concern not to be seen as undercutting those who depend upon private-practice fees for their livelihood would recommend that part-time practitioners with other employment set fees at the higher end of the spectrum. At the very least, setting fees no lower than the association recommended fee would seem to be the minimum expected of public sector employed, part-time private-practice psychologists, in order to be respectful of full-time practitioners in the community.[2]

The Role of APNS

An association published fee guide can be helpful in a number of ways. A guide to fees helps psychologists who are entering practice to have realistic expectations concerning income, and can assist in making decisions concerning affordable expenses. As noted previously, it can also help those in the public sector determine what fees their colleagues might view as appropriate for them to charge

Another major role of an association's fee guide is that it is used by third parties who pay for services, to establish their fees and budgets for psychological services. In this respect, it is important that the Association recognize that if its recommended fees are based upon what is currently charged in the community, it is very likely that insurers and others who set maximum fees will establish fees that lag behind the increases in costs that are experienced by service-providers. Third-party payers are motivated to set their fees at the low end of any suggested scale, and they are unlikely to raise them without some pressure; all the while, service-providers will experience cost-increases that are beyond their control. Psychologists are always free to set fees at whatever level they wish, and can certainly establish fees lower than those recommended by the Association. It is more difficult for them to set fees higher than the Association's recommendations, and many third-party payers will not pay higher fees.

The recent poll of private practice fees that was undertaken by APNS should assist the Association in revising its fee schedule. When I surveyed fee-schedules that are published by other jurisdictions, it became evident that while there is considerable variation, none of the jurisdictions that either provide

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Fees for individual/couple-family therapy per hour by province

BC	AB	SK	MB	ON	NB	NS	NWT
$185	$170 / $180	$140	$150	$220	$150	$140	$170

[2] *I should note that my discussion of this issue does not imply any knowledge of any comparison of part-time versus full-time practitioners' fees in Nova Scotia. It is simply an issue that is often raised in the context of private practice in psychology*

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an online fee schedule or responded to my e-mailed request for information has a lower fee than that currently provided by APNS. (I was unable to obtain information for Quebec and PEI; Newfoundland has no recommended fee.)

The current fee recommendation by APNS was established in December 2005 (http://www.apns.ca/documents/GuidetoFeesandBilling2006.pdf). It is laudable of the executive to have taken the initiative for the much-needed, current fees-survey. Whatever the outcome of the exercise, it is essential that APNS establish a mechanism for annual review of its recommended fee. With easy email access to most members, it should be simpler to update and report a simplified survey of practitioners or to establish some other mechanism for interim updates, and I expect that those in practice would be highly motivated to participate. Unlike a fine Port, the fee guideline does not improve with age, and a five-year-old recommendation becomes a liability when third-parties use it as their standard payment (as does, for example, Veterans' Affairs Canada).

Shifting the burden?

The request from the Nova Scotia government EAP, then, is a request to shift the contributions to psychologists' incomes from Nova Scotia government employees to other clients. Presuming that psychologists have already established their fees for services on the basis of sound business practice, that is, on a reasonable assessment of costs and sources of income, simply reducing the income side of the ledger by accepting lower fees from a group of clients will provide a strain on the business. The significance of this strain will vary, depending upon the proportion of such clients served in any particular practice. But the overall impact on professional services is clearly to shift the burden for covering fees from Nova Scotia government resources to others.

In my experience, psychologists are prone to considering fee issues in isolation from the multiple facets of their businesses, as well as undervaluing their services in the larger societal context. Doing so runs the risk of upsetting the balance in the business, thereby threatening its stability, and in the longer term making the prospect of the private practice of psychology less attractive to bright and ambitious students.

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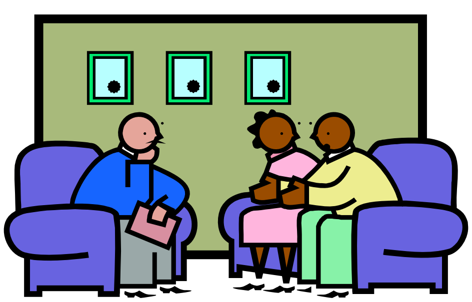

HOW TO TELL YOUR PATIENTS THAT YOU HAVE CANCER: A PSYCHOLOGIST'S JOURNEY ~ Robin McGee, Ph.D.

