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MESSAGE FROM THE CHAIR**Keith Wilson**

In this issue of *Canadian Clinical Psychologist*, you will find a call for nominations for people who would be willing to serve on the Executive Committee in the position of either chair-elect or member-at-large. This provides me with an opportunity to introduce the current members of the Executive, and also to update the membership on some of our ongoing projects and responsibilities.

The position of member-at-large is presently held by Paul Hewitt, from the University of British Columbia. In this position, Paul is responsible for maintaining the Section Newsletter as a thriving concern (in partnership with our inimitable editor, David Hart). Paul will be stepping down from the Executive in June, and we are hoping to find an enthusiastic volunteer to take his place. We know that Paul will be tough to replace; after all, he's a leading expert on the topic of perfectionism!

Candace Konnert, from the University of Calgary, is our treasurer. In addition to making sure that your dues are spent wisely, Candace maintains an active research program in the psychology of ageing.

Charles Morin from Laval University, now is the chair-elect. You will find a profile of Charles later in this issue. Many of you may already know Charles -- his research in the treatment of insomnia has earned him an early career award from the American Psychological Association.

Finally, we have "the Wilson boys", as John Service likes to call us. Allan, from the Nova Scotia Hospital in Halifax, is our past chair. Although Allan will also end his term on the Executive in June, he will maintain an active advocacy role in his capacity as the recently elected vice-president of CRHSPP (congratulations Allan). In this exalted company, my position as chair has been an easy one to fill. In my "day job," I am a clinical psychologist at The Rehabilitation Centre in Ottawa.

The role of the Executive Committee is to oversee the business of the Clinical Section. This largely comprises the publication of the newsletter, the arrangement of section-sponsored activities for the CPA annual convention, responding to CPA requests on matters that require the input of the clinical psychology community, and supporting advocacy initiatives that promote clinical psychology. Most recently, these initiatives have included mailing copies of our information brochure, "The Clinical Psychologist in Canada," to members of provincial legislatures. We are also sponsoring a position paper on empirically validated treatments that will outline the Section's stance with regard to the emerging developments

*(Continued on page 3)***MESSAGE DU PRÉSIDENT****Keith Wilson**

Le présent numéro du *Psychologue clinicien canadien* renferme un appel de candidatures qui s'adresse aux personnes disposées à siéger au Comité exécutif à titre de président désigné ou de représentant des membres. Ceci m'amène à vous présenter les membres actuels du Comité exécutif et de vous mettre au fait de certains projets en cours et des responsabilités connexes.

Paul Hewitt, de la University of British Columbia, occupe actuellement le poste de représentant des membres. Il est chargé d'assurer l'essor du bulletin d'information de la Section (en collaboration avec David Hart, notre inimitable rédacteur en chef). Paul quittera le Comité exécutif en juin, et nous espérons lui trouver un remplaçant enthousiaste. La tâche ne sera pas facile, car, après tout, Paul est un spécialiste du perfectionnisme!

Candace Konnert, de la University of Calgary, est trésorière. Non seulement veille-t-elle à ce que vos deniers soient dépensés judicieusement, mais elle gère également un programme de recherche active en psychologie du vieillissement.

Charles Morin, de l'Université Laval, est président désigné. Vous trouverez une notice biographique de Charles ailleurs dans ce numéro. Bon nombre d'entre vous connaissez peut-être déjà Charles; ses recherches sur le traitement de l'insomnie lui ont valu un prix en début de carrière de l'*American Psychological Association*.

Enfin, il y a les *Wilson boys* selon l'expression de John Service. Allan, du Nova Scotia Hospital à Halifax, est président sortant. Il termine son mandat au Comité exécutif en juin, mais il continuera de promouvoir activement la psychologie en tant que vice-président désigné du RC-POSS, poste qu'il occupe depuis peu. Nos félicitations Allan! Dans cette joyeuse cohorte, il ne m'est pas difficile de remplir mon mandat de président. Le jour, je suis psychologue clinicien au Centre de réadaptation d'Ottawa.

Le Comité exécutif a pour mandat de surveiller les activités de la Section de la psychologie clinique, ce qui comprend principalement la publication du bulletin d'information, l'organisation des activités parrainées par la Section pour le congrès annuel de la SCP, le traitement des demandes adressées à la SCP sur des questions qui exigent l'apport de psychologues cliniciens et l'appui des projets de promotion de la psychologie clinique. Tout récemment, nous avons envoyé par la poste des exemplaires de notre brochure d'information *Le psychologue clinicien au Canada* aux membres des législatures provinciales. Nous parrainons aussi l'élaboration d'un énoncé de principe sur les traite-

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KEN BOWERS REMEMBERED

Professor Kenneth S. Bowers of the University of Waterloo Psychology Department died on Thursday, July 4, 1996 after a year's suffering with brain cancer. Kenneth leaves his wife Patricia, also a professor in the psychology program, three sons and their families.

Dr. Bowers was born in the State of Illinois in 1937 and earned an undergraduate degree majoring in Philosophy and minoring in both Zoology and Chemistry at the University of Illinois in 1959. He continued at Illinois for his Ph. D. in Clinical Psychology which was awarded in 1964. Ken came immediately to the Waterloo campus and to embark on an illustrious academic career. He was on duty by the fall term of 1964-65 with an assistant professor rank and also a part-time service role in the campus student counselling service. Ken had been one of the architects of the University of Waterloo Clinical Training Program and on occasion served as its Chairperson. He was deemed a highly valued colleague by other faculty and a superior mentor by his students.

Dr. Bowers was perceived as an academically adventurous individual whose work gravitated towards topics of great mystery (the workings of hypnosis, the intricacies of unconscious processes, operational definitions of personal intuitions, as well as question pertinent to psychosomatic disorders). His work earned him many awards. He received the F. S. Baily Award as the best undergraduate philosophy student in 1959 at the University of Illinois. As a graduate student, he had a U.S. Public Health Fellowship for several years, and his post-graduate research earned the best research project and the best theoretical paper of the year on multiple occasions from the Society of Clinical and Experimental Hypnosis. Ken was elected to be the President of that society a few years ago. He also had fellowship status in the APA, the CPA, and the Hypnosis Society.

Other major awards were given for work described in his publications, including two books (*Hypnosis for the Seriously Curious*, in 1976, and the *Unconscious Reconsidered* in 1984, the latter in collaboration with Don Meichenbaum). He has published many chapters and a large number of scientific papers, and presented conference papers and special lecture.

