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CLINICAL PSYCHOLOGIST

Newsletter of the Clinical Section of the Canadian Psychological Association
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Inside...

Message from the Chair
David J. A. Dozois, Ph.D.

Many of us are familiar with the analogy of a teacher who stood before the class and picked up a large empty jar. The teacher began to fill the jar with medium sized rocks and asked the students if the jar was full. The students responded in the affirmative. The teacher then added some pebbles which rolled into the remaining areas between the rocks. Then the teacher poured some sand into the jar. The sand filled up every remaining space so that the jar was now completely full. This analogy, of course, refers to setting priorities and utilizing time in a purposeful and effective manner. If sand was placed in the jar first there would be no room for the rocks or pebbles. Similarly, although the smaller things in life are important, we should ensure that the higher priorities are not missed.

The Clinical Section Executive is involved in a number of tasks each year and it is sometimes challenging to balance all of the priorities of the Section. Each year, a considerable amount of effort is devoted to conference planning. I am not at all suggesting that this is akin to the sand in the above analogy, but it is something that we are involved with annually. In addition to reviewing all of the submissions from its members (with the help of external peer reviewers), the executive committee also arranges a number of Section-sponsored events, including keynote addresses, the preconvention workshop, the master clinician presentation, mini-workshops, invited symposia, conversation sessions, the annual business meeting and the social reception. Our excitement for the conference program grows throughout the year as we confirm our speakers and schedule our events. In the midst of this excitement, however, it is important for us to continue working on other business and new initiatives.

As Dr. Ian Nicholson noted in a recent issue of *Psynopsis* (Nicholson, 2004), one of these new initiatives is the first annual "February is Psychology Month". Dr. Nicholson mentioned the CPA and the provincial/territorial associations will be joining efforts to promote psychology across the country. He also encouraged CPA members to think of strategies for showing psychology off to the public. I would like to reiterate the importance of this initiative and encourage each member of our Section to make some sort of contribution, no matter how small.

For a variety of reasons, some of us may tend to steer away from tooting our own professional horn. Some of us may see it only as a form of self-enhancement. I believe, however, that the public is very interested in hearing what psychology has to offer and that this information is also in the best interests of the public. Think, for example, of the prophylactic benefits of cognitive therapy (CT) for depression. A number of clinical trials have indicated that CT yields comparable results to interpersonal psychotherapy and antidepressant medication, with all of these active treatments producing superior results than placebo control conditions (Hollon, Haman, et al., 2002; Hollon, Thase, & Markowitz, 2002). CT also appears to be as effective as antidepressant medication for the treatment of severe depression (e.g., DeRubeis, Gelfand, Tang and Simons, 1999).

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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 2004-2005, the Section requires nominations for the position of Chair-Elect (a three-year term, rotating through Chair and Past Chair). Continuing members of the Executive for 2005-2006 will be Dr. Catherine Lee (Chair), Dr. David Dozois (Past-Chair), Dr. Adam Radomsky (Member at Large) and Dr. Kerry Mothersill (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 25th, 2005**.
Send nominations for the Executive to:
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In addition to the efficacy of CT for symptom reduction, are compelling data that suggest that this form of treatment also has an added prophylactic benefit relative to pharmacotherapy (Hollon, DeRubeis, & Evans, 1996; Hollon, Thase, et al., 2002). In fact, numerous studies have now shown that CT yields approximately half the relapse rates that are evident with antidepressant medication, an effect that is at least as powerful as maintaining patients on continuance medication (Hollon, Thase, et al., 2002). Would the public not be interested in knowing this information? I recently saw a client who had suffered from panic disorder for a number of years. He saw many mental health experts and was prescribed a myriad of medications to little avail. I saw him for 8 sessions of cognitive-behavioural therapy and he was panic-free. During our last session, he said to me "I really wish that someone had told me about the importance of exposure a long time ago…it has made such a difference to my life". I am sure that many of you could share similar stories of patients who have made substantial life changes and wished that someone had referred them for psychotherapy earlier. Psychology Month is an incredible opportunity to spread the word about the good work that we do.

Another concern that members may have is that they are not apprised of the latest research to feel comfortable doing something like a public lecture. The reality, however, is that most of the public just wants to hear some pointers regarding what they can do to to better parent, to deal with stress, to help their child with a learning disability, or to know when their older parent may be experiencing dementia. What the public would like to hear is basic and practical information. So contact your local library and tell the staff about Psychology Month. Mention that you are willing to do a public talk related to your area of practice and expertise.

Most of us remember the Breck Hair Shampoo commercial that said, "I told two friends, and they told two friends, and so on, and so on, and…" This commercial illustrates the importance of word of mouth. Promoting psychology in our own communities does not have to involve a lot of work. If every Section member did just one small thing to promote psychology during the month of February, the impact could be substantial. I would love to see the general public demand better access to psychosocial interventions (see Collins, Westra, Dozois, & Burns, 2004). Although this may seem like a pipe dream, I think it could happen if we each did our part.

I began this column with the analogy of the jar of rocks, pebbles and sand. As the Executive of the Clinical Section sorts out its future priorities, we would also like to ensure that your voices are heard. We will soon be circulating a brief survey through the listserve. We hope that every member of the Section will respond to this survey because would like to learn what the membership considers the top priorities for the Section.

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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).

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Deborah & Keith Dobson
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Summary of the Unapproved Minutes of the Annual Business Meeting
Friday, June 11, 2004
St Johns, Newfoundland

Present:

Laurene Wilson, Pat McGrath, David Clark, Bob Robinson, Thomas Hadjistavropoulos, Ken Craig, Michelle DeLisle, Margaret Lumley, Adam Radomsky, Ian Nicholson, Keith Wilson, Leslie Graff, Mike Coons, David Hodgins, David Dozois, Kerry Mothersill, Catherine Lee.

