College of Occupational Therapists of Ontario

STANDARDS FOR PSYCHOTHERAPY

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STANDARDS FOR PSYCHOTHERAPY

Store at Tab #2 of your Registrant Resource Binder

Introduction

The purpose of this document is to ensure that occupational therapists in Ontario are aware of the minimum expectations for the performance of psychotherapy.

The *Regulated Health Professions Act* (RHPA, 1991), as amended, acknowledges occupational therapists as autonomous practitioners. The regulation of the profession requires occupational therapists to practise according to established standards and principles of practice, and to apply these standards consistently in a responsible, intentional manner within the health care environment.

With the passing of the *Psychotherapy Act* (2007), the RHPA added psychotherapy with clients who have a serious disorder of thought, cognition, mood, emotional regulation, perception or memory to its list of controlled acts. (A controlled act is any of the actions and/or activities defined in Subsection 27(2) of the RHPA.) Providing psychotherapy to clients with less serious disorders, however, remains in the public domain.

The College of Occupational Therapists of Ontario (the College) expects occupational therapists to comply with the standards in this document for psychotherapy practice **with all clients**. The Controlled Act of Psychotherapy will not be enacted until a future date. In the meantime, these standards apply to occupational therapists performing psychotherapy even though psychotherapy with clients who have a serious disorder of thought, cognition, mood, emotional regulation, perception or memory is not yet a controlled act. This standard is intended to apply to all psychotherapy that occupational therapists perform, regardless of whether or not psychotherapy with clients with a serious disorder constitutes a controlled act.

Occupational therapists will be authorized to perform the controlled act of psychotherapy under amendments to the *Occupational Therapy Act* (1991). This Act has been amended to require members to perform the controlled act in accordance with the regulations.

When Registrants choose to perform any controlled act in their capacity as an occupational therapist – whether it is directly authorized to them or permitted by another authorization method – it is to be performed in keeping with the requirements of the law, regulations and the standards of practice of the profession. Consequently, when performing psychotherapy, Registrants must ensure they are acting within the scope of the profession of occupational therapy. The legislated scope of practice in the *Occupational Therapy Act* (1991) reads:

> The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure (1991, c. 33, s. 3).

The scope of practice and the authority to perform psychotherapy from the *Occupational Therapy Act* (1991) reads:

Occupational Therapy Act, 1991
S.o. 1991, last modified 2007, chapter 10
Schedule R

Note: *On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, subsection 17 (1) by adding the following section:*

Authorized Act

3.1 (1) A member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. 2007,c.10, Sched. R,s.17(1).

(2) A member shall not perform the procedure provided for in subsection (1) unless the member performs the procedure in accordance with the regulations. 2007, c. 10, Sched. R, s. 17(1).

This authorized Act applies to registrants in all regulatory health colleges with access to the controlled act of psychotherapy. As indicated in the definition, using psychotherapy techniques is a controlled act only when the client has a serious disorder that may seriously impair him or her. **Regardless of whether or not psychotherapy is a controlled act, occupational therapists who practice it are responsible for managing their practice in accordance with the** *Standards for Psychotherapy***.**

The College of Occupational Therapists of Ontario has determined that it will work with the definition of *psychotherapy* that the College of Physicians and Surgeons of Ontario (CPSO) uses in its document, *CPSO Response to the Health Professions Regulatory Advisory Council*, (HPRAC's) *Regulation of Psychotherapy Questionnaire* (CPSO, 2005). The College of Occupational Therapists of Ontario recognizes that this definition may not conform to all of the published models and/or philosophies of psychotherapy and mental health care. The definition of psychotherapy in this CPSO document is as follows:

Psychotherapy is any form of psychological intervention for psychiatric or emotional disorders, behavioural maladaptations and/or other problems that are assumed to be of a psychological nature, in which a practitioner deliberately establishes a professional relationship with a patient/client for the purposes of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Intervention or therapy is initiated after a thorough assessment of the patient/client's presenting complaints, including exploration of biological, psychological, social and cultural factors contributing to the patient/client's disorder or condition. The relationship established between patient/client and practitioner is used to facilitate change in maladaptive patterns and to encourage the patient/client to learn and test new approaches.

Psychotherapy includes psychoanalysis, psychodynamic psychotherapy, cognitive therapy, behaviour therapy, conditioning, hypnotherapy, couple therapy, group therapy and all other forms of treatment/intervention in which the major technique employed is communication, although drugs and other somatic agents may be used concurrently.

Differences Between Psychotherapy and Counselling

There is an ongoing debate on the similarities and differences between psychotherapy and counselling. Some authors have expressed that psychotherapists are qualified to provide counselling, while counsellors may or may not be qualified to provide psychotherapy.

Counselling and psychotherapy share many common areas. If counselling was to be placed on one end of a continuum and psychotherapy on the other end, there would be a large area of overlap in the centre.

Psychotherapy concentrates on the client's emotional problems for the purpose of changing defeating patterns of behaviour, promoting positive personality change, growth and development, and re-organizing the personality. Psychotherapists frequently work with a variety of theories or combinations of theories, and may use one or more procedures or models to try to achieve desired results (Corsini, 2008). Psychotherapy may be a long-term intensive process that identifies emotional issues and their cause. Often, the cause of emotional issues is found within the relationships in the family of origin. Psychotherapists, though, may utilize short-term or behavioural models, in the "here and now" of the client's life, as not all psychotherapy models focus on the family of origin.

Compared to counselling, psychotherapy may focus on a deeper, more fundamental process of change, and the development of insight about thoughts, feelings and behaviours. Clients engaged in psychotherapy may have more serious mental health issues and conditions than those seeking counselling.

The power imbalance between the occupational therapist and the client is often greater in the practice of psychotherapy than in counselling. Psychotherapy treatment typically takes place in an office setting, but it is recognized that occupational therapists may use settings other than an office for some models of psychotherapy. If providing psychotherapy, the psychotherapist usually has no other role with the client. An occupational therapist treating a client for physical impairments resulting from a stroke, for example, and also practicing psychotherapy with the client is practicing in a dual role. This is acceptable if the client has consented to both practices and understands the different roles in which the occupational therapist is practicing.

