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**CLINICAL PSYCHOLOGIST**

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**Message from the Chair**

Deborah Dobson, Ph.D.

*Welcome and What's New*

We are now well into the fall season, with its new classes, clients, students, interns and a more hectic pace than July and August. I hope that all of you had a relaxing and interesting summer as well as a pleasant Thanksgiving!

I would first of all like to express my great appreciation to our outgoing Executive Members. Dr. Catherine Lee has just completed four years on the Executive and has been elected to the President-Elect position of CPA. Congratulations, Catherine! We look forward to working with you in your new role. I want to extend a tremendous thank you for all of your hard work for the Clinical Section. Your wisdom, responsiveness and good common sense will be missed. I also extend my thanks to Andrea Ashbaugh, who has been our student representative and went far beyond the call of duty in her work with us. Andrea was very enthusiastic and it was great to have her ideas for new projects. She developed several proposals for student grants and awards, one of which was initiated at the June conference. This travel grant will be continued and will allow more students to be involved at annual conferences. Andrea was an excellent representative for clinical students. Thanks, Andrea!

I am pleased to welcome two new people to our Executive—they are Dr. Patricia Furer, who has taken the reins of the Secretary-Treasurer position, and Melissa Kehler, who has assumed the Student representative position. Patricia joins us from the Department of Clinical Health Psychology at the University of Manitoba and the Anxiety Disorders Program at St. Boniface

General Hospital. Melissa joins us from the Department of Psychology at the University of Regina. Dr. John Pearce is continuing on with the Executive as the Chair-Elect, Dr. Christine Purdon has stepped into the Past-Chair role and Dr. Andrew Ryder continues in the Member at Large. Thanks as well to Drs. Margo Watt and Jessey Bernstein for their hard work with the Canadian Clinical Psychologist.

The national conference in Ottawa was a huge success with record numbers of presentations and attendees. We were pleased to see so many clinical psychologists there not only to present and attend sessions, but to renew old friendships and form new ones. Our annual awards were presented and further details regarding the winners can be found in this newsletter. Information is also available in this issue for nominations for next year's awards and executive positions. Please consider nominating a deserving colleague or suggesting to students that they apply for the awards. The Executive has been planning possible activities for the 2008 conference in Halifax and it already looks like we will have several exciting and unique sessions, including a pre-convention workshop, public address and mini-workshop during the conference itself. We have been working with several other sections to co-sponsor some of these activities in order to include more members and to collaboratively work on areas of mutual interest. Further details will be announced soon! In the meantime, the deadline for submissions to the conference approaches. Check out the CPA website for further submission information. The submission deadline is November 15<sup>th</sup> and the conference dates are June 12<sup>th</sup> to 14<sup>th</sup> 2008.

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**Call for Nominations  
Officers of the Clinical Section**

An easy and meaningful way you can show your support for the Clinical Section is to participate in the election process.

For 2008-2009, the Section requires nominations for three positions (1) the position of **Chair-Elect** (a three-year term, rotating through Chair and Past Chair); (2) Member-At-Large (a two-year term); and (3) the position of **Student Member** (a one-year term). Continuing members of the Executive for 2008-2009 will be Dr. John Pearce (Chair), Dr. Patricia Furer (Secretary-Treasurer), and Dr. Deborah Dobson (Past-Chair).

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 statement from the nominee confirming his/her willingness to stand for office, and
- a letter of nomination signed by at least two members or Fellows of the Clinical Section.

Deadline for receipt of nominations is March 25th, 2007.

Send nominations for the Executive to:

**Dr. Christine Purdon, Past Chair**  
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*Autumn Reflections—Looking inward, Looking outward*

Clinical psychologists tend to be busy and have full practices, no matter what area of work they are in. In my experience, it is unusual for someone to be looking for something new to add to their already full plate of activities and balance can be hard to attain in our lives. And yet, there are so many exciting and important ways in which we can be involved within our profession as well as within our society as a whole. We may spend a great deal of time looking inward—assessing our practices, debating our research findings or critiquing different types of interventions. Most of us have been trained as researchers, which involves bringing a critical mindset to our practices. Looking inwardly has its advantages, in that we seldom overstate our case, are typically accountable, ethical and professional in our practices with students, research participants and clients. Yet the downside can be that we get caught in looking inward and can lose sight of the bigger picture.

It is also important to look outward, so that we can bring the best of what we do and how we approach problems to the many global and national problems that we face both as psychologists and as citizens. Canada is the only G8 nation in the world without a national mental health strategy. People struggle to find the services that they need for effective treatments, even when these treatments exist. Most people who are homeless have serious and persistent mental health problems and/or addictions. The new National Mental Health Commission has just begun with Michael Kirby at its chair. Two psychologists are on the Board of Directors and Dr. John Service has assumed the role of Executive Director. As psychologists, we clearly will be involved in this most important process and have a voice. It's an exciting time! One of the key goals of this Commission is to work to diminish the stigma and discrimination that many of our clients with mental health problems face every day. Another goal is to work to disseminate evidence-based information on all aspects of mental health and mental illness to government, stakeholders and the general public. As you read this, please consider how the Clinical Section should be involved in this process. Send me an e-mail or write to another one of the Executive members with your ideas. We will be discussing possible ideas and proposals at our January meeting. Let's not only have a voice, but let it be loud!

Another crucial issue for our society as a whole is the disturbing increase in chronic illnesses, such as Type II diabetes and in obesity rates in children, youth and adults. How can we as clinical psychologists address this problem with our clients and their families as well as promote behavior change on a broader level? One of the steps the Section has taken is to provide a free public lecture every year, prior to the annual conference in order to disseminate our knowledge. Dr. Michael Vallis has agreed to provide a public lecture in Halifax called "Winning the Battle of the Bulge: Real World Strategies for Obesity Management." If you live in Halifax and would like to help publicize this lecture, let us know.

These are two current opportunities that we have before us, among many other possible ones. Please let us know of ways in which you or your colleagues have been involved in disseminating what we do. We look forward to hearing from you.



## Co-Editors' Commentary

### Bad News; Good News!

The bad news is that Dr. John Service has left the position of Executive Director of CPA, a position which he has held for the past 14 years. The good news is that he has assumed the position of Executive Director of the new Mental Health Commission of Canada.

The creation of a Mental Health Commission was a key recommendation of the Standing Senate Committee's 2006 report entitled, "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada." The report outlined the need for a Commission to provide an ongoing national focus on mental health issues. The activities of the Commission (Chair: Senator Michael Kirby) are to be focused in three areas: developing a national mental health strategy; sharing knowledge and best practices for the benefit of Canadians from coast to coast to coast; and undertaking public awareness and education in order to combat the hurtful stigma associated with mental illness.

The Commission appears to be off to a very good start by securing the appointment of John Service. Indeed, if Dr. Service is half as successful in his new position as in his former, then mental health consumers, researchers, and service providers (including clinical psychologists) have reason for optimism.

Psychology," a new addition to the Clinical Newsletter and one that we hope will become a regular feature. Each issue, we will reserve space to present a Clinical Psychologist - researcher, academic, and/or clinician - who is making a

significant contribution to the field in Canada. We are hoping to profile individuals employed in various capacities from across the country - universities, hospitals, correctional facilities, community-based clinics, armed forces, business and industry, private practice, etc., We welcome all suggestions of people to profile and, of course, welcome offers for submission (and explicitly invite students to think about composing a profile).

-M.W. & J.B.



