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Message from the Chair

Update on Clinical Section activities

Charlotte Johnston

In this, my first column as chair of the clinical section, I'll use the space to bring you up-to-date on various activities of the clinical section and some issues in the funding of psychology research that are of relevance to many clinical psychologists.

First, with special thanks to the efforts of Lorne Sexton, last years clinical section chair, the clinical section had a very successful convention in Halifax. The section sponsored a number of workshops, symposia, and conversation sessions, in addition to the poster sessions. These were all well attended, with lively discussion and question periods. The section capitalized on the fact that the executive of APA Division 12 were in Halifax for their mid-year meeting at the same time as CPA and we sponsored several offerings by top-notch clinicians from this APA group. The clinical section is currently in the midst of planning for next year's convention in Ottawa (June 29 to July 1, 2000), including several workshops and symposia. As always, we encourage submissions and suggestions that will help us plan clinically relevant and interesting offerings.

In addition to the usual business of budgets and awards at the clinical section business meeting in Halifax, the section voted to accept the report of the Task Force on Empirically Supported Treatments, chaired by Dr. John Hunsley, and to work, within practical limits, to implement the recommendations of that report. One way we are working to enact these recommendations is by including workshops and miniworkshops at the annual convention that will provide an opportunity for clinical psychologists and students to learn about empirically supported treatments. In addition, the section is working to develop simple fact sheets describing empirically supported psychological treatments for various health and mental health problems that could be used in public education and advocacy/lobbying efforts.

The Halifax convention also provided the opportunity for the clinical section of CPA to meet jointly with the executive of Division 12 of APA (Society of Clinical Psychology). This joint meeting was a great opportunity to share information, to learn from each other about the commonalties and unique aspects of clinical psychology in Canada and the US, and to strengthen collaborative bonds between our two groups.

Finally, in the last few lines of this column, I want to describe some news regarding psychology funding that will have relevance to many members of the clinical section. CPA, through its membership in the Canadian Consortium for Research, has been working hard lobbying the federal government for funding for psychological research and education, including restoring Canadian Health and Social Transfer (CHST) for post-secondary education to 1994/1995 levels, more funds for university research, and a doubling of SSHRC's budget. To be successful, this lobbying effort needs the support of Canadian psychologists. One way to contribute is to write to your MP. The Federation for Humanities and Social Sciences has a template on their web site (www.hssfc.ca) which could be used to create such a letter. The more of us that send letters, the better the odds of ensuring the future of psychological training and research in Canada. Finally, as most of you know, health research funding in Canada is undergoing a major change with the creation of the Canadian Institutes for Health Research (CIHR) which was announced in the federal

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Inside...

Clinical Section Executive Officers 1999–2000

Chair

Charlotte Johnston, Ph.D.
Department of Psychology
2136 West Mall
University of British Columbia
Vancouver BC V6T 1Z4
Tel: 604-822-6771; Fax: 604-822-6923
email: cjohnston@cortex.psych.ubc.ca

Past Chair

Lorne Sexton Ph.D.
St. Boniface General Hospital
409 Tache Ave.
Winnipeg MB R2H 2A6
Tel: 204-235-3088; Fax: 204-237-6264
email: LSexton@GWmail.SBGH.Mb.Ca

Chair-Elect

Lesley Graff, Ph.D.
Department of Clinical Health Psychology
University of Manitoba
PX 246 - 771 Bannatyne Ave.
Winnipeg MB R3E 3N4
Tel: 204-787-3490; Fax: 204-787-7480
email: lgraff@exchange.hsc.mb.ca

Secretary/Treasurer

Deb Dewey, Ph.D.
Alberta Children's Hospital
1820 Richmond Rd. S.W.
Calgary AB T2T 5C7
Tel: 403-229-7365; Fax: 403-543-9100
email: dmdewey@ucalgary.ca

Member at Large

Deborah Dobson, Ph.D.
Department of Psychology,
Foothills Medical Centre
1403 - 29th St. N.W.
Calgary AB T2N 2T9
Tel: (403) 670-4804; Fax: (403) 670-2060
email: ddobson@ucalgary.ca.

Newsletter Editor

Sharon Cairns, Ph.D.
Counselling and Student Development Centre
375 MSC, 2500 University Drive, N.W.
University of Calgary
Calgary AB T2N IN4
Tel: 403-220-5893; Fax: 403-284-0069
email: scairns@ucalgary.ca

Call for nominations

Officers of the Clinical Section

Show your support for the Clinical Section by participating in the election process. For 2000-2001, the Section requires nominations for the position of **Chair-Elect** (a three-year term, rotating through Chair and Past Chair) and **Secretary-Treasurer** (a two-year term).

Continuing members of the Executive for 1999-2000 will be Lesley Graff (Chair), Charlotte Johnston (Past-Chair), and Deborah Dobson (Member-at-Large).

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 March 31, 2000. Send nominations for the Executive to:

Lorne Sexton Ph.D.
St. Boniface General Hospital
409 Tache Ave.
Winnipeg, MB R2H 2A6
Tel: 204-235-3088; Fax: 204-237-6264;
email: LSexton@GWmail.SBGH.Mb.Ca

Submissions invited

The Canadian Clinical Psychologist/Psychologue Clinicien Canadien invites submissions from Section members and others. Brief articles, conference or symposia overviews, and opinion pieces, 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

Empirically based decision making in clinical practice

Larry E. Beutler, Ph.D.

An Invited Address
Canadian Psychological Association, June, 1999

Recent years have seen a proliferation of treatments for a variety of mental health and health conditions. In mental health alone there are hundreds of different treatments, both psychological and psychopharmacological. In the midst of this explosion of theories, there has been a corollary proliferation of legal charges against practitioners for the use of ineffective practices, and mass media stories on harmful therapeutic procedures.

A cursory review of newspaper and television stories reveals a significant number of distressing media reports and stories that uncover harmful forms of psychological interventions. These various newspaper articles, television specials, and news stories all color the view that the public has of our profession. Unfortunately, there is more than a modicum of truth to the picture painted by these stories. This is a field in which the creative expression of the theorist has always been valued more than either the truth or the clinical utility of the theory.

A thesis of this paper is that these standards of evidence—the criteria by which we have accepted an assertion as being true or factual—is exceedingly low. Theorists and practitioners of these theories have rightly and wrongly, openly or implicitly held that an advocate's sincerity and one's own, individual experience and belief are sufficient evidence upon which to base clinical practices and upon which to risk a patient's well-being. Clinicians' faith has often held that, when placed side-by-side, scientific evidence is a poor alternative to the importance of these personal beliefs, private experiences, and sincerity. To leave patient well-being and functioning to the dubious validity of sincere beliefs in appealing clinical theories is to risk more abuses.

Why is there so much reluctance to consider demonstrable treatment outcomes as a key part of deciding if a treatment is useful and beneficial? This alternative seems so obvious, but if implemented, contemporary managed health care and service delivery programs would be faced with the very real problem of ensuring that all services within their domain provide the treatments that are identified as effective. That would mean that clinicians would need to be trained and maintained at specified levels of performance, and health care companies would have some responsibility for ensuring that this was done.

But, practitioners would also have to accommodate to this decision. They would face the possibility that they may have to give up favored positions and theories for which evidence of effectiveness is lacking and adopt others, in order to increase the scientific credibility of their work.

