



canadian CLINICAL PSYCHOLOGIST

Newsletter of the Clinical Section of the Canadian Psychological Association
Volume 14, No. 1
October, 2003

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Message from the Chair

The executive committee of the Clinical Section recently held our fall teleconference to discuss plans for the conference program for CPA's annual conference to be held in St. John's, Newfoundland from June 10 to June 12. Much of the energy of the executive goes into planning these events and I must say that it is quite stimulating and pleasurable to think of the myriad of possibilities for excellent speakers, workshops, conversation hours and symposia. This year we are hoping to introduce a Master Clinician session that will allow participants to observe and participate in a sample therapy session with a simulated client. I think it will be a lot of fun. Planning is also, of course, influenced by a few anxiety-provoking unknowns. Will the exotic nature of St. John's attract a larger than average attendance? Will touring The Rock compete with our exciting program? How many submissions should we expect from the growing membership of the clinical section this year?

Two members of our executive, Catherine Lee from the University of Ottawa and Susan Graham from the University of Calgary have proposed a conversation session for the conference on ways to attract women into clinical academic careers. Academia continues to be male-dominated, despite an increased sensitivity to the gender imbalance over the past number of years. Where are all the women? The session will focus on structural and personal factors that encourage and discourage women from pursuing academic positions. We hope that students, in particular, will find the discussion beneficial.

The clear need for this conversation hour contrasts dramatically with another gender trend within our profession. Earlier this

week my colleagues and I welcomed our new class into the clinical psychology graduate program at the University of Calgary. Once again, we warmly welcomed a class comprised entirely of women. Our program has 36 female students and 5 male students. Our program is not unique – the Canadian Association of University Teachers 2003 statistics indicate that 73% of psychology masters and doctoral students in Canada are women. Where are all the men?

This trend is not limited to psychology graduate programs. At the University of Calgary, for example, 59% of graduate degrees overall and 61% of undergraduate degrees this year were awarded to women. An article in the *Washington Post* described a similar situation in the United States. Male students dominated undergraduate programs from the 1870s to the early 1980s, except for a brief period during World War II. Since the 1980s the proportion of women to men has been increasing.

The *Washington Post*, with its conservative leaning, views the disparity as a posing a major crisis for big business because of the possibility of a dwindling number of men with the expertise to fill corporate executive positions. In contrast to this simplistic analysis, attention to the issue of academic gender disparity at the faculty level has been sophisticated and sustained. Much effort has been made to understand and moderate disparity. It is clear that such attention to the undergraduate and graduate disparity is also warranted. Understanding of the factors and potential solutions are necessary. The diversity of clinical psychologists and teachers of clinical psychology needs to reflect the diversity of the clients and students who we service.

David Hodgins

CLINICAL SECTION EXECUTIVE OFFICERS 2003-2004

Dr. David Hodgins, Chair
Department of Psychology
University of Calgary
2500 University Dr. N.W.
Calgary, Alberta T2N 1N4

Phone: (403) 220-3371
Fax: (403) 282-8249
email: dhodgins@ucalgary.ca
web: <http://www.psych.ucalgary.ca/People/Faculty/hodgins/>

Dr. David Dozois, Chair-Elect
Department of Psychology
University of Western Ontario
London, Ontario, N6A 5C2

Phone: (519) 661-2111 ext. 84678
Fax: (519) 661-3961
email: ddozois@uwo.ca
web: <http://www.sscl.uwo.ca/psychology/faculty/dozois.html>

Dr. Kerry Mothersill, Past-Chair
Outpatient Mental Health Services,
Colonel Belcher Hospital,
1213 - 4th Street S.W.
Calgary Alberta, T2R 0X7

Phone: (403) 943-2445
Fax: (403) 943-2441
email: Kerry.Mothersill@CalgaryHealthRegion.ca
web: <http://www.ucalgary.ca/md/CHS/nhrdb/people/0000092.htm>

Dr. Catherine Lee, Secretary-Treasurer
Centre for Psychological Services
11, Marie Curie,
Ottawa, Ontario, K1N 6N5

Phone: (613) 562-5800 ext. 4450
Fax: (613) 562-5169
email: cmlee@uottawa.ca

Dr. Susan Graham, Member at Large
Department of Psychology
University of Calgary
2500 University Dr. N.W.
Calgary, Alberta T2N 1N4

Phone: (403) 220-7188
Fax: (403) 282-8249
email: grahams@ucalgary.ca
web: <http://www.psych.ucalgary.ca/People/Faculty/ams/>

Mike Coons, Student Representative
Department of Psychology
Waterloo University
Waterloo, Ontario, N2L 3G1
Phone: 905-634-7071
Email: mcoons@worldchat.com

Newsletter Editors:

Dr. Deborah Dobson
Outpatient Mental Health Program,
Colonel Belcher Hospital,
1213 - 4th St. S.W.,
Calgary, Alberta, T2R 0X7
Phone: (403) 943-2461
Fax: (403) 943-2441
email: ddobson@ucalgary.ca

Dr. Keith Dobson
Department of Psychology
University of Calgary
2500 University Dr. NW
Calgary, Alberta, T2N 1N4
Phone/ fax: (403) 220-5096
email: keith.dobson@ucalgary.ca

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 2004-2005, 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 2003-2004 will be Dr. David Dozois (Chair), Dr. David Hodgins (Past-Chair) and Dr. Catherine Lee (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 **March 28th, 2004**.
Send nominations for the Executive to:

Dr. Kerry Mothersill, Past Chair
Outpatient Mental Health Services,
Colonel Belcher Hospital,
1213 - 4th Street S.W.
Calgary Alberta, T2R 0X7
Fax: (403) 943-2441

CLINICAL PSYCHOLOGY

2002-2003 Annual Report

Section Executive

The Executive Committee was comprised of Michel Dugas (past chair), David Hodgins (Chair-elect), David Dozois (Secretary-Treasurer), Susan Graham (Member-at-Large) and Kerry Mothersill (Chair). The Executive met in person at the CPA convention in Vancouver (2002) as well as in Calgary for a mid-winter meeting. In addition, two teleconference meetings were held in September 2002 and April 2003. The section has 395 full members and 201 student members.

Convention Program

The section received and reviewed eighty-seven submissions to the CPA Convention in Hamilton. Clinical section presentations at the convention will include fifty-seven posters, seven symposia, two conversation sessions, five theory reviews and two workshops. The section sponsored activities will include a CPA-invited presentation by Martin Antony (Recent Advances in the Treatment of Anxiety Disorders), a section keynote presentation by David Wolfe (Preventing Abuse in Adolescent Dating Relationships) a pre convention workshop by Laurie Gillies (Interpersonal Therapy for Depression), a mini-workshop by Terry Pezzot-Pearce (Parent Assessments: An Overview) and a mini-workshop by Randi McCabe (Enhancing Motivation for Treatment in Eating Disorders). In addition, John Pearce and Richard Steffy will be leading a discussion on Applying for Internship: Perspectives from an Internship and Academic Director. Keith Dobson and Ian Nicholson will lead a discussion on Ethical Issues.

Awards and Elections

Charles Morin was awarded the status of Fellow of the Clinical Section. Dr. Morin was selected on the basis of his outstanding contribution to psychology in the areas of science, practice and service. The Executive awarded the Ken Bowers Student Award to Ms. Karen

Ip of the University of British Columbia for her presentation at the CPA convention in Hamilton.

