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PSYCHOLOGUE CLINICIEN CANADIEN

The Newsletter of the Clinical Section CPA/Journal De La Section De Psychologie Clinique De La SCP

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Revised Publication Schedule

The newsletter will for now be published twice a year, in October and April, instead of three times a year (February/May/November). In effect, the February issue has been omitted on this occasion and the May issue has been moved up.

The executive took this decision in consideration of the budget, as well as out of a desire to have an issue out earlier in the Spring so as to provide Section members with timely information related to, and well in advance of, the CPA convention. The new timing of the newsletter (Fall/Spring) will in general also fit better with the timetable of committee meetings (Summer - CPA, Winter - January Conference).

A change in the publication schedule of the newsletter requires that a corresponding change be made to the by-laws, which of course requires in turn a vote by the membership at the next business meeting.

The revised publication schedule will therefore be discussed further at the AGM. We look forward to your attendance and input.

May I take this opportunity to note that I will regretfully be leaving the position of Editor as a result of other demands on my time. My very best wishes to my successor.

Submissions Invited

The Canadian Clinical Psychologist/Psychologue Clinicien Canadien invites submissions from section members and others. Brief articles, conference or symposia overviews, opinion pieces, and the like are all welcome. Submissions will be screened for merit and length as a condition of acceptance for publication. The thoughts and views of contributors are strictly those of the author(s) and do not necessarily reflect the position of either the Section, or the Canadian Psychological Association, or of any of its officers or directors. Please send your submission, in English or French, directly to the editor, preferably either on disk or via e-mail attachment. The newsletter is published three times a year. Submission deadlines for these issues are as follows: October 20 (November Issue), January 20 (February Issue), and April 20 (May Issue).

Newsletter Editor

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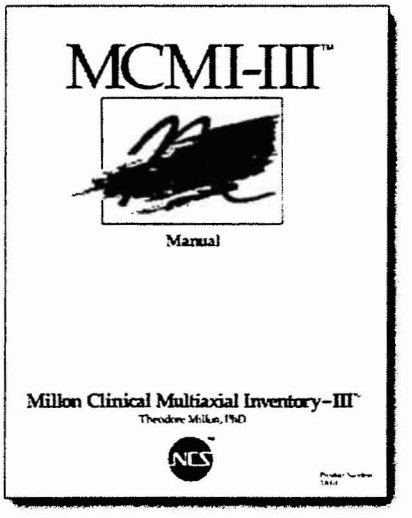

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Message from the Chair

Charles Morin

As I am looking at the program for the next CPA meeting in Edmonton, I believe members of our section will be very pleased with the content and delivery of the program. In addition to six pre-convention and one post-convention workshops, there will be four symposia, five mini-workshops, three conversation sessions, four theory reviews, and more than 70 posters of potential interest to our section. The presentations will address both scientific and professional issues and will cover a broad range of themes relevant to clinical psychology (e.g., anxiety, affective, eating, substance abuse, and sleep disorders; HIV/AIDS, abused/neglected children, internship, supervision, practice issues in northern communities).

On a different note, the work of two task forces should be of interest to our section membership. First, a CPA-appointed task force on Psy.D. programs has recently completed a preliminary document which is currently being circulated for discussion and comments. I would strongly urge you to read this document and to forward your comments directly to Dr. Bob Robinson (Task Force Chair). In my opinion, this document will have a significant impact in shaping the future of Canadian training programs in clinical psychology. The Clinical section also asked another group (John Hunsley, chair) to prepare a document presenting a Canadian perspective on Empirically-Supported Therapies (EST). The preliminary document was discussed extensively at our Winter meeting in Winnipeg and it is expected that a revised draft will be made available in the near future to our membership for comments.

