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Refugee Mental Health Santé mentale des réfugiés

Ben C. H. Kuo, PhD, C. Psych.
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SPECIAL ISSUE/ ÉDITION SPÉCIALE

Refugee Mental Health Santé mentale des réfugiés



- 4 Responding to refugee mental health needs by training Canadian psychologists in cultural clinical competence
- 6 Le développement des compétences culturelles des psychologues dans leurs pratiques cliniques au Canada pour mieux répondre aux besoins des réfugiés en matière de santé mentale
- 8 Welcoming refugee children: The role of psychological first aid interventions
- 10 Refugees and PTSD: Where do we stand?
- 11 Trauma, attachment, and child mental health in refugee families in Canada
- 12 Working with refugees from Syria and the Middle East: A guide to better helping without cultural bias
- 14 Looking to God, within or both? Coping in Muslim Syrian refugees
- 16 Education, employment and mental health outcomes for Syrian refugee newcomers
- 17 Refugee mental health implications of immigration policy based on economic interest

18 Free circulation of scientists: Implications for international psychology conferences

20 CPA HIGHLIGHTS

22 FAITS SAILLANTS
DES ACTIVITÉS
DE LA SCP

ETHICS CORNER / L'ESPACE ÉTHIQUE

26 "If you serve too many masters, you'll soon suffer:"
Multiple relationships in graduate school

28 Si tu as trop de maîtres à servir, ta souffrance
s'annonce comme imminente : les relations
multiples dans le contexte des études supérieures

24-25 LAUREATES OF THE 2018 CPA CERTIFICATE OF ACADEMIC EXCELLENCE
LES RÉCIPENDAIRES DU CERTIFICAT D'EXCELLENCE UNIVERSITAIRE DE LA SCP 2018

30 2018 Robert Sommer Award for best student paper in environmental psychology

Responding to refugee mental health needs by training Canadian psychologists in cultural clinical competence



*Ben C. H. Kuo, PhD, C. Psych., Professor,
Department of Psychology, University of Windsor*

During the preparation of this issue of *Psynopsis*, daily reports of mass exodus of refugee populations around the world filled the news cycle - the caravan of migrants marching from Honduras towards the U.S. via Mexico; Venezuelan refugees fleeing to Colombia and other South American countries; Rohingya Muslims' escaping from Myanmar to neighbouring Pakistan; and the continuous plight of Syrian refugees as they are dispersed to different nations, including Canada. These and other events are a sobering reminder that multiple, concurrent, large-scale population displacements have become the chilling 'new normal' for the global community.

In 2018, the United Nations High Commissioner for Refugees reported a total of 68.5 million forcibly displaced people worldwide, of which 40 million are internally displaced people, 3.1 million are refugees, and 3.1 million are asylum seekers.¹ Meanwhile, recent data showed that Canada ranked second highest among Western countries for resettlement of refugees in 2016.² Taken together, these stats clearly show it

is imperative that Canadian psychologists be ready and able to address the critical psychological and mental health needs of the increasing number of international refugees and asylum seekers who are arriving at our doorstep and are being integrated into our communities across Canada.^{3,4}

Refugees in Canada have diverse nationalities, ethnicities, languages, religions and faiths, regionalisms, levels of education, socioeconomic statuses, and migration and sociopolitical histories. The issues facing refugees are also highly complex with sociopolitical, cultural, health, psychological, legal, and logistic needs and implications. As such, their health and mental well-being must be assessed in view of their pre-, during, and post-migration experiences.⁴ Existing literature recommends culturally-informed clinical training for clinicians for effective treatment and support for refugee children, adults, and families.^{5,6} However, current models and resources for training psychologists to work with refugees are scarce.

In 2006, the Multicultural Council of Windsor-Essex, the largest newcomer settlement agency in Windsor, Ontario, made an urgent appeal to registered psychologists in the city to offer therapy to under-served refugee survivors being

resettled in our area. In response to this call, I initiated, designed, and implemented an eight month-long supervised multicultural practicum in the in-house psychological clinic of the Department of Psychology at the University of Windsor. This multicultural practicum aims to provide: a) much-needed therapy services to refugees being referred and supported by the Multicultural Council and b) training opportunities for our advanced clinical students to develop first-hand cultural clinical competence through working with culturally- and linguistically- diverse refugees. Since its inception, every year, four to five doctoral-level practicum students have participated in this service-based training program after completing a full-semester didactic course in multicultural therapy/counselling. The philosophy of this refugee-focused multicultural practicum is grounded in the principles of *multicultural counselling competency*, *traumatology*, and *liberation theory* as recommended by Gorman⁵ and the American Psychological Association⁶ for treating refugee survivors. Its pedagogical and delivery model, on the other hand, is informed by the concepts of service-based learning, community-university partnership, and interprofessional collaboration.

Following the initial pre-therapy didactic seminars, which survey critical clinical and cultural issues pertaining to refugee survivors, student therapists provide weekly therapy to their refugee clients with the assistance of a trained language interpreter supplied by the Multicultural Council. The agency, through its case managers, supplies further logistics support for refugee clients to attend their weekly therapy sessions (i.e., refugee clients' needs for employment, housing, education, financial, transportation, and immigration services), and as their instructor, I provide student trainees with weekly group supervision, informed by the principles described above. Through this training model, student therapists are given the rare opportunity to gain first-hand clinical experience supporting refugee clients, to implement and exercise culturally-informed clinical interventions and skills, and to engage in interprofessional collaboration with community agencies and organizations. Over the last 12 years, this service-based training program has provided much-needed mental health support and intervention to a significant number of refugees in the Windsor area. Of equal importance, it has helped foster motivation, compassion, and confidence in many young psychologists who have gone on to work with refugee populations in their careers. Interested readers are referred to Kuo and Arcuri⁷ and Kuo⁸ for more in-depth discussions of this practicum.

The above represents one example of how psychologists and psychology training programs can contribute to the improvement of refugee mental health in Canada, but there are many more. This issue features articles by various Canadian experts on refugee mental health with diverse perspectives and recommendations for psychologists.

Rousseau and Miconi describe a creative, school-based intervention program in Montreal for refugee children and youth – an often-neglected segment of the refugee population. Using non-intrusive and non-stigmatizing art and play activities, their workshops create a safe and fun environment and pro-

vide emotional support for younger refugees. Ahmad provides a brief review of current treatment programs for PTSD for refugees and reminds clinicians of the importance of viewing and assessing refugee PTSD from a contextual perspective, giving consideration to other pre- and post-migration stress factors. Barnes and Theule point to the critical link between parental trauma and the mental health of refugee children and make a strong case for further research of this relationship. Abdulrehman points to the importance of a therapist's multicultural and cultural clinical competence in providing effective and culturally-responsive mental health interventions to Syrian and other Middle Eastern refugee clients. He also provides a helpful resource, titled "Working with refugees from Syrian and surrounding Middle East countries" for mental health professionals working with these populations. On the basis of a focus group study, Qasim and Hynie identify common stressors faced by Syrian refugees in Canada and point to Islamic faith as a key coping strategy for Syrian newcomers in responding to these post-migration stressors. Krzesni asserts that Canadian immigration policy, which increasingly places admission criteria on the economic attributes of refugees, can disadvantage refugee applicants and render lasting negative impacts on the well-being of refugees. Finally, Bridekirk and Hynie highlight that discrepancies between refugees' pre-migration expectations and post-migration outcomes may be predictive of their mental health. In particular, they indicate that the ability to find employment plays a key role in determining refugees' long-term health outcomes and integration in the host society.

I hope this issue of *Psynopsis* can serve as a call to Canadian psychologists to continue enhancing our role and capacity in improving the emotional and psychological health and well-being of refugees in Canada and beyond, particularly in this time of global refugee crisis.

Dr. Ben C. H. Kuo is a full professor of clinical psychology and the Director of Multicultural Clinical and Counselling Research Group at the University of Windsor. As a clinician, Dr. Kuo has worked and treated international students, immigrants, refugees, racial/ethnic minorities, and non-minority individuals in the U.S., Canada, and Asia. Dr. Kuo is also an active researcher in cross-cultural psychology and multicultural counseling/psychotherapy. He has lectured and taught internationally in Taiwan, China, Thailand, New Zealand, Russia, Brazil, and Canada as a distinguished visiting professor. In 2017, Dr. Kuo received the Outstanding Research Award: Establish Research/Scholar Category and the Faculty of Arts, Humanities, and Social Science's Dr. Kathleen E. McCrone Teaching Award at the University of Windsor in recognition of his contributions to research and teaching, respectively.



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

Le développement des compétences culturelles des psychologues dans leurs pratiques cliniques au Canada pour mieux répondre aux besoins des réfugiés en matière de santé mentale

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Tout au long de la préparation de ce numéro de *Psynopsis*, les médias rapportaient quotidiennement des exodes de populations réfugiées à travers le monde – une caravane de migrants marchant du Honduras aux É.-U. en passant par le Mexique; des réfugiés du Vénézuéla fuyant leur pays pour gagner la Colombie ou d'autres pays de l'Amérique du Sud; les musulmans Rohingyas se sauvant du Myanmar pour franchir la frontière du côté du Pakistan; et le sort lamentable des réfugiés syriens pour qui la route semble interminable alors qu'ils sont disséminés partout dans le monde y compris ici au Canada. Ces tristes événements, comme beaucoup d'autres, nous rappellent que ces déplacements massifs de populations, qui s'opèrent simultanément dans le monde, représentent la terrible « nouvelle réalité » qui frappe la communauté mondiale.