Report from the Chair (David Hodgins)

Section Executive

The Executive Committee was comprised of Kerry Mothersill (past-chair), David Dozois (chair-elect), Catherine Lee (secretary-treasurer), Susan Graham (member-at-large), Mike Coons (Student representative) and David Hodgins (chair). The Executive met in person at the CPA convention in Hamilton (2003) as well as in Calgary for a mid-winter meeting. In addition, two teleconference meetings were held in September and May and many ad hoc email discussions occurred. The section has 414 full members and 185 student members (compared with 395 and 201 in 2003).

Convention Program

The section received and reviewed 116 submissions to the 2004 convention. Clinical sections presentations at the convention include two poster sessions, three symposia, seven conversation sessions, two theory reviews, a pre-convention workshop and two convention workshops.

The section sponsored activities include a CPA-invited presentation by Patrick McGrath (Psychosocial issues in pain in infant, child and youth health: A potpourri), a pre-convention workshop by Sherry Stewart and Patricia Conrod (Substance-use disorder treatment and early intervention; Cognitive-behavioral strategies matched to the motivational bases underlying substance misuse), workshops by Michael Vallis (Motivational enhancement and behaviour change) and Christine Chambers (Life as an early career clinical psychologist: A how-to guide for getting started on research, teaching and clinical practice). Kerry Mothersill will lead a conversation on preparing for your pre-doctoral internship and Catherine Lee will lead a discussion on women in academe.

We are particularly pleased to offer the first in what we hope will be an ongoing "Master Clinician Series". David Clark will demonstrate an intervention for unwanted intrusive thoughts in the context of a live role play. This session will be followed by a social hour for section members. Dr. Clark will also be providing a general public lecture on treatments for anxiety and depression. A public lecture is also a new venture for the section.

Awards

We are again awarding the status of Fellow of the Clinical Section and Ken Bower's Student Research Award at our AGM. David A. Clark and Thomas Hadjistavropoulos have been elected fellows. Michelle M. DeLisle is the winner of the student award and Margaret N. Lumley was the first runner up.

Communications

The section's biannual newsletter, Canadian Clinical Psychologist, was published under the stewardship of Deborah and Keith Dobson and the section website is maintained by David Hart. The clinical listserve continues to be used judiciously for section business although we expanded the mandate to allow announcements of employment opportunities.

Ongoing Projects

Our strategic planning discussions seem to veer toward the issue of advocacy. Kerry Mothersill has launched a project (described in the Canadian Clinical Psychologist) to promote the small but significant advocacy steps that individual psychologists take. He also presented a paper on the effectiveness of psychological treatments in health care to the Healthcare Middle Management conference in Toronto. A summary of this paper was sent to the regional and national disability management offices of the major insurance companies. Catherine Lee spearheaded a successful effort to have CPA take an evidence based public position against the use of physical punishment with children.

Finally, the section development and promotion of the psychology fact sheets, coordinated by Susan Graham, continues. The latest stats from the CPA website suggest that these are very popular, with over 10,000 hits in 2003. Twenty-four Facts sheets are now to posted in PDF format (as requested at last year's AGM)

Fact Sheets completed: 2003-2004

Assessing Pain in Children	Ken Craig
Post-partum depression	Valerie Whiffen
Autism	Isabelle Smith
Parenting	C. Lee and I. Manion
Problem Gambling	D. Hodgins
Female Sexual Dysfunction	E. Reissing

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Fact Sheets in progress

Smoking Cessation	S. Currie
Having a family member with psychopathology	C. Lee & D. Dozois
Refugee experience	M. Young
Headaches	G. Asmundson

The Chair's report was approved by the membership (moved by: Ian Nicholson; seconded by Kerry Mothersill; carried).

Report from the Secretary/Treasurer (Catherine Lee)

Financial Statement

The year-end financial statement indicates that there is presently $11,639.38 in chequing and $3,993.68 in GICS. The GICs were renewed in February and March 2004. The total assets of the clinical section are $15,633.06.

Summary of the Minutes of the Executive Meeting

June 11th, 2004, St. Johns, Newfoundland

Present: Mike Coons (student representative); David Dozois, Chair; David Hodgins, Past-chair; Catherine Lee, Secretary-Treasurer; Kerry Mothersill

Review of conference

Pre-convention workshop

13 people were registered, 10 attended. Feed-back forms indicate high level of satisfaction.

Public lecture

It was agreed that the lecture had gone well; attendance at 23 people was disappointing; we discussed strategies for advertising including liaising with university media relations departments.

Michael Vallis workshop: well-received and well-attended.

Pat McGrath keynote: inspirational and well-attended;

Master clinician: excellent attendance. Well-received. It was agreed that we should require 1.5 hours for the master-clinician presentation;

2005 Conference Planning

We brainstormed about potential presenters including:

Media coverage of public lecture is essential

Essential that master-clinician slot be extended to 1.5 hours.

Special Projects

We talked about the importance of consulting the membership for their ideas about special projects to promote psychology.

Membership of the executive

As efforts to recruit a sixth new member to the executive have been unsuccessful, Kerry Mothersill agreed to assume the role of secretary-treasurer and Catherine Lee agreed to assume the role of chair-elect.

Clinical Section List Server

Members of the Clinical Section may submit employment notices or information about their Internship Programs for distribution via the list server. Please place either "Employment Notice" or "Internship Notice" in the subject heading and email your request to cpa@lists.cpa.ca The notice will be reviewed prior to acceptance. The Clinical Section Executive limits postings to these two subject areas only in order to help reduce general email messages.

If you have not already received information through the list server, please send your email address to kerry.mothersil@calgaryhealthregion.ca and type "Subscribe" in the subject heading (please ensure that your email address is correct).

To access information about the list server, visit: http://lists.cpa.ca/mailman/listinfo/cpa.

The Clinical Section would again like to acknowledge CPA for its generous support in providing this service at no cost to the section.