Thus, a criterion based on empirical evidence would seem to be well fit to the establishment of an objective standard for defining practice, but science is by no means clear about what would constitute adequate evidence of a treatment's safety and benefit. Research studies vary in quality, often reach different conclusions, and do so with varying levels of relevance for clinical practice.

Two methods have been proposed to develop a scientifically sound criterion of effective treatment: (1) Consensus Panels, in which identified "experts" debate and reach agreement on the nature of what is the best practice or treatment, or (2) Literature reviews by single authors or groups, with a focus on the development of recommendations for practice guidelines. Both methods are replete with potential and real bias, however. They invariably reflect the biases of the panel who defines who is expert or of those who review the literature.

Efforts to employ truly reliable and objective standards to the definition of what treatments are and are not "empirically supported" have been few. An important point of debate, in these efforts, however, has been the definition of when a specified treatment has passed the test of effectiveness. Almost all standards have resolved this

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debate by relying on a specified number of studies that have employed highly structured treatments that are delivered via a manual. Unfortunately, most clinicians do not adopt the particular behavioral and cognitive theories that are most readily adaptable to this format. The resulting treatments that are recommended are not very practical for use by managed care companies either, because these companies are not inclined to commit the resources necessary to ensure that there is a sufficiently large cadre of practitioners available to represent the various methods and manuals that are identified. But, even if managed care companies were so inclined, there are also unexpected side effects of applying structured manuals. Conventional manuals are inordinately rigid, and this is distasteful to clinical practitioners and may even result in a deterioration of clinicians' general therapeutic skill.

Why is there so much reluctance to consider demonstrable treatment outcomes as a key part of deciding if a treatment is useful and beneficial?

The author and colleagues (Beutler et al; in press) have attempted to address these needs by modeling a method of defining treatment guidelines that are empirically supported but flexible and theory-neutral, based upon a combination of literature review and cross-validational research methods. They applied this procedure to the study of (non-bipolar) depression, with the objectives of developing a set of empirically informed guidelines that can be applied within a variety of theoretical frameworks. These guidelines focus on the tasks of fitting the level of treatment and the nature of interventions to the predisposing qualities of patients.

Briefly, this method began with a literature review, not unlike those undertaken by others who have endeavored to develop treatment guidelines. From this literature review, the authors distilled 25 principles that, based on consensual agreement, summarized the conditions under which different classes of treatment would best work with depressed patients. A second step was to initiate a confirmatory literature review in which these same variables were inspected in research literature that had used samples of patients with conditions that frequently were associated with depression (e.g., generalized anxiety, chemical abuse, minor depression, etc.). In a third step, the authors initiated a systematic cross-validational test of these principles in a sample of 289 outpatients drawn from three archival and one prospective data sets. The result was a consolidated list of 18 principles that form the basis of Basic and Optimal guidelines.

The fourth step in this process is currently underway and consists of an independent, prospective study of a treatment based on these principles contrasted to the usual manualized treatment, using a randomized clinical trial design. The focus on defining and applying principles of intervention rather than specific, theory-specific techniques, is designed to ease the process of instituting empirically supported interventions in actual clinical settings. In this phase, we are testing the ten principles from this list that apply specifically to the application of individual psychotherapy.

Our emphasis is on training therapists to apply their preferred procedures and techniques in a flexible and discriminating manner. Our goal is to refine and validate a model for training an artful clinician who applies empirically informed procedures in a maximally effective way. The resulting flexibility is expected to make it easier for clinicians to learn the procedures and to increase the likelihood that they will continue to use them, once learned.

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Membership renewal

Your membership is very important to the health of the Clinical Section. Please ensure that you renew your section membership when you renew your membership in CPA. That done, go one step further and encourage a colleague to join. We can only be an effective voice for clinical psychology in Canada if we have a large membership.

Relative costs of pharmacological and psychological treatments of anxiety and depression

John R. Walker, Ph.D.
Department of Clinical Health Psychology
University of Manitoba, Winnipeg, Manitoba

Many of us who completed our clinical programs more than five or ten years ago took our clinical training at a time when the costs of the medication component of pharmacological treatment (independent of the provider costs) were much lower than they are today. In the training programs I was exposed to, there was little emphasis on understanding the costs of various treatments. At times the proponents of pharmacological treatments have emphasized that they are less costly than the available psychological treatments. The health care field has been rapidly evolving and there has been the development of many new medications for treatment of problems such as anxiety and depression. The costs of newer generations of medication treatment (such as the selective serotonin reuptake inhibitors - SSRIs - for anxiety and depression) are considerably higher than the costs of previous generations of treatment (such as the tricyclic antidepressants). The pharmaceutical industry has been very active in marketing new products with primary care and specialist providers and there has been considerable competition among the companies for a market which has been expanding rapidly. There has also been an increase in efforts to market directly to consumers through news releases, direct media advertising, and partnerships with community groups.

At the same time as there has been rapid growth in development of pharmacological treatments of common mental health problems, there has been a parallel growth in research on psychological treatments of many of the same disorders. In fact, psychological treatments were often well developed and evaluated by the time specific pharmacological treatments were evaluated. Meta-analytic studies suggest that psychological treatments and pharmacological treatments have a similar degree of effectiveness (in the short term at least) for a variety of disorders including panic disorder (Gould, Otto, & Pollack, 1995), social phobia (Taylor, 1996), and major depression (Dobson, 1989, Hollon, Shelton, & Loosen, 1991). However, unlike pharmacological treatments, psychological treatments are not marketed by large corporations who legitimately have major incentives for successful marketing efforts. As a result, psychological treatments have lagged behind in their availability to consumers in most areas of North America.

Informed Choice for Consumers

The availability of treatment options is very desirable from the consumer's point of view and real choice is improved by having treatments which differ considerably from each other -- as is the case with pharmacological and psychological treatments. Some of the aspects of meaningful choice include being informed about the treatment options, having access to the various treatments, and having adequate information to use in decision making. These factors are especially important in ensuring that the consumer is given the opportunity to provide truly informed consent to treatment. Our impression has been that, in many cases, the treatment offered to a particular consumer depends more on the training of the health provider contacted initially than on the informed choice of that consumer. Further, the explanation or description provided to the consumer about his or her problem has often been so minimal as to be potentially misleading. In a medical setting, the patient may be told that he or she has a "biochemical brain imbalance" which can be remedied by taking an antidepressant medication. In a psychological treatment setting the client may be told that he or she has learned maladaptive ways of coping which can be remedied by learning new coping techniques. In each case, there may be elements of truth in the explanation but it limits the discussion to such a degree that it may not encourage the individu-

al's participation in a realistic choice about treatment.

Given this perspective, it is important for health service providers, including psychologists, to have high quality information available on the treatments which have been empirically evaluated for particular problems, the characteristics of the treatments, and their advantages and disadvantages. Considering the allegiances which professionals tend to develop for the approaches they practice, it may be most useful in the long run to have information prepared by more neutral authorities (such as consumer groups) with the assistance of professionals knowledgeable about the research literature on both psychological and pharmacological treatments.

Some of the issues to be addressed in a discussion of the advantages and disadvantages of various treatments are illustrated in Table 1 which compares pharmacological treatments (specifically SSRI antidepressants) and psychological treatments (for anxiety disorders, specifically cognitive behaviour therapies). These factors are important in allowing the individual to make an informed choice about treatment. Unfortunately, educational materials which provide this much detail (or more) in describing alternative treatments are certainly not widely available.

