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Inside...

Message from the Chair

The Enemy Is Us

Lorne Sexton

These are indeed interesting times for Psychology. In the USA psychologists are bombarded with the restrictions of managed care. In Canada, program management has swept the country, making professional disciplines (and direct access to psychology services) an endangered species. We are living in a bio-reductionistic era, with Prozac and Viagra heralded as saviours. McLean's magazine presents a cover story on male health, and discusses treatments for depression at length without a single reference to psychological approaches. After all, "All it is...is a chemical imbalance of the brain." (McLean's, February 22, 1999, p. 33).

As I encounter these and other frustrations and challenges, I am reminded of my favourite quotation from the now extinct newspaper cartoon philosopher, Pogo. In the Best of Pogo version (1982, but first used in a cartoon in 1953), the often quoted saying appears: ***We have met the enemy and he is us.*** Indeed, I truly believe that often psychologists are their own worst enemies.

Very similar sentiments were expressed bluntly by Patrick DeLeon, APA president-elect, in a book chapter entitled "Expanding Roles in the Twenty-First Century." (found in Resnick & Rozensky, *Health Psychology Through the Life Span*, 1996). DeLeon notes that as a rapidly maturing profession, only recently legitimized through licensing, but increasingly important in the public's eye, our self concept as a profession has not kept pace. As a result:

- "we often act as though we are paraprofessionals, not professionals"
- "we often do not act as if we have the resources or authority"
- "we often do not act like professionals, willing to accept clinical responsibility"
- "psychologists...must stop putting themselves down and, instead, learn to value their own expertise."

Much of our self-limiting and self-handicapping behaviours stem, as implicated in the last quote, from low professional self-efficacy beliefs. Too many psychologists have internalized the pharmaceutical propaganda of the Prozac era. Our methods not only work, they are often superior. We have a responsibility to the public to know our own expertise and assert it through public policy. But first we must believe in ourselves.

Elsewhere in this newsletter, Deborah and Keith Dobson discuss public access to efficacious psychological treatments. As pointed out in a review by Antonuccio, Danton, and DeNelsky (1995), much of the idea that Prozac is a breakthrough treatment for depression is a myth. Research increasingly indicates that SSRIs have little increased efficacy over tricyclic medications: lower side effects possibly, but no breakthrough or real change in the last couple of decades in the ability of antidepressants to control depression. Indeed, to quote Antonuccio et al., "the preponderance of evidence suggests that drug treatments do less well than psychotherapy during follow-up and are not more effective than psychotherapy with endogenous, severe, or chronic depression." Rather than putting patients on life long antidepressants, an increasing trend in order to prevent relapse, empirically based best practice should be to provide cognitive, interpersonal, and other potentially valid interventions as the first treatment. Psychological treatments are as or more effective, safer, have lower relapse rates, and can even

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Clinical Section Executive Officers 1998–1999

Chair
Lorne Sexton, Ph.D.
McEwen Bldg.
St. Boniface Hospital
409 Tache Ave.
Winnipeg, MB, R2H 2A6
Tel: (204) 235-3088, Fax: (204) 237-6264

Past-Chair
Charles Morin, Ph.D.
École de Psychologie
Université Laval
Pavillon FAS
Québec, QC, G1K 7P4
Tel: (418) 656-3275, Fax: (418) 656-5152
cmorin@psy.ulaval.ca

Chair Elect
Charlotte Johnston, Ph.D.
Dept. of Psychology
University of British Columbia
Vancouver, BC, V6T 1Z4
Tel: (604) 822-6771; Fax: (604) 822-6923
cjohnston@cortex.psych.ubc.ca

Secretary Treasurer
Deborah Dewey, Ph.D.
Alberta Children's Hospital
Behavioral Research Unit
1820 Richmond Rd. SW
Calgary, AB, T2T 5C7
Tel: (403) 229-7365; Fax: (403) 229-7221
deb@ach.ucalgary.ca

Member at Large
Lesley Graff, Ph.D.
PX246 - 771 Bannatyne Ave.
Winnipeg, MB, R3E 3N4
Tel: (204) 787-3490; Fax: (204) 787-4879
lgraff@exchange.hsc.mb.ca

Newsletter Editor
Sharon Cairns, Ph.D.
University Counselling Services
University of Calgary
2500 University Dr. NW
Calgary, AB, T2N 1N4
Tel: (403) 220-5893; Fax: (403) 284-0069
scairns@ucalgary.ca

Halifax hosts

Canadian Psychological Association

60th Annual Convention

May 20–22, 1999

See insert for Clinical Section activities

Clinical Section Website

http://play.psych.mun.ca/~dhart/clinical

- Executive
- Purpose of Clinical Section
- Current Projects
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- Brochure: The Clinical Psychologist in Canada(in French and English)
- Definition of Clinical Psychologist
- Fellows of the Clinical Section
- Ken Bowers Student Research Award Winners
- Annual Convention

"The Enemy Is Us" continued from front page

cost less. We need to boldly state this as clinicians, and take these claims to the institutional and governmental policy makers.

Richard Suinn, APA President, makes a similar case for the efficacy of psychological interventions for cancer. In his column in the APA Monitor (February, 1999), Suinn discusses the power of psychological interventions. "With cancer, studies have demonstrated the effectiveness of psychoeducational group sessions for removing distress and the emotional turmoil after diagnosis, strengthening the immune system, controlling pain, improving the relationships between patients and oncologists, strengthening family and other support systems, raising self-esteem and optimism, and resolving the many problems of daily adjustment facing those with this catastrophic disease." In addition, psychological interventions save thousands of health care dollars per patient in reduced hospitalization. Suinn points out that if a drug were introduced with these claims, it would be front page news and the public would be clamouring for access to it. It is our job as psychologists to communicate with the public and the medical community about the effectiveness of psychological interventions. We must at the same time shift our public identity away from psychologists as narrowly defined mental health professionals and towards psychologists as broadly based primary-health-care-professionals.

The Clinical Section also bears some responsibility towards valuing our own expertise, shaping our identity, and influencing policy decisions. At our January, 1999 meeting, we briefly discussed our mission. We quickly arrived at the following statement: ***The mission of the Clinical Section is to promote clinical psychology as a science and a profession to the public, other professions, government, and psychologists themselves.*** We want feedback on this either in writing or at our business meeting in Halifax.

With this in mind, we have initiated a project with John Service, CPA Executive Director, and to include other CPA Sections, to create clinical fact sheets for various disorders. These fact sheets will be developed by prominent Canadian psychologists, and delineate the effectiveness of psychological models and interventions. These fact sheets will be targeted at governments, but they will also be distributed on the Internet to the public. CPA Internet fact sheets could be downloaded by practitioners and used as brochures for patients and other interfacing professions such as family practitioners. The Clinical Section has very little money, but we have a wealth of some of the best educated and articulate professionals found anywhere: you. Its time we put you to work.

Psychological treatments are as or more effective, safer, have lower relapse rates, and can even cost less than pharmacotherapy. We need to boldly state this as clinicians.

For convention goers, we will be targeting your self-efficacy with presentations by three prominent key note speakers. Larry Beutler will discuss evidence-based eclectic decision making. Ed Craighead will discuss the prevention of relapse in depression. Tom Ollendick will present a discussion on socially withdrawn and aggressive children. Popular mini-workshops are also in the program, including a Section-sponsored workshop by Josie Geller for eating disorders. For readers of this newsletter, we will continue our recent format of providing you with clinically relevant information and reviews.

The message in all this, however, is that it is your individual self-efficacy and willingness to promote psychological treatments that counts. It is not CPA's job, nor provincial associations', rather it is all of ours as individual psychologists. We have found the enemy, and they are us.

By the way, the saying from Pogo was an interesting twist on a military quote. The original is attributed to Oliver Hazard Perry, and is found in a book by R. B. McAfee entitled "History of the Late War in the Western Country" (1816). The original reads: ***We have met the enemy and they are ours***

With some belief in our methods we can win these various battles we find ourselves in, and indeed the future will be ours.

Letters to the Editor

Empirically supported treatments

Dear Editor,

I have some serious reservations about the draft report on Empirically Supported Treatments in Psychology as well as the recommendations contained therein.

The report is based on assumptions that are embedded in behavioural and cognitive-behavioural approaches to psychotherapy. Notions that are fundamental to such orientations (e.g., the purpose of psychotherapy is to treat psychopathology) are not necessarily to be found across all approaches (e.g., psychoanalytic, humanistic and feminist therapies). Of particular relevance is the discrepancy in goals across divergent theoretical orientations and with it, the difference(s) in criteria for effective outcome.