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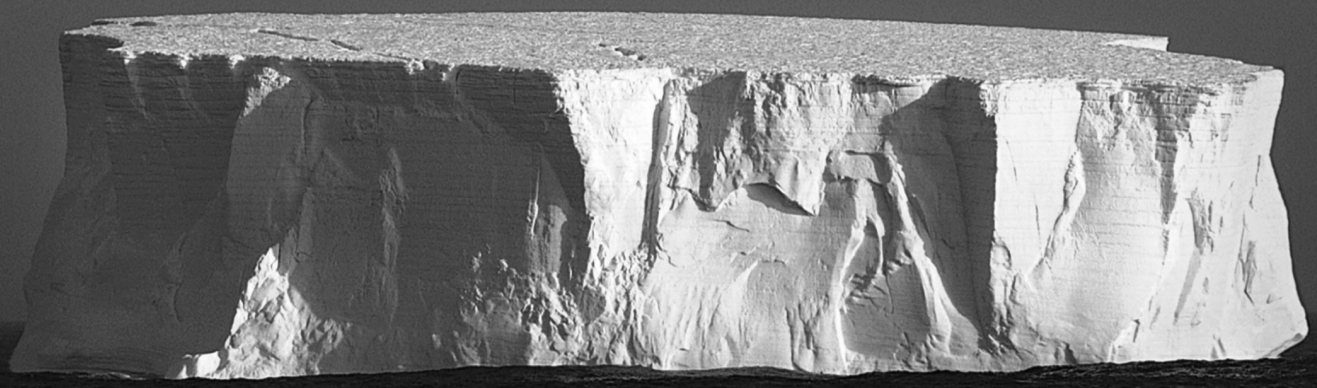

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A051

The following is a summary of the paper presented by the Ken Bowers Student Award Winner, Ms. Michelle DeLisle, at the 2004 Conference. Please also see page 11.

Depression, Hopelessness, and Psychache as Increasingly Specific Predictors of Suicidal Manifestations

Michelle M. DeLisle and Ronald R. Holden
Queen's University

Abstract

One hundred suicide attempters and 267 university undergraduate students were recruited from the community and from an introductory psychology subject pool, respectively, to investigate whether depression, hopelessness, and psychache (i.e., unbearable psychological pain) are increasingly more strongly associated with suicidal thoughts and behavior. The Beck Depression Inventory, the Beck Hopelessness Scale, the Psychache Scale, and the *Internal Perturbations* and *Extrapunitive/Manipulative Motivations* scales of the Reasons for Attempting Suicide Questionnaire were administered to measure the predictors. The *Suicidal Desire* and *Suicidal Preparation* scales of the Scale for Suicide Ideation along with participant ratings of the number of lifetime suicide attempts and suicide intent during the most recent attempt represented the four criteria. To assess the importance of each predictor, the criteria were regressed simultaneously on all predictors and statistically significant standardized regression weights were compared. Results indicated that psychache or internal perturbations were the factors most strongly associated with suicidal desire and suicidal preparation in suicide attempters. However, depression and psychache were found to co-predict suicidality in university undergraduates. Implications for the accuracy of statistically predicting suicide in relatively high risk compared to low risk populations are presented.

Suicide is among the ten leading causes of death in Canada, and is the second leading cause of death among individuals aged 15 to 24 years (Health Canada, 1994). Each year over 3000 Canadians take their lives. The impact of these potentially preventable deaths on families and friends of suicide victims is likely immense. Thus, understanding the risk factors associated with suicide represents one of the most important challenges in the new millennium.

A number of key psychological risk factors for suicide have been identified over the past three decades. Beck's model of depression (Beck, 1967) suggests that increased suicidality may arise as an indirect consequence of the types of distorted beliefs and expectations that depressed people experience, particularly, negative views about themselves, the world, and the future (Reinecke, 2000). Depression has consistently emerged as the most common

psychiatric diagnosis in suicidal individuals, and is estimated to occur in 40 to 70 % of suicide completers (Davis, 1989; Rihmer, Barsi, Veg, & Katona, 1990).

However, not all depressed individuals are suicidal. Beck (1967) also noted that pessimism or hopelessness also appeared to be a critical suicide risk factor among depressed people based on observations from his clinical work. Abramson, Alloy, and Metalsky (1990) suggest that only a subtype of depressed individuals, who express a sense of hopelessness are at risk for suicide (Dieserud, Røysamb, Ekeberg, & Kraft, 2001). Research over the past 15 years has strongly supported that hopelessness is a key mediator of the relationship between suicidality and depression in adults (Beck, Brown, & Steer, 1989; Rotheram-Borus & Trautman, 1988; Salter & Platt, 1990).

However, Shneidman (1993) has recently proposed that psychache (i.e., unbearable psychological pain) is the most specific factor associated with suicide, and that the effects of all other psychological variables, such as depression or hopelessness, are mediated by psychological pain. Shneidman coined the term, *psychache*, to refer to the intense anguish, or hurt that leads to suicide. Among college students, worst ever psychache experienced has been found to correlate significantly with suicidal ideation (Lester, 2000). Internal perturbation-based motivations have also outperformed hopelessness in statistically predicting suicide intent and number of attempts in prison inmates and suicide ideators (Holden & Kroner, 2003; Johns & Holden, 1997).

The purpose of this research was to evaluate a model for statistically predicting suicide risk with depression, hopelessness, and psychache as increasingly specific factors associated with progressively greater suicidality in both attempter and university undergraduate samples. It was hypothesized that psychache or internal perturbations would emerge as the strongest statistical predictor of suicidal behavior in both suicide attempters and university undergraduates.

