In the Matter Of:

College of Psychologists of Ontario

BARBARA WAND SEMINAR

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1 BARBARA WAND SEMINAR IN PROFESSIONAL ETHICS
2 MONDAY, JANUARY 21, 2019
3
4 BARRY GANG: Could I ask everybody to
5 please take their seats? A very warm welcome to
6 the Barbara Wand seminar. We are going to start
7 right on time because most of the people who are
8 participating are in the warmth of their own homes
9 or offices and not dealing with weather-related
10 subway delays and things like that.
11 So, good morning. I'm Barry Gang. I'm
12 the Deputy Registrar at the College and the
13 Director of Professional Affairs.
14 Some people who became registered
15 within the last 28 years might not know why the
16 seminar is called the "Barbara Wand Seminar."
17 Dr. Wand was the Registrar of first the board and
18 then the College between 1976 and 1991.
19 And in 1991, the Ontario Board of
20 Examiners in Psychology instituted the annual
21 Barbara Wand Seminars in Professional Ethics,
22 Standards, and Conduct in recognition of her
23 contributions to the profession of psychology.
24 In 2016, it became a semi-annual
25 half-day event to make it more accessible, roughly

1 around the same time as we went online so people
2 from all over the province could participate.
3 So today we have, between the people
4 who are here in the room with us and the people
5 online and most of whom I think are in groups
6 online, we have about roughly 2,000 people
7 attending the Barbara Wand seminar, and we're very
8 excited about this.
9 Before we get into the program, I'd
10 like to invite Dr. Lynette Eulette, the president
11 of the College, come up and formally open up the
12 morning.
13 LYNETTE EULETTE: So, good morning, and
14 welcome on behalf of the College Council. We're
15 really glad that you are participating; we're glad
16 you're here, and we're also very thrilled about the
17 number of people that are online.
18 I'd like to also thank Barry Gang and
19 his crew for organizing today, for putting together
20 topics that are relevant to what we do every day.
21 I think the council itself is quite supportive of
22 the Barbara Wand Seminar, and for that reason,
23 we've been able to provide the seminar to members
24 without cost. We think that's a really healthy
25 thing to do.

1 We also are very supportive of people
2 learning in groups and with each other, and so
3 hopefully this morning you will be able to talk
4 with your peers and colleges about the things that
5 you are learning and hearing and that can make it
6 even more important and more effective for your
7 practice. So I hope you have a good morning and,
8 yeah, learn together. Thanks.
9 Barry Gang: So most of you are joining
10 us by webcast. You're going to have an opportunity
11 to send questions about the presentations, but I
12 should warn you -- I mean, even though we are
13 really excited about the numbers, what we found in
14 the past is because of the number of online people
15 and because of the time lags, addressing questions
16 live just has never worked as well as we would
17 like.
18 So we're going to monitor questions as
19 they come in, and if they arrive in time to still
20 be relevant to what's going on at the podium, we
21 will try to have them asked, but please be rest
22 assured that any questions that you do send in will
23 be answered hopefully quickly.
24 Anybody who is here and doesn't have
25 the address to send them to, it is really easy, but

1 ask any of the people at the College afterwards.
2 It is bwsquestions@cpo.on.ca. Please don't send
3 your I.T. questions to that e-mail address because
4 nobody who is monitoring it will know how to answer
5 them.
6 Those of you who are online have
7 Stephanie's e-mail address, smorton@cpo.on.ca, and
8 rather than joining the long queue of questions,
9 you may want to try out the kind of advice that has
10 always worked for most people: Exit and reload the
11 webcast, try a different browser, refresh your
12 screen, and the worst case scenario is that you may
13 miss some of it, but the whole thing will be
14 available on our website likely within 24 hours.
15 So we plan to be done by 12. We will
16 have one break from 10:45 to 11. We're going to
17 keep as strictly on schedule as we can because most
18 of you are out there, not with us, and you need to
19 know when the breaks are and when to come back,
20 trying to rush through business things because
21 there's some really good material today.
22 Everybody wants to know about CPD and
23 how many credits are you going to get for this, so
24 I will tell you now. You get one credit for any of
25 you who are spending the half day together either

1 here or in groups out there in Category A-8, and
2 that's to recognize the importance of
3 intercollegial contact and interaction, plus three
4 credits for hours of learning in Category B-2, and
5 you can count all of that in your ethics list of
6 ten credits.
7 People ask about documentation. Keep
8 whatever confirmation you have of registration, and
9 if you are out there in a group and you haven't
10 registered on your own, just swap an e-mail with
11 whoever has registered, and that will be enough.
12 I probably don't need to remind you and
13 it is tiresome to hear, but every once in a while,
14 we all forget to put our phones on silent, so
15 please do that. And those of you who want to be
16 connected, there is wifi here. It's "Vantage
17 Guest," and you don't need a password to get in.
18 So next I'd like to call up Dr. Rick
19 Morris; he's the Registrar and Executive Director
20 at the College.
21 Every time we ask what people would
22 like to do at the Barbara Wand, it's tricky issues,
23 tricky issues, and more tricky issues, so we are
24 committed to keeping the tricky issues coming.
25 Those of you who don't know Rick, and

1 it's hard to imagine anyone other than a brand new
2 member not knowing him, worked for many years
3 before coming to the College in children's mental
4 health, but he's been in regulation for a long
5 time, and he's been with the College for a long
6 time, and he frequently makes presentations to
7 members and non-member groups in Ontario and
8 beyond.
9 He's been involved in -- I'm going to
10 just shorten it all -- regulatory organizations
11 across North America, and I'm going to call Rick up
12 now.
13 RICK MORRIS: Thanks, Barry, and good
14 morning everyone. I want to add my welcome to all
15 of you to this year's Barbara Wand Seminar. It is
16 very gratifying to see so many people here in
17 person, those of you that braved the cold. We did
18 receive a number of e-mails from people saying, oh,
19 it's too cold to come; can I please come in by
20 webinar? So I do -- I'm pleased to see so many
21 people who are here today.
22 It's also gratifying to know, as Barry
23 said, there are so many people participating by
24 webinar. Barry said about -- totally, about 2,000,
25 so that's close to half the membership when you

1 think about the number of members it'll be.
2 Certainly there are students because
3 we've been encouraging students to join as well,
4 but it's growing and growing and grown to the point
5 now that we're -- you know, the seminar is being
6 participated in by about half of the membership,
7 which is great. So I certainly want to welcome all
8 of you.
9 I prepared four tricky issues for
10 today. They're in your materials, and we'll see
11 how many we can cover in the time that's been
12 allotted to me.
13 So we want to take a look at the first
14 one. This one is entitled "Reporting Elder Abuse."
15 And, as you know, for any of you who have seen
16 these kinds of things, this kind of presentation
17 before, it's an interactive presentation, so I'm
18 going to be relying primarily on those in the room
19 to make this an interactive presentation.
20 So let's start with this first one.
21 "You're assessing an elderly
22 patient. She's made an application
23 to a long-term care facility, which
24 facilitated the assessment to assist
25 in determining her best placement as

1 the faculty offers a range of
2 service levels.
3 The client is living at home, was
4 brought to the appointment by her
5 daughter and her personal support
6 worker. During the interview, you
7 begin to become concerned about
8 possible elder abuse, as the client
9 mentioned that her worker is
10 sometimes very rough with her. Your
11 concern is heightened by bruises you
12 notice on her arms.
13 When you ask the daughter about
14 this, she indicates that the worker
15 told her that her mother slipped
16 getting out of the bathtub. You
17 consult some notes about elder abuse
18 reporting obligations from a tricky
19 issue presentation that you attended
20 in the past. And those notes
21 correctly tell you six choices or
22 maybe there's a seventh one that you
23 can think of and add for us.
24 The mandatory abuse reporting
25 obligations prescribed in the

1 Long-Term Care Homes Act only apply
2 to residents of a facility. As this
3 client is not yet a resident,
4 there's no reporting obligation, or
5 while the client is not yet a
6 resident, the assessment was
7 prompted by the facility to
8 determine proper placement;
9 therefore, the reporting obligations
10 apply; or, since the Long-Term Care
11 Homes Act of 2007 does not apply,
12 one must turn to the Vulnerable
13 Elderly Protection Act, 2014, which
14 requires reporting of 'abuse or
15 neglect that resulted in harm or a
16 risk of harm'; or, since there's no
17 statutory requirement to report,
18 one's hands are tied, as it would be
19 a breach of confidentiality to
20 notify anyone of your concerns.
21 PHIPA permits one to disclose
22 personal health information for the
23 purpose of eliminating or reducing a
24 significant risk of serious bodily
25 harm; this would permit you to

1 report the suspected abuse.
2 Or, lastly, abuse of this nature
3 must be reported to the police, as
4 there's no authority with the
5 responsibility to ensure elder
6 protection comparable to the CAS for
7 reporting child abuse."
8 So I'm going to turn to the people who
9 are in the room with me, all about 100 of you.
10 What do you think? And you can do this
11 out loud because I'm a long way out here. What do
12 you think? One, two, three, four, five -- I was
13 going to say and/or six, but they all can't be --
14 there can't be an "and" six. They can't all be
15 right. Thoughts? Who's brave enough to start?
16 Yeah, Nina?
17 QUESTION/COMMENT: [Indecipherable].
18 RICK MORRIS: So because she's not a
19 resident, then long-term care home actually --
20 you're saying that No. 1 would be -- could be an
21 appropriate answer. Since she's not a client,
22 there would be no reporting obligation because it
23 wouldn't apply under that act.
24 Okay. So we have first person to
25 respond -- thank you very much -- said No. 1 is a

1 possible option or a good response.
2 You could also go the other way.
3 You're allowed to sort of say, well, it's certainly
4 not this one or certainly not that one. We can go
5 by process of elimination.
6 QUESTION/COMMENT: [Indecipherable].
7 RICK MORRIS: Okay. So the answer in
8 the room, one of the answers in the room is it's
9 not --
10 QUESTION/COMMENT: [Indecipherable].
11 RICK MORRIS: No. 1 seems accurate
12 because this person is not a client, not a
13 resident, so there would be no reporting
14 obligation.
15 But then No. 3 looks likes a good
16 answer: The Vulnerable Elderly Protection Act of
17 2014. Okay. I see a few people nodding. Any
18 other? Yes.
19 QUESTION/COMMENT: Can we rule out
20 No. 4?
21 RICK MORRIS: Can we rule out No. 4?
22 Can we rule out No. 4? Good question. Okay. Yes,
23 we can rule out No. 4, so now we're down to 5 --
24 QUESTION/COMMENT: [Indecipherable].
25 RICK MORRIS: So we'll go back to No. 3

1 because, certainly, we can't be in a situation
2 where if you have a concern about harm, it doesn't
3 matter who that harm is to that once hands are tied
4 and you're just stuck with it and end of story.
5 Okay. So we got a couple votes for
6 No. 3. We've ruled out No. 4. We've said No. 1
7 looks okay as well because it's a not-reporting
8 obligation.
9 Other ideas? There's still another one
10 that is a reasonable idea.
11 QUESTION/COMMENT: [Indecipherable].
12 RICK MORRIS: Sure, sure.
13 QUESTION/COMMENT: I think 5 is also
14 true.
15 RICK MORRIS: 5. The PHIPA --
16 QUESTION/COMMENT: I think 5 would go
17 with 3. My understanding is, ideally, PHIPA is
18 consistent with other acts.
19 RICK MORRIS: Okay. So what's being
20 said in the room is that No. 5 seems to go with
21 No. 3, the idea that PHIPA would be consistent with
22 other acts and it would allow us to disclose
23 personal health information even in a confidential
24 situation for the purpose of eliminating or
25 reducing the risk of serious bodily harm. Okay.

1 Anybody violently object to any of the
2 things that we've talked about? So that means
3 everybody likes what we've talked about?
4 Okay. So let's go through them, and
5 I'll tell you what I think in terms of the answers.
6 Certainly the first one, as was pointed out, is not
7 correct. This individual is not in a long-term
8 care facility; therefore, the Long-Term Homes Care
9 Act doesn't apply.
10 There's certainly an obligation to
11 report abuse for someone who is in the long-term
12 care facility or in a retirement home, and those
13 are the two things, but it's very much
14 facility-dependent. So it's not elder abuse
15 reporting legislation generally the way child abuse
16 reporting is; it really is facility-dependent. And
17 if you're not in a facility, doesn't apply.
18 And No. 2, just because they're in the
19 process of applying for it doesn't make them a
20 resident, so No. 2 doesn't make sense.
21 No. 3, it looks like it's a good one,
22 but I made it up. It's kind of a trick question.
23 There's no such thing in Ontario as the Vulnerable
24 Elderly Protection Act, 2014. So I did spend a bit
25 of time trying to think of something that'd really

1 sound really official, and I thought that one
2 sounded really official. Okay. It obviously did
3 because some people said, yeah, that's a good one.
4 So maybe there should be a piece of
5 legislation like that, but that's not our job. So
6 there is no such thing as that act that would
7 protect the rest of the elderly population rather
8 than those just in the facility.
9 And just as an aside, supporting what I
10 said earlier, there isn't elder abuse legislation
11 in Ontario. There are in some American
12 jurisdictions such as California which has
13 legislation that is similar to our child abuse
14 legislation, which puts an obligation on anyone if
15 they know about elder abuse.
16 I've never looked up what the
17 definition is of "elder" because I'm a little
18 afraid to look up and see what's considered
19 "elderly" in California, but they do have that kind
20 of legislation.
21 So we don't. We don't have specific
22 elderly abuse legislation, so the fact that this
23 person is living in their home, we don't have a
24 mandatory reporting obligation. At the same time,
25 we don't necessarily just have to sit by and let it

1 happen as suggested in No. 4.
2 Certainly, probably the best way to go
3 about it would be to use the PHIPA section,
4 Section 40 or 41 of PHIPA, which says that a health
5 information custodian may disclose personal health
6 information for the purpose of eliminating or
7 reducing a significant risk of serious bodily harm.
8 So based on that, one could certainly let someone
9 know about it.
10 There is no obligation as suggested in
11 No. 6 that, well, since there's no authority that
12 you have to go to the police. In the case that
13 we're talking about, it may be that the daughter
14 that brought the elderly person to see you may be a
15 more appropriate person to talk with and to raise
16 your concerns with as opposed to the police or some
17 other authority.
18 If you're going to be using the PHIPA
19 reason for breaching confidentiality, the purpose
20 is eliminating or reducing a significant risk of
21 harm, you want to go to and tell whoever it is that
22 you think is in a position to do that, to eliminate
23 or reduce harm; who's in the best position? So
24 it's not as though there is a body like there is a
25 CAS for children that one has to report to.