One of my concerns about the recommendations in the draft report is that they serve to validate, if not to reify, the assumptions of the behavioural and cognitive-behavioural models; it is as if these models are to be the standard by which other therapeutic orientations and their outcomes are to be evaluated. Practitioners of other psychotherapy approaches are entitled to object to hegemony by behaviourists and cognitive-behaviourists; these recommendations leave only marginal room for recognizing the value and effectiveness of clinical orientations aimed at a different set of goals. Such objections are noted briefly in the report (e.g., a reference on page 8 to Silverman, 1996) but are dismissed.

The CPA report cites the work of APA's "template" committee as a model for its own recommendations. It is noteworthy that APA's "template" committee is in the process of revising its own 1995 recommendations based on the objections and alternatives suggested by APA's Division 39, Psychoanalysis and Division 32, Humanistic Psychology. (CPA has no corresponding divisions.)

In 1997, APA's Division 32 developed humanistic guidelines for professional practice, "Guidelines for the Provision of Humanistic Psychosocial Services," which were published in *The Humanistic Psychologist, 25*(1). These serve, in part, as a response to APA's "template." A recent article by Bohart, O'Hara and Leitner (1998) entitled, "Empirically Violated Treatments: Disenfranchisement of Humanistic and other Psychotherapies," published in *Psychotherapy Research*, addresses some of the problems associated with APA's initial "template" formulation. The latter article is from a special issue of *Psychotherapy Research, 8*(2) devoted to this subject. Clearly, the issue of empirically supported treatments continues to generate controversy beyond that discussed in the CPA report.

The document sent to CPA Clinical Division members is a draft, intended to stimulate member feedback. I hope there will be a continuing forum for consultation and discussion before these recommendations are accepted as policy. Should there be an opportunity to participate further in the consultation process, I would be eager to do so.

Peggy J. Kleinplatz, Ph.D.

Response to Dr. Kleinplatz:

We support Dr. Peggy Kleinplatz's concerns regarding recent Canadian Psychological Association (CPA) efforts to standardize psychotherapy guidelines.

We implore our Canadian colleagues to consider the following recent developments within the American Psychological Association (APA): First, in response to the firestorm of protest by such APA Divisions as 32, 39, 42, and 24, the Template Implementation Work Group (the APA committee authorized to develop psychotherapy guideline policies) has (a) agreed to a three-year reassessment period in which all original Template policies, including those that embody narrow stringency standards, will be reviewed and possibly revised;(b) added a new, humanistically oriented member to the committee; and (c) shown significant responsiveness to the wave of criticisms from various divisions.

We believe the APA committee is recognizing that psychologists hold a wide range of views on the goals of psychotherapy, what constitutes appropriate outcome criteria, and how one determines the efficacy and effectiveness of therapeutic interventions.

We hope this summary of recent developments in APA will help underscore the rel-

Continued on page 7 "EST Letter"

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Empirically supported treatments in psychology: Response to the discussion document

Lesley Graff
Member-at-large
Clinical section executive

Thank you to all who took time to provide feedback on the discussion document that was enclosed in the previous newsletter, entitled "Empirically supported treatments in Psychology: Recommendations for Canadian professional psychology" and prepared by the Clinical section's task force. The quantitative and qualitative information has been summarized below. There are still opportunities to communicate your concerns and/or support regarding the EST initiative and the task force report, including writing the Clinical section executive, sending a letter to the editor of this newsletter, or attending the EST-related convention sessions in Halifax in May.

There are still opportunities to communicate your concerns and/or support regarding the EST initiative and the task force report, including writing the Clinical section executive, sending a letter to the editor of this newsletter, or attending the EST related convention sessions in Halifax in May.

Nineteen surveys were returned and three people wrote with general comments regarding the discussion document. Replies were received from psychologists in British Columbia, Alberta, Manitoba, Ontario, Quebec, and New Brunswick.

Empirically Supported Treatments.
The vast majority of respondents (90%) agreed *in principle* with the need for evidence-based psychological treatments. About half, however, had some concerns about the EST initiative that was launched in the United States. The comments reflected concerns such as: a) untested therapies could mistakenly be assumed to be ineffective, b) the EST list could be misinterpreted and restrict practice to only EST approaches, c) research to date reflects efficacy but not effectiveness, and criteria for ESTs perpetuates that focus, and d) cognitive-behavioral treatments are over-represented, perhaps not because they are more effective, but because they are easier to evaluate, given the current methodologies.

Task Force Report.
With regard to the task force report itself, and the impact of the EST initiative on Canadian psychology, almost two-thirds of the respondents indicated general support, and did not have any specific concerns. For those who did have some misgivings about the report, the issues centered around three main points: a) some felt the report did a good job of describing the concerns and problems that arose in the American experience with the EST initiative, but then did not integrate that information into the recommendations to ensure that the Canadian experience does not replicate those same problems, b) some indicated that the report did not go far enough to highlight the American/Canadian differences in psychological service delivery and payment, and devise direction with those differences in mind, and c) many had reservations about some aspect of the recommendations, which are further elaborated below.

Report Recommendations.
The task force report proposed 12 recommendations, each of which members were asked to endorse, reject or modify. All of the recommendations were supported by a 60% or greater majority. The recommendations that received the most support (85% or higher) called for Canadian representation on APA EST task force and practice guidelines committees, developing a national data base on treatment outcomes, lobbying for funding support for treatment effectiveness research,

and developing continuing education in empirically supported treatments. The majority of concerns raised regarding the task force recommendations did not question the basic nature of the recommendations, but instead urged caution and prudence in their implementation. Some respondents felt that the recommendations were premature and that we should continue to monitor and study the issue. Other respondents felt that ESTs should be encouraged, but not required, at the level of training, accreditation, or registration. Others suggested that the first priority should be promoting education in ESTs, and that this should happen before external groups (e.g., government, funding agencies) are approached. Concerns were also raised with the practicality of some recommendations (e.g., the expense of establishing a national database). A small minority of respondents, who had fundamental objections to the notion of ESTs, was strongly opposed to any of the recommendations being implemented.

General Feedback.

Several respondents took the time to offer general comments and suggestions regarding the issue of ESTs. Some of these responses urged the Clinical section to move quickly to implement the recommendations so that, as a discipline, we become actively involved in the shaping of health care policy and so that we remain abreast of colleagues in other countries and in other disciplines. For some, the ESTs were seen as promoting a move to accountability in the profession, and not as a move to the endorsement of any one particular model of psychotherapy. Several of the general comments endorsed the idea of ESTs, but expressed concerns such as: a) journal publication policy may result in negative outcomes for ESTs being missed, and b) the work on ESTs could discourage work on the effectiveness of other forms of therapy. Finally, some respondents voiced strong, philosophical objections to the Task Force report. It was argued that the assumptions of ESTs are central to cognitive-behavioral or behavioral therapies, and that different therapies (e.g., psychoanalytic or humanistic) have different goals, and therefore different outcome criteria that are not reflected in the EST approach.

Future Directions.

Where do we go from here? Despite general support and endorsement, only a quarter of those responding felt that the report was ready to be accepted in full and recommended as policy to CPA. The majority of respondents encouraged further discussion at the Clinical section's annual business meeting and through panel discussion at the upcoming CPA convention. There were a few additional suggestions offered for future steps, including encouraging broader dissemination of the report (e.g., publication in a Canadian journal), encouraging further research and task forces on the issue, and urging the section to begin the work of promoting ESTs within CPA.

At this point, further discussion regarding the EST initiative and the Canadian task force report has in fact been planned through activities at CPA's annual convention in Halifax, including panel discussion and symposia, the task force report as an agenda item for the section's business meeting, and a joint meeting of APA Division 12 (Clinical) and CPA Clinical section executives. The section executive plans to gather input through these forums in order to determine the next step regarding the recommendations from the report.

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evance and legitimacy of Dr. Kleinplatz's concerns as CPA considers going down this same road.