Colleagues have described Ken Bowers as one of the top theorists and researchers in the field of hypnosis. He is credited with the development of a theory of hypnotic remembering that has been labeled the "theory of dissociated control". He also remembered for his *Psychological Review* paper in 1973 entitled "Situationism in Psychology: An Analysis and a Critique". A colleague described that paper as a "true tour de force that stopped in its tracks the then rampant ... denial of individual differences". This paper is highly respected by personality theorists and is a part of the legacy Ken Bowers left us.

In his final days, Dr. Bowers put forward a *Psychological Bulletin* article that is having a substantial impact on understanding of the false memory syndrome area. In the views of his colleagues at Waterloo, throughout Canada and the continent, his loss is a very unfortunate and abrupt conclusion to a career that was reaching its peak level of performance.

The Executive of the Clinical Section at its January meeting decided to name the annual student research award in honour of Ken Bowers, to be known henceforth as the **Ken Bowers Student Award**

... Message from the Chair

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on this topic.

If you have an interest in contributing to the preservation and growth of the discipline in these ways, why not consider standing for election into one of the positions on the Executive Committee?

... Message du Président

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ments à validation empirique, qui décrira la position de la Section à l'égard des nouveaux développements en la matière.

Si vous désirez contribuer au maintien et à la croissance de la discipline, pourquoi ne pas poser votre candidature à l'un des postes du Comité exécutif?

Now we're facing the consequences

A Conversation with Nicholas Cummings

The following interview appeared in November 1996 issue of the AAAPP newsletter, Cummings, N. (1996). *Now we're facing the consequences. The Scientist Practitioner*, 6 (1), 9-13.

Editor's Note: *I read this article on the SSCP mail list, concluded it would contribute to our understanding of changes occurring in Canada, requested and was given permission to reprint. As a courtesy and for your information, at the end of the interview is some information about AAAPP and how to join it.*

Nicholas Cummings is a former president of the American Psychological Association and has been one of the leaders of the movement to integrate psychology into behavioral health services offered within managed care settings. Cummings worked for many years at Kaiser-Permanente, one of the first health maintenance organizations in the country. He then took this knowledge into a highly successful private business, Biodyne, which can be seen now as an opening wedge in the movement towards managed care in mental health services. His Foundation, funded in part from the proceeds from the sale of Biodyne, recently awarded the first Psyche prize, the largest cash prize in psychology, to Rutgers psychologist Arnold Lazarus. The following interview was conducted at Dr. Cummings home by outgoing AAAPP president Steven Hayes on October 3, 1996.

Hayes: You've been involved in managed care for along time. There's a group of the practice base in psychology that thinks that what were facing right now is a temporary glitch, that were somehow going to go back to the glory days of fee for service psychology. I'm interested in what you think, looking ahead over the long term, about whether or not what were seeing here is really a fundamental realignment of how mental health services are going to be delivered and paid for. Is this a temporary problem that psychologists are facing?

Cummings: Quite the contrary. I think you're seeing the industrialization of health care. What we see now is not going to be what we see in ten or twenty years anymore than what we see now in an automobile has any resemblance to Henry Fords Model T. Once Henry Ford invented the assembly line we never went back to the horse and buggy. We've emerged from a cottage industry to an industrialized industry and once industrialization takes place there's no going back. One of the questions I'm constantly asked is, "why are we industrializing?" That's not the question. The question is, "what took us a hundred years after manufacturing to industrialize and fifty years after retail?" Here you have something that takes twelve percent of the gross national product and it took a hundred years to industrialize. That is the real phenomenon. I think it speaks to the tremendous confidence that the American

people had in the professionalism of the health care practitioner that it took that long.

Hayes: Fee for service mental health care was dominated by doctoral practitioners, it was dominated by small group practices, it was dominated by high fees. What do you think are the three or four biggest differences between the modern world were heading into and where we have been in the 70s and 80s?

Cummings: Every industry, as supply increases, prices go down. The one exception was health care and the reason for that was that the professional controlled both the supply and the demand. So the more physicians we had, the more demand. If you got too many doctors and they had to divide smaller and smaller parcels of patients they would up the number and cost of procedures and the lab tests and everything that they were doing. So consequently, the demand never went down because we have a lot of doctors. The government was waiting all those years for the day that the supply of doctors would solve the problem: "boy, then were going to see health care prices drop." But what they didn't bank on and what every economist now knows "When doctor controls both supply and demand, prices go up."

For example, research addressed this question: "what is the biggest predictor of how many patients per capita will be hospitalized in psychiatric facilities?" The answer was the number of psychiatrists in that community. It had nothing to do with need. And this permeated the whole fee for service system.

Now we have removed the control from the professional so that the doctor neither controls supply nor demand. Now they desperately try to control supply. They want to figure how to cut down on the number of practitioners that are graduating and so forth, but that has limited impact and demand now is totally out of their hands.

Its in the industrialized system that we've now evolved. Right now, we were in the Model T Ford stage, we are nowhere near the Lamborghinis and the Porsches that were going to see years from now.

It is a start. The remarkable thing is that even the beginning, changes in this industry have tremendously slowed the accelerating inflation curve that was just going off the wall. In many instances they've actually reduced costs.

Hayes: Specifically within the behavioral health care, especially with fully capitated systems and staff model systems, use of the "lowest competent provider" is now the rule of the day. In that context are we past a place in which doctoral level psychologists are going to be the dominant deliverer of psychological services?

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"Right now, were in the Model T Ford stage, we are nowhere near the Lamborghinis and the Porsches that were going to see years from now."

...Conversation with Nicholas Cummings

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Cummings: Yes, we have. I hate to say that, but we have. What's really going to make this possible is the development of better protocols and guidelines that masters level technicians will be able to follow. My own research we found years ago that the best protocol will cover somewhere between 30 and 35 percent of the population for which it is intended. The other 60, 65 percent needs clinical judgment. And that's where the doctoral level providers must be.

Hayes: And then wouldn't a major part of the job of the doctoral level person be to turn that 65 percent into 60 and then 50 and then 40 and so on? Its not going to be just normal delivery services even with complex cases but its treatment in order to do treatment development.

Cummings: You're absolutely right. You don't have the automotive engineer down on the assembly line putting in rivets. The doctoral level psychologists will be developing the protocols, and testing the protocols. The goal will always be to raise that 30 percent of protocol responsive cases to 40, to 50, to 60, hopefully to 90. There's a level at which we might get alarmingly close to the cookbook stage. That is far off and there will always be room for clinical judgment.

