



canadian CLINICAL PSYCHOLOGIST

Newsletter of the Clinical Section of the Canadian Psychological Association
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Message from the Chair

Catherine M. Lee, Ph.D.

Thanks and welcome

I would like to begin by offering warm thanks to Dr. David Hodgins, who has just completed his mandate on the Executive of the Clinical Section. David's quiet dedication to the section was very much appreciated. We are grateful too to Mike Coons, the first student member of the executive who worked to define a role for students within the section. I am delighted to welcome new members to the executive: Dr. Christine Purdon from the University of Waterloo, the new Chair-Elect, and Andrea Ashbaugh from Concordia, the new Student Representative. Special thanks are due to Drs. Deborah and Keith Dobson, who have produced the section newsletter for many years. We are grateful to our webmaster, Dr. David Hart, for maintaining the section website. We welcome the new editorial team of Dr. Margo Watt, who will be responsible for soliciting and acquiring material, and Jessey Bernstein, who will be responsible for production.

Convention

The Montreal convention was a resounding success. We are pleased that clinical psychologists from across the country gathered to exchange ideas and to learn from one another. Most of the informal feedback has been very positive. However, there is always room for improvement, so we welcome comments and suggestions so that we can make future conventions even better. Some of the ideas we have received are relate to logistics. So, for example, we think it would be a good idea for the Public Lecture to be offered in a community venue such as a library rather than at the convention hotel.

Plans for the Calgary convention include stimulating presentations addressing is-

sues in the delivery of psychological services to children, adolescents, and adults. Consistent with the mission of the section to promote clinical psychology, special activities will focus on ways that psychologists can effectively use the media to inform the public about effective services.

Honours and Awards

A rewarding part of section activities is the recognition of excellence in student and nonstudent members. Details of the *Ken Bowers Award* can be found on page 12. The announcement of *Fellow status awards* can be found on page 8.

Newsletter

At the Annual Business Meeting members voted to move to an electronic version of the newsletter. This will substantially reduce production costs as well as editorial time. You will therefore receive a message via the listserve announcing that the newsletter has been posted on the section website. All you will need to do is to click on the link.

Psychology Works

The fact sheets prepared by members of the clinical section can be found <http://www.cpa.ca/factsheets/main.htm>. These pdf files can be downloaded for distribution to students, clients, and the general public. In the first eight months of the year, there were over 95,000 visits to the fact sheets. This is an impressive record. I encourage you to check out the fact sheets. If there is a topic on which you would like to see a fact sheet, please let us know. Dr. Adam Radomsky is working with the executive to update the fact sheets, looking at ways to organize them, as well as mechanisms for ensuring that they are updated regularly.

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CLINICAL SECTION EXECUTIVE OFFICERS 2005-2006

Dr. Catherine Lee, Chair
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
<http://www.socialsciences.uottawa.ca/psy/eng/profdetails.asp?login=clee>

Dr. David Dozois, Past- Chair
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
<http://www.sscl.uwo.ca/psychology/faculty/dozois.html>

Dr. Christine Purdon, Chair-Elect
Department of Psychology
University of Waterloo
Waterloo, Ontario, N2L 3G1

Phone: 519-888-4567 x3912
Fax: 519-746-8631
email: clpurdon@uwaterloo.ca
<http://www.psychology.uwaterloo.ca/people/clpurdon>

Dr. Kerry Mothersill, Secretary-Treasurer
Outpatient Mental Health Services,
Health on 12th,
1213 - 4th Street S.W.
Calgary Alberta, T2R 0X7

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

Dr. Adam Radomsky, Member at Large
Department of Psychology
Concordia University
7141 Sherbrooke Street West
Montreal, Quebec, H4B 1R6

Phone: (514) 848-2424, Ext 2202
Fax: (514) 848-4523
Email: Adam.Radomsky@concordia.ca
<http://www-psychology.concordia.ca/fac/Radomsky/>

Andrea Ashbaugh, Student Representative
Department of Psychology
Concordia University
Montreal, Quebec,

Phone: 514-848-2424 ext. 2199
Email: ar_ashba@alcor.concordia.ca

Outgoing Newsletter Editors:

Dr. Deborah Dobson
email: ddobson@ucalgary.ca

Dr. Keith Dobson
email: keith.dobson@ucalgary.ca

Incoming Newsletter Editors:

Dr. Margo Watt
Department of Psychology
St. Francis Xavier University, P.O. Box 5000
Antigonish, Nova Scotia B2G 2W5
Phone: (902) 867- 3869
Fax: (902) 867-5189
Email: mwatt@stfx.ca

Dr. Jessey Bernstein
Department of Psychology
Concordia University
7141 Sherbrooke St. West
Montreal, Quebec H4B 1R6
Phone: (514) 824- 2424 (EXT. 5208)
EMAIL: DrBernstein@gmail.com

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 2006-2007, the Section requires nominations for the position of Chair-Elect (a three-year term, rotating through Chair and Past Chair), Secretary- Treasurer, the Member-at-Large, and Student Member. Continuing members of the Executive for 2006-2007 will be Dr. Christine Purdon (Chair-elect), Dr. Catherine Lee (Chair), Dr. David Dozois (Past-Chair)

Although there is no requirement for the following, the Section does support equitable geographical representation and gender balance on the executive.

Nominations shall include:

- (a) 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, 2006.