Kirk J. Schneider, Ph.D.,
Chair, Template Oversight Committee,
Division 32, APA
David N. Elkins, Ph.D.
President, Division 32, on behalf of the
Division 32 Board

Upcoming Conferences of Interest

May 20–22, 1999

International Conference on Adapting Tests for Use in Multiple Languages and Cultures

Washington, DC

Contact: Donna Everett, ETS,
Rosedale Road
MS 06-N
Princeton, New Jersey 08541
Fax: (609) 683-2800
deverett@ets.org

Public access to empirically supported treatments

Deborah J.G. Dobson
Calgary Regional Health Authority

Keith S. Dobson
University of Calgary

The profession of clinical psychology has a long history of outcome research through its research training and the focus on the scientist-practitioner model in most Canadian training programs. The recent emphases on empirically supported treatments (ESTs) in the United States (Chambless, et al., 1998; Pilkonis, in press) and Canada (Dobson & Craig, 1998; Hunsley et al., in press) has increased the awareness among many practitioners regarding the need to offer the most effective treatment for a given patient's problem. Professional practice guidelines are increasingly being discussed and developed. For example, the Canadian Psychiatric Association has recently published guidelines for treatment of schizophrenia that includes social skills training (Bassett et al., 1998). Other guidelines call for routine inclusion of exposure and response prevention for obsessive compulsive disorder (March, et al., 1997) and cognitive therapy for depression (Munoz et al., 1994). Mental health professionals in the fields of psychiatry and psychology are aware of the development of practice guidelines and the need to provide or obtain these treatments for their patients.[1]

Our sense is that the need and demand for empirically supported treatments greatly outweigh the availability.

Another force that is encouraging the development of empirically supported treatments and evidence-based practices are the third-party payers of those treatments. Regional health authorities are calling for measurement of outcomes to demonstrate the effectiveness of treatments (Read & Gehrs, 1997). These outcomes often are related to patient satisfaction and cost-effectiveness, with the goal of reducing costs to the health care system. Finally, it is our impression that the public at large is increasingly sophisticated in its knowledge about effective therapies, and often asks for these treatments by name.

The above factors create a very receptive climate for the services of psychologists trained to provide empirically supported treatments. A number of problems originate, however, because our sense is that the need and demand for these treatments greatly outweigh the availability. Some of the problems regarding public access to ESTs include:

1. **Lack of control over the provision of ESTs.** We have encountered therapists trained in numerous fields who state that they do "cognitive therapy". Because of the notion that "changing thoughts creates behaviour change and increases positive feelings" is a simple one, untrained therapists may avail themselves of the notion that they are qualified to provide these treatments, especially after they have attended a workshop or two. No systematic educational experience or supervision has occurred. A recent article in *The Behavior Therapist* asks the question "What is *not* cognitive-behavioral psychotherapy?" (Smith, 1999) Loosely defined, almost any intervention can be viewed as cognitive-behaviour therapy, which dilutes the treatment to an almost useless form. To define cognitive therapy(or any other therapy) so loosely is a disservice to our patients.
2. **Lack of appropriate training programs.** Many professionals are genuinely interested in learning to provide empirically supported treatments in a competent fashion, however, do not have the resources or interest to attend a graduate program in psychology or to do a one-year internship (if such upgrading opportunities existed). Licensing programs are beginning to develop in the U.S.,[2] although similar processes have not begun in Canada. Dialogue over the need for these programs would be a first step. Would licensing to provide ESTs be considered a specialty, requiring post-graduate work or could professionals be

trained in specific skills be supervised by doctoral psychologists (e.g. behavioural. technicians)? Considering the numbers of patients who could benefit from treatment, it is likely unrealistic to expect that all services would or could be directly provided by licensed psychologists.

3. **Lack of public awareness.** Some patients have a high level of awareness of empirically supported treatments through their own education or research. The first author (D.D.), for example, has had three patients with obsessive compulsive disorder all separately note an article demonstrating that behaviour therapy can result in neurological changes assessed by MRI scans (Baxter, et al., 1992). The general public, however, still struggles with the distinction between a psychologist and a psychiatrist. Many general practitioners do not have access to the recently published information on ESTs. Most patients begin the process of seeking help through their family physician. One step would be to begin providing information to GPs. As noted by the Section 26 Task Force (Hunsley, et al., in press) CPA, through its Clinical Section, could also serve a very important advocacy function.
4. **Lack of publicly funded resources for the provision of treatments.** To some degree, increased awareness through treatment guidelines has created more demand than can be met at present. It remains true that most patients have greater access to treatments that do not have empirical support. The most common example is that patients access supportive treatments through general practitioners, counselling centers or mental health centers that may be somewhat helpful but have been demonstrated in many cases to be of lesser effectiveness. Support groups are commonly free and easily available. These supports are often very useful, what should they be considered treatment? Can a health care system that is attempting to be efficient and accountable continue to provide less effective therapies and not provide those that have demonstrated effectiveness? We are of the opinion that ESTs provide a basis for arguing for public funding, through direct provincial fee-for-service of those practitioners who provide these services to appropriate clinical problems.

What are some solutions?

- Psychology should present a unified front through the adoption of the need for empirical support in training, research and service delivery;
- Evidence-based practice guidelines should continue to be developed and implemented;
- Alternative methods of training and credentialing need to be developed;
- Education for individuals in the "front lines" of clinical care with patients should be provided;
- Public education about evidence-based practice in psychology need to be conducted at a broad level;
- There should be advocacy and lobbying for increased funding for services that are evidence based. Although we recognize that the corollary of this position is controversial—that there should not be advocacy or lobbying for treatments without efficacy or efficiency data—we argue that psychology cannot continue to accept the null hypothesis that all therapies work and that "all should have prizes," when the data simply does not support that perspective.
- Perhaps most importantly, we need to stop being modest. The field of psychology has developed and tested the effectiveness of numerous treatments. We know that we have treatments that work. Some are more effective than the best that biological psychiatry has to offer. We need to determine ways in which to educate our patients, the general public, other professionals, and funding sources.

Psychology should present a unified front through the adoption of the need for empirical support in training, research, and service delivery.

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Footnotes

[1] The authors acknowledge their primary affiliation with cognitive and cognitive-behavioural therapies. We have tried to make our arguments general here, even though our examples primarily come from the perspective of our primary affiliation.

[2] Training and credentialing programs are offered for Barlow's Panic Control Therapy through the Center for Stress and Anxiety, Boston University and Beck's Cognitive Therapy through The Beck Institute in Bala Cynwyd, Pennsylvania. A certification program in Cognitive Therapy (the Academy of Cognitive Therapy) is in development and will begin to offer credentialing, likely later in 1999.

Upcoming Conferences of Interest

June 13–18, 1999

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Fax (514) 343-2452
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http://www.ialmh.org

July 12–14, 1999

20th International Conference of the Stress and Anxiety Research Society (STAR)

Cracow, Poland

Contact: Tytus Sosnowski, Faculty of Psychology
University of Warsaw
ul. Stawki 5/7, 00-183
Warsaw, Poland
Telephone: 48 22 831 11 65
Fax: 48 22 635 79 91
star99@sci.psych.uw.edu.pl
http://www.psych.uw.edu.pl/star99/

July 29–31, 1999

International Conference on Reconstructing Health Psychology: Critical and Qualitative Approaches

St. John's, NFLD

Contact: health99@morgan.ucs.mun.ca
http://www.med.mun.ca/health99

August 14-18, 1999

Annual Meeting of the American Psychological Association

San Francisco, California

Contact: APA Convention Office
750 First Street N.E.
Washington, DC
200002-4242 USA / (202) 336-6020

The Wechsler Adult Intelligence Scale—Third Edition: The Canadian Standardization Study

Donald H. Saklofske
University of Saskatchewan

Denise K. Hildebrand
The Psychological Corporation

Psychologists rely upon norm-referenced standardized tests for diagnosis and intervention planning. Traditionally, Canadian practitioners have used tests developed in the USA which, in most cases, does not present us with any major difficulties, except when assessing some areas of school-based achievement. Potentially more problematic for Canadian psychologists is the use of standard test scores derived from USA based normative data when the task is to determine the relative performance of their clients (Beal, 1996; Saklofske, 1996).

Recent findings suggest that Canadian children perform differently than their American counterparts on standardized tests of general mental ability. While there are essentially no meaningful score differences between the countries on tests that measure very specific or narrow cognitive abilities (e.g, Draw-A-Person, Matrix Analogies Test; see Saklofske, Yackulic, Murray, & Naglieri, 1992), a different finding emerges for more complex measures of intelligence. The Canadian standardization study of the Wechsler Intelligence Scale for Children – Third Edition (WISC-III; Wechsler, 1991) produced results which indicated that Canadian children score, on average, 3 to 4 Full Scale IQ points higher than American children. These results call into question the accuracy of American normative information on tests which have widespread use in Canada (e.g., Wechsler scales). The Canadian norms for the WISC-III were consequently generated in order to address this validity issue (Wechsler, 1996). Thus, it appears that new intelligence tests yield different scores when compared with earlier versions, due to improved psychometric qualities and the Flynn Effect (Flynn, 1987), but that these differences vary between Canada and the USA.