Method

Participants

Study 1. One hundred suicide attempters were recruited from the community through newspaper advertisements, as well as from pre-screening sessions for the introductory psychology course subject pool at Queen's University, Kingston, Ontario. Participants ranged in age from 17 to 67 years (M = 26.19, SD = 12.57). Ninety percent of participants were women. No information on race or ethnicity was collected. Participants were treated in accordance with the ethical standards of the American Psychological Association.

Study 2. Two hundred and sixty-seven university undergraduates were recruited from a first-year psychology subject pool at Queen's University, Kingston, Ontario. Participants ranged in age from 15 to 45 years (M = 19.13, SD = 2.81). Eighty-seven percent of participants were women. No information was collected on race or ethnicity.

Materials

The materials are identical for studies 1 and 2.

Beck Depression Inventory-Revised (BDI). The BDI (Beck & Steer, 1987) is a 21-item instrument that assesses depression severity in adolescents and adults. Responses are coded on a 4-point scale on which symptoms increase in severity from 0 to 3, and are based on the test taker's experience over the past week. The BDI has demonstrated high reliability and validity.

Beck Hopelessness Scale (BHS). The BHS (Beck, Weissman, Lester, & Trexler, 1974) measures hopelessness, or the extent of negative expectancies about the future in adolescents and adults. The BHS consists of 20 true-false statements, and higher scores represent greater levels of hopelessness. The BHS has demonstrated adequate psychometric properties.

Psychache Scale. The Psychache Scale (Holden, Mehta, Cunningham, & McLeod, 2001) consists of 13 items that measure psychache (i.e., unbearable psychological pain) in adults. Responses are coded on a 5-point Likert scale. The Psychache Scale has an alpha coefficient of .94, and demonstrates adequate psychometric properties.

Reasons for Attempting Suicide Questionnaire (RASQ). The RASQ (Holden, Kerr, Mendonca, & Velamoor, 1998) consists of 14 items that assess the motivation for suicide in clinical and nonclinical populations. Responses are coded on a Likert scale ranging from 1 (*Completely Disagree*) to 5 (*Completely Agree*). The RASQ has been found to yield two scales, a 6-item *Internal Perturbations* scale and an 8-item *Extrapunitive/Manipulative Motivation* scale (Holden et al.) with alpha coefficient reliabilities of .80 and .71, respectively.

Scale for Suicide Ideation (SSI). The SSI (Beck, Kovacs, & Weissmanm, 1979) is a 19-item rating scale that assesses the presence and severity of suicidal ideation and intent in adolescents and adults. Coefficient alpha reliabilities of .90 and .87 were obtained in the original standardization sample. Subsequent factor analysis has yielded two scales, *Suicidal Desire* and *Suicidal Preparation* (Holden, Mendonca, & Mazmanian, 1985). *Suicidal Desire* taps individuals' ambivalence about living or dying, as well as the frequency and duration of suicidal desires. *Suicidal Preparation* refers to a more active stage that involves planning the act (i.e., methods of self-harm).

Procedure

Study 1. Suicide attempters, who responded to newspaper advertisements, were sent questionnaire booklets by mail. Suicide attempters who were identified through the subject pool screening were provided with the same package in person. The package contained a letter of information, a consent form, and a debriefing sheet with information on local counseling resources, as well as the BDI, BHS, Psychache Scale, RASQ, and the SSI. Participants were then asked to mail the completed questionnaire booklets back to the researcher using the self-addressed, stamped envelopes provided. No direct rewards were offered as compensation.

Study 2. University undergraduate participants used the identical questionnaire package as in study 1. Participants were provided with the materials at the time that they volunteered for the study. The questionnaire booklet required approximately 1 hour to complete. After participants returned the completed consent forms and questionnaire booklets to the researcher, they were given a debriefing sheet and credit toward their course research requirement.

Results

Study 1. To assess the importance of each predictor, criterion scales were regressed simultaneously on all predictors and statistically significant standardized regression weights were compared. For number of previous attempts, R^2 = .08, no significant prediction emerged from consideration of the predictor variables. Interestingly, for suicide intent, R^2 = .18, only extrapunitive/manipulative motivations contributed significant, unique explanatory variance. For the suicidal desire scale, R^2 = .63, psychache contributed the greatest variance, and for the suicidal preparation scale, R^2 = .26, only internal perturbation-based reasons was found to contribute significant, unique explanatory variance. These findings suggest that extrapunitive/manipulative motivations was the predictor most strongly associated with suicide intent, and that psychache or internal perturbation-based reasons were most strongly associated with suicidal desire and suicidal preparation, respectively.

Study 2. Criterion variables were regressed simultaneously on all predictors as in study 1. For number of attempts, R^2 = .25, depression contributed the greatest unique variance. For suicide intent, R^2 = .20, and suicidal desire, R^2 = .63, internal perturbations emerged as the most important predictor. For suicidal preparation, R^2 = .44, depression contributed the greatest variance. These data suggest that depression has the strongest association with number of previous attempts and suicidal preparation, while internal perturbations, a concept related to psychache, appears to be most strongly associated with suicide intent and suicidal desire.

General Discussion

The hypothesis that depression, hopelessness, and psychache constitute increasingly specific factors that are progressively more strongly associated with suicidality was partially supported. However, the key suicide predictors appeared to differ in high risk and low risk groups. In the relatively high risk suicide attempter sample, psychache or internal perturbations was the strongest

statistical predictor of suicidal desire and suicidal preparation. In no case did either depression or hopelessness emerge as the strongest statistical predictors for any of the suicide criteria. However, in the lower risk university undergraduate sample both depression and internal perturbations statistically co-predicted suicidality. Therefore, psychache or internal perturbations may improve statistical suicide prediction among individuals who have a history of suicide attempts, but their importance as predictors in lower risk populations is less clear.