Counselling is not in and of itself psychotherapy. Counselling is usually more directive or educative, and can include health education, guidance or advice-giving regarding a specific issue. It stresses support, problem solving and the provision of information. Also, it is usually less formal and short-term. (Counselling, though, is not to be confused with short-term models of psychotherapy, for example, brief psychodynamic psychotherapy.) Counselling usually carries less emotional intensity, insight and depth. Counsellors depend on their specialized knowledge and common sense (CPSO, 2005).

There are instances in which emotional support and/or problem solving is part of the occupational therapy plan of intervention. Occupational therapists should not confuse the counselling and support they give a client recovering from a physical condition, such as a stroke, with psychotherapy. Such a client did not come to the occupational therapist for the purpose of psychotherapy. **He or she came for an occupational therapy intervention that is unrelated to a mental health condition.**

Occupational therapists working in areas which do not initially focus on mental health services may not have the requisite competency to perform psychotherapy, and may need to take care and manage dual roles that may develop with the client. Clients may require a referral for psychotherapy to receive more intensive therapy for emotional issues or to a physician for an assessment for medication. The occupational therapist may then choose to continue to counsel the client, with client consent, while he or she is on medication or receiving psychotherapy from a qualified practitioner.

While at times it may be difficult for the occupational therapist to determine whether he or she is practising counselling or psychotherapy with a client, the registrant is advised to consider the level of risk involved in the intervention. The practice of psychotherapy usually carries more risk to the client, which is one reason why it is being proposed as a controlled act.

To guide occupational therapists in determining whether they are practising psychotherapy or counselling, further descriptions have been developed describing characteristics of both practices in Appendix 1.

Transference

In many areas of occupational therapy practice, transference occurs in the therapeutic relationship. Through introspection and personal reflection, and/or supervision/mentoring/case review, occupational therapists are encouraged to examine how their own needs/issues may be surfacing in therapeutic relationships. In psychotherapy, the concepts of transference and counter-transference, which exist in the therapeutic relationship, may be utilized as therapeutic tools, while in counselling these concepts are utilized less frequently. Refer to Appendix 2 for additional information on transference.

The *Standards for Psychotherapy* are not based on any one psychotherapeutic theoretical orientation, such as behavioural, cognitive, analytical or psychodynamic. Rather, they emphasize the process of ethical decision-making in psychotherapy.

Psychotherapy Classifications

Several hundred varieties of psychotherapy are described in the literature. For the purposes of these standards, the following terms are used (Ennis, 1998):

Treatment orientation:

- Psychodynamic (psychoanalytic)
- Cognitive/behavioural
- Strategic/systems
- Experiential

Treatment formats:

- Individual
- Group
- Family or couple

Refer to Appendix 3 for a chart describing the major types of psychotherapies in the treatment formats described above.

Some of the following standards refer to clinical practice. The appendices that follow the standards provide further clarification. Occupational therapists are advised to consult the literature for more information on the theories and/or literature from which these standards have been developed.

APPLICATION OF THE STANDARDS OF PRACTICE FOR PSYCHOTHERAPY FOR OCCUPATIONAL THERAPISTS

- The following standards describe the minimum expectations for occupational therapists.
- The performance indicators listed below each standard describe more specific behaviours that demonstrate the standard has been met.
- It is not expected that all performance indicators will be evident at all times, but could be demonstrated if requested.
- There may be some situations where the occupational therapist determines that a particular performance indicator has less relevance due to client factors and/or environmental factors. Such situations may call for the occupational therapist to seek further clarification.

- It is expected that occupational therapists will always use their clinical judgement to determine how to best meet client needs in accordance with the standards of the profession.
- It is also expected that occupational therapists will be able to provide a reasonable rationale for any variations from the standard.

Pursuant to the *Regulated Health Professions Act* (RHPA, 1991), the College is authorized to make regulations in relation to professional practice. The College's *Professional Misconduct Regulation* (2007), establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession," constitutes grounds for professional misconduct.

College publications contain practice parameters and standards which should be considered by all Ontario occupational therapists in the care of their clients and in the practice of the profession. College publications are developed in consultation with occupational therapists and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

OVERVIEW OF THE DRAFT STANDARDS FOR PSYCHOTHERAPY

Standard 1	Scope of Practice
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1. Scope of Practice

Occupational therapists have been authorized to perform psychotherapy according to the standards of practice for the profession. Occupational therapists are expected to be transparent about their accountability.

Standard 1

The occupational therapist will perform the intervention of psychotherapy within the scope of practice of the profession of occupational therapy, acknowledging the authorized act contained within the *Regulated Health Professions Act* (RHPA, 1991) and will have the knowledge, training, skill, and judgement to perform the intervention safely, effectively and ethically.

Performance Indicators

An occupational therapist will:

1.1 Determine how the practice of psychotherapy fits within his/her scope of practice of occupational therapy;

1.2 Recognize parameters of professional and personal competency (knowledge, skill and judgement), including any limitations to perform psychotherapy safely, effectively, and ethically;

1.3 Perform psychotherapy in accordance with the standards of practice and the code of ethics for the profession of occupational therapy;

1.4 Refer to other providers of psychotherapy if the client requires treatment beyond the scope of practice of occupational therapy, or beyond the limits of the clinician's knowledge and skill;

1.5 Recognize and manage any dual roles when working with the client in occupational therapy interventions other than psychotherapy;

1.6 Be familiar with the legislation relating to the practice of psychotherapy.

2. Competency Attainment

Occupational therapists will ensure they have adequate knowledge, training, skills, attitudes, abilities and judgement to perform this intervention safely, ethically and effectively. An occupational therapist is expected to have attended credible training programs/courses in psychotherapy. The specific psychotherapy educational program should be taught by someone who is qualified to practice psychotherapy, and should include both theoretical and practical components. This includes psychotherapy training/courses

which may have been offered to occupational therapists in their work sites. In addition to training programs/courses, attainment of competency to practice psychotherapy includes having the knowledge, skills, judgement and experience which may be derived from a mixture of professional development activities such as supervision, or on the job supervised practice/education, workshops, courses, rounds, conferences, observed care, mentoring, journal clubs, supervision, audio-tapes, videotapes, computer learning programs, knowledge of current literature, and evidence of best practices (Freebury R. et al, 1998).

The type and combination of training methodologies undertaken by the occupational therapist should be sufficient to include the attainment of these competencies.