The finding that Canadian children earned higher scores than their American peers on the WISC-III gives rise to the question, "Do Canadian adults earn higher scores than their American counterparts on the adult version of the Wechsler scales?" For this reason, the present study was initiated in Canada at the time that the Wechsler Adult Intelligence Scale—Third Edition (Wechsler, 1997) was being standardized in the USA. (see Saklofske, 1998, for a brief description of the WAIS-III). The principal project directors are Dr. Denise Hildebrand, now with The Psychological Corporation in San Antonio and Dr. Don Saklofske, University of Saskatchewan. Dr. Richard Gorsuch has managed most of the data analysis on this project.

Similar to the Canadian WISC-III findings, preliminary results indicate that Canadian adolescents and adults score higher than their American counterparts on all WAIS-III IQ scores and Index scores.

Data were collected on 740 adolescents and adults from across Canada using the WAIS-III Standardization Edition. The Canadian sample was based upon the 1991 Canadian Census data and was stratified according to the following demographic variables: age (ages 17 to 89 years), sex, education level (ranging from incomplete high school education to university degree), ethnicity (British, French/European, other single origins, multiple origins), and region (Western provinces, Ontario, English-speaking sites in Quebec, and Eastern provinces). Overall, the data gathered during this two year study approximated the Canadian population's demographics; how-

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ever, the lowest and highest age ranges were under-sampled as were those adults representing the lower education categories (e.g., less than grade 9). Given the small number of subjects in the upper age ranges, data were collapsed for the subjects above 70 years of age.

Test items were re-scored according to the item content of the published version of the WAIS-III (1997). Raw scores were converted to subtest scaled scores and Index and IQ scores based upon the American normative information. The sample was then weighted according to the target Canadian demographic stratification variables. Means and standard deviations were computed for all scaled and standard scores. A factor analysis was also completed to determine if the factor structure of the WAIS-III was upheld using Canadian data.

Similar to the Canadian WISC-III findings, the preliminary results of the present study indicate that Canadian adolescents and adults score higher than their American counterparts on all WAIS-III IQ scores and most Index scores. These differences were most salient on the Verbal scale, especially for the younger age groups. Similar age trends in performance were noted for the Canadian sample and American normative group; for example, performance on the Processing Speed Index subtests followed a linear decline across age. Adults in the highest age groups performed more slowly on motor tasks than adults in the younger age groups. The factor analysis results support the four factor structure found in the American normative group. Currently underway is an item analysis and qualitative review of those subtests most likely to show individual item response variability between Canadian and American samples.

SUMMARY

The major determination to be made at this point is whether these data are sufficiently comprehensive to permit the generation of sound Canadian norms for the WAIS-III. The current data analyses support the psychometric integrity of this intelligence test (e.g. reliability and validity). As well, we are quite confident about the Canadian-American differences outlined above. The decisions to collect more data for specific age groups, and to generate norms using either the current or an expanded data set, will be made in the very near future.

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Upcoming Conferences of Interest

August 25–29, 1999

5th European Conference on Psychological Assessment

Patras, Greece

Contact: Demetrios Alexopoulos
Section of Psychology
University of Patras, Greece
Fax: 30 61 997740 or
30 61 997772
dalexopl@upatras.gr

Psychological Assessment and Treatment of Motor Vehicle Accident Victims

William J. Koch & Regan Shercliffe
Vancouver Hospital & Health Sciences Centre and Simon Fraser University

Motor vehicle accidents (MVAs) are frequent stressors in modern society, with up to 6 million MVAs occurring in the United States each year. Lifetime prevalence for exposure to this type of stressor is 23 percent, and between 11 and 30 percent of these victims will develop some substantial psychological disturbance. Other psychological conditions that occur at high frequencies following MVAs are "accident phobia," depression, and somatoform pain disorder. Less common, but still notable conditions that may arise from MVAs include panic disorder, body dysmorphic disorder, obsessive-compulsive disorder, and generalized anxiety disorder.

Assessment

Context effects are particularly important in the assessment and treatment of MVA victims. Interestingly, the amount of damage to vehicles is not a good predictor of later psychological disturbance, and the relationship of physical injury severity to psychological disturbance (e.g., PTSD) has been the subject of inconsistent findings. There is some evidence that residual disabilities, pain, or disfigurement predict PTSD status, and pain problems in general appear to interfere with effective treatment of PTSD. Other stressors occurring subsequent to the MVA have been shown to increase the probability of PTSD and interfere with recovery. Thus, a comprehensive assessment of an MVA victim will always include some assessment of pain status, extent of pain-related disability, and other life stressors.

MVA-related injuries are handled differently across legal jurisdictions. In tort litigation jurisdictions (where victims must sue to obtain compensation), psychologists may fulfil two different roles. The treating clinician role includes an ethical obligation to advocate for the client's well being. This role is different from that of a psycho-legal assessor whose job is to evaluate the veracity and severity of the client's psychological condition, as well as to offer an opinion with respect to the relation of that condition to the subject MVA and the extent of functional disability caused by the condition. Psychologists all too often get these roles confused. As should be obvious, one can not objectively evaluate a client and simultaneously be an enthusiastic advocate for them in a civil court action because of the potential for bias. Clients are frequently unaware of these differences and must be formally warned about the limitations of the psychologist's role as well as any limitations on confidentiality.

Context effects are particularly important in the assessment and treatment of MVA victims.

Litigation Stress is a concept of some recent interest. We have attempted to measure the extent to which MVA victims suffer stressors specific to their litigation/rehabilitation, and have polled both forensic psychologists and lawyers about their beliefs in this construct. Issues that are perceived by both these groups of professionals as contributing greatly to litigation stress are uncertainty about recovery, financial hardship, role changes, and adjuster-plaintiff conflict. Interestingly, both groups of professionals noted at a high frequency that preexisting personality vulnerabilities were also a source of litigation stress (Koch et al., submitted). While litigation stress may be a construct familiar to those who work with personal injury clients, our initial attempts to measure this construct and predict patient response to cognitive-behavioural therapy have been less successful. Only a few items of our litigation stress scale appear to predict treatment outcome in our current treatment outcome study (Taylor, Fedoroff, & Koch, submitted).

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However, litigation stress remains a potentially fruitful research area, as will research concerning the role of resource loss in maintaining psychological distress.

Assessment of MVA victims requires that psychologists pay careful attention to delineating the boundaries of the traumatic event, which may encompass far more than the moment of impact, and may include subsequent treatment by health care professionals. Also required in this are structured diagnostic interviews because they help clinicians to adhere to diagnostic criteria (c.f., Garb, 1998), and may reduce common assessment errors, such as confirmatory bias (e.g., seeking information only to confirm, but not disconfirm, a PTSD diagnosis). Similarly, psychologists in this area must be aware of both population base rates (e.g., MVA-PTSD of approximately 11 percent from epidemiological surveys), versus setting-specific base rates (e.g., 15 percent in a chronic pain centre, 39 % to 50% in a PTSD treatment centre).

The most effective treatment components for MVA-PTSD at this time appear to be exposure-based interventions, but both cognitive restructuring and relaxation interventions may be helpful treatment adjuncts.

Behavioural observation and physiological assessment of MVA victims is helpful because MVA-PTSD subjects frequently have elevated heart rate to reminders of the trauma, specific phobics frequently have elevated heart rate during exposure to the phobic stimulus or activity, and habituation-associated decreases in heart rate are a useful learning experience for such patients during treatment.

While many MVA-PTSD litigants may exaggerate their symptoms, estimates by even the most skeptical authorities in this area suggest that only 20 to 30 percent of personal injury litigants exaggerate their symptoms. Our own data using Ben-Porath's new infrequency psychopathology scale suggest that the average MVA litigant presenting with psychological difficulties is no more likely than a similarly-distressed psychiatric in-patient without litigation to exaggerate symptoms. Nonetheless, when conducting a psycho-legal assessment, it is of critical importance to assess for symptom exaggeration (Rogers, 1997).