Send nominations for the Executive to:

Dr. David Dozois, Past- Chair
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

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Evidence Based Practice

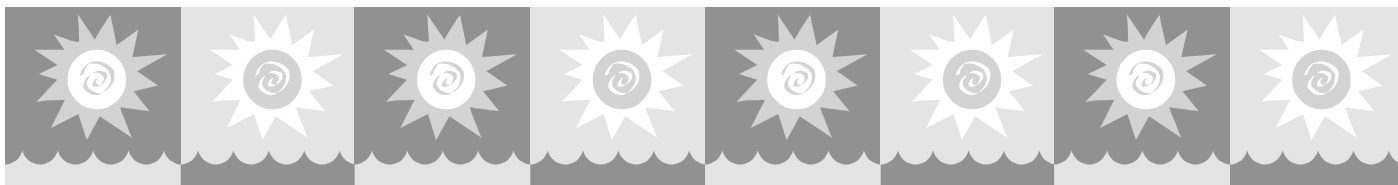
In August 2005 the American Psychological Association released a Policy Statement on Evidence-Based Practice in Psychology. The summary can be found at: <http://www.apa.org/practice/ebpstatement.pdf> and the full document at: <http://www.apa.org/practice/ebpreport.pdf>.

Consistent with definitions of evidence-based practice adopted in medicine, APA defines evidence-based practice in psychology (EBPP) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2005). EBPP covers the gamut of psychological services, including assessment, case formulation, and the therapeutic relationship, as well as specific treatments. EBPP reflects a decision-making process for integrating different types of research evidence. The APA statement highlights the need for research to balance both internal and external validity, recognizing that no study can optimize both. The statement also highlights the potential value of different types of research evidence. An important distinction is drawn between *efficacy* studies that are designed to determine whether a treatment works, and *clinical utility* studies designed to determine whether an efficacious treatment is feasible in a particular setting.

The importance of clinical expertise in EBPP is highlighted. Clinical expertise is multifaceted, including interpersonal and analytic skills, as well as a commitment to life-long learning. Psychologists must identify the best

research evidence and integrate it with information about each individual client to deliver and evaluate whether services are helpful. Scientific training prepares clinical psychologists to formulate and test hypotheses in the delivery of services. However, because psychologists are not immune from the heuristics and biases that affect everyone, they must be sensitive to the limits of their knowledge and competence, and open to corrective feedback. In addition to a scientific orientation to the delivery of services, psychologists require strong interpersonal skills to develop an effective relationship with clients. They must be sensitive to the diversity of client experience and the way it affects service delivery.

In recent years, the important issue of evidence-based practice has generated both enthusiasm and scepticism. The APA policy statement is based on the work of a task force that drew together psychologists representing diverse views about psychological practice. The resulting document is an inclusive one that re-asserts the scientific foundation of our profession, recognizing the range of research that can inform practice, and the diverse clientele that our practice must serve. The APA statement should provide encouragement for psychologists to continue to exercise scientific thinking in selecting and evaluating the services they provide to a diverse clientele. It also should provide strong encouragement for additional research to determine whether untested treatments are helpful, and to address the feasibility and cost-effectiveness of efficacious treatments in diverse contexts.



Farewell from the Outgoing Co-Editors

It is hard to imagine that it is already five years that we have been co-editing this newsletter, but it is, and so we have elected to pass the torch. This newsletter is one of the major communication devices for the Section on Clinical Psychology, and we have appreciated the opportunity to help out the Section with this important function. We believe the newsletter has developed a fairly predictable and professional look, and does a nice job of both reflecting the ongoing business of the Section, as well as articles that are hopefully of interest to Section members. Given the recent decision to move this newsletter of electronic form, it will be important for the new co-editors to manage the delicate balance of both reflecting and also advancing issues in the new format. We encourage all members of the Section to take an active role in this process, both by offering ideas about how the Newsletter should evolve, as well as contributing to its specific content. If we have a particular concern from our experience, it is that it was sometimes difficult to get members to share their thoughts or ideas with their colleagues. Although this difficulty was no doubt born in part out of too much work for everyone, in part it seems to us to have reflected a reluctance to communicate these ideas, sometimes due to fear of controversy. We welcome Drs. Jessey Bernstein and Margo Watt as incoming co-editors and wish them the best for their work to come!

Deborah and Keith Dobson, (Outgoing) Co-editors.

Summary of the Minutes

CPA Section on Clinical Psychology

Summary of the Minutes: Executive Committee, Spring Teleconference

Date: April 14, 2005

Present: David Dozois (Chair), Catherine Lee (Chair-Elect), David Hodgins (Past-Chair), Kerry Mothersill (Secretary-Treasurer), Adam Radomsky (Member-at-Large), Michael Coons (Student Member)

Highlights

- There are 464 regular members and 204 student members for a total of 668 in the Clinical Section. The current bank balance is \$9,649.35 and the total assets are \$13,718.91. The expenses since January 29, 2005 were reviewed.
- A job description for the Student Member position was developed and circulated. Discussion also ensued regarding the nomination and election process. It was decided that the general process of electing executive members would be used in electing the student member. Potential Student Representative(s) may be nominated by student and non-student section members and names would be sent to the Past-Chair. An election, if required, would take place at the Annual Business Meeting.
- Eight submissions were received for the Ken Bowers Student Research Award. Some of the criteria for the submission process were clarified (e.g., that the student must be a member of the Clinical Section at the time of submission) and will be noted in the next call for papers.
- The preconvention workshop has been announced on the list serve. Announcements were also sent local hospital and learning institutions in Montreal. An announcement will also be forwarded to the Student Section list serve.
- The arrangements for the public lecture (including the title) were discussed. Other conference-related preparations were also made.
- A member of the Section has agreed to have her name stand for the position of Chair-Elect. A call for the student member nomination will be through the list serve. A. Radomsky will coordinate the election duties at the Annual Business Meeting given that D. Hodgins will not be in attendance.
- Given that K. Dobson and D. Dobson will resign as newsletter editors, an announcement will be made through the list serve to obtain a newsletter editor.
- Two nominees for Section Fellow designations were received. One individual will be given the award this year and the other next year, as she will be at the conference in

Calgary. This would not preclude having additional awards next year.