But we have to make room for masters level providers. This is going to surprise you. Group practices owned by doctoral practitioners have more non-doctoral people than group practices owned by managed care companies. Once he or she is at risk, psychologists sees the light and say: "Why should I be putting a Mercedes engine on a bicycle?" And so they gear the level of training to the task that has to be done.

Hayes: But psychology has spent the last twenty years going in the opposite direction. Organized psychology seemed to have the idea that we needed to get rid of the masters level people, crank up the supply of doctoral people, change the model away from scientist-practitioners, and add layer upon layer of specialization and practice restrictions. As a result, how many doctoral psychologists even have the training to fit into the world that is coming? Do you think that we have prepared for our students to do what is now needed, either in the university-based programs or professional school programs?

Cummings: No, no. We're training great psychologists for the 1980s! Were not prepared for the 90s or the year 2000 whatsoever. Henry Seaman at the National Psychologist resurrected an editorial of mine in the APA Monitor that came out in 1974 where I pleaded with the APA to assign a rightful role to the doctoral level psychologists, a rightful role to the masters level psychologists, forget about the Psy.D. because the Psy.D. is nothing more than an excuse to have doctoral level practitioners. He or she would still be called doctor but it was clearly an accommodation of the

APA's determination to keep psychotherapy exclusively at the doctoral level. If we had gone the route that I suggested in 1974 our problems would be solved now. We wouldn't have this glut of Ph.D. psychologists who want to do psychotherapy one-on-one and still have a practice. The masters level people would be in their rightful place, the Ph.D.s would be in their rightful place and the APA wouldn't be in this terrible crisis.

Hayes: I wonder if were not doing the same thing all over again with the idea that we should have more and more specialty training and limit practice within specialty domains. The National College for example, or the development of different accreditable specialties and competencies. Or prescription privileges, which would add another two or three years to what we are already doing in six or seven years. Meanwhile we some really trying to crush masters level people to the point that they are even eliminated in the states where they have any

kind of psychological associate licensing. It seems like our major professional adjustments have been in the opposite direction of what you're talking about.

Cummings: Your question is really a very astute one. The APA is trying to salvage the bad decisions we made in the 60s and 70s. Uwe Rheinart, the Princeton health economist, says the age of specialization is over, that the LPN is going to be doing the work of the RN, the RN is going to be doing the work of the physician, the GP is going to be doing the work of the specialist, and the specialist is going to be driving taxicabs. So what is the APA doing; its creating more and more specialization! The prescription privilege thing can go either way. We might end up adding more years, which would be a ridiculous way to go, but on the other hand prescription privileges have been extended downward rather than upward. Nurses are prescribing, optometrists are prescribing, podiatrists are prescribing, and in many states, pharmacists are now prescribing so that this would be more of a reduction of specialization, I think. Unless the APA, in its inimitable style, makes this an incredible super specialty... which they're likely to do because they consistently go in the wrong direction, no question.

Hayes: Lets deal with prescription privileges because that's something that AAAPP has been involved in . We have exerting leadership to slow down the movement towards it. And one of the things that has moved AAAPP to take a position is we fear that really what were trying to protect with the prescription privilege movement is the Mom and Pop level of health care. It isn't that were going to now fit into the industrialized health care system as a cost-effective, value-added professional that can also prescribe. It seems to me that the fantasy is that were going to have our private practice offices being filled now by people who are coming in for fifteen minute med-checks at eighty

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"But we have to make room for masters level providers."

CPA Adopts Two New Sets of Guidelines - Commentary by Jean Pettifor

Guidelines for Non-Discriminatory Practice Adopted November 1996

There are many groups of people representing specific interests that believe that they have been excluded, or suffered discrimination within the larger society, because they are different, devalued and considered deviant. Such groups may be identified by their ethnicity, gender, sexual orientation, socio-economic status or disabilities. The demands for social justice include protesting exclusion, patriarchy, and discrimination, and, supporting inclusion, respect, egalitarianism and participation. The concerns relate to research methodologies and interpretation of results, to teaching and professional training, and to access to appropriate services. Some groups, most notably women, have obtained special guidelines and standards approved by professional bodies. The Canadian Psychological Association has approved a number of policies and guidelines on gender issues. Our generic ethical principles emphasize respect and caring for all people without discrimination and emphasize the need for professionals to be self-reflective and sensitive to their own attitudes, beliefs and biases in order to be accepting of diversity. However, this is the first time that CPA has adopted guidelines for non-discriminatory practice that are generic to all kinds of discrimination and all kinds of populations.

The strength of the Guidelines for Non-Discriminatory Practice is that they are linked directly to the Canadian Code of Ethics for Psychologists, which provides the moral framework for all psychological activities. Each of the four principles, Respect for the Dignity of Persons, Responsible Caring, Integrity in Relationships, and Responsibility to Society, are described as they apply to diverse populations. Consistent with the code of ethics, professionals are expected to take extra responsibility that vulnerable people are treated with respect and caring. The tone is proactive. The narrative is followed by 21 guidelines for ethical practice with diverse populations.

Guidelines for Psychologists in Addressing Recovered Memories Adopted August 1996

The guidelines were developed for psychologists who encounter clients dealing with forgotten or recently remembered life events. The goal is to promote competent care in therapeutic work with clients, as well as to provide guidelines for evaluating the appropriateness of practices should there be questions about the competence of the practitioner. The primary purpose is to support psychologists in serving the public good, rather than engaging in controversy over the "false memory syndrome" or the relevance of empirical research on memory. The guidelines are aspirational to aid in practical decision making rather than mandatory rules or exhaustive behaviours.

A strength of the guidelines is the referencing to the principles and standards of the Canadian Code of Ethics for Psychologists. The issues in the recovered memory/false memory debate all have an underlying moral framework of how to provide beneficial rather than harmful services. Each of the seven general statements is described in terms of its application to addressing recovered memories and each is referenced to the Canadian Code.

The general statements are listed below:

1. The psychologist's primary purpose is to serve the best interest of the client.
2. Psychologists clarify their roles as therapists and counsellors and avoid multiple relationships that may impair their professional objectivity.
3. The psychologist obtains specialized competence in addressing recovered memories.
4. The psychologist acknowledges and strives to overcome unjust discrimination.
5. The psychologist maintains professional objectivity and impartiality in presenting legal evidence.
6. The psychologist always informs clients about the limits of confidentiality generally, and, in considering potential litigation, informs clients specifically about the limitations on confidentiality.
7. The psychologist has a responsibility, which may be undertaken in various ways, for helping to eliminate negative aspects of society, but in doing so must never place the welfare of individual clients at risk.