A number of limitations of the present study are noted. First, in the university undergraduates there was a restriction in range due to low scores on all of the measures. As well, very few men participated in both studies. Second, the questionnaires were designed as quick screening tools, not as diagnostic instruments. Therefore, the generalizability of the findings to clinical populations requires further research. Third, the research employed correlational, cross-sectional designs, and measures of the predictors and the suicide criteria were taken concurrently. Therefore, inferences about causality cannot be made.

Despite the considerable challenges that statistical suicide prediction presents, such efforts are necessary in order to identify and treat individuals at high risk for suicide. The present study supports the utility of psychache in terms of improving the accuracy of suicide prediction, as well as by serving as a direct target of intervention for groups at high risk for suicide. Accurate suicide prediction is vital in both hospital and community settings, where interventions involve using limited resources to target the needs of clients at highest risk for suicide. Because it is only by identifying key suicide risk factors that life-saving interventions can be tailored to meet the needs of individuals at various levels of risk most effectively, the refinement of current suicide prediction models merits further research.

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Summary of the Minutes
Teleconference Executive Committee Meeting
Friday September 17, 2004

Present: David Dozois, Chair; David Hodgins, Past-chair; Catherine Lee, Secretary-Treasurer; Kerry Mothersill **Regrets:** Mike Coons (student representative)

Membership and Financial Report (Kerry)

Kerry reported that there were 200 student and 435 regular members in the Section. Current bank balance was $9839.53 and total assets were $13,860.26. The expenses since June 11 were reviewed.

Summaries of Executive Meetings for Web Site (David H.)
David H. to send minute summaries of the ABM and June 11, 2004 Executive Meeting to David Hart for the website and to Deb Dobson for the newsletter.

Update on Fact Sheets (Adam)

The Fact Sheets on Sexual Dysfunction. Pain and Gambling are being finalized by CPA office. John Service indicated that they have a system for tracking the Fact Sheet development process. Adam will set up our own tacking process to ensure timely posting on the CPA website. The possibility of developing a Fact Sheet on Bipolar Disorder was discussed. Adam will identify individuals who may wish to prepare a Fact Sheet on this area. David D. discussed the issue of CPA's desire to extend fact sheet preparation to other sections with Ian Nicolson. Ian indicated that he would bring our concerns to the Board with regard to the establishment of a process for reviewing submissions.

List Serve Update (Kerry)

Kerry to send a note to the membership via the list serve advising how to make a post concerning employment opportunities. A summary of how the list serve works will be sent to Deb for the newsletter. David Hodgins will update the web site. This responsibility will be added to the duties of the Past President.

"Join Us" ad in *Psynopsis* (David D.)

David D. sent this to Ivan for inclusion in the next issue of Psynopsis.

CPA 2005 Convention

The bulk of the conference call was spent discussing potential speakers and activities for the convention. Catherine and Adam will look into ways of publicizing the public lecture and the Pre Convention workshop.

Student Awards 2005 (Catherine)

It was decided to offer a student award of $500.00 again this year. The increase of the award to $500.00 had the desired effect of increasing the number of submissions for the award. Limitations will be maximum of 10 pages (Title page, Abstract page plus 8 pages of text) plus references. Changes will be made in the Newsletter notice

Review of Clinical Submissions to CPA 2005, Preparation of Information re Clinical Section Sponsored Events for Web Site, Newsletter & Listserve (Catherine)

Catherine has lined up 8 reviewers for submissions.

Call for Fellows (Catherine)
Discussion of potential fellows. Call advertised to members.

Call for Nominations to the Executive (David H.)
We need a Chair Elect. Potential candidates discussed**.**

Nomination for CPA Board (Practitioner)

It was agreed that we would put a call to the membership though the list serve (David D.). One nomination was been received.

New Initiatives for 2004-2005 (David)

Advocacy
David D. to contact John Service and Ian Nicholson about how the section could contribute to the national initiative.

Survey of Membership

David to draft a brief survey and circulate to the executive for comment.

Mid-winter Meeting, location and dates (David D., Catherine)
The meeting will be held in Ottawa. January 29, 2005 is the date of the meeting.

Other Business

Preconvention Workshop: Criteria for canceling a preconvention workshop. Issues include number of members who have registered, if presenter has booked flight specifically to present the workshop, etc. David D. will contact CPA about the timing of workshop cancellation. It was agreed that we would advance the pre convention workshop person as a Category 1 speaker to assist in covering costs of registration and travel. Adam to review the workshop fee structure and make a recommendation.

Closure of the Internship: The Section needs to be responsive to closures. We are waiting to hear from Mike about this issue.

Dr. David Dozois, Section Chair, congratulates Michelle Munchua DeLisle, from Queens University, the winner of the Ken Bowers Student Research Award at the 2004 conference. See page 7 for her article.

Dr. David Dozois, Section Chair, offers congratulations to Margaret Lumley , from Queens University, the runner-up for the Ken Bowers Student Research Award at the 2004 conference.

Meet A New Section Fellow:

Dr. Thomas Hadjistravopoulos

Dr. Hadjistavropoulos is Professor of psychology and director of the Centre of Aging and Health at the university of Regina. He completed his Bachelors degree at McGill University and his doctorate at the University of Ssaskatchewan.

Dr. Hadjistravopoulos has contributed 63 scientific peer-reviewed articles, book chapters and books to the literature, and has demonstrated innovative thinking in the area of pain and its control in aging seniors, particularly those suffering from dementia. He has also developed measures of pain for this population. The success of his research has recently been acknowledged by CIHR in the form of a New Emerging Team grant.

Dr. Hadjistravopoulos has a high level of grant support from CIHR and SSHRC and has won a number of awards. He is a fellow of CPA and serves as Chief Editor of *Canadian Psychology*.

He has made a number of important contributions to the Canadian Psychological Association, the Canadian Pain Society, CIHR, and the Saskatchewan Psychological Association.

Dr. David Dozois, Section Chair, congratulates Dr. Hadjistravopoulos at the 2004 Conference.