Finally, it is election time and I would encourage you to get involved in the section activities by nominating a colleague or yourself for the position of chair-elect. Although I was somewhat reluctant initially to take on this type of responsibility it turned out to be an excellent opportunity to become more aware of professional issues facing clinical psychology. Overall, it has been a very good learning experience and I would encourage you to also get involved. I would also like to take this opportunity to thank Keith Wilson, past-chair, and Candace A. Konnert, secretary-treasurer, both of who have done an outstanding job on the executive over the past three years. Keith and Candace will be rotating off the executive at the end of the current year.

See you in Edmonton!

Psychology Works! The Development of an Advocacy Campaign*

Alan MacDonald and Susan Jerrott
Dalhousie University

*The following is an excerpt from the introductory section of a campaign kit currently being constructed by graduate students Susan Jerrott and Alan MacDonald.

The discipline of Clinical Psychology has kept a low profile in the public conception of health-care in this country. Let's face it, we as psychologists are not marketing wizards nor are we public relations experts. Our expertise lies in research, program evaluation, assessment and helping individuals and families to cope with emotional and psychological distress. We do a good job and we provide a valuable service to the community. However, in failing to promote our talents and accomplishments, the public is often confused about where to turn if they are experiencing difficulties. Moreover, we find ourselves competing with several levels of professionals for health-care dollars, including psychiatrists, clinical social workers, nurses, counselors, occupational therapists...even physiotherapists. When budget cuts have to be made, the disciplines which have demonstrated themselves to be invaluable, both in terms of skills and in terms of public demand, are those which will flourish. Given recent cutbacks in the psychology departments of several Ontario hospitals, psychology appears to be in danger of losing this battle.

The problem mentioned above is compounded by the stigma which continues to linger about mental health issues. Many people still believe that they should be able to deal with psychological or emotional

difficulties on their own. For whatever reason, people believe that these types of problems represent a sort of weakness. Seeking help for emotional difficulties sometimes becomes a shameful secret. Meanwhile, individuals have no difficulty going to see a doctor for an infection or a broken limb. Psychological problems, however, can be just as debilitating as physical ailments in terms of emotional distress, physical impact and occupational disruption. During our campaign, we relied on a useful analogy to illustrate this point. We drew attention to a recent survey conducted by the American Psychological association (APA) which found that 70% of respondents did not know when or where to seek help for an emotional problem. "Imagine," we said, "if 70% of people with a broken leg did not seek help from a doctor. There would be a lot of people walking around in pain and many would not be walking at all."

In our own survey of individuals in small communities throughout Nova Scotia, we found that the majority of respondents had a positive attitude about the value of psychological services. However, they often lacked knowledge about the expertise of psychologists, how to properly evaluate when they needed psychological help and how to access that help. Given the low profile of psychological services, competing health care professions, stigma attached to seeking help and lack of public knowledge about psychology and how it may be accessed, it was clear to us that some sort of advocacy plan was necessary to increase awareness of psychology in Canada. Such an effort has already been launched by the APA in the United States.

We felt it would be important to introduce psychology as a valuable health care service and de-mystify some of the ideas and misconceptions surrounding the discipline. In addition, we wanted people to gain some recognition of when they should seek help for an emotional or psychological problem. In keeping with this goal, we also wanted people to have more information about how to access psychological services in their communities and explain the network of services available. Finally, and perhaps most importantly, we wanted to reduce the stigma associated with mental illness and contribute to normalizing the process of seeking psychological assistance. Prejudice and misunderstanding are rooted in a fear of the unknown. We felt that providing information in a non-threatening format, through interactive presentations and media interviews, would address gaps in the public knowledge.

In developing a methodology for raising awareness of psychology in the province of Nova Scotia and Canada, we wanted to do more than a one-shot advocacy campaign. We wanted to create a vehicle for advocacy which could be used by professionals across the country. We knew that several questions needed to be addressed: What would be the most important information to get across to the public? What would be the most effective means of disseminating this information? Which part of the population would be targeted? How would we create a tangible link between the information being presented and psychological services in the province? How would we assess the effectiveness of the campaign? How could we capture the spirit and information of the campaign into a kit that could be used by other professionals across the country?