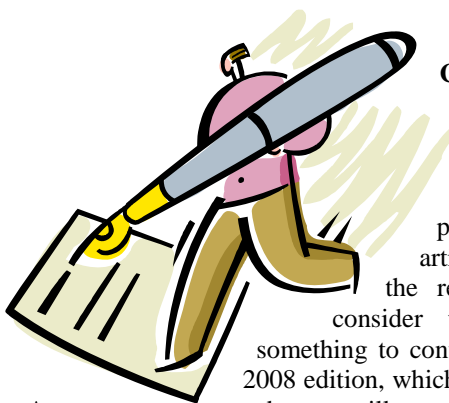
*The following was intended for the Spring 2007 edition of this Newsletter, but was mistakenly omitted. Our apologies. – M.W. & J.B.*

I would like to extend a huge thank you to the following members who reviewed submissions to the 2007 CPA conference in Ottawa. There was a record number of submissions and all the help was greatly appreciated by the Section Executive.

Thanks to:

Stephane Bouchard  
Tavis Campbell  
Shawn Currie  
Kate Diskin  
Keith Dobson  
Susan Graham  
David Hodgins  
Charlotte Johnston  
Candace Konnert  
Kerry Mothersill  
James Nieuwenhuis

-Deborah Dobson, Chair-Elect



### Have You Considered That You Might Have Something to Contribute?

As you peruse the variety of articles and reviews in the rest of this edition, consider whether you have something to contribute to the Spring 2008 edition, which comes out in April.

As you read, you will see that we accept and publish a variety of pieces, from original articles to reviews to research participant requests and more. For example, as we did last Spring, we plan to devote space in our next edition to the efforts of section members who have been involved in activities promoting "February is Psychology Month." You can simply send us a summary of what you or your organization did, and even some photos if you have them. As always, we welcome submissions from students as well as full-fledged Clinical Psychologists.

Finally, if you have a look at the last few editions of this newsletter, you will see our "Profiles in Clinical



**Summary  
of Minutes of Fall Teleconference Meeting**  
September 10, 2007

**Present:**

Deborah Dobson (Chair), Christine Purdon (Past-Chair), John Pearce (Chair-Elect), Patricia Furer (Secretary-Treasurer), Andrew Ryder (Member-at-Large), Melissa Kehler (Student Member).

**Highlights:**

- John Service has resigned as Executive Director of CPA. He is moving to the position of Executive Director of the Canadian Mental Health Commission. Karen Cohen as been hired as the Acting ED.
- Deb's comments on behalf of the Section about the CPA Strategic Plan have been forwarded to C. Lee.
- John, Deb, and Jill Evans, research assistant, have been archiving Clinical Section documents to CDs. May be able to include at least some of this material on the Clinical Section website.
- The Practitioner's seat on the CPA Board is vacant. Nominations will be reviewed.
- Current bank balance for the Clinical Section is \$13197.60. Investments as of June 2007 are at \$4230.
- There are currently 273 student members of the Clinical Section and 526 regular members.
- Melissa will send a notice about the 2007 Student Travel Award winners for the Clinical Section Fall newsletter. Feedback and suggestions from the 2007 participants was summarized. A suggestion was made that students who have not applied for the awards also be involved in the adjudication process to minimize conflict of interest. We will ask students applying for the Travel Awards to attend the entire conference to minimize scheduling problems with adjudication.
- We discussed the role of "Clinical Student Hosts" for CPA 2008. Melissa will send out requests for student volunteers from Halifax in March or April 2008.
- John will be accepting the applications for 2008 Ken Bowers Award. Noted that 3 reviewers for the award are needed. Deb suggested that we have each reviewer review and rank order all the applications.
- Melissa and a colleague will write a student column for the fall Clinical Section newsletter.
- We briefly reviewed the Clinical Section Student Grant (up to \$2000) to apply to host a conference or workshop. This grant is to allow students to have experience organizing such events and increase student access to extra clinical training. We will discuss this further at the mid-winter meeting after the executive has had the opportunity to review the original work on this proposal.
- Deadline for submissions for the Fall newsletter is Oct 5.
- Call for nominations for Clinical Section fellows. John will update the information for the website, the listserv, and for the fall Clinical Section newsletter.
- Call for nominations for Section Executive Officers. Christine noted that we will need nominations for the Chair-Elect, Member-At-Large, and Student Representative positions.
- Trish to sort out recent potential Clinical Section listserv difficulties with Nigel Flear.
- The new Clinical Section website will be ready in a few weeks. An email announcing the new website will be posted on the listserv when appropriate.
- Andrew provided an update on current status of the Fact Sheets.
- 2008 Conference updates: Michael Vallis has agreed to do a Public Lecture on obesity management as well as a Master Clinician workshop on life style intervention (co-sponsored with the Section for Health Psychology). Sandi Byers will be doing a pre-convention workshop. This will probably be co-sponsored by SWAP.
- Discussed various ideas to facilitate the promotion of the Public Lecture such as sending posters to local physicians' offices, doing a news release, and contacting Halifax colleagues.
- John indicated that reviewers will be needed for conference submissions. We agreed that having only one reviewer for posters is acceptable. This will reduce the workload.
- Discussion about decision-making criteria for poster submissions: We agreed that it is important for Honors students to submit their research to CPA and we would like to facilitate this as much as possible even though they may not have research data by the submission deadline.
- Other potential conference activities may include an Internship Q & A session and symposia related to Clinical Practice Guidelines and Pediatric Pain.
- John suggested that the Canadian Mental Health Commission will likely be requesting submissions. We need to consider whether the Clinical Section should be involved in this. We would need to discuss this with CPA but we agreed that we would be very open to opportunities for involvement.
- The Clinical Section Mid-winter meeting will be in Calgary on January 26, 2008.

-Submitted by Patricia Furer, PhD., C, Psych.  
Secretary-Treasurer



## Section on Clinical Psychology La Section de la psychologie clinique

### Unapproved Minutes of the Annual Business Meeting

Thursday, June 7, 2007

Ottawa, Ontario

#### Present:

Martin Antony, Andrea Ashbaugh, Sarah Bellefontaine, Jessey Bernstein, Michelle Blain, Chandra Ciccone, David Clark, Deborah Dobson, Thomas Hadjistavropoulos, Candace Konnert, Catherine Lee, Ian Nicholson, John Pearce, Christine Purdon, Adam Radomsky, Andrew Ryder, Lorne Sexton, Steve Taylor, Margo Watt, Allan Wilson, David Zuroff

#### 1. Approval of Agenda (Christine Purdon)

The agenda of the June 7, 2007 Annual Business Meeting was approved as written. Moved by Catherine Lee; seconded by Andrew Ryder; carried.

#### 2. Approval of Minutes of the June 8, 2006 Annual Business Meeting (Christine Purdon)

The minutes of the June 8, 2006 Annual Business Meeting were approved as circulated. Moved by Martin Antony; seconded by Catherine Lee; carried.

#### 3. Report from the Chair (Christine Purdon)

##### Section Executive

The Executive Committee included Catherine Lee (Past-Chair), Christine Purdon (Chair), Deborah Dobson (Chair-Elect), John Pearce (Secretary-Treasurer), Andrew Ryder (Member-at-Large) and Andrea Ashbaugh (Student Representative). The Executive had two teleconference meetings (September 2006 and April 2007) and two in-person meetings (June 2006 and January 2007), as well as regular email correspondence and phone contact throughout the year.