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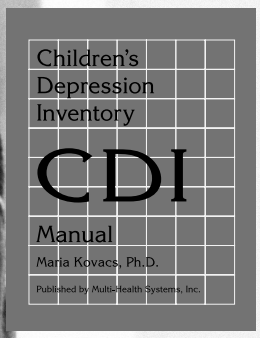

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Meet A New Section Fellow:
Dr. David Clark

Dr. David Dozois, Section Chair, congratulates Dr. Clark at the 2004 Conference.

Dr. David Clark is a Professor at the University of New Brunswick, where he has been a leader in psychopathology in Canada for the past two decades. He is an accomplished researcher both in the areas of depression and anxiety (specifically OCD) and has been a major contributor to landmark publications. He is internationally renowned as a leader in the CBT literature and has collaborated extensively with Dr. Aaron Beck.

He is the type of academic clinical psychologist who serves as a prototype for other professionals to emulate. He clearly ranks within the very top few clinical psychologists in Canada and, as one of the letters of nomination noted, "almost no one would match him in both research and clinical contributions".

Two areas make Dr. Clark most deserving of this recognition: (1) his scholarship -- he has approximately 90 book chapters and research articles which has provided important visibility for Canadian psychology. Chief among his contributions is a book co-authored with Aaron Beck *The Scientific Foundations of Cognitive Theory and Therapy for Depression* - this book is truly an opus magnum as it reflects the distillation of about 1500 books, articles and chapters into what is the most comprehensive and up to date discussion of this model of depression. This book (and others he has written) has set a new standard to which other books will be compared.

The second area of contribution has been in training and education. He has been the director of the clinical program at UNB for several years now and has guided the program to accreditation with CPA and APA.

He has also served on CCPPP and the CPA accreditation panel. In addition to all of these contributions, Dr. Clark is also a nice person who is warm, interested in others and kind.

More Small Steps in Promoting Psychology

Kerry Mothersill, Ph.D.

In the April 2004 issue of the Canadian Clinical Psychologist, psychologists across the country indicated how they were promoting the profession in a number of innovative ways. Here are some additional examples.

Carl von Bayer reported on a plan in Saskatoon for a student-run primary health care clinic to be operated by medical, nursing, pharmacy, and other health care trainees. The program is modeled on a similar effort by UBC students in the downtown east side Vancouver. The Vancouver program has no psychology involvement. However, the student leaders of the new Saskatoon project were very receptive to having graduate students in clinical psychology participate. Eleven graduate students and several faculty in the University of Saskatchewan Doctoral Program in Clinical Psychology have become involved. The name of the new clinic adopted by the group was suggested by one of the psychology students: SWITCH – Student Wellness Initiative Toward Community Health.

Michael Oosterhoff wanted to pass on information about a provincial organization initiative. He is forming a committee for the Early Career Psychologists (ECP) task force for the Ontario Psychological Association (OPA). It was noticed that there is a real gap in support, information, and network for ECPs after graduation and internship. This, combined with the changes in practice and funding sources (e.g., insurance, loss of hospital psychology departments) makes the transition challenging. The task force is focusing on 4 projects.:

1. One is to create a section on the OPA website devoted to ECP concerns and resources (e.g., list serve, web/bibliographic resources, mentorship links) to address issues such as transition, early career practice, licensing, business and ethical issues, relevant education, training, and job opportunities.
2. Another project is the completion of an on line needs survey of supervised practice registrants, interns, and training program grads in the province to further identify and guide the activities of the ECP task force.
3. A third project is to develop a mentoring program for ECPs that actively identifies seasoned psychologists interested in responding to career related questions from identified ECPs.
4. Finally, a fourth project will be to organize within the OPAs annual 2005 conference a stream of workshops and seminars addressing the issues and concerns identified by the ECP task force.

Myles Genest noted that at the request of the regional Global television station, he have been appearing on Global Noon, a daily phone-in program once per month. He reviews a recent piece of psychological research in the first segment, then talks more generally about the area, often with the assistance of another psychologist from his practice They respond to any calls received from the public. Recent programs have dealt with pain; learning disabilities in adolescents; communication in couples; the aftermath of automobile accidents; resilience; and PTSD.

Laurene Wilson indicated that she has been co-hosting "National Anxiety Disorder Screening Day" which has been held for the past several years on the first Wednesday of May. News releases are sent out and Laurene has been interviewed on radio and for the newspaper. Although psychologists seem leery of the media at times, she thinks that the exposure and education is great for the mental health issue and for the profession.

Maureen Milligan advised that Gene Flessati has been featured regularly on A-Channel's Big Breakfast morning show (Calgary). In this last year, Gene has completed 14 interviews on a range of topics. He works diligently to survey the current research related to the topics he discusses. His interviews are evidence based and he seeks to not only explain the nature of the disorder or issue, but also addresses treatment and/or adaptive coping strategies. In addition, he frequently participates in radio interviews and has been featured in newspaper articles on a range of issues.

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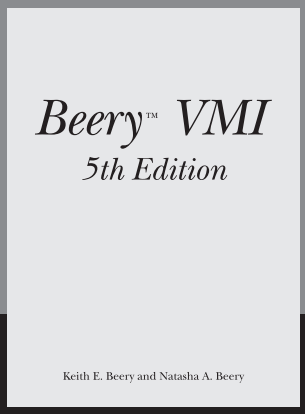

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New Advances in Psychological Treatment for Bipolar Disorder

Martin D. Provencher

Affective Disorders Program, Centre Hospitalier Robert-Giffard

Bipolar disorder is a chronic, debilitating illness associated with a erratic symptom course and marked functional deficits that interfere significantly with the patient's functioning. For over 90% of patients, the illness is characterized by the recurrence of mood fluctuations over their lifetime. Although pharmacotherapy is the cornerstone for the treatment of bipolar disorder, clinically significant problems remain for many patients taking medications. These include medication non-adherence, marked residual symptoms, high relapse rates, suicide rates of between 15% to 20% and significant impairment in social and occupational functioning.