Occupational therapists currently practicing psychotherapy after years of experience in mental health, are expected to engage in a self-reflective process in order to determine whether they are able to meet the standards of practice as set out in this document.

Definitions

Observed Care

Observing psychotherapy given by others, (usually through one-way mirror or instructional videos) often for training purposes.

Supervision

Working with a practitioner qualified in psychotherapy in a variety of teaching models to improve/enhance therapy skills.

Attitudes

Recognition that both process and content variables are generally present and require appropriate consideration; awareness of the importance of individual and group dynamics in therapy, educational, social and professional groups; appreciation of the effectiveness of therapy to ameliorate client distress and to modify dysfunctional behaviour; and appropriate therapist confidence and preparedness to conduct psychotherapy (Leszcz, M. et al, 2008).

Credible training programs

A credible course of training in a model of psychotherapy involves theory, supervised practice and/or observed care offered by a person who is qualified to practice psychotherapy.

Standard 2

The occupational therapist, in addition to having experience in mental health, will perform psychotherapy following successful completion of a credible course of training, which may include a combination of activities such as courses, on the job training, and/or supervised experience (supervision).

Performance Indicators

An occupational therapist will:

2.1 Prior to performing psychotherapy, complete professional training which may consist of credible education courses or credible on the job training courses, including a component of consistent supervision with an experienced practitioner in the type of psychotherapy being offered;

2.2 Have experience in mental health practice prior to practising psychotherapy as follows:

2.2.1 Have completed no less than the equivalent of 1 year of full time occupational therapy practice in mental health in a facility/team or related program with access to training, observed care, regular supervision and/or peer mentoring, in order to then practise psychotherapy in a facility/team environment, or;

2.2.2 Have completed no less than the equivalent of 2 years of full time mental health occupational therapy practice, in a team or related program with access to on the job training, regular supervision, observed care, and/or peer mentoring, in order to then practise psychotherapy in an independent practice environment.

2.3 Be competent in assessing clients as candidates for psychotherapy;

2.4 Know the evidence for the relevance and effectiveness of the psychotherapy interventions used and appropriately select, apply and evaluate these interventions based on the client's individual needs;

2.5 Know the indications, contraindications, benefits, and limitations of various psychotherapies for diagnostic categories;

2.6 Have access to and know when to seek additional supervision, consultation and/or education in psychotherapy when needed;

2.7 Know when to refer a client for a second opinion or to another qualified health care professional, including for a physical assessment;

2.8 Have processes in place to refer a client to a physician or an appropriate qualified health care professional for a consultation or for concurrent pharmacotherapy;

2.9 Learn and understand the effects of the medications, drugs and substances that clients may be taking, including adverse reactions;

2.10 Decline to perform psychotherapy if the performance of the intervention is outside of his or her current personal knowledge, skill and judgement;

2.11 Recognize and understand the place and role of transference and counter-transference in psychotherapy;

2.12 Attain an awareness of various psychotherapeutic modalities and their effect on specific populations, in addition to one's preferred model of practice;

2.13 Know the key clinical skills which are contained within each model utilized, and the basis of each theory. (Cameron, P. et al, 1998).

3. Continuing Competency and Supervision

Continuing competency in psychotherapy has two components: supervision (defined as working with a qualified practitioner of psychotherapy, or team to improve, and enhance therapy skills) and professional development. The OT practising psychotherapy should engage in ongoing supervision once initial competencies have been attained. Supervision formats may include paid or unpaid models. Frequency and duration of supervision is dependent on the skill development of the occupational therapist, as evidenced in feedback from supervisors, and peers, tracking of client outcomes, and reflection on one's practice. OTs may move from supervision to a consultation model following the period of supervision. Consultation models may include models using peer feedback.

Models of supervision include formal supervision, informal supervision (including peer supervision), team case reviews and consultation. An occupational therapist will ensure continuing competency by engaging in a combination of formal supervision and mentorship with an experienced psychotherapist, consultation, clinical education programs, courses, conferences, workshops, peer supervision, personal reflection, reading, case review, mentors' support networks, online teaching modules, and research. Those occupational therapists practising in areas where supervision is not locally available are expected to seek other avenues of acquiring supervision, such as use of electronic communication methods. It is the responsibility of the occupational therapist practising psychotherapy to engage in these activities to ensure ongoing competency.

Various models of psychotherapy supervision may be found in Appendix 4.

Competency and Skill Development of the OT through the Supervision Process may be found in Appendix 5.

Standard 3

The occupational therapist will maintain ongoing competency by engaging in regular, consistent, and ongoing learning activities for a minimum of two years. This will include a combination of formal and informal supervision activities and continuing education methods. The occupational therapist will engage in less formal supervision/mentoring/peer support activities, such as consultation, for the duration of psychotherapy practice. Professional development activities should be ongoing for the duration of the OT's psychotherapy practice.

Performance Indicators

An occupational therapist will:

3.1 Demonstrate his/her competency to perform psychotherapy in accordance with current practice in the models in which the OT practises;

3.2 Ensure that he/she has appropriate competency and continuing competency to practise psychotherapy;

3.3 Assume full responsibility to seek out and utilize needed supervision or consultation, support and resources on an ongoing basis;

3.4 Be able to provide the rationale and intent behind their practice activities with respect to performing psychotherapy;

3.5 Maintain the judgement, knowledge, attitudes and skill required to continue to provide quality care when continuing to provide psychotherapy as part of the occupational therapy practice;

3.6 Have access to and know about methods of continuing education in one's model of psychotherapy;

3.7 Have methods in place to determine accomplishment of client goals;

3.8 Utilize methods such as feedback scales and self-reflection to monitor the quality of the therapeutic relationship;

3.9 Adapt, evolve and/or change the therapeutic approach over time, as the therapist's understanding of the client's condition evolves, and as various approaches prove to be more or less useful;

3.10 Participate in regular professional development activities in psychotherapy interventions that ensure current ongoing knowledge, skill, ability and judgement to perform psychotherapy, which includes, but is not limited to workshops, clinical education programs, courses, conferences, peer supervision, consultation, personal reflection, reading, case reviews, mentors' support networks, online teaching modules, and/or research, while continually updating his/her knowledge of current psychotherapy practices;

3.11 Consider a move from supervision to a consultation model for ongoing peer support/review following a period of supervision, feedback, and self reflection of competencies. Recognition that more time may be needed to move to the peer consultation model may be determined by the OT's skill development, personal reflection processes, and supervisor's and peer's advice;

3.12 Inform the client of the existence of the supervision process and obtain their consent for the discussion of their case.