##### Section Initiatives

The Clinical Section has continued its advocacy for the profession through public education, such as the ongoing revision of the fact sheets. The Section's biannual newsletter, *Canadian Clinical Psychologist*, was published under the editorship of Margo Watt and Jessey Bernstein. We have received positive feedback about the quality of the newsletter. Christine Purdon expressed her appreciation to Drs. Watt and Bernstein for their excellent work as the newsletter's co-editors.

The Section has provided generous support to students, including complementary admission to the pre-convention workshop for students who assist with the workshop, the Ken Bowers Award for Student Research, the newly-

inaugurated Student Travel Award and a proposal to develop an award for students who wish to organize educational events. The Executive has also hired students to assist with administrative tasks.

#### Convention Program

The Section contributed to a full program for the 2007 CPA Convention. In addition to general programming with poster sessions and symposia, the Section sponsored: (1) a pre-convention workshop by Dr. John Walker on the treatment of childhood anxiety disorders; (2) a keynote presentation by Dr. David Zuroff on the treatment of depression; and (3) a public lecture and master clinician workshop by Dr. Martin Antony on the treatment of obsessive-compulsive disorder.

The Chair's report was approved by the membership. Moved by: Catherine Lee; seconded by Deborah Dobson; carried.

### Appel De Candidatures Membre du comité exécutif - Section clinique

Votre participation au processus d'élection des membres du comité exécutif est importante pour la Section clinique.

Pour l'année 2008-2009, la Section clinique doit combler deux postes : (1) la poste de **président(e) élu(e)** (mandat de trois ans qui comprend une année comme président(e) élu(e), une année comme président(e), et une année comme président(e) sortant(e)); (2) une poste de **Member-At-Large** (mandat de deux ans); et (3) **membre étudiant(e)** (mandat d'un an). Les trois personnes qui poursuivront leur mandat en 2008-2009 seront Dr. John Pearce (président élu), Dr. Patricia Furer (Secretary-Treasurer), et Dr. Deborah Dobson (présidente sortante).

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

Les candidatures doivent être accompagnées:

- d'une confirmation de la candidate ou du candidat acceptant de siéger au bureau de direction selon le poste assigné, et
- d'une lettre d'appui signée par au moins deux membres ou Fellow de la Section clinique.

Date limite de réception des candidatures: le 25 mars 2007.  
Faire parvenir les candidatures à l'attention de :

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Email: clpurdon@uwaterloo.ca

**CPA Clinical Section Fellow Award**

**Welcome to our New Section Fellow—  
Dr. Martin Antony**

Deborah Dobson, PhD, R. Psych.  
Calgary Health Region  
University of Calgary, Calgary, Alberta

The Clinical Section of CPA awards Fellow Status on an annual basis to psychologists within Canada who have made an outstanding contribution to the development, maintenance and growth of excellence in the science and practice of clinical psychology. Dr. Antony's nomination was supported by glowing letters from Drs. Karen Rowa, Peter Bieling and Randi McCabe. The Clinical Section is delighted to welcome Dr. Antony as the new Fellow for 2007.

After obtaining his undergraduate degree at the University of Toronto, Martin Antony completed his Ph.D. at the University of Albany, State University of New York in 1994, under the supervision of David Barlow. He returned to Canada for a position at the Clark Institute of Psychiatry and then became the Founding Director of the Anxiety Treatment and Research Centre at St. Joseph's Healthcare in Hamilton. While in Hamilton, he also founded the Clinical Psychology Residency Program. In 2006, he became a professor at the Department of Psychology at Ryerson University. In addition, he continues to maintain involvement in Hamilton as the Director of Research in the Anxiety Treatment and Research Centre. He has become the Director of Graduate Studies and the Clinical Training Coordinator in the Department of Psychology at Ryerson.



*Dr. Martin Antony receives the 2007 Clinical Section Fellow Award from Section chair Dr. Deborah Dobson*

Dr. Antony's energy, hard work and creativity has led to the publication of more than 20 books and over 100 scientific articles and chapters on cognitive behavior therapy and anxiety disorders. His many honors include a career award from the Anxiety Disorders Association of America. He was the recipient of the President's New Researcher Award for CPA in 1999 and the David Shakow Award for Early Career Contribution for Division 12 of the American Psychological Association in 2001. He is a Fellow of both the CPA and APA. He has served on the boards of the Association for Behavioral and Cognitive Therapies and the Society of Clinical Psychology, APA. He has been active on a number of editorial boards, including serving as Editor of the *Clinical Psychologist* and *Cognitive and Behavioral Practice*. In addition, Dr. Antony has given many professional workshops around the world, is a widely sought out supervisor and maintains a clinical practice.

To quote from his letters of nomination, Dr. Antony is the "quintessential example of the clinician-scientist model. He combines his educational and training commitments with clinical work and research in a smooth and seamless manner." "He has not only been a wonderful teacher but also inspired many, including myself, by the example of excellence he sets." Clearly, Dr. Antony has been a role model for many research students and clinical trainees. He has made a tremendous contribution to the field of anxiety disorders and has helped improve the lives of many people. .



*Dr. David Zuroff (top) of McGill University, and Dr. Steven Taylor of the University of British Columbia formally receive their 2006 Clinical Section Fellow Awards at the 2007 CPA conference in Ottawa.*

**Advancing Group Treatment  
for Adolescents with OCD**

Kerry Collins, Ph.D., C. Psych &  
Julie Eichstedt, Ph.D., C. Psych  
Children's Hospital  
London Health Sciences Centre, London, Ontario

In recent years, there has been increasing emphasis on the use of empirically-supported treatments for various clinical disorders. In the case of Obsessive-Compulsive Disorder (OCD), Cognitive Behavior Therapy (CBT) has been advanced as the treatment of choice, either alone or coupled with medication (Barrett, Healy-Farrell, & March, 2004; Franklin, Foa, & March, 2003; King, Leonard, & March, 1998). One of the challenges in working with children and adolescents with OCD is that youth with this disorder tend to be embarrassed and secretive about their symptoms and often come to the attention of service providers as a result of their parents, rather than of their own accord. Moreover, the therapeutic work required of them in CBT is challenging. Youth are encouraged to ignore or “boss back” quite persistent and compelling obsessive thoughts and to tolerate significant anxiety rather than performing compulsions. For the above reasons, it can sometimes be challenging to engage youth in the therapeutic process and to secure their compliance in completing therapy homework.

At the Children's Hospital, we have run a group treatment program for adolescents with OCD over the past few years. The treatment protocol is primarily based on the work of Dr. John March and colleagues (1997, 1998, 2007); however, it has evolved based on clinical practice. In particular, we have found that developing new and inventive ways to teach and practice core CBT skills, as well as conducting CBT in group format, has increased the youth's engagement in therapy and improved individual outcomes. Further modifications have also occurred in response to feedback from teen clients, their parents, clinical observations, results of program evaluation, and research developments in the field.

One major development in the Teen OCD group has included increasing the number of exposure and response prevention (E/RP) exercises and presenting these exercises in a fun, “game” format. A growing body of research supports E/RP in the treatment of OCD (Abramowitz, 1996; Franklin, March, & Garcia, 2007; Piacentini, March, & Franklin, 2006). E/RP involves purposefully facing anxiety-provoking situations (e.g., touching “germs” in bathroom) and resisting the related compulsive behavior (e.g., washing hands repeatedly). Presently, there is debate in the literature about whether cognitive versus behavioral interventions are more responsible for treatment gains (e.g., Clarke, 2005). From our clinical experience, both treatment elements are

important, but starting E/RP as early as possible in treatment assists clients to make necessary functional gains in their daily life.