Fortunately, over the past five years or so, several empirically supported treatments (ESTs) using psychological interventions have emerged. Accumulating evidence in the literature suggests that these interventions are efficacious for bipolar disorder when used in conjunction with appropriate pharmacological treatment (Craighead, Miklowitz, Frank, & Vajk, 2002; Provencher, Baruch, Tremblay, Lafleur, & St-Amand, 2004). In this paper, I will review four interventions that have shown the most empirical support: Psychoeducation, Cognitive-Behavioural Therapy (CBT), Interpersonal and Social Rhythm Therapy (IPSRT), and Family Focused Therapy (FFT).

Psychoeducation

The main objective of psychoeducation is to give patients and their families adequate knowledge about the illness, to teach self-management skills in order to improve adherence to medication and prevent recurrence of mood episodes. Several studies have shown the efficacy of psychoeducation (for a review, see Huxley, Parikh, & Baldesssarini, 2000). One of the first well-structured group psychoeducation program specifically designed for bipolar disorder is the "Life Goals Program" developed by Bauer and McBride (2003). This program is structured into two sequential phases. Phase 1 involves 5 to 6 sessions of structured psychoeducation targeting the following topics: information about the disorder and its' biological underpinnings, identification of triggers and strategies to manage manic and depressive symptoms, discussion of treatment issues (pharmacological and psychosocial), stigma related to bipolar disorder and formulation of an extensive relapse prevention plan. Phase 2 is open-ended and goal-driven. The focus of Phase 2 is to assist patients in identifying self-defined functional goals that they have not been able to meet in their life because of the illness. Using a predominantly behavioural approach, the therapist assists the patients in defining these goals in objective and feasible terms, and in applying strategies to reach them.

Initial outcome data suggests that the program is feasible, improves knowledge about the illness and that most patients (70%) reach their self-defined goals after treatment (Bauer, McBride, Chase, Sachs, & Shea, 1998). At the Affective Disorders Program of the Centre Hospitalier Robert-Giffard (CHRG), we have successfully implemented the first phase of the "Life Goals Program" for inpatients recently hospitalized for an episode of bipolar disorder. We have found that the structured group psychoeducation phase led to an increase in self-acceptance and knowledge about the disorder.

The most convincing data supporting efficacy of group psychoeducation for bipolar disorder comes from studies by Colom and Colleagues. In a first study, Colom, Vieta, Martinez-Aran et al. (2003) randomly assigned 120 patients with bipolar disorder to either 21 sessions of group psychoeducation given by two PhD level psychologists experienced with the treatment of bipolar disorder or to an unstructured support group. Results showed that patients receiving group psychoeducation had significantly fewer bipolar episodes and hospital admissions and that the time between episodes was significantly increased compared to patients in the unstructured group. Furthermore, significantly fewer patients in the psychoeducation group relapsed during the treatment (38% versus 60%, respectively), and two years following treatment (67% versus 92%, respectively). These results were replicated in a second study in which 50 patients that were highly adherent to their medication regimen were randomly assigned to one intervention or the other (Colom, Vieta, Reinares, et al., 2003).

Cognitive-Behavioural Therapy

A second intervention that has proven to be efficacious in the treatment of bipolar disorder is Cognitive-Behavioural Therapy (CBT). In bipolar disorder, the main goals of CBT are to reduce manic and depressive symptoms, restore psychosocial functioning and to prevent relapse of mood episodes. Essentially, CBT for bipolar disorder has been adapted from CBT for depression (Beck, Rush, Shaw, & Emery, 1979). Several treatment manuals outlining theoretical foundations and clinical applications have been published (Basco & Rush, 1996; Lam, Jones, Hayward, & Bright, 1999; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Interventions used in CBT protocols for bipolar disorder include psychoeducation, mood monitoring, activity scheduling and regulation, cognitive restructuring of depressive and hypomanic thoughts, problem-solving and relapse prevention. Several studies have shown the efficacy of CBT in bipolar disorder.

For example, Scott, Garland, & Moorhead (2001) randomly assigned 42 patients to either CBT or to a wait-list control group. Results showed that CBT led to a significant decrease of depressive and manic symptoms and to an increase in global functioning compared to patients in the control group. Furthermore, CBT led to a significant reduction in the number of relapses (66% versus 21%, respectively), in the number of hospital admissions (48% versus 21%, respectively) and in medication non-adherence rates (48% versus 21%, respectively). Another study (Lam et al., 2003), randomly assigned 103 patients to either CBT or to treatment as usual (TAU). Results showed a significant reduction of bipolar episodes (44% of patients versus 75%, respectively), in the number of days spent in an episode (27 days versus 88 days, respectively) and in the number of hospital admissions (15% of patients versus 33%, respectively) for the patients receiving CBT. Furthermore, patients receiving CBT had significantly better social functioning, fewer mood-related symptoms, and less fluctuation of their manic symptoms.

Other studies using CBT or CBT principles have shown it to be effective in open trials using a group format (e.g., Patelis-Siotis et al., 2001), with patients currently in a major depressive episode (Zaretsky, Segal, & Gemar, 1999), in increasing medication adherence (Cochran, 1984) and in reducing manic relapses (Perry, Tarrier, Morriss, McCarthy, & Limb, 1999). For the past two years, we have been implementing individual CBT for outpatients presenting with bipolar disorder at the Affective Disorders Program. Although data collection is currently ongoing, preliminary observations show that CBT seems to be effective for most patients in reducing depressive symptoms and improving functioning.