Cost of Treatments

A major issue from the point of view of the consumer and the health system is the cost of various treatments. Many providers and consumers are not well informed about the costs of various treatments and little research is available about this topic. Currently consumers frequently make decisions about treatment in the absence of realistic information about what a given treatment may involve in terms of cost and time commitment. In a psychological treatment setting a consumer may begin treatment without a discussion of how many sessions are typically used to treat the problem. In a medical treatment setting the consumer often starts treatment by receiving free samples of a medication from the provider without a discussion of how much the medication costs when the individual starts to pay for the prescription and how long the treatment is usually continued. Health service planners often lack this information also. The situation may be complicated by the fact that payment for the treatment may come from different sources - such as the publicly funded health care system, private health insurance (for medication and for private psychology services), and from the individual's own resources.

There has been more extensive work carried out on the cost of pharmacological treatment although this work has not been widely available. In fact, there has been a considerable amount of work in a field called pharmacoeconomics which looks at the costs and benefits arising from pharmacological treatment of various disorders. These economic analyses may become very complex, especially when considering the many financial impacts of a disorder beyond just the cost of treatment - factors such as lost time from work, reductions in productivity, and additional health service utilization (see for example Salvador-Carulla et al., 1995). In general this field has demonstrated very dramatic financial impacts of a variety of disorders (including anxiety and depression) and at least the potential of large beneficial effects with successful treatment. Even with evidence for the potential of producing large beneficial effects with moderate treatment costs, the question remains of who will pay and how sufficient resources will be found to deal with the large numbers of persons who experience mental disorders.

Antonuccio and colleagues (1997) published one of the few studies comparing cost estimates for pharmacological treatment (fluoxetine) and psychological treatment (CBT) for major depression. Their estimated costs for two years of treatment of major depression are shown in Table 2. Little data are available on the rate of return of symptoms following the discontinuation of treatment with the SSRIs (which have often been evaluated in trials of 12 to 20 weeks duration), but preliminary evidence suggests that the rate of return of symptoms is considerably higher than that found for cognitive-behaviour therapy (e.g., Stein et al., 1997). Consequently, specialists in pharmacological treatment are often recommending treatment durations of one to two years after an episode of depression or anxiety disorder. The estimate of the cost of CBT in this study allowed for twenty one-hour individual sessions of individual or group cognitive behaviour therapy. The authors note that while group therapy is less costly than

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Table 1. Advantages and Disadvantages of Medication Treatment and Cognitive-Behavioral Treatment.

Factor	Medication Treatment	Cognitive-Behavioral Treatment
Efficacy	Extensive research indicating satisfactory efficacy (A)	Extensive research indicating satisfactory efficacy (A)
Availability	Prescribed by a family doctor, or a specialist in psychiatry (A)	Treatment provided by a specialist in CBT - may be more difficult to obtain (D)
Complexity of treatment	Medication may be taken on a reasonably simple schedule (A)	Requires more time and effort, individuals with limited education may find the treatment difficult (D)
Side effects	Side effects are not uncommon, may wear off over the weeks (D)	No indication of side effects (A)
Duration of Treatment	Treatment should continue for at least 6 to 12 months	Treatment is usually time limted– in the range of 3 to 4 months (A)
Effect of discontinuing treatment	Limited evidence on long-term effectiveness, return of symptoms is not uncommon when medication discontinued (D)	More evidence on long-term effectiveness, maintenance of gains when treatment is completed is common (A)
Cost of treatment	May be more costly in the long run (D)	May be more costly in short run, less costly in long run (A)
Effect on related problems	Likely to be helpful with related anxiety and depression problems (A)	Likely to be helpful with related anxiety and depression problems (A)
Safety during pregnancy	Limited evidence, usually patients are encouraged not to become pregnant while on treatment (D)	No problem (A)

Note: (A) - Advantage, (D) - Disadvantage

Table 2. Estimated Treatment Costs (U.S. dollar) for 2 years of Treatment of Major Depression.

	Individual CBT	Group CBT	Fluoxetine	Fluoxetine and individual CBT
Provider Cost	$2000	$950	$1120	$2800
Medication Cost	0	0	3629	3629
Total Direct Cost	2000	950	4749	6429

Note: Adapted from Antonuccio, Thomas, & Danton, 1997.

Table 3. Direct Cost of Group Program for Panic Disorder Provided in Different Settings

Setting	Estimated Cost	Cost to Participant
SELF-HELP ASSOCIATION	$280	$280
ANXIETY CLINIC (PUBLIC)	$367	$45
PRIVATE PRACTICE*	$865	$865

* Note: Private insurance coverage may be available.

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individual therapy, it also requires more time for the participant (two hours per session) and this produces some increase in indirect costs. It is clear from Table 2 that cognitive behavioral treatment has a considerable cost advantage in comparison to medication treatment. The estimated cost of combined treatment (which is often advocated by proponents of pharmacological treatment) is considerably higher. To date there is little evidence that combined treatment is more effective than either treatment alone, although there is growing evidence that cognitive-behavioral treatment may reduce the relapse rate following discontinuation of medication treatment in the case of depression (e.g., Fava et al., 1998).

We have developed some estimates of the cost of treatment of panic disorder in our Anxiety Disorders Program located in a publicly funded teaching hospital. In Table 3, the cost in our setting is compared to the costs in a self-help program (which delivers the same program with similar outcomes) and in a private practice setting which is also able to use the same program. The data from our community also illustrates the different costs to the participants depending upon who is paying for the service. The public anxiety program charges only for the book and workbook used in the program but has a long waiting list (up to one year). The self-help association has a considerably shorter waiting list but participants pay a fee which just covers the cost of operating the group with a leader who is a member of the self-help association (not a mental health professional) who has participated previously in treatment and has gone on to develop group leadership skills. Since the group in the private practice is run by a registered psychologist some of the fee may be paid by private health insurance. Most treatment in the private practice is provided in individual therapy because it is difficult to have enough clients ready for a group all at one time. All of the psychosocial treatment alternatives are considerably less costly than treatment with antidepressant medication provided in the same community. The service provider charges for medication treatment are covered under Medicare and do not fall on the individual. The medication cost for treatment with an SSRI are in the range of $640 for a year, although this may vary considerably depending upon the dose, dispensing fees, and size of prescriptions. Many individuals carry private health insurance which cover the majority of this cost. Provider costs, which are paid by the health care system, are also significant. Work done in other settings suggest that they are often roughly equivalent to half or two thirds of the cost of the medication.

As an alternative to group therapy, another way to reduce the cost of psychosocial treatments (and consequently to increase the number of individuals who can be served) is to provide the treatment over fewer sessions, often with the use of supplementary educational materials. Clark and his coworkers (Clark et al., 1999) evaluated treatments of panic disorder which provided either 7 or up to 14 hours of therapist time over a three month acute treatment period and three month follow up. The lengthier program repeated the protocol they had been using earlier, while the shorter program was augmented with self-study educational modules. Both treatment programs produced excellent results with good maintenance of gains at 3 and 12 months.