David Dozois will be assuming the position of chair-elect on the Executive Committee. He has completed a two-year term as secretary-treasurer. Catherine Lee has kindly agreed to take on the secretary-treasurer duties.

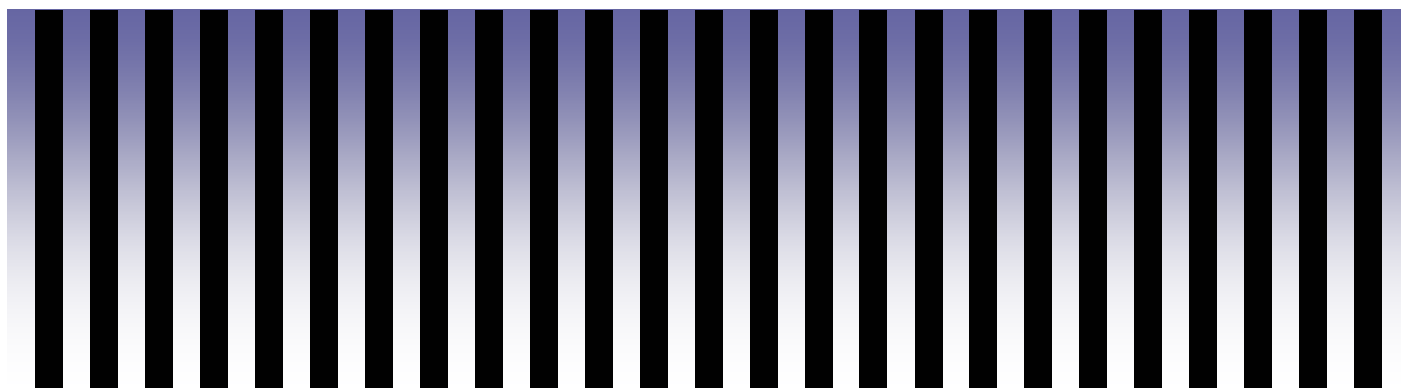
Communications

The section's biannual newsletter, Canadian Clinical Psychologist, was published under the stewardship of Deborah Dobson and Keith Dobson. The editors were successful in securing a multi-issue advertising contract with Multi-Health System. A new website was created under the guidance of Leslie Graff and continues to be maintained by our webmaster, David Hart. The clinical section list serve continues to be an efficient means for communicating with members.

Ongoing Projects

The clinical section brochure was updated and made available on line on our website. Additional FACT SHEETS were added to the existing collection of informational reviews in important areas for clinical psychologists. For the first time, a student representative from the CPA student section served on the Executive Committee. A motion will be put forward to the membership at the business meeting to establish a permanent student representative position on the Executive. The section contributed to the lobbying efforts to encourage the Ottawa hospital to reconsider its decision to downsize the psychology department. Additional lobbying efforts directed at third party payers are currently in the planning stages. An expansion of the section-sponsored activities at the Convention has been discussed. Future activities will include therapy presentations by master clinicians as well as presentations for the general public.

Kerry J. Mothersill, Past-Chair



The Challenges of Mental Health

By Dr. John Walker

Reprinted with permission from the *Winnipeg Free Press*, September 14, 2003.

More than 2.6 million Canadians — one in ten adults — are struggling with a common mental-health problem. Among young people aged 15 to 24, it's almost one in five. This compares to the five per cent of Canadians with diabetes, five per cent with heart disease, and six per cent with a thyroid condition. In the last year, 4.7 per cent of Canadians experienced an anxiety disorder and 4.5 per cent faced major depression. Alcohol dependence afflicts 3.8 per cent of men and 1.3 per cent of women. Moderate-risk or problem gambling affects two per cent. For each of these problems, the rate is higher — often much higher — for younger Canadians before dropping off gradually with age. And, as we can all imagine, for each Canadian coping with a mental-health problem, several other family members often feel the impact.

The Canadian Community Health Survey of Mental Health and Well-being, released by Statistics Canada last week, (see www.statcan.ca, or www.cpa.ca/StatsCan.htm) found treatment rates for these problems were just as staggering as their prevalence. In a survey of 37,000 Canadians from across the country, just 32 per cent of those identified as having one of these mental-health problems had seen or talked to one or more health professional about it in the previous year. Most of these contacted a family physician (26 per cent), while 12 per cent consulted a psychiatrist and eight per cent a psychologist. And, again, the rate of contact was even lower among young people.

But the survey does not include information on whether those making contact with the health-care system actually received effective treatment. Previous community surveys have found that many do not. While the survey did not include people living in First Nations communities, the unmet needs there are even higher, given the difficult social and health conditions they face.

These numbers represent a daunting challenge for our society. Mental-health problems are associated with increased health costs, reduced productivity in school, the workplace and the home, and missed life opportunities. Young people with anxiety problems, for example, have been found to make less progress in education and careers. Direct and indirect costs (lost productivity) of anxiety disorders in Canada have been estimated in the range of \$100 billion.

How should Canada respond to this challenge? The temptation will be for mental-health providers and managers to ask for more of the same resources to provide more of the same services. Unfortunately, health planners discovered as far back as President John F. Kennedy's

Commission on Mental Health in the 1960s that there has never been — and can never be — an economically viable system that can provide adequate treatments to all those with mental-health problems.

This means we cannot solve population health problems until we develop effective approaches to prevention. Examples from other areas of health abound. We do not really solve the problem of lung cancer until we reduce the rate of smoking in the population. We do not solve the problem of head injuries until we ensure that most drivers are wearing seatbelts and most cyclists don helmets. Treating individuals after the problem develops is very expensive and generally produces modest results at best. Cautious health-care providers may respond that we can't really do anything about prevention until we understand much more about the causes of anxiety and depression. They may also say that we should not spend even one dollar on prevention until we have done everything we can for everyone suffering from these problems.

But the reality is that we already know a great deal about the causes of anxiety and depression. Research over the last 25 years has clearly identified risk-factors: starting life with a temperament prone to the development of anxiety and depression (often genetic factors); adverse experiences during childhood (a family that has difficulty due to conflict, abuse or poor parental coping); chronic life stresses (living in poverty or difficulty in relationships); and life stresses close to the onset of the mental-health problem.

Fortunately, each of these risk factors responds to environmental change, including changes in the ability of the individual, family or community to cope with these problems. As with smoking and lung cancer, changing the risk factors will change the outcome.

Convincing policymakers to devote more resources to prevention is not an easy matter. Prevention efforts often involve different personnel with different skills — educators or community workers rather than traditional health-care providers. The latter often face heavy workloads and naturally put more energy into advocating for more of their style of services than for prevention. The public has an easier time understanding the need for resources to help a person suffering today, as compared to those required to prevent a problem that will happen some time in the future. As well, prevention approaches often involve low-tech rather than high-tech solutions, so there is no commercial interest. In contrast, there is often strong commercial interest in marketing new pharmaceuticals and medical technologies, and these capture a large proportion of any new health-care dollars.

The good news is that some very promising prevention approaches are already gathering scientific support. The extent of the evidence for their effectiveness varies, but is often stronger than the evidence for treatment technologies that are widely implemented.