Récemment, l'Agence des Nations unies pour les réfugiés annonçait qu'un total de 68,5 millions de personnes avait été déplacé de force à l'échelle de la planète, dont 40 millions à l'intérieur de leur propre pays, 25,4 millions comme réfugiés et 3,1 millions comme demandeurs d'asile.¹ Parallèlement, des données récentes montrent que le Canada occupait, en 2016, le deuxième rang parmi les pays occidentaux d'accueil pour la réinstallation des réfugiés.² Mises ensemble, ces statistiques montrent clairement qu'il s'avère essentiel que les psychologues du Canada puissent faire face aux besoins criants des réfugiés internationaux et des demandeurs d'asile en matière de santé mentale et de santé psychologique qui arrivent et qui sont intégrés à nos communautés à travers le pays, et dont le nombre ne cesse de croître.^{3,4}

Les réfugiés qui arrivent au Canada proviennent de différentes nations, appartiennent à diverses ethnies et parlent des langues différentes auxquelles se mêlent autant de régionalismes. Ils pratiquent diverses religions et montrent une diversité de croyances, de niveaux d'éducation et de statuts socioéconomiques. Et ils ont tous connu des contextes de migration et socioéconomiques particuliers. Les problèmes auxquels ils font face demeurent extrêmement complexes sur les plans socioéconomiques, culturels, psychologiques, légaux

et logistiques ainsi qu'en matière de santé, autant pour l'ampleur de leurs besoins que pour l'ampleur des conséquences. En tant que tel, leur santé et leur bien-être mental doit faire l'objet d'une évaluation qui tient compte de leurs expériences pré-migratoires, de leurs expériences durant leur migration et de leurs expériences post-migratoires.⁴ Pour mettre en place un traitement efficace et apporter un solide soutien aux enfants, aux adultes et aux familles réfugiés, la littérature sur le sujet recommande que les cliniciens suivent une formation clinique axée sur la culture.^{5,6} Cependant, les ressources et les modèles actuels de formation destinée aux psychologues orientés sur le travail avec des réfugiés s'avèrent limités.

En 2006, le MCC⁵ du comté de Windsor-Essex, lequel est l'organisme de services d'établissement des nouveaux arrivants le plus important à Windsor en Ontario, a lancé un appel pressant aux psychologues agréés de la ville afin que ces derniers traitent par thérapies les réfugiés s'installant dans la région, en raison du manque de ressources à leur disposition. En réponse à cet appel, j'ai pris l'initiative de concevoir et de mettre en place, à la clinique affiliée au département de psychologie à l'Université de Windsor, un programme de stage pratique supervisé de huit mois lequel intègre une approche axée sur la culture. Ce stage pratique vise deux buts : a) offrir aux réfugiés référés et encadrés par le MCC des services de thérapies dont ils ont particulièrement besoin et b) offrir des occasions de formation aux étudiants de niveau avancé afin qu'ils puissent développer leurs compétences cliniques en travaillant avec des réfugiés présentant une grande diversité tant culturelle que linguistique. Depuis la mise en place du programme, quatre ou cinq doctorants prennent part chaque année à ce stage pratique, lequel comporte un cours didactique en counseling/thérapie multiculturel que les doctorants doivent suivre avant de se livrer au stage pratique. Le fondement philosophique de ce stage pratique axé sur la diversité culturelle des réfugiés repose sur trois éléments : les principes de compétences en counseling en contexte multiculturel, la traumatologie et la mise en liberté, comme le recommandent Gorman⁶ et l'American Psychological Association⁷ pour traiter les réfugiés rescapés. D'autre part, le modèle de prestation du stage et la méthode pédagogique s'y rattachant reposent sur

les concepts d'apprentissage fondé sur les services, de partenariat communauté-université et de collaboration interprofessionnelle.

Suivant les séminaires pédagogiques initiaux, lesquels font état des graves problèmes auxquels les réfugiés rescapés font face, les étudiants-thérapeutes proposent à leurs clients réfugiés des séances de thérapie hebdomadaires avec l'aide d'interprètes qualifiés provenant du MCC. Cet organisme, par l'entremise de ses gestionnaires de cas, offre un appui logistique étendu aux clients réfugiés en plus du soutien qui leur est apporté pour qu'ils puissent profiter des séances de thérapies (c.-à-d. les besoins des réfugiés liés à l'emploi, au logement, à l'éducation, aux finances, au transport et aux services d'immigration). À titre d'instructeur des étudiants-thérapeutes, j'assure chaque semaine leur supervision en groupe selon les principes énoncés antérieurement. L'utilisation de ce modèle de formation contribue à donner aux étudiants-thérapeutes des occasions uniques d'acquérir des expériences cliniques directes auprès des clients réfugiés, lesquelles comprennent la mise en place de plans d'interventions cliniques culturellement adaptés, le développement d'appétitudes pour exercer dans le domaine et l'établissement et le maintien de liens de collaboration interprofessionnelle avec des agences et des organisations communautaires. Au cours des 12 dernières années, ce programme fondé sur l'offre de services a permis d'offrir à un nombre important de réfugiés de la région de Windsor un soutien en santé mentale fort nécessaire. De façon tout aussi importante, le programme a stimulé la motivation et éveillé la compassion de plusieurs jeunes psychologues et leur a donné la confiance de poursuivre leur carrière en travaillant auprès de populations de réfugiés. Les lecteurs intéressés sont invités à consulter Kuo et Arcuri⁸ et Kuo⁹ pour en apprendre davantage sur ce programme de stage.

Cette approche fournit un exemple de la façon dont les psychologues et les programmes de formation peuvent contribuer à améliorer la santé mentale des réfugiés au Canada, mais il en existe beaucoup d'autres. Ce numéro de *Psynopsis* comprend des articles rédigés par divers experts dans le domaine qui proposent une variété de perspectives et de recommandations aux psychologues.

Rousseau et Miconi décrivent un programme créatif d'intervention en milieu scolaire offert à Montréal pour les enfants et les adolescents réfugiés – un segment de la population réfugiée souvent négligé. Au moyen d'activités récréatives et artistiques non intrusives et non stigmatisantes, les intervenants créent dans le cadre d'ateliers un environnement sécuritaire et amusant tout en apportant un soutien émotionnel à ces jeunes réfugiés. Ahmad donne un aperçu des programmes actuels de traitement du TSPT chez les réfugiés et rappelle aux cliniciens l'importance d'observer et d'évaluer ce trouble dans une perspective contextuelle en tenant compte des facteurs de stress « pré- » et post-migratoire. Barnes et Theule attirent l'attention sur le lien étroit entre les traumatismes parentaux et la santé mentale des enfants réfugiés et insistent fortement pour que d'autres recherches sur cette rela-

tion voient le jour. Abdulrehman parle de l'importance de la compétence clinique liée aux dimensions culturelles et multiculturelles afin d'offrir aux clients réfugiés syriens ou du Moyen-Orient des traitements en santé mentale efficaces et culturellement adaptés. Il suggère aussi aux professionnels de la santé mentale qui travaillent avec ces clientèles de consulter un document¹⁰ comportant des conseils pratiques sur des aspects à considérer pour interagir avec eux. Sur les conclusions d'une étude menée auprès d'un groupe de réflexion, Qasim et Hynie ont été en mesure d'identifier les facteurs de stress les plus courants chez les Syriens réfugiés au Canada et indiquent que la foi islamique joue un rôle clé dans l'adaptation des nouveaux arrivants syriens qui tentent de composer avec les facteurs de stress post-migratoire. Krzesni affirme que la politique d'immigration canadienne, laquelle s'appuie de plus en plus sur les aspects économiques des réfugiés comme critère d'admissibilité, peut jouer contre les demandeurs du statut de réfugié et entraîner des répercussions négatives durables sur le bien-être de ces derniers. Pour finir, Bridekirk et Hynie mettent en évidence que les écarts entre les attentes prémigratoires des réfugiés et l'aboutissement de leur parcours post-migratoire peuvent être prédictifs de l'état de leur santé mentale. Aussi, ils indiquent notamment que la capacité des réfugiés à se trouver un emploi est un facteur clé déterminant de leur état de santé à long terme et de leur capacité d'intégration à la société hôte.

Je souhaite que ce numéro de *Psynopsis* nous serve d'encouragement à continuer de renforcer notre rôle et notre capacité à améliorer la santé et le bien-être émotionnels et psychologiques des réfugiés au Canada et au-delà de ses frontières, surtout en cette période de crise de réfugiés à l'échelle mondiale.

Le Dr Ben C. H. Kuo est un professeur titulaire en psychologie clinique et le directeur du groupe de recherche en counseling et en pratique clinique adaptés à la culture à l'Université de Windsor. À titre de clinicien, le Dr Kuo a travaillé avec des étudiants étrangers, des immigrants, des réfugiés, des minorités raciales/ethniques et des particuliers de groupes non minoritaires des É.-U., du Canada et d'Asie. Le Dr Kuo est également un chercheur actif en psychologie interculturelle et en counseling/psychothérapie adapté à la culture. Il a présenté de nombreux exposés et a enseigné à titre d'éminent professeur invité à Taïwan, en Chine, en Thaïlande, en Nouvelle-Zélande, en Russie, au Brésil et au Canada. En 2017, il a reçu le prix d'excellence en recherche dans la catégorie recherche/universitaire établi et le prix Dre Kathleen E. McCrone en enseignement à la faculté des arts, des sciences humaines et des sciences sociales à l'Université Windsor en reconnaissance de ses contributions à la recherche et à l'enseignement.



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Welcoming refugee children:

The role of psychological first aid interventions



Cécile Rousseau, MD, Professor, Division of Social and Transcultural Psychiatry, McGill University and Diana Miconi, MA, PhD, Post-doctoral Fellow, McGill University

As a result of changes in American migratory policies, the number of refugee claimants irregularly crossing the Canada-United States border has dramatically increased since the end of 2016.¹ To accommodate the increasing number of refugees arriving in Montreal (more than 30,000 from January 2017 to August 2018), the Quebec government has opened temporary shelters characterized by instability, constant control by authorities, and limited resources and spaces, placing great stress on families and children. Refugee families are usually expected to stay in these shelters from two to four weeks – a period of high uncertainty. During this time, adults are expected to look for housing, apply for financial support, and begin their immigration claim. Meanwhile, children who are not yet in school remain in the shelters all day and are often looked after by older siblings and adolescents, while their parents are busy organizing the family resettlement. Many of these children have suffered trauma and numerous losses associated

with organized violence and a difficult migratory journey prior to their arrival in Canada. Most of them are affected by the fact that the shelters constitute a stressful environment and that their parents are only partially emotionally and physically available during this transition period.