Our approach has been to incorporate E/RP exercises into each group session, beginning in week 1 or 2, and further assigning teens continued practice at home in between each session. This contrasts the March and Mulle (1998) treatment protocol in which E/RP is emphasized during the second phase of treatment (approximately week 6). As a result, clients in our groups have demonstrated early success in resisting their compulsive behavior, and then have begun to generalize this skill to fight additional symptoms. Further benefit of the in-session group E/RP exercises is that they facilitate team building, rapport, and individual courage to challenge OCD. Both teens and co-leaders complete E/RP activities together using a game-format, such as “Fear Factor Challenges,” with prizes awarded for participation. Adolescents have commented that they find it fun and feel supported when they engage in these activities together with their peers. Additional gains of completing exposure exercises in a group context comes from the opportunity it provides to observe either more confident teens tackle the situation, or conversely, watching someone who was previously quite afraid overcome their anxiety. We have found that seeing others participate in these exercises can empower teens to work even harder at challenging their OCD.

The translation of E/RP tasks into fun and engaging “Fear Factor Challenges” has been a major achievement in our group therapy. Each Challenge is planned in relation to the OCD symptoms shared among group members, taking into consideration the limitations of a hospital setting. To date, a variety of exercises have targeted fears of germs and contamination worries. These include the Fear Factor Public Bathroom Challenge, in which clients touch a range of anxiety-provoking objects, from the door handle, sink taps, hand dryer, toilet flusher, to the toilet seat and water (if the teen dares!). Upon completion, teens resist washing their hands until their anxiety has decreased and they are encouraged to delay washing as long as possible to prove to themselves that nothing bad will happen to them (in contrast to what the “OCD bully” tells them). Although the adolescents experience anxiety during the exercise, they manage to stay positive and focused during the task, making jokes to each other in order to get through it. Moreover, pre- and post-exercise anxiety ratings show substantial decreases in the intensity of their fear.

Additional E/RP exercises have been the “Haunted House,” “Dirty Clothes Challenge,” and the “Laundry Game.” Again, these interventions target fears of germs by having the teens face anxiety-provoking items and resist washing their hands or changing their clothes. In the

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Haunted House, group members wear blindfolds and are guided through touching a series of “scary” items by the co-leaders. Items are carefully selected based on teens’ specific OCD symptoms and they do not present any real health risk. Typically, these would include previously used hair bands, bars of soap, body sponges, face clothes, and towels. Teens monitor their anxiety level and try to touch all of the items with their hand, but often the harder items are touched briefly with one finger. The dirty clothes challenge functions the same way, in that group members pass a range of previously worn clothing to each other and practice coping with their anxiety. At the top of the fear hierarchy is a sweaty and slightly stinky t-shirt for the teens to touch and wear over their clothes. Although this is a very difficult challenge, several group members have been able to complete this task and even nicknamed the t-shirt the “sweatmonster 3000.” In the laundry game, the teens form small groups and compete with each other in relay format to grab “dirty” pieces of clothing to fill their team’s laundry basket. Small prizes are awarded to the winning team and teens are then assigned this continued task as homework to ensure generalization to their daily life.

The “Clean Sweep Game” was designed to address OCD hoarding behaviors and teens are asked to bring in a variety of personal items that they have been saving over time. The types of items vary among the teens, ranging from years of school assignments and notes, to stuffed animals and birthday cards, to books and rocks. Parents assist teens with their collection of items from home for this exercise by helping them fill and carry in garbage bags or bins of personal items from their bedrooms. For the game, teens in the group are again paired together and asked to help each other throw away (donate or recycle) items to challenge their OCD. Ten minutes is allowed for the task and at the end of the time limit, group members vote on the teens who have demonstrated the best reduction of hoarding items.

The benefit of the “Fear Factor Challenges” is that teens are willing to engage in difficult E/RP tasks and actually seem to enjoy the challenge of overcoming their anxiety together with their peers. They seem to be motivated by the competitive aspect of these challenges, seem proud of their accomplishments afterward, and speak highly of these exercises and the group overall.

Although the results of these treatment changes have not been evaluated through rigorous investigation, the group has yielded continued positive client outcomes on program evaluation measures. Specifically, significant reductions have been observed on the Children’s Yale-Brown Obsessive Compulsive scale (CY-BOC; Scahill et al., 1997) and the Leyton Obsessional Inventory (LOI; Berg et al., 1988) from pre- to post-treatment. In fact, the result of paired t-test statistics from the past two groups

combined (N = 14; mean age = 14.8) is impressive on both the CY-BOC ( $t = 3.9, p < 0.01$ ) and LOI ( $t = 6.2, p < 0.01$ ). Clinically, the E/RP exercises appear to greatly affect outcome, as teens that have shown the most progress on these exercises (both in-session and for homework) have increased treatment gains. To summarize, we have found that implementing empirically-supported interventions in unique and inventive ways has helped to engage youth in a difficult treatment process, while enjoying treatment at the same time.

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- 2007 QOCDF CONGRESS -

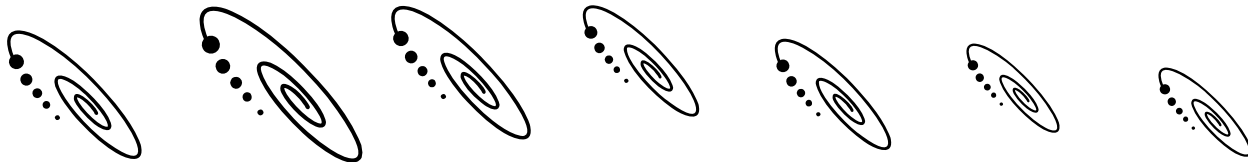
Me and my OCD:  
The person and the problem

<http://fqtoc.mtl.rtss.qc.ca>

Saturday November 3<sup>rd</sup>, 2007

Guest speaker Randy Frost is a world-renowned specialist in the field of obsessive-compulsive disorder and compulsive hoarding. He has co-written, among others, the books *Buried in Treasures* and *Compulsive Hoarding and Acquiring*.





### On-Line Participant Recruitment: Mental Health and Criminal Justice Professionals

A Master's student in the Department of Psychology at Simon Fraser University currently working on a thesis under the supervision of Drs. Kevin Douglas and Stephen Hart is recruiting **mental health and criminal justice professionals** who work with cases where either **stalking or intimate partner violence** are suspected or known to have occurred. Ability to read and write in English required.

The focus of the study is on the process of decision-making in risk assessment cases involving stalking or intimate partner violence. Participation in this study will involve reading one case history and making a series of risk estimates and case management decisions. The study can be completed on-line and will require approximately 60 minutes of your time. A free Mental Health, Law and Policy Institute (SFU) publication is available for first 150 participants to complete the survey (e.g., Stalking Assessment and Management Guide, HCR-20, HCR-20 Companion Guide, Risk for Sexual Violence Protocol).

If you are interested in participating in this study or would like to obtain further information, please contact Kim Reeves at [kreeves@sfu.ca](mailto:kreeves@sfu.ca). This study has been approved by the Simon Fraser University Office of Research Ethics.