Interpersonal and Social Rhythm Therapy

A third intervention is Interpersonal and Social Rhythm Therapy (IPSRT), which is an adaptation of Interpersonal Therapy for depression (Klerman, Weissman, Rounsaville, & Chevron, 1984) by Frank et al. (1994) for the treatment of bipolar disorder. The main objectives of IPSRT are to reduce interpersonal stress while regulating circadian rhythms by maintaining a stable and healthy daily routine (good sleep hygiene, meals, exercise, social contact, etc.). In an initial study, Frank et al. (1997) randomly assigned 38 patients to either IPSRT or to treatment as usual (TAU). Results showed that IPSRT led to greater stability of daily activities compared to TAU. No significant differences were found on symptom levels between groups following treatment. In a second study with 82 patients, Frank et al. (1999) showed that symptom improvement was better for patients who did not change treatment modality (IPSRT vs. TAU) during the course of the study.

Family Focused Therapy (FFT)

A fourth intervention is Family Focused Therapy (FFT) developed by Miklowitz and Goldstein (1997) from family interventions used in the treatment of schizophrenia. FFT involves 21 family sessions over the course of nine months and is divided in three phases: psychoeducation, communication training, and problem-solving training. Miklowitz and colleagues (Miklowitz et al., 2000; Miklowitz, George, Richards, Simoneau, & Suddath, 2003) randomly assigned 101 patients to either FFT (N = 31) or to case management (N = 70). Results showed a significantly higher number of patients that did not relapse (71% versus 47%, respectively), a longer time before relapse and a significant reduction of depressive symptoms for patients receiving FFT compared to case management. Another study using FFT showed it to be more efficacious when delivered in the original family-focused psychoeducational therapy format compared to an individually focused patient intervention delivered without the presence of family members (Rea et al., 2003).

Conclusion

Over the past five years, several psychological interventions have emerged and shown empirical support as an adjunct to medication in the treatment of bipolar disorder. These interventions include psychoeducation, CBT, IPSRT, and FFT. Although different, these interventions all share common components, including early emphasis on thorough psychoeducation about the illness, acquisition of self-management skills, and elaboration of a concrete and written relapse prevention plan. Currently, several outcome trials are underway in Canada, the United States, England, and Europe. For example, a large NIH-funded multicenter trial is currently ongoing in the United States. The study, named Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), is comparing the effectiveness of CBT, IPSRT, and FFT in a large sample of bipolar patients (up to 1000 patients will be randomly assigned to one treatment or the other). Results of this study will surely lead to better understanding of which type of treatment for which type of patient is more effective, and which treatment components are essential ingredients in the treatment of bipolar disorder.

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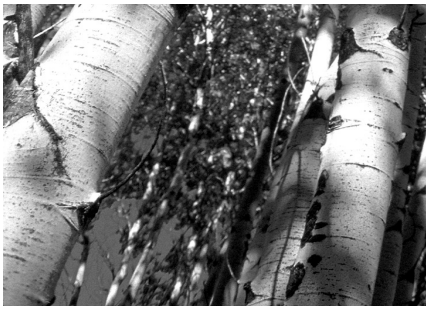


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Minnesota Multiphasic Personality Inventory— ADOLESCENT

The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A™) test is an empirically based measure of adolescent psychopathology. The MMPI-A™ test contains adolescent-specific scales and other unique features designed to make it especially appropriate for today's youth.

MACI™
Millon™ Adolescent Clinical Inventory
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MAPI™
Millon™ Adolescent Personality Inventory
by Theodore Millon, PhD, DSc, Catherine J. Green, PhD, and Robert B. Meagher, Jr., PhD

The Millon Adolescent Personality Inventory (MAPI™) test is a brief self-report inventory that focuses on adolescent personality characteristics, including coping styles, expressed concerns, and behavioural patterns.

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Call for Nomination: Section Fellows

In accordance with the by-laws for CPA sections, the Clinical section calls for nominations from it's 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 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 1, 2005 to:
Catherine M. Lee, Ph.D., C.Psych.
Centre for Psychological Services
11 Marie Curie
Ottawa, Ontario K1N 6N5
fax: (613) 562-5169
email: cmlee@uottawa.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 1 mars 2005 à l'attention de :
Catherine M. Lee, Ph.D., C.Psych.
Centre des Services Psychologiques
11 Marie Curie
Ottawa, Ontario K1N 6N5
télécopieur: (613) 562-5169
courriel : cmlee@uottawa.ca

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, and the most meritorious submission is recognized with a certificate and an award of $500. 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 Montreal 2005; (2) submit a brief) manuscript in APA format describing the study, and (3) be prepared to attend the Clinical Section Business meeting at the Montreal convention, where the award will be presented. Please follow the following requirements: the manuscript should be double spaced, with margins of at least 2cms; in a 12 font, contain a title page, abstract, a maximum of ten pages of text, plus additional pages for references, tables, and figures. Manuscripts that do not conform to these criteria will not be reviewed. The deadline for submission of applications is March 25, 2005. Submissions in either English or French should be sent by email to: cmlee@uottawa.ca. If you have any questions about the submission process, please do not hesitate to contact Dr. Lee by email cmlee@uottawa.ca or by phone (613-562-5800, ext. 4450).

Prix Ken Bowers Pour Recherche Effectuee Par Un(e) Etudiant(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 2005, un certificat et une bourse de 500$ 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 Montréal; (2) soumettre un court manuscrit décrivant l'étude selon le format de l'APA; et (3) être présent(e) à la réunion d'affaires de la Section Clinique du congrès à Montréal le prix sera décerné. Veuillez suivre les consignes de présentation : le manuscrit doit être à double interligne, avec des marges d'au moins 2 cms, un fount 12, avec une page titre, un résumé et un maximum de 10 autre 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 25 mars, 2005. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées par courriel à cmlee@uottawa.ca Si vous avez des questions au sujet du processus de soumission, n'hésitez pas à contacter le Dr. Lee par courriel cmlee@uottawa.ca ou par téléphone au : 613-562-5800, poste 4450.