Building on twenty years of experience with the development of school-based prevention programs,^{2,3} a team of Montreal youth mental health professionals implemented regular art and play activities in the shelters in 2017-2018. In line with the psychological first aid principles established by the World Health Organization,⁴ the objective of the art and play workshops was to establish a minimal routine through ritualized activities to foster a sense of safety in the children. The workshops also aimed to provide children with a safe space of expression of their experience and to facilitate the creation of temporary relationships. Given the uncertainties surrounding the families, the activities were not designed to facilitate disclosure or work through trauma or grief; however, when disclosure happened, or emotions were expressed, the workshop facilitators would provide validation of the child's experience and emotional support.

Activities targeted three age groups: 3-5 year-olds, 6-11 year-olds, and 12-18 year-olds. They were implemented twice a week in three shelters in the Montreal region over an eight-month period, and the program was evaluated qualitatively through focus groups with youth, parents, and service-providers. Overall, the workshops were perceived as a useful and effective means to decrease child and youth anxiety and acting out behaviours. Younger children who were displaying externalized behaviours usually calmed down during and after the workshops. They were intensely seeking attention and physical contact, touching and climbing on the workshop facilitators, fighting for attention and for toys and material. Of importance, this space was often the only moment dedicated in the shelter to creative activities and play, which are essential to the development of young people. Adolescents took advantage of the activities to create support networks among peers and, often, to express solidarity and resilience through collective pieces of art work. These were also privileged moments during which they did not have to care for their younger siblings.

Although it was not one of the initial objectives, the workshops also appeared to be an effective and non-stigmatizing means to screen major mental health and cognitive difficulties in children. This was particularly true in the younger group (the 3-5 year-olds) in which trauma is often missed because of its non-specific presentation (through dysregulation) and because of their limited capacity for verbal expression.⁵ In older children, beyond the stress-related disorders, autistic spectrum disorders and cognitive difficulties were also identified. In the absence of resources to address these problems rapidly, the transmission of this information to overwhelmed parents was a sensitive matter at this specific time, as it may have increased their anxiety without providing them with proper means to mobilize

themselves toward appropriate help-seeking. Although very invested in their work, the workshop facilitators often felt emotionally drained. They also felt impotent, perceiving the limit of what they could offer compared to the magnitude of the children's needs.

This intervention was unfortunately limited in time because of limited resources. Nonetheless, its evaluation suggested that psychological first aid interventions are useful for refugee children of all ages. They appear to decrease anxiety, buffering the stress associated with the uncertainty of the initial period of resettlement. Results also suggest that toddlers should not be forgotten, and that early detection of mental health problems is

possible through non-stigmatizing procedures. This experience confirmed that, in a time of few psychosocial resources, concertation and partnership among schools, community organizations, and mental health professionals is warranted to develop interventions that can address at least some of the needs of refugee children in the sensitive arrival period.^{6,7}

In summary, from a clinical and applied perspective here are some take-home messages: 1) because parents are overwhelmed and the children have no established routine, the early resettlement period may be very stressful for

refugee children; 2) around arrival, refugee children benefit from play and art activities, which help them to restore a sense of safety; and 3) these activities can be a good occasion to identify at risk children and provide some information and guidance to the schools that will welcome them.

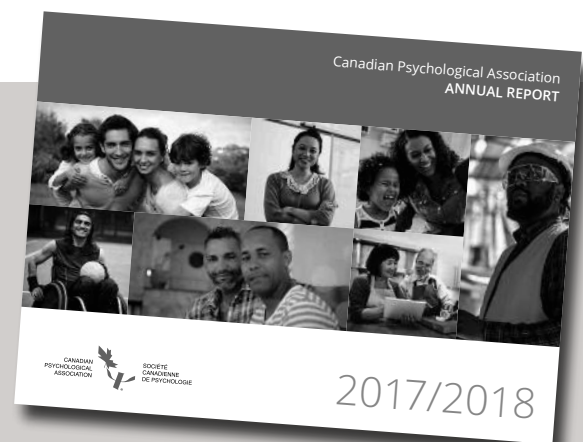
Meanwhile, children who are not yet in school remain in the shelters all day and are often looked after by older siblings and adolescents, while their parents are busy organizing the family resettlement.

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Refugees and PTSD: **Where do we stand?**

*Farah Ahmad, MBBS, MPH, PhD, Associate Professor, School of Health Policy and Management, York University
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Recent estimates suggest there are 22 million refugees globally who are fleeing regions afflicted by conflicts, wars and violent extremism.¹ Some of these refugees migrate to neighbouring countries, while others seek refuge in resettling countries, whose numbers have increased from 14 to 37 countries between 2005 and 2016.² Exposure to multiple traumatizing events throughout the migration process often leads to post-traumatic stress disorders (PTSD) among refugees. Although varying rates of PTSD are reported across countries, it is a common mental health problem and its prevalence could be as high as 44%.³

In the last few decades, several treatment programs (pharmacological, psychological, social or multi-modal) have been examined for effective care of PTSD in the general population, veterans and refugees.⁴ A review of evidence-based clinical treatment guidelines reveals that professional recommendations exist in several developed nations for use of one or more of such treatment approaches.⁵ In Canada, cognitive behaviour therapy (CBT) is recommended as the first line of treatment. Pharmacological treatment with Selective Serotonin Reuptake Inhibitors (SSRI), such as Fluoxetine, Paroxetine, and Sertraline, and with Selective Serotonin Norepinephrine Reuptake Inhibitors (SNRI), such as Venlafaxine XR, is also recommended.⁶ In the United States, the Department of Veterans Affairs has detailed guidelines for screening and management of PTSD⁷ that, in addition to the above-mentioned medications and some others, recommends a number of psychotherapy interventions such as CBT, eye movement desensitization and reprocessing (EMDR), relaxation techniques, imagery rehearsal, hypnotic techniques, and group therapy. In the United Kingdom, the NICE guidelines⁸ suggest that five brief psychological sessions may be effective if treatment starts within the first month after the traumatic event. If treatment is sought later, medical treatment with Paroxetine, Sertraline and Venlafaxine and psychotherapy with CBT and EMDR is recommended; however, drug treatment should be avoided as routine first-line treatment because the evidence for effectiveness of drug treatments in PTSD is very limited. Similarly, the World Health Organization (WHO) recommends psychotherapy using trauma-focused individual or group CBT, EMDR, and stress management while medications are to be considered only if these measures fail,⁹ possibly due to the context of low-resource countries that often fall under the

WHO's mandates. Nevertheless, there exists inconsistency across guidelines in terms of when and how these psychological, pharmacological, and other approaches could be offered or combined. This poses challenges for professionals involved in planning settlement programs for refugees in diverse settling countries in the West.

Further, treatment plans for refugee populations need to consider pre- and post-migration factors and conditions identified as contributors to PTSD. In addition to the severity and number of traumatic events experienced, being female and of older age, language difficulties, literacy, unemployment and family separation are pertinent.¹⁰⁻¹³ Studies with refugees settled in Western countries have shown that acculturative stress and exposure to new stressful events could prolong and worsen the symptoms.¹⁴⁻¹⁶ Such stressors could arise not only from differences in values and perspectives, but from difficulties in securing descent employment and experiencing a deficit in social networks compared to what existed in their countries of origin. Further, the complexity of settlement process poses barriers for many refugees experiencing PTSD symptoms and may prevent them from either seeking professional advice or complying with a care plan.¹⁷ Indeed, a broader approach for PTSD treatment holds promise for refugee populations.

Psychologists can contribute in multiple ways towards addressing common mental health conditions, including PTSD among refugees. They can engage with policy makers – an upstream approach – by offering experiential knowledge to inform the development of comprehensive inter-sectoral mental health programs, which are much needed for PTSD care. They can collaborate with researchers – a midstream approach – to generate evidence and improve treatment guidelines for PTSD. Psychologists can also work with professional bodies and community groups to advocate for timely access of evidence-supported psychotherapy interventions, such as CBT, to refugees living with PTSD. As frontline clinicians, their adoption of culturally sensitive best-practices* can go a long way in improving the overall quality of care for refugees in need of mental health care. Finally, psychologists should remain vigilant about the risk of over-diagnosing PTSD and take into account the agency and resilience among members of the refugee community.

* <https://www.cpa.ca/practitioners/Cultural>

For a complete list of references, visit www.cpa.ca/psynopsis

Trauma, attachment, and child mental health in refugee families in Canada

Jennifer Barnes, MA, PhD candidate, University of Manitoba and Jennifer Theule, PhD, C. Psych., Assistant Professor, University of Manitoba

The world is currently experiencing a global refugee crisis, with a reported 14 million refugees worldwide.¹ Refugees have often undergone a wide range of trauma throughout the various stages of their migration process,² and women and children have been found to be particularly susceptible to the development of Post-Traumatic Stress Disorder (PTSD). Studies have found that female refugees with past mental health diagnoses who have experienced two or more traumatic events have a 71% chance of being diagnosed with PTSD,³ and approximately 30% of Syrian refugee children meet criteria for PTSD.⁴ As Canadians, we are not only required to assist in providing refugees with basic humanitarian needs, but are also responsible for providing much-needed evidence-based and trauma-informed psychological support and intervention.⁵ However, advocates claim that Canada is not doing enough to support refugee mental health⁶ and little research on refugee mental health has been published within Canada.