**Workshop Review:  
Anxiety During Childhood: Assessment, Treatment,  
and Models of Early Intervention**

Veronica Asgary  
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On June 6<sup>th</sup>, 2007, Dr. John R. Walker presented a workshop entitled “Anxiety during childhood: Assessment, treatment, and models of early intervention” during this year’s annual Canadian Psychological Association conference in Ottawa, Ontario. Dr. Walker is a clinical psychologist and Director of the Anxiety Disorders Program at St. Boniface General Hospital. He is also a Professor of Clinical Health Psychology at the University of Manitoba and adjunct professor in the Departments of Psychology and Community Health Sciences. Much of his prolific research focuses on risk factors for anxiety disorders and the cognitive-behavioral treatment of anxiety disorders. Dr. Walker has co-authored a self-help book on shyness (Stein & Walker, 2001) and has edited a practitioner’s guide on panic disorder and agoraphobia (Walker, Norton, & Ross, 1991).

Epidemiological data suggests that anxiety disorders are extremely common, with a lifetime prevalence of 31.2% (National Comorbidity Survey, 2007). Moreover, the median age of onset for a lifetime anxiety disorder is 11 (Kessler, Berglund, Demler, Jin, & Walters, 2005). Interventions therefore should concentrate on early treatment and prevention in childhood and youth. Dr. Walker’s workshop focused precisely on issues related to assessment, intervention, and prevention of childhood anxiety disorders.

The workshop presented empirical findings and epidemiological data on different types of anxiety disorders, practical exercises and resources for professional toolkits, and evidence-based treatment strategies. The audience was encouraged to participate by asking questions and sharing personal and professional experience.

Dr. Walker began the workshop by explaining the importance of epidemiological research in order to understand the extent of health problems, the causal effects of health problems, and for educating both the public and service providers. Epidemiological data for various childhood anxiety problems was reviewed. Dr. Walker highlighted that individuals at risk for developing anxiety problems can be identified during childhood through behavioral inhibition. For example, these children typically attempt to remain close to their caregiver, take longer to warm to new adults or children and often avoid new people.

In fact, Dr. Walker specified that children who display behavioral inhibition are 12 times more likely to develop social phobia and are 21 times more likely to develop agoraphobia. He concluded that children and adolescents with anxiety disorders are at higher risk later in life for anxiety disorders, affective disorders, substance use and abuse, and academic difficulties.

Next, Dr. Walker discussed assessment material that his team uses at the Anxiety Disorders Clinic at St. Boniface General Hospital. He provided the audience with templates for both parent and youth versions of the History and Information Forms. He also supplied copies of the Spence Children’s Anxiety Scale (Spence, 1997) along with scoring procedures. This measure, which can be used to reliably assess childhood anxiety symptoms, is also available for professional use at Spence’s website (<http://www2.psy.uq.edu.au/~sues/scas/#top>). Sample brochures with tips for parents with children with anxiety problems were also provided.

Various treatments for anxiety disorders are available, including psychological, pharmacological, and combined options. Dr. Walker recommended that service providers be aware of the diverse treatment options in order to be able to make appropriate recommendations to clients. Moreover, he suggested that service providers use a supportive stance when discussing a treatment option with clients, rather than undermining or creating doubt about another type of treatment. That being said, he reviewed pharmacotherapy’s advantages (such as accessibility, helpfulness when treating comorbid conditions, less active participation required) and disadvantages (including the return of symptoms upon discontinuation, limited research on the optimal duration of treatment, and higher costs in the medium and long term than psychological treatment). He subsequently visited the advantages (such as a demonstrated effectiveness, good maintenance gains after treatment, the reduction of costs due to the time limit on treatment) and the disadvantages (including difficulty accessing services and more time and effort are required by the client) of cognitive-behavioral therapy (CBT).

According to Dr. Walker, combining medication treatment and CBT does not have additive effects. In fact, he informed us that the combination of both types of treatment results in higher rates of relapse upon discontinuation than CBT alone. This can be explained by the high rate of the return of symptoms once medication has been ceased. Dr. Walker suggested that as an alternative to combined treatment, clients and service providers work collaboratively to make a decision as to which treatment options would be better for the individual client. This process might include providing clients with

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written information on the advantages and disadvantages of each option and allowing the client sufficient time to decide. This in turn will increase compliance and treatment adherence.

Research conducted by Dr. Walker and his team has suggested that parents of children with anxiety disorders may be particularly receptive to verbal approaches with their children and may benefit from guidance with positive practices such as the use of praise and reward. Overall, parents require support and validation of their efforts.

Recent research on the treatment of anxiety disorders has examined the various components of treatment. Dr. Walker presented Barlow and colleagues' three key components which include altering coping appraisals, reducing emotional avoidance, and modifying emotional action tendencies to increase problem solving efforts (Moses & Barlow, 2006). He also reviewed Chorpita's (2007) modular CBT for anxiety disorders in children where children receive a set of core modules (such as establishing a fear ladder, education about anxiety, exposure, and maintenance) and have the option of adding supplementary modules if necessary. Dr. Walker ended the section on treatment by examining the importance of exposure, which is the most effective and reliable approach to anxiety reduction, and provided practical explanations of how to apply exposure strategies with children. He also included resources for home tool kits that professionals can use in practice or provide to their clients.

Finally, Dr. Walker underscored the importance of prevention and early intervention. He reviewed large scale prevention research projects conducted by Dadds and colleagues and Rapee and colleagues. Next, he explained the project his team has been working on at the University of Manitoba entitled "Coaching for confidence: Evaluation of a community-based early intervention program for kindergarten-aged children with anxiety." The team has invited parents to attend five two-hour sessions at a local school, a follow-up session two months after completion, and a final contact scheduled for 12 months later. Initial results suggest that parents rate their children as having fewer anxiety symptoms and rated themselves as having higher parenting confidence after attending the prevention groups. Twelve month follow-up data has yet to be collected.

Dr. Walker concluded the workshop by presenting certain characteristics that might be desirable for prevention programs. These include employing community and school-based venues rather than clinic-based ones, reaching out to families rather than waiting for referrals, supporting parents in their roles rather than blaming, and using a highly structured program based on sound knowledge of child

development to facilitate dissemination. Overall, this workshop was very informative for individuals seeking additional information on childhood anxiety disorders and different research advances. Dr. Walker supplied us with useful tools and updated studies. His engaging, humorous style and personal anecdotes kept us looking for more – and provided us with a few good laughs!

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### Student Column

#### The Initial Clinical Supervision Experience in Graduate School: Negotiating Two Sets of Expectations

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The first experience students have with clinical supervision typically occurs in graduate school. In some programs, clinical experience is built into classes or labs; nonetheless, for the vast majority of students, the first time substantial effort is devoted to clinical work is during the first practicum. This first clinical experience is a pivotal time for students. It helps students explore whether or not they truly want to do clinical work, and helps them build competence in a therapeutic setting. This experience can also be a time of great uncertainty, since students go to their first clinical setting with certain expectations about what their clinical and supervision experiences will be like, and quickly find they must negotiate two sets of expectations: their own and their supervisor's.

The expectations students bring into their first clinical experience are derived from many sources, including written information about the training setting, experience with other supervisors (e.g., in research training), discussions with supervisors and instructors, discussions with students at all levels of the graduate program, and perhaps even media depictions of clinical psychology. As students prepare for supervision in their first clinical training setting, they typically develop expectations about topics such as:

- the supervisor's presence and level of support in initial therapy sessions
- the supervisor's availability for *ad hoc* and scheduled meetings
- the supervisor's expectations with respect to making audio or video recordings of sessions
- the dynamics of supervision sessions

Depending on the degree of similarity between the student's expectations about clinical supervision and the reality of the supervision experience, the student may experience a great degree of uncertainty in the initial weeks of supervision. This is the time when the student begins to understand how his or her expectations compare to the realities of a specific clinical setting. Often, the student finds that his or her supervision expectations are not necessarily the same as those of the supervisor.