*For complete copies of both documents contact the Canadian Psychological Association, #205, 151 Slater, Ottawa, Ontario K1P 5H3
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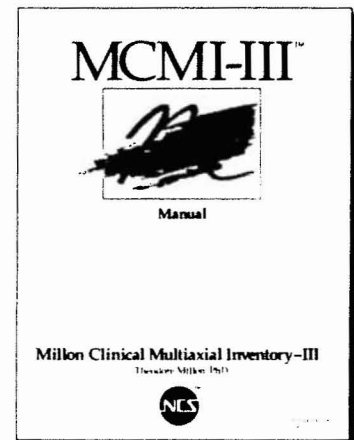
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...Conversation with Nicholas Cummings

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or ninety dollars instead of having to fight for a managed care company to allow us to charge eighty dollars an hour when we feel like we should be charging a hundred and twenty for psychotherapy. There is a problem here but this response might, if we don't act carefully, take us in the opposite direction of showing that we can provide an economically justifiable benefit in the health care system based on what we actually know.

Cummings: If we take it in that direction it will be more of the same. I've predicted that fifty percent of doctoral level psychologists will not be in practice by the year 2005. If psychologists get prescription privileges we might lose twenty five percent of them and the other twenty-five percent will come out of psychiatry. The managed care company is going to say to psychiatry, "Why should we pay your higher fees when you can get a psychologist to do it?" Just like they tell us in psychotherapy now, "Why should I pay your fees when I can get a masters level person to work cheaper." So I'm afraid that most people who are looking for prescription privileges are looking for a way to somehow save private practices.

Hayes: Fairly quickly within managed care doesn't it seem clear that our competition would not be psychiatry but RNPs? And do we really want to compete with a doctorate plus additional training with RNs?

Cummings: If we use prescription privileges as a very small part of our practice, as an adjunct to psychotherapy, we wouldn't have that problem. Its when the tail wags the dog that we could be in trouble. There was a movement that I headed around 1970 in the APA to look at the prescription issue. The committee came out with a report saying that if psychology did indeed get prescription privileges it would stop doing as much research and innovation in psychotherapy. And immediately I saw that this was right and I reversed my position. Psychology became the preminent psychotherapy profession because not having the access to prescriptions and having the ability to do research we have come up with psychotherapies nobody even dreamed of twenty-five years ago. We will probably lose that. Once you have the prescription pad it is such an easy way out just to reach across your desk and pull the damn thing out.

Hayes: There are a number of people who think that psychotherapy can't cost-justify itself in the health care system because its always going to be cheaper just to write a prescription. Even within psychology you can see a real loss of faith. Are we on the losing side of a cost-benefit debate that will lead us into irrelevancy?

Cummings: I don't think so. You know, when I was CEO of the company that had 14.5 million subscribers and we were seeing thousands and thousands and thousand patients from coast to coast most of the people we saw in psychotherapy had already had medication fail. They went for

the quick-fix first. They finally come into psychotherapy to get some relief for their symptoms and their pain. So I don't think medication will ever put us out of business. Absolutely not. But it behooves us to make our treatment procedures more and more cost effective. We can no longer afford long term therapy for the sake of the doctor. There are patients that should get longer term therapy about fifteen percent. But this is because these people should get longer term care not because the therapist needs it.

Hayes: It seems as though we have built, in our university studies and also in our practice base, a model that ignores all kinds of behavioral health problems simply because they don't fit a particular syndrome or classification, or there isn't a sixteen session protocol that can be delivered once a week fifty minutes. An example that is dear to your heart is primary care. And yet it seems as though we just walked away from this issue and have abandoned it to others. It is as if it is not psychology is there is not a separate office and a separate waiting room.

Cummings: Psychotherapists of the future will only be doing one-on-one psychotherapy with about twenty-five percent of the patients. And the rest will be group therapy and maybe fifty percent will be psycho-educational models. The Hawaii study, for example, showed with chronic conditions such as asthma and emphysema and diabetes and so forth, that psychotherapy raised costs, but a five session psycho-educational model reduced costs tremendously.

People who have chronic conditions, people who have pain, people who have anxieties and phobias they cant understand love to be educated about their own condition.

Hayes: What kind of implications does that have for organizing our training programs? What are the barriers that we have to face inside the discipline to move into the primary care setting and to very, very short term interventions for problems that are not even considered to be "psychiatric" syndromes?

Cummings: I've seen tremendous, if not a dismal ignorance. Most training departments in psychology have no idea what's happening out in that world. My hunch is that it probably is going to get better as these program are broken from the bottom up. When students find out they don't have jobs, they don't have incomes, they don't have a livelihood when they graduate and the word filters down then new graduates coming in are going to demand changes just like the new breed of medical students changed the medical schools a decade ago. And of course managed care changed medicine only a decade before there was a behavioral health so now it is our turn. I think its going to come from the students. Unfortunately University faculty live on their own momentum they keep doing whatever they've always been doing.

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Most training departments in psychology have no idea what's happening out in that world.

...Conversation with Nicholas Cummings

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Hayes: How do you see the health care system reorganizing itself as an industry as a business?

Cummings: We will have universal care. The question is "How will it be done." And managed care may make it economically possible. Managed care is the centerpiece for all health plans that look toward universal health care in the United States. Government medicine has not worked. It introduced a new kind of rationing that nobody anticipated. Europe is looking at what we're doing and now they are trying to privatize it. They're going to keep the single payer system. England has gone ahead with what they call fund holding. 60 percent of the physicians will be fundholders by April 1997. They get a pot of money for taking care of a population. In the United States, managed care has done an incredible job of bringing down costs. They really have. It's creating a whole host of other problems that we're now in the process of solving. One thing I think you're going to see over the next five, six, seven years is regulation. Government is going to enter the field through regulation. You never have an industry that goes from ground zero to seventy percent of the market in ten years that doesn't end up getting regulated. It happened to the railroads and it happened to the telephone.

Hayes: AAAPP has fostered an initiative to really look at how we can link the behavioral sciences to the health care industry in the form of practice guidelines, treatment protocols and things of that kind where the best available scientific evidence is linked standards of care instead of simply cost reduction in the form of session limits and other first generation cost reduction efforts. Where do you think that's going? This sort of general issue of clinical pathways, treatment protocols, practice deadlines and so forth?