Treatment

Treatment of MVA-PTSD is in its infancy. Two controlled trials in different centres are near completion (Taylor, Fedoroff, & Koch at LTBC; Blanchard & Hickling, at SUNY-Albany), while one controlled trial was recently completed as a dissertation (Fecteau, 1999). These studies will show variable success and it appears that MVA-PTSD may be more difficult to treat than PTSD related to other stressors (e.g., sexual assault). The most potent aspects of treatment for MVA-PTSD appear to be imaginal and *in vivo* exposure. Applied relaxation training and cognitive restructuring of danger expectancies may be helpful treatment adjuncts because MVA-PTSD clients are often hyperaroused, have soft tissue pain complaints, and appear to over-predict danger from vehicular travel. However, these components have not been evaluated empirically as to their contributions to successful treatment.

There are a number of pitfalls in imaginal exposure therapy for MVA-PTSD. First, if the script is less than 5 or 10 minutes long, patients must be encouraged to repeat reading/saying the script several times in order for their anxious arousal to habituate. Second, many patients find themselves reacting with anger to such memories. This is a negative prognostic sign. MVA-PTSD clients whose primary affect is anger may require specific treatment for problematic anger. Third, therapists must disrupt clients' attempts to engage in covert avoidance during imaginal exposure (e.g., superficial descriptions of the accident scene rather than their emotional response or fearful predictions).

With respect to *in vivo* exposure, it is helpful for the therapist to accompany the client to get such treatment off to a good start. In particular, the therapist must help the patient identify the "false alarms" he/she experiences during car travel, common triggers for those alarms (e.g., screeching tires, large vehicles), "safety compulsions" (e.g., grasping door handles tightly, back seat driving), and to establish appropriate anxiety self-monitoring so that the client can detect decreases in his/her anxiety during exposure travel. As with imaginal exposure, it is easy for clients to become sensitized during car travel because of the short duration of some fearful

exposures. Often triggers for fear will be passed in a matter of seconds (e.g., intersections, on-ramps to freeways), so that we recommend "looping" exposures where clients are instructed to drive through specific intersections or sections of roadway repeatedly until they notice a decline in their fear.

When clients respond poorly to *in vivo* exposure therapy, we suggest looking for the following complications; short exposure durations (e.g., less than 30 minutes), angry affect during exposure, escape behaviour or unrestrained safety compulsions, or false alarms near the end of *in vivo* exposure sessions.

Safety compulsions that functionally resemble the compulsions in obsessive-compulsive disorder may interfere with habituation during driving exposures. It is helpful to encourage the client to suppress those compulsions (e.g., grasping door handles, back seat driving).

As in any therapy, it is important to have clients monitor their progress as this may serve as both motivation and reward when they see improvements. Self-monitoring of anxiety levels during imaginal or *in vivo* exposure is helpful. For clients who are very driving avoidant, I (wjk) often have them chart their progress using a local road map and a highlighter.

It is helpful to think of driving exposure assignments as behavioural experiments in which the client evaluates their predictions of danger (e.g., frequency of MVAs at a given intersection, frequency of bad driving habits in other drivers) by making specific, concrete predictions and gathering data to evaluate these predictions. This has given rise to our "Starbucks assignment," in which clients are asked to sit in a Starbucks coffee shop at an intersection and simultaneously count passing cars, instances of good or bad driving behaviour, and actual accidents. Psychologists in less caffeine-dependent settings than Vancouver will have to find their own good places to observe traffic.

We believe that most MVA-PTSD and accident phobic clients show the following cognitive manifestations of fear: over-prediction of danger and of their own fear during travel, selective attention to motor vehicle travel threat information, under-prediction of their own as well as other people's driving competence, catastrophic predictions of negative outcomes from potential future accidents, as well as under-prediction of their own coping abilities. We routinely try to challenge these beliefs either through behavioural experiments or Socratic discussion.

Summary

The psychological consequences of MVAs are complex and psychologists who work with such MVA victims may have diverse assessment and treatment roles. The litigation context of such injuries creates a number of complications of which psychologists must be aware. Assessment must include structured diagnostic interviewing, behavioural observation, and frequently measures of malingering. The most effective treatment components for MVA-PTSD at this time appear to be exposure-based interventions, but both cognitive restructuring and relaxation interventions may be helpful treatment adjuncts.

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Conflict in the context of practicum training in clinical psychology

Candace Konnert
University of Calgary

An integral part of the scientist-practitioner model of training in clinical psychology is the practicum experience. Often, clinical training programmes place more emphasis on research and devote less attention to practicum training. As a result, many critical issues related to practicum training are rarely dealt with at a programmatic level, including the identification, management, and resolution of conflict. Conflict can be due to both systemic and individual factors, each of which are discussed in turn, followed by recommendations for minimizing conflict.

Systemic Sources of Conflict in Practicum Training

At the systemic level, students often report feeling "caught between two worlds," the academic and applied. Ideally, the practicum experience should complement course work and provide students with the opportunity to get hands-on experience. However, students often report a lack of integration, and they may be exposed to disparate views and practices across settings. For example, few training programmes emphasize projective assessment, yet these techniques are often used in clinical settings (Watkins, Campbell, Nieberding, & Hallmark, 1995).

Compounding this problem are the expectations of supervisors in each setting. Research supervisors often cannot understand why students are not more active researchers; practicum supervisors tend to emphasize the expedient completion of case notes and psychological reports. Given the demand characteristics of clinical work, and the tendency for many students to prefer clinical activities over research, it is often research that suffers.

Furthermore, clinical psychologists are debating the future of their discipline and how best to prepare trainees beyond their traditional roles as service providers in the areas of assessment and intervention, for example into areas such as program evaluation and health care administration (Fox, 1994). Academic faculty, clinical supervisors, and students may hold different views about how training is conceptualized and implemented, and these diverging views may lead to conflict.

Another factor that may precipitate conflict relates to the maintenance of quality control in community-based practicum settings. A variety of questions related to quality control need to be addressed. First, what are the necessary qualifications for practicum supervisors in terms of academic preparation and experience? Second, what sanctions, if any, can a training programme realistically impose on a supervisor who is performing poorly and what is the best method of giving negative feedback? This becomes particularly problematic when the information is obtained through anonymous evaluations provided by students. Third, what are the rights and responsibilities of practicum supervisors and how much power should they exert over training issues? For example, how much input should they have into the training programme itself (e.g., philosophy of training, theoretical orientation, policies and procedures)? Some would suggest that a high level of involvement is appropriate given that practicum supervisors are major stakeholders in the training enterprise, while others would resist this. Fourth, how can using students as cheap labour be avoided, particularly in a time when mental health resources are increasingly scarce? This is less of an issue in settings where training is a mandate; however, in the future, it is likely that clinicians in private settings will be called upon to provide supervision and it is here that quality control will be more difficult to monitor.

Individual Sources of Conflict in Practicum Training

In general, conflict tends to arise around three types of situations: conflicts due to differences in theoretical orientation and beliefs about what interventions are effective; conflicts related to the supervisor's style of supervision (e.g., too little supervision, lack of positive reinforcement); personality differences within

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the supervisory relationship; and varying perceptions about the relationship (e.g., a collegial versus a more traditional student-teacher relationship). Conflicts arising from personality differences are least likely to be resolved, while conflicts related to supervisory style are often resolved to the satisfaction of both supervisee and supervisor. On a broader level, the following additional factors increase the probability that conflict will occur.

Definitional Problems

Although dissatisfaction with supervision is a common experience (Marwit, 1983), only a few studies have investigated those variables that contribute to positive and negative supervisory experiences. In general, high-quality supervision is related to the perceived expertise and trustworthiness of the supervisor, an emphasis on personal growth rather than the teaching of technical skills, and expectations and feedback that are communicated in a clear and concise manner (Allen, Szollos, & Williams, 1986). In addition, positive supervisory experiences occur when the supervisor and supervisee share common behavioral styles and theoretical orientations, and when the supervisor perceives the trainee to be interested in feedback and suggestions regarding professional development (Kennard, Stewart, & Gluck, 1987).

Identifying potential sources of conflict and establishing guidelines to avoid conflict are the first steps in creating a training environment in which all partners can work effectively and harmoniously.

In contrast, poor supervisors are perceived as unsupportive and aloof, resulting in students feeling threatened and vulnerable. In response to this, students may begin to engage in anxiety-avoidant maneuvers such as censoring what is said to the supervisor or engaging in various forms of resistance (Hutt, Scott, & King, 1983). A particularly difficult situation arises when a supervisor attributes work deficiencies to defects in a student's personality (Rosenblatt & Mayer, 1975). If the student challenges the supervisor's attribution, this may be viewed as resistance. Allen, Szollos, and Williams (1986) report that authoritarian treatment and sexist behavior are particularly detrimental to the supervisory relationship.