In reality, supervisors may have more limited time than expected for supervision because of their own clinical responsibilities, as well as supervision of other trainees or administrative duties. Supervisors may have some expectations regarding what students have learned through their respective clinical programs and so may be less likely to emphasize some topics, unless the student specifically requests it. In addition, supervision may include discussing topics other than sessions with clients, such as learning from selected readings, current issues in clinical psychology, or eliciting student views on what is helpful or missing from the supervision meetings.

For example, while preparing for her first clinical experience, one of the authors thought it was likely that her supervisor would act as co-therapist for the first few therapy sessions, that there would be lengthy weekly supervision meetings, that audio-recording or direct observation of the majority of sessions would be required, and that the supervisor would review the entire session with her. She believed that supervision would be a fairly passive process on her part, and that the supervisor would provide positive and negative feedback about most aspects of the therapy session. In fact, there were subtle but significant differences between expectations and reality. For example, although the student's primary supervisor did not act as co-therapist, the supervisor provided opportunities for the student to act as co-therapist with other psychologists. Although weekly individual supervision was provided, meetings were not as lengthy as expected, but regular group supervision was arranged in addition to individual supervision. In addition, the student had more opportunities to actively participate in supervision than expected, since she was asked to select portions of the audiotapes to play back during supervision. In general, the student experienced more responsibility than expected in conducting therapy and in defining the content of the supervision sessions, but she also received at least as much support as expected in carrying out these responsibilities.

So what strategies might be helpful when negotiating the differences between student expectations and the reality of your practicum situation?

#### 1. Understand your practicum setting:

- Are other psychologists available for quick questions?
- Is your primary supervisor available for brief, unscheduled meetings?
- What have other students experienced?

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2. Talk to your supervisor about both of your expectations for supervision. Revisiting this conversation after a few weeks can be helpful. You may wish to cover topics such as:


- Meeting times
- How much time supervisors have to review assessment reports or session tapes
- What areas your supervisor is willing to provide assistance with and what s/he expects you to do more independently
- What goals your supervisor would like you to meet (e.g., number of therapy cases, number of assessments completed, knowledge in specific areas).

3. Be prepared to take initiative:

- Come to supervisory meetings prepared with questions about your experiences, specific questions about clients, and sections of audio or videotape to review already selected. This demonstrates that you have put some thought into what you would like to get out of the supervision session.
- Remember...it is okay to suggest alterations to supervision as you go.
- If you would like more guidance on a particular case or more opportunity to review audio or videotapes with your supervisor, then ask for it. Particularly with your first practicum experience, your supervisor may be willing to provide you with more supervision at the beginning, and as you progress and develop your skills the nature of supervision may change.

A clinical supervisor is someone who is introducing you to the profession in a way that research supervisors or course instructors have not done before. Your supervisor is there to help you develop new clinical skills and to further refine your existing skill set. However, this may be accomplished through direct instruction or by encouraging you to do this independently through reading, reflection, and practice. While you may not get the supervision experience you were first expecting, you might experience something even better.

This article is meant to promote thinking about what your own expectations are of clinical supervision and to provide some ideas as to how you can negotiate the differences in expectations you have about supervision compared with what supervision may look like in a clinical setting. If you have further questions about supervision, talk to your Director of Clinical Training, upper-level students, or your clinical supervisor.



## Congratulations to Student Travel Award Winners!

The Student Travel Awards were designed to help Clinical Section students from across Canada finance travel to the annual conference of the Canadian Psychological Association. Additionally, this award was especially designed to encourage communication between Clinical Section students and to promote peer review among students. This year marked the first successful implementation of these awards. Thanks to all the students who were involved in the adjudication of students' work, including posters and oral presentations.

First prize, with a value of \$500, went to Debbie Semple from Calgary, Alberta. Second prizes of \$200 each were awarded to students coming from the two regions in Canada other than where the conference was held, in this case the East and West regions. This year, second prizes were awarded to Valerie Grant from Halifax, Nova Scotia and to Jenny Horch from Calgary, Alberta. The abstracts describing these students' winning work appear below.

Applications for the 2008 Student Travel Awards will be available in the spring, for students planning to attend the 2008 CPA conference in Halifax.

### 2007 Student Travel Award Abstracts



**First Prize: Deborah Semple**



#### **The Relationship between Maternal Symptoms of Attention-Deficit/Hyperactivity Disorder (ADHD) and Mother-Infant Interaction**

Deborah L. Semple<sup>1</sup>, Eric J. Mash<sup>2</sup>, Jerilyn E. Ninowski<sup>3</sup>,  
and Karen M. Benzies<sup>4</sup>, University of Calgary,  
Department of Psychology<sup>1,2,3</sup> and Faculty of Nursing<sup>4</sup>

The relationship between maternal ADHD symptoms and specific maternal behaviors was examined in 17 mothers of infants aged 3 to 8 months. It was hypothesized that maternal ADHD symptoms would be related to lower levels of sensitivity and stimulation of development, and higher levels of intrusiveness and negative regard. Hierarchical multiple regressions revealed that maternal ADHD symptoms significantly predicted maternal insensitivity, and negative regard towards their infant, over and above maternal psychopathology. These preliminary findings suggest that mothers reporting higher levels of ADHD symptoms experience difficulties in interactions with their infants. Early interventions that address these difficulties may be warranted to facilitate development and reduce the likelihood of adverse outcomes in their children.

**2007 Student Travel Award Abstracts:****Second Prize: Valerie Grant****The Role of Child Temperament in the Prospective Prediction of Anxiety Among Canadian Children**

Valerie V. Grant, Alexa Bagnell, Christine T. Chambers, & Sherry H. Stewart  
Dalhousie University and IWK Health Centre

We tested the hypothesis that caregiver-reported child temperamental variables, behavioral inhibition and fussy/difficult temperament, at ages 2-3 years would prospectively predict child anxiety symptoms at ages 4-5 years, 6-7 years, 8-9 years, and 10-11 years in a sample representing the Canadian population, the National Longitudinal Survey of Children and Youth sample (initial weighted  $n = 768\ 600$ ), while controlling for basic demographic variables. Only fussy/difficult temperament at 2-3 years predicted caregiver-reported child anxiety at 6-7 years. Both behavioral inhibition and fussy/difficult temperament at 2-3 years predicted caregiver-reported child anxiety at 8-9 years. However, fussy/difficult temperament no longer predicted anxiety at 8-9 years when behavioral inhibition was statistically controlled. One explanation for this discrepancy in prediction is that behavioral inhibition (versus fussy/difficult temperament) is more relevant to adaptation in social situations, which become increasingly important as children age. Temperament at 2-3 years did not significantly predict either caregiver- or child-reported anxiety at 10-11 years, suggesting that, as children age, environmental factors become more important contributors to anxiety than early temperament. These results suggest that preventive interventions for anxiety should be aimed at young children with elevated behavioral inhibition or fussy/difficult temperament in an effort to prevent anxiety disorders at 6-9 years.