Cummings: I helped midwife the American Managed Behavior Healthcare Association. I had hoped it would fulfill that function; that it would pool knowledge, it would encourage knowledge, it would form knowledge and the whole industry would benefit. What has happened is that the industry has become incredibly competitive. It has become so competitive that margins are getting down to tissue paper thin levels. And when companies start losing money or nearly losing money then they try to find a way to differentiate each other. They want to say "See, we're better than X, Y, Z." During this period where the margins are so thin, everybody is terrified of sharing knowledge. Everybody acts as if he or she has a black box. Nobody has a black box. They're all doing the same damn thing but they've gone so far as to say, "I won't share my application form for practitioners to go on the network because I have the best application form in the industry." And when you look at it, it isn't the best form. But everybody has gone to the cus-

tomers and said, "We have all of these things that nobody else has." So we were going through that period where everybody's playing the cards close to the vest. When we get over that, then I think we're going to start pooling knowledge and doing a better job of linking practice to that.

Hayes: One of the things AAAPP is trying to do is to try to get people in the room and begin to take down some of the proprietary boundaries. We have a conference in November to begin to do that [see story of page 2 of *The Scientist Practitioner*, 6 (1)]. How are we going to go from this very proprietary stage to one in which is a more open linkage between the best available knowledge and the standards of care that are built into delivery systems?

Cummings: I have a tremendous faith in the entrepreneurial system. Eventually the marketplace will decide who is the best but we have to get through this stupid period where about 75% of the companies in existence today are going to die. It's that simple. They're too many companies doing the same thing, trying to differentiate themselves. Right now this competition is fueling tremendous potential knowledge that one of these days is going to break loose and we're all going to become the recipients.

I remember in 1950 when we learned to

freeze food and housewives quit canning in jars and there were hundreds of frozen food companies on the market. And I remember a professor I was taking economics from said, "In two years there are going to be

five frozen food companies." And he was right. And the ones that survive it are going to be the best ones. They're going to know how to do it; the best and the cheapest. We're in that stage now. When you get over this period the industry is going to fund this kind of thing just like the automotive industry funds a tremendous amount of research that benefits all of the companies. They all chip in, they all pool knowledge. Essentially the only thing the automotive companies hide from each other is the body of what next years model is going to look like. The internal combustion engine, braking systems: all that knowledge is available to all of them. Nobody has anything that the others don't have and it's done by the automotive research institutes. I think eventually we'll have that. That's what I tried to do when I formed the Biodyne Institute. "X" portion of the dollars that American Biodyne generated would go to research, and we would publish it and it would be available to everybody. The Biodyne Institute did the Hawaii project. The data from the Hawaii project became the appendix to every RFP for every managed care company that was applying for a Medicaid contract.

Hayes: Is there any way to prevent the transition that is happening in health care through guild activity?

(Continued on page 10)

"How are we going to go from this very proprietary stage to one in which is a more open linkage between the best available knowledge and the standards of care that are built into delivery systems?"

...Conversation with Nicholas Cummings

(Continued from page 9)

Cummings: You don't ever stop industrialization by self interest. You may slow it down, you may derail it for a while but once industrialization starts it rolls right over that. And I can tell you, I talk to employers, they have written off our professional guilds. They consider them moribund, they consider them selfish. There was a time years ago when the American Medical Association were the bad guys and the American Psychological Association were the good guys. Now we're the bad guys. The American Psychiatric Association, and the American Psychological Association: we're the bad guys. Employers tell me those organizations are going to go down the tubes.

Hayes: Design a psychology training program to fill the need you see coming.

Cummings: [laughter] Well, I failed at this once when I helped found the professional school movement. I always felt that the people that are the most aware of the research that needs to be done are the people that are in the trenches. I wanted to bring practitioners and researchers together under one roof where it had always been academically dominated. And unfortunately the opposite effect took place and it became professionally dominated. I found out that runaway professionals are no better than ivory tower academicians. The professional school movement has dragged their feet probably more than anybody when it comes to managed care.

A few are now finally getting on board but most of them are still turning out students that want a shingle, a couch, and a Mercedes in the driveway.

Hayes: As a discipline and as a profession, what's your prediction? Are we going to succeed or shoot ourselves in the foot?

Cummings: I think as a profession as we know it today we're going to shoot ourselves in the foot. APA is a problem. We might be able to solve that if we retire every private practitioner over fifty and then APA would no longer have to be held accountable to these atavistic Neanderthals who are the power structure within the APA. I think psychology as we know it and its institutions are not going to survive. What follows it, whether its a AAAPP or APS or what, I don't know. More and more people on the cutting edge of the profession are leaving APA. It used to be the scientists, now it's also the cutting edge practitioners. Who knows? I'd hate to see it, you know. If I live another fifty years I don't think I will want to call myself a past president of an organization that will no longer exist.

Hayes: I think and lot of practitioners think that managed care is about "will I pay you and how much?" as opposed to "what will you do with this person and what is the outcome?" The second generation of managed care is different. I don't think people realize that's coming.

Cummings: It is coming. Its already started, especially in

staff models. I've seen staff models go both ways. Most of the staff models that went belly up were because the staffs, instead of being on the cutting edge being excited having these clinical based conferences and doing research and refining their protocols, became like the post office. "I'm salaried, the less I have to do the better." But the protocols and innovations are coming. The Kaiser family tried to foster this: they had a huge array of small grants in the ten to fifty thousand dollar range. They rewarded the practitioners that came up with good ideas. Most of the work that I did at Kaiser was on this kind of funding. Kaiser in those days was on the cutting edge.

Hayes: What effect do you think changes in managed care will have on prevention in behavioral health areas?

Cummings: As far as behavioral health we are getting in to real protocols that address targeted conditions. These protocols usually have three aspects: 1) treatment, 2) management of the condition and 3) prevention. These vary a fair amount with the particular conditions that are being addressed. Some have more management than treatment; some have more treatment than management; some have more prevention than treatment and so on. It varies.

Let's take some examples. Say you have a group treatment protocol for persons with borderline personality disorder. It probably has more management and treatment than prevention. On the other hand, take a parenting protocol. It will have more prevention

than treatment. So I think we are approaching prevention from a somewhat different standpoint, but nit is very important in managed care. The model of prevention for half a century was the public health model. That does not lend itself that well to where we are coming from, but prevention is still very important.

Hayes: Is psychology a victim of its success? Is that what is making the transition so hard?