Our initial feeling was that a series of presentations in various parts of the province accompanied by media coverage and interviews would have the best chance of getting our message out to people. We knew, however, that talks or presentations can be swallowed up in major urban areas and it is often difficult to make an impact or receive effective media coverage. For this reason, we felt that it was important to start at the community level, particularly smaller communities. In small communities presentations have the benefit of reaching a large proportion of the population through word of mouth and, we felt, might have a bigger impact on individuals. In addition, we knew that smaller communities do not have the same level of exposure to access to psychological services compared to larger urban areas and therefore might be more interested in presentations which addressed psychological concerns. Thus, we developed a grass-roots-type campaign, targeting communities of 20,000 people or less in various geographical regions of the province of Nova Scotia -

Yarmouth, New Glasgow, and Glace Bay.

Using the Attitudes Towards Seeking Professional Help Scale (Fisher and Turner, 1970) and APA's telephone questionnaire from their recent advocacy campaign as a template, we designed a survey to assess knowledge and attitudes about psychology in the province of Nova Scotia. The survey had the two-fold purpose of: 1) isolating areas of misunderstanding or lack of confidence in psychological services to help us in deciding what information would be important to communicate to the public; and, 2) helping us to see changes in attitudes, if any, after the community presentations were complete.

Surveys were sent out to randomly selected households in each community we visited, both before our presentations and after. Moreover, we adapted the surveys for use during the actual presentations so that we could assess the impact of our talk on the individuals who were in attendance (a direct measure of the effectiveness of our presentation). Analysis of the data from these questionnaires is still in progress.

Obviously, we knew that the quality and content of our presentations would be the central component of the entire campaign. We had to be sure to get across a message that could be easily digestible and that would make an impact on our potential audience. It was important to keep our goals firmly in mind while developing the presentations. We wanted to introduce psychology as a health-care service, outline the benefits of psychology and explain the mechanisms of psychological intervention. We chose to house these objectives within a framework of a particular topic (anxiety) to provide information on how psychology could help individuals, families and groups to address a pertinent psychological concern.

We also wanted to make the public aware of the network of psychological services available in the province and how they might be accessed. Our hope was to build bridges with communities by coordinating our efforts with psychological services in each area. Thus, we decided to bring in liaisons from the psychological field in each community to provide our audience with first-hand information about accessing services in their local area.

The media also played an instrumental role in communicating our message to the public. Through interviews and coverage of our presentations, we were able to reach a much larger cross-section of the population, both locally and provincially. We were interviewed by several newspapers, radio stations and a live call-in talk show on the Global Television Network. Of course, once the media becomes involved with a project like this, the presenter no longer has complete control over what information is related to individuals or what angle might be given to one's work. Thus, based on our personal experiences, we have included an extensive section on media relations in our campaign kit.

We are presently taking everything that we have done to this point - the rationale for the project, the surveys, the interviews, the presentations, the media coverage - and packaging it for others to use as an effective advocacy tool. Our goal is to have professionals from large and small communities working together towards the common cause of raising public awareness of psychological services across Canada. All the information and materials necessary to continue our work will be in the campaign kit. We are including a how-to checklist for developing a series of presentations in other provinces, names of contact people, a detailed presentation script, a video of the presentation, hand-outs and pamphlets, presentation materials, evaluation forms, feedback results and, perhaps most importantly, a first-hand account of some of the issues and difficulties (and pleasures) involved in conducting this campaign.

We are using the phrase 'Psychology Works!' to describe this campaign because, essentially, this is the message we want to get across to the Canadian public. The word psychology will continue to be on everyone's lips in the future It is our hope that some real meaning and understanding of the importance of the word will soon accompany it.