**2007 Student Travel Award Abstracts:****Second Prize: Jenny Horch****Is Disordered Gambling Stigmatized? A Comparison Across Health Conditions**

Jenny D. Horch. & David C. Hodgins  
University of Calgary

Disordered gambling stigma was examined. University students (117 male, 132 female) rated vignettes describing males with five health conditions (schizophrenia, alcohol dependence, disordered gambling, cancer, and a no diagnosis control with subclinical problems) on a measure of attitudinal social distance. A mixed ANOVA revealed a large main effect of condition, a main effect of sex, an order by condition interaction, and a sex by condition interaction. In keeping with hypotheses, disordered gambling was more stigmatized than the cancer and control conditions. Interactions suggested that disordered gambling stigma is influenced by context and participant characteristics. Perceived dangerousness, controllability attributions, and familiarity were also examined. As predicted, perceived dangerousness was positively correlated with social distance scores. Controllability attributions were negatively correlated but accounted for minimal variance in social distance scores. Familiarity ratings were unrelated to social distance. A within subjects design highlighted the importance of context. Implications for treatment modalities are discussed.

**2007 Ken Bowers Student Research Award:  
Poster Summary**

**Parenting Goals, Child-related Disagreements, and  
Children's Internalizing and Externalizing Behavior  
Problems**



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University of Ottawa, Ottawa, Ontario

A large body of research has demonstrated that marital conflict is strongly linked to children's adjustment (Davies & Cummings, 1994). In particular, conflicts between mothers and fathers regarding their child seem to be particularly damaging (Grych & Fincham, 1990). It is unknown however, whether the links between disagreement and child behavior problems are related to conflict between parents, or are simply the result of parents holding different views of child-rearing.

Parenting goals are the outcomes parents wish to achieve with their children in specific situations (Hastings & Grusec, 1998), and have been demonstrated to influence how parents react to and behave towards their children. Because mothers and fathers may have differing goals, the coordination of parenting between them may present a challenge. Therefore, it is of great importance to examine concordance between the goals held by a child's mother and father.

This study was designed to examine the relationship between parenting goals, child-related disagreements and children's internalizing and externalizing behaviour problems. A central question was whether both child-related disagreements and concordance in parenting goals would be predictive of reports of children's behavioral problems.

122 two-parent families participated in the study. The average age of mothers and fathers was 32.85 years (range 22 – 45 years) and 35.18 years (range 24 – 54 years) respectively. Families were eligible to participate if both the mother and father lived together, both parents worked outside the home, and their oldest child was preschool-age.

Eligible families were sent a questionnaire package which included a demographics questionnaire, as well as the Child Related Disagreements scale (CRD; Jouriles et al., 1991), the Parenting Goals Measure (PGM; Hastings & Grusec, 1998), and the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000). Packages also included a letter emphasizing the importance of independent responding. Families received a \$30 honorarium for participation.

Similarity between parenting goals was determined by calculating the intraclass correlation coefficients (ICC; Maguire, 1999; McGraw & Wong, 1996; Shrout & Feiss, 1979) between the ratings of each mother and father on the PGM. ICC can range from -1 which represents complete dissimilarity between the ratings of a mother and father, and +1 which represents total similarity in the goals. In general, parents had moderate agreement ( $M = .48$ ;  $SD = .25$ ) in their goals for children, though they ranged from quite similar (.88) to quite different (-.27).

Scores on the Child Related Disagreements (CRD) measure were summed to obtain a total score for the CRD ( $M = 32.82$ ;  $SD = 8.95$ ). CRD scores ranged from 21 to 82, representing a range from no child-related disagreements to very frequent disagreement.

A series of sequential multiple regressions were performed to determine whether the addition of the PGM-icc and CRD improved the prediction of children's externalizing problems, over and above child age. Analyses were conducted separately for mothers and fathers, examining reports of behavior problems in daughters and sons.  $R$  was found to be significantly different from zero after step 2 for both mothers and fathers of sons, and for mothers of daughters ( $R^2 = .15$ ,  $.17$ ,  $.19$  respectively (adjusted  $R^2 = .10$ ,  $.12$ ,  $.15$  respectively)). For fathers of daughters,  $R$  remained nonsignificant after step 2,  $R^2 = .09$  (adjusted  $R^2 = .05$ ). However, for each parent-child gender combination, only CRD scores were a significant predictor of children's internalizing scores ( $t$ 's = 2.48-3.58, all  $p$ 's < .05).

A second set of sequential multiple regressions was conducted to determine whether the PGM-icc and CRD improved prediction, over and above child age, of children's internalizing problems.  $R$  was found to be significantly different from zero after step 2 for both mothers and fathers of daughters, and fathers of sons ( $R^2 = .31$ ,  $.18$ ,  $.14$  respectively (adjusted  $R^2 = .27$ ,  $.12$ ,  $.09$ )).



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respectively)). For mothers of sons,  $R$  remained nonsignificant after step 2,  $R^2 = .11$  (adjusted  $R^2 = .06$ ). However, for each parent-child gender combination, only CRD scores were a significant predictor of children's internalizing scores ( $t$ 's = 2.24-3.33, all  $p$ 's < .05).

Consistent with other research, this study showed that child-related disagreements were predictive of parents' reports of both children's internalizing and externalizing problems. However, differences in parenting goals were not associated with reports of children's behavior problems. This seems to suggest that it is conflict, rather than differences, between mothers and fathers which is of great importance to children's well-being.

These findings have practical implications for the delivery of services to families of children with both internalizing and externalizing problems as they underline the potential for damaging effects of child-related disagreement, but also show that differences in parenting goals are not necessarily problematic.

In future research, it would be interesting to use direct observation in the examination of child behavior. This would allow us to examine parenting goals in relation to children's actual behavior, rather than parent reports of children's behavior. To increase the generalizability of these results, many different types of families would need to be assessed to determine whether these patterns of results apply to other family structures. In addition, it would also be of interest to examine the association between marital conflict and behavioral problems over time, as the child gets older.

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*Sarah Bellefontaine received her Honors B.A. from Concordia University in Montreal in 2006. She is currently in the Clinical Psychology doctoral program at the University of Ottawa. Sarah's research interests lie in the areas of parenting, parent-child relationships as well as Attention Deficit/Hyperactivity Disorder (ADHD). She has presented at several scholarly conferences, and was funded last year by the Social Sciences and Humanities Research Council of Canada's Master's Scholarship. Congratulations, Sarah, for winning the 2007 Ken Bowers Award!*

## KEN BOWERS STUDENT RESEARCH AWARD

The Ken Bowers Student Research Award was established to honor the enormous contributions of Dr. Ken Bowers (1937-1996) to the field of clinical psychology. Dr. Bowers is widely considered to have been one of the world's pre-eminent hypnosis researchers. In addition, he is renowned for his contributions to our understanding of personality, revolutionizing the trait-situation debate through his assertion of a situation-by-person interactional model. One of Dr. Bowers' last works was a highly influential paper on memory and repression that appeared in a 1996 volume of *Psychological Bulletin*. Dr. Bowers saw the philosophical foundations of inquiry as the common basis for both research and clinical practice. He was a consummate scientist-practitioner who devoted his career to the Department of Psychology at the University of Waterloo. The memory of his intellectual rigor and scholarship continues to shape UW's clinical training program.

The Ken Bowers Student Research Award is given by the Clinical Section to the student with the most meritorious submission to the Clinical Section of the CPA annual convention. **All students whose presentations have been accepted within the Clinical Section program are invited to apply.** The winning submission is recognized with a certificate and \$750.00, and the student is invited to describe her/his work in the fall edition of the Clinical Section newsletter, *The Canadian Clinical Psychologist*.