- Current executive members will update their role descriptions. The need to update the descriptions each year for the spring teleconference meeting will be placed in all descriptions.
- A nomination was been submitted for the Canadian Health Services Research Award.
- K. Mothersill will arrange for the additions and deletions of members to the list serve.
- A. Radomsky discussed the need to ensure that there is little in the way of content overlap among the Facts Sheets. Additional topics may be referenced to existing ones.
- Reminder letters were sent to individuals who have not renewed their membership for 2005.
- Suggestions from the membership survey regarding improvements to the web site were sent to the Web Master; ideas for improvements to the newsletter will be forwarded to the new editor when she/he is identified. D. Dozois will present the results of the survey to the members at the ABM.

Summary of the Minutes: Annual Business Meeting

Friday, June 10, 2005, Montreal, Quebec

Present: Laurene Wilson, Pat McGrath, Adam Radomsky, Keith Wilson, Leslie Graff, David Dozois, Kerry Mothersill, Catherine Lee, Christine Purdon, Margo Watt, Deb Dobson, Keith Dobson, Jennifer Mullare, Christian Webb, Jessy Bernstein, Doug Symons, Michel Dugas, Katy Kamkar, Lorne Sexton.

Highlights

- The Executive Committee included David Hodgins (past-chair), Catherine Lee (chair-elect), Kerry Mothersill (secretary-treasurer), Adam Radomsky (member-at-large), Mike Coons (student representative) and David Dozois (chair). The Executive had two in-person meetings and two teleconferences, as well as regular email correspondence throughout the year. The Section maintains a healthy membership with 464 regular members and 204 student members (total of 668), which represents a 10% increase over the last couple of years (599 in 2004 and 596 in 2003).
- The Section contributed a full program for the 2005 convention. A total of 170 submissions were reviewed.

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- In addition to general programming, the Clinical Section also sponsored the following activities: (1) a CPA-invited presentation by Janet Polivy (False Hope, Obesity, and Eating Disorders: The Effects of Unrealistic Expectations about Dieting); (2) a pre-convention workshop by Zindel Segal (Mindfulness-Based Cognitive Therapy and Prevention of Relapse in Major Depression); (3) a master-clinician presentation by Keith Dobson (Behavioral Activation and Cognitive Therapy Approaches to Depression: An Introduction and Demonstration); (4) workshops by Sophie Bergeron (Sexual Disorders Involving Pain) and Sheila Woody (an Evidence-Based Approach to Treatment Planning); (5) a symposium by Adam Radomsky, Sheila Woody, Kieron O'Conner, Laura Summerfield, & Christine Purdon (New Advances in OCD Research); (6) conversation sessions lead by Kerry Mothersill (Your Predoctoral Internship: How to Prepare and Receive Excellent Training) and Rick Morris (Privacy Legislations and Professional Practice); (7) a public lecture by Keith Dobson (Psychological treatments are more effective than medication in the treatment of depression); and (8) a social reception.
- The section's biannual newsletter, *Canadian Clinical Psychologist*, was published under the editorship of Deborah and Keith Dobson. The Section website was maintained by David Hart. This web site was updated recently to provide links to information on evidence-based practice. The clinical list serve continues to be used judiciously for section business and for other announcements. Sincere thanks were expressed to Keith and Deb Dobson for their many years of editing the *Canadian Clinical Psychologist*. Margot Watt and Jessy Bernstein were welcomed as the new co-editors.
- The Section's strategic planning continues to focus on advocacy. The executive distributed a survey to the membership regarding the priorities of the Section and the quality of the services provided. Results indicated that the membership was pleased with the quality of our website, listserve, newsletter, preconvention workshops, and fact sheets. Members were also asked what the Section can specifically do for them and for the profession as a whole. The main themes that emerged were increased advocacy and taking a more proactive stance on evidence-based practice. The executive is working on developing an action plan based on this feedback.
- The development and promotion of psychology fact sheets was coordinated this year by Adam Radomsky.
- The executive committee was involved in promoting the CPA/CPAP directed initiative, Psychology Month.
- The executive regularly responds to information requests from the media. This year, we developed a distribution list of past executive members and Section Fellows to facilitate the process of finding appropriate contacts for a broad range of topics.
- The 2004-2005 year-end financial statement indicates that there is presently \$10,299.35 in chequing and \$4069.56 in GICS. The GICs were renewed in February and March 2005. The total assets of the clinical section are \$14,368.91. This year's finances are close to the predictions of the budget approved at the annual business meeting in June 2004. The Section is awaiting a second dues cheque from CPA that will be the income in line with budget expectations. Members of the executive have absorbed some costs (e.g. teleconference cost, preparing a list of lapsed members) within the budget of their own institutions. The costs of the mid-winter meeting are variable depending on the distance travelled by members of the executive.
- \$2,000.00 has been allocated to special projects that fall under the rubric of promoting clinical psychology.
- There has been a positive response to the invitation to post job announcements on the list serve.
- Congratulations were expressed and welcome was extended to Christine Purdon who became the Chair-Elect by acclamation.
- Four nominations for Student Representative to the Clinical Section Executive Committee were received with one subsequent withdraw. An election was held via email ballot. The successful candidate was Andrea Ashbaugh.
- In recognition of their important contributions to clinical psychology, the Section awarded the status of Fellow to M. Dugas and C. Johnston (Dr. Johnston will receive this award at the 2006 convention in Calgary). The important contributions that Dr. Dugas has made to the treatment of generalized anxiety disorder and worry and to the profession were outlined.
- C. Lee presented the Ken Bowers Student award to Christian Webb from McGill University. Jennifer Mullane from Dalhousie University received an honourable mention.
- K. Dobson made some suggestions that would increase the feasibility of sending the newsletter electronically. Eliminating picture adds, using less dense pictures and not scanning pictures would significantly reduce the download time. A link could be sent with the Newsletter to ensure that members had the most recent version of Adobe to increase the downloading speed. The list serve will be updated again by the Secretary-Treasurer in order to ensure that as many members as possible can be contacted by the list serve. In order to determine if members are accessing the newsletter, a count of the number of hits for months when there is and when there is not a newsletter could be tallied.