Cummings. The big cash in for psychology came when medicine and surgery were tethered to DRGs and the hospitals, the medical and surgical beds were empty. The hospitals said, gee, if we transport all those beds into psychiatric beds that might work. Suddenly psychologists were flourishing. I met psychologists that were making four hundred thousand dollars a year hospitalizing people. All of a sudden it was a cash cow for psychotherapists, a real cash cow. Whereas medical and surgical colleagues were starting to hurt. I said at the time, "We're going to hurt like they do eventually." Nobody believed me. You know what killed General Motors was not only that the Honda Civic is at the right place at the right time; it was one dollar a gallon gasoline. As long as gasoline was 25 cents Americans all wanted these huge V8s that got eight miles to a gallon that roared and rumbled for us.

Hayes: Well, that's kind of like fee for service. We all got

I think as a profession as we know it today were going to shoot ourselves in the foot.

(Continued on page 11)

Charles Morin APA Distinguished Scientific Award

Recently our Section on Clinical Psychology Chair-Elect, Dr. Charles Morin, was honoured by the American Psychological Association with a Distinguished Scientific Award for an Early Career Contribution to Psychology. This is an exceedingly prestigious award granted only to individuals who make marked contributions to the science of psychology early in their careers. We are very pleased for Charles and congratulate him on his achievements and on his award. The following is an excerpted description from the *American Psychologist* (April, 1996) of Charles' background and his research and career accomplishments.

Charles was born in Quebec in 1956 and was raised in a rural community close to Quebec City. After two years in a junior college, Charles enrolled in Laval University in a psychology program with a focus on humanistic/existential perspectives. He graduated in 1979 and worked as a school counsellor for one year and returned to Laval to complete a masters degree in clinical psychology. In 1982, Charles enrolled in a PhD clinical psychology program at Nova University in Ft. Lauderdale, Florida under the supervision of Nathan Azrin where he began his studies on sleep and sleep disorders. Charles completed a clinical internship at the University of Mississippi Medical Center in Jackson, Mississippi and graduated with the PhD in 1986. In the same year, Charles was offered a postdoctoral fellowship in sleep disorders medicine at the Medical College of Virginia and worked independently to increase his knowledge and expertise in the area of sleep disorders. His work was of a very high quality and he became a Diplomate of the American Board of Sleep Disorders Medicine, a credential held by very few psychologists.

At the completion of his post-doctoral studies, Charles was offered a faculty position in the Department of Psychiatry at the Medical College of Virginia and quickly moved to being the Director of the Insomnia Clinic and the Sleep Disorders Center. More recently, Charles returned to Canada and a faculty position at Laval University. He is currently an Associate Professor and Director of the PhD Clinical Psychology program, the Director of a new sleep research centre in Quebec City, and Chair of a task force of the American Sleep Disorders Association.

Charles' research interest has focused on sleep disturbances and has focused on three major pursuits: (1) Cognitive variables in the etiology of sleep disorders; (2) evaluation of the efficacy of nonpharmacological treatments for insomnia; and (3) expanding the applicability of psychological procedures to sleep disturbances in specific populations including the elderly, psychiatric patients, and medical patients. He has received funding from a variety of sources to support his training and research. For example, in addition to receiving funds from the Social Sciences and Humanities Research Council of Canada and from the Fonds pour la Formation de Chercheurs et Aide à la Recherche, he received a FIRST grant from the National Institute of Mental Health to assess outcome of various treatment strategies for late-life insomnia. His research has been continuously supported by the National Institute of Mental Health. His work has led to numerous published articles in top journals (e.g., *Sleep*, *Journal of Consulting and Clinical Psychology*, *Psychology and Aging*) and has published two books, a treatment manual and a self-help book for the public. Once again Charles, congratulations!

...Conversation with Nicholas Cummings

(Continued from page 10)

to roll around with 25 cent gasoline and psychotherapy Cadillacs.

Cummings: Absolutely. Can I give you a quote from Rogers Wright? You probably know Rogers.

Hayes: Oh yeah. Sure do. I've been on the other side of the fence several times with him.

Cummings: I confronted him a few months ago and asked him why a man as bright as he has missed every boat for ten years. And he thought a minute and he said, "Well, I was where all my colleagues were." And I said, "Where's that?" And he said, "When you're practicing in the land of milk and honey, and some guy comes in and spins you around and says, The cow's eventually going to run dry, well, he's just not going to be listened to." And I said, "Rogers, that is probably one of the three honest things I've heard you say in the forty years I've followed you." Yes,

you're absolutely right. The private practitioners had no incentive to lower costs and change their ways to more effective forms of practice. Now we're facing the consequences. Now we're facing the consequences. How about some more coffee?

Hayes: Don't mind if I do.

That is the end of the interview.

Kurt Salzinger and Stephen Hayes graciously gave us permission to reprint the Cummings interview, so the least we can do is to add a short commercial.

*The American Association of Applied and Preventive Psychology (AAAPP most people call it "triple A double P") is a national society of scientifically oriented psychologists in all applied sub-areas of the discipline. It costs \$49 a year (\$34 for students). AAAPP has a truly excellent applied journal, *Applied and Preventive Psychology: Current Scientific Perspectives* (edited by Sam Osipow) that comes free with membership.*

(Continued on page 12)

BRIAN COX

AABT NEW RESEARCHER AWARD

The citation in the March 1997 *the Behavior Therapist* reads: "Brian Cox is Assistant Professor at the University of Manitoba. He was staff psychologist in the Anxiety Disorders Clinic of the Clark Institute of Psychiatry, where he worked with Richard Swinson on several projects, including a telephone-administered behavior therapy study for individuals with panic with agoraphobia. Dr. Cox is widely published in the area of anxiety disorders and is a member of the editorial board of *Behaviour Research and Therapy*. He is collaborating with John Walker to investigate professionally led versus self-help forms of cognitive behavior therapy for social phobia. Dr. Cox wishes to acknowledge the support of his nominator, Ron Norton."

Well done Brian! We are proud to have you with us.

... AAAPP

(Continued from page 11)

and a lively newsletter, the *Scientist Practitioner*, that included this interview and that members receive free, and a national convention that rounds out and supplements the APS convention for applied scientists.