Psychology in Edmonton:
Clinical Psychology Activities for the National Convention
June 3 - 7, 1998

Mark your calendar for June 3 - 7 and make tracks to Edmonton for the 1998 Canadian Psychological Association's 59th annual convention. To help you organize your conference days (or to help those of you sitting on the fence to take the plunge), we give you a preview of many of the activities that may be of interest to clinical psychologists. The list below reflects only one portion of the convention program. The convention's full program includes several distinguished speakers, highlighted in CPA's newsletter, Psynopsis, as well as presentations from other areas of psychology.

Wednesday, June 3

Preconvention Workshop:	Cognitive therapy of depression: Recent developments in theory and practice. K. Dobson**
	** workshop co-sponsored by CPA's Clinical Psychology section and the Psychologists' Association of Alberta

Thursday, June 4

CPA Clinical Section Invited Workshop:	Psychological treatment of insomnia. C. Morin (8:00-10:00, Salon 4)
Clinical Symposium	Topics in stress and coping at work and at home. J. Durup, moderator (8:30-10:30, Salon 9)
CPA Clinical Section Invited Symposium:	Anxiety disorders: An update for the clinician. J. Walker, moderator (10:30-12:30, Salon 4)
Theory Reviews:	The prediction of suicide: Where do we go from here? M. Heisel (10:00-10:30, Salon 15/16)
	Youth gambling: Prevalence, risk factors, clinical issues and social policy. J. Derevensky (11:30-12:00, Salon 13/14)
	The WAIS-III: A psychometric and clinical evaluation. D. Hildebrand (12:00-12:30, Salon 13/14)
Workshop:	Exposure in the treatment of anxiety disorders: Principles and clinical applications. M. Dugas & J. Rheaume (1:00-3:00, Salon 10)
Conversation Session:	Psychology works: An advocacy campaign to bring psychology to the public. A. MacDonald & S. Jerrott (2:00-3:00, Salon 7)

Friday, June 5

Clinical Symposium:	Cognitive and personality vulnerability to depressive symptoms. D. Clark, moderator (8:00-10:00, Salon 17/18)
Workshop:	Assessment and treatment of MVA-related posttraumatic stress disorder. W. Koch (8:00-10:00, Salon 11)
CPA Clinical Section Invited Conversation Session:	How to get the internship you really want. J. Pearce, chair (10:00-11:00, Salon 11)
Clinical Section Reception:	11:00-12:00 noon, Salon 5
Clinical Section Business Meeting:	12:00-1:00, Salon 5
Theory Review:	Salutogenic personality characteristics: A prerequisite for practice in remote communities? C. de Wet (12:00-12:30, Salon 17/18)
Clinical Psychology Posters:	1:00-3:00, Hall B
Workshop:	Ethical dilemmas in professional supervision. G. Lucki (2:00-4:00, Salon 2)
Conversation Session:	Innovations in therapy training and supervision. K. Mothersill (3:00-4:00, Salon 17/18)

Saturday, June 6

Clinical Symposium:	Social phobia: the neglected anxiety disorder? P. Furer, moderator (8:00-10:00, Salon 5)
Workshop:	CPA guidelines for psychologists in addressing recovered memories. J. Pettifor (8:00-10:00, Salon 4)
Clinical Symposia:	Rural and northern clinical practice and training. L. Keith, moderator (1:30-3:30, Salon 17/18)

Sunday June 7

Postconvention Workshop:	Psychotherapy of abused and neglected children. J. Pearce & T. Pezzot-Pearce**

** workshop co-sponsored by CPA's Clinical Psychology section and the Psychologists' Association of Alberta

Fellows of the Clinical Section

John Service is well known in the Canadian psychology community as the Executive Director of CPA. John's interest in psychology was kindled during his undergraduate work with Julian Blackburn at Trent University. He completed a Master's degree at George Williams College in Chicago, after which he moved to Sudbury to teach at the community college level and work in student counseling. John then went to the University of Georgia for his doctoral training, and graduated in 1980. He did his internship at the University of Manitoba.