To be eligible you must:

1. Be a student who is first author of a presentation that has been accepted in the Clinical Section at the CPA annual convention in Halifax, June, 2008
2. Submit an APA-formatted manuscript describing your research\*
3. Be prepared to attend the Clinical Section business meeting at the Ottawa convention, where the award will be presented
4. Be a member of the Clinical Section at the time of submission of your paper\*\*

\*The manuscript must include a title page and abstract page, and must be no more than 10 pages, double-spaced with 2cm margins and 12 point font. Figures, tables and references are not included in the page count. Manuscripts that do not conform to these criteria will not be reviewed. The **deadline** for submission of applications is **March 18, 2008**. Submissions in either English or French should be sent by e-mail to Dr. John Pearce ([john.pearce@calgaryhealthregion.ca](mailto:john.pearce@calgaryhealthregion.ca)). If you have any questions about the submission process, please contact Dr. Pearce by e-mail.

\*\*If you are a CPA member but not a Clinical Section member, contact [membership@cpa.ca](mailto:membership@cpa.ca) or 1-888-472-0657; if you are not a CPA member go to [www.cpa.ca/clinical/membership/index.html](http://www.cpa.ca/clinical/membership/index.html) and be sure to indicate Clinical Section membership on your invoice.

Students can apply for both the Ken Bowers and the Student Travel Award (see article in this issue), but can only win one of these awards per year.

## PRIX KEN BOWERS POUR RECHERCHE EFFECTUÉE PAR UN(E) ÉTUDIANT(E)

Chaque année, la Section de Psychologie Clinique évalue les communications soumises par les étudiants(e)s en vue d'une présentation au congrès annuel de la SCP. En 2008, un certificat et une bourse de 750\$ seront remis à l'étudiant(e) ayant soumis la communication la plus méritoire.

Pour être admissible, l'étudiant(e) doit :

1. être premier(ère) auteur(e) d'une communication touchant le domaine de la psychologie clinique ayant été acceptée pour le congrès à Calgary
2. soumettre un court manuscrit décrivant l'étude selon le format de l'APA\*
3. être présent(e) à la réunion d'affaires de la Section Clinique du congrès à Calgary quand le prix sera décerné
4. être membre de la section quand vous soumettez votre document\*\*

\*Veuillez suivre les consignes de présentation: le manuscrit doit être à double interligne, avec des marges d'au moins 2 cms, un font 12, avec une page titre, un résumé et un maximum de 10 autres pages de texte, plus des pages de références, tableaux, et figures. Des manuscrits qui ne respectent pas ces critères ne seront pas admissibles. La date limite pour la soumission des candidatures est le 18 mars, 2008. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées par courriel à Dr. John Pearce ([john.pearce@calgaryhealthregion.ca](mailto:john.pearce@calgaryhealthregion.ca)). Si vous avez des questions au sujet du processus de soumission, n'hésitez pas à contacter le Dr. Pearce par courriel.

\*\*Si vous désirez devenir membre de la SCP vous pouvez vous abonner à [www.cpa.ca/clinical/membership/index.html](http://www.cpa.ca/clinical/membership/index.html), assurez vous d'indiquer "section clinique". Si vous êtes membre de la SCP, mais pas encore membre de la section clinique, veuillez contacter la SCP par courriel au [membership@cpa.ca](mailto:membership@cpa.ca) ou par téléphone au 1-888-472-0657.

### 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 the national, provincial or local level; (3) leadership on clinical issues that relate to broad social issues; and (4) service outside one's own place of work. Note that clinical contributions should be given equal weight compared to research contributions. 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 18, 2008** to:

**John Pearce, Ph.D., R.Psych.**  
**Child Abuse Service, Child Development Services**  
**2888 Shaganappi Trail N.W.**  
**Calgary, AB T3B 6A8**  
**Tel: (403) 955-5853**  
**Fax: (403) 955-5990**  
 Email: [john.pearce@calgaryhealthregion.ca](mailto:john.pearce@calgaryhealthregion.ca)

### Mises en Candidature Fellows de Section

Conformément aux procédures régissant les sections de la SCP, la section clinique invite ses membres à présenter des candidats pour le statut de Fellow en psychologie clinique. Les critères de sélection sont la contribution exceptionnelle au développement, au maintien et à 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 ; et (4) services rendus à la communauté en dehors de son propre milieu de travail. À ces fins, les contributions cliniques et les contributions en recherche seront considérées comme étant équivalentes. Les dossiers des candidats 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 **18 mars 2008** à l'attention de:

**John Pearce, Ph.D., R.Psych.**  
**Child Abuse Service, Child Development Services**  
**2888 Shaganappi Trail N.W.**  
**Calgary, AB T3B 6A8**  
**Tel: (403) 955-5853**  
**Fax: (403) 955-5990**  
 email: [john.pearce@calgaryhealthregion.ca](mailto:john.pearce@calgaryhealthregion.ca)

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 Email: [mwatt@stfx.ca](mailto:mwatt@stfx.ca)

*Dr. Jessey Bernstein*  
*Department of Psychology*  
*Concordia University*  
*7141 Sherbrooke St. West*  
*Montreal, Quebec H4B 1R6*

Phone: (514) 824-2424 (ext 5208)  
 Email: [DrBernstein@gmail.com](mailto:DrBernstein@gmail.com)



**CPA CALL FOR SUBMISSIONS  
FOR 2007 CONVENTION**

The Convention Committee invites submission to the CPA 69th Annual Convention to be held in Halifax, Nova Scotia, from Thursday June 12 to Saturday June 14, 2008. Further information concerning registration and accommodation will be available soon. ALL PRESENTERS (CPA MEMBERS, NON-MEMBERS, CPA STUDENT MEMBERS AND STUDENT NON-MEMBERS) MUST REGISTER FOR THE CONVENTION.

If you wish to make a submission, go to [www.cpa.ca/convention/](http://www.cpa.ca/convention/), read all instructions and fill in the required information.

Your complete submission must be submitted by NOVEMBER 15th, 2007. Late submissions will not be considered.

**DEMANDE DE COMMUNICATIONS  
POUR LE CONGRÈS DE LA SCP 2008**

Le Comité du Congrès vous invite à lui présenter des propositions pour le 69e Congrès annuel de la SCP qui aura lieu à Halifax (Nouvelle Ecosse) du jeudi 12 juin au samedi 14 juin 2008. D'autres renseignements concernant l'inscription et l'hébergement seront disponibles bientôt. TOUS LES PRÉSENTATEURS (MEMBRES, NON MEMBRES, ÉTUDIANTS AFFILIÉ ET ÉTUDIANTS NON-AFFILIÉS) DOIVENT S'INSCRIRE AU CONGRÈS .

Lisez les directives de présentation des résumés et fournissez les renseignements requis, fournies au site web [www.cpa.ca/convention/](http://www.cpa.ca/convention/)

Votre formulaire de proposition dûment rempli doit être soumis AVANT la date limite du 15 NOVEMBRE 2007. Les communications envoyées après cette date ne seront pas acceptées.

**Must be received by NOVEMBER 15th, 2007.  
Les envois doivent nous parvenir avant le 15 NOVEMBRE 2007.**

**Canadian Psychological Association/  
Société canadienne de psychologie  
Congrès 2008 Convention**

**141 Laurier Ave. West Suite 702, Ottawa, Ontario K1P 5J3  
Tel: 613-237-2144 ext. 323  
Toll free #: 1-888-472-0657  
Fax: 613-237-1674**