Current research supports the view that strengthening the ability of parents, schools and communities to support the development of healthy children and adolescents is the best approach to preventing later mental-health problems. And there is no doubt that reducing child poverty is key. It is already possible to identify young people (pre-school and kindergarten age) who exhibit risk factors for later mental-health problems. Children demonstrating conflict and aggression are at risk for later problems with interpersonal conflict, legal problems and substance abuse. Those experiencing problems with anxiety are at increased risk for later problems with anxiety, depression and substance abuse. Inexpensive classroom programs to assist these children have shown a positive impact on functioning many years later. Evaluations of anxiety programs in Australia, particularly, show long-lasting results from very economical school-based interventions. In late adolescence and early adult years, there have also been promising developments with school-based programs to reduce problems with binge drinking. With adults, mental-health promotion is possible by reducing stress and increasing social support in the workplace and by reducing the impacts of poverty.

Still, there has been very little spent on research or programs of prevention in the mental-health field. The public-awareness campaigns that some people equate with prevention have some value, but they are not remotely adequate. We should be spending more research dollars to develop and evaluate prevention approaches and implement them as they are shown to be effective.

Beyond prevention, there is much that we should be doing to improve the treatment of mental-health problems in Canada. There has been a tremendous effort over the last 10 years to improve the recognition of mental-health problems and the provision of drug treat-

ments in primary care. Much of this effort has been supported by the pharmaceutical industry. Individuals seeking help are often identified more quickly than in the past and offered medication treatment.

But psychosocial treatments, at least as effective as medication for problems such as anxiety and depression, are usually very difficult for primary-care providers and the public to arrange. These treatments are preferred by many consumers (particularly young people) and have the advantage in many cases of longer-lasting results, fewer side effects, and lower medium- to long-term cost.

There is clear evidence that offering treatments closer to where people live (the school, in the case of young people, and the workplace and primary-care community settings for adults) will increase the uptake of services.

Developing strategies to make these services more available has the potential to reduce the cost (per treated individual) and increase the acceptability of treatment for many mental-health problems. Our social services programs should be provided with more support to provide mental health assistance to those most in need, and reach out to the most underserved groups.

As in all areas of health, developing strong public policy that supports health promotion will be the key to reducing the human suffering and economic losses associated with widespread mental-health problems.

Dr. John Walker is a Professor in the Department of Clinical Health Psychology at the University of Manitoba and Director of the Anxiety Disorders Program at St. Boniface General Hospital.

PTSD and Pain: A Fact Sheet

Prepared by

Michael J. Coons, and Gordon J.G. Asmundson

Background

It is common for individuals with symptoms of posttraumatic stress disorder (PTSD) to present with co-occurring pain problems and vice versa. Recent evidence suggests that one of the most common symptom reports of patients with PTSD, regardless of the nature of their traumatic experience, is that of pain. Likewise, patients who have persistent, chronic pain associated with various injuries and health concerns (e.g., motor vehicle accidents, musculoskeletal pain, burns, fibromyalgia, AIDS) often present with symptoms of PTSD. However, in the clinical setting, the apparent

relationship between PTSD and pain often goes unrecognized. It has not been until the past decade that researchers have begun to examine the relationship(s) between PTSD and the experience of pain.

PTSD and its symptoms are associated with greater reporting of physical health problems and physical symptoms. These are also strongly associated with current pain, overall pain ratings, pain-related disability, functional impairment, and increased healthcare utilization. Furthermore, several researchers have reported that PTSD symptoms tend to be elevated in, and impact on, patients with chronic pain and fibromyalgia. It has been reported that between 10%-50% of patients receiving treatment for chronic pain and related conditions in tertiary care facilities have

Continued on next page

symptoms that satisfy diagnostic criteria for PTSD. It has also been shown that a significant number of patients (18.2%) show sub-threshold levels of PTSD symptoms that are sufficient to warrant clinical attention. Results of the National Comorbidity Study showed that those individuals who suffer musculoskeletal pain are four times more likely to develop PTSD than those without.

Risk Factors

Who is at risk for developing PTSD and/or chronic pain? Since researchers have established that PTSD and chronic pain frequently co-occur, it seems logical that the development of these conditions might stem from a common predisposing factor. While several constructs have been suggested to contribute to their development, anxiety sensitivity has been identified as the most promising.

Anxiety sensitivity refers to a dispositional tendency for people to become fearful of anxiety-related physical symptoms (e.g., racing heart, shortness of breath) based on the belief that they may have harmful consequences. For example, a person who has high anxiety sensitivity is likely to become afraid in response to having a racing heart or becoming short of breath. When those with high anxiety sensitivity encounter a traumatic stressor, painful physical injury, or both they would have a more intense emotional reaction than those with lower levels of anxiety sensitivity. Anxiety sensitivity seems to heighten the perceived threat caused by the stressor and amplifies the emotional reaction. This results in an increased risk of developing PTSD, and an increased likelihood that pain will be maintained over time. Although preliminary, there has been a growing body of literature that suggests that this shared vulnerability has a genetic component -- genetic factors have been found to contribute to the development of anxiety sensitivity, and both PTSD and pain. Therefore, people may be at risk for developing PTSD and/or chronic pain if 1) they suffer from one of these related conditions (e.g., PTSD or chronic pain alone, 2) they have elevated levels of anxiety sensitivity, or 3) if there is a family history of high anxiety sensitivity, PTSD, or pain. However, future research is required to confirm these ideas and, importantly, to evaluate other potential shared vulnerability factors (e.g., harm avoidance) that contribute to the development of PTSD and chronic pain.

Clinical Implications

Assessment—For clinicians who conduct diagnostic assessments with patients presenting with symptoms of PTSD, we recommend that they also screen for the presence of existing pain conditions (e.g., fibromyalgia, chronic musculoskeletal pain). Likewise, we recom-

mend that patients presenting with pain complaints, particularly when these are chronic, be assessed for the presence of PTSD symptoms. While consideration of the presence of co-occurring pain symptoms in those seeking treatment for PTSD, and vice versa, is important in facilitating appropriate treatment, we also recommend that levels of anxiety sensitivity be assessed and considered in treatment planning.

Treatment—While treatment studies related to both PTSD and pain have been evaluated independently, the consensus is that cognitive-behaviour therapy (CBT) is the most effective form of treatment to date. Given this, it is logical for clinicians to adapt existing CBT protocols for both PTSD and pain to address these issues when they co-occur. Within the context of these protocols, it seems that incorporating strategies to reduce anxiety sensitivity (interoceptive exposure) could improve the treatment outcome of both PTSD and chronic pain.

Recommended Readings

- Asmundson, G.J.G., Coons, M.J., Taylor, S., & Katz, J. (2002). PTSD and the experience of pain: Research and clinical implications of shared vulnerability and mutual maintenance models. *Canadian Journal of Psychiatry*, 47(10), 19-26.
- Asmundson, G.J.G., Norton, P.J., & Norton, R.G. (1999). Beyond pain: The role of fear and avoidance in chronicity. *Clinical Psychology Review*, 19, 97-119.