With his training completed, John moved on to New Glasgow, Nova Scotia, to fulfill his interest in working in rural mental health. At the Aberdeen Hospital, John rose to the position of Chair of the multidisciplinary Department of Mental Health Services. During that time, John was also very active within the discipline, both at the provincial and national levels. John served on the Nova Scotia Board of Examiners, and participated broadly in the Association of Psychologists of Nova Scotia and the Council of Provincial Associations of Psychology. Within CPA, John has served as Chair of the Ethics Committee, Chair of the Joint CPA/CPAP Task Force on Specialty Designations, and as a member of the Professional Affairs Committee. John became Executive Director of CPA in 1993.

Sam Mikail is a staff psychologist at the Southdown Institute in Aurora, Ontario, a centre that specializes in work with the religious and the clergy. Sam completed his undergraduate education at the University of Waterloo and his graduate training in clinical/community psychology at the University of Saskatchewan. He was a predoctoral intern at the Holy Cross Hospital in Calgary. After his internship, Sam took a position at the Rehabilitation Centre in Ottawa where he stayed for nine years and was instrumental in establishing the accredited internship program at the Royal Ottawa Health Care Group.

Sam is past chair of the CPA Section of Clinical Psychology, and he has recently served as a member of the task force assembled by the Section to review the current status of empirically supported treatments. Sam has also held administrative positions with the Canadian Pain Society, the Canadian Council of Clinical Psychology Programs, and the Canadian Group Psychotherapy Association. Currently, Sam is a member of the executive committee of the Clinical Psychology Section of the Ontario Psychological Association.

In addition to his extensive list of contributions to Canadian Psychology, Sam is renowned for his expertise as a clinician. He is a Diplomate in clinical psychology with the American Board of Professional Psychology.

Positioning Oneself for the Marketplace: A Jack of All Trades but a Master of Some

David J.A. Dozois
University of Calgary

For myself and several other PhD candidates, pre-doctoral internship interviews consumed much of the month of January. In addition to the tensions involved in obtaining an internship, completing this interview period served as a stark reminder that I too will soon be embarking on the next phase in my career - the transition from graduate student to professional. Although there is plenty of excitement associated with this rite of passage, there is also some trepidation. The fact is that psychology graduate students currently face far more uncertainty about the job market than was the case 10-20 years ago. economic and social pressures (e.g., reducing duplication in the health-care system; cut-backs in research grants) have altered the platform on which clinical psychology operates, forcing many psychologists to seek employment opportunities outside of the traditional areas of academia and health-care.

Psychologists are also expected to adopt a larger number of roles and responsibilities than that were in the past. In addition to their roles as researchers, diagnosticians and therapists, many psychologists also perform the duties of consultants, supervisors, business administrators, policy makers, and program evaluators. The roles of psychologists are shifting continually, and the restructuring of education and health-care across the nation, raises numerous questions for students about possible career paths and options. Many students worry not only about whether they will find work, but what type of work they might ultimately be engaged in, and whether graduate training has prepared them adequately for the marketplace.

The purpose of this column is to provide students with a few suggestions for positioning themselves in the marketplace. Given that I have not yet sought employment I cannot speak from personal experience; however, my suggestions are based both on observations of the changing job market and discussions with employed psychologists.

1. Make Connections - We have all heard the cliche, "its not what you know but who you know". Although you are not likely to land a position without a solid academic record and good clinical experience, who you know may also be important. Psychology in Canada consists of a fairly small number of individuals, and it does not take long for connections to pay off. Some excellent ways to network are to attend conferences, to join CPA sections, and to become involved with different committees or interest groups (e.g., I believe that the Clinical Section is still looking for someone who is willing to serve as a Student Representative).