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- The members discussed the relative merits of several new initiatives and projects: Provide Travel Grants for students to attend the CPA Conference; Advocacy – support the attendance of members at interdisciplinary conferences who present on topics that promote the profession; invite submissions from members in order to support local advocacy efforts; Public lectures; TV advertising in partnership with CPA, APA and provincial psychology organizations
- The members discussed several ideas for presentations at next years conference, including: a cross country privacy workshop, a workshop on assisting psychologists interactions with the media (the workshop would include psychologists who are active with print and TV media as well as media representatives), risk assessment and the effectiveness of psychological interventions.

Highlights

- The Section sponsored events at the 2005 CPA Conference was discussed. It appears as though the keynote speakers, workshops, symposium and conversation hours were well received. The Section will take steps to ensure that hotel room and flights are booked early for invited speakers order to take advantage of CPA negotiated rates.
- Michel Dugas has agreed to present a public lecture as well as the Master Clinician’s presentation. Arrangements will be made to hold the public lecture at the Central Library location or some other venue that is easily accessing by the public. Contacts will be made with the Canadian Mental Health Association as well as others to advertise the talk. It was agreed that the Master Clinician presentation should be 2 hours in duration.
- Possible speakers/topics for the preconvention workshop, keynote addresses and other Section-sponsored presentations were also discussed.

Summary of the Minutes: Executive Committee, CPA Conference, Montreal

Date: June 10, 2005

Present: Catherine Lee (Chair), Christine Purdon (Chair-Elect), David Dozois (Past-Chair), Kerry Mothersill (Secretary-Treasurer), Adam Radomsky (Member-at large).

The fall teleconference will be held on Thursday September 8, 2005 from 12 to 2 EST. The Mid-Winter meeting will be held in Ottawa January 28, 2006.

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:

Margot Watt, mwatt@stfx.ca
Jessey Bernstein,
DrBernstein@gmail.com



Clinical Section List Serve

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.

**Welcome our New Section Fellow:
Dr. Michel Dugas**

Fellow Status is awarded by the Clinical Section of CPA to those who have made outstanding contributions to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Dr. Michel Dugas' nomination for Fellow Status was supported by glowing letters from Dr. Marty Anthony, Dr. David Clark, Dr. Anna-Beth Doyle and Dr. Adam Radomsky.

Michel Dugas earned a Ph.D. in clinical psychology from Université Laval in 1997. Following a post-doctoral fellowship at l'Université de Montréal, he joined the faculty in the Department of Psychology at Concordia University in 1998. He has received grant funding from the Canadian Institutes of Health Research (CIHR) and les Fonds pour la formation de chercheurs et l'aide à la recherche du Québec as Principal Investigator, as well as being a co-investigator on several grants from provincial and federal granting agencies. He has published over 60 peer-reviewed papers, mostly on cognitive-behavioural formulations and treatments for worry and GAD. These and other achievements were recently recognized by a CIHR New Investigator Award.

Michel has been one of the leading contributors to our understanding of worry and generalized anxiety disorder. His research at Concordia University and at l'Hôpital du Sacré-Cœur de Montréal has investigated cognitive and behavioural aspects of and treatments for worry and GAD. His model is based on a number of innovative factors including intolerance of uncertainty, and has been highly influential. He is one of a select few researchers who have influenced Canadian psychological research in both English and French literatures. But beyond his impact on Canadian work in GAD, his research has become known throughout the world among people who study and treat anxiety and worry.

Michel's remarkable impact on the field has resulted from more than his research. Michel's students respect him immeasurably and see him as a highly supportive and extremely helpful mentor. One of the challenges facing clinical psychologists interested in evidence-based treatments is the dissemination of this information. Michel is frequently invited to travel to the regions of Quebec, to other parts of Canada, to the United States and to Europe to offer workshops on his model of cognitive-behavioural treatment of GAD.



In addition to Michel's service to the community, he has served CPA very well. Most notable was his tenure as Chair (as well as Chair Elect and Past Chair) of the CPA Section on Clinical Psychology. His exceptional commitments to psychology in Canada are clear in a variety of domains. He represents a clear and strong model of a scientist-practitioner-teacher-colleague and it is for these reasons that he has been elected as a Fellow of the Section.

As Canadian psychologists, we are most fortunate to have Michel among us. His professional contributions are underscored by his level-headed thinking, his sense of humour, his calm presence and his unwavering support for work of the highest quality. All of these are assets that are most valuable and that make him most worthy of this distinction.

Why is it so hard to change?

False Hope and self-change

Janet Polivy

University of Toronto at Mississauga

New Year's resolutions, pre-summer diets, exercise programs, and other self-change attempts are ubiquitous. Most people make at least one such resolution a year, and many make multiple attempts at changing aspects of themselves with which they are dissatisfied. If you, yourself have tried to change, you are probably aware that few of these resolutions succeed, and most are made over and over again.

These repeated attempts, and recurring failures raise two questions: 1. Why do we keep failing to change our behaviour, even when we know we should, and we want to change? And 2. Why do we keep trying again when we failed before?

Let's look at the typical dieter, to illustrate. A young woman is dissatisfied with her weight (and her life), and sees an advertisement for a new diet program that promises she will lose 30 pounds in 30 days, with little or no effort, and that her life will change for the better in every way. Like this hypothetical diet in the ad, self-change programs make big promises, and they raise expectations to an unrealistic level. What is the problem with elevated expectations?

When expectations are unrealistic, they can actually increase the likelihood of failure (Polivy & Herman, 2002). For example, successful results may be rejected as not being good enough when they fail to reach the unrealistic level of change that was anticipated (Polivy & Herman, 1999). Moreover, expecting too much leads people to feel like they are failures, and to be disappointed with themselves when they do not achieve the elevated degree of change they were led to expect (Trottier, Polivy, & Herman, 2005). This cycle of unrealistic expectations of change leading to a self-change attempt, eventual disappointment and failure, and then, new expectations leading to another self-change attempt is what we have called the "False Hope Syndrome."