This is not the article I had hoped to be writing for APNS. I would much rather have written about provincial advocacy, fee schedules, or ADHD. Instead, I must write about what I learned when I had to close my public and private practices, due to a diagnosis of advanced cancer. I am writing to share my journey, in the hopes that others may benefit from my experiences.

Cancer will strike 40% of us by the end of our lives. Of those, half are within their working careers at the time of diagnosis. This means that many working psychologists could experience this illness, and have to cope with its professional as well as its physical impact. No one wants to need this article, but some of you unfortunately will.

What are the ethical and practical considerations a psychologist must make when terminating a practice due to this illness, or any other incapacitating illness? The professional literature has surprisingly little guidance on this matter: most published work on forced termination is about managed care or therapists moving to other jobs. These situations do not yield the same powerful emotions as cancer, either for the patient or the therapist.

When I was diagnosed with Stage III colorectal cancer in May of 2010, I went from someone who had taken only two sick days in the past five years to someone who would need to take the entire year off for extensive treatments. I had no experience with being incapacitated. I did not know how to proceed to turn myself from a highly active busy professional to an invalid, or how to navigate this disjuncture in the best interests of patients.

CPA ethical standards have relatively little to say about therapist illness. The clearest reference is Standard 1.42, which addresses incapacitation of a therapist only in terms of security plans for records: a psychologist must "collect, store, handle, and transfer all private information, whether written or unwritten …in a way that attends to the needs for privacy and security ….This would include having adequate plans for records in circumstances of one's own serious illness, termination of employment, or death". In contrast, the APA standard 3.12 regarding Interruption of Psychological Services is more explicit: "Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement". APA standard 10.09 regarding termination of therapy adds: "When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient".

Another ethical consideration for the ill psychologist is the APA standard 2.06 regarding Personal Problems and Conflicts. It states: "(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner. (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties".

Psychologists must not practice when impaired by serious disease. However, most cancers are insidious, and do not result in functional impairment until well into the illness or treatment. How can a psychologist balance his or her need to guard against impaired practice versus the need to terminate services judiciously?

The thrust of all these standards is that it behooves all psychologists to have a "back up" plan in case of incapacitation or death. NSBEP now requires psychologists to identify alternative psychologists those who will assume practice responsibilities in such

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an eventuality. And yet, the CPA and APA standards give scant guidance on how to manage the *communication* aspects of one's personal tragedy in the context of delivery of psychological services, particularly psychotherapy.

The core ethos of the CPA ethical principles is communication. Careful communication is the mainstay of most competent practice. Ethical principles governing communication, and of careful planning of service delivery and treatments, are the basis for ethical practice when confronted by the threat of incapacitating illness. Application of the spirit of CPA ethical principles and standards helps to shed light on how to negotiate one's exit from psychology work under such dreadful circumstances.

I was of course staggered by my diagnosis. How could this be true? I was a fit, highly active professional in my 40s. I worked over 40 hours each week, happily and industriously. I loved my work, my family, my friends, and my community. I had just finished a term as the President of APNS. And yet, I had to absorb the realization that I was in the grip of a lethal disease, and that my life as I knew was about to take a radical and sudden departure.

My first obligation was communication with those to whom I provide service. I made my first calls within hours of the fateful appointment that gave me my news. In retrospect, I was so aswim with shock that I ought to have waited. My first call was to my supervisor at my public job, the Coordinator of Student Services at the Annapolis Valley Regional School Board. Fortunately (or perhaps unfortunately) she was well experienced with cancer and its debilitating impact on staff. I was naively trying to reassure her that I would be able to meet some of my upcoming work commitments – my mind had not fully grasped the truth of my situation. But she knew. She was supportive but firm – she would put me off work as of that moment. She would make all the necessary arrangements with Human Resources. I would need to cease my direct service work in schools effective immediately.