2. Seek both Breadth and Depth in your Training - Internship Directors and other hospital employers have consistently mentioned to me that the ideal candidates are individuals who have attained sufficient breadth in their training along with some degree of specialization. Breadth is important for flexibility on the job. As previously noted, psychologists do not always work in the specific areas in which they were trained. Thus, obtaining a variety of clinical experiences during training will equip you with the ability to learn new approaches and employ basic psychological principles to a variety of settings and clientele. Conversely, it is also advantageous to have a few areas in which you can claim some expertise (although many psychologists believe that specialty training should be at the post-doctoral level).

3. Value, Use and Conduct Research - I have repeatedly heard students lament that their programs overemphasize theory and research. I have even heard some individuals state that they wished that they never had to conduct research, and that they would prefer to acquire a position that allows them to engage solely in practice. Although the scientist-practitioner model may be criticized by some as unnecessarily forcing practice-oriented students to learn theoretical models and techniques that are not compatible with their career choices, these models and the general-experimental approach relate to clinical practice in several ways. First, and most obvious, the

ability to conduct and consume research enhances one's knowledge base about adaptive and maladaptive behavior, and about the optimal ways to alleviate psychological distress.

Second, a solid grounding in research fosters a particular way of thinking and a certain method of viewing a patient's problems. For example, formulating a god case conceptualization requires skills similar to those involved in formulating research hypotheses and analyzing data.

Third, accompanying the changing roles of psychology has been an increased need to demonstrate outcome efficacy and cost-effectiveness for the services psychologists provide. In the past few years, for instance, a growing trend has involved the identification, promotion, and dissemination of empirically supported treatments. Health care policy-makers and insurance companies are already requiring that psychologists not only provide evidence-based treatment but that they demonstrate that they are providing services in a cost-effective manner.

Finally, during interviews for internship, I became even more cognizant of the value and necessity of research. One site that I interviewed with had recently undergone restructuring, and the only members of its psychology department who were still employed were those who were productive in research. I recognize that there are those individuals who are more invested in practice than research (and vice-versa). However, as a marketing strategy, I believe that it is imperative for students to continue to engage in clinical research and become not only consumers but also producers of knowledge.

4. Be Aware of Market Needs and How to Meet Them - There is some recent discussion that training models in clinical psychology need to be revisited and revised to be more reflective of marketplace needs (Murray, 1998). One counter-argument to this point is that the economy should not dictate the philosophy of training. Clinical programs could, however, enhance student awareness of market trends without jeopardizing their core curriculum. At the University of Calgary, for example, we have had community practitioners provide seminars on setting up a private practice. Some students in our program also arranged for a banker, an accountant, and a lawyer to conduct a workshop on financial issues related to beginning a small professional business. In response to feedback from previous interns, the University of Manitoba Health Sciences Centre has also included private practice as a topic for their upcoming seminar series. Obtaining the information you need to ensure that you will be competitive in the marketplace is limited only by your creativity and motivation.

Students reading this column who are beginning their training should start to think ahead and prepare for the transition from student to professional. Clinically and academically, it is important to be a jack of all trades but also a master of some. Get involved in clinical research, set up seminars on issues related to employment, attempt to get clinical training that allows for both breadth and depth, and begin to make connections early on in your training. Attempting to gain as much experience as you can in both the science and the practice of psychology will put you in good standing for future employment opportunities.

References

Murray, B. (1998, January). Psychology trainers urged to update their programs. APA Monitor, 30.