1 One could go to the police if one felt
2 it necessary, but one doesn't have to go to the
3 police. That's different than, say, Tarasoff and
4 duty to warn in the States and some of the states
5 where it specifically talks about informing the
6 police.
7 QUESTION/COMMENT: I just wanted to
8 mention that the Toronto Police actually have a
9 coordinator on elder abuse, so if you had
10 questions, you could approach that person. It's a
11 good resource to know about.
12 RICK MORRIS: Oh, that's excellent.
13 It's good to know.
14 Okay. Any other questions or comments
15 in the room about this? Okay.
16 Let's go to the next one. Next one is
17 true and false. So this one in terms of
18 interactive should be even easier because, as you
19 know, you have 50% chance of being right, so
20 guessing is really, really good.
21 The other one was a 1-out-of-6 chance
22 or 2-out-of-6. This one's 50 percent chance.
23 Okay. So first one:
24 "It would not be a breach of
25 confidentiality to tell your client

1 the content of an e-mail received
2 from her spouse even if the e-mail
3 was clearly marked 'Private,
4 Personal, and Confidential'."
5 True or false?
6 True and false? I hear some "true."
7 Some people are saying there's not a breach of
8 confidentiality if you receive this e-mail. The
9 next time your client came in, you could say,
10 listen, got a -- received an e-mail from your
11 spouse, and this is what it says, and a number of
12 you are saying that would be fine?
13 And other people are saying "not fine."
14 Okay. That is actually -- and let me just make
15 sure I get this right -- that's actually true; it
16 would not be a breach of confidentiality.
17 Just because you're seeing a client,
18 that doesn't give any kind of an obligation of
19 confidentiality to anybody else in the family, so
20 you don't have any obligation of confidentiality
21 towards the spouse; and therefore, whatever you
22 receive -- now, you might want to give some
23 clinical thought as to how to best handle it
24 depending on the content, but the bottom line is
25 you can consider it, and you can then decide what

1 you're going to do about it. You're not in any way
2 bound to hold on to the information and not share
3 it if you feel it should be shared because there
4 isn't a confidential relationship. Okay?
5 All right. How about the second one?
6 "A summons to appear and a
7 search-and-seizure warrant both
8 require one to release the documents
9 indicated without consent upon
10 receipt of this legal vehicle."
11 True or false? Somebody want to tell
12 me why they think it's false? I agree; it is
13 false. Does anyone want to take a stab? Rosemary?
14 QUESTION/COMMENT: Well, I know because
15 a summons to appear, one has -- I believe the
16 requirement is to appear in court, but one can
17 contest the judge's decision that this information
18 should be made available to the court, so it's not
19 a requirement to turn over the documents.
20 RICK MORRIS: All right. Exactly. And
21 sometimes people confuse a summons, which is
22 basically, as people have heard me talk about it,
23 is an invitation you can't refuse, and that's all
24 that it is. It's an invitation to show up in court
25 at this time, at this place, and usually bring with

1 you whatever is prescribed in the summons.
2 It doesn't give you the authority to
3 release the information to anyone, to the lawyer
4 that has sent the summons, to the court, to
5 anybody.
6 What it does, as we were just told, is
7 it gets you into court, at which point you may be
8 ordered to release the file, but then, in that
9 case, you now have a court order to do so. But
10 just the summons itself doesn't allow you to
11 release the documents.
12 Different from a search-and-seizure
13 warrant. Search-and-seizure warrant is just that;
14 the police can show up in your office. They have a
15 legal search-and-seizure warrant from the courts,
16 which allows them to, as it says, search and seize.
17 So whether or not you have the consent
18 of the client, they have a right to -- a legal
19 right to remove that information and take that
20 information from you.
21 I see some questioning looks. Any
22 questions about that? Okay. Okay, Julie? Or --
23 yes?
24 QUESTION/COMMENT: Oh, hi. Just under
25 that circumstance, do you have some kind of right

1 to ask for whether you can make a copy of what
2 they're seizing before it's gone?
3 RICK MORRIS: Do you have a right to
4 make a copy? Do you have a right...? It would
5 depend on whoever is providing you with the
6 search-and-seizure warrant.
7 My experience with that is unless
8 there's a concern that you're going to somehow
9 tamper with the file, which obviously none of us
10 would, but unless there's a concern about that, my
11 experience has been that very often, you actually
12 get a -- you might even get a phone call in advance
13 telling you that we have this search-and-seizure
14 warrant; we're coming over; it's a warrant to take
15 the file related to so-and-so.
16 And then you could either ask them on
17 the phone -- or not -- but make a copy and even if
18 they then want the original, at least you have the
19 copy.
20 And you also -- although it's called a
21 "search-and-seizure warrant," that doesn't mean
22 they have to rifle through your desk drawers to try
23 and find stuff. I mean, you would be permitted,
24 especially if you have that advanced knowledge,
25 when they come in with the warrant, you could say,

1 okay, you need to search and seize: Here. Search
2 and seize this envelope because here it is; that's
3 all the material.
4 And that's very often -- very often,
5 it's that kind of a cooperative thing as opposed to
6 something that sounds like it has to be contested
7 or whatever.
8 Okay. No. 3:
9 "Annually, health information
10 custodians must submit a privacy
11 breach statistic report to the
12 Information Privacy Commission
13 regarding incidents of lost or
14 stolen information or information
15 that was used or disclosed without
16 authority."
17 True or false? Everybody agree true?
18 False? False. Okay.
19 All those people who said "true"
20 obviously read the last bulletin and obviously read
21 an e-mail that we sent out recently, forwarded from
22 the Information Privacy Commission. This is
23 something that is new, new as of this year.
24 There is a thing, there is a reporting
25 form, and if you're a health information custodian

1 and you've had lost or stolen information or
2 information has been used or disclosed without
3 authority, one has to fill out this form and send
4 it in to the office of the privacy commissioner.
5 The due date for anything that happened
6 in 2018 is the end of March 2019. And I'll just
7 say, there was something -- I know we sent out an
8 e-mail that talked about it. We forwarded the
9 e-mail that we received from the Privacy
10 Commission.
11 Yes? Question over here?
12 QUESTION/COMMENT: So just to clarify,
13 is --
14 RICK MORRIS: Hold on a second. We'll
15 get a microphone to you.
16 QUESTION/COMMENT: My understanding was
17 that a report was mandatory if there had been a
18 breach but that there was no obligation to report
19 in the absence of a breach.
20 RICK MORRIS: If there was a breach?
21 QUESTION/COMMENT: Right. So I said
22 "false" to this because it -- well, maybe I wasn't
23 reading the wording correctly, but it made it sound
24 to me like everybody had to submit an annual report
25 regardless of whether or not there was a breach,

1 but my understanding, and I'm gathering that's
2 correct, is only if there is a breach is one
3 required to submit one of the reports.
4 RICK MORRIS: But my assumption would
5 be if information is lost --
6 QUESTION/COMMENT: Right.
7 RICK MORRIS: -- that would be
8 considered a breach. If information is stolen,
9 that would be considered a breach because -- QQQ
10 right.
11 RICK MORRIS: -- one must assume that
12 it's out there somewhere.
13 QUESTION/COMMENT: That's -- thank you.
14 Right. That's my understanding too.
15 RICK MORRIS: Right, right. Yeah.
16 Okay, good. All right. Let's -- oh, another
17 question over here.
18 QUESTION/COMMENT: Yeah. My
19 understanding is that all of us are health
20 information custodians, so basically what you're
21 saying is someone in private practice, for example,
22 and who loses a file, you know, your person's
23 nightmare, we are a health information custodian
24 and need to report, or is this really something
25 that only applies to institutions?

1 RICK MORRIS: It would apply to any
2 institution or individual who is a health
3 information custodian, so if one -- the best
4 example is if you're a private practitioner, you
5 are the health information custodian of your files.
6 If you work for an organization, if you
7 work for one of the downtown hospitals, then you're
8 not actually -- you aren't the health information
9 custodian; the organization is the custodian, and
10 the organization would be the one that would have
11 to submit this kind of report.
12 So it's only if you are the health
13 information custodian, and so if, as many of our
14 members are, you are a private practitioner,
15 full-time or part-time, and you have your own
16 personal health information files on clients, then
17 you're a health information custodian for this
18 purpose and for the other purposes of PHIPA.
19 Okay. No. 4:
20 "A client can expect a member
21 to correct the clinical file if the
22 client demonstrates to the member's
23 satisfaction that the record is
24 incomplete or inaccurate and gives
25 the member the information necessary

1 to enable the member to make the
2 correction."
3 Can the client expect that of us?
4 Yes, yes, yes? Lots of yeses. Anybody want to say
5 "no," go against the tide?
6 Okay. That's true. Under PHIPA, the
7 client -- and keep in mind that when we talk about
8 PHIPA, we often talk about the client.
9 Well, for the 26 health colleges
10 representing 28 health professions, we're also
11 clients in a lot of ways, whether it's our
12 physician or our dentist or our chiropractor or OT
13 or PT. So we as clients -- first of all, we have
14 the right to access our file. We also have the
15 right to expect that if there's some inaccuracy in
16 our file that we are aware of, that that health
17 professional correct that information.
18 Now what gets corrected there are
19 things which are factual, so if the data -- if your
20 date of birth is wrong or other kinds of things
21 that are factual and can be proven or demonstrated
22 to your satisfaction, that's what gets corrected.
23 The other thing to keep in mind is it's
24 not just the information that you created; it's any
25 information that you have in your clinical file.

1 So if you receive referral material and there are
2 inaccuracies in the referral material, say the date
3 of birth, and the client demonstrates to your
4 satisfaction, shows you their passport, that it's
5 the wrong date of birth, they can expect that we
6 will actually change the date of birth on that
7 file, on that report that's in our file even though
8 we didn't create it. So our obligation is to make
9 sure our file is as accurate and correct as we can.
10 It certainly doesn't apply to
11 professional opinions regardless of how wrong the
12 client might think a previous report was. That
13 isn't enough to require a change. It's just facts
14 as opposed to professional opinions that's in the
15 reports.
16 Last one:
17 "One may not use a collection
18 agency or take a client to small
19 claims court to collect unpaid fees,
20 as this would require one to breach
21 client confidentiality."
22 True or false? False, false?
23 Right. All the prior practitioners out there are
24 saying "false."
25 Yes. I mean, it's unfortunate. It

1 doesn't feel like the kind of thing that members of
2 our profession would want to do or would usually do
3 because we're in the helping profession; it doesn't
4 sound very helpful to turn a file over to a
5 collection agency or take someone to small claims
6 court, but there is no problem in doing that.
7 Certainly, there would be a type of
8 breach because you'd have to provide the name of
9 the client, but that's a permissible kind of thing.
10 I mean, certainly, one doesn't have to. One can
11 decide to take the loss, but if one felt that
12 wasn't what one was prepared to do, then one can
13 take advantage of those things that are available
14 legally.
15 Okay. Let's try this one:
16 Telepsychology.
17 "A colleague asks for your
18 advice on the following situation:
19 She's preparing to move to Manitoba
20 but would like to continue to work
21 with those current Ontario clients
22 for whom telepsych services would be
23 appropriate. She's not sure if she
24 needs to be registered in Ontario or
25 in Manitoba or in both provinces.

1 Of the following, which is the
2 correct advice you provide to her
3 regarding registration and other
4 matters?"
5 Okay. So:
6 "Would you tell her that if her
7 clients are living in Ontario, then
8 she must be registered with the
9 College in Ontario? If this is her
10 only practice, she probably doesn't
11 need to be registered in Manitoba;
12 Or she needs to be registered in
13 Manitoba, not Ontario, since this is
14 where she's located, and therefore,
15 the services are happening;
16 Or to be safe, she should be
17 registered in both jurisdictions,
18 although this would mean double the
19 fees, two sets of standards to
20 adhere to, and compliance with two
21 quality assurance and CPD programs;
22 Or it would be inappropriate to
23 move from in-person service delivery
24 to telepsych for established
25 clients; therefore, she should refer

1 them to an Ontario colleague who can
2 continue to provide in-person
3 service;
4 Or before undertaking telepsych
5 services, she should research
6 available platforms to ensure she is
7 in compliance with PHIPA's
8 requirements for safe and secure
9 transmission of personal health
10 information?"
11 1, 2, 3, 4, 5. What do you think?
12 What kind of advice would you give your colleague
13 who is moving to Manitoba and wants to continue
14 with her ongoing Ontario clients?
15 I see a 5, and I see a 1. 5 and 1 from
16 the person near the back. 1 and 5. 1 and 5 here.
17 QQQ I don't know that 3 is required, but 1 and 5.
18 RICK MORRIS: Okay. So we have a lot
19 of votes for 1 and 5 and then a possible maybe for
20 No. 3; may not be required, might just be a good
21 idea.
22 Any other thoughts? Anybody like 2 or
23 4? Nobody likes 2 or 4. Okay. So we're pretty
24 well unanimous on that. Okay. My thoughts were
25 the same as yours. My thought was I didn't make

1 this one tricky or hard enough.
2 Right. Where the client is is where
3 the service is being delivered, and so if someone
4 from outside of Ontario is going to be delivering
5 services in Ontario, according to the Psychology
6 Act of Ontario, the College can expect that that
7 person will be a member in Ontario because that's
8 what our Psychology Act says: That in order to
9 hold one's self out as a provider of psychological
10 services, to call yourself a psychologist or psych
11 associate, to use the terms and titles, the term
12 "psychological," one needs to be a member of the
13 College.
14 So if you're providing services in
15 Ontario and that's what you're doing when the
16 client is sitting in Ontario, then one needs to be
17 registered here.
18 Question over there?
19 QUESTION/COMMENT: Thank you. If the
20 person would also be taking clients in Manitoba,
21 then they need to be registered in both?
22 RICK MORRIS: Correct.
23 QUESTION/COMMENT: Right.
24 RICK MORRIS: Correct. I mean, our
25 jurisdiction in terms of the College here is what's

1 happening -- what's happening in terms of service
2 delivery to individuals in Ontario? It would be up
3 to the College in Manitoba to worry about the
4 citizens of Manitoba, but you're right.
5 Certainly, if they were providing
6 services there as part of their private practice
7 but then wanted to continue here, they would then
8 need to be registered in both places.
9 Unfortunately at this time -- and we're trying to
10 do something about it -- it means double the fees
11 and double all of the kinds of requirements that
12 any college might have.
13 There are active talks about trying to
14 find a way of having some kind of a simpler
15 inter-jurisdictional way of handling this. But,
16 you know, other jurisdictions similar to ours, some
17 of them have the same problems we have in Ontario
18 because we have a Psychology Act that says who can
19 deliver services in Ontario.
20 And we can't just ignore that and say,
21 oh, we think it makes sense for other people
22 registered in other jurisdictions to be able to do
23 a little bit of work here through telepsych, so we
24 can just disregard the Psychology Act. Can't do
25 that. So that becomes a problem for us and for

1 some of the other jurisdictions.
2 And certainly No. -- you all agree that
3 No. 4 didn't make any sense, which is true.
4 And No. 5 is just a caution that it's
5 really important to know something about the
6 platform that you're using, and I certainly advise
7 people not just simply to use FaceTime or use Skype
8 that came free on your computer because those are
9 not considered to be PHIPA-compliant; they're not
10 considered to be secure.
11 Yes. Question in the back first?
12 QUESTION/COMMENT: What about the
13 opposite? What about if the client who you've seen
14 in Ontario then temporarily moves to another
15 province, say -- like, I guess the question is, how
16 do we determine what is "living"? Is it the day
17 they actually set foot in another province
18 determines --
19 RICK MORRIS: Well, I mean, I use the
20 term "living," but I meant sort of "being," I
21 guess. Technically, if one is going to be
22 providing service from Manitoba into Ontario,
23 whether it's one shot or ongoing, one needs to be
24 registered in Ontario.
25 QUESTION/COMMENT: Okay, thanks.

1 RICK MORRIS: Right. I mean, there
2 certainly is some unofficial leeway. I mean, if a
3 client goes on vacation and is somewhere and is
4 having some serious difficulty, and if they were to
5 phone you to say, listen, I need to talk to you for
6 a couple minutes, the College would not say that
7 you should tell them, sorry, can't talk to you and
8 hang up the phone. You know, there's got to be a
9 little bit of leeway, little bit of common sense in
10 there.
11 But in terms of anything that you could
12 predict and be ongoing, one has to be careful about
13 that, whether it's in Ontario -- working into
14 Ontario. Or if you're interested in another
15 jurisdiction, my advice also is -- if this was
16 reversed, the person was moving to Ontario and
17 wanted to continue in Manitoba, my advice is you
18 should contact the College in Manitoba and get your
19 information from them as to what they would expect.
20 QUESTION/COMMENT: Could I just take
21 you backwards for a second for the previous
22 true/falses?
23 RICK MORRIS: Sure, sure. I think I
24 can go back.
25 QUESTION/COMMENT: For a health care

1 custodian with the movement toward the electronic
2 filing of paper charts, if a file is not stolen or
3 lost but it is accidently destroyed before the ten
4 year, what is the obligation there?
5 RICK MORRIS: I don't believe there's
6 any obligation to report to the IPC. Certainly,
7 the College has retention periods and the client
8 may be rather unhappy with you if they need the
9 report two years down the road or three years down
10 the road and you don't have it available, but that
11 would be more of a you-and-the-College thing to
12 work out as opposed to a Privacy Commission issue.
13 Okay. I think we have one more minute.
14 Maybe just a couple more questions and then...
15 QUESTION/COMMENT: Do you have a list
16 of what the College considers PHIPA platforms that
17 are acceptable?
18 RICK MORRIS: No, I don't. No.
19 Really, I've stayed away from that given the
20 technology just keeps changing. I mean, PHIPA is
21 actually very simple. PHIPA says that we as health
22 information custodians are responsible for the
23 security, maintenance, and secure destruction of
24 information, and it doesn't go on to say "and this
25 is how you do it."

1 So you have to be satisfied, whether
2 it's your paper files or your electronic files or
3 the files that you are sending -- so data in motion
4 is the concept from here to there -- that it is
5 somehow secure, whether it's encrypted or some
6 other thing. So it's really up to each individual
7 to be satisfied that they're meeting the
8 requirements of "safe and secure."
9 One more question. Yes?
10 QUESTION/COMMENT: Yeah. I wanted to
11 get more clarity on establishing the residence of
12 the potential client that you might be seeing
13 because sometimes -- I think just particularly now
14 that we're so much more globalized, there are a lot
15 of people who part of the time will live in Ontario
16 and part of the time outside of Ontario for work or
17 school. So sometimes I have a hard time
18 determining, okay, is this person's established
19 residence in Ontario or not for fulfilling the
20 expectations of the College?
21 So for instance, like, I'll have a
22 client who says they're studying abroad but their
23 parents are here, and they're here often...
24 QUESTION/COMMENT: We can't hear you,
25 Rick.