A public service job has the benefit of infrastructure. My work with the AVRSB had primarily entailed consultation to schools regarding students with behavioral or mental health issues. Now, my responsibilities would have to be transferred to other AVRSB staff. I attended several meetings with my school board colleagues to determine how my services would be delivered by others. I had some unique aspects to my practice that could not be assumed by other staff, given the rare nature of the skills involved. For example, I was the only AVRSB staff person trained in the diagnosis of Autistic Spectrum Disorder. As a result of my illness, and a concurrent maternity leave of one other specialist from public mental health, screening and diagnosis of school-aged children suspected of Autistic Spectrum Disorder had to be suspended. We worked with our mental health partners to craft a memorandum to the doctors and other agencies, informing them of the new limitations to public psychology services.

My next concern, and my biggest challenge, was how to inform my private patients. Over and above my public sector job, I maintained a small but thriving private practice. The practice was limited to psychotherapy, mostly with adults. Although I only saw three patients a week, I had been practicing this way for nearly 15 years. Consequently, I had many longer term patients, and some with very significant diagnoses (Bipolar Disorder, Complex PTSD, OCD). At the time, I had several patients in the middle of protocols for EMDR (Eye Movement Desensitization Reprocessing) therapy for trauma. For those of you who do not know EMDR, the protocol does not lend itself to transfer to another therapist mid-treatment. Sadly and ironically, I was seeing several patients for cancer-related bereavement. I was deeply concerned with the impact of my departure on my private patients, particularly the very vulnerable.

During my graduate years, I had been schooled in a psychodynamic approach to therapy dynamics. The approach I had been trained in clearly emphasized very firm boundaries with clients. Self-disclosure was something I had almost never done. How could I share my news sensitively? How would I handle their understandable reactions? How would I manage the transference (and countertransference) issues? How would I manage the issues involved in transfers to other therapists?

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As another consideration in my case, I practice in a semi-rural area. In small town Nova Scotia, word gets around. I was concerned that my private patients would learn the truth before I could tell them myself. If I worked in a major city, I could perhaps simply announce I was closing my practice for health reasons and share no further. But where I live and work, that approach might not be sufficiently sensitive or even feasible. Moreover, my cancer treatment would oblige me to continuously wear a slow infusion bottle clearly labeled “chemotherapy”. My patients who required a few more sessions to terminate therapy would clearly see it. Should I, or could I, keep the reason for my departure from practice away from patients?

One of my first steps was to call the Association of Psychologists of Nova Scotia. Not only did I need to inform them as part of my obligation as Past President on the Executive, I needed guidance. I asked our assistant, Susan Marsh: did she know of any other psychologist in Nova Scotia who had undergone cancer and possibly faced these same dilemmas?

Susan was indeed able to connect me with a senior psychologist who had experienced cancer in the past – same cancer, same stage. This mentor shared with me that she had been forthright with all her patients, and gave them three options: to wait for her to recover, to transfer to another therapist, or to stop therapy. She wisely counseled me to anticipate that my patients were human, and that I could anticipate all the range of human reaction. They will surprise you, she said. She was right.

I made a list of all my cases. With each case, I weighed the best approach to the forced termination. There were many to consider: how fragile were they? How strong was the therapeutic alliance? How long had I seen them for? Were they in active treatment, or was their next appointment far off? How close was the client to a natural termination: could I reasonably finish with them in the few weeks I had before my daily radiation therapy began? Were their issues and presenting problems such that they would need extra support? For those needing transfers, who would be a good match for them? APA standard 10.10 states that “prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate”. I only had a few weeks before my daily radiation treatments would start – I did not have the time to see each client personally. I resolved to place patients in three categories: those who could be redirected by phone, those who needed a personal session to prepare them for transfer, and those I could reasonably finish with within a few weeks.

I was able to reach many by telephone. These patients were those on my waiting list, those who had only one session, or those whose return appointments were far into the future. I was able to tell them that I needed to close my practice for “health reasons”. It was difficult to hear the note of curiosity and bewilderment in their voices; however, most were satisfied with the list of alternative therapists I provided. For those I needed to redirect with a new referral, I arranged consent to forward my records to the relevant service provider.