4. Evidence-Based Practice

Evidence-based practice reflects the use of available research evidence in conjunction with clinical expertise, knowledge of client status, client preferences and values in evaluating ongoing decisions about whether psychotherapy is appropriate for a specific client. Evidence-based practice involves knowledge about the appropriate process of psychotherapy for a specific individual, regardless of theoretical orientations or models of psychotherapy, i.e. psychoanalytic, psychodynamic, behavioural, as well as various models of psychotherapy.

Standard 4

The occupational therapist will be accountable for determining that the client's condition warrants the use of psychotherapy, and for assessing the clinical results/outcomes of the treatment/intervention. The occupational therapist will make decisions about the initial and continued practice of psychotherapy for the client, based on client consent, preference, clinical status, clinical expertise, and evidence of the appropriateness and efficacy of the preferred model of psychotherapy for the needs of that client.

Performance Indicators

An occupational therapist will:

4.1 Critically appraise literature and supporting scientific evidence to make informed decisions about performing psychotherapy;

4.2 Consider the information known about the client (e.g. desired outcomes/goals, cultural, socio-economic occupational factors, ethnic, disability or health related factors, and environment) to make informed decisions about offering psychotherapy;

4.3 Engage the client in a collaborative approach;

4.4 Determine the need for psychotherapy using appropriate assessments, as relevant to the practice of occupational therapy and interdisciplinary care;

4.5 Determine a reasonable rationale for all decisions about performing psychotherapy with a specific client;

4.6 Gather practice-based evidence, documenting and monitoring outcomes of the intervention, and the outcomes of the therapeutic relationship;

4.7 Discuss alternative treatment(s) with the client and provide other suitable options if psychotherapy is determined to be not appropriate.

5. Informed Consent

Informed consent is an ongoing process to be re-evaluated throughout the intervention process.

Standard 5

The occupational therapist will ensure there is informed and on-going consent obtained from the client to perform psychotherapy, as per *Standards for Consent* (COTO, 2008), which will include a discussion of the following:

a) The nature of the proposed model of psychotherapy;

b) The benefits and risks of psychotherapy to the client;

c) Alternative treatments, including no treatment; and,

d) The option of the client to withdraw consent at any time during the assessment and treatment process.

Performance Indicators

An occupational therapist will:

5.1 Clarify his/her role in the provision of psychotherapy;

5.2 Comply with the *Standards for Consent* (COTO, 2008);

5.3 Consider and discuss alternative treatment(s) with the client and provide other suitable options;

5.4 Respect the client's choice to not have psychotherapy.

6. Risk Management

Occupational therapists should practise psychotherapy within principles and guidelines that recognize and minimize the risks, be alert to contraindications, and be able to manage adverse issues occurring during treatment.

Occupational therapists should have training in recognizing and managing suicidal, aggressive or violent behaviour including the practice of crisis intervention and de-escalation techniques.

Definitions

Dual Relationships

A dual relationship in psychotherapy refers to any situation where the practitioner is in more than one significantly different relationship with one of her/his clients. Examples of dual relationships are when the client is also in a social, financial, or professional relationship with the therapist, such as a student, friend, family member, employee, etc. Dual relationships can be consecutive or sequential (Pope, 1998). Dual relationships between psychotherapists and their clients/patients may be considered inappropriate or unethical. A dual relationship involves a risk that treatment may become biased or influenced by a non-treatment relationship between the professional and client.

Dual relationships should be avoided if possible, or carefully managed, if unavoidable, such as what may occur within a rural or small community (Gotlieb, 1993).

Dual Roles

A dual role occurs when the occupational therapist, in their practice of psychotherapy, also treats the client using other interventions; for example, treatment of a stroke client for physical impairments and in addition, for emotional issues, using psychotherapy. If counselling is utilized with that client, it may be one component of many in the treatment plan and is not considered a dual role. Due to the level of risk involved with the performance of a controlled act, for the purpose of these Standards, psychotherapy is a separate role. Dual roles should be managed carefully.

Standard 6

The occupational therapist will be responsible for recognizing, minimizing and managing the risks of performing psychotherapy.

Performance Indicators

An occupational therapist will:

6.1 Recognize and assess the risk of emotional and mental harm to the client;

6.2 Recognize and assess the risk of physical harm associated with or arising from mental/emotional distress;

6.3 Establish and/or apply policies and procedures for recognizing and managing adverse reactions during, or as a result of psychotherapy;

6.4 Assess and manage a client's crisis or suicidal, aggressive, or violent behaviour, to self and others, if required;

6.5 Be aware of the situation when confidential information may require disclosure (e.g. legal proceedings) or if the client threatens harm to him/herself or others, and be sensitive to the parameters of the information required, in order to preserve confidentiality to the greatest extent possible;

6.6 Be aware of contraindications/negative treatment/intervention effects based on the client's issues and/or model of psychotherapy;

6.7 Discuss the potential risk of temporary worsening of the client's condition as painful or warded-off feelings or experiences are reopened, and that these experiences may be appropriate and a part of the therapy process;

6.8 Recognize and take action when there is a failure in treatment/intervention where the client's status may deteriorate;

6.9 Recognize and manage risks posed by the OT moving into areas beyond his/her training or competence (CPSO, 2005);

6.10 Be aware of and manage dual role risks arising when an OT is treating a client and in addition proposes psychotherapy intervention;.

6.11 Recognize and avoid, or manage dual relationships.

7. Record Keeping

Occupational therapists practising psychotherapy are expected to review and adhere to the College's *Standards for Record Keeping* (2008).

Standard 7

The occupational therapist will document the provision of psychotherapy as per the College's *Standards for Record Keeping* (2008).

Performance Indicators

An occupational therapist will:

7.1 Record such information as the date, duration and model of the psychotherapeutic intervention, including the client's needs, client outcomes, and details of issues requiring referrals to other qualified health care professionals;

7.2 Record observations in progress notes in behavioural, objective terms with a focus on facts relevant to the client's problems and progress towards goals, providing a rationale for professional opinions and judgement;

7.3 Document clinical interventions along with their rationale and clinical effect;

7.4 Manage any supervision notes in a secure manner, confidentially storing and destroying when no longer needed.

8. Delegation to Support Personnel and Assignment to Students

The Controlled Act of Psychotherapy refers to psychotherapy with clients with a serious disorder of thought, cognition, mood, emotional regulation, perception or memory. Therefore the term delegation only applies to the practice of psychotherapy with clients with these serious conditions.