1 RICK MORRIS: Yeah, I turned this off.
2 There we are. It's not a matter of where they're
3 living in terms of establishing residency. It's
4 where they are actually at the time.
5 QUESTION/COMMENT: Okay.
6 RICK MORRIS: So, for example, in
7 Ottawa, we have a lot of members who have practices
8 in Ottawa and someone from Hull, right across the
9 bridge, will come to Ottawa and will see them in
10 their office. That's fine. The person is being
11 seen in Ontario; that person needs to be registered
12 in Ontario.
13 Whether or not they want to register in
14 Quebec is sort of up to them, but they're providing
15 a service in Ontario. Although that individual is
16 going to have the assessment, take the report, and
17 go back across the bridge, the assessment, the work
18 is being done in Ontario. So it is not residency
19 in the sense of how long is a residency period or
20 anything like that.
21 Okay. I'm getting the word that we're
22 not going to have a chance to get to the next one.
23 What I will do as I've done in the past is probably
24 in the next bulletin, which is coming out near the
25 end of this month, I will give you my thoughts on

1 the consent issue and the various answers that are
2 there. Thank you.
3 BARRY GANG: Thank you, Rick. And I
4 know that everybody always says -- one of the
5 comments was: Why weren't there more tricky
6 issues, and why wasn't there more of Rick? But I
7 think you'll also be very happy with the rest of
8 this morning's program.
9 In past surveys, members expressed an
10 interest in training related to cultural diversity,
11 and this makes a lot of sense. There are about 250
12 ethnic origins that were reported by Ontarians in a
13 2016 Government of Canada census, and almost three
14 in ten Ontarians identify themselves as visible
15 minorities.
16 So I think this is a really important
17 and timely seminar, and we're very, very fortunate
18 to have Dr. Natasha Williams who has presented
19 around the globe on these kinds of issues.
20 Dr. Williams is a registered
21 psychologist with the College of Psychologists of
22 Ontario. She's the past chair of the board of
23 directors at Women's Health in Women's Hands, a
24 community health centre for black women and women
25 of culture in Toronto.

1 She's a member and past board member of
2 the OPA, the CPA, and the APA. She was the OPA's
3 diversity delegate representative at the APA State
4 Leadership Conference in Washington in 2011 and is
5 past chair of the OPA Diversity Task Force, whose
6 aim is to raise awareness of the importance of
7 diversity and to promote ongoing efforts to
8 influence social change in the field of psychology
9 practice in Ontario.
10 She's a past faculty member with the
11 bridge training program for internationally trained
12 mental health professionals and a former trainer
13 for TAPE educational services, which provides
14 professional development programs for clinical
15 teams at healthcare centres and human services
16 organization.
17 She's a current trainer with the Adler
18 Graduate Professional School in the CBT certificate
19 program. She's a guest facilitator trainer with
20 CAMH in topics like culturally adapting CBT for
21 English-speaking Caribbean community and
22 motivational interviewing.
23 She is a co-clinical director of Allied
24 Psychological Services, and she operates an
25 anti-oppressive private practice providing

1 assessment, individual and group psychotherapy,
2 corporate consultation, research, supervision, and
3 training services to clients from diverse
4 ethno-racial backgrounds, gender, and socioeconomic
5 backgrounds.
6 So all of that to say is we're very,
7 very fortunate that's she's been able to make time
8 for us this morning.
9 NATASHA WILLIAMS: Thank you.
10 Good morning, everyone.
11 Oh, dear. I know it's early in the
12 morning. I know it's cold outside. But let's try
13 this again: Good morning, everybody!
14 AUDIENCE: Good morning.
15 NATASHA WILLIAMS: Thank you. All
16 right. So first of all, I want to thank Barry and
17 the rest of the team for inviting me to come and to
18 speak on a topic which is very near and dear to me,
19 but my hope is that it will be near and dear to
20 everybody as well.
21 We're in a space and in a place as
22 practitioners -- and I would say healing
23 practitioners -- to understand that in the culture
24 that we are in, living in Toronto, living in
25 Ontario, that we are going to see clients from a

1 diverse population, and we need to be mindful, in
2 my opinion, of the diversity of our population.
3 And it's not only just being mindful of
4 it, but I also want to take this opportunity to
5 challenge everybody in the room as well as online
6 to be not only thinking clinically but critically.
7 And I think those two pieces are very important.
8 You know, we are the custodians of a
9 lot of people's health and wellbeing and
10 livelihood, and I want us to take that very
11 seriously. So in the time that we have -- it is
12 limited; we don't have a lot of time -- but my hope
13 is that you may go away with more questions than
14 you have answers, which is fine. Which is fine.
15 And I think we need to feel comfortable with being
16 uncomfortable.
17 So I may ruffle a couple of feathers,
18 which is okay. I may bring about more questions,
19 and I think that's fine because if we think we have
20 all the answers in terms of how to address cultural
21 diversity with every population, then I haven't
22 done my job. So my hope is is that we can allow
23 space to expand thought.
24 One second. All right.
25 Okay. So I have a little bit of an

1 outline in terms of how I would love to see this
2 day go, and I'm also someone who likes to do these
3 in an interactive style as well. So it's not just
4 that I'm going to be speaking at you guys for, you
5 know, two hours or however much time that we have,
6 but I'd also like this to be an engaging process as
7 well.
8 So for this outline for what we're
9 going to go through today, the first thing we're
10 going to look at is why study cultural diversity?
11 Why has this been such an important topic?
12 And then what I wanted to look at
13 before anything else is what is culture? Because
14 we throw around this term, you know, "cultural
15 diversity," "cultural relevance," but what is
16 culture? I also want to look at what is cultural
17 ethnocentrism and understanding how to measure
18 cultural differences. This is going to be very
19 important.
20 We're going to look at the acronym
21 "WEIRD," and some may know what that means, some
22 people may not, but we will go into that and
23 discuss that a little bit.
24 And then what I wanted to also look at
25 were some guidelines for psychological services to

1 ethnic, linguistic, and cultural diverse
2 populations. The American Psychological
3 Association has kindly provided us with some
4 guidelines, and we can go through some of those as
5 well.
6 At the end of the PowerPoint, I do have
7 some resources that I hope would be helpful to us,
8 but again, it's just a snippet of the amount of
9 resources that are out there in terms of how to
10 address and work with culturally diverse clients.
11 The other thing before we get started
12 that I'd like us to also look at as well before
13 anything else is the -- I want to challenge a
14 little bit some of the language that we do use
15 around culturally diverse clients. A lot of the
16 material, you will notice, is going to say, you
17 know, "ethnic minority" or that type of language,
18 and I'd like us to challenge that for a little bit.
19 Because when you think of the term
20 "ethnic minority," what you have done is compared a
21 whole population of people to another. So we're
22 now saying that we're using one particular
23 population, and in usual terms, we're talking about
24 a European, Eurocentric population, and we're using
25 that as a marker to all other populations.

1 So I want us to be mindful sometimes
2 the terms that we use when we are addressing other
3 populations. I use the term "ethnically diverse."
4 I personally don't like using that term,
5 "minority," because I think that ends up being very
6 political at the end of the day.
7 That is my opinion. I know some people
8 may not agree with that, but I think we do have to
9 be mindful of terminology that we use and how that
10 impacts populations and ethnic populations as well,
11 so let's be mindful of some of the terms that we
12 use and go forward from there.
13 So let's start with why do we study
14 cultural diversity or why even study cultural
15 diversity?
16 The field of psychology needs to be
17 internationalized to make further progress towards
18 understanding the universal nature of the mind. A
19 lot of the difficulty, and especially being able to
20 speak around the world, is that, a lot of times,
21 psychology is framed in a very Westernized,
22 Eurocentric framework, and then a lot of times,
23 that framework is taken and how do I then now fit
24 every other population into that mold?
25 The difficulty with this is that you

1 are now presenting only one framework of the mind
2 that everyone should be fitting into, and this now
3 can cause more harm than good. You may then start
4 to pathologize various populations of people, so we
5 have to be mindful that we need to look at things
6 from a more international perspective and be
7 mindful of that.
8 And we do need to make further
9 progress. I do, at times, you know, critique
10 ourselves as psychologists as well, and I think,
11 you know, as much as we give help and that type of
12 thing, we also have to be mindful of what we may be
13 doing that might be causing harm.
14 And we'll talk a little bit more about
15 that a little later when we start talking about
16 some of the psychological tests that we use and
17 sort of how they are used with ethnic-diverse
18 populations and how, at times, they can be harmful
19 if interpreted incorrectly, so we have to be
20 mindful of that.
21 Researchers from five universities
22 presented studies that suggest the field's
23 understanding of the structure and functioning of
24 the mind may be rooted in a set of centuries-old,
25 Western, philosophical assumptions about what it

1 means to be a person or a group member in an
2 individualist-oriented society.
3 So this, again, you know, ends up being
4 quite troubling. Speaking in several areas -- I
5 mean, recently, I spoke in India; I was also in
6 South Africa last year.
7 A lot of the challenges that a lot of
8 the practitioners have in these countries is these
9 Westernized, philosophical principles or
10 assumptions they're trying to fit their communities
11 in and not giving credence to Indigenous or, you
12 know, things that are working well for their
13 community already but feeling that they're
14 inadequate because we have Westernized philosophies
15 that are starting to create a message of this is
16 better than what you've been doing; you need to fit
17 your population into this in one way, shape, or
18 form.
19 This can be, again, very problematic,
20 and this is why we also talk about -- you know, as
21 psychologists, we're also in a day and age where we
22 start talking about culturally adapting, you know,
23 different approaches like CBT or other modalities.
24 I'm of the camp of, you know, we can't
25 put all our eggs in one basket. So we do have

1 great interventions that we use to help our
2 clients. Do we need to culturally adapt them so
3 that everybody can fit into them? Maybe. Maybe
4 not. There may be practices that that culture or
5 that community are already using that could be more
6 beneficial versus saying, everyone needs to fit
7 into a CBT modality. So this is why I say we need
8 to think clinically as well as critically as well
9 in terms of this.
10 And also, when we talk about
11 assumptions of what it means to be a person or a
12 group member in an individualist-oriented society,
13 we talk about the continuum of an
14 individualist-oriented society and a collective.
15 And if you have a community which works in more of
16 a collective style, trying to fit them into an
17 individualist modality is actually going to cause
18 more harm because that is not how their community
19 operates. So we do have to understand that piece
20 as well.
21 Psychological research may have
22 mistaken specific cultural twists for universal
23 principles because most of the research subjects as
24 well as the researchers over the past 50 years have
25 been Americans or Europeans.

1 Again, when we start talking a bit more
2 about test measures, the way that the test measures
3 have been normed, a lot of the times how we look at
4 certain psychological interventions and the way
5 that they have been normed, we have to give
6 credence to this understanding. Now, I'm not the
7 person to say throw out the baby with the bath
8 water, right? It's not about that.
9 But what we have to look at is be
10 mindful of -- for example, if we use tests,
11 personality tests that have been normed on over 70
12 to 80 percent of a European population, what does
13 that look like for the individual who is taking
14 that test and that is not from that population?
15 How do we ensure that we are not pathologizing that
16 individual because they're not from the larger
17 population? Again, being mindful.
18 So what we need to look at as well is
19 what is culture? Because again, we're throwing out
20 this term; let's just make sure that we're all on
21 the same page when we're talking about what is
22 culture, and then we can work from there. So from
23 foundation, we work up.
24 "Culture" refers to:
25 "The cumulative deposit of

1 knowledge, experience, beliefs,
2 values, attitudes, meanings,
3 hierarchies, religion, notions of
4 time, roles, spatial relations,
5 concepts of the universe, and
6 material objects and possessions
7 acquired by a group of people in the
8 course of generations through
9 individual and group striving."
10 So that's just a mouthful. Let's put
11 it that way. I'll give you more of a practical
12 definition, and I like to use myself sometimes as
13 an example.
14 So I'm born here. I'm born and raised
15 in Toronto. My parents are from the Commonwealth
16 of Dominica, not the Dominican Republic -- let me
17 put that out there -- but the Commonwealth of
18 Dominica, a small island in the Caribbean, about
19 70,000 people.
20 Even though I know that I am born here
21 and that I am Canadian, it is difficult for me at
22 times to identify with being Canadian because I've
23 had several experiences in my lifetime where people
24 have come up to me and asked me, where are you
25 from? And when I say, I'm born here, I'm Canadian,

1 [I'm met with] no, no, no, no, no; where are you
2 from?
3 So I cannot, in their mind's eye, be
4 Canadian. I have to be from somewhere else.
5 Right? Even though I completely understand
6 culturally I'm Canadian, that's not necessarily
7 where I identify or where I'm most comfortable.
8 And now, mind you, over the course of
9 my upbringing, I have also been raised to say that
10 I was Dominican first, Canadian second because
11 that's where my strength and where my pride has
12 come from.
13 But let's not, for lack of a better way
14 of saying it, let's not get it twisted. I am
15 Canadian, right, and I also claim that as well, but
16 that had to evolve over a lifetime.
17 Now, for myself, if someone similar to
18 me came into a psychological practice or came to
19 see a practitioner, my experience as a
20 Canadian-born, Dominican-parentage individual may
21 be different from somebody who has immigrated here,
22 who may have a different experience, who has now
23 come from one country to another and are in two
24 completely different cultures, someone that has
25 maybe come from their country of origin as a

1 doctor, as a lawyer, as a teacher and who has now
2 come to this country possibly and is not in the
3 same profession that they have left behind. So we
4 may have different cultural approaches or cultures,
5 but also understanding that our experiences are
6 going to be very different.
7 "A culture is a way of life of
8 a group of people, the behaviours,
9 beliefs, values, and symbols that
10 they accept, generally without
11 thinking about them, and they are
12 passed along by communication and
13 imitation from one generation to the
14 next."
15 So it's the norms; it's the values;
16 it's what we espouse as people. And for a lot of
17 people, that is their normal.
18 Sometimes, until they have now,
19 fortunately or unfortunately, are in front of a
20 practitioner and now that their normalcy is no
21 longer seen as normal for whatever reason because
22 they're now put against sometimes Westernized
23 philosophies and sometimes we as practitioners
24 become closed-minded. So again:
25 "Culture is a symbolic

1 communication. Some of its symbols
2 include a group skill, knowledge,
3 attitudes, values, and motives. The
4 meanings of the symbols are learned
5 and deliberately perpetuated in a
6 society through its institutions.
7 It is how things are passed down
8 orally, read, through exchange, and
9 interaction. Culture is the
10 richness of each individual.
11 Culture consists of patterns
12 explicit and implicit, of and for
13 behaviour acquired and transmitted
14 by symbols, constituting the
15 distinctive achievement of human
16 groups including their embodiments
17 and artifacts.
18 The essential core of culture
19 consists of traditional ideas and
20 especially their attached values.
21 Cultural systems may, on the one
22 hand, be considered as products of
23 action and, on the other hand, as
24 conditioning influences upon further
25 action."