The second group was those with whom I had a longstanding treatment relationship for serious diagnoses. With each patient I arranged a session in which I told them I had to close my practice, and I told them why. Although this degree of self-disclosure went against my grain, it seemed to me to be the only genuine thing to do. I reasoned that these individuals needed to know that I was not leaving them for any lesser reason than cancer. Also, I did not want them to hear my news from elsewhere. One patient had that misfortune, and was badly shaken by it before I could reassure them in person. Out of respect for the work we had done together, I felt it best to be straightforward with these individuals. Prior to these sessions, I was in touch with other therapists who I considered good matches, and thus was able to offer an alternative therapist. I was able to reassure them that I had taken every possible step to ensure continuity to their care, and I offered a joint session between us and the new therapist to facilitate handover. They had the option of finding their own therapist or terminating; however, each one of these patients accepted the transfer I had arranged.

I was indeed surprised by many of my patients’ reactions. Instead of crumbling, or crying, or becoming angry, most were wonderful. Some reacted with genuine shows of affection (“But I love you!” one said, as she jumped from the chair to hug me).

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Some were stunned, and needed several repetitions of my news to absorb it. Some responded with a kind of sober awe. Some patients announced with confidence that they were well enough to wait for me to recover to resume treatment. My mentor was right: many of those I thought would fall apart were strong and brave. Only one patient betrayed impatience and fear, but was reassured by an alternative referral. And my own reactions? I was genuinely touched and impressed with the degree of compassion and maturity my patients demonstrated, even though it felt so odd to be on the receiving end of their concern.

The next step involved transferring patients to other therapists. I was blessed with caring colleagues who came, pro bono, to joint sessions that I arranged to facilitate transfer. Because the patients had been prepared by my individual session with them, the focus of the transfer sessions was to meet and share with the new therapist. Their relief and mine was palpable, and our partings were dignified by the warmth and support of the incoming therapist.

The third and final category was those patients who were very close to a natural termination, but had a few important aspects of their protocols to complete. Most of these were EMDR patients. I had several concerns with my remaining patients. Would they feel they needed to take care of me, and hence not be forthcoming with their issues? Would they "fly into health" prematurely? Would they deem their own issues to be insignificant against what they knew of mine? Was I truly able to focus on them, given the distress and preoccupation that I was experiencing? With each case, the best solution to these concerns was the negotiation of a very clear treatment plan and goals. Fortunately, EMDR has a very structured protocol. But with all patients, the clearer the plan from the onset of therapy, the clearer the path towards mature conclusion. The specificity of the plan allowed both me and the patient to hone in on the work that had to be done. I was pleased and relieved to see that each of my remaining patients was able to adopt a focused approach to their remaining therapy. I may have been aided in this by the fact that I continued to feel well, and that I had no side effects from my chemotherapy, so that they were reassured by my apparent health. Each one of the remaining patients completed therapy with flying colours. When the time came, I was able to embark on my daily radiation treatments with a clear conscience and a clear schedule.

The final challenge arose with regard to former patients who wanted to do things for me. Once the word of my illness spread throughout the small Valley community, several patients contacted me to offer me concrete help: lawn-mowing, food, drives to medical appointments. How to handle their kind, well-meaning offers of tangible help? Would such help cross important boundaries better left in place? Would they be injured or hurt if I refused their assistance? Would I deprive them of a meaningful act of closure or respect? Once I came home from a medical appointment to find that my lawn had been mowed by a former patient, who had left a note explaining her good deed. For most of these situations, I was able to suggest alternative arms-length gestures that seemed appropriate. If I could match these gestures to a meaningful aspect of the patient's therapy with me, this seemed to satisfy all requirements. For example, one of my PTSD patients, who I had transferred to another therapist, had identified "70s music" as a resource and a "safe place" for himself during his work with me. When he offered to drive me to appointments, I asked him instead if he would make me a CD of his favourite 70s music. "That way," I told him, "when we each listen to it, you can think of me getting better, and I can think of you getting better". I accepted with grace all the gifts I was given, especially the homemade "get well" cards made by my child patients, and thanked the donors with genuine gratitude.

How to summarize what I learned? Although it is difficult to keep one's composure when surprised by cancer, there are others out there who can assist you to do so. APNS can help. I learned again the importance of service delivery and therapy planning, both before and after a diagnosis of cancer threatens that plan. I learned about the generosity of colleagues. I learned about the importance of frank and genuine interaction with patients when both of us are humbled by fate and the human condition. All of my experiences underscored for me the beauty and value of what we do as psychologists, and confirmed for me that our work has been one of the most proud purposes of my life. God willing, I will return to that work someday.