Delegation is a term used in the *Regulated Health Professions Act* (1991) that has been understood as the transfer of the legal authority to perform a controlled act or a component of a controlled act to a person, regulated or unregulated, who is not normally authorized to perform the act. The word "delegation", when used in the legal context of authorizing someone to perform a controlled act, does not have the same meaning as *assign*, which means to request a support staff to perform a task that is not a controlled act. Due to the training, knowledge, and skill required in the practice of psychotherapy, the controlled act of psychotherapy may not be delegated to support personnel. The controlled act of psychotherapy infers that clients are vulnerable to risk posed by the severity of their illness. Psychotherapy practised with clients who are not seriously mentally ill as per the *Occupational Therapy Act* (1991), is not a controlled act.

Support personnel may be involved with clients in mental health programs, carrying out other interventions.

It is not considered *delegation* when a student becomes involved in a controlled act. However, due to the sensitive nature of some psychotherapy treatment, it may not always be in the client's best interest or appropriate for a student to be present in the session. Students may be included in a multi-disciplinary teaching environment in education programs of individual, group and family psychotherapy, or as part of their student placement with an occupational therapist. Students may participate in psychotherapy sessions with consent of the client, and may take part in post-session discussions and case reviews. OTs should use clinical judgement when including students in their psychotherapy sessions. Students who do participate in the controlled act of psychotherapy should be directly supervised by the OT, or another member of the team during the session. As students are often in placements for a short period of time, they may be present for only a portion of the term of the psychotherapy intervention. The continuity of the intervention may be negatively impacted by a change in therapist part-way through, however if another consistent therapist is present throughout the therapy process, continuity should not be impacted.

In a collaborative, multidisciplinary setting, the occupational therapist may participate in the supervision of a variety of students in psychotherapy interventions.

Standard 8

The occupational therapist will not delegate the whole or parts of the controlled act of psychotherapy to support personnel. Students may participate in psychotherapy interventions in the presence of the student supervisor.

Performance Indicators

An occupational therapist will:

8.1 Be present during the entire process of psychotherapy, including when students are involved;

8.2 Ensure students' level of skills, knowledge, and confidence in learning to perform psychotherapy with clients;

8.3 Provide appropriate training and resources to students prior to their involvement in psychotherapy;

8.4 Ensure that students are provided the appropriate level of supervision in order that psychotherapy is completed in a safe and therapeutic manner;

8.5 Ensure that informed consent is given by the client for the participation of students in psychotherapy sessions;

8.6 Manage student supervision in a collaborative manner when the student is involved in a psychotherapy session with another qualified health care professional;

8.7 Neither delegate nor assign psychotherapy interventions to support personnel.

9. Accountability

Standard 9

The occupational therapist will be accountable for determining that the client's condition warrants the use of psychotherapy, for selecting an appropriate model of intervention and for the appropriate performance of the intervention.

Performance Indicators

An occupational therapist will:

9.1 Be responsible for performing psychotherapy, including managing any risks and adverse reactions;

9.2 Be aware of and apply relevant national and provincial statutes, as well as professional regulations, essential competencies, standards, guidelines, and employer policies that relate to psychotherapy;

9.3 Assume responsibility in judging his/her own current competency to perform psychotherapy;

9.4 Comply with the ethical practices of the profession of occupational therapy;

9.5 Respect the client/therapist relationship;

9.6 Accept professional responsibility for the performance of psychotherapy;

9.7 Appreciate when she/he does not have the competence, knowledge, skill or judgement to perform psychotherapy with a client, and refer the client to an appropriate qualified health care professional;

9.8 Assume responsibility to make the client and the referral source aware of any limitations on the practice of psychotherapy, within the scope of occupational therapy practice;

9.9 Present suitable options and recommendations, when the most appropriate services for a client cannot be offered by the occupational therapist, such as when the client is not suitable for psychotherapy.

10. Professional Boundaries

The concept of professional boundaries is crucial to the maintenance of a respectful client/therapist relationship. The client/therapist relationship is by definition an unequal relationship, which results in a power imbalance due to the client's health condition, vulnerability, unique circumstances and personal history. A client's desire to improve his or her health leads to a need to establish trust in the professional. If the occupational therapist uses this position of power and/or takes advantage of the client's vulnerability by violating boundaries, it is an abuse of power, whether done consciously or unconsciously.

Occupational therapists should refer to the *Standards for Professional Boundaries* (COTO, 2009) when considering issues of boundaries with clients in the course of psychotherapy. Standard 10 describes the avoidance of a personal relationship with a client. In a psychotherapy practice, where there has been a

course of psychotherapy with a client, there should not be a personal relationship developed following treatment termination. This is viewed as a potentially harmful situation. The *Standards for Professional Boundaries* (COTO, 2009), 10.1(c), suggests a two-year period of time should pass following treatment, before beginning a personal relationship with a client. For the practice of psychotherapy, it is not appropriate to develop a personal relationship with a client at any time.

It is recognized that in smaller communities, an occupational therapist may encounter a client in the community. These casual contacts are not considered personal relationships, nor friendships.

Standard 10

The occupational therapist will maintain a respectful client/therapist relationship as per the College's *Standards for Professional Boundaries* (COTO, 2009). The OT should not have a close personal relationship with the client at any time, including following the termination of psychotherapy.

Performance Indicators

An occupational therapist will:

10.1 Comply with the *Standards for Professional Boundaries* (COTO, 2009);

And in addition:

10.2 Never develop a close personal relationship at any time with a client, including following treatment termination;

10.3 Refrain from entering into a dual relationship, such as providing psychotherapy to a family member of a client, friends of a client or where there was a prior relationship/friendship with the client;

10.4 Provide and document a clear rationale in the situation where the model of psychotherapy may indicate an action which may be perceived as a boundary crossing in other models of psychotherapy (e.g. meeting the client out of their usual therapeutic setting to address phobic behaviours in situ);

10.5 Consider disclosing personal information to a client to be inappropriate, with the exception of utilizing that information as a specific part of the treatment process.