Patterns of intergenerational trauma, which is thought to occur through the change of a parent's ability to function as a caregiver due to their trauma, have been found within resettled refugee mothers and their children.⁷ Among refugee populations, parents' PTSD symptoms⁸ and torture experiences⁹ are related to children's psychological distress and internalizing and externalizing behaviours. In particular, refugee mothers' post-traumatic and depressive symptoms appear to mediate the effect of past maternal torture experiences on children's adjustment and are thus thought to be mechanisms of transmitting trauma from mother to child.⁷ This is consistent with literature on the strong relationship between maternal trauma and attachment security¹⁰ – mothers who have experienced trauma can show frightened, frightening, dissociative behaviour and withdrawal, which is associated with disorganized child attachment security.¹¹ Maternal stress has also been



shown to have large effects on mother-infant interactions, with mothers showing less sensitive responding and reduced emotional tones during interactions.¹² Caregivers who have difficulty regulating themselves, which is common after experiencing trauma, are often impaired in their ability to accurately respond to and reflect their children's mental states.¹³ As a result, children must attempt to regulate their own states of arousal without assistance.

Given the strong links between child non-secure attachment and later child psychopathology,¹⁴ it is important from a clinical standpoint to further investigate these relationships with regards to refugee mental health. Nevertheless, there are only two studies considering the relationship between maternal trauma and child attachment in refugee populations. The first examined the relationship between intra-family trauma communication style, children's attachment security, and psychosocial adjustment in refugee families in Denmark.¹⁵ The results of this study suggested the trauma experienced by parents may be transmitted across generations through disruptions in children's attachment security. That said, results were inconclusive about the effects on internalizing problems. The

Continued on page 13

Working with refugees from Syria and the Middle East:

A guide to better helping without cultural bias



*Rehman Y. Abdulrehman, PhD, C. Psych., Director,
Clinic Psychology Manitoba*

About four years ago, a male medical colleague who volunteered at Syrian refugee camps in Greece asked me how to overcome the cultural and religious barriers that prevented women from obtaining basic medical care. Though extremely well meaning, he had assumed the women were refusing care from male physicians due to culture or religious beliefs, not because of trauma due to rape, which we now know was used as a weapon of war. This presumption about the culture and religious beliefs of Middle Eastern and Muslim people was critically obstructive to patient care, as it interfered with the basic knowledge this professional, despite her diligence and sincerity working in this area. And that is when I knew we had to have a resource on the culture of Middle Eastern and Muslim people to enable well-meaning people to work more effectively with refugee and newcomer populations from Middle Eastern and Muslim countries.

Models of cross-cultural competence consistently encourage us to first be mindful of ourselves, our bias, and our cultural identities before seeking to understand the culture of our clients so we can build harmonious and productive working alliances. Yet we live in a world where misconceptions about Muslims and people of Middle Eastern descent are common. Even in a country we consider to be more progressive, Statistics Canada's most recent poll noted a 253% increase in hate crimes against Muslims from 2012-2015.¹ Forum research polls in 2016 also found that 67% of Canadians surveyed believe that immigrants (with the political climate focusing on Syrian refugees) should be screened for "anti-Canadian values."²

The rhetoric behind these fears is often based on the conflation that the values of Muslims and Middle Easterners reflect the values of terrorist organizations. Although we may believe such fears and xenophobia belong to older generations, predominantly white groups, or right wing voters, polls in the United States³ found that Islamophobic beliefs existed in high

numbers in other minority groups as well (32% among African Americans, 36% among Hispanic Americans, with rates higher in other groups) in a broad range of groups, including young people, people of colour, and more left wing voters.

Though Canadians, perhaps more than others, have worked hard to be receptive to Syrian and other Middle Eastern refugees, the startling statistics noted above show that even those who hold no outward discriminatory beliefs, still often have a misunderstanding of the cultures, values, and world views of Muslims and Middle Eastern people.

In workshops I run on working with newcomers and refugees, I incorporate the stories of lived experience of people who were once refugees from this region themselves. It's not uncommon to hear, from women especially, about the microaggressions they've encountered from very well-meaning professionals that often created a chasm between them, inherently making it less likely that they will seek further support from them.

One such example, common to many young women, is that of a young woman who recalled feeling ashamed of her ethnic and cultural identity, ultimately choosing to not wear the headscarf or hijab to appear more "Canadian." She recalled being lauded by teachers and health professionals for freeing herself of the shackles of her religion when in fact, she had only done so due to the discrimination and isolation she had experienced when she had worn her hijab.

Another example is of a young boy, who out of a cultural sign of respect, would never look his teacher in the eye. Because he was new to Canada and had difficulty with English, his teacher assumed he had developmental and/or attention difficulties and placed him in a segregated classroom for the remainder of the year, further socially isolating him. Again, though the teacher meant well, the teacher misinterpreted the boy's sign of respect and lack of language and created further social difficulties that have had longstanding effects on the boy.

Although it is critical for us, as mental health professionals, to be aware of our own bias, there remains a strong need to also understand the nuances and details of the cultures of those with whom we live and work. I am pleased to have contributed to a free resource, entitled "Working with refugees from Syria and surrounding Middle East countries" that was created in an effort to help balance the scales of cultural information, with a special addendum on issues of mental health. The team that created this resource consisted of professionals from around the world, both locally and in the Middle East, and of broad cultural and religious backgrounds. Some were experts in the culture, others were experts in trauma, many were experts in both.

It is, in the end, a small drop in the bucket of knowledge we must accumulate when working with cross-cultural populations. But it is, we feel, a heartfelt and important resource, particularly in politically conflictual times, where a lack of good information can sway the good practice, despite the best intentions of volunteers and health professionals everywhere. On behalf of the contributing team, I encourage you to download, read, and share this free resource with anyone you feel may find it helpful.

<https://clinicpsychology.com/wp-content/uploads/2016/04/tip-sheets-final.pdf>


Trauma, attachment, and child mental health in refugee families in Canada

Continued from page 11

second study examined the relationship between parental PTSD, adverse parenting, and child attachment in a population of Middle-Eastern refugees in the Netherlands.¹⁶ The results of this study indicated parental PTSD symptoms were directly related to child attachment non-security and disorganization; however, the effect of parenting strategies was unclear.

It is imperative that we, as psychologists, work to address this research gap involving the refugee population in Canada. A mother's mental health not only impacts her but also her children, even those who were not directly exposed to trauma, and understanding the mechanisms at play in these trauma relationships is crucial to providing evidence-based interventions to these families. It will also help us to better target interventions. For example, providing attachment-based, family therapy in addition to individual treatment for PTSD for refugee mothers may assist in improving the mental health of refugee children. In light of this, we are currently examining the effects of maternal PTSD on child attachment security and variables that may affect this relationship, such as the mother's own attachment security, depressive symptoms, parenting strategies, and social support. Additionally, we will be looking at the relationship between maternal trauma and child internalizing and externalizing behaviours. Refugee mothers and their children are currently being recruited in Winnipeg, Ottawa, Toronto, and Montreal. We are examining this issue in children between the ages of 18 months and five years with mothers who speak Arabic, Farsi, French or English.

We hope this study will help contribute to our understanding of the key factors interacting with trauma within refugee families so that we will be able to provide more evidence-based interventions to this vulnerable population in Canada. We also hope this study will lay the research groundwork for the development of attachment- and family-based clinical treatments for this population. It is imperative that we develop and provide appropriate resources for refugee families, and that psychologists become involved (both through research and clinically) to avoid a potential mental health crisis for these newcomers to Canada.



Looking to God, within or both? Coping in Muslim Syrian refugees

*Kashmala Qasim, M.Sc., PhD candidate, York University, and
Michaela Hynie, PhD, Professor, York University*

Refugees experience several unique challenges, such as trauma, disrupted social networks and limited economic prospects making them vulnerable to poor mental health. The ongoing Syrian refugee conflict has sparked an increasing academic interest in assessing pre-and post-migration predictors, and the resultant psychological consequences.

The Syrian population consists primarily of three religious groups: Muslims (87%), Christians (10%), and Jews (3%). We conducted focus groups with 37 practicing Muslim Syrian refugees recruited from a Mosque in Toronto to better understand how they were coping with the challenges of resettlement. When asked about their top challenges in migrating to Canada, participants emphasized the lack of English language skills as the primary barrier to finding employment and settling smoothly into Canadian society. In addition to language skills, almost all participants mentioned the high cost of housing, difficulties in continuing education, and poor acceptance of non-Canadian work experience and documentation by Canadian companies and institutions. However, the men and women we spoke with in our study embodied a sense of gratitude of migrating to a country in which they can safely raise

their children and appraised their challenges as providing opportunities to come closer to God, as well as to give back to their host country as citizens, rather than as permanent guests.

For many of the participants, a primary coping mechanism was their Islamic faith, both institutional (e.g., attending the local Mosque) as well as personal (e.g., five daily prayers, reciting the Qu’ran). According to Pargament and Raiya, religious coping methods are ‘ways of understanding and dealing with negative life events that are related to the sacred.’ The participants in our study used their faith as an active form of coping, which incorporated an internal locus of control and positive reframing of negative events (i.e., looking at suffering as a test from God, not a punishment). Several participants mentioned using faith as a medium for problem solving and social support based coping by being proactive in looking for resources in the community, placing their trust in God, undertaking religious activities to assist others and asking God for patience and strength. Additionally, participants expressed acceptance of their situation as a conscientious choice, as opposed to being hopeless with their life situations, seeing their circumstances as a punishment or reappraisal from God, or passively deferring their situations to their religion – all of which can be negative forms of faith-based coping.

Islamic faith was also used to frame their responses to financial hardship since resettling. All those who contributed to the discussion explicitly mentioned verses from the Qu'ran about managing money wisely and keeping in line with the Prophetic teachings to deter from extravagance and pay off their debts. The resettlement process and the support Syrian families are receiving, however, challenged the definitions of basic needs versus luxury for many of our participants, including spending money on buying only groceries for a large family, versus considering purchasing the newest iPhone for their teenager. For example, one participant detailed an account of living off a single loaf of bread for her whole family during their time in a Jordan-based camp. However, upon arriving to Canada, sponsors started to drop off duplicate donations of not only food, but pieces of furniture, clothing and electronics. One mother reported that this became so severe that she feared her children would become spoiled and entitled to this help.