Lack of Education and Training

Although supervision is a common activity among clinical psychologists it is sadly neglected in terms of education and training (Leddick & Bernard, 1980). Less than 10 to 15% of supervisors have attended formal courses in supervision, and readings about supervision are rarely included in curricula at either the predoctoral or postdoctoral level (Hess & Hess, 1983; McColley & Baker, 1982). Professional and accreditation organizations have not adopted standard criteria for demonstrating expertise in supervision. As a result there is no consensus regarding the requisite skills necessary to assume supervisory responsibilities, and most supervisors begin the process blindly.

Ambiguous or Unmet Expectations

Research clearly indicates that trainees come to the supervisory relationship with a set of expectations about what will occur. These expectations vary somewhat as a function of training level: for example, novice students expect a highly structured experience with more negative feedback, while advanced trainees are less concerned with didactic instruction and making mistakes. Nevertheless there are common and predictable student expectations (see Leddick & Dye, 1987 for review). Conflict occurs when trainees are unsure of their supervisors' expectations, when there is a mismatch between students' and supervisors' expectations, and when students receive conflicting messages about the expectations for supervision. Each of these are associated with greater work-related anxiety, general work dissatisfaction, and dissatisfaction with supervision (Olk & Friedlander, 1992).

Issues of Confidentiality

Although the boundaries of confidentiality are clearly specified in the therapeutic relationship, this is not the case in the supervisory relationship. And unlike the therapeutic relationship, practicum supervisors, academic faculty, and trainees are likely (and often encouraged) to socialize. Supervision carries with it a degree of intimacy in which the student is not only being evaluated but may self-disclose important personal information.

Confidentiality extends not only to personal information but also to evaluation procedures and documents. Experience suggests that much of the information disclosed in the context of supervisory relationship is not as private and confidential as one would hope, in spite of the fact that the Canadian Psychological Association Code of Ethics recognizes the rights of supervisees to reasonable personal privacy. McCarthy, Kulakowski, & Kenfield (1994) surveyed 229 supervisees and reported that 20% were not sure whether their supervisors maintained confidentiality, and 3% knew they did not.

Lack of Clarity Around Issues Related to Due Process

Students have rights and privileges which include the right to procedural and substantive due process in all aspects of academic training, including the practicum experience. Procedures for evaluation and remediation, as well as conditions for termination must be clearly specified at the onset of training. Feedback should be provided to the student at regular intervals and be continuous throughout training. Moreover, students should be given the opportunity to evaluate their practicum settings and supervisors, not as token gestures but in a meaningful way that has consequences for those who are found to be less than adequate. Research indicates that supervisors never (27%) or rarely (48%) solicit supervisee feedback (McCarthy, Kulakowski, & Kenfield, 1994).

Student deficiencies can be broadly grouped into academic and nonacademic categories, the latter of which includes personal factors such as lack of self-confidence or initiative, negativity, inflexibility, immaturity, or psychopathology. Policies and procedures around academic criteria are generally easier to establish and enforce because assessment is more objective. Those involved in training are often reluctant to document and take action to address students' personal deficiencies. Nevertheless, the absence of clear policies and criteria around these issues leads to conflict. Evaluations, sanctions, and the worst case scenario of termination, are perceived by students as arbitrary, capricious, and prejudicial.

Recommendations for Minimizing Conflict

Conflict can be minimized by establishing guidelines, many of which follow from the preceding discussion. First, a close liaison should be maintained between faculty in the training programme and clinical supervisors in the community, as this increases the probability that conflicts will be identified and resolved early on. Critical to this partnership is the appointment of a Practicum Coordinator in the training programme, whose responsibilities include acting as a liaison to community agencies, disseminating information to students about practicum placements, monitoring student progress, and mediating conflict situations.

Second, the expectations and goals of practicum training should be clearly defined, including the parameters of confidentiality, the rights and responsibilities of supervisors and supervisees, and information about evaluation, remediation, and appeal procedures. Care should be taken to ensure that those responsible for evaluation are separate from those involved in hearing and adjudicating appeals. Given that students and clinical supervisors vary in terms of their expectations and goals for training, these should be reviewed and negotiated at the onset of each new placement.

Third, many of the problems and pitfalls associated with practicum training could be avoided by providing students with some preparation for practicum training. The stresses associated with beginning a practicum are predictable. Initially, many trainees report feeling like "impostors," lacking the requisite skills and knowledge to adequately help clients. In addition, there are stages of development in learning to be a clinician. As the trainee gains experience and moves through the developmental sequence, the supervisor-supervisee relationship changes as well (see Bernard & Goodyear, 1992, for a review of developmental models). These common experiences and developmental stages could be discussed in a forum which brings together students at various levels of training, with the idea that senior students would act as mentors assisting their junior colleagues in negotiating the hazards of training. Included should be research-based discussions of the supervisory process, such that the next generation of supervisors are better prepared to assume supervisory roles. Also, beginning students would be well-advised to investigate placements before they commence training, including service requirements, goals and expectations of the facility, and the predomi-

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nant theoretical orientations and styles of supervisors. This reduces the possibility of a poor match between what settings have to offer and students' needs.

In summary, the practicum experience has the potential to create conflict; however, the responsibility for addressing the conflict is often diffuse and unrecognized. Identifying potential sources of conflict and establishing guidelines to avoid conflict are the first steps in creating a training environment in which all partners can work effectively and harmoniously.

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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. The thoughts and views of contributors belong strictly to the author(s), and do not necessarily reflect the position of either the Section, the Canadian Psychological Association, or 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 twice a year. Submission deadlines are as follows: September 15 (October issue), and March 15 (April issue).

Editor
Sharon L. Cairns, Ph.D.
E-mail: scairns@ucalgary.ca

Assistant Editor
E. A. Meyen Hertzsprung
E-mail: eyhertzs@ucalgary.ca

Layout and Design
Evan Hertzsprung
E-mail: hertzspe@cadvision.com

Highlighting our Fellows

Michael C. King

Dr. Michael King has a long and distinguished record of clinical achievement and service to the profession of Clinical Psychology. In 1996, in recognition of his strong organizational and leadership skills, he was appointed as the Manager of Psychology Clinical Support Services (Adult) in the Acute Care Sector of the Calgary Regional Health Authority (CRHA). In addition to this administrative position, he is a clinical neuropsychologist with the CRHA. He is Adjunct Professor, Programme in Clinical Psychology, and Adjunct Associate Professor, Medical Bioethics, Faculty of Medicine at the University of Calgary. As evidence of his clinical expertise, he achieved diplomas in Clinical Psychology and Clinical Neuropsychology from the American Board of Professional Psychology.

Michael is an active member of many professional organizations, including the College of Alberta Psychologists (CAP), the Psychologists Association of Alberta (PAA), the Canadian Psychological Association (Fellow), and the Canadian Register of Health Service Providers in Psychology. He has held multiple executive positions within each of these organizations, and has made major contributions. Among his principal contributions to psychology, Michael was actively involved in the drafting of the Psychology Profession Act and in helping to move the Act to passage. He was also centrally involved in the formation and initial operation of the Canadian Register of Health Service providers in Psychology. In partnership with one of our other fellows, Dr. Keith Dobson, Michael planned and guided the Mississauga Conference on Professional Psychology. This conference had a major impact on the discipline of Clinical Psychology in Canada, and is regarded as one of the pivotal events in the development of the profession. Currently, Michael is a Site Visitor for the Canadian and American Psychological Association accreditation committees. In May, he will take office as President-Elect of the College of Alberta Psychologists. In the community, he is a member of the Board of Directors of the Provincial Health Ethics Network, and of the Alzheimer's Society, Calgary Chapter.

Overall, Michael has established himself as a key player and influential force in professional psychology, both at the provincial and national levels. His commitment to excellence and his dedication to the discipline make him an ideal choice for Fellow status within the Clinical Section.

Allan R. Wilson (photograph not available)

Allan is a clinical psychologist who is well-known in both eastern and western Canada. He received his B.A. from the University of Waterloo, then completed a master's degree in clinical-community psychology at Acadia University. For his doctoral training, Allan attended the University of Saskatchewan. Allan then traveled south for his internship at the Baylor College of Medicine in Houston.