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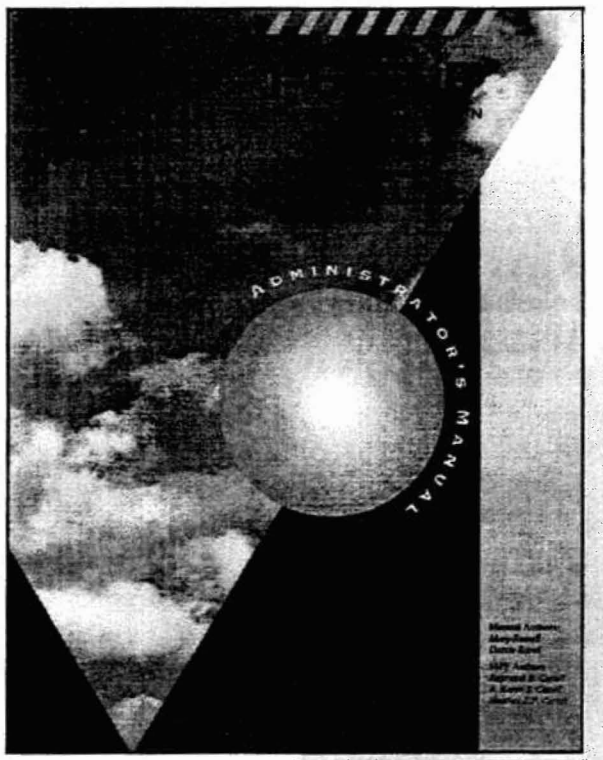

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Self-Oriented Perfectionism and Enhanced Stress Response to an Achievement-Related Stressor

Carol Ann Flynn
University of British Columbia

This study focuses on one of the three forms of trait perfectionism described by Hewitt and Flett (1991). Self-oriented perfectionism is the requirement for oneself to be perfect, and includes behaviors such as maintaining unrealistic standards for oneself and self-critical evaluations of behavior. Hewitt and Flett (1991) suggested that each dimension of perfectionism is associated uniquely with various facets of psychopathology and maladjustment. However, the mechanisms by which perfectionism influences behavior and psychopathology have yet to be clearly established. Hewitt, Flett and Endler (1993) suggest that perfectionists may create ego-involving stressors and that once a stressor or failure situation is encountered, perfectionists may experience the adverse more aversely than others. That is, perfectionism may be a stress generator and a "stress-enhancer" (Hewitt, Flett & Ediger). Perfectionists also may employ inappropriate coping strategies when confronted with a stressor.

Based on the notion that self-oriented perfectionism influences the stressfulness of achievement events, the following hypotheses were formulated. First, those scoring high on the perfectionism scale should be less satisfied with their performance on an achievement task, after controlling for actual performance, than those scoring low. Second, self-oriented perfectionism should predict the intensity of the stress response as indicated by: a greater increase in negative mood following the test, more elevated heart rate during the test, and a greater increase in cortisol levels following the test. Third, self-oriented perfectionism should predict a greater duration of stress response as demonstrated by: greater negative mood, more elevated heart rate, and more elevated cortisol levels at recovery. Finally, the interaction of self-oriented perfectionism and both emotion and task-oriented coping styles should predict enduring stress.

Participants for this study were 130 undergraduate volunteers. Upon arriving at the lab, subjects filled out the Multidimensional Perfectionism Scale (MPS: Hewitt & Flett, 1991). After nine minute, subjects engaged in Jacobson's Progressive Muscle Relaxation (Barlow & Craske, 1994). Subjects then completed the Positive and Negative Affect Schedule (PANAS: Watson, Clark & Tellegen, 1988), a self-report measure of the subject's mood and then provided a saliva sample which represented baseline cortisol levels. At thirty minutes, the experimenter introduced a bogus intelligence test. Following the test, students provided a second salivary sample (the "post-test" sample) and completed the PANAS. They also evaluated their performance and rated the credibility of the test. After another thirty minutes, the "recovery" salivary sample was taken and students completed a final PANAS. Heart rate was recorded throughout the study using chest strap monitors.