APNS CONTINUING EDUCATION WORKSHOPS 2010—2011

continuingeducation
lifelong learning for wellness
APNS
Association of Psychologists of Nova Scotia

February 25, 2011

Trauma-Focused Cognitive Behavior Therapy for Children with Complex PTSD and Multiple Negative Life Events, Dr. Vicky Wolfe

Rowe Bldg., University Avenue, Halifax

Traumatic experiences unfortunately affect large numbers of children and adolescents – and when it rains, it pours. Some youth experience multiple serious negative life events (e.g., traumatic events, maltreatment, loss, failure), and these events often spawn a host of life stressors and daily hassles. In this workshop we will examine the impact of multiple traumas and negative life events on youth, with a focus on short- and long-term effects related to Complex PTSD, mood disorders, and changes in world view and coping. As well, we will review the basic tenets of Trauma-Focused Cognitive Behavior Therapy, with adaptations for youth exposed to multiple traumas, including strategies for helping youth tell their story and process trauma-related issues.

Targeted Audience

- Mental health clinicians (psychology, social work, counseling, psychiatry, nurses) who work with children, adolescents, and families
- Anyone interested in work with disadvantaged youth, youth in foster care, and youth with histories of trauma, maltreatment, and serious negative life events

May 27, 2011

Overcoming Trauma & Addiction with Love, Strength & Power: A 16-Step Empowerment Approach, Dr. Charlotte S. Kasl

Dalhousie University, Halifax

Addictions often begin as an attempt to escape overwhelming feelings of fear, helplessness, anger and loneliness that stem from trauma, abuse, and alienation. The 16-step model, based on love, not fear, encourages people to develop a sense of mastery, explore creativity, attune to their authentic voice, take action on their behalf, foster supportive relationships, and find the confidence to live by their values. This workshop will explore how the 16 steps parallel psychological and neurological approaches to restoring mental health, and help people overcome the symptoms of trauma that often underlie addiction. The workshop will include lecture, discussion and a video of women talking about their experiences in two 16-step groups.

Targeted Audience

Psychologists, counselors, addiction counselors, students, nurses, doctors, people recovering from addictions and trauma. Administrators of addiction and trauma programs.

Oct. 24, 2011

Motivational Interviewing
Dr. Henny Westra
Venue: t.b.a.

Ethics for Psychologists

October 2011 **South Shore/Halifax**

In Planning 2011-12014

2011	**Workshop/Discussion on Parental Capacity Assessment**
May 25th, 2012	**Behaviour Therapy for TIC** **Dr. Douglas Woods**
Oct. 26, 2012	**Executive Functioning in Children** **Dr. Peg Dawson**
May, 2013	**Acceptance & Commitment Therapy,** **Dr. John P. Forsyth**
Oct. 25, 2013	**Chronic Insomnia** **Dr. Charles Morin**
2014	**APNS Conference**

These are just some of the topics we have been researching. If you have any comments on these or would like to suggest other topics or speakers please contact the APNS office at apns@apns.ca

APA COUNCIL REPORT ~ Charles Hayes, Ph.D.

There are two items that may affect those APNS members who are also members of APA. The recent APA Member vote that was held in a attempt to ensure that small jurisdictions like Nova Scotia would retain their representative seat on the APA Council of Representatives failed. It was the intention of the Council to protect such seats. Unfortunately the membership rejected the proposed changes.

The loss of this key vote means that our APNS seat continues to be in some jeopardy if not enough of the joint APNS/APA members give their representational vote to APNS. The threat is real; in that some small jurisdictions lost their representational seats in the past.

There is little doubt that this issue will come before the Council of Representatives again. It has remained a contentious issue because it pits regional seats like the APNS seat against interest jurisdictions like Neuropsychology. Some of the larger interest jurisdictions and larger regional jurisdictions can win extra representational seats at Council thereby increasing their effectiveness on key issues. However, the large jurisdictions seeking extra seats puts small jurisdictions under threat.