Back in Saskatoon, Allan worked for five years in the Student Counselling Service of the University of Saskatchewan, and then moved on to the Saskatoon City Hospital. At both sites, he was able to hone his interest in clinical training and supervision, and helped to develop psychology services generally in the Saskatoon area. In 1989-90, Allan was the vice-president of the Saskatchewan Psychological Association.

The east coast beckoned, however, and in 1990 Allan moved to Nova Scotia to take up a position at the Camp Hill Medical Centre. Allan helped to develop their accredited internship program before moving over to the Nova Scotia Hospital in Dartmouth, where he is presently the psychology professional practice leader. He also has an appointment as assistant professor in the Department of Psychology at Dalhousie University, and is their coordinator of clinical placements. In 1993-94, Allan served a term as president of the Association of Psychologists of Nova Scotia.

Allan has also been very active in promoting the discipline at a national level. In 1995-96, Allan served as the chair of the CPA Section of Clinical Psychology. He has also been a member of the executive committee of the Canadian Register of Health Service Providers in Psychology.

FELLOWS of the Clinical Section of CPA

Harvey Brooker
John Conway
Ken Craig
Keith Dobson
Anna Beth Doyle
John Goodman
David S. Hart
Charles Hayes
Michael King
Andree Liddell
Sam Mikail
Jean Pettifor
Susan Pisterman
Pierre Ritchie
Robert Robinson
John Service
Richard Steffy
Janet Stoppard
Allan Wilson

Members of the Clinical Section of CPA

Listing of those who paid their section dues for 1999

Newfoundland
Berman, Tamara

Prince Edward Island
Smith, Philip Bruce

Nova Scotia
Boutilier, Joan
Braha, Dr. Richard
Byrne, Dr. Joseph M.
Corkum, Valerie Lynn
Genest, Dr. G.E. Myles
Hartley, Susan
Hendrick, Dr. Jennifer
Howes, Dr. Janice
Ludman, Dr. Wendy Lynne
Matwychuk, Dr. Alana K.
Sperry, John
Stewart, Dr. Sharry
Vallis, Michael
Wetmore, Ann Anita
Wilson, Dr. Allan R.
Zehr, Richard

New Brunswick
Byers, Dr. Elaine Sandra
Charest, Guylaine
D'Amours, Pierrette
Landry, Nicole
McNeil, Kevin
Mureika, Juanita M.
Roxborough, Charlene
Stoppard, Dr. Janet M.
Theriault, Vicky
Theriault-Whalen, Claudia
Wright, Dr. Nicola

Province de Que'bec
Aboussafy, David
Belanger, Eliane
Bergey, Annie
Blais, Marie Claude
Bortolussi, Lina S.
Boucher, Nancy
Bougard, Lise
Carrier, Sylvie
Cosgrove, Renee-Charlotte
Costil Tiziana
Debigare, Jacques
Dobkin, Dr. Patricia
Doyle, Dr. Anna-Beth
Ducharme, Jennifer
Dugas, Michel
Gaudreau-Asselin, Nicole
Gauthier, Dr. Janel
Giannopoulos, Constantina
Godbout, Claudine
Gosselin, Dr. John J.
Hopps, Sandra
Karavasilis, Leigh
Kearney, Helene
Kiely, Dr. Margaret C.
Kokin, Morris
Larouche, Dr. Louise
Lautman, Claude J.
Lemieux, Dr. Marc
McGillivray, William
Mercier, Katia
Morel, M. Gilles
Morin, Charles
O'Connor, Christine
Prostak, Michelle
Renaud, Andre
Rodinos, Evelyn
Romano, Elisa
Rothenberg, Pearl C.
Schachter, Steven
Villemure, M. Jocelyn
Voss, Kirsten

Ontario
Ashbourne, Daniel T.
Bax, Karen Ann
Bienert, Dr. Helen
Boulais, Dr. Gilles
Bourdeau, Patricia
Breitman, Dr. Kenneth E.
Brooker, Dr. Harvey
Camargo, Dr. Robert J.
Church, Dr. Michael
Colletta, Salvatore
Crawford, N. Lynn
Cupchik, Dr. Will
Dhawan, Sonia
Douglas, Jonathan
Edwards, Melanie
Erickson, David, H.
Fleming, Dr. Stephen J.
Gaudreau, Jennifer G.
Gerber, Dr. Marilen J.
Gick, Mary
Gilmour-Barrett, Dr. Karen
Girash, Martin
Goldstein, Cathy
Goodman, Dr. John T.
Gouws, Jacques
Govoni, Richard
Greenham, Stephanie
Groves, Dr. John R.
Hall, Elizabeth
Henderson, Katherine
Hunjan, Sandeep
Hunsley, John Desmond
Hyde, Dr. Susan
Johnson-McLean, Linda
Johnston, Dr. Linda
Josefowitz, Dr. Nina
Kahgee, Sylvia
Kleinplatz, Peggy, J.
Kumchy, Dr. C.I. Gayle
Lamarche, Corole
Lane, Christopher
Langdon, Leslie
LeBlanc, Jean-Luc
Lee, Alison Claire
Lee, Catherine
Lefebyre, Monique
Lesonsky, Elaine
Levene, Marlene
Levesque, Dr. Bertrand
Liddell, Marie Andree
Mamuza, Joelle
Manion, Dr. Ian G.
McKenzie, Sandra
McKinlay, B. Duncan
McKinnon, Cathy J.
McLeod, Kristen
Medlock, Dr. L.
Meyers, Susan
Mikail, Samuel
Miller, Dr. Harold, R.
Miller, Larry S.
Muirhead, Dr. James
Mungai, Dr. Wangui
O'Grady, Dr. Paul
Partridge, Dr. Katherine
Pisterman, Susan
Purdon, Christine L.
Raghunan, B.Roy
Rayko, Donald
Ridgley, Dr. Jeanne Newton
Ritchie, Dr. Pierre L.J.
Roldych, Dr. Gerlinde M.
Rothstein, Dr. Marsha
Roy-Cyr, Dr. Yolande
Rucklidge, Julia
Rumstein, Orly
Savoie, Jessica
Schmidt, Dr. Nancy
Seagram, Belinda
Searles, Hilary
Shaffer, Dr. Cynthia
Sicoli, Lisa
Siddiqui, Dr. Masud H.
Sinclair, Dr. Carole, M.
Snow, Dr. W. Gary
Steffy, Dr. Richard A.
Stein, Dr. Steven J.
Tasca, George
Taylor, Daniel
Thompson, Rita
Toukmanian, Dr. Shake G.
Trembley, Dr. Carole
Valerio, Helen Patricia
Voyer, Marlene
Walker, William
Warnke, Shelley
Watson, Kimberley
Wilson, Keith
Zivian, Ms. Marilyn T.

Manitoba
Barbopoulos, Anastasia
Berger, Naomi
Breed, Marita
Broder, Rebecca
Brolund, Dr. Jay W.
D'Entremont, Dr. Barbara
Enns, Kenneth Loewen
Feldgaier, Dr. Steven
Graff, Lesley
Grayston, Alana
Greenwood, Leanard
Gretz, James
Johnson, Edward
Keith, Lisa
Lambert, Dr. Glenna A.
Martin, Dr. David G.
Martin, Dr. Robert M.
McIlwraith, Robert D.

Moore, W. Allan D.
Newton, Dr. James H.
Osachuk, Timothy
Rowan, Vivienne Carole
Sexton, D. Lorne
Whitney, Dr. Debbie

Saskatchewan
Arnold, W. James
Carroll, Dr. Linda
Chartier, Mr. Brian M.
Elliott, Jason J.C.
Farthing, Dr. Gerald R.
Goff, Laurie
Hadjistavropoulos, Thomas
Hanna, Cindy
Masson, Andre
McMullen, Ms. Linda M.
Miller, Colleen M.
Oke, Carrie
Stockdale Winder, Fern
Von Baeyer, Carl