In general, the results supported the hypotheses. Individuals high in self-oriented perfectionism gave lower ratings of self-satisfaction with performance than did other subjects ($p<.0001$), indicating that they were more likely to perceive their performance as a failure. They also experienced more intense stress responses than others both during and immediately following the test. They reported greater increases in negative mood ($p<.05$), and experienced greater heart rate elevations during the math task ($p<.05$). Although cortisol levels were not elevated for all individuals high in self-oriented perfectionism following the test, perfectionism among those who believed the test was valid did predict higher levels of cortisol post-test ($p<.05$). Finally, those high in self-oriented perfectionism continued to experience more elevated heart rate than those low in self-oriented perfectionism at recovery ($p<.05$) and this difference was especially strong for those who reported using task-oriented coping strategies ($p<.016$).

These results provide a key to understanding the mechanism by which self-oriented perfectionism interacts with stress to produce depression. Here, we have demonstrated that self-oriented perfectionists experience less satisfaction with their performance

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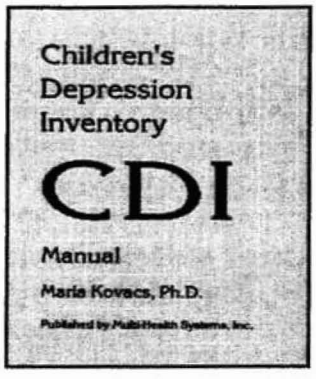

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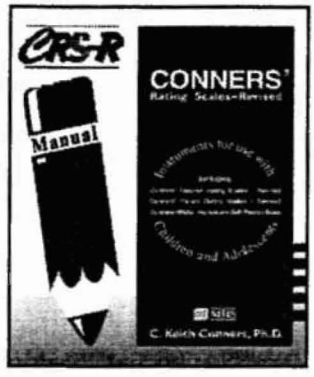
A self-report measure of depressive symptoms in young persons aged 7 to 17



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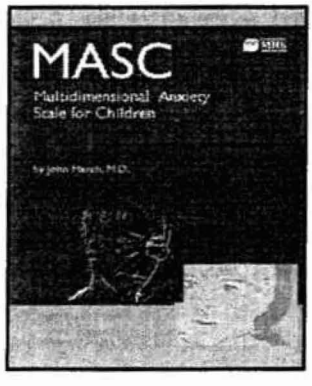
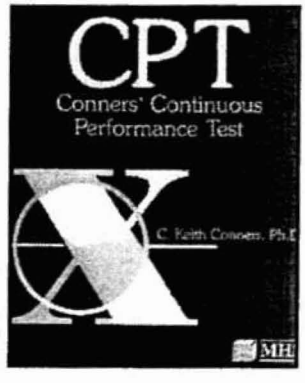
Child/Adolescent Version and Parent Version
A computerized diagnostic interview based on the DSM-IV™ for ages 6 to 12 and 13 to 17



Multidimensional Anxiety Scale for Children
A self-report instrument used for assessing the major dimensions of anxiety in youths aged 8 to 19 years



Conners' Continuous Performance Test Computer Program
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Feelings, Attitudes, and Behaviors Scale for Children
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and more negative mood following an achievement stressor. Repeated episodes of stress led to feelings of low mood and critical evaluation of performance , both of which are aspects of depression symptomatology. The physiological dependent measures provided additional evidence that self-oriented perfectionism is linked to increased stress. Heart rate response during a task is described as indicating strong effort and task involvement (e.g., Arnetz & Fjellner, 1986). Therefore, it appears that self-oriented perfectionists are trying more actively to succeed on this task than other subjects. This is similar to suggestions that perfectionists attempt to be perfect in most or all of their tasks (Flett, Hewitt, Endler & Tassone, 1995). As a result, one would expect these individuals to expend undue effort and energy in many situations in daily life. This could increase the frequency of perceived stressors and the magnitude of stress response leading to long term consequences for both physical and mental health.

The present study is particularly exciting because it demonstrates that three different domains of stress response are affected by self-oriented perfectionism: mood, heart rate, and cortisol levels. This finding has important implications for understanding the physical and mental health of perfectionists. This is also one of the few studies to identify a personality variable that influences physiological arousal in both men and women which should make perfectionism an essential variable in the study of cardiovascular disease.

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