11. Discontinuation

Discontinuation is a process that is referred to as "termination of treatment" in psychotherapy. Occupational therapists' practice of termination will vary according to their orientation and model of practice. Improper termination can be destructive to the client. Some psychotherapists see "termination" as an ending to the treatment relationship, requiring very careful and thorough preparation with the client. (Freebury, R. et al. 1998). Other therapists view *termination* as an interruption in what may be an ongoing series of periods of therapy. Wherever possible, there should be an agreement between the client and occupational therapist that the client has achieved what can reasonably be expected from psychotherapy, before discontinuation (Katz, 1986).

Unilateral termination occurs when the OT or client determines that termination should occur.

Standard 11

The occupational therapist should conduct termination of therapy, as a therapeutic process whether as a result of agreement between the client and the OT, or by a decision made by the OT, client, or funder.

Performance Indicators

An occupational therapist will:

11.1 Develop and document a process for termination of therapy for each client at the appropriate time;

11.2 Implement unilateral termination of treatment for the following reasons;

- 11.2.1 Further treatment would not produce additional benefits,
- 11.2.2 The client has withdrawn consent,
- 11.2.3 Treatment goals have been met,
- 11.2.4 The occupational therapist does not feel competent to provide the necessary treatment after assessment of the condition,
- 11.2.5 Transference or counter-transference is consistently considered to be therapeutically destructive,
- 11.2.6 The occupational therapist is ceasing practice, changing practice or moving to a different type of practice,

11.2.7 The client is consistently or significantly non-compliant with appointment times, medications, explicit conditions of treatment or simple treatment recommendations in the psychotherapy process,

11.2.8 The client is engaging in threatening, harassing, assaultive or other negative behaviours which have been identified as an issue for termination,

11.2.9 Boundary violations have occurred,

11.2.10 Termination has been chosen as a constructive, therapeutic strategy, or

11.2.11 There has been non-payment of the therapy accounts, contravening the established agreement of payment with the client,

11.3 Inform the client of the reason for termination;

11.4 Discuss post-termination options with the client;

11.5 Make a referral to another qualified health care professional, or discuss options if further treatment is indicated; and

11.6 Document the unilateral termination or mutual termination process including;

11.6.1 Reasons for termination,

11.6.2 All relevant correspondence,

11.6.3 Arrangements made for the provision of the client's future care,

11.6.4 Verbal discussions with the client, family and colleagues when appropriate.

APPENDIX 1

Some General Characteristics of Counselling and Psychotherapy

There is continual debate in the field of mental health as to the similarities and differences between the two practices of psychotherapy and counselling. The following distinctions may be viewed as general characteristics to facilitate the occupational therapist's decision to determine which modality is being practised.

Psychotherapy	Counselling
• Frequently a long-term process, however there are short term models (i.e. 8 – 12 sessions); • Time frame of treatment may range from a few months to years.	• Most often a short-term process; • Visits may range from one to twelve sessions, while some models may carry on over a longer period of time.
• A longer-term process of treatment that identifies emotional issues, and their background; • Intensity and length of therapy depends on how well the client can deal with all of the new found learnings, and is able to integrate these new feelings and behaviours; • Time may be needed for the client to modify existing defenses in the process of psychotherapy.	• Generally is a relatively brief process which may target a specific symptom or problem, and offers suggested ways of dealing with it.
• Problems may be inherent in the client's personality.	• Problems may be more reality-oriented.
• Frequently, psychological problems have built up over the course of a long period of time; • May focus on chronic and severe physical and emotional conditions, as well as mental illnesses, which carries a higher degree of risk in treatment; • Represents a deeper, more fundamental or involved process of change with more disturbed clients.	• Usually does not focus on severe emotional, or mental health conditions and illnesses, and is usually lower risk; • May focus on more practical, observable and conscious behaviours and feelings; • Often focuses on clients in the "normal" range of functioning, or those without neurotic problems who have become victims of pressures from the outside environment; • Often deals with clients with adjustment, developmental or situational concerns; • May provide an opportunity for the client to work towards living in a way he or she experiences as more satisfying and resourceful.
• Deals with emotional problems through a therapeutic relationship for the purpose of changing defeating patterns of behaviour, promoting positive personality change, growth and development, and re-organizing of the personality.	• Helps people deal more effectively with issues that cause difficulties and distress.

• Facilitates client self-understanding and self-awareness, including insight about thoughts, feelings and behaviours and interactions with others; • Clients are helped to resolve issues and problems through processes of self-exploration and personal development; • Client is helped to integrate positive behaviours; • May focus on gaining insight into thought processes and general functioning rather than specific problems; • May focus on client's past unresolved issues from the family of origin; • May focus on changing parts of the personality and to control unpleasant emotions and behaviours.	• Process may sometimes be similar to psychotherapy, but is not psychotherapy; • Helps to facilitate change in thoughts, feelings/mood, behaviours and experiences that may interfere with one's optimum or desired level of health; • Helps clients to view their situation and issues of concern from a broader perspective and enables them to make life enhancing choices and decisions; • Helps clients to overcome obstacles to their personal growth; • Client may be offered suggestions and advice for dealing with problems; • Outcomes may include resolution of the problem, achieving an understanding, or perspective, or acceptance of the problem, and taking action to change the situation; • May involve action planning and testing of behaviours within the client's life experience, not just talking;
• Transference and countertransference often utilized;	• May work with transference and countertransference, only occasionally;
• Goal may include a change of lifestyle; • Goals may be to gain self-knowledge, and to deal with defenses which have worked in the past and are no longer working or useful; • Goals may include behaviour change.	• Setting of goals and revisiting those goals, so that progress can be measured; • Goals may be to change behaviour within the existing lifestyle, and adjust to situations; • Goals may include wellness, personal growth, healing, problem solving; • Goals may include helping individuals develop and utilize full coping skills potential;
• Therapist tries to understand reasons for resistance, and uses this to learn how to help the client make personality changes.	• Therapist tries to reduce resistance as it may be viewed as opposing or going against problem solving.
• May utilize structured or manualized approach;	• May utilize a structured approach to help people identify problems and crises, and encourages positive steps to resolve these issues;
• Therapist usually has no other role with the client; • Most models usually don't involve physical contact with the client;	• May be one part of a treatment plan; • May involve a sense of intimacy, if OT required client to disrobe in a previous phase of the treatment plan for a specific assessment, or had some clinical physical contact, and then performs counselling for another specific part of the intervention plan.