Recommendations for the Clinician

Work in our setting indicates that many individuals in the community and persons coming to specialty mental health services typically indicate a stronger preference for psychological treatment than for pharmacological treatment (e.g., Walker et al., in press). Cognitive-behaviour therapy has strong evidence for treatment efficacy and much stronger support than pharmacological treatment for the maintenance of gains after treatment has been completed. In spite of these factors, in most areas of the Canadian health care system pharmacological treatment is much more accessible than psychological treatment. With intensive marketing efforts on the part of the pharmaceutical industry this gap appears to be widening. Maintaining an awareness of the costs of alternative treatments as well as the advantages and disadvantages of each may assist service providers and consumer groups in advocating for the availability of psychological treatment services. The cost of services may change considerably over time and from region to region and it is important to have good information on the cost of service in a particular setting in

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order to adequately inform consumers and health service planners. A number of good examples of approaches to establishing costs and benefits are available (O'Farrell et al., 1996; Sclar et al., 1995; Yates, 1994).

Informing the consumer about treatment alternatives and their advantages and disadvantages is an important part of the process of obtaining informed consent for treatment. Clinicians should have a thorough understanding of the costs and benefits of all the available treatments in order to engage in planning with consumers, health service administrators, and payers.

Although psychological treatments may have a cost advantage in many settings at this point, it is important not to be complacent about the appeal of the treatment to consumers. Just as the pharmaceutical industry has been active in promoting pharmacological treatments, it is important for those providing psychological treatments to effectively market their treatments. If an active advocacy and marketing process does not take place the treatments will always be much less available than pharmacological treatments. Continuing attention to managing and documenting the costs and increasing the benefits of treatment will be necessary to establish a significant place in the health care system. The use of high quality educational materials, homework between treatment sessions, group treatment approaches, and spaced treatment sessions with planned follow up have all been found to be helpful in reducing costs. Potential benefits of treatment include reduced health care expenses including medication costs, reduced absence from work, and increased ability to work. In order for these potential benefits to be realized it is important for the clinician to consider making a review of these goals a routine part of treatment planning. Return to work on the part of disabled individuals can be very challenging but also very beneficial. Individuals are more likely to achieve this goal if they receive well planned assistance based on an understanding of some of the psychological factors (particularly anxiety) which may interfere with return to work. Finally, it will be important to inform consumers and health service planners about the relative costs and benefits of the empirically supported treatments.

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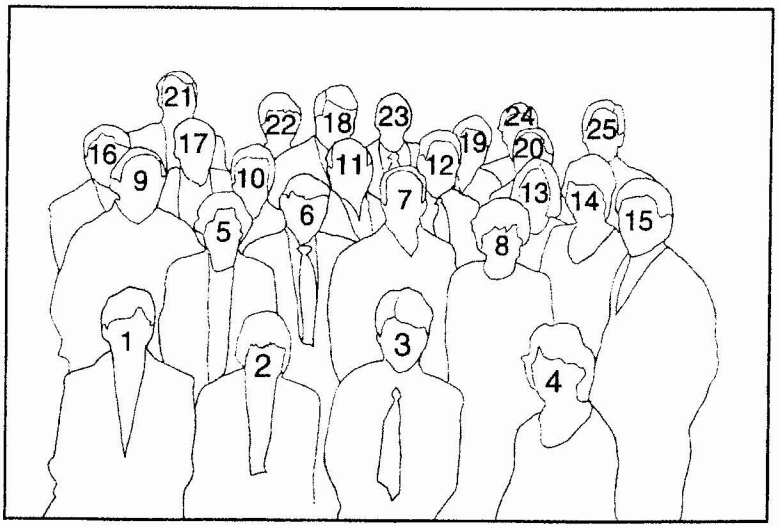
budget of 1999 and is to be implemented by April 1, 2000. As I understand it, the CIHR is intended to coordinate national research efforts, and to encompass the full spectrum of health concerns including social and psychological aspects. Obviously, how the CIHR develops will have major implications for the funding of much clinical psychology research. You can keep up-to-date on the development of the CIHRs through their website (www.cihr.org).

Let me close by re-iterating an invitation that has often appeared in the chair's column of this newsletter. Please write or email members of the section executive with any and all suggestions for section activities—and remember that contributions to the newsletter are always welcome.

Would you like your e-mail address published in the newsletter so that more of your colleagues can correspond with you? Send your e-mail address to the editor:

scairns@ucalgary.ca



APA's Division 12 Board Members

The spring division board meeting was held in Halifax, Nova Scotia in conjunction with the annual meeting of the Canadian Psychological Association. Division leaders took this opportunity to invite board members of the CPA Clinical Section to their meeting to exchange views and information. Division 12 Board Members and their guests in the picture include:

1. Sheila Woody; 2. Deborah Dewey, U. Calgary, CPA Clinical Section (CPA-CS) Treasurer; 3. Paul Rokke; 4. Charlotte Johnston, U. British Columbia, CPA-CS Chair; 5. Annette Brodsky; 6. Jerome Resnick; 7. Joseph Scroppo; 8. Asuncion Austria; 9. Carl Zimet; 10. Norman Abeles; 11. John Service, Executive Director, CPA; 12. Michael Goldberg; 13. Susan Hartley, President, Association of Psychologists of Nova Scotia, Rep. of Council of Provincial Association of Psychologists; 14. Lesley Graff, U. Manitoba, CPA-CS; 15. Sam Mikail, CPA Board of Directors (Practitioner); 16. Barry Hong, Rep. Medical School Psychologists; 17. Larry Beutler; 18. Lynn Rehm; 19. Edward Craighead; 20. James Johnson; 21. Lorne Sexton, U. Manitoba, Past-Chair, CPA-CS; 22. Paul Pilkonis; 23. Thomas Ollendick: 24. Anthony Spirito; 25. William Haley

Internet resources for clinical psychologists, Part I

Shawn R. Currie
Addiction Centre, Foothills Hospital, Calgary, AB

In the last five years, the Internet has provided easy access to a wealth of mental health resources for both professionals and consumers. In this two-part article, I will be providing a general overview of the potential of the Internet to aid in the work of clinical psychologists. This first article will focus on resources for the professional. In part two, the use of the Internet as a research tool will be explored, including its controversial use in "online" data collection. First, a brief introduction to the Internet is in order.

Brief History and Description of the Internet

Although the Internet has been around since about 1982, it was the advent of the World Wide Web (WWW) with its graphical interface in the early 90's that brought the Net to a larger audience of otherwise computer-naive consumers and professionals. The Web's HyperText Mark-up Language [HTML]) is both easier to read and to use compared to the text-based Internet tools like 'telnet' or 'ftp.' The number of web sites (homebases for individuals or organizations wishing to post information or other services on the net) has increased exponentially in the last few years. With a personal computer, an Internet service provider (you may have free access through your university affiliation) and searching software (called web browsers), a user can search web sites, download or print documents of interest, and connect to other related sites virtually 24 hours a day. The major shortcoming of the Internet is the accelerating hardware and software requirements needed for efficient searching. To stay current, you need to invest in a high speed (Pentium is now the standard), large memory (2 Gbytes or more of hard drive space), and multimedia capable computer system. With an older and slower computer model (e.g., 486 MHz), searching the Internet is slow and frustrating. Internet software is also getting more complicated every day—the latest version of Netscape Mail may leave you fondly remembering the days of writing paper and stamps!