1 The richness of culture is so important
2 in terms of the wellbeing of an individual, and I
3 think that's the important thing to understand. It
4 gives meaning and purpose to that individual. So
5 again, being mindful of that.
6 "Culture is the sum of total of
7 the learned behaviour of a group of
8 people that are generally considered
9 to be in the tradition of that
10 people and are transmitted from
11 generation to generation.
12 And culture is a collective
13 programming of the mind that
14 distinguishes the members of one
15 group or category of people from
16 another."
17 For example, with my culture, again,
18 coming from the Commonwealth of Dominica, a lot of
19 times people may believe because I'm from the
20 Caribbean everybody from the Caribbean is alike.
21 I'll stop everyone right there. In
22 Dominica -- Dominica is an English-speaking island,
23 but we also speak a French Creole, so part of that
24 generation -- part of that tradition has been
25 passed down to me. I do not speak it, but I

1 understand it, but also, the traditions that have
2 been espoused as a result of that French Creole
3 upbringing.
4 What makes that interesting as well is
5 that we have other islands, for example, that have
6 a similar French Creole upbringing, French Creole
7 tradition but not exactly the same.
8 So our sister island is Saint Lucia.
9 Saint Lucia and Dominica are sister islands; we are
10 similar in culture as well as upbringing. What was
11 fascinating is to understand if we look at Haiti,
12 for example, Haiti also speaks Creole. Their
13 Creole is different from ours. Even though it is a
14 French Creole, it is also rooted in a lot of
15 Afrikaans, so what happens is is now their culture
16 and what they represent and their symbolism ends up
17 being a little different.
18 But a lot of times, we will group all
19 of this together and say that we're Caribbean,
20 that's fine, and again, that ends up being a
21 misconception. So it's also understanding that
22 within culture, there's going to be a lot of
23 differences as well.
24 I had a colleague come to me, or a
25 colleague several years ago say to me, well, you

1 know, I visited this certain island how many times;
2 I should be able to work with people from that
3 background. No, you cannot. Not right away,
4 anyway. Just because you've been to the island a
5 few times doesn't mean you know every single
6 solitary person and their experience of that one
7 island.
8 Let's be careful with saying those
9 types of statements because then you're going to
10 fall into a trap in terms of how does this person
11 individually experience their life versus
12 collecting them all and saying, well, I've been to
13 this country or I've seen a couple people from this
14 background; I know exactly how I can work with
15 everybody.
16 "Culture in its broadest sense
17 is cultivated behaviour. That is,
18 it's the totality of a person's
19 learned, accumulated experience,
20 which is socially transmitted, or
21 more briefly, behaviour through
22 social learning."
23 As an adjunct to this, this can also
24 mean how ideas and thoughts about mental health and
25 mental illness are transmitted through a culture,

1 through a population as well. This will also
2 impact how somebody from an ethnically diverse
3 population or community is going to come and
4 approach you regarding their health and their
5 mental wellbeing. That's also important.
6 Because a lot of times -- you know, I
7 could do a whole other talk about the stigma of
8 mental health in ethnic communities and what does
9 that look like and how does that then affect
10 help-seeking behaviour? Being mindful of that as
11 well. A lot of it's going to be a lot of being
12 mindful.
13 Any questions so far? Okay.
14 Absolutely.
15 QUESTION/COMMENT: We have so-called
16 "standardized tests."
17 NATASHA WILLIAMS: Yes.
18 QUESTION/COMMENT: For example, we have
19 the MMPI, which is supposed to be the golden
20 instrument, which is incorrect.
21 NATASHA WILLIAMS: Right.
22 QUESTION/COMMENT: Because, for
23 example, I have had a patient from the Mekong
24 Delta, which is south of Saigon, or now it's called
25 a different city.

1 NATASHA WILLIAMS: Right.
2 QUESTION/COMMENT: And he asked, can
3 you hear voices? And she said, yes. Can you see
4 spirits? And she said, yes. And he diagnosed her
5 as psychotic, and she's not.
6 NATASHA WILLIAMS: Right.
7 QUESTION/COMMENT: When you ask her
8 what were the voices, she says, well, Ragnan (ph)
9 told me that I must do certain things, and I hear
10 those voices in my head.
11 NATASHA WILLIAMS: Um-hmm. Right.
12 QUESTION/COMMENT: And then she claims
13 to see an aura when she's doing whatever, massages
14 or something. And here is a situation.
15 Now, as you just pointed out, that we
16 talk about the West Indies or Caribbean -- there's
17 no such thing. Each island is very different.
18 Trinidad, Grenada, Saint Vincent, Saint Lucia --
19 NATASHA WILLIAMS: That's right.
20 QUESTION/COMMENT: -- Martinique,
21 they're all very different and they have all
22 different idiosyncratic behaviours.
23 Okay, thank you. That's all I'm going
24 to say.
25 NATASHA WILLIAMS: Thank you for that,

1 and I appreciate your comments. Absolutely.
2 Something like the MMPI, for example, I
3 have seen a very similar misdiagnosis using that
4 tool as well. I've seen where a client had been
5 diagnosed with schizophrenia after saying that
6 they've heard voices and that sort of thing.
7 He was from an African country, and in
8 that country, he was a Pentecostal Christian. And
9 with that charismatic Christianity, you can, you
10 know, hear the Holy Spirit and hear God's voice and
11 that sort of thing, and unfortunately -- I was a
12 student at the time, and unfortunately, the
13 practitioner didn't line up some additional
14 questions to understand what this client meant and
15 diagnose this young African-Canadian male with
16 schizophrenia.
17 So it's definitely something I have
18 seen quite significantly, and this is why I say we
19 need to start to think critically and clinically
20 when we're actually using these tests because we
21 are now in a space where we can change the
22 trajectory of an individual's life negatively if we
23 utilize these tests incorrectly.
24 As practitioners, when we're using
25 these tests, these psychological tests, these tests

1 are one avenue in our clinical assessment. I think
2 a lot of times what we do, to our detriment, is we
3 only use the psychological test as a means to
4 describe the individual.
5 This is why, for example, when you are
6 doing a psychological assessment, it's not just the
7 results of the test measures. You have done a
8 clinical interview as well. You've hopefully
9 reviewed a file as well. You've possibly gathered
10 collateral information from the client, from the
11 client's close relatives or something of that
12 nature when you are conducting a psychological
13 assessment.
14 This is how we are trained as
15 psychologists and set us apart from other
16 practitioners that are doing this type of work. So
17 we have to take our training to the next level.
18 QUESTION/COMMENT: Thank you. This is
19 a wonderful beginning to warm up the day. I want
20 to comment about culture --
21 NATASHA WILLIAMS: Yes.
22 QUESTION/COMMENT: -- and add and hear
23 your reflection or addition to what I'm about to
24 say.
25 NATASHA WILLIAMS: Absolutely. QQQ as

1 I listened and looked at one of your definitions
2 about self and others, I was thinking about a Zulu
3 idiom which talks about a person is a person
4 through other persons. And I want to talk about
5 the culture of psychology, which I don't want to
6 forget in the process because we, historically,
7 have been trained with a medical model. It's not
8 to throw out, as you said, the baby with the bath
9 water, but as a profession, it was not necessarily
10 very strong about primary and secondary prevention.
11 It was kind of loaded, historically,
12 and although we have now the golden thread of
13 aiming to do a gap analysis, the profession itself,
14 if you look, it's not just the issues about global
15 interventions that are applicable to all, but look
16 at the terms. It's not been that long ago that we
17 used populations as "culturally disadvantaged."
18 This is a term that was used not
19 necessarily because it was a diverse population
20 beyond the socioeconomic factors. So we came a
21 long way, but not long enough.
22 So to be mindful about the adaptation
23 of our skills, unless we do a cultural check-in
24 with all the "isms" that we bring because we are
25 private people before we become psychologists --

1 NATASHA WILLIAMS: Absolutely.
2 QUESTION/COMMENT: -- surprise,
3 surprise -- we are not going to do a gap analysis
4 that is going to be adapting our own skills and
5 knowledge as we go along, and we might even remain
6 reactive rather than proactive.
7 NATASHA WILLIAMS: Absolutely.
8 QUESTION/COMMENT: So just a comment.
9 NATASHA WILLIAMS: Absolutely. Thank
10 you so much for that. I know with my training, it
11 was similar. I was trained in the U.S., and a lot
12 of the training in the U.S. was a very groupthink
13 kind of training: This is how you work with the
14 African-American client. This is how you work with
15 the Asian-American client. This is how you work
16 with the Native American client. Okay. Now, you
17 have this training, go forth and prosper.
18 And again, such harm and damage that
19 can be done when you group everybody in those types
20 of terms and say, okay, you know what, you have
21 your cultural sensitivity training; you're good to
22 go.
23 And that in and of itself -- I had to
24 come back to it while I was going back and forth,
25 but coming back to Toronto, I had to decide, if I'm

1 going to be a practitioner, a psychologist for a
2 long period of time, I'm going to have to unravel
3 some of that training because I am going to cause
4 more harm than good, so unravel some of that and
5 keep myself relevant. What is this? This doesn't
6 work.
7 So what do I need to do now? Research
8 more, see what I need to do to actually make sure
9 that I'm not doing harm to others.
10 And it also spoke to my own experience
11 as well being a black woman and sort of seeing, if
12 this is how psychology is seeing me, for example,
13 how can I perpetuate that back and then cause more
14 damage? So something has to change here.
15 So again, be proactive versus reactive.
16 Absolutely. We do have, I think, to get out of
17 that sort of medical modality or medical model
18 piece, in a sense, so that we can be more proactive
19 and come from that end of it versus coming from
20 that reactionary position.
21 There's a question at the back there.
22 QUESTION/COMMENT: Yeah, I love your
23 approach, and I think it's so important to save a
24 few minutes when we're also in the process of
25 training others for what I would call the meaning

1 of behaviour. And others can provide examples from
2 when they were training me, but I'll provide one.
3 I was training a person from the Middle
4 East in how to do therapy with a fourth-generation
5 Ontarian WASP male with adult ADHD, learning one of
6 the professions. And the client was always late
7 and frequently brought his lunch and got it out and
8 started eating as the session would begin.
9 And in supervision, you know, the
10 person that I was training just felt that the
11 client was so disrespectful, like, had a real
12 counter-transference, if you will, to the level of
13 disrespect in the behaviour as shown.
14 And so it's just a general comment, but
15 the meaning of "behaviour" is a source of
16 discussion.
17 NATASHA WILLIAMS: Um-hmm, um-hmm. Can
18 I ask you, how were you able to work with that
19 clinician in terms of that counter-transference?
20 Because again, that person is now
21 coming from their own mindset and perspective,
22 saying, look at this behaviour, this is absolutely
23 disrespectful, and that could then affect the
24 therapeutic relationship.
25 QUESTION/COMMENT: Yes. Well, you

1 know, first of all, I was quite impressed with the
2 trust level of the person I was working with, that
3 they were very willing -- well, I'm not sure if
4 "willing" is exactly the way it started -- but as
5 time progressed, to discuss these issues in our
6 supervision.
7 NATASHA WILLIAMS: Um-hmm, right.
8 QUESTION/COMMENT: So number one is to
9 acknowledge the trust, to open up to the issue, and
10 then -- actually, I -- we used, as many people in
11 this room probably know, there's very good work in
12 the last decade -- well, in the last few decades in
13 adult ADHD and looking at the struggles.
14 And so we were able to look at what it
15 means to start where the client is at, and that,
16 you know, you could spend a few sessions just
17 starting where the client is at, right? So the
18 trusting in being able to talk about stuff that's
19 not going okay and then also trying to find a way
20 to talk about what is the communication going on in
21 this room, kind of.
22 NATASHA WILLIAMS: Right, right. Thank
23 you for that. The other piece I also wanted to
24 just throw out there and to challenge a little bit
25 is the one thing that came to mind for me when you

1 were discussing that scenario was that possibly
2 that clinician's -- what that clinician's idea of
3 therapy is. Because a lot of times we may be,
4 again, putting clients in our framework of what
5 therapy is, in a box.
6 A lot of times, we work in silos. So
7 literally, it's come to my office, 9 to 5, in this
8 room, here's a chair here, here's a chair here, and
9 this is therapy. And there may be some challenges
10 to that depending on the type of client that has
11 come into your office.
12 You know, I have some of my fellow
13 colleagues and clinicians who, instead of that
14 client coming into the office and sitting in the
15 chair, they come into the office, and they will
16 cross their legs, and they sit on the floor. And
17 what does that look like for that exchange or that
18 therapy, for that therapy session?
19 For some of my other fellow clinicians,
20 what they will do is if the confines of the four
21 walls of the office is not suitable or not
22 comfortable, sometimes I'll say, well, why don't
23 you go to where the client is at? And at some
24 points in time, it could be, you know what, I just
25 want to go outside in the park and sit down, and

1 what does that look like?
2 And I'm not saying this is for
3 everybody, but sometimes we may then have to
4 challenge, depending on the types of clients that
5 we're seeing, what is therapy, or what is sort of
6 the therapeutic environment? Yes?
7 QUESTION/COMMENT: I just want to make
8 a statement with regards to therapy and
9 therapeutic. I can go to the best therapist who
10 says he has all kinds of degrees or he has whatever
11 experience, and he can prescribe therapy.
12 NATASHA WILLIAMS: Right.
13 QUESTION/COMMENT: But I can go to the
14 barman, and I can talk my heart out, and he
15 listens, and he talks, and that becomes
16 therapeutic.
17 NATASHA WILLIAMS: Right, right, right.
18 QUESTION/COMMENT: So if you go to a
19 psychologist, and the therapy is not therapeutic,
20 you're wasting your time.
21 NATASHA WILLIAMS: Absolutely,
22 absolutely.
23 QUESTION/COMMENT: Thank you.
24 NATASHA WILLIAMS: Very good point.
25 QUESTION/COMMENT: Yeah, let me follow

1 up on that a little bit. We have some techniques,
2 and we apply them to people.
3 NATASHA WILLIAMS: Right.
4 QUESTION/COMMENT: And that's a problem
5 because at some level -- and this is what I want to
6 talk about. We need to face the resistance in
7 ourselves because in some way, you're putting
8 yourself on the line.
9 NATASHA WILLIAMS: Right.
10 QUESTION/COMMENT: It's uncomfortable.
11 NATASHA WILLIAMS: Right.
12 QUESTION/COMMENT: And so I also think
13 we have to look at the resistances that are built
14 in.
15 NATASHA WILLIAMS: Right.
16 QUESTION/COMMENT: And, you know, those
17 are reinforced and be willing to look at ourselves,
18 and that's not paid attention to --
19 NATASHA WILLIAMS: Absolutely.
20 QUESTION/COMMENT: -- and I think we
21 need to pay more attention to it.
22 NATASHA WILLIAMS: Thank you so much
23 for that, and I'll get to you in one second.
24 Just to respond to that as well, I
25 teach CBT. So for some of my students, what I will

1 ask them to do is to be comfortable with being
2 uncomfortable because, a lot of times, the reason
3 that a lot of the students want CBT is they're
4 looking for what will make me as a clinician be
5 comfortable in each session.
6 So part of it is, yes, I want to help
7 my clients, but I also want to feel comfortable in
8 therapy. I have this, you know, tried-and-true
9 modality, and if I know that I have that on me, I
10 know that I as a clinician am going to be
11 comfortable, right, because I have this certain
12 skill, and I can espouse it to the client.
13 And I'm like, at what point do you
14 sometimes need to be comfortable with being
15 uncomfortable and your own resistance and that sort
16 of thing as well.
17 So I thank you for bringing that up
18 because I think a lot of times we don't turn the
19 mirror on ourselves enough, and I think we do have
20 to look at ourselves and look at some of the hard
21 truths with ourselves as clinicians. And, yes,
22 we're human beings as well, as you were mentioning
23 earlier. We are human beings. That means we're
24 human beings; we're people first; what do we bring
25 to the table as well, and what are some of our

1 resistances or some of our hang-ups as well?
2 Sometimes we don't take the time to do
3 that because we're like, oh, we're the clinician,
4 we're the expert, we are supposed to, supposed to,
5 supposed to. We need to stop that and turn the
6 mirror upon ourselves.
7 QUESTION/COMMENT: You're talking about
8 humility.
9 NATASHA WILLIAMS: Right? Right?
10 Exactly.
11 QUESTION/COMMENT: As professionals, we
12 don't always practice that, you know.
13 NATASHA WILLIAMS: Um-hmm.
14 QUESTION/COMMENT: Anyway, I just
15 wanted to say thank you so much for this. It's a
16 pleasure.
17 And I'm not sure if you're aware and if
18 the other people listening are aware, but I just
19 completed -- it was a joint project with the
20 Canadian Psychological Association and the
21 Psychology Foundation. We had a task force, which
22 was psychologists as well as Indigenous people, and
23 we have a document, which is to guide psychologists
24 to be in compliance with the calls to action that
25 came out of the Truth and Reconciliation

1 Commission.
2 NATASHA WILLIAMS: Ahh.
3 QUESTION/COMMENT: Okay? So I think
4 it's a very important document.
5 NATASHA WILLIAMS: Absolutely.
6 QUESTION/COMMENT: I feel very
7 privileged to be part of this group. The document
8 is extremely powerful in terms of talking about the
9 effect that psychology has had on Indigenous
10 Peoples and how to move forward.
11 And I'm learning every day. Every time
12 I'm on the phone with Indigenous People, I learn,
13 and it's affected my practice. I'm doing things
14 differently now. I believe that if we become more
15 respectful of Indigenous People, we will be more
16 respectful of everyone.
17 You know, for example, the whole idea
18 of individual assessment doesn't always work with
19 people who have a group psychology. I mean, all of
20 a sudden, they're in a room with one other person?
21 They don't function very well that way.
22 NATASHA WILLIAMS: Absolutely.
23 QUESTION/COMMENT: So, you know, I've
24 sort of begun to -- and, you know, moving away from
25 that goes against the rules that come from Pearson

1 and the test makers who are the keepers of Western
2 psychology.
3 NATASHA WILLIAMS: Right.
4 QUESTION/COMMENT: And, you know, we
5 need to wake up, you know, and who are we listening
6 to? How do we move forward?
7 I mean, I was at one OPA conference,
8 and most of the sessions were given by the test
9 makers, you know, the people from Pearson. And,
10 you know, it wasn't science. It was marketing.
11 Right?
12 NATASHA WILLIAMS: Right.
13 QUESTION/COMMENT: Anyway, so this
14 document is now done, and we're in the process of
15 kind of finding ways to disseminate it. So I know
16 there are 2,000 people listening right now.
17 So if anyone's interested, you know, if
18 you're a CPA member especially, you can get a copy
19 of this. It's 36 pages, but it's very important
20 that we all educate ourselves and, you know, just
21 come to the table about this, you know? That's all
22 I wanted to -- are you aware of this?
23 NATASHA WILLIAMS: No, I was not aware,
24 so thank you for that, and I would love to actually
25 get a copy of that document as well.