Michael J. Coons, Ph.D. Candidate

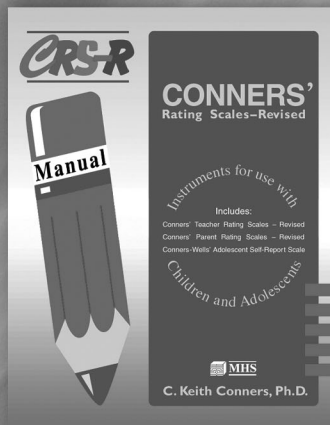
Michael completed his M.A. in clinical psychology at the University of Regina and is currently a doctoral candidate at the University of Waterloo. He has been publishing in the areas of anxiety, fear, and pain. Currently, he is conducting his doctoral research at the Anxiety Treatment & Research Centre, St. Joseph's Healthcare in Hamilton, Ontario under the supervision of Dr. Christine Purdon and Dr. Martin Antony.

Gordon J.G. Asmundson, Ph.D.

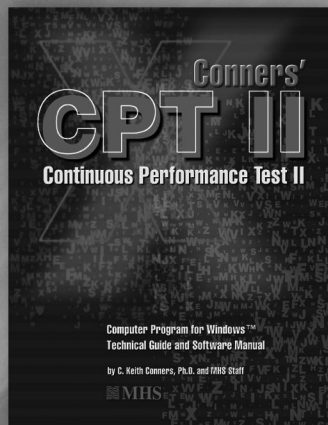
Dr. Asmundson is currently a CIHR-RPP Investigator, Professor, and Research Director in the Faculty of Kinesiology and Health Studies, and holds adjunct appointments in the Department of Psychology at the University of Regina and Department of Psychiatry at the University of Saskatchewan. Dr. Asmundson's innovative research has focused on the areas of chronic pain, PTSD, and health anxiety. He is now the principal investigator of a CIHR New Emerging Teams grant that will explore the risk factors associated with the development and maintenance of PTSD.

ADHD Across the Lifespan

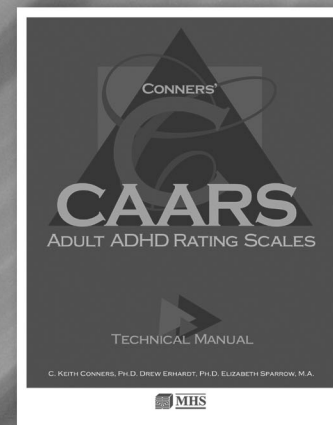
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Summary of Minutes
Meeting of the Executive Committee
June 13th, 2003, Hamilton Ontario

Present: David Dozois, Chair-Elect; Susan Graham, Member-at large; David Hodgins, Chair; Catherine Lee, Secretary-Treasurer; Kerry Mothersill, Past-Chair

1. Concern was expressed at the inclusion of a *mind-reader* at the McGraw Hill display at the CPA Convention in Hamilton. It was decided that a letter would be sent to the publisher in order to convey our reservations about the message this may be sending to others about the nature of Psychology.

2. Convention Planning for 2004

The possibility of including a Master Clinician presentation at the CPA conference was discussed. This would involve the demonstration of a therapy session by an experienced clinician. A number of possible topics for pre convention workshops were considered including supervision, addictions, workplace issues and the treatment of anxiety. In light of the low proportion of graduate students seeking an academic position, we discussed the possibility of a conversation hour on the challenges and rewards of an academic career. Additional ideas for symposia were discussed.

CPA Section on Clinical Psychology
Summary of the Minutes of the Executive Committee
Fall Teleconference Meeting
September 12, 2003

Present: Mike Coons, Student Representative; David Dozois, Chair-Elect; Susan Graham, Member-at large; David Hodgins, Chair; Catherine Lee, Secretary-Treasurer; Kerry Mothersill, Past-Chair

1.0 Membership and Financial Report

Catherine presented the Secretary-Treasurer's report. There is presently \$7,796.05 in chequing and \$3,906.77 in GICs. As of September 2003, there are 212 student members and 399 nonstudent members of the section. Consistent with the trend in recent years, the number of members is gradually increasing. The announcement which is regularly placed in *Psynopsis* will continue to be used. A copy will be circulated to all members.

2.0 CPA 2004 Convention program (June 10-12, 2004).

a. Sherry Stewart has agreed to present a preconvention workshop on addictions. The process of awarding CE credits will be clarified with CPA.

b. There was agreement in principle for the Clinical section to co-sponsor a workshop on Ethics with the Student Section.

CPA Category A Keynote and CPA Category B: Speaker Discussions were held as to the topics to be

covered and individuals to invite.

Master Clinician: The master clinician presentation will be a two-hour session including role-play interview and audience questions. It would be beneficial to videotape the session. A potential speaker will be invited. The same individual will also be invited to give a one-hour public lecture.

Mini-workshop and Symposia: Potential presenters for a three-hour workshop as well as symposia topics were discussed.

Conversation hour.

a. The regular conversation session on *Internships* will be offered. We will have a panel on *Women in Academe*.

b. Mike reported that clinical students had appreciated a Student section panel on issues in clinical training and suggested it be repeated.

We agreed on the general principle of soliciting suggestions from the membership about topics of interest for future conventions. For 2004, the chair of the Newfoundland Psychological Association will be asked for ideas.

3.0 McGraw-Hill Ryerson update

David Hodgins read the letter received from McGraw-Hill in response to the complaint sent by the Clinical section following the June 2003 convention. Members of the Executive were satisfied with the apologetic tone of the letter.

4.0 Fact Sheet update

Susan reported that she has agreements from authors to prepare fact sheets on: post-partum depression, parenting, smoking cessation, problem gambling, autism and learning disabilities. Inquiries will be made at AABT about their process of soliciting and reviewing fact sheets. In addition, the invitation letter will be reviewed to ensure that it highlights the importance of a balanced presentation of empirical findings. There has been a request that fact sheets be available in pdf format so that they have a more professional appearance. Inquiries will be made with CPA concerning these two issues. We discussed other possible topics including sexual disorders.

5.0 Listserve update

As Secretary-Treasurer Catherine is now responsible for the listserv. We agreed that it is a useful medium to solicit input on the needs of members of the section, but that it should not overlap with the Newsletter.

6.0 Newsletter update.

David H. reported that Deb & Keith Dobson are preparing the fall newsletter. There is no need to include a notice informing members of the listserv. The text of calls for nominations will be reviewed.

7.0 Call for nominations to executive.

Notices will be placed in the newsletter.

Continued on next page

8.0 Ken Bowers Student Award

It was decided to offer only one award of \$500 in 2004 in order to increase the number of submissions for this award. To advertise the award more widely, notices will also be placed in the Student section of *Psynopsis*. In addition, DCTs will be solicited through CCPPP to disseminate information about the award.

9.0 Midwinter meeting

The midwinter meeting is confirmed for January 31st 2004 in Calgary

10.0 Canadian Council of Health Service Executives meeting

Kerry reported that there has been no news on this file from CPA.

11.0 Advocacy work – Efficacy of psychological interventions

Kerry has assembled a list of purchasers of assessment and therapy services to whom to send information on efficacy of psychological interventions. We agreed to allocate up to \$200 for secretarial assistance to this project.

12.0 New business.

Mike Coons raised the issue of internship stipends. All members of the executive agreed on the desirability of interns having higher stipends, but also cautioned the need for an integrated strategy on this topic. John Service will be asked for more information and the topic will be tabled for the mid-winter meeting.

Meeting adjourned at: 12:50.