Professional Resources

Psychology associations and mental health information. There are now hundreds of web sites devoted to mental health issues or targeted at mental health professionals. Table 1 is just a sample. For more comprehensive listings, see Kerns, Mateer, and Brousseau (1998) or better yet, John Grohol's book, *The Insider's Guide to Mental Health Resources Online, 1999 Edition.* Two of the best sites are Mental Health Net and Internet Mental Health. Most of the major psychology associations also have home pages on the web. Both the Canadian and American Psychological Associations maintain active web sites. The CPA site includes job postings, task force reports, and many links to other psychology-oriented sites. The APA site is more comprehensive, and includes information for consumers and pages for members only (formal log-on is required). Sites like APA's can serve an important function in enhancing public awareness of the work of psychologists and mental health issues in general.

The Internet provides quick and easy access to most bibliographic databases. PsychInfo, Medline and the latest addition 'ClinPsych' (a subset of PsychInfo) are all available online. As a research tool, online access to these databases is very convenient (more on this in Part II).

Professionals can also benefit from conducting quick literature searches from the comfort of their office or home. This can be a real perk for psychologists who work in areas without a university library. Access to Medline is usually free, but the web-based PsychInfo requires a subscription. I still have a preference for the text-based OVID service, which can be accessed by modem for free through most university libraries. The web-based versions of these databases tend to be slow, partly because of all the advertising now on the Internet.

The latest trend is having access (for a fee)

to full text journal articles online. I have yet to be sold on the advantages of this service. If you're like me, you read journal articles at home, on long plane flights, or long commutes. With online access, you still have to print the article off your computer. As well, I prefer bound journals to archive rather than a pile of stapled papers. On the other hand, online journals offer quick and convenient access to new literature, and you only need to print the relevant articles, leading to longer-term savings of money, space and trees.

Other psychology-related information can be found on the web by using one of the available "search engines" (e.g., Yahoo or Alta Vista). If your are familiar with Boolean search strategies, using a search engine is surprisingly easy and efficient if you make good use of your operators. Still, finding what you want tends to be hit or miss, and you usually have to sort through endless pages of irrelevant information. There are meta-search engines like Inference Find (www.infind.com) which search in parallel across the other search engines and filter out bad or outdated links. Better yet is APA's PsychCrawler (www.psychcrawler.com) which only searches known psychology-orienting web sites.

Networking. Many professionals use e-mail as a secondary form of communication. One major advantage of e-mail is the ability to send a detailed message directly to a colleague instead of routing it through a receptionist or leaving it on an answering machine. Setting up meetings, checking waiting lists, and sending/receiving referrals is much faster using e-mail than conventional forms of communication. These days I get quicker responses to my e-mail messages than my phone messages. As with faxes and office mail, one needs to take the proper steps to ensure confidentiality. Web browsers like Netscape offer varying levels of security by using encryption software to scrabble confidential information until it reaches its destination.

It is relatively easy to locate people on the Internet. Lost track of an old supervisor or former student? Check out APA's online directory of members. The limitation of this service is that both you and the person you are seeking need to be APA members. You can also search the online white pages for any large city in the world, although be forewarned that these listings can be two to three years out of date.

There are also many mailing lists and newsgroups for mental health professionals. Some mailing lists require you to submit proof of your credentials before joining. Most of these lists are not moderated or edited, which means you may have hundreds of messages to sort through if you neglect to check it for a few days. There are some web-based newsgroups as well. One of the more interesting sites is Behavior OnLine which offers online case conferences and the ability to chat with well-known behaviour therapists.

Conferences and continuing education. Most conferences are posted on the web now making it so easy to check the program and registration/submission deadlines before making the decision to submit or go. Now you can even register and submit an abstract online. Conference information on the Internet is usually updated faster than print forms. For example, I recently found my workshop posted on the conference web page long before I received the written confirmation that it was accepted. The APA and CPA web sites maintain a calendar of conferences and other professional events. There are now online continuing education courses and Internet-based distance education. Check out the AudioPsych site for complete listings.

The Internet provides quick and easy access to most bibliographic databases.

Consumer-oriented internet resources. Many of our clients surf the web. Clinicians may want to stay current about the available Internet mental health resources targeted at consumers. There are just too many to review here, and new web sites are appearing every day. Mental Health Net-Selfhelp Resources (web address in Table 1) is probably the most comprehensive site and an excellent gateway to other online resources. There are also hundreds of mailing lists and newsgroups focusing on specific disorders (e.g., panic disorder or alcoholism) which can act as virtual support groups for consumers. Professionals are discouraged from subscribing to these lists, but can certainly make clients aware of their existence. A complete list is available at Psych Central.

Online therapy? You knew it was coming. Online therapy reminds me of a scene from the

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Table 1 A Sample of Good Internet Sites for Clinical Psychologists

Site	Internet Address (http://)	Comments
	Organizations	
CPA	www.cpa.ca	Job postings, conference info, many links to other sites
APA	www.apa.org	Many resources and an online directory of members
AABT	www.aabt.org/aabt	Member directory and a clinical referral service
	Databases	
Medline	www.nlm.nih.gov/database/medline.html	Public access to MEDLINE and related databases
PsychInfo	www.apa.org/psychinfo/psychinfo.html	Access to PsychInfo, ClinPsych and many online journals ($)
Psychology journals	www.psychwww.com/resource/journals.htm	Comprehensive listing of psychology journals with web sites
	Mental Health Sites	
Mental Health Net	www.cmhc.com	Comprehensive list of resources and articles for mental health professionals; gateway to other mental health sites on web
Internet Mental Health	www.mentalhealth.com	Lots of disorder-specific information; directory of mailing lists
Behavior OnLine	www.behavior.net	Online case conferences
Psych Central	psychcentral.com	Mailing lists for professionals and consumers on mental health issues
Anxieties.com	www.anxieties.com	Good self-help information for anxiety disorders, although lots of book promotion.
	Continuing Education Resources	
AudioPsych	www.audiopsych.com	Cotinuing education courses delivered in multimedia format (audio, text and slides)
	Online Therapy	
NetPsychology	www.netpsych.com	Information and discussion about offering mental health services online

Note: AABT = Association for the Advancement of Behavior therapy; $ = fee involved.

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movie *The Lonely Guy* in which Steve Martin's character has a session with his psychiatrist through the building's intercom system (at the end, the psychiatrist asks Steve to deposit a check in his mailbox!). Of course this is not 'online,' but the scene makes you think: 'Is that really therapy?' The debate over the ethics and practicality of offering mental health services in cyberspace is just getting started, so expect to hear more on this topic in months to come. For now, most agree that online therapy is not really therapy but could still be regarded as a form of therapeutic intervention much in the way that telephone support is seen as a valid service. For psychologists in private practice, the Internet could be an opportunity to advertise their services. Some suggest that e-mail could be used as an adjunct service, perhaps to handle routine matters such as booking/cancelling appointments, arranging fees, etc. Extending this further, perhaps clients could submit homework (e.g., self-monitoring) or complete assessment measures online for you to review before a session. How about conducting collateral assessments via e-mail with spouses or family members who can't attend in-person appointments? All of these possibilities have obvious advantages and disadvantages which need to be explored. Who knows, in five years maybe some professionals will have "Minimal Hardware/ Software Requirements" listed on their business cards.