1 QUESTION/COMMENT: We will definitely
2 send it to you.
3 NATASHA WILLIAMS: And I think what it
4 also speaks to as well is the evolution of learning
5 for us as clinicians. We need to continually
6 evolve. We need to continually evolve. Once we
7 stay stuck in where we were trained 10 years ago,
8 15 years ago, or whatever the case may be,
9 understand that that's going to cause harm.
10 QUESTION/COMMENT: Yeah.
11 NATASHA WILLIAMS: Right? We need to
12 evolve and expand our mindset in terms of how we
13 work with our patients on a day-to-day basis.
14 Because, again, what I have noticed is,
15 more and more, we are having people that are being
16 unjustly diagnosed or pathologized and that then
17 changes the trajectory of their entire life.
18 QUESTION/COMMENT: Yeah. Just to add
19 to that, one of the things I've learned is that
20 even a diagnosis has a different meaning -- getting
21 a diagnosis --
22 NATASHA WILLIAMS: Yes.
23 QUESTION/COMMENT: -- has a different
24 meaning to a lot of Indigenous Peoples.
25 NATASHA WILLIAMS: Absolutely.

1 QUESTION/COMMENT: You know, it's like
2 they're no longer a person. They become that
3 diagnosis.
4 NATASHA WILLIAMS: Absolutely.
5 QUESTION/COMMENT: And it can have a
6 very -- we're all talking about anti-stigma, but to
7 an Indigenous Person, it's, like, times ten. Much,
8 much more extreme, right?
9 NATASHA WILLIAMS: Absolutely. I know,
10 for example, with a lot of people that are coming
11 from the Caribbean, a lot of the thought process in
12 terms of diagnosis or mental illness is very
13 polarized. It's either you're very good or you're
14 absolutely crazy.
15 And the minute you put that label on
16 somebody, it's not just the individual that is
17 affected; it is the entire family at times because
18 that label follows the entire family. So then the
19 family is now stigmatized as a result of that;
20 they're now ostracized from their community as
21 well, and then the family as a collective who needs
22 help cannot receive that help as a result of that
23 as well.
24 So, you know, we have to be mindful of
25 our language, of what we see as a diagnosis. A lot

1 of times -- remember the DSM is a Westernized tool
2 and measure. A lot of times, the language that's
3 in the DSM does not resonate to, you know, 80% of
4 the world, right? So what does that look like, and
5 how do we then still be in a position to help but
6 also not pathologize and ostracize at the same
7 time? So again, this is going to be quite tricky
8 for a lot of people.
9 QUESTION/COMMENT: How would achieve
10 that? I'm curious. Like, you're sitting with
11 somebody and [Indecipherable] cultural issues, how
12 would you manage that in a clinical session? I'm
13 just curious, like, what vocabulary you've tried to
14 use or approach you've used that's been successful?
15 NATASHA WILLIAMS: Someone asked to
16 repeat the question because they didn't hear it.
17 QUESTION/COMMENT: Just to take it a
18 step further and be a little more concrete, I'm
19 wondering how do you apply that in a clinical
20 session when you know in a culture that it could be
21 polarizing, or worse -- it's already stigmatized
22 here in North America; let's be honest -- it can
23 stigmatize a family, but I'm curious to know if
24 you've had approaches that you find more helpful
25 with language or approach that stigmatizes the

1 issue less for the individual or the family?
2 NATASHA WILLIAMS: Right, right. One
3 of the first things that I do in my session is I
4 take a step back. And I call it "lean back," which
5 is, I guess, maybe not the most create term, but
6 the thing is is that I want to get the client to
7 sort of educate me in terms of language. And that,
8 for me, is a starting point versus me superimposing
9 what I believe the language is going to be.
10 If I can then have that understanding
11 and give space in the session for the client to
12 start to educate me, what does that language look
13 like? What does it look like in your community?
14 You know, how would there be possible ostracization
15 if there is this label put upon you?
16 If I can come from that perspective
17 first before then jumping in and saying, you know,
18 let's fix this, let's fix this, let's fix this,
19 then I can actually create a dynamic where we can
20 be joint in this healing process. So I actually
21 take the step back and have the client educate me
22 first so that I understand what the language is.
23 Sometimes, I have a lot of clients that
24 will come to me because they know that I'm, you
25 know, a black woman, Caribbean, that kind of thing,

1 so they have this assumption, let's put it that
2 way, that I will thoroughly understand what is it
3 that their experience is, but I don't go in with
4 that. Just because you and I are from the
5 Caribbean doesn't mean our experiences are the
6 same.
7 So I do take that step back, and I will
8 say, well, what is your experience? How does your
9 family experience this? What are your views? And
10 that type of thing. Then I can cultivate my
11 intervention from that standpoint versus from a
12 very reactionary position.
13 QUESTION/COMMENT: Natasha, you just
14 said something that has a therapeutic benefit. You
15 are asking the client to educate you. You are
16 giving some power --
17 NATASHA WILLIAMS: Absolutely.
18 QUESTION/COMMENT: -- and you are
19 teaching listening.
20 NATASHA WILLIAMS: Right.
21 QUESTION/COMMENT: And that's connected
22 into the nonverbal behaviours that obviously are
23 not universal that we can utilize check-ins with
24 clients both during sessions of therapy and during
25 assessment.

1 NATASHA WILLIAMS: Right.
2 QUESTION/COMMENT: And I'm thinking
3 about the interpretation of certain behaviours as
4 was said earlier, not because they are on the MMPI,
5 but because they are culturally loaded.
6 NATASHA WILLIAMS: Right.
7 QUESTION/COMMENT: What are the
8 implications of becoming hystrionic as a way of
9 expressing grief? Does it mean that we are
10 pathologizing the person, or are we understanding
11 within the context of that culture?
12 NATASHA WILLIAMS: Absolutely.
13 QUESTION/COMMENT: So what is the
14 context of everything?
15 NATASHA WILLIAMS: Right.
16 QUESTION/COMMENT: What are the
17 implications for my self-image? And I think that
18 one of the things we tend to not do that well is
19 the aspirational goals we have and intervention
20 that have to actually be interventions that take
21 into account that maybe the goal is completely
22 unrelated to a positive self-image that the person
23 has in a culture, such as being assertive in how
24 you demonstrate your improved self-esteem.
25 Are you boasting? Are you taking over?

1 Are you not listening? Is this a good goal in an
2 expected outcome? What are we doing with all that?
3 NATASHA WILLIAMS: Right.
4 QUESTION/COMMENT: So the issue of the
5 nonverbal behaviour and issues around somatization
6 as a way of expressing emotions are definitely not
7 that crystallized in our knowledge and
8 intervention.
9 NATASHA WILLIAMS: Absolutely.
10 QUESTION/COMMENT: So I just thought
11 maybe you can comment about some of these things.
12 NATASHA WILLIAMS: Right, right. I
13 think a lot of times -- thank you for that.
14 I think a lot of times what we need to
15 do as clinicians is humble ourselves, and I don't
16 think we humble ourselves enough. We end up coming
17 from a standpoint of the, you know, we are the
18 expert; we have to do this; we have to intervene;
19 we have to intervene. And a lot of times what
20 happens is, from a nonverbal perspective, that can
21 possibly be seen as threatening.
22 So what happens is that we don't create
23 an environment of safety and support for that
24 client or individual, so they don't feel
25 necessarily that they can heal wholly because I am

1 not in a space where I feel that I'm 100%
2 comfortable, or, yeah, comfortable enough to do the
3 necessary healing that needs to happen.
4 So I think that's an important piece
5 that we have to -- we have to continue to espouse,
6 I think, to be humble enough to be educated by the
7 client so that we can actually conduct that healing
8 work appropriately.
9 Any other comments or questions?
10 QUESTION/COMMENT: [Indecipherable].
11 NATASHA WILLIAMS: No. Go ahead,
12 please.
13 QUESTION/COMMENT: [Indecipherable]
14 speak about Indigenous Peoples --
15 NATASHA WILLIAMS: Right.
16 QUESTION/COMMENT: -- and I fly quite
17 often to a place called Psiquantum, Sault Lookout,
18 Sandy Lake, which is close to the Arctic Circle.
19 It takes me three aircraft to get there.
20 And one of the things you said there is
21 that you have to be educated. You are not going to
22 prescribe therapy. You are going to engage in a
23 therapeutic relationship, and what you're saying is
24 exactly that. If you go and think that you are
25 going to be Dr. X, they will tell you to go to

1 hell, and if you annoy them, the chief of the tribe
2 will throw you out.
3 NATASHA WILLIAMS: Absolutely.
4 QUESTION/COMMENT: When I fly to some
5 of these places, there are no roads. The OPP picks
6 me up, and they go with heavy artillery for my own
7 safety, and I have to go in there, and I have to
8 listen to them patiently without interrupting and
9 whether they say anything because, in fact, one of
10 the places, Psiquantum, is the highest suicide rate
11 of young women in the world. Not Ontario. In the
12 world. And I have to take all of those things into
13 consideration.
14 What is this young lady going to do if
15 she's depressed? The first thing she does is to
16 commit suicide. And if we provide therapy without
17 engaging in a therapeutic relationship, as you were
18 saying, being educated and humbling ourselves --
19 and you may have to sit on a couch, which most
20 probably, the bloody dog has been there for days,
21 and you go in your suit, and the next day, you
22 know, you have to get dry cleaned. Sometimes you
23 have to take water, and they don't offer you water
24 just because you are thirsty. They offer you water
25 to see if you're going to take it.

1 NATASHA WILLIAMS: Right.
2 QUESTION/COMMENT: It is part of their
3 communication. And all of these nonverbal
4 behaviours you are talking about, these behaviours
5 have to be taken into account as well. Thanks.
6 QUESTION/COMMENT: I just have to add
7 this because the Indigenous People in our group,
8 the first thing they said to us was one of the
9 things that's happening in Ontario is
10 psychologists -- and this was their word -- get
11 "airlifted" into the Northern Communities, do an
12 assessment, and leave.
13 NATASHA WILLIAMS: Right.
14 QUESTION/COMMENT: And they said to us,
15 please stop this because they don't take the time
16 to develop trust or they think that ten minutes can
17 develop trust.
18 NATASHA WILLIAMS: Right.
19 QUESTION/COMMENT: Trust is not -- you
20 know, they take a child away from their parents or
21 an individual away from their community, put them
22 in a room. They feel very unsafe and, you know,
23 why should I trust this person? They don't open
24 up, they don't participate in the assessment in a
25 meaningful way, they get a very low score, they get

1 a diagnosis, and that's the end of it. And so it's
2 a very damaging process that's happening.
3 NATASHA WILLIAMS: Absolutely.
4 QUESTION/COMMENT: And this needs to
5 stop. I mean, they do want our help. I mean,
6 people are committing suicide. Youth are
7 committing suicide. You know, high opioid use up
8 there. You know, they're coming to us for help;
9 please come and help. But we have to do it in a
10 different way.
11 NATASHA WILLIAMS: Absolutely. And I
12 think we have to be -- we have to open up our minds
13 to do things in a different way. A lot of times
14 what's happening is that we feel that -- or a lot
15 of clinicians feel like that I'm going to swoop in,
16 I'm going to save the day, and then I'm going to
17 leave, and I'll pat myself on the back, and I've
18 done a great job. And that's incorrect. It's
19 absolutely incorrect. It's absolutely wrong to
20 think that that's how we're going to be the savior
21 of the world.
22 We have been tasked to be healers,
23 clinicians and healers. So with that task, we have
24 to take this task very seriously, but in the midst
25 of that, we also have to learn how to do this,

1 right? It's not just, okay, we've received this
2 one set of training, let's just go and do this, and
3 that's it. We need to evolve, and the ways and
4 training of old is not working. We need to open up
5 our minds.
6 I know you have a question, but I know
7 there was two questions back there before yours, so
8 if you don't mind, and then we'll come to you
9 afterwards. Yeah?
10 QUESTION/COMMENT: I'm not exactly sure
11 how to phrase this. I think it's a question, but
12 it's a huge issue that's -- you know, when I look
13 around the room, I wonder about the issue of our
14 own perception of white privilege --
15 NATASHA WILLIAMS: Okay.
16 QUESTION/COMMENT: -- and the impact of
17 working with folks who have a long history of
18 misuse and abuse and trauma and the impact of that
19 experience on just how they perceive us --
20 NATASHA WILLIAMS: Thank you. Right.
21 QUESTION/COMMENT: -- but also how we
22 can understand, just by being who we are, you know,
23 with every good intention, may not be the solution
24 to the problem.
25 NATASHA WILLIAMS: Right.

1 QUESTION/COMMENT: It's tricky. Are
2 you going to speak about these issues?
3 NATASHA WILLIAMS: I will try my best
4 with the time that I have. I mean, I think that's
5 another seminar. You can invite me back, right?
6 But, yes. Thank you for bringing that
7 up because I think a lot of times, if you want to
8 call it that elephant in the room or anything of
9 that nature, or sometimes a very uncomfortable
10 topic is talking about that sense of white
11 privilege and what does that bring to the table or
12 bring to the therapeutic relationship or the
13 attempts to forge a therapeutic relationship? That
14 has to be understood.
15 It may be difficult for somebody from
16 another ethnic community to come to you because
17 they see you as part of their oppression, and how
18 do I then facilitate healing with somebody who
19 looks like my oppressor?
20 That is a difficult conversation to
21 have. And it may be that that person in
22 particular, you cannot be part of their healing,
23 and that's just it. We cannot heal everybody. So
24 in that aspect, it could be that, you know what, I
25 am looking for someone who looks more like me to

1 facilitate that healing.
2 But yes, if we look around the room,
3 that's tough. There are not a lot of psychologists
4 from ethnically diverse communities, so we're
5 having that difficulty as well. It's just a
6 reality.
7 I know I've said this before, and I
8 think a couple of colleagues may have heard me say
9 this, but I do have people that come and contact my
10 office just because they know I'm a black woman.
11 And for them, it's like, well, you know
12 what, I don't want to regurgitate my history or try
13 to train somebody to understand what I'm going
14 through. My hope is that if I connect with someone
15 that looks like me, they can understand my
16 experience, hence to facilitate my healing.
17 In saying this, though, I also don't
18 want to be of the person that because somebody is
19 European or whatever the case may be that they
20 cannot do that healing work with other communities.
21 There still has to be an aspect of respect, coming
22 into that dynamic and saying, listen, understanding
23 that there is white privilege here, you know, do I
24 sit back and be educated before we can actually
25 engage in this healing process, and how can that be

1 facilitated?
2 So sometimes a client will come in from
3 another ethically diverse population, and they will
4 sit and actually do that healing work with somebody
5 from another community because right at the onset,
6 at the beginning, the environment that was fostered
7 or created was one of mutual respect and healing,
8 and they did not feel that they were going to be
9 judged, and they felt safe. And just with being
10 able to facilitate that type of environment, the
11 healing can be done regardless of the cultural
12 background of the clinician.
13 I know there was another question back
14 here, and then I'll get to yours.
15 QUESTION/COMMENT: Thank you so much
16 for your, I think, very skillful provocation of
17 this group. You know, when I listen to this, I
18 just feel like you're talking about power and
19 you're interrogating, I think, a lot of
20 unquestioned power that occurs, yes, in
21 institutions and in our practices but also in the
22 ways psychology's foundational knowledge functions.
23 I mean, even -- like, I'm an Indigenous
24 Person, and I work almost exclusively -- hello,
25 Robin -- I worked with Robin on that report and