CCPPP Liaison Report

Laurene J. Wilson, August 2003

As a member-at-large within the Canadian Council of Professional Psychology Programs (CCPPP), I have been appointed liaison to your section. The CCPPP is a fraternal organization committed to representing and coordinating Canadian graduate programs and internships in professional psychology (clinical, counselling, neuropsychology, and other applied psychology disciplines) (<http://www.usask.ca/psychology/ccppp/>). For example, the organization publishes a popular directory of Canadian training programs each year. Members also have the opportunity to meet annually at the CPA convention for a "reduced fee" pre-convention workshop focusing on training issues.

There were many interesting developments within the organization this year. At the annual general meeting in Hamilton, members considered the question of the necessity of concurrent accreditation by CPA and APA. A number of organizations have expressed an interest in moving towards CPA only accreditation (e.g., due to costs of maintaining both), but fear negative impacts in doing so "alone". (e.g., to quality and quantity of applicants, program reputation). Given the apparent desire of many programs to make this move, a motion was passed that the CCPPP supports Canadian programs moving towards CPA only accreditation. A second motion (passed unanimously) stated that programs wishing to make this move should make their wishes known to CCPPP and CCPPP will help facilitate the process (e.g., through a memorandum of agreement of these programs, identifying a mutually agreeable date). Programs not yet accredited or having only one accreditation will also be invited to be signatories, to show their support and intended compliance with the process.

Guidelines for letters of reference to Canadian internships were developed and utilized on a voluntary basis in this year's internship match. The CCPPP undertook an evaluation of the project, finding over 70% of letter writers (i.e., clinical supervisors) and letter recipients (i.e.,

internship programs) endorsing their continued use. Specific feedback was incorporated through minor revisions and the 2003 edition has been posted on the CCPPP website (<http://www.usask.ca/psychology/ccppp/ref-letters/>). This project caught the attention of colleagues in the United States (e.g., APPIC; CUDCP) who considered our guidelines for adoption in this year's match. However, they ultimately decided to postpone adoption in the US pending further consideration.

The CCPPP has developed a sub-committee to work on the question of internship funding. In Quebec particularly, there are many unpaid internships. An increasing future demand for internship slots is anticipated in Quebec, as Psy.D. programs "open". As such, the need for additional placements with funding in Canada is anticipated.

Also in keeping with our mission as a national organization, CCPPP is also working towards greater inclusiveness of our Quebec colleagues through translation of our documents and website. To date, the mission statement and by-laws have been translated and we are continuing to have additional documents reviewed.

The CCPPP is also reviewing its membership criteria to enhance clarity and transparency. During this process, formal membership applications will also be developed. In the mean time, programs wishing to join CCPPP may still make their applications by following existing criteria posted on the website (<http://www.usask.ca/psychology/ccppp/joining.htm>). The CCPPP launched a listserv for member programs this year, and was well regarded by the membership. The website will be under-going a facelift in the coming months which will be found at the following new URL: <http://www.ccppp.ca>.

If you have any comments or questions for the CCPPP, please contact the authour at: laurene.wilson@saskatoonhealthregion.ca.

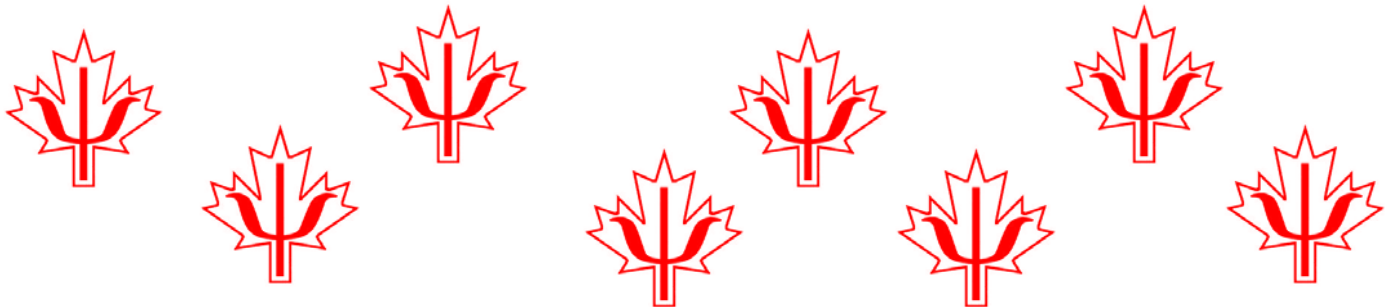
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Submissions Invited

This newsletter, the Canadian Clinical Psychologist/ Psychologue Clinicien Canadien invites submissions from Section members and students.

Brief articles, conference or symposia overviews, and opinion pieces, are all welcome. The thoughts and views of contributors belong strictly to the author(s), and do not necessarily reflect the position of the Section, the Canadian Psychological Association, or any of its officers or directors.

Please send your submission, in English or French, directly to the editors, preferably either on disk or via e-mail attachment to either of the editors.

The newsletter is published twice per year. Submission deadlines are as follows: September 15th (October issue) and March 15th (April issue).

Editors:

Deborah & Keith Dobson

ddobson@ucalgary.ca

keith.dobson@ucalgary.ca



Acculturation, Family Environment, and Disordered Eating: A Comparative Study of North-American and Asian Born Chinese Students

Karen Ip^a, M. Alexis Kennedy^a, Joti Samra^{a, b}, & Boris B. Gorzalka^a

^a Department of Psychology, University of British Columbia

^b Associate, Odyssey Health Services, Vancouver, BC

Disordered eating is a pattern of abnormal and maladaptive attitudes and behaviours towards food and feeding. It has been suggested that disordered eating may be exacerbated by the process of acculturation, whereby immigrants come to incorporate the values of the mainstream culture into their own identity. However, the relationship between acculturation and the development of eating pathologies remains unclear, with studies often obtaining contradictory results (e.g., Davis & Katzmann, 1998, 1999). These incongruous findings may be due to the fact that acculturation may not be the strongest predictor of disordered eating. Instead, family environment may play a more central role in the development of eating pathologies than acculturation alone (McCourt & Waller, 1996; Haudek, Rorty, & Henker, 1999).

The present study sought to investigate the contributions of acculturation and family environment to eating pathology in four groups of Chinese individuals of different origins: those born in Canada, and immigrants to Canada from Hong Kong, Taiwan, and Mainland China. Three hypotheses were generated. First, it was predicted that increased levels of acculturation into Western culture would be related to a greater endorsement of eating pathology. The second hypothesis was that participants born in Canada would report more disordered eating symptomatology than participants born outside Canada. The third hypothesis was that family environment would prove to be a stronger predictor of disordered eating than acculturation.

Methods

Five hundred and twenty-seven undergraduate students from two large universities in British Columbia participated in the study in return for course credit. All participants identified themselves as ethnically Chinese, and their reported birth countries were distributed as follows: 205 were born in Canada (M age = 18.9, SD = 1.6), 194 were born in Hong Kong (M age = 19.8, SD = 2.9), 104 were born in Taiwan (M age = 19.5, SD = 1.7), and 24 were born in Mainland China (M age = 19.3, SD = 1.4).