We have identified 4 kinds of unrealistic expectations that contribute to false hope: amount, speed, ease and rewards. People tend to expect to change a greater amount than is feasible, more quickly and more easily than is possible, and to receive more benefits or rewards for changing than will actually occur (Polivy & Herman, 2002).

Unrealistic expectations contribute to failure, but are they the whole story? Why is it so hard to change our behaviours when we want to? There appear to be several other reasons. Often the nature of the change attempted mili-

tates against success. Taking dieting as an example: people are trying to change from eating the foods they like in the quantities they prefer to eating foods that they don't like as much and in quantities less than they want to eat. Perhaps it isn't surprising that people have difficulty making such changes!

In addition, self-changers face a classic approach-avoidance conflict. Specifically, The value of approaching the goal is weaker than the desire to avoid the punishing behaviors necessary to achieve the goal. As Trope and Liberman (2000) showed, abstract goals are more attractive, and seem simpler when they are further away than when they are close; at the same time, concrete negative events appear less costly and difficult when they are distant than when they are close. Thus, starting a self-change attempt (with the actual concrete change off in the distance) is attractive and feels easy, but making the necessary changes is often uncomfortable and feels more costly once the change effort begins.

Another problem is that our lack of understanding of how goals and the temptations that interfere with them operate mitigates against avoiding the temptations and achieving the goals. People are prone to the "time discounting effect," which involves discounting or devaluing larger, later rewards (e.g., weight loss) in favor of smaller, immediate rewards (e.g., dessert) (Trope & Liberman, 2000). We all say that we prefer a larger reward later over a smaller reward now in the abstract, but we will often reverse that preference when actually confronted with the small reward. This reversal is what leads dieters to abandon their long-range diet goals when confronted by tempting, high-calorie food, such as dessert, in the present.

Our reaction to a temptation and our ultimate ability to achieve the goal also depend on our affective state at the time of exposure to the temptation (Loewenstein, 2000; Loewenstein & Angner, 2003). For example, what Loewenstein calls "hot-cold empathy gaps" make it difficult to maintain our resolve to achieve the long-term goal. People are likely to underestimate how hard it will be to forego tempting food in the future when they make their resolve in a "cold" (not hungry, no food cues present) state, but will face a "hot" situation in the future (tempting food will be present). It's easier to plan to skip dessert later-- say, after dinner-- right after lunch when we are satiated and dinner seems far away, than at the dinner table when dessert arrives. If the food cues are right in front of you, though, (e.g., an open bag of candy), the goal (weight loss) becomes less attractive. We tend to plan to diet and lose weight at times when we are not confronted with tempting food cues, but we break the diet when the food appears. Thus our approach to achieving our goals tends to underestimate the power of temptations to interfere with our success. This helps to make failure to meet our goals more likely than success.

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Why do people continue to make new self-change attempts after they have failed repeatedly at the same change? There seem to be several factors that contribute to the tendency to keep trying to alter a particular aspect of the self. For one thing, merely making the decision to change feels good (Polivy & Herman, 2002). Deciding to do something about what one perceives as a problem is a way to take control of the problem, and helps one to feel more likely to succeed and like one is more able to change (Trottier et al., 2005). Also, most change attempts do succeed initially, and these early successes are remembered better later, with those who succeed early on actually reporting having been more successful than those who fail right from the beginning (Polivy, Herman, & Krawiec, under review). Finally, the expected rewards for changing are so desirable, that they keep motivating people to try to achieve them (Trottier, et al., 2005). Feeling in control, remembering previous (short-lived) successes, and hoping for the rewards of changing all seem to suffice to allow one to forget all the previous failures to change.

The false hope syndrome of self-change thus seems to involve a 3-stage cycle beginning with unrealistic expectations about change combined with rosy memories of past successes and a pleasant feeling of being in control. This rosy glow allows us to forget our past failures to change, ignore the fact that we are about to give up things we like to do and try to force ourselves to do things we don't like to do, and make decisions to resist temptations when we are not actually being tempted by them. This first stage is followed by a second stage of harsh reality, wherein we must actually resist the temptations when they are present and we do want them (and the ultimate goal has faded into the distance and seems less attractive), and we slip up, give in, and abandon the whole enterprise as being too difficult at this time. This makes us feel like we have failed, and we are disappointed with ourselves. But, fortunately, this, too, fades, and we enter stage 3, where a new self-change program appears, promising that this time will be different and we will succeed, so we begin the cycle again.

Self-change is thus difficult, especially for something like dieting or eating, where the behavior being changed is one that gives us so much pleasure, and that we must do every day. On the other hand, it is difficult to resist the lure of false hope when the promises are so attractive. So how can we turn false hope into real hope for self-change? It seems to me that we should be doing essentially the opposite of what we are doing. We need to acknowledge (to ourselves and to anyone we are trying to help) that change is not fast, easy, huge, or unbelievably rewarding. Instead, we must accept that in order to be

lasting, change needs to be sustainable, which generally means it will be slow, difficult, involve small steps, and will have only modest payoffs. The first step toward actually changing then may be to recognize what we've been doing wrong.

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This paper is a summary of an
Invited Address at the 2005
CPA Conference in Montreal,
Quebec.



Welcome to the Student Column

Andrea R. Ashbaugh, M.A.
Ar_ashba@alcor.concordia.ca

As the 2005-2006 student representative for the Clinical Section of CPA, I am pleased to introduce a new column in the *Clinical Psychologist* written for and by students. As graduate students, we are not only scholars attending a university, we are also young professionals, discovering what it means to be a clinical psychologist in Canada. Because we are still in the process of acquiring new skills and expanding our knowledge base, there are topics and issues that are of interest to us that may be less relevant to our more seasoned colleagues. It is hoped that this column will provide students of clinical psychology the opportunity to learn and express their opinions about issues that touch graduate students. Topics that could be explored in this column include the do's and don'ts of applying to graduate school, how to find a good internship site, or what the job market is like for clinical psychologists in the future. Not only will the topics in this column be relevant for students, it is hoped that students will contribute articles to the newsletter. If you are interested in writing an article for the student column of the *Clinical Psychologist*, you can send your article to the newsletter editor, Margo Watt, mwatt@stfx.ca. This is a great opportunity for students to express their views about important topics related to clinical psychology in Canada. If you have any questions or comments, please feel free to contact me at ar_ashba@concordia.ca. As your student representative I'm interested in hearing what students have to say.