• Usually takes place in a private office setting.	• Takes place in a diversity of settings.
• Is usually practiced by regulated professionals, specially trained and supervised; • Often is seen as requiring more skill than counselling, conducted by professionals trained in psychotherapy models; • May require a greater depth of training; • Practice may be a controlled act.	• May be practiced by regulated professionals and non-health professionals, or those experienced in the nature of the specific problem, (e.g. addictions, or trained in a particular area of behavior change or control); • Practice is not a controlled act.

Stuart, W. (1985), Dryden, W. (2000), Davies, G. (2009), Burnard, P. (1999), Sommers-Flanagon, R. (2004), Cameron, P. (1998), Corsini, R.J. (2008).

Similarities between Counselling and Psychotherapy

The following are some of the similarities between the two practices:

- Client brings their assets, skills and strengths to the therapy
- Elements of the therapy may deal with clients' attitudes, feelings, interests, goals, self-esteem and related behaviours
- Both may use an eclectic approach, similar methods and more than one technique
- Nature of the therapeutic relationship is the basic means of healing
- Outcomes may appear similar in some instances
- Both types of therapy occur when someone who is troubled, invites and allows another person to enter into a particular kind of relationship with them that is not readily available in everyday life
- A place is provided where the person can tell their story, where they are given encouragement to tell of their experience in their own time and way, including the expression of feelings and emotions
- Whatever is discussed is private and confidential

In a recent text by Corsini (2008) he states that psychotherapies are methods of learning. Psychotherapies are intended to change people, to make them think differently (cognition), to make them feel differently (affectation) and to make them act differently (behaviour). Psychotherapy is learning. It may be learning something new or relearning something one has forgotten; it may be learning how to learn, or it may be unlearning. Paradoxically, it may even be learning what one already knows. Psychotherapy is usually person-oriented and is a process of helping people discover why they think, feel, and act in unsatisfactory ways.

The information in Appendix 1 was derived from a number of texts, articles and academic papers. Due to the overlapping content and similarities of the information, much of it was combined and integrated so that individual citations could not be attributed to individual authors.

APPENDIX 2

Understanding Transference

Greenson, R.R. (1967) stated that transference may be seen as, "the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present, which do not befit that person, but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. The two outstanding characteristics of a transference reaction are: it is a repetition and it is inappropriate."

Transference is typically an unconscious process where the attitudes, feelings, and desires of the client's early significant relationships get transferred onto the OT. This dynamic can reflect a positive or a negative traumatic experience, such as abuse or the absence of nurturing during childhood. As the client's relationship with the OT deepens, the situation triggers familiar feelings related to previous connections with others. The client begins to experience the therapist in the present, in much the same way she/he experienced a significant person from her/his past.

According to Doidge et. al. (1998), "Counter-transference can be a response to the client's transference, especially if it is intense. The OT can become involved in the transference, and has his or her own transferences in response." Doidge et al (1998) reports that counter-transference has to do with certain, but not all feelings a therapist can have towards a client. It includes the feelings the therapist picks up from the client that are mixing with the therapist's own feelings, emotions and past relationships.

Working with counter-transference is much the same as transference, with the addition that the OT has a responsibility to the client to deal with his/her own issues, and to minimize (it's never eliminated) the impact of countertransference in the therapy.

When the therapist accepts the client's transference, boundaries should be established whereby the client can express all of his feelings, including sexual ones, in the security that the therapist will accept her/his feelings and not act out against her/him (as others may have in his past).

Acceptance and awareness are the key therapeutic tools to working with transference. Acceptance and awareness lead naturally to understanding and separating the past relationships from the current relationship with the OT. While this occurs in any therapeutic relationship, it may be a goal of psychotherapy.

For example, the OT may represent the people in the client's life who have loved him and/or rejected him. The love interest is projected onto the therapist because the therapist may be the only person currently in the client's life who is completely accepting of the client, and views the client without judgement or agenda. The interactions between the OT and the client have brought these feelings into the therapeutic relationship as transferred feelings. There is some inherent danger in transference to both client and OT. Some OTs may transfer their own fears and feelings from past relationships onto a client. It is the OT's responsibility to recognize what these feelings represent to her/him and to keep them from impacting the process of therapy.

It is important to recognize transference and countertransference as a normal occurrence in therapy. In some models of psychotherapy, for example, transference is used as a means to explore and understand how the client's early experiences influence current relationships and behaviours. In the course of psychotherapy, the OT may work with the client to recognize how these previous relationships have been destructive for the client, and a task of the psychotherapy is to work through them towards developing more positive ways of interacting.

Transference actually operates in all of our relationships to some degree. Part of the supervision process in psychotherapy is to help the OT recognize and manage these feelings of countertransference. Transference is not always evidence of a mental health problem or issue; it may be a reaction of one person to another, based on past relationships.

Transference - as defined in the College's *Standards for Professional Boundaries* (2009)

Transference is generally defined as the set of expectations, beliefs and emotional responses that a client brings to the therapist-client relationship. Transference reflects what past experiences a client has had with other important authority figures, such as a parent or love interest. Transference involves how those experiences influence the client's relationship with his or her occupational therapist. For example, whether the client likes, idealizes, feels attracted to, or feels irritated or angry toward the occupational therapist (Kaplan & Sadock, 1998).

Examples of Transference and Counter-transference

In all client/therapist interactions, no matter what the area of practice, physical, mental health, or psychotherapy, the individual's internal needs are often brought to the surface in the therapy relationship. The following are examples of some client internal needs and the accompanying behaviour of the therapist. It is important to note that the countertransference response to the client's transference will always vary depending on the individual OT.

PATTERN	TRANSFERENCE	COUNTER-TRANSFRENCE
	Client	Occupational Therapist
Needy	Sees therapist as nurturing mother/caregiver; dependent, or sees therapist as non-nurturing mother; hurt, angry.	Overly involved in caring for client, or repulsed by client's needs.
Compliant	Pretends that everything the therapist does, works for her/him.	Believes the client's compliance is genuine.
Defiant	Refuses to cooperate with much of the therapy. Fights with therapist and criticizes her approach.	Feels ineffective and incompetent. Feels hurt by criticisms or becomes frustrated with client. Gets into arguments and power struggles with client.