AAAPP has a number of national initiatives. For example, it has sponsored A National Planning Summit on Scientifically-Based Behavioral Health Practice Guidelines as part of a sustained effort in the development of science-based standards of practice, and has an initiative to slow the rush toward prescription privileges for psychologists

1996-97 AAAPP Board is as follows

President: Kurt Salzinger, Hofstra University

Member at Large: Kathy Grady, Massachusetts Institute of Behavioral Medicine; Ellen Kimmel, University of South Florida; Robyn Dawes, Carnegie-Mellon University; Victoria Follette, University of Nevada. Secretary: G. Terence Wilson, Rutgers University

If you want to join AAAPP, fax, email, or mail to AAAPP, Department 199, Washington, DC 20055-0199

Dues: \$49.00 (International members add \$10.00; student subtract \$15)

The normal AAAPP address is AAAPP, 1010 Vermont Avenue, N.W., Suite 1100, Washington, DC 20005-4907 (this is the same as the APS address)

The AAAPP phone number is (202) 393-7073, FAX: (202) 783-2083

The email address is AAAPP@capcon.net

CONVENTION UPDATE

Arrangements have been made for an exciting program of the Section-sponsored events at the CPA convention in Toronto. On Wednesday, June 11, there will be a pre-convention workshop on "Interpersonal Psychotherapy for Depression" given by Laurie Gillies and Edward McAnanema. IPT has been generating a lot of interest lately, so this skills-oriented day-long workshop promises to be a terrific opportunity to learn more about it. Enrollment is limited, however, so register early.

During the convention proper, we will also be hosting a symposium on "A Canadian Perspective on Research and Treatment Issues for Depression," chaired by David Clark. This symposium will feature some of the country's foremost depression researchers providing overviews of their research programs. This will be a good place to acquire a broad perspective on recent developments and new directions in Canadian research on depression.

Anxiety disorders will also be well represented. Michel Dugas and Stéphane Bouchard will be conducting a two-hour workshop on "Cognitive Behavioural Treatment of Panic Disorder and Generalized Anxiety Disorder," two problems for which effective CBT protocols have been developed and validated.

Finally, there will be two Section-sponsored conversation hours. Deborah Dobson will chair a session on "Issues in Internship Selection," while Robert McIlwraith will chair a session on "Rural and Remote Communities: Issues for Clinical Psychology Training and Practice."

See you in Toronto!
Charles Morin

BULLETIN

Summary of Paper Submissions for the next CPA Meeting:

There were 77 submissions for poster presentations and 12 submissions for oral presentations. All submissions were peer-reviewed.

Charles Morin
February 28, 1997

networking

Our Home Page

The Clinical Section home page is ready for presentation. Look for it soon via the CPA home page!
<http://www.cpa.ca/sections/Clinical.html>

Clinical Section E-Mail Directory

The email directory lists those addresses submitted to the editor for inclusion. You are invited to submit your name for inclusion so that more of your colleagues can correspond with you on the internet.

Are you interested in having a Canadian Clinical mail-list forum? Let us know. Send your email address to the editor :
 (dhart@play.psych.mun.ca)

Carl von Baeyer	vonbaeye@duke.usask.ca
Arthur Blue	ablue@mail.techplus.com
Lorraine Breault	lbreault@oanet.com
John R. Cook	jcook2@UVic.CA
Dave Erickson	DERickso@ROHCG.ON.CA
Stephen Fleming	sfleming@yorku.ca
Larry Sun Fong	lsfong@web.net
Thomas Hadjistavropoulos	hadjistt@meena.cc.uregina.ca
David S. Hart	dhart@play.psych.mun.ca
Paul Hewitt	phewitt@cortex.psych.ubc.ca
John Hunsley	hunch@uottawa.ca
Michael C. King	mking@acs.ucalgary.ca
Leslie Langdon	leslie_langdon@cclink.metrodesk.metrotor.on.ca
Sam Mikail	smikail@neptune.on.ca
Wayne Nadler	wnadler@trytel.com
Rhona Steinberg	Rhona_Steinberg@sfu.ca
Allan Wilson	ARWILSON@GOV.NS.CA

URLs OF INTEREST !

CPA Home Page - <http://www.cpa.ca/>

CLINICAL INTEREST SITES

www.algy.com/anxiety/anxiety.html
 The Anxiety-Panic Info Resource - tAPir

The Elder Abuse Home Page
<http://healthy.uwaterloo.ca/bear/>

Regarding Evidence Based Medicine (EBM) I found the Centre for Evidence-based Medicine's home page.
<http://cebim.jr2.ox.ac.uk/docs/adminpage.html>
Nice presentation. Obviously a work in progress. Look for CATs: "The CATbank will be a creation, storage and retrieval facility for a collection of CATs (CriticallyAppraised Topics)."

<http://www.mhsource.com/help/ref.html>
Mental Health Infosource

<http://www.cityscape.co.uk/users/ad88/psych.htm>
Psychiatry On-Line, web site of the International Journal of Psychiatry

<http://child.cornell.edu/APSAC/apsac.home.html>
The American Professional Society on the Abuse of Children (APSAC), an interdisciplinary professional society .

<http://www.digev.com/TechPsych/>
The URL was part of the Clinton inaugural display. It points to a variety of uses of the internet by psychiatry and psychology.

DISASTER & TRAUMA WEB SITES

http://play.psych.mun.ca/~dhart/trauma_net/
The home page for the Canadian Traumatic Stress Network

<http://hoshi.cic.sfu.ca/epix>
EPIX - The Emergency Planning Information Exchange Centre for Policy Research on Science and Technology, Simon Fraser University, Vancouver, BC

<http://www.dartmouth.edu/dms/ptsd/>
The National Center for PTSD on the World Wide Web, includes access to the PILOTS Database (THE database on PTSD), a substantial portion of the PILOTS Database User's Guide, and staff directories for several National Center divisions . .

(Continued on page 14)

... URLS OF INTEREST*(Continued from page 13)***DISASTER & TRAUMA WEB SITES**

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The home page for the Canadian Traumatic Stress Network

<http://hoshi.cic.sfu.ca/epix>
EPIX - The Emergency Planning Information Exchange Centre for Policy Research on Science and Technology, Simon Fraser University, Vancouver, BC

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<http://gladstone.uoregon.edu/~dwb/trauma.htm>
David Baldwin's excellent Trauma Info Pages, the most informative site on PTSD and related topics.

<http://www.istss.com/>
Web site of the International Society for Traumatic Stress Studies

<http://www.psy.uq.edu.au:8080/PTSD/>
Grant Devilly's PSYCH TRAUMA PAGES from the Psychology Department at The University of Queensland.