Changes to APA Accreditation in Canada: What students should know

When I was applying for graduate school I read about how important it was to go to a school that is CPA *and* APA accredited. I was told that attending such a school would provide me with the greatest opportunities for finding a job. Naturally, the news that the Committee on Accreditation (CoA) of APA has proposed to discontinue the accreditation of Canadian clinical psychology programs was alarming. What would this mean for the reputation of our programs, especially in the United States? How would this influence job opportunities for future psychologists trained in Canada?

My initial reaction, as I am sure was the reaction of many students currently attending a jointly accredited program in Canada, was one of anxiety. However, as my cognitive-behavioural training has taught me, before I allow my anxiety to run away with me, I should examine the evidence to determine if there really is anything to be anxious about. The purpose of this article is to provide students with tools to obtain information so that they can better understand the consequences of this APA decision.

Why does APA wish to cease accrediting Canadian programs?

Issues regarding the joint accreditation of psychology programs in Canada are not new. Although APA and CPA accreditation began as very similar processes, the accreditation models have diverged in recent years. For a brief history of CPA accreditation see <http://www.cpa.ca/accred%20history.pdf>. Currently, whereas CPA accreditation is more prescriptive in orientation (e.g., certain predetermined criteria must be met to achieve accreditation), accreditation by APA is outcome based (e.g., a program must demonstrate that the training in a given program meets the program objectives and goals of that program). The perspective of the various governing bodies involved in clinical psychology on CPA-only accreditation can be found at some of the websites listed at the end of this article. Because of the increasing differences in CPA and APA accreditation, as well as other differences between Canada and the United States, the APA has proposed to discontinue accrediting Canadian programs.

Should we be worried?

In evaluating the potential consequences of APA's decision, it's important to consider both the broad implications for psychology programs and internship sites in general, and the implications for specific programs. To understand the broader implications, considering the opinion of various professional psychology governing bodies with regards to CPA-only accreditation is useful. The Canadian Council of Professional Psychology Programs (CCPPP) has been advocating the programs voluntarily adopt a CPA-only accreditation policy since June 2003 (<http://www.ccppp.ca/en/cpa-only.html>). Although CCPPP recognizes the initial utility that joint accreditation had, they now generally believe that it is time for CPA accreditation to develop independently from APA accreditation, especially given their divergent models. In contrast, a recent survey of CCPPP members, suggests that opinions regarding CPA-only accreditation are diverse. Whereas most academic programs do not support this change, the majority of internship programs do support the proposed change.

CPA-only accreditation is recognized by both the Association of Psychology Postdoctoral and Internship Centers (APPIC), responsible for postdoctoral and internship training and the Association of State and Provincial Psychology Boards (ASPPB), an association of licensing boards in the United States and Canada. One of the requirements for the Certificate of Professional Qualification in Psychology (CPQ) granted by the ASPPB, which is designed to enable licensing mobility, is that the individual has received a doctoral degree from either an APA or CPA accredited program (<http://www.asppb.org/mobility/cpq/requirementswhat.aspx>).

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APA and CPA accredited internship sites are recognized as meeting doctoral membership criteria by APPIC (http://www.appic.org/about/2_3_1_about_policies_and_procedures_internship.html). This suggests that professional governing bodies recognize the equivalency of APA and CPA accreditation, though it is unclear if individual members of these governing bodies (e.g., state/provincial licensing boards, pre-doctoral internship settings) share this view. The Accreditation Panel of the CPA (Hanigan & Cohen, 2001) queried individual members of the Council of Directors of Clinical Psychology Programs (CUDCP), ASPPB, and APPIC about their perception of graduates from CPA-only accredited programs. Of the small sample of members that responded, the majority indicated that CPA-only accreditation would not be a barrier, though lack of American citizenship could be. It is unclear, however, whether the large number of members of these agencies who did not respond share this view. If individual members of APPIC in the United States do not recognize CPA-only accreditation, this could have implications for internship availability for graduates from Canadian programs due to the limited number of internship sites available in Canada (Cohen, 2005).

The impact of the proposed changes to Canadian accreditation by the APA is likely to depend on the nature of individual programs. Programs that are already CPA-only accredited are likely to have a different perspective on these proposed changes than programs that are dually accredited. Furthermore, Canadian programs that are closely tied to the United States, such as those programs that are near to the border, are likely to have a different opinion of these changes than programs with fewer ties to the United States. To understand how these changes might affect specific programs, students are encouraged to consult and discuss APA's proposed changes with their program directors, professors, as well as current and former students.

Concluding Remarks

I will refrain from expressing my opinion regarding this issue, because it's important for each student to come to their own conclusion about how to evaluate APA's proposed changes to the accreditation of Canadian programs. I will say this, however; after evaluating the evidence, I can say with confidence that my anxiety regarding this issue has declined.

Most of the comments posted on the APA website regarding this proposal come from faculty members and individuals having already completed graduate training. Their experiences as students at jointly accredited programs and as psychologists having worked both in Canada and the United States certainly affords them hindsight regarding the advantages and disadvantages of a

jointly accredited program. I hope that armed with the resources provided to you in this article, students will also voice their comments and opinions regarding the proposed discontinuation of APA accreditation in Canada. Comments may be posted until November 2, 2005 at the following website, <http://apaoutside.apa.org/accredsurvey/public/>.

References and Useful Resources:

APA. Proposed changes on concurrent accreditation with Canada.

www.apa.org/ed/accreditation/public_comment.html

APPIC. APPIC membership criteria: Doctoral psychology internship programs.

http://www.appic.org/about/2_3_1_about_policies_and_procedures_internship.html

ASPPB. General CPQ requirements.