Passive-aggressive	Experiences the therapist as pressuring her to perform. Consciously wants to please the therapist, but fails to do therapy correctly, or if she/he does, fails to progress in life or denies progress. Unconsciously, this is an expression of anger at the therapist and an attempt to defeat the therapist, who is experienced as attempting to control and change the client.	Becomes frustrated with the client for failing, or feels ineffective and incompetent
Controlling	Refuses to allow therapist to do much. Must be in control of the therapy.	Gets into a power struggle with the client
Codependent	Tries to take care of the therapist. Picks up on clues of therapists' pain or life struggles and engages therapist in talking about them. Notices therapist's insecurities and assuages them.	Allows client to take care of him and support him
Prideful	Expects therapist to appreciate or admire her/him, acts superior and demeaning toward therapist.	Therapist becomes resentful or angry at client for grandiosity or condescension and challenges her/him in an unsupportive way.

Reference lost.

Understanding the mechanism of transference which surfaces in many of the client's interactions in his/her own life, helps the OT to become aware of the client's transference to the therapist and the impacts of the therapist's countertransference to the client.

The OT who knows how to recognize and manage transference will be more effective. It can be utilized as a tool in psychotherapy and can be a useful way of bringing the client's feelings and needs to the surface and working on ways to deal with them.

APPENDIX 3

Types of Psychotherapy, Clarkin, F. and P. (1991)

Orientation	Format		
	Individual Models	**Group Models**	Family Models
Psychodynamic	Psychoanalysis, Focal therapy, Psychodynamic Psychotherapy	Insight-oriented heterogeneous group therapy (Wolf)	Insight-oriented marital/ family therapy (Ackerman, Framo)
Cognitive/ Behavioural	Cognitive treatment of depression (Beck), Rational-emotive therapy (Ellis)	Group treatment of agoraphobia Assertiveness training groups	Behavioural marital/family treatment (Falloon, Jacobson, Patterson)
Strategic/Systems	'Uncommon therapy' (Erikson)	Most heterogeneous group therapies	Structural family therapy (Minuchin), Strategic family therapy (Haley), Paradoxical family therapy (Palazolli)
Experiential	Client-centred therapy (Rogers), Existential therapy (May)	Gestalt (Peris), Psychodrama (Moreno), Most homogeneous group therapies	Experiential family therapy (Whitaker)

This is not a complete list of treatment orientations, however, these examples are considered to be commonly used. There are a number of treatment models which fall under these broad forms of psychotherapy, e.g. under the psychodynamic orientation are models of psychoanalysis, focal therapy, psychodynamic psychotherapy, and brief psychodynamic therapy. Other treatment modalities include but are not limited to; supportive, interpersonal, cognitive, behavioural, conditioning, hypnotherapy, transactional analysis, neuro-linguistic programming, eye movement desensitization and reprocessing, (EMDR), dialectical behavioural, mentalization, family systems, couple therapy, and eclectic therapies.

APPENDIX 4

Models of Psychotherapy Supervision, Rice L.N. (1980)

Model	Goal	Nature of Relationship
1. Lecturer	Conveys global conceptual schemes and demonstrates technique.	The listener can choose to tune out, to become an acolyte, or to choose some middle range of engagement with the lecturer.
2. Teacher	Presents specific goals and content within a curriculum for competency or mastery. Generates enthusiasm and provides an ideal or model.	Super-ordinate to subordinate.
3. Case Review	Reviews cases focusing on recognizing the session's events and guiding future interactions.	Elder, experienced to younger, less experienced.
4. Collegial Peer	Consults with peers to gain support or for a critical review that does not jeopardize one's career.	Shared intimacy and trust.
5. Monitor	Maintain standards and ensures mandated guidelines (e.g., for accreditation) are met.	Censor; censures and corrects.
6. Psychotherapist	Helps student psychotherapist comprehend the client's perspective and interventions.	Secure and trusted model in which doubts and hopes can be expressed without external consequence.
7. Coach	Focuses on linking explicit or semantic learning (content) with procedural knowledge while building confidence and hope and benignly correcting.	Trusted elder who has walked in the student's shoes; may be a co-therapist.
8. Educator	Enables student to attain skills, builds higher order judgement skills, and establishes a psychotherapeutic identity.	A role super-ordinate (and inclusive of the other roles) that is careful to see that cognitive and emotional growth proceed apace with skill development.

According to Greben (1994), the supervisor/supervisee relationship is a professional one which reflects the personalities, attitudes and values of the two participants. The supervisor teaches, guides, and does not treat the supervisee. In the case of all good didactic and training experiences, the student or trainee, while learning about the subject at hand, learns more about him or herself.

APPENDIX 5

Skill Development of the OT through the Supervision Process

In maintaining competency in the practice of psychotherapy, the occupational therapist should build on the skills developed through training, with skills that are developed through the ongoing supervision process. Alonso (1985) describes five activities of the supervisor which enable the occupational therapist to maintain these skills:

1. Didactic teaching includes teaching the therapist to listen in order to hear subtleties in the patient's communication.

2. Imparting an appropriate attitude towards clients which implies neutrality, an open-minded curiosity combined with a non-judgemental stance and the maintenance of an attitude of hovering attention.

3. Expanding the affective capacity of the therapist implies the capacity to deliberately feel and contain intense and primitive feelings. In other words, teaching the therapist both to empathize and to accept a sense of ambiguity.
4. Developing the capacity to work in the metaphor of the transference.

5. Supporting the therapist.

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The Working Group of Colleges with Access to the Controlled Act of Psychotherapy.

During 2008, and a large part of 2009, the Working Group for Psychotherapy was comprised of the Colleges of Psychology, Social Work and Social Service Workers, Occupational Therapy, Nursing and Physicians and Surgeons. In 2008, discussions took place about the definition of psychotherapy contained in the College of Physicians and Surgeons of Ontario document" CPSO Response to the Health Professions Regulatory Advisory Council, (HPRAC; Regulation of Psychotherapy Questionnaire", (CPSO, 2005). The College appreciates the opportunity to have had a multi-disciplinary exchange of views with the Working Group during the development of these standards. In the fall of 2009, the representative of the College of Registered Psychotherapists and Registered Mental Health Therapists joined the Psychotherapy Working Group.