<http://www.mnsi.net/~rmccall/homepage.html>
VA Victim-Assistance Online, an excellent resource developed by Randy McCall, Windsor, Ontario.

<http://www.erols.com/icisf/Intro.html>
The International Critical Incident Stress Foundation, Inc., the CISD site.

<http://rdz.stjohns.edu/trauma>
Charles Figley's The Traumatic Stress Network.

Do let us know of any sites you have created or visited that could be valuable for your colleagues. We will add them to our directory (i.e., publish them in the next newsletter).

A Request Forwarded ...

Date: Tue, 04 Feb 1997 14:32:12 -0300
From: "Basileu G. Menezes" <basileu@cce.ufpr.br>
To: awilson@ac.dal.ca
Subject: Virtual Reality - Software and Hardware
Dr. Allan R. Wilson
My Name is Basileu G. Menezes, I'm a System Analyst in University Federal of Parana in Curitiba - Brazil, and student of first year of Psychology.
Actually we are working with Computer Graphics, Multimedia and Virtual Reality (3D Studio 4.0, 3D Max, VRCreator and Toolbook).
I would like to know who are develop projects with Virtual Reality (software and hardware - HMD's) in psychology.
Thanks for your attention.

Basileu G. Menezes

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FROM _____

CALL FOR NOMINATIONS OFFICERS OF THE CLINICAL SECTION 1997-98

One of the most obvious and meaningful ways you can show your support for the Clinical Section is to participate in the election process.

For 1997-98, the Section requires nominations for the position of Chair-Elect (a three-year term, rotating through Chair and Past-Chair) and Member-at-Large (a two-year term). Continuing members of the Executive for 1997-98 will be Charles Morin (Chair), Keith Wilson (Past-Chair), and Candace Konnert (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 April 15, 1997.

Send nominations for the Executive to:

Dr. Allan Wilson
Professional Services
The Nova Scotia Hospital
Box 1004
Dartmouth, Nova Scotia
B2Y 3Z9

editor's address
David S. Hart, Ph.D.
2343 West 7th Avenue
Vancouver, BC
V6K 1Y4

PRIX KEN BOWER POUR RECHERCHE EFFECTUÉE 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 certificat et une bourse de 250\$ seront remis à l'étudiant 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 dernière doit être acceptée pour le congrès de Toronto; 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 Toronto lorsque le prix sera décerné.

La date limite pour soumettre une application est le 30 avril 1997. Les demandes peuvent être formulées en français ou en anglais à l'attention de:

Charles M. Morin, Ph.D.
École de psychologie
Pavillon Félix-Antoine-Savard
Université Laval
Québec (Québec)
G1K 7P4
Tél.: (418) 656-3275 Fax: (418) 656-3646

STUDENT RESEARCH KEN BOWERS AWARD

Each year, the Section on 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 Toronto; (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 Toronto Congress, where the award will be presented.

The deadline for submission of applications is April 30, 1997. Submissions may be in either English or French.

Charles M. Morin, Ph.D.
School of Psychology
Pavillon Félix-Antoine-Savard
Université Laval
Québec (Québec) G1K 7P4
Tel (418) 656-3275 Fax (418) 656-3646

Fellows of the Clinical Section

Harvey Brooker

John Conway

Ken Craig

Keith Dobson

Anna Beth Doyle

John Goodman

David S. Hart

Charles Hayes

Andrée Liddell

Jean Pettifor

Susan Pisterman

Pierre Ritchie

Robert Robinson

Richard Steffy

Janet Stoppard

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 documentations of innovative programs; (2) Service to professional organisations 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 April 30, 1997 to:

Charles M. Morin, Ph.D.

School of Psychology

Pavillon Félix-Antoine-Savard

Université Laval

Québec (Québec)

G1K 7P4

Tel (418) 656-3275 Fax (418) 656-3646

DEMANDE DE PRÉSENTATION DE MISES EN CANDIDATURE 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 guise 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 propre milieu 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 30 avril 1997 à l'attention de:*

Charles M. Morin, Ph.D.

École de psychologie

Pavillon Félix-Antoine-Savard

Université Laval

Québec (Québec)

G1K 7P4

Tél.: (418) 656-3275 Fax: (418) 656-3646

MEMBERS OF THE CLINICAL SECTION OF CPA

LISTING OF THOSE WHO PAID THEIR SECTION DUES FOR 1997

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LIDDELL, MARIE ANDREE

Nova Scotia

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VALLIS, MICHAEL
WETMORE, ANN ANITA
WILSON, DR. ALLAN R.

Prince Edward Island

SMITH, PHILIP BRUCE

New Brunswick

BOUDREAU, SUZANNE
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EDITOR'S NOTE

The *Canadian Clinical Psychologist* has the potential to serve clinical psychologists across Canada as a forum for presentation of ideas and information about practice. The voice of the Clinical Section of CPA has no other platform, except for the Clinical Web Page whose birth is much delayed. Were the Clinical Section to provide leadership for clinical psychologists, the *Canadian Clinical Psychologist* is the essential medium through which to reach members. You may wish to leave matters to provincial associations, but if you would have a national voice, act so as to invigorate the Clinical Section of CPA. You have no other national representation. There is no other means for you to exchange ideas with colleagues across our country.

The present editor of the *Canadian Clinical Psychologist* has enjoyed a long run. Six volumes is enough. Fresh ideas and a renewed vision should now enliven these pages. A new editor will create the next volume. But who? Send nominations to **Paul Hewett** of the Section Executive.

D.S.H.

NEWSLETTER SCHEDULE

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Clinical Section Executive Officers 1996-97

Chair

Keith Wilson, Ph.D.
Psychology Department
Rehabilitation Centre
505 Smyth Road
Ottawa, K1H 8M2
Tel 613-737-7350 ext 5608
Fax 613-737-7056

Past Chair

Allan Wilson, Ph.D.
Psychology Department
The Nova Scotia Hospital
Dartmouth, NS B2Y 3Z9
Tel 902-464-3184
Fax 902-464-3460
awilson@ac.dal.ca

Chair-Elect

Charles Morin, Ph.D.
École de Psychologie
Laval University
Pavillion F.A.S.
Quebec, P.Q. G1K 7P4
Fax 418-656-3646
email: Charles-
M.Morin@psy.ulaval.ca

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Telephone: 514 382-3000 and 1 800 363-7800
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Canadian Clinical Psychologist/
Psychologue clinicien canadien
EPSE, 2125 Main Mall
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