1 work almost exclusively in community, and, you
2 know, even the way I'm hearing our communities
3 talked about today so far reveals so much of, I
4 would say, the anthropology gaze of this
5 discipline.
6 All that has been spoken of is our
7 damage, which is not coincidentally neutral. It
8 comes from colonization --
9 NATASHA WILLIAMS: Yes.
10 QUESTION/COMMENT: -- which, actually,
11 psychologists are implicated in that history in
12 very intimate ways.
13 So I don't know. I think two questions
14 I wonder about is do you really feel like we can --
15 do you think it's possible for psychologists to
16 suspend damage? Do you think it's possible for
17 psychologists, as we currently train them in
18 Canada, to suspend this damage-centered view?
19 And do you think it's possible for
20 racialized, Indigenous communities, immigrant
21 communities to refuse the imposition of these
22 practices? And as an Indigenous person in this
23 space, as a psychologist, and to others in this
24 space who are also coming from different social
25 locations, how would you encourage practices that

1 refuse this imposition, or what would you recommend
2 people do to oppose it?
3 Because it's -- you know, the word
4 "white privilege" came up. There's sort of an
5 unbearable whiteness to our space.
6 NATASHA WILLIAMS: Right.
7 QUESTION/COMMENT: And you don't have
8 to -- you know, in Canada, there are less than five
9 Indigenous researchers who are working in higher
10 education in psychology programs. You know, in the
11 Province of Ontario, we have less than 30 trained
12 psychologists, not all of whom are registered. I
13 mean, we are talking substantial disparity.
14 NATASHA WILLIAMS: Absolutely.
15 QUESTION/COMMENT: So what do you think
16 we should do on that level in terms of what we do
17 to prepare people?
18 NATASHA WILLIAMS: Oh, man. Thanks for
19 that question. Loaded question. And I don't think
20 I have all the answers. I will be honest with you.
21 I think psychology has a long way to go. I'm not
22 going to be -- I'm not going to be completely
23 pessimistic, but I also want to be real.
24 I think we are continually perpetuating
25 the same damage through our training, and that is a

1 problem in and of itself. If you keep on
2 perpetuating the same thing, you're going to get,
3 you're going to continue to foster that damage
4 throughout just in terms of ingraining it from the
5 foundation. If our training is the foundation,
6 we're still now perpetuating the same damage.
7 So what we need to start looking at is,
8 from a foundational perspective, how do we change
9 some of that training?
10 I believe that there is a movement that
11 is starting to look at challenging how we are being
12 trained, not only looking at Westernized modalities
13 and sort of how we're seeing things, but
14 implementing, you know, other ways of viewing and
15 training psychologists, but again, I think it's few
16 and far between.
17 And I think the other piece, if we're
18 also looking at the people that are being trained
19 and who are actually accessing graduate programs
20 and being trained, again, in terms of
21 ethnic-diverse communities, it's very few. So, you
22 know, we're still perpetuating this wheel.
23 So again, I don't really have all the
24 answers, but I think from a foundational level, we
25 have to start chiselling away from that foundation,

1 and I think that's going to be tough.
2 QUESTION/COMMENT: Yes. We're
3 clinicians and healers, and we're used to working
4 with individuals or small groups or families, but
5 Esther mentioned primary and secondary prevention.
6 We are often embedded in large efforts
7 that, in fact, go against all this. For example,
8 macroeconomic models that have an assumption which
9 is called a demographic transition. Namely, the
10 prosperity is correlated with small family size,
11 and we've got climate change besides.
12 So we go in and intervene and we say,
13 oh, well, you got to either directly or indirectly,
14 for example, by encouraging women in the culture to
15 become entrepreneurial, but we're not looking --
16 we're not giving people a choice, and we're not
17 looking at the impact of what we're doing.
18 NATASHA WILLIAMS: Right.
19 QUESTION/COMMENT: And psychologists
20 are often -- I mean, I have no easy answers to that
21 because we're often embedded as part of what's --
22 NATASHA WILLIAMS: Of the issue.
23 QUESTION/COMMENT: -- going on. So you
24 need to not look just at the individual in clinical
25 dimensions. You also need to look at all the

1 larger efforts and intervention and aid projects
2 and everything else that goes on.
3 NATASHA WILLIAMS: Absolutely,
4 absolutely. It makes sense. I'm getting the -- I
5 think it's time for a break.
6 QUESTION/COMMENT: There are closed
7 caption interpreters who need a break.
8 NATASHA WILLIAMS: Okay, yes.
9 Absolutely. Okay. So if anyone else has
10 questions, please hold on to them so when we come
11 back from break, we can resume from this point.
12 So I guess it's time for us to take a
13 15-minute break, and we'll come back.
14
15 (BREAK)
16
17 BARRY GANG: Okay. We have a little
18 bit less than an hour, so if everybody could please
19 take their seats, we have got a lot more to hear.
20 NATASHA WILLIAMS: All right,
21 everybody. Welcome back. When you need to go, you
22 need to go. It's okay.
23 Okay. All right. As we're settling
24 back in, I just want to check in with everybody
25 first before we just keep on going. Can I just

1 ask, how was the pace so far of the first part? Is
2 everybody okay?
3 QUESTION/COMMENT: Yes.
4 QUESTION/COMMENT: Do you want tea or
5 coffee?
6 NATASHA WILLIAMS: I've got tea. Thank
7 you. All right.
8 And so the pace was good? Everyone's
9 okay? No one's feeling -- is anyone absolutely
10 overwhelmed and...?
11 Okay, all right. I usually like to
12 check in with the temperature of the room just to
13 make sure that we're not too hot, not too cold, and
14 not too overwhelmed. That's the basis at the end
15 of the day. All right.
16 QUESTION/COMMENT: [Indecipherable].
17 NATASHA WILLIAMS: We hope so. I do
18 want to get to that.
19 I know that, you know, in the midst of
20 preparing for this, there's a lot of information
21 that I've put in, and my hope is that -- and I was
22 just telling somebody else. I go, usually my
23 slides are very wordy, but I usually like to impart
24 that to anybody who's actually in a seminar in with
25 myself so you have this for material going forward,

1 sort of as a tool or a resource.
2 My hope is that we can get to the
3 guidelines because they have been disseminated
4 through the American Psychological Association.
5 My other hope is that we may not get to
6 them point-by-point-by-point, but as we are going
7 through our discussions and questions and that kind
8 of thing, that it will actually parallel what some
9 of the guidelines are, anyway, of the American
10 Psychological Association. Okay?
11 So to continue, I know that, before the
12 break, we left off with a couple of questions.
13 There were still some questions in the room, so I
14 want to be mindful of that and make sure that we
15 address those questions that were left behind.
16 So did anyone else have a question or a
17 comment that was left behind from previous?
18 Oh, I guess not. Okay, okay. And so
19 it doesn't look like the question is there, so
20 that's fine. Again, as questions come up, please
21 feel free to ask away.
22 From the feedback that I've been
23 getting from most people, it sounds like having the
24 questions and the dialogue as we go along is the
25 best way, and I was mentioning to people, it's

1 better than just reading a whole ton of slides
2 because I think anybody can do that versus let's
3 engage and make sure that we can do that as a group
4 and as a group of psychologists.
5 So let's continue, then. Let's see
6 where we are. Let me go back. Okay.
7 So why don't we talk just a little bit
8 about cultural ethnocentrism, I think, which is
9 also important that we also need to discuss and
10 sort of bring to our awareness, especially as
11 practitioners. So if we talk about cultural
12 ethnocentrism and its definition:
13 "Ethnocentrism is the belief
14 that one's own culture is superior
15 to that of other cultures. It is a
16 form of reductionism that reduces
17 the other way of life to a distorted
18 version of one's own.
19 This is particularly important in
20 cases of global dealings when either
21 a company or an individual is imbued
22 with the idea that methods,
23 materials, or ideas that worked in
24 their own home country will also
25 work abroad. Environmental

1 differences are therefore ignored."
2 I wanted to bring this up because a lot
3 of times, this is the viewpoint that we work from,
4 and we can be guilty of working from an
5 ethnocentric point of view. And I think a lot of
6 times what I would charge us as psychologists to do
7 is to go abroad.
8 And the reason I say that is because,
9 yes, I've had my experience being a black woman,
10 being trained as a psychologist, some of the "isms"
11 that I have personally gone through, being trained
12 and becoming a psychologist and working in the
13 field. But I think beyond that training, and I
14 think someone asked about sort of our Westernized
15 training, my training has double- and triple-fold
16 when I decided to go to international conferences
17 and understand how, internationally, psychologists,
18 A, are being trained; and B, are actually or
19 possibly actually pushing back against that
20 training and being able to help their communities.
21 So that in and of itself has been, I
22 think, a powerful tool, and being able to step
23 outside of our Westernized box to see how other
24 practitioners are doing things, I think, has been
25 an absolute -- I want to say maybe even a healing

1 experience because it allowed me to come back with
2 more questions than answers, and I had to be
3 uncomfortable with that because now I had to flip
4 all of my training on its head and say, yes, this
5 is how I've been trained, but what else is going
6 on? I may have been only looking at things from a
7 very narrow point of view. I need to push my
8 boundaries and see what else is out there and
9 understand how we are practicing.
10 And a lot of times with ethnocentrism,
11 it's something that is not necessarily overt but
12 covert -- or vice versa. Either way, what happens
13 is that it's not something we're doing maliciously.
14 It's something that's, since its been engrained in
15 us for such a long period of time, we believe it's
16 the norm.
17 So we end up bringing that into our
18 session: Again, wanting to come in with our cape
19 and saying that we're going to go and heal the
20 world with our points of view. And we, again, have
21 to be very cautious of doing that because I think
22 what we are doing, again, is causing more harm. We
23 are actually doing a lot of damage in these
24 communities that are already damaged and are
25 seeking help.

1 Imagine that you are coming in with
2 your traumatic past and you're looking for help and
3 you're being further traumatized. That, in and of
4 itself -- you know, we need to hold ourselves
5 accountable for that. And if that means we have to
6 ruffle our own feathers, sit in that discomfort for
7 a little while and sort of figure out what can we
8 now to figure some of this out, then we must do
9 that.
10 I think we will not evolve as
11 psychologists or as a profession, if we do not look
12 and become uncomfortable. If we continue to stay
13 in our discomfort, we're actually not going to be
14 proper practitioners.
15 And that's why I said at the beginning
16 of the talk that I may -- you know, not everyone
17 may be happy with me. Not everyone, you know,
18 will -- I may ruffle a couple of feathers, but my
19 hope is that if I've done so, then I've done my job
20 because I think it's about time we get out of our
21 comfort zone.
22 As psychologists, I think we've been
23 working in silos way too long. Just having a talk
24 with a couple people during the break, we were just
25 talking about, you know, two -- we want to heal

1 community, but we don't want to go into the
2 community to do it, and why is that?
3 There's this, again, and what was said
4 earlier -- I believe, Esther you mentioned it is
5 that we're trained in a medical model, so a lot of
6 times, there's this air of, you know, I've got my
7 doctorate or I've got my this and that, and, oh,
8 well, I can't go into the community now. That's
9 other people's work. I need to stay in my office
10 and I need to work within my four walls.
11 And I challenge that. Let's put it
12 that way. And I think, as a profession, we need to
13 start challenging how we do our work.
14 And it's not saying -- again, I think
15 there are many different paths to healing, but I
16 think what we have done as a profession is that we
17 have only believed that this silo approach to our
18 work is one of the only ways and neglecting others.
19 So I want us to actually sit with that
20 for a second and just -- you know, again, if we go
21 away with more questions than answers, then that's
22 fine. That means we have to seek out how we're
23 going to respond to those questions even further,
24 and my hope is that while we're going through this
25 presentation and as we are sort of dialoguing as

1 colleagues that we can do that, so what we can do
2 at the end of the day is push the profession
3 forward.
4 There are so many people in this
5 society that are looking to us for help, and if we
6 can provide that help, let's do so, but let's also
7 look at ourselves to make sure that once they're
8 reaching out to us for help, that we can provide
9 them with what they need.
10 QUESTION/COMMENT: [Indecipherable].
11 NATASHA WILLIAMS: You need the
12 microphone.
13 QUESTION/COMMENT: I apologize for
14 interrupting again, but we have --
15 NATASHA WILLIAMS: Why are you
16 apologizing?
17 QUESTION/COMMENT: Well, because --
18 NATASHA WILLIAMS: No, no, no, don't.
19 Please don't apologize. I'm actually very happy.
20 Please go ahead.
21 QUESTION/COMMENT: We talk about
22 ethnocentrism, but the problem is this: We also
23 have a new concept called the Dunning-Kruger
24 Syndrome --
25 NATASHA WILLIAMS: Okay.

1 QUESTION/COMMENT: And Dunning-Kruger
2 Syndrome -- D-U-N-N-I-N-G, K-R-U-G-E-R -- it is the
3 same problem we are having where the psychologist
4 thinks that he knows much more than the patient,
5 and what he does not or she does not realize is
6 that he or she knows considerably less, and he
7 thinks that he's better and he acts more stupid or
8 she acts more stupid, and this is where the
9 ethnocentrism comes in.
10 NATASHA WILLIAMS: Absolutely.
11 QUESTION/COMMENT: And if we look up
12 the Dunning-Kruger Syndrome, you'll see what you've
13 said in a different language.
14 NATASHA WILLIAMS: Right, right. Well,
15 I think it goes back to humility, and you had
16 mentioned before, I think we do have to come from a
17 place of humility. How do we understand that --
18 understanding that the therapeutic relationship,
19 the term there is "relationship." It's not a
20 dictatorship.
21 So it's not about dictating. It's
22 about understanding of the client and allowing the
23 client the space to provide us with the
24 understanding, not with assumptions of the
25 understanding, and I think that's a major

1 difference.
2 QUESTION/COMMENT: Hi.
3 NATASHA WILLIAMS: Hi.
4 QUESTION/COMMENT: This is actually in
5 follow-up to the gentleman's comment over there
6 before the break.
7 NATASHA WILLIAMS: Yes.
8 QUESTION/COMMENT: I just wanted to add
9 something to the conversation that I often think
10 about when I think about cultural competence and
11 cultural sensitivity in our profession, and that is
12 the idea that poverty is racialized. There's an
13 over-representation of ethnically diverse or
14 racialized people living in poverty, and we had
15 talked about sort of access to training and sort of
16 not enough representation within the profession,
17 and it also applies to people accessing mental
18 health services.
19 So I recently had -- and I worked as a
20 settlement councillor before starting grad school.
21 I worked with a lot of South-Asian women, and the
22 reason why I decided to enter grad school as a
23 mature student was because I was finding so many
24 people from my community wanting to see me just
25 because of my background and then not having the

1 training to sort of support them.
2 NATASHA WILLIAMS: Right.
3 QUESTION/COMMENT: I had, recently, a
4 couple who is having marital problems, and they
5 were looking for counseling, and they really just
6 wanted to see someone with a similar background,
7 but they couldn't afford it, and I couldn't find
8 practitioners that were of their community that
9 offered a sliding scale.
10 So I wonder, as a profession, if part
11 of addressing the question of how do we move things
12 forward is having more discussions about how do we
13 increase access for people who can't afford, maybe
14 through more sliding scale, maybe through more
15 pro bono, maybe through a commitment because, like
16 you said, it's a cycle, right?
17 NATASHA WILLIAMS: Absolutely.
18 QUESTION/COMMENT: So we have people,
19 more racialized people living in poverty, and then
20 they're not getting the intervention, and then they
21 continue to be in that cycle.
22 NATASHA WILLIAMS: Absolutely.
23 QUESTION/COMMENT: So how do we
24 interrupt that? And it's just something that I
25 thought was an important part of the conversation.

1 NATASHA WILLIAMS: Yeah, absolutely. I
2 know access to services is a huge issue. With the
3 work that I was doing as a board member of Women's
4 Health in Women's Hands, I saw that firsthand.
5 Women's Health in Women's Hands is a community
6 health centre, so all of the services are funded
7 through the LHINs, and they serve a priority
8 population of black women and women of colour from
9 four priority groups.
10 So part of that access is that they can
11 get medical care such as doctors or nurses, but
12 they also have access to mental health and mental
13 health therapists as well. Their wait list is at
14 least six to nine months at least or even longer
15 now just in terms of getting that kind of access,
16 but it does speak to the huge issue of being able
17 to access our services as psychologists as well.
18 It's a tough one.
19 I know for myself, I do do some
20 pro bono. I have some sliding scale. I have
21 other -- you know, I have some of those mechanisms
22 in place, but for me, it never seems to be enough.
23 It's just really, really tough.
24 So I think it's a larger political
25 question, I think, as well just in terms of

1 Ontarians having the ability to have access to our
2 services because right now, it's either you pay
3 out-of-pocket, or you have some kind of insurance.
4 And sometimes with a lot of, you know,
5 racialized communities, they have neither, so
6 they're left with very minimal options or very long
7 wait lists or, again, wanting to see somebody from
8 the community and they can't or, you know. Again,
9 it perpetuates a larger cycle.
10 All right. I'm going to -- I'll talk a
11 little bit about layers of culture, and then from
12 there, what I want to do is I want to make sure --
13 and Barry keep me on time, please. Thank you very
14 much. I want to make sure that we address the
15 guidelines for providers as well. So just want to
16 make sure we're addressing what the members want.
17 So I just want to talk just a little
18 bit about layers of culture, and the reason I want
19 to say this is because a lot of times we, as
20 psychologists, we end up using -- I call it
21 "group-think." So the minute you see, you know,
22 that someone is from a particular country or
23 whatever the case may be, we think, oh, we know.
24 We know how to treat them because they're from this
25 country or that country.