The biggest challenge for all the participants in this study was the discrepancy between their expectations of Canadian society versus the reality. The men in our study expressed their concerns about the individualism of Canadian culture, especially as it relates to gender roles, the perceived lack of importance given to family ties and the value they themselves placed on retaining Syrian traditions. In contrast, the women expressed distress relating to the multiple roles they must now fulfill, including taking language classes, rearing children, managing the household, finding employment, and addressing the needs of extended family still residing in Syria. As one

woman jokingly said: “Canada is number one; number one in hardship for women.”

These brief conversations with recently arrived Syrian families provided us with a glimpse into the challenges they face as well as coping strategies for adjusting to a new country and a foreign culture; all of these challenges are compounded by their financial uncertainty in Canada. The participants in our study reflected on their struggles; demonstrated agency to improve their conditions; and used their Islamic faith personally, institutionally and as a community, to help them achieve some sense of stability and hope for their new journey, branded by the world as a Syrian refugee.

Overall, the participants in this study were extremely eager to contribute to research and share their experiences so much so that over half the participants initially refused compensation for their time. Both the men and women also provided us with questions for future directions, and even offered their time for the next research study. This is an important consideration for researchers to conduct community-based participatory research to include the voices of their participants in the research design, and to examine topics that are the most urgent for refugee families. Finally, it would be helpful for mental health clinicians working with Syrian refugees to work alongside Imams of local mosques to incorporate spirituality and faith-based interventions in secular forms of psychotherapy.

For a complete list of references, visit www.cpa.ca/psynopsis

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Education, employment and mental health outcomes for Syrian refugee newcomers

*Jonathan Bridekirk, PhD candidate, York University, and
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Between November 4, 2015 and June 30, 2018, Canada relocated and resettled over 56,000 Syrian refugees nationwide. Syrian newcomers vary widely in terms of their socioeconomic (SES) backgrounds, previous employment, qualifications, and education. It is often assumed that those with higher levels of education will find integration easier because they are better able to learn English/French and are more likely to find employment. However, past research finds that mental health outcomes for refugees are poorest for those with the highest pre-migration socio-economic status. As part of a national longitudinal study with Syrian refugees, the Syrian Refugee Integration and Long-Term Health Outcomes in Canada project (SyRIA.lth), we are exploring this phenomenon to better understand the gap between employment expectations and outcomes among almost 2,000 Syrian refugees across Canada, and the consequences it can have for newcomer mental health.

Employment and poverty have been identified as key determinants of health and are common challenges in refugee integration.^{5,6} Employment is essential for newcomers to support their families, rebuild their lives in Canada, and reestablish themselves as contributing members of society. Because of the role employment plays in one's sense of self-worth and social status, unemployment has been found to have direct effects on mental health.^{4,7} Refugees who are actively seeking employment, but are unable to attain employment, are at greater risk for depression and social withdrawal. Over time this could contribute to poorer mental and physical health.⁶

The issue is not just about finding employment, however, but about finding appropriate employment.⁸ As with other newcomers, Syrian refugees may struggle to find employment that commensurate with their skills, experiences, and qualifications, and this may be more challenging for those with higher qualifications. One longitudinal Canadian study found that refugees with higher education and qualifications are more likely to be over-qualified when and if they find employment.⁸ Moreover, those who perceived themselves to be more over-qualified for their current jobs demonstrated the greatest decline in mental health.⁷



Poorer mental health outcomes may be partially due to greater inconsistencies between pre-migration expectations and post-migration outcomes, compared to other migratory groups.⁹ Immigrants choose whether and when to migrate, and can prepare for migration in terms of securing appropriate education, training, accreditation and information, and, in Canada, are often selected on the basis of their perceived fit with economic opportunities in the country.^{5,6} Refugees are forced to leave their country of origin with little choice or preparation, have little choice over where they move to, and often leave behind many of their economic resources.⁶ As a result, they are less likely to speak the language of the country they migrate to, often cannot bring or provide evidence of skills, training or accreditation, and may not have the skills needed or appropriate for the country they move to.² These circumstances place refugees at a disadvantage when seeking employment and at greater risk for poorer mental health and well-being.^{4,9} However, most research examining pre-migration SES, expectations, and well-being among refugees has been cross-sectional and has not followed refugees over an extended period of time.^{8,10,11} With current Syrian integration initiatives in Canada, there is more opportunity to explore the relationships between past socioeconomic status, education backgrounds, expectations, and post-migration employment experiences. Understanding how different resettlement conditions predict successful pathways to integration for diverse newcomers can help us strengthen resettlement support to assure their long-term well-being.⁹

For clinicians working with Syrian refugees, it is important to consider the quality and experiences of post-migratory conditions for individuals and their families.^{9,10} Although the manner of refugees' arrival in Canada leads us to have concerns about premigration trauma, such as experiencing war and conflict, the impact of these pre-migratory stressors may be mitigated and decreased over time in the presence of favourable post-migratory conditions.¹² Thus, it has been recommended that a multi-modal approach be used for refugee newcomers with mental health concerns that combines therapy (i.e., pre-migratory trauma) with assistance surrounding practical issues regarding post-migratory experiences.⁹

For a complete list of references, visit www.cpa.ca/psynopsis

Refugee mental health implications of immigration policy based on economic interest



David Krzesni, M.Ed., doctoral student,
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Canada is often considered a leader on immigration policy, but sometimes these policies can have negative consequences on the mental health of refugees.¹ Canada's immigration policy is driven by economic interests and most newcomers are admitted based on a point system that ranks their desirability.^{1,2} Canada's policy also aims to disperse newcomers away from traditional immigration magnet cities (i.e., Toronto, Vancouver, and Montreal) according to regional capacity and labour needs.³ Consequently, as the prominence of economic immigration grows, the proportion of refugees to economic immigrants admitted to Canada shrinks.⁴

However, refugee claims are not explicitly judged based on the claimant's economic desirability. The Immigration and Refugee Board of Canada (IRB) reviews claims according to the risk a refugee claimant presently faces and the risk (e.g., health, security, criminality) they might pose to Canada.⁵ However, the process hinges on the ruling of the IRB judges who are political appointees not required to have any special qualifications.⁶ And if a refugee has had a previous claim denied by the IRB, they can never apply again.⁵ In the context of broad focus on the economic desirability of newcomers, it is

possible that refugee claims are being approved or denied based on judges' political affiliation and consideration of the desirability of the refugee rather than the risks that they face or the risk they present to the Canadian society.

It seems that organizations serving refugees in Canada are responding by working to open alternative pathways (i.e., economic immigration pathways) for refugees and shifting their own discourse from one of civic responsibility toward refugees to a discourse promoting the potential economic contributions of refugees.⁷ Such efforts are surely well-intentioned and pragmatic attempts to secure protection for vulnerable people through all available pathways and to adapt their own messaging and advocacy work to an audience that might be more economically than socially motivated. However, they may be reinforcing rhetoric that qualifies one's deservingness of asylum with their social or economic desirability. This could, in turn, shape public opinion and policy that will contribute to a decrease in asylum for the most vulnerable refugees who may be deemed "undesirable." This is a dangerous precedent because refugees, by definition, face potentially life-threatening situations.

Continued on page 19

Free circulation of scientists:

Implications for international psychology conferences



John Berry, PhD, Member of the CPA's International Relations Committee

Note: This article has been endorsed unanimously by the CPA's International Relations Committee and the Canadian National Committee for Psychology and is supported by the CPA's Scientific Affairs Committee.

It is essential for the development of international psychology that psychologists be able to freely engage with others around the world, without limitations to their travel or communications. Unfortunately, this is not always the case. While the free circulation of some psychologists may be limited by their countries of origin, most problems arise from actions taken by the countries psychologists hope to visit.

The International Science Council's Statute 7 on the Principle of Freedom and Responsibility in Science states:

[...] The free and responsible practice of science is fundamental to scientific advancement and human and environmental well-being. Such practice, in all its aspects, requires freedom of movement, association, expression and communication for scientists, as well as equitable access to data, information, and other resources for research. It requires responsibility at all levels to carry out and communicate scientific work with integrity, respect, fairness, trustworthiness, and transparency, recognising its benefits and possible harms.

In advocating the free and responsible practice of science, the Council promotes equitable opportunities for access to science and its benefits, and opposes discrimination based on such factors as ethnic origin, religion, citizenship, language, political or other opinion, sex, gender identity, sexual orientation, disability, or age.

This principle is adhered to by the International Union of Psychological Science and was recently formally endorsed by the CPA's board of directors. In recent years, it has come to the fore as a result of entry restrictions being placed on residents or citizens of certain countries.* Most notably the United States has placed blanket bans on residents of Chad, the Democratic Peoples Republic of Korea, Iran, Libya, Somalia, Syria, Venezuela and Yemen. While Canada has no blanket bans in place at present, individuals may be denied entry into Canada because of criminal or other factors (e.g., late or incomplete visa applications; lack of sufficient resources to stay in, or eventually leave, Canada).

The principle of free circulation of scientists means that scientific organizations should choose not to host international conferences in countries that may prevent some members from attending based on their country of residence or citizenship. In order to discover whether international scientists have recently faced any visa problems while trying to enter Canada, we canvassed the organisers of three international congresses held in Canada in 2018.

Peter Graf (International Congress of Applied Psychology, Montreal), Saba Safdar (International Congress of Cross-Cultural Psychology, Guelph) and Kim Noels (International Conference on Language and Social Psychology, Edmonton) reported that there did not appear to be any problems stemming from the national origin (or related characteristics) of the hundreds of applicants seeking a visa to come to Canada for their conferences. They did, however, report a number of other problems, mainly due to the lack of timeliness and completeness of applications.