Alberta
Amundson, Dr. Jon
Banks-Vilegas, Tracy
Bennett, Wayne Llewellyn
Bergen, Anne-Marie
Bickley, Dr. Richard S.G.
Boulter, Pamela
Braun, Colleen
Breault, Lorraine, J.
Brink, Harvey
Cadman, Theodore Phillip
Cairns, Sharon
Carey, Dr. Robert T.
Casey Tait, Donna
Currie, Dr. Shawn
Day, Holly
De Wet, Charles
Dewey, Deborah
Dillon, C. James
Dobson, Deborah J.G.
Dobson, Dr. Keith Stephen
Dozois, David
Egger, Lori
Graham, Susan
Griffiths, Dr. Lyn
Hauck, Joy
Hertzsprung, E. A. Meyen
Hodgins, David Carson
Joyce, Anthony
King, Dr. Michael
Kirchen, Magdalena
Konnert, Dr. Candace
Large, Sandra Faye
Martin, Janis
Mash, Dr. Eric J.
McClung, Eda
Milligan, Maureen
Mishra, Rama
Mothersill, Dr. Kerry J.
Muir, Douglas
Nelson, Calla G.
Nieuwenhuis, James
Pagliaro, Dr. Louis A.
Payne, Larry
Pencer, Alissa H.
Pettifor, Dr. Jean L.
Rach-Longman, Katharina
Robinson, Dr. Robert W.
Schmalz, Barbara
Van Mastrigt, Dr. Robert L.
Walters, Diane
Zendel, Dr. Ivan

British Columbia
Aronchick, Barbara
Bodnarchuk, Mark
Boissevain, Dr. Michael D.
Bowman, Dr. Marilyn L.
Brandimayr, Dawn
Brotto, Lori
Brouillette, Celine
Bruce, Sherri Anne
Carmichael, Dr. John A.
Colby, Mr. Robert L.
Connors, Dr. Angela
Cook, John Roy
Cox, Dr. David Neil
Craig, Dr. Kenneth D.
De Almeida, Elias
Doerksen, Edward
Edgell, Dr. Dorothy
Ehrenberg, Marion
Eveleigh, David
Flynn, Carol Ann
Foreman, Michael E.
Fransblow, Mr. Jerome I.
Hart, Dr. David, S.
Harvey, Natasha
Hewitt, Paul
Howes, D'Anne
Johnston, Dr. Charlotte J.
Kline, Dr. Robert G.
Koch, William
Kort, Beverley
Larre, Lucien
Ley, Dr. Robert G.
Lustig, Dr. Stephen D.
Parker, Sandra
Pelletier, Marie Helene
Ryder, Andrew
Samson, Deborah Christine
Spellacy, Dr. Frank J.
Starzomski, Andrew
Stein, Leonard M.
Steinberg, Dr. Rhona H.
Tiedemann, Georgia L.
Uhlemann, Dr. Max R.
Way, Dr. Gayle M.
Welch, Dr. Steven John
White, Karen
Wilkie, Colleen F.
Yan, Bernice

United Kingdom
Cuthbertson, Mr. Andrew

Clinical section e-mail directory

This edition of the newsletter was to contain an e-mail directory listing addresses submitted to the editor for inclusion. However, due to low response, the e-mail listing will appear in the Fall edition. You are invited to submit your name and address so that more of your colleagues can correspond with you on the internet. Send your e-mail address to: scairns@ucalgary.ca

BROCHURE
The Clinical Psychologist in Canada

This brochure provides information on the nature of Clinical Psychology, the training required to become a Clinical Psychologist, and the types of services and activities Clinical Psychologists provide (e.g., service provision, research, and teaching).

Send Order To:
Dr. Deborah Dewey
Alberta Children's Hospital
Behavioral Research Unit
1820 Richmond Rd. SW
Calgary, ABT2T 5C7

I wish to order _____ brochures @ $0.35 each
Language: English _____ French _____
My cheque for $ _____ is enclosed.
(Make cheque payable to: Clinical Section CPA)

FROM: _____
_____
_____
_____

Call for Nominations

Officers of the Clinical Section

Bringing Clinical Psychology Into the New Millennium

An easy and meaningful way you can show your support for the Clinical Section is to participate in the election process. For 1999–2000, the Section requires nominations for the position of ChairElect (a three-year term, rotating through Chair and Past Chair) and Member-At-Large (a two-year term).

Continuing members of the Executive for 1999–2000 will be Charlotte Johnston (Chair), Lorne Sexton (Past-Chair), and Deborah Dewey (Secretary-Treasurer).

Although there is no requirement for the following, the Section does support equitable geographical representation and gender balance on the executive.

Nominations shall include: (a) a statement from the nominee confirming his/her willingness to stand for office, and (b) a letter of nomination signed by at least two members or Fellows of the Clinical Section.

Deadline for receipt of nominations is May 10, 1999.

Send nominations for the Executive to:

Dr. Charles Morin
École de Psychologie
Université Laval
Pavillon FAS
Québec PQ GIK 7P4

Appel de Candidatures

Membres du bureau de direction—Section clinique

Introduisant la psychologie clinique dans le nouveau millénaire

Votre participation au processus d'élection des membres du bureau de direction est une façon importante de donner votre appui à la Section clinique. Pour l'année 1999–2000, la Section clinique doit combler les postes de président élu et de membre délégué.

Charlotte Johnston (présidente), Lorne Sexton (président sortant) et Deborah Dewey (secrétaire-trésorière) poursuivront leur mandat respectif pour 1999-2000.

Bien qu'il n'existe aucune exigence formelle, la Section clinique privilégie une représentation géographique équitable et une égalité des sexes dans la composition de 1'exécutif

Les candidatures doivent être accompagnées: (a) d'une confirmation de la candidate ou du candidat acceptant de siéger au bureau de direction selon le poste assigné, et (b) d'une lettre d'appui signée par au moins deux membres ou Fellow de la Section clinique.

Date limite de réception des candidatures: le 10 mai 1999.

Faire parvenir les candidatures à l'attention de:

Charles M. Morin, Ph.D.
École de psychologie
Pavillon Félix-Antoine Savard
Université Laval
Québec (Québec)
G1K 7P4

Halifax hosts 60th annual convention

Clinical psychology activities—May 20, 21, 22, 23, 1999

Thursday May 20

Conversation Session	Is Psychology in Trouble? A discussion of a Public Advocacy Campaign *Susan Buffet-Jerrott & Allan* McDonald (8:00–9:00, Mariner 3)
Clinical Symposium	Examination of the Influences of Attachment During Life Transitions *Elaine Scharfe* (8:00–10:00, Mariner 4)
Clinical Posters	9:00–11:00, Port Royal D
Clinical Symposium	Current Issues in Tourette Syndrome *Gary Shady* (11:00–1:00, Mariner 4)
Clinical Section Business Meeting	11:00–12:00 Highland 11
CPA Invited Speaker	Empirically Based Decision Making in Clinical Practice *Larry Beutler* (12:30–2:30, Port Royal C)
Clinical Symposium	Early Identification and Treatment of Autism: From the lab to the Clinic *Isabel Smith* (1:00–3:00, Mariner 4)

Friday May 21

Theory Review	Suicide in the Elderly: Preventing Tragedy in our Seniors *Marnin Heisel* (8:00–8:3 0, Mariner 2)
Conversation Session	Internship Selection and the Computer Matching Process: Issues for Interns and Internship Directors, *David A. Clark* (8:00–9:00, Highland 6)
CPA Clinical Section Invited Speaker	Relapse and Recurrence of Depression and their Prevention. *W. Edward Craighead* (9:00–10:30; Highland 6)
CPA Clinical Section Invited Speaker	Socially Withdrawn and Aggressive Children: A Social Learning Theory Analysis. *Thomas Ollendick* (10:30–12:00, Highland 6)
Theory Review	Misunderstandings and Misrepresentations of Intensive Short-Term Dynamic Psychotherapy *Michelle McCallum* (11:30–12:00, Highland 9)
Clinical Section Invited Symposium	Empirically Supported Therapies in Psychology *Patrick McGrath* (12:00–2:00, Highland 6)
Clinical Section Invited Conversation Session	Empirically Supported Psychological Treatments: Recommendations for Canadian Psychology *Charlotte Johnston* (2:00–3:00, Highland 6)
Clinical Section Reception	3:00–4:00 Highland 6
Conversation Session	Giving Psychology Away: The Dissemination of Psychological Treatments *Randy Patterson & Merv Gilbert* (3:00–4:00, Highland 9)

Saturday May 22

Clinical Section Invited Workshop	Anorexia Nervosa and Bulimia Nervosa: Current Advances in Assessment and Treatment *Josie Geller* (8:00–10:00, Highland 7)
Clinical Section Invited Conversation Session	In Search of an Internship *Allan Wilson* (10:00–11:00, Highland 7)
Conversation Session	Eating Disorders 2000: Research Directions for the new Millenium *Jane Walsh* (10:00–11:00, Highland 8)

Sunday May 23

Post-Convention Workshop	Planning and Marketing a Private Practice in Psychology. *Richard Allon* (8:30–5:00)