The second issue affecting APA/APNS members has to do with a recent decision by APA to try to rationalize savings for those psychologists who are registered with other psychological organizations. In the past there was a wide variance in dues charged for joint membership. Members of both CPA and APNS have enjoyed a particularly favourable dues position with APA. Fully one-half of the APA dues were waived for members in either CPA or APNS.

APA is now considering a reduction of only $25. for members of CPA or APNS, which would be consistent with that being offered by all other psychological affiliate organizations. If this is put into effect it could seriously impact both CPA and APNS membership. This is an issue which will be raised at the February meeting in Washington, DC. CPA will make a submission to APA because of historical arrangements with APA that followed the division of the North American Psychological Association into CPA and APA.

CPA has a long-standing relationship with APNS which includes the printing of CPA journals, joint standards on vetting University graduate program credentials and other arrangements. CPA will be making a submission to Council at the February meeting.

I will be working with CPA to try and have the former dues arrangement re-instated for CPA and APNS. The loss of the favourable dues arrangement with APA could lead to a loss of key members in Nova Scotia further putting into jeopardy our APNS representational seat on the Council of Representatives.

Respectively submitted
Charles Hayes, PhD.

NSBEP NOTES from Allan R. Wilson, Ph.D., Registrar

Dealing with Complicated Situations

Many times psychologists find themselves encountering complex situations. Such scenarios involve ethical issues, but can also include conflicts between standards of practice and legislation or legal requirements, and even conflicting pieces of legislation.

What should a psychologist do?

To help with the process, the following points are offered:

When encountering challenging ethical scenarios, psychologists are referred to the ethical decision making process outlined in the Canadian Code of Ethics and to Standard III.38 that states:

"Seek consultation from colleagues and/or where appropriate groups and committees, and give due regard to their advice in arriving at a responsible decision, if faced with difficult situations."

Providing consultation on specific issues frequently requires expertise in the area of practice under consideration. As such, the most appropriate consultation is likely to be provided by colleagues working in the same or a related area. Registrants are also encouraged to obtain a legal opinion where applicable.

There are situations encountered in which psychologists become legally compelled to act in a way that contravenes the standards of practice. For example, this could be the result of a subpoena requiring the release of the complete psychological record including the raw data. When the release of data is ordered by the Court, psychologists are not expected to refuse compliance. In those cases when ordered by the Court to disclose information inappropriately, the psychologist's responsibility ends once he/she has requested that the Court make adequate provision for the ethical handling of the data.

Pieces of legislation can also conflict. Because of the myriad of nuances that exist across situations, a blanket policy is not always practicable. In such situations, psychologists should obtain a legal opinion. McFarlan Rowlands offers some free legal consultation as part of their insurance program.

One of the ways to deal with complicated ethical issues is through the informed consent process. Psychologists who choose to perform work for a third-party payer must ensure that they establish informed consent at the onset of that work in a way that fully informs the client of possible ramifications set out by the third party agreement or legal requirements. If a psychologist feels that he/she cannot agree to the possible consequences that result from completing such work, he/she must seriously consider in advance whether to pursue such work. Psychologists must be aware that if at a later date they are legally compelled to do something related to this work, the standards of practice do not serve as a defense to break the law. Legislation does not always support our Standards. Psychologists are not expected to refuse legal compliance.

If certain legislation has a bearing on a psychologist's area of practice this too needs to be captured during the informed consent process. It is therefore imperative that psychologists be familiar with legislation that might influence their practice, e.g. Workers' Compensation Act, etc. The Board's document, entitled "Standards of Practice", includes a listing of relevant legislation and may be accessed via the following URL:
http://www.nsbep.org/downloads/
Binder_Standards_Legislation_Guidelines.pdf

Submitted by ~

Matthew Wagner, B.A., Assistant to the Registrar
Allan Wilson, Ph.D., Registrar

Acknowledgements

Congratulations to the following who have recently become Registered Psychologists*

Tricia Beattie, M.A.
Daniel Chorney, Ph.D.
Erinn Hawkins, Ph.D.
Jessica Ius, Ph.D.
Rodney Keddy, M.Ed.
Kim MacLean, Ph. D.
Bonnie McNeill, Ph.D.
Karen Mercer, M.Sc.
Tara Power, Ph.D.
Natalie Rosen, Ph.D.
George D. Schurman, M.Sc.
Laurie L. Tracey, M.A.
Lindsay Uman, Ph.D.
Marc Woods, Ph.D.