Peter Graf highlighted these problems in his comments, which are supplemented with examples provided by Saba Safdar and Kim Noels. Based on email inquiries and phone calls with embassy officials, visa problems could be traced to the following (in order of importance/frequency):

1. Though the time required is usually specified on embassy websites, many applicants did not give themselves enough time to submit their visa applications. In one case, the applicant's university delayed sending her visa application to Canadian authorities. In another, the applicant submitted their application from a third country (rather than their country of citizenship), which caused a delay.
2. Visa applications now require increasingly detailed information, and many applicants failed to read and follow the instructions and/or did not provide all of the information or documents required for their visa application.
3. Applications were rejected because the information provided was not sufficiently specific. For example, a street address and confirmation of a reservation are required when providing hotel information, not just the name of the hotel. Similarly, to confirm the intention to return home, it may be necessary to provide a copy of an employment contract.
4. Visa applications are expensive, and if one fails, a new application must be filed. Late or rush applications are also substantially more expensive. A few applicants did not apply early enough because of a lack of funds or did not have the funds to re-apply after their first application was rejected.

We call on all members of the CPA to share knowledge of the core principle of free circulation with their students, colleagues and professional associations in order to avoid problems when organising international conferences or dealing with prospective international students and academic visitors. Information about the specific difficulties encountered during the congresses this year should also be shared to assist applicants in the proper submission of their applications for visas to Canada.

Refugee mental health implications of immigration policy based on economic interest

Continued from page 17

The economic desirability discourse implicitly suggests that refugees are undesirable and are a burden on communities, unless they prove their potential to contribute to the economy. There is a global tide of xenophobia toward immigrants, especially refugees, based on a political discourse inciting fear that they pose a threat to our economies and national security.² If this discourse is not challenged, we may see the trend toward a decreasing proportion of refugees to economic immigrants admitted to Canada grow, and refugees already settled in Canada may face both increasing stigma and discrimination and decreasing community integration, belongingness, and self-worth particularly among refugees who are unemployed or cannot work. As a result, refugees could experience a trend toward lower wellbeing and mental health.⁸

Dispersal policies may also impact the wellbeing and mental health of refugees by not adequately accounting for their needs and preferences. While refugees are less likely than other immigrants to have a preference for a specific community prior to their arrival, their need for social support, community, and permanent housing often cause them to relocate to more supportive or welcoming communities.⁹ Many refugees relocate immediately or within a short period after arriving to their initial destination, but the prevalence of such secondary migration is not well studied, nor is the impact of secondary migration on refugee mental health.⁹ Furthermore, local service organizations are resourced according to refugees' intended destination, not where they actually settle. As a result, regional organizations may not have accurate information on the size and demographics (e.g., languages or countries of origin) of the population they serve and, therefore, may lack the resources they need to provide adequate services, including mental health services, to refugees.

Refugees already tend to experience lower wellbeing and a high incidence of trauma,⁸ and immigration policy and discourse in Canada, and around the world, threaten to contribute to an environment that could exacerbate these mental health disparities. Psychologists and service providers should consider how policy and political context impact the wellbeing of their clients and engage in their own communities to foster, promote, and protect a more welcoming environment. More research is needed on the relationships between immigration policy and refugee mental health and wellbeing, particularly at the community level. Census data suggest that there are communities (e.g., Waterloo Region in Ontario) where the proportion of refugees to economic migrants is growing rather than shrinking and a better understanding of whether and how these communities may be more welcoming in spite of national and global trends may be illuminating.⁴ More research on the wellbeing and wellbeing determinants of refugees throughout Canada, particularly in such exemplar communities, is essential. More research is also needed on how dispersal policies and refugee mobility affect the settlement process and mental health and wellbeing of refugees.

For a complete list of references, visit www.cpa.ca/psynopsis

CPA HIGHLIGHTS

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

1 2019 national convention

Thank you to everyone who submitted an abstract for our 2019 national convention in Halifax, NS. The review process is officially underway! Stay tuned for more information about acceptance letters, registration, etc.



2 Committee presentations

We presented to the Standing Senate Committee on Social Affairs, Science and Technology on child and youth mental health on October 18. We also presented to the Standing Committee on Agriculture and Agri-Foods on November 22 about the mental health challenges faced by Canadian farmers, ranchers and producers and e-mental health solutions. Many thanks to our sections and members who assisted us in the preparation of both our presentations.



3 CAMIMH Hill day

On October 2, we participated in the Canadian Alliance on Mental Illness and Mental Health's Mental Illness Awareness Week Hill day on Parliament Hill. We had a number of meetings with MPs to discuss improving parity between mental and physical illness in Canada and improving access to mental health care before attending a reception with MPs, political staffers, and our CAMIMH partners.

4 Bylaw changes

On September 21, members who attended our virtual town hall meeting voted to adopt advance electronic voting. As a result, members were able to vote in advance of our virtual meeting on October 19 on proposed changes to our board's structure. Changes to our bylaws require a confirmation by special resolution of the members, which means they must be passed by a majority of no less than two-thirds of the votes cast. All five motions presented were approved by the membership.

5 Accreditation

Congratulations to the University of British Columbia Counselling Services internship programme that was accredited, as well as to the three doctoral programmes and the seven internship programmes that were reaccredited at the Accreditation Panel's meeting in November. A full list of accredited programmes is available on our website.

6 Pharmacare

On September 28, we sent a letter to Dr. Eric Hoskins, Chair of the Advisory Council on the Implementation of National Pharmacare, in response to the council's invitation to Canadians to share their views and ideas about a national Canadian pharmacare plan. While we fully support a government initiative that gives Canadians equitable access to prescription medications, our letter highlights some concerns we have about how a national pharmacare plan may affect access to psychological services.

7 The Canadian Way 2.0

On November 1, we joined fellow members of the Health Action Lobby in releasing our new policy consensus statement, the Canadian Way 2.0. As part of the launch, we participated in a press conference on Parliament Hill where we answered media questions related to mental health. We also met with MPs to discuss improving access to evidence-based mental health care and senior's care.

8 New Editor of *Canadian Psychology*

We are pleased to announce that Dr. Vina Goghari has been appointed as the Editor of *Canadian Psychology* from 2019-2022. Thanks to Dr. Daniel Voyer for his commitment and service to the journal during his tenure as Editor.

9 Medical assistance in dying

On October 31, our President Dr. Samuel Mikail presented as part of a panel with Michael Bay and Dr. Brian Mishara on medical assistance in dying at the Mental Health Commission of Canada's National Collaborative for Suicide Prevention's meeting in St. John's. The meeting was held in advance of the Canadian Association for Suicide Prevention's conference.

10 Professional development ethics workshop

On November 23, we hosted a full day workshop in Ottawa on the latest changes to the *Canadian Code of Ethics for Psychologists* and challenging ethical decision making. Many thanks to Dr. Carole Sinclair for her excellent presentation and for guiding participants through difficult ethical scenarios. A web-based version of the workshop is currently in development.



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des activités de la SCP



Voici la liste des principales activités menées depuis la publication du dernier numéro de *Psynopsis*. Écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique semestriel, Nouvelles de la SCP, pour vous tenir au courant de toutes les choses que nous accomplissons pour vous!

1 Congrès national 2019

Nous désirons remercier ceux et celles qui ont soumis une proposition de communication pour notre Congrès national de 2019 à Halifax en Nouvelle-Écosse. Le processus d'évaluation suit son cours! Restez à l'affût pour en savoir davantage sur les lettres d'acceptation, l'inscription, etc.

2 Présentations de comités permanents

Le 18 octobre, nous avons fait une présentation au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie sur la santé mentale des enfants et des jeunes. Le 22 novembre, nous avons aussi fait une présentation au Comité permanent de l'agriculture et de l'agroalimentaire les défis auxquels faisaient face les fermiers, les grands éleveurs et les producteurs canadiens en matière de santé mentale et nous leur proposons des solutions de services électroniques en santé mentale. Nous désirons remercier sincèrement les sections et les membres qui nous ont aidés à préparer nos présentations.

3 Journée de lobbying sur la Colline du Parlement de l'ACMMSM

Le 2 octobre, nous avons participé à la journée de lobbying organisée par l'Alliance canadienne pour la maladie mentale et la santé mentale (ACMMSM) dans le cadre de la Semaine de

sensibilisation aux maladies mentales. Nous avons rencontré plusieurs députés afin de discuter de l'amélioration de la parité entre la maladie physique et la maladie mentale au Canada et de l'amélioration de l'accès aux soins de santé mentale, avant d'assister à une réception avec les députés, les membres du personnel politique et nos partenaires de l'ACMMSM.

4 Changements aux règlements

Le 21 septembre, les membres qui ont participé à notre séance de discussion ont adopté une proposition relative au vote électronique par anticipation. Par conséquent, les membres ont eu l'occasion de voter sur les cinq motions relatives à la structure de gouvernance de la SCP proposées par le conseil d'administration en avance de notre assemblée extraordinaire des membres le 19 octobre. Pour modifier nos règlements, nous avons besoin d'une confirmation obtenue par la voie d'une résolution extraordinaire des membres, ce qui signifie que les modifications doivent être adoptées par au moins les deux tiers des votes exprimés. Les cinq motions ont été approuvées par les membres.

5 Mise à jour concernant l'agrément

Nous transmettons nos félicitations au programme d'internat de la University of British Columbia Counselling Services qui a obtenu son agrément lors de la réunion du jury en novembre, et aux trois programmes doctoraux et sept programmes d'internat doctoraux qui ont renouvelé leur agrément. Une liste complète des programmes agréés se trouve sur notre site Web.



6 Assurance-médicaments

Le 28 septembre, nous avons envoyé une lettre au D^r Eric Hoskins, président du Conseil consultatif sur la mise en œuvre d'un régime national d'assurance-médicaments, en réponse à l'invitation du Conseil, qui souhaite obtenir les points de vue et les idées des Canadiens sur un régime national d'assurance-médicaments au Canada. Même si nous appuyons pleinement une initiative du gouvernement qui vise à donner aux Canadiens un accès équitable aux médicaments sur ordonnance, notre lettre met en lumière quelques-unes de nos préoccupations concernant la façon dont un régime national d'assurance-médicaments risque d'affecter l'accès aux services psychologiques.