The Eating Disorders Inventory-2 (EDI-2; Garner, 1991) was employed to assess the frequency with which the respondent experiences pathological attitudes and behaviours associated with food and feeding. The EDI-2 consists of 11 subscales, of which 3 will be of primary interest: Drive for Thinness, Bulimia, and Body Dissatisfaction.

The Family of Origin Scale (FOS; Hovestadt, Anderson,



Karen Ip receives the 2003 Ken Bowers Award from Chair Dr. David Hodgins, in Hamilton,

Piercy, Cochran, & Fine, 1985) was employed to inquire about the level of autonomy and intimacy characteristic of a respondent's primary family. The responses are summed to arrive at a total score, with higher scores indicative of a healthier family environment.

The Vancouver Index of Acculturation (VIA; Ryder, Alden, & Paulhus, 2000) consists of 22 questions assessing an individual's level of acculturation into North American culture, as well as their retention of their heritage culture. The two subscales are the Heritage subscale, which indicates the level of identification with one's heritage culture; and the Mainstream subscale, which indicates the level of identification with mainstream North American culture.

Finally, the participants' body mass index (BMI) was calculated using self-reported height and weight (i.e., weight in kilograms divided by height in metres squared).

Results

Differences on the measures described were considered for the four groups using Analysis of Variances. On the EDI-2, Chinese born in Taiwan obtained significantly higher scores on the Drive for Thinness subscale than Canadian born Chinese, $F(3, 521) = 4.65, p = 0.007$. In terms of BMI, the Canadian participants had a significantly higher BMI than both the Hong Kong and the Taiwan participants, $F(3, 513) = 4.625, p < 0.05$.

A series of hierarchical multiple regression analyses were performed, with the EDI subscales as the dependent variables, and the participants' country of birth, BMI, the Mainstream and Heritage subscales of the VIA, and the FOS as the predictors. The birth country was entered in block 1, BMI in block 2, the two VIA subscales were entered in block 3, and the FOS was entered in block 4.

For Drive for Thinness scores, BMI ($\beta = 0.16$), VIA Mainstream scores ($\beta = -0.17$), and FOS scores ($\beta = -0.13$) all emerged as significant predictors in the final model ($R^2 = 0.02$). For Bulimia scores, BMI ($\beta = 0.17$), VIA Mainstream scores ($\beta = -0.10$), and FOS scores ($\beta = -0.12$) again emerged as significant predictors in the final model ($R^2 = 0.02$). The same pattern was obtained with the Body Dissatisfaction subscale, with BMI ($\beta = 0.28$), VIA Mainstream scores ($\beta = -0.16$), and FOS scores ($\beta = -0.18$) emerging as significant predictors ($R^2 = 0.03$). It is interesting to note that the relationships between the VIA Mainstream scale and the EDI-2 subscales were in the negative direction, indicating that as acculturation to mainstream culture increased, the risk for eating pathology decreased.

Discussion

The present study sought to determine whether two factors, namely acculturation and family environment, were related to disordered eating symptomology. The first hypothesis predicted that Canadian-born Chinese participants would report the greatest number of pathological eating attitudes and behaviours of the four groups; however, this was not the case. In fact, all four groups of Chinese participants were highly similar in terms of their scores on the EDI-2.

One explanation for this null finding is that the immigrant groups in actuality do face an increased risk of developing eating pathologies. However, this risk was not expressed in the present study because of the differences between the groups in their current BMI's. Because the BMI's of the Taiwan and the Hong Kong born participants were significantly lower than that of the Canadian participants, the two immigrant groups may have had less reason to adopt pathological eating behaviours. It may be that if the immigrant groups were as heavy as the Canadians, they would begin to exhibit greater eating pathologies.

The second hypothesis concerning acculturation stated that greater levels of acculturation would be related to greater eating pathology. This hypothesis was not supported, as results suggested that acculturation into a Western country may actually lower, not increase, the risk of developing an eating disorder.

The third hypothesis concerned the relative contributions of acculturation and family environment to the endorsement of disordered eating symptomology. It was hypothesized that family environment would prove to be a stronger predictor of eating pathologies than acculturation alone. This last hypothesis was confirmed. In regression analyses, the FOS emerged as a significant

predictor of all EDI-2 subscales, significantly accounting for a portion of the variance in scores above and beyond what had already been explained by birth country, BMI, and the VIA subscales. In general, a healthier family environment was related to less instances of disordered eating.

The fact that a supportive family may be related to a decreased risk for developing an eating pathology suggests that a healthy family environment may serve as a protective factor (Stice, 2001). Although it was not investigated in the present study, protective factors that may exist in the Chinese family include an emphasis on family harmony, a sense of collectivism, and filial piety. All these factors may contribute to decreased conflicts within the family, which may decrease stress and feelings of isolation, and consequently decrease the risk of developing eating pathologies.

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Review of the Interpersonal Therapy of Depression (IPT) Workshop

**Presented by Dr. Laurie Gillies,
Department of Psychiatry,
University of Toronto,
at CPA, Hamilton, June, 2003. (Sponsored by the
Clinical Psychology at CPA.)**

Dr. Gillies presented an informative and lively discussion of IPT, its' background, contributors, history, current applications, and future applications.

As strong adherents of the cognitive-behavioral approach, we were interested in learning about IPT as another empirically supported treatment approach. We had expected to hear about an approach that was very different and distinct from the therapy approach we use. However, our impression of IPT has changed, as although it seems as though there are unique aspects of IPT, but definitely hybrid components of other therapies as well. This summary and review of the workshop reflect our own musings and analysis of the material presented in the context of the type of work we typically do.

Similarities

We noticed that IPT and CBT are very similar in terms of the practical, problem-solving nature of the therapy, the active role of the therapist, and the emphasis on psychoeducation. Perhaps these are more common factors of therapies that have been empirically validated (whether this is a clinical effectiveness issue or a factor of the types of therapies that are easily amenable to standard research protocols remains to be seen).

Differences

We were also struck with some of the differences between IPT and interpersonal therapy as defined by Irving Yalom and others. Specifically, the relationship between therapist and client was not used as much as one would have expected (i.e., attended to specifically only if resistance becomes an issue). Perhaps this is a function of the short-term nature of IPT rather than specifically a function of the theoretical orientation of this therapy.

Additionally, although many techniques are quite similar (i.e., activity scheduling, behavioral activation, cognitive challenging), the focus in IPT is quite strictly on the social domain. So, for example, increasing activities largely means increasing social activities rather than activities in general.

Issues

In reviewing our understanding of IPT and its similarities and differences with other forms of therapy, the following issues arose.

1. It would be informative to conduct a component analysis of IPT to determine the common and unique ingredients, as well as to tease apart what components of the therapy are responsible for its efficacy.
2. It would also be helpful to review overlap with interpersonal, cognitive-behavioral, and other therapies to determine what is unique to IPT.

One issue, and in fact our most compelling reason to attend this workshop, is that of effecting change in individuals suffering from long-standing interpersonal deficits. This is a difficult issue in clinical work, and our hope was that IPT would offer some novel ideas for helping with this issue. However, it makes logical sense that a very short-term therapy would have less success in dealing with ingrained difficulties compared to a longer-term approach. This highlighted the importance of longer-term therapies (i.e., interpersonal therapy, schema-focused therapy) in dealing with such ingrained or characterological issues.