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Ken Bowers Student Research Award

Each year, the Section of Clinical Psychology reviews papers that have been submitted by clinical students for presentation at the annual CPA convention. The most meritorious submission is recognized with a certificate and an award of $250. In order to be eligible, you should: (1) Be the first author of a submission in the area of clinical psychology that has been accepted for presentation in Ottawa; (2) Submit a brief (i.e. up to 10 pages, double-spaced) manuscript describing the project, and (3) Be prepared to attend the Clinical Section Business meeting at the Ottawa Congress, where the award will be presented. The deadline for submission of applications is March 31, 2000. Submissions may be in either English or French and should be forwarded to:

Lesley Graff, Ph.D
Department of Clinical Health Psychology
University of Manitoba
PX 246 - 771 Bannatyne Ave.
Winnipeg, MB R3E 3N4
Tel: 204-787-3490; Fax: 204-787-7480;
email: lgraff@exchange.hsc.mb.ca

Prix Ken Bowers pour recherche effectué par un étudiant

Chaque année, la Section de Psychologie clinique passe en revue les communications qui ont été soumises par les étudiants en vue d'une présentation au congrès annuel de la SCP. Un certificate et une bourse de 250$ seront remis à l'étudiante ayant soumis la présentation la plus méritoire. Pour être admissible, vous devez: (1) être le premier auteur d'une présentation touchant le domaine de la psychologie clinique. Cette derniere doit être acceptée pour le congrès de Ottawa; (2) soumettre un bref résumé de 10 pages à double interligne décrivant l'étude; (3) être présent à la réunion de la section des affaires cliniques du congrès de Ottawa lorsque le prix sera décerné. La date limite pour soumettre une application est le 31 mars, 2000. Les demandes peuvent être formulées en français ou en anglais à l'attention de:

Lesley Graff, Ph.D
Department of Clinical Health Psychology
University of Manitoba
PX 246 - 771 Bannatyne Ave.
Winnipeg, MB R3E 3N4
Tel: 204-787-3490; Fax: 204-787-7480;
email: lgraff@exchange.hsc.mb.ca

Socially withdrawn and aggressive children: A social learning theory analysis

Thomas H. Ollendick
Department of Psychology
Virginia Polytechnic Institute
and State University

The early identification of students at risk for academic and behavioral problems is critical if we are to mount successful prevention and intervention programs in our schools. It has long been known that academic and behavioral problems place youth at increased risk for school failure and/or dropout, mental health problems, and legal complications. Moreover, their lives are frequently characterized by feelings of low self-esteem, general inadequacy, and worthlessness.

Children most at risk for academic and behavioral problems are described in the psychological literature as either withdrawn/neglected or aggressive/rejected children. As a means to identify these two types of children, my colleagues and I turned to their teachers and fellow students. We selected fourth grade students based on our earlier findings that our identification process was most reliable at this grade level (when the children were approximately 10 years of age).

A two-pronged approach was used to identify "at-risk" youth. First, teachers were asked to nominate up to three students in their classrooms who fit definitions of adjusted, withdrawn, and aggressive children, respectively. Second, students in each teacher's classroom were asked to "circle the names (on a class roster) of the three students in this classroom you like the most." They were also asked to rate each student on a 5-point scale ranging from "not at all" to "a lot" in answer to the question "How much do you like this student?" Based on standard sociometric criteria, the 636 fourth grade students were classified as popular, controversial, neglected, rejected, or average. Students who were identified by their teachers as withdrawn and their peers as neglected were identified as "withdrawn" (76 or 12%), whereas those identified by their teachers as aggressive and by their peers as rejected or controversial were identified as "aggressive" (74 or 12%). Finally, students identified by their teachers as adjusted and by their peers as popular or average were identified as "adjusted" (75 or 12%).

Perhaps to no surprise, adjusted students were found to be more assertive, to possess higher internal locus of control, and to report higher levels of social competence and self-efficacy than both their withdrawn and aggressive peers. With respect to social behavior, adjusted students were found to engage in more positive social interactions and less solitary behavior than withdrawn children. The two groups did not differ on rates of negative interactions, which were very low for both groups. In contrast, the aggressive students were observed to display higher levels of negative interactions than their adjusted peers, but did not differ from them on rates of positive or solitary interactions. Differences were also found on academic performance. Both withdrawn and aggressive children obtained lower scores than their adjusted classmates on standardized tests of ability and achievement administered at the end of the fourth grade. Across the various dimensions, aggressive children were determined to be more at risk than withdrawn children; however, both groups were identified as at risk compared to their adjusted peers.

Five years later, these students were followed up in the ninth grade. The findings for the aggressive and withdrawn students varied and will be described separately. Academically, withdrawn children continued to perform more poorly than adjusted students. They received lower grades, lower standardized ability and achievement scores, failed more grades, and were three times more likely to have dropped out of school (9.4% compared to 2.9%). Moreover, they continued to be perceived as more socially withdrawn by their peers and their new teachers. Finally, and somewhat unexpectedly, they were two times

more likely to have committed a delinquent offense than their adjusted peers (12.5% compared to 5.8%).

Even poorer outcomes were found for the aggressive children at the 5-year follow-up. Academically, aggressive students also continued to perform more poorly than adjusted (and withdrawn) students. They received even lower grades and more frequently failed a grade than their withdrawn and adjusted counterparts and performed even more poorly on standardized ability and achievement tests. Moreover, they continued to be perceived as less likable and as more aggressive by their ninth grade peers and as more problematic by their teachers. Finally, they were more likely to have dropped out of school (15.4%) and to have committed a delinquent offense (20.0%) than either the withdrawn (9.4% and 12.5%, respectively) or adjusted students (2.9% and 5.8% respectively.

Quite evidently, these outcomes do not portend well for the youth identified to be at risk. Moreover, it should be noted that these findings were obtained when the youth were in the ninth grade and 14 years of age on average. Inasmuch as school drop out and delinquency rates become even more pronounced in later adolescent years, the prognosis for these youth is not good. Given the nature of our findings, it is clear that we were successful in identifying students at risk. For example, 84% of the youth who committed a delinquent offense and 87% of the students who dropped out of school were in one of the two nominated at-risk groups.

Based on these findings, we mounted an intervention program aimed at addressing these social and behavioral deficits in a different cohort of at-risk fourth grade children. Forty eight withdrawn children, 48 aggressive children, and 48 adjusted children, identified in the same manner as indicated above, were randomly assigned to a manualized, cognitive-behavioral (CBT) intervention or to a manualized, attention control condition. The CBT intervention consisted of 16 group sessions of social skills training, social problem-solving training, and self-instruction training. The attention control intervention also consisted of 16 sessions and was Rogerian-based and non-directive and reflective in nature. It was focused on affect development, values clarification, and attainment of insight. Six to eight children participated in each group which was composed of 2-3 withdrawn children, 2-3 aggressive children, and 2-3 adjusted children (who served as role models). The treatment sessions were conducted while the children were in the fourth grade. Six monthly booster sessions were provided in the fifth grade in an effort to maintain and generalize the gains observed in the fourth grade. Subsequently, the children were followed into the ninth grade to determine the long-term effectiveness of the interventions.

Measures of locus of control, self-efficacy, and outcome expectancy were obtained at the end of the fourth grade (posttreatment), end of the fifth grade (one-year follow-up), and at the end of the ninth grade (5-year follow-up). In addition, sociometric ratings and teacher ratings were obtained at these same points in time, as were indices of academic performance. Finally, the number of children who failed a grade, dropped out of school, and committed a delinquent offense was recorded at the end of the ninth grade. Results differed for the withdrawn and aggressive children.

Adjusted students were found to be more assertive, to possess higher internal locus of control, and to report higher levels of social competence and self-efficacy than both their withdrawn and aggressive peers.