<http://www.asppb.org/mobility/cpq/requirements.aspx>

CCPPP. The CCPPP CPA-only Accreditation Movement.

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Ken Bowers Award

The Ken Bowers award is presented annually in honour of psychologist Ken Bowers who made a significant contribution to clinical psychology throughout his career. Students whose abstracts have been accepted for the convention are invited to submit a longer paper describing their study. The CPA Section on Clinical Psychology received eight submissions this year. There were three reviewers - two from within the Clinical Section executive and one external to this committee who is a Fellow of the Clinical Section. The members of the review panel were impressed by the quality of the submissions.

This year the award was made to **Christian Webb** from McGill University for his paper: *The Role of Self-Criticism, Dependency, and Hassles in the Course of Depressive Illness: A Multi-Wave Longitudinal Study*, co-authored with John R. Z. Abela, Clara Wagner, and Philippe Adams. The committee was unanimous in judging this paper to be the most meritorious in terms of both methodology and clarity of presentation. See article starting on page 13)

Jennifer Mullane from Dalhousie University will receive an honourable mention for her paper: *Evaluation of a Behaviourally-Based Sleep Intervention Program for Children with Attention Deficit Hyperactivity Disorder and Dyssomnias*, co-authored by Penny Corkum.

Both papers are fine examples of the work of promising young scientist-practitioners, and are proud to honour them. We look forward to these students joining the ranks of Canadian clinical psychologists.



Section Chair, Dr. Catherine Lee, with Christian Webb, in front of his award-winning poster.

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Dr. Margo Watt
Department of Psychology
St. Francis Xavier University, P.O. Box 5000
Antigonish, Nova Scotia B2G 2W5
Phone: (902) 867- 3869
Fax: (902) 867-5189
Email: mwatt@stfx.ca

The Role of Self-Criticism, Dependency, and Hassles in the Course of Depressive Illness: A Multi-Wave Longitudinal Study

Christian A. Webb, John R. Z. Abela, Clara Wagner,
and Philippe Adams
McGill University
Abstract

The current study utilized a multi-wave longitudinal design to examine whether dependency and/or self-criticism influence the course of depressive symptoms in a community sample of adults with a history of major depression. In addition, we examined whether self-esteem serves as a buffer against the development of depressive symptoms following increases in hassles in individuals possessing such traits. At Time 1, 102 participants completed measures assessing depressive symptoms, self-criticism, dependency, and self-esteem. Every six weeks for the next year, participants completed measures assessing depressive symptoms and hassles. High self-criticism was associated with greater elevations in depressive symptoms following elevations in hassles in low but not high self-esteem individuals. Results with respect to dependency, however, were contrary to hypotheses. High dependency was associated with elevations in depressive symptoms following elevations in hassles in high self-esteem individuals. In contrast, high dependency was associated with chronically elevated depressive symptoms in low self-esteem individuals.

Introduction

Researchers from diverse theoretical orientations have proposed that certain personality traits serve as vulnerability factors to depression (Beck, 1983; Blatt & Zuroff, 1992). Although differences exist in conceptualizations, each theory proposes a personality predisposition focused on interpersonal issues and another focused on achievement issues. Psychodynamic theorists label these two personality predispositions as dependency and self-criticism (Blatt & Zuroff, 1992). Individuals high in dependency are concerned with interpersonal issues; they need the approval of others to maintain a sense of well-being. Dependent individuals are hypothesized to be at risk for developing depression when they perceive disruptions in their relationships with others, interpersonal loss, and/or social rejection. Individuals high in self-criticism, on the other hand, are concerned with achievement issues; they need to meet their own and/or others' standards to maintain a sense of well-being. Self-critical individuals are hypothesized to be at risk for developing depression when they perceive that they are not meeting such standards.

The Specific Vulnerability Hypothesis

Blatt and Zuroff's (1992) specific vulnerability hypothesis posits that individuals who possess personality predispositions are only at risk for developing depression following the occurrence of negative events congruent with their personality vulnerabilities. More specifically, it is hypothesized that dependent individuals are at risk for developing depression following negative interpersonal events, whereas self-critical individuals are at risk

for developing depression following negative achievement events. However, Blatt and Zuroff's (1992) specific vulnerability hypothesis has obtained mixed results (see Zuroff, Mongrain, & Santor, 2004 for review). Although some studies have found strong support for this hypothesis, others have obtained support only in dependent individuals or self-critical individuals. In addition, some studies have failed to provide support for the specific vulnerability hypothesis in either subtype.

In the typical study examining the specific vulnerability hypothesis, self-criticism, dependency and depressive symptoms are assessed at Time 1. Depressive symptoms and negative events are assessed at Time 2 (e.g., six weeks later). Separate analyses are then conducted examining the following two hypotheses: (1) self-criticism will interact with negative achievement, but not interpersonal events, to predict increases in depressive symptoms and (2) dependency will interact with negative interpersonal, but not achievement, events to predict increases in depressive symptoms. Negative events tend to be assessed using self-report measures in which the events are classified by experimenters as either interpersonal or achievement in nature.

The degree of support obtained for the specific vulnerability hypothesis using such a design hinges upon the extent to which several conditions are met. First, in order for support to be obtained, participants must perceive negative events in the same manner as do the experimenters. Personality predispositions, however, have been hypothesized to influence how individuals perceive events (e.g., Blatt & Zuroff, 1992). Therefore, self-critical individuals may perceive events traditionally classified as interpersonal as relevant to achievement motivations. Similarly, dependent individuals may perceive events traditionally classified as achievement-related as relevant to interpersonal motivations. If personality predispositions influence individuals' perceptions of the negative events that occur in their lives, experimenter classification of negative events as either achievement or interpersonal may fail to capture the idiosyncratic meaning assigned to negative events by participants.