1 So a lot of times -- so people even
2 within the same culture carry several layers of
3 mental programming within themselves. Different
4 layers of culture exist at different levels.
5 So a couple of the levels that I've
6 listed here is the national level; so that's
7 associated with the nation as a whole. So again,
8 the country of origin -- again, I used Dominica as
9 an example. So, you know, Dominica has its own
10 national level or national culture, but then we
11 also talk about the regional level, so that's
12 associated with ethnic, linguistic, or religious
13 differences that exist within that nation.
14 In Dominica, for example, I'll give you
15 a little bit of a personal example. So in
16 Dominica, my mother was born in the capital, which
17 is Roseau, and my father was born in Marigot, which
18 is more of the countryside.
19 Remember I mentioned that it's an
20 English-speaking country, but they also speak a
21 French Creole. My mother speaks the French Creole,
22 my dad does not, and that's because of the
23 different regions that they were born in.
24 So we look at some of those linguistic
25 pieces and understand that regardless that you have

1 a national -- they're both from Dominica, and
2 they're proud to say that they're from Dominica --
3 when you start talking about it, just start to
4 break it down.
5 At a regional level, they both spoke
6 English, but my mother also spoke Creole, which my
7 dad could understand but could not reply. So my
8 mother was very happy, actually. So she would then
9 speak to her friends, and, you know, gossip, and my
10 dad had no idea what was going on.
11 But it gives you, then -- again, just
12 within that example, you have linguistic
13 differences on the same island of 70,000. So you
14 don't want to sit and assume, oh, this person comes
15 from Dominica, and I know exactly what's going on.
16 We already have linguistic differences.
17 You've got the gender level, which is
18 associated with gender differences, female versus
19 male.
20 Generational level: So associated with
21 the differences between grandparents and parents,
22 parents and children. And it's very interesting,
23 this generational level will also be very prevalent
24 when we start talking about immigration, when we
25 talk about separation and reunification issues,

1 when it comes to different people that we see.
2 When I talk about separation and
3 reunification, a lot of times you'll have the
4 family that was separated in the home country and
5 one came and immigrated here, you know, prepared a
6 life, and then brought up children or whomever else
7 to come in and meet them, and what does that
8 dynamic look like? So you've got generational
9 issues as well.
10 We also look at the social class level,
11 so associated with educational opportunities and
12 differences in occupation. And again, adding on to
13 that, what does that look like from an immigration
14 standpoint?
15 A lot of the Caribbean immigration, for
16 example, that occurred in the '60s was with women
17 that came who were teachers and nurses and that
18 back home, and then they came here to become
19 domestics, and what does that look like? And
20 leaving their children behind, so again, the
21 separation and reunification when they were then
22 either stabilized and/or received status, then came
23 back here and then brought their children, and what
24 does that look like in terms of the multilayers of
25 culture?

1 We also look at the corporate level.
2 So associated with the particular culture of an
3 organization, applicable to those who are employed.
4 That is a whole other -- I talk about some of the
5 psychology of organizations and culture and a lot
6 of the "isms" that can manifest themselves from an
7 organizational standpoint. I won't get into it
8 because that's another talk for another day. You
9 can invite me again for that piece as well.
10 I'll just keep on coming. That's just
11 what I will do. Okay. Oops, sorry.
12 So let's go through measuring cultural
13 differences, and then from there -- I know I was
14 going to talk about the phenomenon of WEIRD, but I
15 know that we spent quite a bit of the morning
16 starting to talk about sort of the challenges of
17 using psychological tests and test measures and
18 those types of things.
19 So I know we talked about it briefly.
20 I know we didn't get into too much detail, but I
21 believe that since we want to really -- we do have
22 a call to talk about some of the guidelines to
23 providers for psychological services. I'll go to
24 that afterwards. Okay.
25 So measuring cultural differences:

1 "So a variable can be
2 operationalized either by single or
3 composite measure techniques. A
4 single measure technique means the
5 use of one indicator to measure the
6 domain of a concept.
7 The composite measure technique
8 means the use of several indicators
9 to construct an index for the
10 concept after the domain of the
11 concept has been empirically
12 sampled.
13 Hofstede has devised a composite
14 measure technique to measure
15 cultural differences among different
16 societies."
17 So I wanted to just bring this to the
18 forefront or bring this to attention so that we can
19 sort of see with this research. Now, mind you,
20 it's old research from '97, but I think it still
21 has relevance in terms of looking at how to measure
22 cultural differences.
23 So we have the Power Distance Index:
24 "This index measures the degree
25 of inequality that exists in a

1 society."
2 So a lot of times when we look at that
3 power distance piece, the way that I -- one example
4 that I would give is that, a lot of times, I will
5 tell people or tell not clients, per se, but even
6 then, when I walk out of these four walls, I walk
7 out [into] society as a black woman. That is how I
8 am seen.
9 So what happens is that I do have an
10 understanding. It's not always right at the
11 forefront because that would be very overwhelming,
12 but it's also understanding that in that walk or as
13 I go out that door, I know that that inequality
14 exists and that they look at me with those -- with
15 that -- understanding that inequality.
16 Again, if it's at the forefront, then,
17 my goodness, I would be overwhelmed 24 hours a day,
18 but it's an underlying understanding that being a
19 woman and being a black woman walking out of that
20 door, there are certain things that possibly will
21 follow me as a result of that. There's a power
22 imbalance and difference.
23 "Uncertainty Avoidance Index is
24 the index that measures the extent
25 to which a society feels threatened

1 by uncertain or ambiguous
2 situations."
3 It's a lack of understanding. Because
4 I don't understand something, I feel threatened by
5 it, and I think what was very interesting was what
6 one of our members mentioned about, you know,
7 assessing a client, and the client says that they
8 hear voices, and then all of a sudden they're
9 schizophrenic, right, without really understanding
10 its context.
11 I have another example. It's actually
12 one of the examples I have in the slides where --
13 I'll get to you, yeah.
14 There's another example that I was made
15 privy of where a client who was from the Caribbean
16 was being assessed, and what she had mentioned
17 was they were asking about an anxiety symptoms.
18 They were doing a bit of an anxiety interview
19 protocol, and one of the things that she had
20 mentioned is that "I shower about two, three, four
21 times a day." And so in my mind, I'm like, yeah,
22 and...?
23 But for that clinician, unfortunately,
24 that led that clinician down the line to diagnose
25 that client with OCD. And I was like, oh, my

1 goodness. Meanwhile, being raised as a Caribbean
2 woman, you showered how many times a day if it was
3 hot. The minute you came in from work, you know,
4 you showered before you came in; you showered when
5 you came home. Like, I mean, this was just
6 something that we did.
7 So now being pathologized for taking a
8 shower more than once a day was definitely an
9 issue, but again, that uncertainty. Before you
10 actually start asking some more questions about
11 that versus saying automatically that this person
12 is diagnosed with obsessive-compulsive disorder,
13 you know, was a huge issue for that client.
14 QUESTION/COMMENT: I just wanted to ask
15 you about your thoughts on how to have discussions
16 with your clients, obviously, about sort of their
17 experience just in terms of, you know, going out
18 into the real world and experiencing that power
19 differential. This was the last slide before?
20 NATASHA WILLIAMS: Yes, yes, yes.
21 QUESTION/COMMENT: So speaking with the
22 clients about it, but I think also more kind of
23 relevant to the discussion that we've been having
24 this morning, how would you talk about that even
25 within your own kind of colleague group or...?

1 So I know sometimes, you know, if a
2 colleague might, you know, say something or mention
3 something that maybe is indicative of their lack of
4 knowledge or ignorance about kind of that power
5 differential, it's hard to have a discussion in
6 that moment.
7 NATASHA WILLIAMS: Um-hmm.
8 QUESTION/COMMENT: So I guess I'm just
9 kind of asking about your thoughts on how to sort
10 of bring this to the table in a comfortable,
11 accepting manner while at the same time not having
12 the other person feel attacked or defensive because
13 that then kind of creates this wall and there's no
14 communication there.
15 NATASHA WILLIAMS: Right, right. The
16 first thing that came to mind to me is that why
17 does the conversation have to be comfortable?
18 QUESTION/COMMENT: That's a good point.
19 NATASHA WILLIAMS: Most likely it won't
20 be. Because if we are going to coddle the
21 conversation and make it comfortable, then I don't
22 think the conversation will have relevance. So I
23 think, first and foremost, we have to get out of
24 the mindset that the conversation is going to be
25 comfortable.

1 Now, I'm not saying that we have to be
2 disrespectful. That's a completely different
3 story. I don't have to be disrespectful to you,
4 but I have to understand that bringing up that
5 conversation, bringing up the issues of either
6 white privilege and/or maybe inappropriate mindset
7 or those kinds of things, I think if I understand
8 this is not going to be a comfortable situation but
9 it has to be brought up for whatever reason -- if
10 it's because this colleague, you know, might
11 actually be doing harm to clients, as an example --
12 then I think, you know, regardless, it's going to
13 have to be brought up.
14 And a lot of times, it literally is
15 coming from a respectful standpoint and just
16 saying, you know, in my experience, from what you
17 are saying, I find that that can be more harmful
18 than good to a client or whatever the case may be.
19 The other thing is, and I'm wondering
20 if you're talking about from colleague-to-colleague
21 as well, if you're talking about just from a client
22 perspective versus some of the colleague's views
23 towards another colleague.
24 QUESTION/COMMENT: That too.
25 NATASHA WILLIAMS: You know, that can

1 also be another issue as well. And then that's
2 where I would -- you know, we're talking about a
3 person-to-person interaction, then. Right? How
4 would you address a friend, or how would you
5 address somebody that maybe espouses views about
6 you that you know are either incorrect or are
7 embedded with several fallacies?
8 So again, I think if you approach it
9 by -- it's not going to be a comfortable
10 conversation because the more we try to say, you
11 know, how do we make this so that, you know, we
12 temper it, you're not going to have the
13 conversation.
14 QUESTION/COMMENT: I think too the kind
15 of -- the feeling in today's society has a lot of
16 anger in it.
17 NATASHA WILLIAMS: Um-hmm.
18 QUESTION/COMMENT: So I think one of
19 the things to just be really mindful, if you want
20 the other person, whoever it may be, whether that's
21 a client or a colleague, is to sort of make sure
22 that you're being aware of, you know, your
23 emotions, your anger, how you're displaying or how
24 you're sort of communicating that.
25 NATASHA WILLIAMS: Right, right.

1 QUESTION/COMMENT: Because, like I
2 said, I feel like there can be a lot of anger when
3 there's these sort of disparities and ideas.
4 NATASHA WILLIAMS: Um-hmm. And I think
5 the other thing as well is that what I'm
6 responsible for is to bring up the conversation.
7 I'm not responsible for changing that person's
8 mind. And I think a lot of times, we feel like the
9 minute I've said it, they need to act upon it, and
10 they need to change their mind. They don't need to
11 do a thing, actually.
12 If I've brought up, you know, what I
13 feel is either disparity or you exuding your white
14 privilege or whatever the case may be, and you
15 choose to stay in that white privilege, I can't do
16 anything -- I'm not going to sit there and ram that
17 down somebody's throat.
18 It's not my responsibility to change
19 that person's mind, but it is to bring it out there
20 and to say, listen, I see what's going on here; I'm
21 going to inform you of what I see. And then from
22 there, if you choose to stay in that, you know --
23 but again, I'm not going to have clients in harm's
24 way, either, right?
25 QUESTION/COMMENT: Thank you.

1 NATASHA WILLIAMS: You're welcome.
2 We talked about this piece already, so
3 I'm not going to -- we talked about it a little
4 bit. It was talking about the collective versus
5 the individual sort of mindset. So the
6 Individualism Index, or the index measures the
7 extent to which a society is individualistic.
8 "Individualism refers to a
9 loosely knit social framework in a
10 society in which people are supposed
11 to take care of themselves and their
12 immediate families only.
13 The other end of the spectrum
14 would be collectivism. That occurs
15 when there is a tight social
16 framework in which people
17 distinguish between in-groups and
18 out-groups. They expect their
19 in-groups to look after them in
20 exchange for absolute loyalty."
21 So again, looking at -- when we are
22 doing our interventions, what does that look like
23 as well? Sometimes we're looking at someone who
24 espouses a collective framework, and we're trying
25 to use our individualistic ideologies upon that

1 client.
2 Masculinity Index, so this is
3 achievement versus relationship and:
4 "This index measures the extent
5 to which the dominant values are
6 assertiveness, money, and things,
7 achievement, not caring for others
8 or for quality of life, and the
9 other end of the spectrum would be
10 femininity relationship."
11 This is loaded in and of itself,
12 anyhow. Let's not get it twisted because when we
13 start talking about issues of masculinity and
14 femininity -- okay? So I'm just putting it out
15 there.
16 QUESTION/COMMENT: [Indecipherable].
17 NATASHA WILLIAMS: Yes.
18 QUESTION/COMMENT: When I was teaching
19 at one point, I had about -- I think it was about
20 eight female students, and there were about three
21 male students, and I found that the women there
22 were more neurologically wired than the male
23 students.
24 NATASHA WILLIAMS: How so?
25 QUESTION/COMMENT: When I looked at

1 their notes, because I would sometimes talk to
2 someone and say, you know, let me see what your
3 notes look like. And I'd find that the women had
4 more organized notes, one; two, they were able to
5 discuss -- they may not be able to write everything
6 down, but they could discuss it.
7 But the men had difficulty in writing
8 the notes, retrieving the notes, and actually, they
9 know what to say, but it cannot come out in a
10 written form.
11 NATASHA WILLIAMS: Okay.
12 QUESTION/COMMENT: And why does it
13 happen? Because when we were little, girls are
14 taught five senses: Seeing, hearing, touching,
15 tasting, and smelling. They have a doll, and they
16 tell the doll, don't cry. They develop
17 sensitivity. It develops language. It develops
18 lots of things.
19 The boys are taught to use
20 onomatopoeia, you know, use this kind of sub-verbal
21 language. [Sound Effects]. "Kick the damn ball.
22 Hit it." And they use limited language, but the
23 limited language sometimes are more directed
24 towards aggressive behaviour.
25 Men and women, they get married

1 eventually. The woman wants to talk about what has
2 happened and the transactions which went on, and
3 the guy gets upset because "You're talking too damn
4 much. Why don't you just shut up? Let me go on."
5 And therefore, we have that difficulty
6 from infancy. Goes right into the whole subject of
7 masculinity. Thanks.
8 NATASHA WILLIAMS: Okay. Thank you for
9 that. What I will say, again -- because I think
10 this can be very loaded. Because now we're talking
11 about, you know, socialization and upbringing of
12 men and women and sort of what we are trained to
13 see and the way we are trained as men and women. I
14 think this can be a very loaded, very loaded topic,
15 and I'll be honest, I don't know if we have the
16 space to really digest and disseminate sort of that
17 piece.
18 But again, that's why I was saying, you
19 know, as much as, you know, this is one of the
20 indexes -- you know, again, I think it's going to
21 be up for quite a bit of interpretation and
22 dialogue.
23 We have one other question, and then
24 we'll get to the guidelines.
25 QUESTION/COMMENT: It's just a quick

1 comment that beyond, I don't know, social
2 understanding of masculinity and femininity that
3 are in flux, hopefully, many individuals in the
4 population now do not think in terms of duality,
5 and, you know, I think we have to be very aware
6 that it's a nonbinary culture and just coming to
7 understand that.
8 I just spent the last weekend with two
9 gay women, young gay women, who referred to each
10 other as "they" the whole time we were together.
11 NATASHA WILLIAMS: Right, right.
12 QUESTION/COMMENT: You know, I think we
13 have to be sensitive to how people are perceiving
14 their own --
15 NATASHA WILLIAMS: Absolutely.
16 QUESTION/COMMENT: -- gender,
17 sexuality, whatever, beyond all the other cultural
18 issues around gender.
19 NATASHA WILLIAMS: Exactly. And again,
20 are we now espousing more, again, Eurocentrism as
21 well when we're talking about this binary or polar
22 male/female kind of piece as well? So, you know,
23 again, a lot of things that we're going to have to
24 do is blow up a lot of the things that we -- the
25 way that we've been thinking for quite some time.