For the withdrawn children, the cognitive-behavioral intervention was superior to the attention control condition on all measures at post-treatment, 1-year follow-up, and 5-year follow-up. Moreover, whereas 16.6% of the withdrawn children in the attention control condition failed a grade, only 8.3% of those in the CBT intervention did so. Similarly, 12.5% of those in the attention control condition dropped out of school, while only 4.2% of those in the CBT intervention did so. Finally, 12.5% of those in the attention control condition committed a delinquent offense; 4.2% of those in the CBT condition did so. Clearly, findings favored the CBT condition on a host of measures for the withdrawn children.

For the aggressive children, the outcomes were less favorable but still highly positive. Basically, children in the CBT condition were found to be superior to those in the attention

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control condition on the self-report measures of locus of control, self-efficacy, and outcome expectancy at post-treatment, 1-year, and 5-year follow-up. Furthermore, they were found to be rated as less aggressive by their teachers than their attention control counterparts. However, they were not found to be superior to the attention control children on measures of sociometric status or academic grades at any of these measurement points. However, at 5-year follow-up, 29.2% of the attention control children had failed a grade, 25.0% had dropped out of school, and 33.3% had committed a delinquent offense. In contrast, 12.5% of the CBT children had failed a grade, 8.3% had dropped out of school, and 12.5% had committed a delinquent offense. Clearly, the pattern of findings favored the CBT condition over the Rogerian-based attention control condition.

In summary, our early identification and intervention studies show that at risk children can be identified reliably and that effective school-based interventions can be enlisted to prevent many of the insidious outcomes that occur with these children in the absence of intervention. We have also found that social learning constructs (e.g., locus of control, self-efficacy, outcome expectancy) that guide us and the development of our CBT interventions are modified as a result of treatment and that such changes serve to mediate altered behavioral and academic outcomes. We are currently testing the predictive utility of this model by following the at-risk children through their high school years and determining the long-term outcomes of our interventions. Although much remains to be accomplished, we have learned much in the process.

Call for nominations—Section Fellows

In accordance with the by-laws for CPA sections, The Clinical Section calls for nominations from its members for Fellows in Clinical Psychology.Criteria for fellowship are outstanding contribution to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Some examples are: (1) Creation and documentation of innovative programs; (2) Service to professional organizations at national, provincial, or local level; (3) Leadership on clinical issues that relate to broad social issues; (4) Service outside one's own place of work; (5) Clinical supervision should be equated with research supervision.In order for nominees to be considered for Fellow status by the executive council, nominations must be endorsed by at least three members or Fellows of the Section, and supportive evidence of the nominee's contribution to clinical psychology must accompany the nomination.Nominations should be forwarded by March 31, 2000 to:
Lesley Graff, Ph.D • Department of Clinical Health Psychology
University of Manitoba • PX 246 - 771 Bannatyne Ave.
Winnipeg, MB R3E 3N4 • Tel: 204-787-3490; Fax: 204-787-7480;
email: lgraff@exchange.hsc.mb.ca

Demande de présentation de mises en candidatures—Section des fellows

Conformément aux procédures régissant les sections de la SCP, la section clinique invite les membres à présenter des mises en candidature pour le statut de Fellow en psychologie clinique. Les critères de sélection sont la contribution exceptionnelle au développement, le maintien et l'accroissement de l'excellence dans la pratique scientifique ou professionnelle de la psychologie clinique. En quise d'exemples: (1) Création et évaluation de programmes novateurs; (2) Services rendus aux organismes professionnels de niveau national, provincial ou régional; (3) Leadership dans l'établissement de rapports entre la psychologie clinique et les problèmes sociaux de plus grande envergure; (4) Services rendus à la communauté en dehors de son propremilieu de travail; (5) La contribution clinique est équivalente à la contribution en recherche.Les dossiers des candidats nommés pour le statut de Fellow seront examinés par le comité exécutif. Les mises en candidature doivent être appuyées par au moins trois membres ou Fellow de la Section et la contribution du candidat à la psychologie clinique doit y être documentée.Les mises en candidature devront être postées au plus tard le 31, mars 2000 à l'attention de:
Lesley Graff, Ph.D • Department of Clinical Health Psychology
University of Manitoba • PX 246 - 771 Bannatyne Ave.
Winnipeg, MB R3E 3N4 • Tel: 204-787-3490; Fax: 204-787-7480;
email: lgraff@exchange.hsc.mb.ca

Anorexia nervosa and bulimia nervosa: Current advances in assessment and treatment

Josie Geller, Ph.D.
St. Paul's Hospital Eating Disorders Clinic
University of British Columbia

The eating disorders are disabling illnesses that diminish life quality and can have lethal consequences. They are characterized by dietary restriction, bingeing, compensatory strategies, and cognitive/affective features. A number of challenges that are unique to the eating disorders may significantly impact assessment and treatment. These include experiencing symptoms as ego-syntonic, denial of the seriousness of symptoms, and ambivalence about treatment and/or recovery. Each of these challenges can raise intense reactions in therapists, and impact upon the nature of the relationship between client and therapist. The purpose of this year's workshop was to review current assessment and treatment strategies, taking into account these specific challenges.

Assessment

Eating disorder symptoms can be assessed using questionnaire measures of symptom severity, semi-structured clinical interviews, and self-monitoring techniques. A description of assessment tools used in the eating disorders is provided in Table 1. The EDI-2 is a standardized, multiscale questionnaire that provides three scales of specific eating disorder symptoms, and eight scales that assess personality characteristics associated with the eating disorders. The three symptom subscales, Drive for Thinness, Body Dissatisfaction, and Bulimia, are frequently used as measures of symptom severity. The EAT is a widely-used screening tool of general thoughts, feelings, and behaviours associated with the eating disorders, and the EDE is an investigator-based, semi-structured interview that provides both a continuous symptom severity score and diagnostic status. Self-monitoring of antecedents and consequences of eating and purging can also be a useful first step in developing an awareness of symptom patterns, and in assisting both client and therapist to develop an understanding of the function of eating disorder symptoms. A number of self-report questionnaires are also available to assess key cognitive symptoms of eating disorders, such as body esteem, the extent to which self-esteem is based upon shape and weight, and body image distortion. Examples of well-validated measures of these constructs are also provided in Table 1.

Although not currently a part of standard clinical practice, an increasing number of clinicians and researchers are emphasizing the need to assess readiness for change in this population. To date, most research has used an adapted form of the Stages of Change Questionnaire, which is based on the transtheoretical model of change (Prochaska & DiClemente, 1983), and provides total scores for each of precontemplation, contemplation, action, and maintenance stages. The Readiness and Motivation Interview (RMI; Geller & Drab, in press; Geller et al., 1999) was developed to address criticisms of the SCQ in individuals with eating

Table 1. Eating Disorder Assessment Tools

Behavioural Symptoms	Cognitive Symptoms	Readiness and Motivation
Eating Disorders Inventory-2 (Garner 1991)	Body Esteem Scale (Mendelson et al., 1996)	Stages of Change Questionnaire (Blake et al., 1997)
Eating Attitudes Test (Garner et al, 1982)	Shape and Weight Based Self-esteem Inventory (Geller et al., 1997)	Readiness and Motivation Interview (Geller & Drab, in press)
Eating Disorders Examination (Fairburn & Cooper, 1993)	Body image distortion techniques	
Self-Monitoring		

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by providing an open format in which the complexity of thoughts and feelings about readiness for change can be explored with the interviewer, and by providing both individual stage of change scores for each symptom dimension (bingeing, cognitive, purging, and restricting), as well as total scores. The RMI has been shown to possess good psychometric properties and to be a better predictor of behavioural change treatment engagement and drop-out than the SCQ (Geller, Cockell & Drab, 1999; Geller, Cockell, Zaitsoff & Goodrich, 1999).