7 Le modèle canadien 2.0

Le 1^{er} novembre, nous nous sommes joints à nos collègues du Groupe d'intervention action santé (GIAS) pour procéder au lancement de notre nouvelle déclaration de consensus politique : Le modèle canadien 2.0. Dans le cadre de ce lancement, nous avons assisté à la conférence de presse qui s'est tenue sur la Colline du Parlement et avons répondu aux questions des médias relatives à la santé mentale. Nous avons également rencontré des députés avec lesquels nous avons parlé de l'avancement des soins fondé sur des données probantes et plus particulièrement de l'amélioration de l'accès aux soins de santé mentale et des soins aux aînés.

8 Une nouvelle rédactrice en chef pour la revue *Psychologie canadienne*

Nous avons le plaisir d'annoncer la nomination de la D^{re} Vina Goghari à titre de rédactrice en chef de la revue *Psychologie canadienne*. Ce mandat vise la période 2019-2022. Merci au D^r Daniel Voyer pour son engagement envers la revue et son apport durant son mandat comme rédacteur en chef.

9 L'aide médicale à mourir

Le 31 octobre, notre président, le D^r Samuel Mikail, a fait une présentation portant sur l'aide médicale à mourir dans la cadre de la réunion du groupe de collaboration pancanadien sur la prévention du suicide de la Commission de la santé mentale du Canada qui s'est tenue à St. John's. Il prenait part à cette réunion en tant que membre d'un panel d'experts avec Michael Bay et le D^r Brian Mishara. Cette rencontre était organisée préliminairement au Congrès national de l'Association canadienne pour la prévention du suicide.

10 Atelier de développement professionnel sur l'éthique

Le 23 novembre, nous avons organisé à Ottawa un atelier d'une journée portant sur les derniers changements apportés au *Code canadien de déontologie professionnelle des psychologues* et les façons de remettre en question la prise de décision éthique. Nous adressons nos sincères remerciements à la D^{re} Carole Sinclair pour son excellente présentation et pour la façon avec laquelle elle a su orienter les participants en offrant des pistes de réflexion sur des cas éthiques complexes. Gardez l'œil ouvert pour une version en ligne de cet atelier.

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"If you serve too many masters, you'll soon suffer:" Multiple relationships in graduate school

Ian Nicholson, PhD, C. Psych., Member,
CPA Committee on Ethics; President-Elect,
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The risk level and acceptability of... dual or multiple relationships... might be partially dependent on *cultural or geographic factors* and the specific type of professional relationship (e.g., long-term psychotherapy vs. organizational consultation vs. community-oriented activities). In some situations, for instance, a dual or multiple relationship *might be inevitable or culturally expected* (e.g., in rural, indigenous, or immigrant communities), or could enhance the benefit of an activity. However, in all such situations, the psychologist is responsible for making an honest appraisal of the *benefits and risks* involved in the *context of the specific situation*, including but not limited to: determining the feasibility of alternatives in light of those risks and benefits; deciding whether to enter into or continue the relationship; establishing relationship boundaries appropriate to the work being done; and managing the relationship (e.g., by seeking advice or establishing other safeguards) to ensure that the dignity, well-being and best interests of the member(s) of the public are protected.¹ (Italics added.)

Graduate school is in a unique environment. Young adults are there for only a few years, and most of their activities are with a relatively small group. Often, they are surrounded with the same people for their education, employment, and social life. Unlike the undergraduate

experience, there generally is not a distinct summer break where students leave and return to the environment in the fall. It is also a very hierarchical environment. Although the hierarchy is based on knowledge and experience, and individuals often rise through it quickly, it is nonetheless a hierarchy with strong differences in power and responsibility. Thus, graduate students are immersed in a small, high pressure, hierarchical environment, where they are required to assume multiple roles.

Graduate students often see themselves as a separate community. Although they spend considerable time with faculty, they realize that faculty are in a different category and that there is an evaluative component in those relationships. Also, graduate students often don't see themselves as citizens of the city in which they are living to attend school, making them feel more isolated and dependent on each other in their small separate community.

Small groups of individuals, in high-pressure environments, for long hours over many months often develop strong bonds. This can be due to mere proximity, as they attend the same small seminars, work in the same labs, or share offices, but strong, and often lifelong, friendships can develop. In some instances, even romance occurs.

When new students enter into graduate school, they're entering a new environment unlike any they may have experienced before. Often, they are in new cities where they have few, if any, family or social connections. They are also required to start assuming a new role as the previous role of undergraduate student, with its unique cultural norms, is no longer appropriate in the graduate school environment. In this new role and this new environment, they look for guidance from senior students – generally those in

their program or their lab. Therefore, in addition to filling the role of mentee to a research supervisor, they step into the role of mentee or junior colleague to the more senior students in their program. This can put them in a very vulnerable position because they are isolated and need to rely on others within this new small academic community.

After a few years in this environment, they too become more senior graduate students, slowly developing into the role of informal mentors. Along with informal roles, the program often puts them into a more senior role within the small hierarchy of the community. For example, a senior graduate student may be a teaching assistant for a graduate level course. If they're taking a course in supervision, they may be required to provide formal supervision to more junior graduate students. In their labs, they may take on the role of research coordinator for the faculty advisor. They also may supervise junior graduate students' research within the lab, particularly research for their own doctoral dissertation. As such, even though these communities may be small and ever transitory, with students entering and leaving regularly, they are uniquely set up to have important and significant dual roles between senior and junior graduate students.

Having these types of dual roles is seen as culturally normative within a graduate program. The senior graduate students typically learn how to navigate the dual roles based on the experiences they had when they were junior graduate students (not that long ago). However, the efficacy of this model of navigation is dependent upon whether the senior graduate students learned healthy or unhealthy ways of handling these multiple roles when they were in the more vulnerable position of junior graduate student. Each program devel-

ops its own cultural or local norms based on the histories of the students that came before.

One model of understanding graduate training in psychology is to see it as a developmental continuum. When one starts graduate school, one comes in with the identity and mindset of the student. Generally, having come from the undergraduate milieu, this way of thinking about their role dominates their approach to their role when starting graduate school. However, by the end of graduate school, the self-identity of the student has become closer to that of a professional.

This progression cannot be seen as a simple stepwise development from year to year. For example, it would not be the case that someone in fourth year would be twice as far along this developmental journey as someone in second year. It is more likely that the rapid immersion at the beginning results in a rapid learning of the new norms of the small community, with subtle markers in the transitional stages of the development.

Because of the vulnerability of graduate students during this time of rapid transition, it is important that programs recognize and attempt to manage the ethical dilemmas and potential for harm that can result from such dual roles. As Standard III.31 of the *Code* states:

Manage dual or multiple relationships or any other conflict-of-interest situation entered into in such a way that bias, lack of objectivity, and risk of exploitation or harm are minimized. This might include involving the affected party(ies) in clarification of boundaries and expectations, limiting the duration of the relationship, obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a primary client or employee about becoming a research participant).

The following are examples of practical steps graduate programs can take to help protect graduate students.

1) Early in their entry into graduate school, graduate students should be made clearly aware of the potential risks and pitfalls inherent in their new roles. This would include the likely or required multiple relationships that will occur with the other graduate students, particularly those at different levels of progression through the program. It also would include discussion of the multiple roles they may have with a faculty member who may be their research supervisor, their course instructor, their employer through a grant, their work supervisor through a teaching assistantship, their senior collaborator, and possibly even their clinical supervisor.

2) Ensure that there are policies and procedures in place to deal with any issues that may arise due to the multiple roles students may fill, and that new graduate students are taught how these protect them. As students progress through the program and develop in

their roles, they should also be reminded of how the policy and procedures affect them.

Graduate programs have been small communities with their own unique cultures for centuries. However, as our profession develops in its understanding and appreciation of how these environments can place vulnerable graduate students at risk, it is incumbent on those with more power and authority in these communities to recognize the potential negative impact of multiple relationships, and to minimize any potential risk of exploitation or harm.

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

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



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Si tu as trop de maîtres à servir, ta souffrance s'annonce comme imminente : les relations multiples dans le contexte des études supérieures

Ian Nicholson, Ph. D., C. Psych., membre du comité de déontologie de la SCP; président désigné de la SCP

Le niveau de risque et d'acceptabilité des [...] relations doubles ou multiples [...] pourrait dépendre en partie de *facteurs culturels ou géographiques* et du type particulier de relation professionnelle (par ex. : psychothérapie à long terme par opposition à une consultation organisationnelle par opposition à des activités de développement communautaire). Dans certaines situations, par exemple, une relation double ou multiple *pourrait s'avérer inévitable ou culturellement attendue* (par ex. : en milieu rural, dans les communautés autochtones ou dans les communautés immigrantes), ou pourrait être susceptible d'améliorer le bénéfice d'une activité. Toutefois, dans tous les cas, le psychologue a la responsabilité de faire une évaluation honnête *des avantages et des risques impliqués en tenant compte de la spécificité de la situation*, incluant notamment, sans s'y limiter, ce qui suit : déterminer la faisabilité des autres solutions possibles à la lumière de ces risques et avantages; décider s'il établira ou poursuivra la relation; établir les limites de la relation appropriées en fonction du travail effectué; et gérer la relation (en demandant conseil ou en établissant des mesures de protection supplémentaires, par exemple) pour s'assurer que la dignité, le bien-être et les intérêts supérieurs des membres du public sont protégés.¹

[ORIGINAL MODIFIÉ]

L'environnement dans lequel se poursuivent les études supérieures demeure particulier. Les jeunes adultes interagissent dans cet environnement pour seulement quelques années et la plupart de leurs activités s'exercent au sein d'un cercle relativement restreint. Souvent, les mêmes personnes les entourent dans leurs activités de formation supérieure, professionnelles et sociales. Contrairement, au calendrier des études de premier cycle, il n'existe pas vraiment de période estivale où les étudiants prennent une pause de leurs études pour ensuite revenir à la fin de l'été. Le cadre de l'environnement des études supérieures demeure aussi très hiérarchique. Même si cette hiérarchie s'appuie sur la connaissance et l'expérience, chacun peut gravir rapidement des échelons bien qu'il existe des différences significatives en matière de pouvoirs et de responsabilités. Ainsi, les étudiants aux cycles supérieurs baignent

dans un petit milieu hautement exigeant et hiérarchique, où ils doivent assumer plusieurs rôles.