1 Again, I am mindful of time. I know I
2 don't have a lot of it, so what I want to do is --
3 I'm skipping through quite a few because I want to
4 get to the guidelines.
5 Okay. So what's interesting is that
6 the American Psychological Association has provided
7 guidelines for psychological providers in terms of,
8 you know, ethnic, linguistic, and culturally
9 diverse populations. And again, I use the term
10 "guidelines." You know, a lot of times, we see
11 guidelines, and we're like, oh, I've got a
12 template, and I've got exactly what I need.
13 No. These are guidelines in terms of
14 how to, again -- again, how to provide
15 psychological services to ethnic and linguistic and
16 culturally diverse populations.
17 So No. 1 is saying:
18 "Psychologists educate their
19 clients to the processes of
20 psychological intervention such as
21 goals and expectations, the scope,
22 and where appropriate, legal limits
23 of confidentiality and the
24 psychologist's orientation."
25 So, see, what's very interesting here

1 is as much as -- again, this is a guideline.
2 Because as much as we'll say that the psychologist
3 will educate their client to the process of
4 psychological intervention, this is from their
5 perspective.
6 We now have to understand, what is the
7 client's expectation of what's happening here
8 versus we're automatically coming from a top-down
9 this is how this is going to go.
10 Because within that first interaction,
11 you may also realize that both of you may not even
12 be a fit. I might not be able to provide services
13 for this client because the way that I believe that
14 I should intervene, and if I've given the client
15 enough space to actually help me understand how
16 they believe I should intervene, maybe it doesn't
17 work.
18 Let's also realize that we're not the
19 saviors of the world, per se. I had to come to the
20 realization really quickly that I cannot help
21 everybody. There were some people that I had to
22 realize that, you know what, this is either beyond
23 me, or I am not comfortable with this, or I don't
24 believe I have the expertise to work with this
25 individual, or whatever the case may be, and I had

1 to do one of two things.
2 The first thing was I had to refer that
3 client to someone who I thought would be a better
4 fit for them, and B, I had to look inside myself
5 and understand why was that uncomfortable for me?
6 Because a lot of times we do one and
7 not the other. We'll refer out and say, oh, you
8 know, that client, it doesn't work for me, I'm
9 uncomfortable, whatever, but we don't do the
10 introspection and try to understand why was it
11 uncomfortable? Could it be simply a training
12 thing? Okay, this client, you know, shows symptoms
13 of schizophrenia, and I am not trained to work with
14 this, and that's fine, or does it go deeper than
15 that? So we need to do the self-reflection as well
16 to understand what is going on here.
17 "Second, the psychologists are
18 cognizant of relevant research and
19 practice issues as related to the
20 population they serve."
21 This is interesting, and the reason I
22 say these are guidelines because we also -- I also
23 say any time we're getting this type of
24 information, guidelines or whatever the case may
25 be, I don't swallow it whole. I have to question

1 it, and the thing is, that's why we're
2 practitioners in the first place. We want to
3 actually get the information, and I'm happy that
4 there's these guidelines, but I also want to think
5 about them or approach them critically as well.
6 Now, I look at No. 2, and it says:
7 "Psychologists are cognizant of
8 relevant research and practice
9 issues that are related to the
10 population being served."
11 But if we also look at the research, a
12 lot of the research is not done on the ethnically
13 diverse communities in the first place, so we also
14 know that this research is going to be limited in
15 scope as of right now, and I also mention this in
16 terms of us as practitioners in Ontario.
17 A lot of times, what we are doing and a
18 lot of the work that has been done, we are taking
19 information from the United States or from England
20 and superimposing it upon our population here,
21 understanding that living in Canada, living in
22 Ontario comes with its own challenges and own
23 issues that we cannot necessarily utilize all of
24 the research that is coming from another country.
25 So we just need to be mindful of that.

1 Yes, research and practice for the
2 populations being served, we also don't want to use
3 a group-think mentality: Oh, this is how you work
4 with, you know, African-Canadians, so this is what
5 you need to do. Watch out for that, you know,
6 because then you're going to utilize --
7 You want to use it, basically, as a
8 base: Okay, I have a bit of an understanding, but
9 I cannot bring that bias to the forefront -- easier
10 said than done; don't get me wrong -- but I can't
11 necessarily just bring that bias to the forefront
12 just because someone comes to my office and says
13 they're from Jamaica or they're from Trinidad or
14 they're from -- you know, and I read some of the
15 research that says people that are in the
16 Caribbean -- everybody, you know, thinks in a
17 certain way, so I'm now going to go to the
18 forefront of that session with that mentality.
19 I haven't talked to the client. I
20 haven't asked them what their individual dynamic
21 and perspectives are. I've just gone with "I read
22 this research article right before the client came
23 in." Mindful, cognizant, and being able to think
24 critically and clinically as well.
25 "Psychologists recognize

1 ethnicity and culture as significant
2 parameters in understanding
3 psychological process."
4 We need to understand how being part of
5 that ethnic group has actually perpetuated some of
6 the understanding of psychology, psychological
7 process, mental illness, for that matter. How do
8 they see themselves?
9 A lot of times, the stigma of mental
10 health in and of itself is a barrier to
11 understanding the psychological process. A lot of
12 times, you have people that, because of that
13 stigma, they come in with trepidation already, so
14 it's not about how do I intervene right away versus
15 how do I make a safe environment for them, for them
16 to understand further what possibly is going on.
17 Also, in the midst of it, sitting down
18 and actually understanding from the client's
19 perspective, not just saying, okay, here we go, and
20 coming from a very top-down, heavy perspective.
21 We have to understand that sometimes as
22 a -- I sometimes look at the stigma of mental
23 health. I talk about the stigma of mental health
24 particularly in the African-Canadian community. I
25 do a lot of talks on that, and just that in and of

1 itself ends up being a significant barrier.
2 Because we talk about how do we -- you
3 know, how do we intervene, what do we do, how do we
4 get clients into our office? They're not even
5 coming because that stigma and the stigma of mental
6 health is so strong. We could talk about any
7 intervention we want; they're still not at our
8 door.
9 So let's take a step back and help to
10 understand what is it that's going on with that
11 stigma and that understanding of mental health from
12 an ethnic and cultural perspective before we're
13 starting to adapt this measure and adapt that
14 measure and do all of these things. You could
15 adapt it all you want, but you'll have an empty
16 chair, so let's understand that.
17 "Psychologists respect the
18 roles of family members and
19 community structures, hierarchies,
20 values, and beliefs within the
21 client's culture."
22 Again, we want to -- we have to take a
23 step back. I think, if nothing else, the message
24 today is humility. It's being able to respect that
25 because of how we understand things and the way

1 that we have been trained, a lot of us have been
2 trained in a Westernized model does not mean that
3 that is that client's norm.
4 Understand how the role of the family
5 comes into play. Because you pull out the client
6 and you're working with them on a one-on-one basis,
7 why are we not looking at how the family is also --
8 you know, how the parents or the grandparents or
9 the aunts or whatever are an integral role, play an
10 integral part in this person's upbringing and the
11 way that they understand things.
12 For myself, for example, I mentioned to
13 you that I'm born here. Yes, I had my parents.
14 What my parents did is that they sent for my
15 relatives to come from Dominica to actually raise
16 me here, so I was in a household of eight. So it
17 was not just myself, my parents, and my sister; I
18 had four cousins that lived with us altogether, and
19 they were all integral in part of my upbringing.
20 I had one cousin in particular --
21 because my parents did not want me to be in day
22 care, what they ended up doing was bringing that
23 cousin so that that cousin lived with us, so all of
24 my care was done at home.
25 If that is the example, if now

1 myself -- if I was now pulled out of that dynamic,
2 if I was suffering from some sort of mental
3 illness, and I was pulled out of that dynamic and
4 just worked from a individual perspective, not
5 understanding collectively who has been involved in
6 my upbringing and sort of my way of life, you're
7 going to be missing a huge part of my upbringing.
8 Because we're looking at it from a very
9 different perspective of, you know, where is your
10 mother, where is your father, maybe a sibling, and
11 not understanding that I had cousins who I called
12 "aunts" because my cousins -- anything past ten
13 years above my age, they were "auntie and uncle
14 so-and-so." There was no way I was calling them
15 just by their first name, but anyway, you know.
16 So again, there was a respect factor,
17 but at the end of the day, these people were highly
18 involved in my upbringing, and you would have to
19 bring them on board to fully understand who I was
20 or who I am.
21 "Psychologists respect clients'
22 religious and/or spiritual beliefs
23 and values, including attributions
24 and taboos, since they affect world
25 views, psychosocial functioning, and

1 expressions of distress."
2 Again, very important because if you do
3 not understand how this person expresses themselves
4 from a religious or spiritual vantage point, you
5 might pathologize behaviour. And that's what you
6 had mentioned quite eloquently in terms of this
7 person hearing voices. Same thing with the client
8 that was diagnosed with schizophrenia, but again,
9 it was coming from a very charismatic, Christian
10 background.
11 So again, it's really trying to
12 understand those pieces before you pathologize
13 because, again, we are using measures that will ask
14 questions -- do you hear voices, do you see things,
15 and that kind of thing -- and if they respond
16 "yes," without having that additional information,
17 you can then take the results of that measure and
18 say that person has whatever-DSM diagnosis or
19 whatever diagnosis you want to give them.
20 So again, we are trained to amalgamate
21 information, not to just pluck out one piece and
22 say the test says this and let's diagnose. We, as
23 clinicians, are trained to amalgamate all types of
24 information to hopefully formulate a comprehensive
25 understanding of a client, and that's what sets us

1 apart as psychologists in comparison to other
2 practitioners. And I think we need to hold our
3 heads high in terms of that aspect, but we don't
4 utilize it enough because, again, we are so
5 espoused on the medical model.
6 "Psychologists interact in the
7 language requested by the client,
8 and if this is not feasible, make an
9 appropriate referral."
10 This for me, I think, is a huge one,
11 and I was just speaking with one of my colleagues
12 in regards to this.
13 A lot of times, it's difficult because
14 sometimes you may not find the language there, but
15 we have to make every possible avenue to make sure
16 that the client can express themselves in their
17 language. Because if they have to now have to use
18 another language or a secondary language to try to
19 express themselves, unfortunately, you're not going
20 to be able to get the fullness of this client's
21 experience.
22 So, you know, again, this is going to
23 bring up a lot of questions in regards to use of
24 interpreters and those types of things. I have my
25 own views in terms of that. I mean, it's a bit

1 tough.

2 I will say when it comes to

3 psychotherapy, because I appreciate the sensitivity

4 of the psychotherapy dynamic, I will not use

5 interpreters in psychotherapy because I think it

6 has to be done in their language to get the

7 fullness of what I think is required for the

8 healing, which means if English is not their

9 primary language -- for me, anyway -- I will seek

10 out and hopefully create, get that referral done.

11 Because I think it is going to be a more enriching

12 process versus having them speak into another

13 language.

14 But again, this piece can be difficult

15 especially -- you know, there's not a lot of us

16 psychologists, and sometimes there could be

17 languages that can be very remote, and I've seen

18 that example as well. So this can be tough in and

19 of itself.

20 QUESTION/COMMENT: [Indecipherable].

21 BARRY GANG: I'm just very conscious of

22 the time, and I wonder if we could pick this up

23 afterwards.

24 NATASHA WILLIAMS: Oh. We'll take that

25 up a little later, okay? Okay. So just to

1 continue with the guidelines:
2 "Psychologists consider the
3 impact of adverse social,
4 environmental, and political factors
5 in assessing problems and designing
6 interventions."
7 So again, how this person has -- how
8 their lived experience has impacted sort of their
9 way of being but also in how we design the
10 interventions.
11 And the thing is, when we talk about
12 designing interventions, remember, it's not just us
13 as clinicians designing the intervention. I think
14 it's going to be very important to understand that
15 the client has to be part of the design of the
16 intervention so that the intervention can actually
17 be as most utilized as possible.
18 "Psychologists attend to as
19 well as work to eliminate biases,
20 prejudices, and discriminatory
21 practices."
22 We have to espouse to get to that place
23 where we understand that, you know, we aim to
24 eliminate those types of things in our practice,
25 and if it is brought to our attention, that we are

1 cognizant to say, okay, maybe we did not understand
2 or how do we get additional training or whatever
3 the case may be, but understanding to -- trying our
4 best to make sure that we eliminate these types of
5 things in our clinical practice on a day-to-day
6 basis.
7 "Psychologists working with
8 culturally diverse populations
9 should document culturally and
10 socio-politically relevant factors
11 in their records."
12 So with these guidelines, what they're
13 also looking at is making sure that we also
14 document what it is from a cultural and political
15 standpoint, what is it that is affecting the
16 client? So it is not just -- it's not that we're
17 dialoguing and we're not documenting. So we also
18 need to document as well.
19 Okay. So again, these were the major
20 guidelines. I know that we went through them
21 fairly quickly, and I know that they're also online
22 as well with the American Psychological
23 Association.
24 My hope is that as we've gone through
25 some of these guidelines, what's important is that

1 you're also not only just taking them
2 wholeheartedly. I think it's a great start in
3 terms of having these guidelines, but I also think
4 that we have to think critically about them as well
5 and that while this is a good start, this is not a
6 be-all and end-all.
7 And I think what it should make you
8 mindful of is that we still have a lot of work to
9 do in terms of being able to become better
10 practitioners, not only with ethnically diverse
11 populations, but populations. You know, let's
12 think of it this way: It's not just that this is
13 just a subset and then we work differently with
14 other clients.
15 We're talking about or what I'm hoping
16 that we are getting out of this discussion is that
17 we need to think differently about some of our
18 approaches as psychologists overall.
19 So I know that we're pretty much out of
20 time. I don't know if we have maybe time for maybe
21 a question or two, and then I'm pretty sure I'm
22 going to get the hook to get off the stage.
23 QUESTION/COMMENT: Thanks. All of the
24 guidelines that you've shared with us from the APA
25 are looking at the client, and just a comment I

1 would like to make is that these are all very
2 important factors that we should actively examine
3 in ourselves --
4 NATASHA WILLIAMS: Absolutely.
5 QUESTION/COMMENT: -- as clinicians
6 when we bring ourselves to the table in a
7 relationship.
8 NATASHA WILLIAMS: Absolutely. And I
9 appreciate that. I always want us to reiterate
10 that as well is that we have to look at ourselves.
11 A lot of times when I do -- I do
12 supervision, some clinical consultation and
13 supervision. What I've noticed is that, you know,
14 the clinician will come in and want to just talk
15 about the client. The client did this, the client
16 said that, I tried this, and it didn't work.
17 And I'm like, well, let's turn this
18 around for a second: What is your role in this?
19 And then that's where sometimes they're stunned for
20 a second, and I'm like, well, this is a -- if we're
21 talking about relationship, it's not one-sided.
22 What does the relationship look like? And
23 sometimes people -- again, some people are not
24 comfortable with being uncomfortable, and you got
25 to do that, I think, to grow as a clinician.

1 QUESTION/COMMENT: [Indecipherable].
2 NATASHA WILLIAMS: All right. That's
3 the hook that I was telling you about already. So
4 thank you very much, everyone, for your time.
5 BARRY GANG: Well, it's kind of
6 unfortunate that we only reserved the morning for
7 this. I think what you got was Chapter One or
8 maybe even just the introduction, but I don't think
9 we ever expected that we would deal with this topic
10 in the way that it really needs to be dealt with,
11 and I really hope that this stimulates a lot of
12 discussion, and it's really, you know, a
13 career-long discussion.
14 Anyway, we very much appreciate what
15 you've done this morning and I think what you've
16 stimulated.
17 Thank you to all the staff who helped
18 put this together, to Vantage Venues. You're going
19 to get evaluation forms very shortly. Please fill
20 them in because we use that information not only to
21 look at how we do things but what we're going to be
22 next because there will be another one of these in
23 another six months or so.
24 If anybody missed any of the
25 presentation, it should be online within about a

1 day or so, I believe. It'll be on the Barbara Wand
2 Seminar page on the website.
3 Thank you all for taking the time. We
4 have a very small token of our appreciation for
5 Dr. Williams, which I'll give you after, and please
6 stay warm. Oh, and please leave these at the desk.
7
8 (END).
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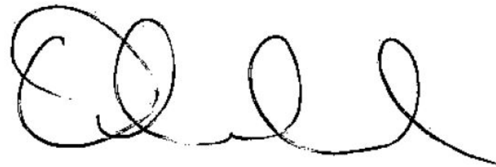
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