Table 2.
Treatment of Anorexia Nervosa and Bulimia Nervosa

Treatment Type	Reference
Bulimia Nervosa: Cognitive Behaviour Therapy	Cognitive behaviour therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. (Fairburn, Marcus, & Wilson, 1993)
Bulimia Nervosa: Interpersonal Therapy	Interpersonal psychotherapy for bulimia nervosa. (Fairburn, 1993)
Bulimia Nervosa Guided Self-Help	Cognitive-behavioral self-help for binge eating disorder (Carter & Fairburn, 1998)
Bulimia Nervosa: Psychoeducation	Brief group psychoeducation for bulimia nervosa (Davis, Olmsted & Rockert, 1990)
Anorexia Nervosa: Cognitive Behaviour Therapy	Cognitive-behavioral therapy for anorexia nervosa (Garner, Vitousek, & Pike, 1996)
Anorexia Nervosa: Readiness and Motivation Therapy	Enhancing Motivation for Change in treatment-resistant eating disorders (Vitousek, Watson, & Wilson, 1998)

Treatment

While a number of empirically-validated treatments for bulimia nervosa have been established, research on treatment of anorexia nervosa is still in its infancy. Table 2 provides references for the most well-known treatments for bulimia, including cognitive behaviour therapy, interpersonal therapy, guided self-help, and psychoeducation. Although little empirical research exists on the efficacy of treatments for anorexia nervosa, both a CBT model (Fairburn & Shafran, 1999) and treatment (Garner, Vitousek & Pike, 1996) have been described. Finally, in response to growing interest in the issues of treatment ambivalence and motivation in individuals with eating disorders, treatment models that directly address readiness for change have been developed (Treasure &Ward, 1997; Vitousek, Watson, and Wilson, 1998), and are currently being evaluated (Treasure et al., 1999).

In sum, good questionnaire and interview measures are available for assessing eating disorder symptoms and readiness status. Future research is needed to examine the utility of motivational interventions in individuals with eating disorders.

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Food word memory bias in high restraint women

Anne L. Israeli, & Sherry H. Stewart
Department of Psychology
Dalhousie University, Nova Scotia.

Editor's Note: Anne Israeli is the winner of the 1999 Ken Bowers Student Research Award. Congratulations Anne! The following is a brief summary of her research.

According to cognitive theories of eating pathology, individuals with eating disorders are believed to have highly elaborate schema (i.e., cognitive structures) which focus on food, weight, and shape information (Bemis-Vitousek & Hollon, 1990). Overuse of these schema can lead to information processing errors such as selective attention toward, and selective memory for, schema-related cues. These information processing biases may contribute to many of the maladaptive behaviors (e.g., food preoccupation, binge eating) observed in eating disordered individuals. Since restrained eaters, as identified using the Restraint Scale (RS; Herman & Polivy, 1980) demonstrate many of the characteristics observed among clinical eating disordered patients such as periods of overeating and food preoccupation, it has been suggested that schema theory may be relevant not only to understanding the eating pathology of clinical eating disorder patients, but also to understanding the full spectrum of disordered eating patterns. Conversely, the results of studies using restrained eaters as clinical analogs have been mixed. For example, several studies have demonstrated selective attention for schema information in restrained eaters (see Francis et al., 1997), whereas studies examining memory for schema information have produced mixed results (e. g., positive findings: Baker, Williamson, & Sylve, 1995; King, Polivy, & Herman, 1991; negative findings: Sebastian, Williamson, & Blouin, 1996).

University women high and low in dietary restraint (as determined by RS scores) were compared in terms of memory for forbidden food versus animal control words, incidentally encoded during a pleasantness-rating task. We predicted that high restraint women would remember more forbidden food words (but not more animal control words) than low restraint women. We also hypothesized that high restraint women (but not low restraint controls) would remember more forbidden food than animal control words.

Methods

Sixty-seven female undergraduate psychology students at Dalhousie University volunteered to participate in the study as part of an in-class laboratory (Mean age in years = 22.2, SD = 4.5). Participants were classified into high and low restraint groups using a cutoff score of 16 and above to classify participants as high in dietary restraint (see Heatherton et al., 1988). The mean Restraint Scale scores for the low and high restraint groups were 9.2 (SD = 3.4) and 19.4 (SD = 3.2), respectively.

Participants viewed the 30 stimulus words (15 forbidden food, 15 animal control) which were randomly presented on an overhead screen at the rate of one word per 6 seconds and were asked to provide pleasantness ratings for each word. Participants were unaware that they would be later asked to recall the words. Five minutes after viewing the word lists, participants completed a free recall test (5 minutes were given to complete this task), the Restraint Scale (Herman & Polivy, 1980), and questions concerning body weight and height, age, years in university, and socioeconomic status.

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Sharon Cairns, scairns@ucalgary.ca
375 MSC, 2500 University Drive,
University of Calgary, Calgary, Alberta, T2N 1N4

Results

Mean (and Standard Deviation) Free-Recall Scores

	Restraint Group		
	Low	High	Overall
Word Type	(N = 38)	(N = 29)	
Forbidden Food	9.00 (1.74)	9.34 (2.10)[a]	9.14 (1.90)
Animal Control	8.97 (1.76)[b]	7.86 (2.10)[ab]	8.49 (1.90)
Overall	8.99 (1.41)	8.60 (1.91)	8.82 (1.65)

[a]significant difference ($p < 0.05$) using Bonferroni Multistage Comparisons
[b]significant difference ($p < 0.05$) using Bonferroni Multistage Comparisons
Possible range of free-recall scores = 0–15

Conclusions

The aim of the current study was to examine whether women high in dietary restraint display a memory bias for forbidden food cues on an incidental explicit recall task. Contrary to schema theory, an absolute memory bias for food cues in high vs. low restraint women was not observed. However, consistent with schema theory predictions, there was evidence for a relative memory bias in which high restraint participants, but not low restraint participants, remembered significantly more forbidden food vs. animal control words. Therefore, these results provide only partial support for Bemis-Vitousek and Hollon's (1990) schema theory.

Furthermore, high restraint women did recall significantly fewer animal control words than low restraint participants. The present pattern of results might be taken to suggest that cognitive deficits in restrained eaters relative to controls may be evident for information from outside the schema domain, whereas such deficits might be overridden when restrained eaters are processing information from within the forbidden food-schema domain. Alternatively, exposure to schema relevant stimuli, like forbidden food words, may evoke more widespread cognitive activity that shifts restrained eaters' processing resources toward schema relevant information. This shift may interfere with the processing of information from outside the schema domain by limiting available attention or storage capacity for non-schematic information.

Please contact Anne Israeli, #205-408 Regent Street, Fredericton, NB, E3B 9K2, email ego@nb.sympatico.ca for further information.

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Deborah Dobson	ddobson@ucalgary.ca
Sandra Hopps	shopps@irdpq.qc.ca
Catherine Lee	cmlee@uottawa.ca
Maureen Milligan	mmilligan@home.com

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