Souvent, les étudiants aux cycles supérieurs trouvent qu'ils forment une communauté singulière. Même s'ils passent beaucoup de temps avec les membres du corps professoral, ils reconnaissent que ces derniers appartiennent à une catégorie à part et que les relations qu'ils entretiennent avec eux comportent une composante évaluative. Aussi, il arrive fréquemment que ces étudiants ne se considèrent pas des résidents de la ville où ils poursuivent leurs études; pour cette raison, ils se sentent isolés et dépendent les uns des autres pour fonctionner dans leur petite communauté isolée.

Les personnes qui travaillent en petits groupes pendant de longues heures durant plusieurs mois, dans des environnements de haute pression, développent fréquemment de solides liens entre eux. Bien que la proximité entre eux facilite ce rapprochement, étant donné qu'ils suivent les mêmes séminaires, travaillent dans les mêmes laboratoires et partagent des bureaux de travail, des amitiés véritables, lesquelles dureront souvent toute une vie, peuvent se développer. Dans certains cas, même un amour romantique peut voir le jour.

Lorsque de nouveaux étudiants entreprennent des études supérieures, ils font face à un nouvel environnement, lequel leur était, pour la plupart, jusqu'à lors inconnu. Souvent, ces étudiants se trouvent dans de nouvelles villes, où ils n'ont pas ou peu de famille ou de liens sociaux. Ils doivent également commencer à assumer un nouveau rôle puisque celui d'étudiant de premier cycle, auquel se rattachent des normes culturelles particulières, se révèle inapproprié dans un environnement d'études aux cycles supérieurs. Dans ce rôle et cet environnement relativement nouveaux, les étudiants cherchent à être conseillés par les étudiants dont la formation est plus avancée que la leur – habituellement des étudiants inscrits dans le même programme qu'eux ou qui travaillent dans le laboratoire avec eux. Conséquemment, en plus de jouer le rôle de stagiaire rattaché à un superviseur de recherche, il joue le rôle de mentoré ou de collègue junior pour les étudiants plus avancés dans leur programme. Les mentorés peuvent ainsi se trouver dans une position très vulnérable, car ils sont isolés et ils doivent se fier aux autres membres de cette nouvelle petite communauté universitaire.

À leur tour, après quelques années passées dans cet environnement, ces mentorés avancent dans leur programme et développent tranquillement leur rôle de mentor informel. Aussi, à mesure que les mentorés poursuivent leur progression,

les rôles informels qu'ils jouent évoluent en importance alors qu'ils montent dans la hiérarchie de cette petite communauté. Par exemple, des étudiants en fin de parcours aux cycles supérieurs peuvent jouer le rôle d'assistant à l'enseignement pour un cours aux cycles supérieurs. S'ils suivent un cours qui porte sur la fonction de supervision, on pourrait leur confier la supervision formelle d'étudiants en début de parcours aux cycles supérieurs. Dans les laboratoires, ils peuvent assumer le rôle de coordonnateur de recherche pour le conseiller de la faculté. Ils pourraient également être appelés à superviser les recherches en laboratoire des étudiants en début de parcours aux cycles supérieurs, particulièrement des recherches liées au sujet de leur propre thèse de doctorat. En tant que tel, bien que ces communautés soient petites et toujours éphémères du fait que les étudiants arrivent et partent continuellement, l'unicité de leur constitution joue un double rôle significatif entre les étudiants en début de parcours et ceux en fin de parcours aux cycles supérieurs.

Ces doubles rôles à l'intérieur d'un programme de deuxième ou de troisième cycle sont considérés comme culturellement normatifs. Les étudiants en fin de parcours aux cycles supérieurs apprennent généralement à naviguer à l'intérieur de l'exercice de leurs doubles rôles en fonction des expériences qu'ils ont vécues lorsqu'ils étaient en début de parcours (il n'y a pas si longtemps après tout). Cependant, l'efficacité de ce modèle de navigation dépend de la façon avec laquelle ces étudiants en fin de parcours ont appris à assumer ces différents rôles – dans un cadre sain ou malsain – alors qu'ils se retrouvaient dans une position de vulnérabilité accrue en tant qu'étudiants en début de parcours. Chaque programme développe ses propres normes culturelles ou locales selon le vécu des étudiants qui sont passés par là.

Pour mieux comprendre la formation des étudiants en psychologie aux cycles supérieurs, il faut situer le modèle de formation dans un contexte de continuum développemental. Lorsqu'un étudiant commence ses études aux cycles supérieurs, il fait son entrée en adoptant l'identité et l'attitude d'un étudiant. Il pense encore en fonction d'un milieu universitaire d'études de premier cycle et cet axe de réflexion au sujet de son rôle structure son approche relativement à son rôle lorsqu'il commence ses études de cycles supérieurs. Cependant, l'identité du moi de l'étudiant en fin de parcours aux cycles supérieurs s'apparente plutôt à celle du professionnel.

Il ne faut pas considérer cette progression comme une simple évolution progressive d'année en année. Par exemple, il serait faux de dire qu'un étudiant en quatrième année est deux fois plus avancé dans sa démarche de développement qu'un étudiant de deuxième année. Il est fort probable que le fait de plonger rapidement dans l'environnement en début de parcours favorise un apprentissage rapide des nouvelles normes de la petite communauté, avec des marqueurs subtils dans les étapes de transition du développement.

En raison de la vulnérabilité des étudiants durant cette période de transition rapide, il s'avère important que les programmes reconnaissent les dilemmes éthiques et les risques potentiels que posent ces doubles rôles et qu'ils trouvent des façons de les gérer. Comme le prévoit la norme III.31 du *Code* :

Gérer les relations doubles ou multiples ou toute autre situation de conflit d'intérêts en cours de manière à réduire au minimum les risques de partialité, de manque d'objectivité, d'exploitation de la situation ou de préjudice. Cela pourrait inclure la ou les partie(s) touchée(s) dans la clarification des limites et des attentes, limiter la durée de la relation, obtenir de la supervision ou de la consultation continue pendant toute la durée de la relation double ou multiple, ou faire participer un tiers à l'obtention du consentement (p. ex. : approcher un client principal ou un employé pour considérer la possibilité de devenir un participant à la recherche).

Les exemples suivants donnent une idée des mesures concrètes que les programmes peuvent adopter pour aider à protéger les étudiants aux cycles supérieurs.

Veiller à clairement informer les étudiants, dès le début de leurs études aux cycles supérieurs, des risques et des obstacles potentiels inhérents à leurs nouveaux rôles. Cette information ferait notamment état des relations multiples nécessaires ou possibles avec les autres étudiants aux cycles supérieurs, en particulier avec des étudiants qui se trouvent à différentes étapes du parcours de leur programme. L'information porterait également sur les multiples rôles qu'ils auraient à assumer pour le compte de différents membres de la faculté : leur superviseur de recherche, un professeur ou un chargé de cours, leur employeur (par l'entremise d'une subvention), leur superviseur de travail dans le cas d'un poste d'assistant à l'enseignement, un collaborateur principal et peut-être même leur superviseur clinique.

Veiller à ce qu'il y ait des politiques et des procédures en place afin de régler tout problème qui pourrait survenir en raison des multiples rôles qu'un étudiant aurait à assumer et s'assurer que les nouveaux étudiants aux cycles supérieurs soient au courant de ces politiques et procédures et de la façon dont elles peuvent les protéger. À mesure que les étudiants poursuivent leur progression dans leur programme et qu'ils définissent leurs rôles, il faudrait veiller à leur rappeler comment ces politiques et ces procédures les touchent.

Les programmes d'études supérieures sont, depuis des siècles, de petites communautés en soi qui possèdent chacune leur propre culture. Cependant, à mesure que notre profession approfondit sa compréhension de comment ces environnements peuvent exposer les étudiants qui poursuivent des études aux cycles supérieurs, particulièrement les plus vulnérables, à des risques, il incombe à ceux qui exercent dans ces communautés du pouvoir et de l'autorité la responsabilité de reconnaître l'impact négatif potentiel des relations multiples et de minimiser tout risque potentiel d'exploitation ou de préjudice.

Invitation : N'hésitez pas à nous écrire pour nous faire part de vos commentaires ou de vos idées de sujets pour de futurs articles dans notre rubrique «L'espace éthique» à ethicscttee@cpa.ca.

Pour la liste complète des références, consultez notre site Web www.cpa.ca/psynopsis

2018 Robert Sommer Award for best student paper in environmental psychology

The Environmental Psychology Section is pleased to announce that Ms. Elizabeth Williams is the 2018 winner of the Robert Sommer Award for her paper, "Content and prevalence of environmentalist stereotypes in Canada: A psychological perspective." Ms. Williams' work was completed as a graduate student within the Institute for Resources, Environment and Sustainability (IRES) at the University of British Columbia.

The Robert Sommer award commemorates Dr. Sommer's research accomplishments at the Saskatchewan Hospital in Weyburn, as well as his significant impact on the emerging field of environmental psychology in the 1950s. The \$150 award is judged by an independent panel of three reviewers based on an extended abstracts of students' original research in environmental psychology. The call for submissions for the award opens at the end of the year.

Congratulations to Liz for her outstanding work!



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