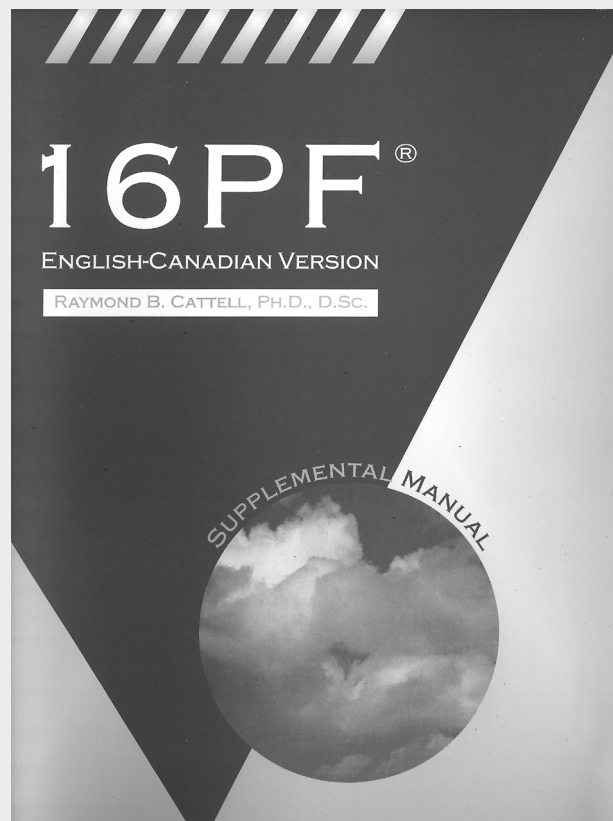
Summary

IPT offers a gentle, practical, and efficacious approach to the treatment of depression. Its strengths, in our minds, are the importance placed on the protective factor of social support, and the strategies used to facilitate and enhance social connection. Especially in a day and age where we seem to be becoming increasingly disconnected from extended family and friends, and more reliant on "efficient" methods of communication rather than ones that connect us emotionally to others, this type of therapy would seem to be a useful and needed approach.

The workshop presented by Dr. Gillies was informative and thought-provoking and definitely worth attending. The value of this workshop speaks to the continued importance of having such seminars as part of the annual convention as they allow students, clinicians, and researchers to learn more about diverse areas of practice in a convenient and accessible manner.

This review was written by Drs. Barbara Backs-Dermott and Kate Hamilton, of the Calgary Health Region.

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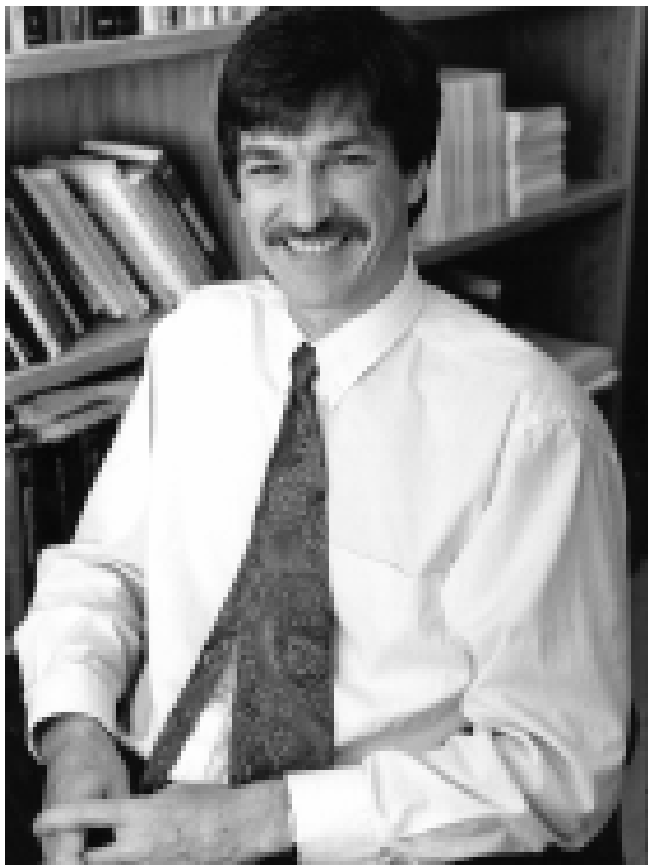
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**The Section on Clinical Psychology
welcomes its latest Fellow:
Dr. Charles Morin**



Charles Morin obtained his Bachelors and Masters degrees from Laval University and then, following the dream of many a Quebecoise, migrated to Florida. He completed his Doctorate degree at Nova University in Fort Lauderdale under the supervision of Nathan Azrin. He completed his predoctoral residency at the University of Mississippi Medical Centre and a postdoctoral fellowship at the Sleep Disorders Centre at the Medical

College of Virginia. From 1987 until 1994, he was the Associate Director and then the Director of the Sleep Disorders Center in the Department of Psychiatry at the Medical College of Virginia. He returned to Laval University in 1995. He currently is a Professor of Psychology, the Director of the Clinical Psychology Doctoral Program and the Director of the Sleep Disorders Centre at the Centre de Recherche Université Laval/Robert Giffard.

Dr. Morin has left his mark in the area of therapy of sleep disorders, in particular, the treatment of insomnia. In recognition of his contributions at an early age, he was awarded the Distinguished Scientific Award for an Early Career Contribution to Psychology by the American Psychological Association (Health Psychology) in 1995. He is a Fellow of Division 12 of APA and of the American Sleep Disorders Association. He has a Diplomate with the American Board of Sleep Disorders Medicine. Closer to home, he is the current president of the Canadian Sleep Society and has been the Chair of the Clinical Section of CPA (1998). At the time of his nomination, Dr. Morin had published 77 peer reviewed articles in top journals and no less than five books. He has successfully obtained research funding from a number of organizations, currently including the National Institute of Mental Health and IRSC-CRM. Despite this level of activity and his international profile, Dr. Morin has continued to support and promote Canadian clinical psychology.

To quote one of his nominators: "En bref, sa contribution a couvert tout le spectre de la psychologie clinique et a su déborder sur une reconnaissance internationale, don't la psychologie clinique au Canada bénéficiera pour bien des années encore." Dr. Morin exemplifies the values of clinical psychology as a true scientist-practitioner and has made highly significant contributions in clinical practice, research and training.

Clinical Section List Serve

The CPA Section on Clinical Psychology initiated its list server, in August 2001, in order to inform members about important news and events, and to disseminate information generated from the Executive of the Section. Every member of the Section (who provided CPA with their email addresses) were placed automatically on the list server.

It is not the Executive's intention to use the list serve as an open forum for discussion nor to advertise on behalf of members of the Section. The list serve will simply be used for Section news. We intend to operate in the best interests of our members, and your email addresses will be protected and kept completely confidential.

Ideally, all Section members will be active on the list server. If you have not already received information through the list server, please send your email address to Dr. David Dozois at dzois@uwo.ca, and type "Subscribe" in the subject heading (please ensure that your email address is correct). To access information about the listserver, type <http://lists.cpa.ca/mailman/listinfo/cpa>.

The Executive Committee of the Section on Clinical Psychology anticipates that the list server will be an effective means of communicating with its members and we hope that you will take this opportunity to join the list. We would again like to acknowledge CPA for its generous support in providing this service at no cost to the section.