Congratulations to the following who have recently become Candidates*

Ashley Boutilier, M.A.S.P.
Anna G. Campbell, Ph.D.
Carissa D. Clement, M.A.
Valerie Grant, Ph.D.
Meaghan Hollett, M.A.S.P.
Alison Jessome, M.A.S.P.
Lindsay Leighton, M.A.S.P.
Amy Manuel, M.A.
Carlye Smith-MacKenzie, M.A.
Angela Pfammatter, M.Sc.
Kate Turner, M.A.

This information provided by NSBEP as of January 2011

APNS
Association of Psychologists of Nova Scotia

Welcomes its Latest Members as of January, 2011

Ashley Boutilier, M.Sc.
Carissa D. Clement, M.A.
Meaghan Hollett, M.A.S.P.
Alison Jessome, M.A.S.P.
Lindsay N. Leighton, M.A.
Kate MacDonald, B.A.
Amy Manuel, M.A.
Angela F. Pfammatter, M.Sc.
Marcel P. J. Peloquin, M.A.
Tara Power, Ph.D.
Carlye Smith-MacKenzie, M.A.
Kate Turner, M.A.

We would like to thank the membership for supporting APNS in its efforts to promote the interests of Nova Scotia psychologists through advocacy, continuing education and the support of special interests in the field.

IMPORTANT NOTICE

APNS will be consulting with the Provincial Mental Health Advisory Committee to help identify the major gaps in the current Mental Health system and offer recommendations for improvement. We would like to get feedback from you, our members, to ensure that your opinions and suggestions are represented. Please take 5 minutes to give us your input using the following web link:

http://athena.smu.ca/survey/index.php?sid=26516&lang=en

All input from APNS members must be received by the end of day Friday February 11, 2011

APNS MEMBER RATE AVAILABLE NOW

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Website: www.cambridgesuiteshalifax.com

Until April 30, 2011 $119*
***Parking included until April 30, 2011**
***Blackout dates: Feb 11-27, 2011**

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Please contact the chair or APNS office for further information or to communicate changes to the list of committees & representatives.

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Public Education Campaign Coordinator: Dean Perry

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Contact the APNS Office for more info on how to contact your regional rep.

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Publications:
Debra Garland, Editor

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Charles Hayes
Janice Howes (Disaster Response Co-ordinator)

Child & Adolescent Psychology Interest Group (CAP-I) is comprised of psychologists who work with children and adolescents and their families. Meetings are bi-monthly during the academic year to share information on topics of interest and to provide an opportunity to get to know our colleagues who work in a range of settings (schools, hospitals, universities, private practices, forensic settings, etc).

Testing Interest Group
various

Advertising Rates

The acceptability of an ad for publication in APNS publications is based on legal, social, professional, and ethical considerations. Also, an ad must be in keeping with the generally scholarly and professional nature of the publication. All content submitted is subject to APNS approval, and may be withheld with refund for any reason.

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"Nova Scotia Psychologist:"

Businesses

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3/4 Page	$400.00	
1/2 Page	$300.00	
1/4 Page	$250.00	
Business Card	$200.00	

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3/4 Page	$300.00
1/2 Page	$250.00
1/4 Page	$150.00

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Monthly Member E-mail	$15	

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Not-for-profit *(incl. schools / hospitals)*

Event / Workshop	$50.00	per 45 days
Job Postings	$50.00	per 30 days

APNS Member Print Ad Rates

"Nova Scotia Psychologist"

Full Page	$90.00	
3/4 Page	$75.00	
1/2 Page	$50.00	
1/4 Page	$30.00	
Business Card	$25.00	
Event / Workshop	$25.00	
Job Postings	$25.00	
Inserts	$25.00	for single sheet paper, additional costs as per weight as relates to postage cost
Mail-Outs	$100.00	plus mailing costs by weight x # of members
Mass E-Mail	$150.00	
Monthly Member E-mail	free	

APNS Member Website Ad Rates

Event / Workshop	$25.00	per 30 days
Job Postings	$25.00	per 60 days

Publication Information

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