REPORT ON DIVERSITY TRAINING IN CANADIAN CLINICAL PSYCHOLOGY INTERNSHIPS

Brian L. Brooks, M.Sc., Ph.D. Candidate and
Alisa R. Mintz, M.Sc., Ph.D. Candidate,
Program in Clinical Psychology, University of Calgary

There is little doubt Canada is a diverse country. The Canadian landscape includes persons from a variety of ethnicities, religions, and languages. According to the 2001 Canadian Census, 13% of the Canadian population identify themselves as visible minorities and almost half define their ethnic origin as non-British or non-French. Additionally, 18% of Canadians identify their first language as a non-official language and the population is divided amongst many different religious denominations. And if the past decade is an indication (e.g., over 1.8 million people immigrated to Canada), the Canadian landscape will continue to change.

As a result of the culturally diverse Canadian population, clinical psychologists are likely to encounter individuals from diverse backgrounds seeking mental health services. It can be argued that clinical competency requires increasing competency in cultural issues through awareness of the role of unique cultural experiences on client's mental health (Sue, Bingham, Porche-Burke, & Vasquez, 1999). Clinicians and researchers in clinical psychology have become increasingly aware of the role of cultural factors in personality development and functioning (Sue, 1999). Studies suggest there may be cross-cultural differences in the pathways to which mental health problems arise, the course of disorder and treatment outcomes. As a result, cross-cultural differences need to be considered in the conceptualization and treatment of mental health problems. As psychologists interact professionally with diverse persons, they must rely on many resources (e.g., psychological theories pertaining to diversity, current literature, prior training, ethical standards, etc.) to ensure they are providing the most appropriate services for their clients. It has been argued that cultural competency should be fostered and developed early on in a psychologist's professional development, such as at the level of the pre-doctoral internship (Hertzsprung & Dobson, 2000).

The Canadian Psychological Association (CPA) recognizes the diversity of Canadians and the importance of establishing cultural competence. As reflected in the 2002 Accreditation Standards for Pre-Doctoral Psychology Internships, the CPA takes a strong interest in the training of future psychologists regarding issues of diversity. However, little is known about how diversity training is implemented at internships and whether interns receive sufficient diversity training for their roles as psychologists.

We conducted a survey of diversity training at internship sites listed in the 2002 Canadian Council of Professional Psychology Programs (CCPPP) guide. Directors of Internship Training (DITs; total $N = 38$) were asked to complete an enclosed survey (65.8% return rate, $n = 25$) in order to examine the level of diversity

training for interns across Canada. The objectives of this study were to: (1) evaluate the different methods used in diversity training, (2) determine whether DITs believe current interns are sufficiently prepared with diversity training, and (3) survey the DITs' opinion of the 2002 CPA Accreditation criteria regarding diversity training.

Of the internship sites that returned the survey, 84% were accredited from the CPA, the APA, or both. 9 out of every 10 sites had mission statements, and half of the mission statements contained references to and specific learning objectives related to diversity.

The DITs varied in how important and how effective they perceived the different methods to be for interns' diversity training. Although some of the sites *required* the diversity training techniques to be undertaken by their interns, the majority of techniques were reported to be only *encouraged* of their interns. The DITs rated the perceived effectiveness of all of the surveyed training methods as at least *moderately effective*. "Hands-on" techniques (i.e., therapy, assessment, teaching or training others, specific rotations, etc.) were rated as the most effective methods, while the indirect training techniques (i.e., access to readings, research, observational learning, discussion groups, etc.) were perceived to be the least effective. Interestingly, there were no significant relationships between whether a site permitted, encouraged or required a method and how effective the DIT rated that training method.

Regarding the preparation of interns on diversity issues, nearly three-quarters of the DITs believed that interns complete the program with training in diversity that was sufficient for their roles as clinical psychologists; however, many DITs also indicated that diversity training requires ongoing learning post-internship. One of the methods for ensuring adequacy on diversity training is through periodical performance evaluations. 64% of the sites evaluated their interns' performance on diversity issues, and these evaluations occurred on average every 3.75 months during the internship year.

Finally, regarding the DITs perception of the 2002 CPA Accreditation Criteria for diversity training, 76% of the DITs believed the criteria were about right in terms of prescriptiveness and do not need to be changed, while 8% believed the criteria need to be more prescriptive for internship training sites. 16% of the sites did not respond to this question. The results of this study suggest that techniques involving direct exposure to culturally diverse clients are the preferred training methods at internships, which is consistent with the "hands-on" experiential training model of internships. Overall, most DITs are generally satisfied with the level of diversity training interns receive and believe the CPA accreditation criteria for internships are sufficiently prescriptive for diversity training.

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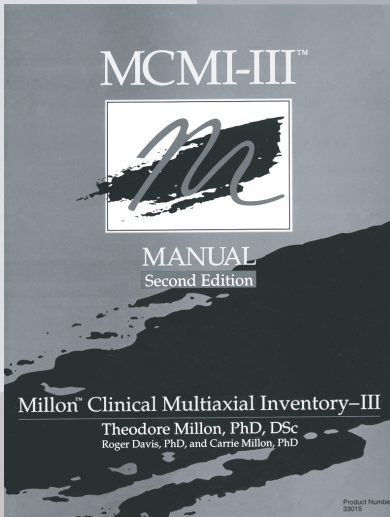
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MISES EN CANDIDATURE - FELLOWS DE SECTION

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 29 mars 2004 à l'attention de:

Dr. David Dozois, Chair-Elect

PRIX KEN BOWERS POUR RECHERCHE EFFEC- TUÉE PAR UN(E) ÉTUDIANT(E)

Chaque année, la Section de Psychologie Clinique évalue les communications soumises par les étudiants(es) en vue d'une présentation au congrès annuel de la SCP. En 2002, deux bourses seront remises. Un certificat et une bourse de 300\$ seront remis aux deux étudiants(es) ayant soumis les communications les plus méritoires. 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 de Vancouver; (2) soumettre un résumé de 10 pages à double interligne décrivant l'étude; et (3) être présent(e) à la réunion d'affaires de la Section Clinique du congrès de Vancouver lorsque les prix seront décernés.

La date limite pour soumettre les candidatures est le 29 mars, 2004. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées à:

Dr. David Dozois, Chair-Elect

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 equated with 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 29, 2004 to:

Dr. David Dozois, Chair-Elect

KEN BOWERS STUDENT RESEARCH AWARD

Each year, the Section of Clinical Psychology reviews papers that have been submitted by clinical students for presentation at the annual CPA convention. The most meritorious submission is recognized with a certificate and an award of \$300. In order to be eligible, you should: (1) Be the first author of a submission in the area of clinical psychology that has been accepted for presentation in Ottawa; (2) Submit a brief (i.e. up to 10 pages, double-spaced) manuscript in APA format describing the project, and (3) Be prepared to attend the Clinical Section Business meeting at the Ottawa convention, where the award will be presented.

The deadline for submission of applications is March 29, 2004. Submissions may be in either English or French and should be forwarded to:

Dr. David Dozois, Chair-Elect

Mail Nominations to:

Dr. David Dozois,
Department of Psychology
University of Western Ontario
London, Ontario, N6A 5C2

Phone: (519) 661-2111 ext. 84678
Fax: (519) 661-3961
email: ddozois@uwo.ca