Second, in order for support to be obtained, dependency and self-criticism must be inversely related. Thus, if individuals display high levels of *both* self-criticism and dependency, they will exhibit non-specificity. Consequently, when examining self-criticism and dependency as vulnerability factors to depression in isolation of one another, individuals possessing both personality predispositions will appear to violate the specific vulnerability hypothesis. Past research has found dependency and self-criticism to be either orthogonal constructs (e.g. Santor, Zuroff & Fielding, 1997) or positively associated (e.g. Abela et al., 2003) indicating that many individuals possessing personality predispositions to depression are vulnerable to developing depression following both negative interpersonal and achievement events.

Last, in order for obtain support, individuals who possess high levels of self-criticism or dependency and who develop depressive symptoms must only be experiencing high levels of stress in the domain congruent with their personality predisposition.

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If such individuals are also consecutively experiencing high stress in the domain not congruent with their personality predisposition, they will appear to violate the specific vulnerability hypothesis, even if their symptoms are truly being triggered by domain congruent stressors. Given that levels of interpersonal and achievement stress as assessed by self-report inventories have been found to exhibit a high degree of association, it is likely that stress in one domain of an individual's life spills over into other domains making reliable detection of specific vulnerability effects difficult.

Given that (1) personality predispositions likely influence individuals' perceptions of the stressors that occur in their lives, (2) self-criticism and dependency are either orthogonal constructs or positively associated, and (3) levels of self-reported interpersonal stress and achievement stress exhibit a high degree of association, we propose that researchers are likely to obtain more consistent support for self-criticism and dependency as vulnerability factors to depressive symptoms by both conducting analyses pertaining to self-criticism and dependency simultaneously and by examining their interaction with overall levels of stress rather than with interpersonal or achievement stressors in isolation.

The Buffering Role of Self-Esteem

The causal mediation component of Blatt and Zuroff's (1992) theory proposes that individuals who possess personality predispositions are at risk for developing depressive symptoms following negative events because such events generate depressogenic thinking. Protective factors, such as high self-esteem, may prevent the outcome of depressive symptoms by decreasing the negative impact of depressogenic thoughts on the affective, cognitive, behavioral, and physiological symptoms of depression. For example, an individual who is high in self-criticism, but who possesses high levels of self-esteem, may engage in harsh self-scrutiny following failure, while at the same time maintaining the belief that he/she is overall a good person. In contrast, an individual who is high in self-criticism and low in self-esteem is likely to have a very fragile sense of self-worth that may be shattered even in the face of mild adversity. High levels of self-esteem have previously been shown to protect participants possessing cognitive vulnerability to hopelessness depression from developing depressive symptoms following negative events (e.g., Abela, 2002; Metalsky et al., 1993). Due to the similarities between the causal mediation component of the hopelessness theory and Blatt and Zuroff's (1992) theory, high levels of self-esteem may also act as a protective factor against depressive symptoms in individuals possessing personality predispositions to depression.

Goals of the Current Study

The current study utilized a multi-wave longitudinal design to examine whether the personality predispositions of dependency and/or self-criticism influence the course of depressive symptoms in a community sample of adults with a history of major depressive episodes. In addition, we examined whether self-esteem serves as a buffer against the development of depres-

sive symptoms following increases in levels of hassles in individuals possessing high levels of self-criticism and/or dependency. The use of a multi-wave longitudinal design allowed us to take an idiographic approach towards examining Blatt and Zuroff's (1992) vulnerability hypothesis. More specifically, we examined whether the slope of the relationship between hassles and depressive symptoms *within* participants varied *across* participants as a function of personality predispositions to depression and/or self-esteem. One advantage of utilizing such a multi-wave idiographic approach is that by obtaining repeated assessments of levels of hassles and depressive symptoms within individuals over an extended period of time, we are able to gather a relatively reliable estimate of each participant's degree of stress reactivity (e.g., his or her slope of the relationship between hassles and depressive symptoms). Given that vulnerability-stress theories are essentially theories of differential stress-reactivity, such an idiographic approach represents an ideal way to test their vulnerability hypotheses.

Method

Participants

The participants in the current study were taking part in a larger project examining vulnerability to depression in children of parents with a history of major depressive episodes. Participants were recruited through ads placed in local English newspapers and by posters placed throughout the greater Montreal area. The posters and newspaper ads specified that the current study sought to recruit parents with a history of major depressive disorder and with children between the ages of 6 and 14. Respondents were invited to participate in a telephone interview where a diagnostician administered the affective disorders module of the Structured Clinical Interview for the DSM-IV (SCID-I; First, Gibbon, Spitzer, & Williams, 2001). Those who met criteria for a current or past major depressive episode were invited to participate in the study. The final sample consisted of 102 participants (88 women and 14 men). Participants' ages ranged from 27 to 53 with a median age of 41.

Procedure

During the initial assessment, participants completed demographic forms, consent forms, and the following questionnaires: (1) Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), (2) Depressive Experiences Questionnaire (Blatt, Quinlan, & D'Afflitti, 1976), and (3) Rosenberg Self-Esteem Scale (Rosenberg, 1965). The second phase of the study involved a series of 8 telephone follow-up assessments occurring every 6 weeks for the subsequent year. At each follow-up assessment, participants completed the following questionnaires: (1) BDI, and (2) Hassles Scale (HAS; Delongis et al., 1988).

Results

To test our hypothesis that higher levels of either dependency or self-criticism would be associated with greater fluctuations in depressive symptoms following fluctuations in hassles, we utilized multilevel modeling. Analyses were carried out using

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the SAS (version 8.1) MIXED procedure and maximum likelihood estimation. Our dependent variable was within-subject fluctuations in BDI scores during the follow-up interval (FU_BDI). As FU_BDI is a within-subject variable, BDI scores were centered at each participant's mean such that FU_BDI reflects upwards or downwards fluctuations in each participant's level of depressive symptoms compared to his or her mean level of depressive symptoms. Our primary predictors of FU_BDI were dependency (DEP), self-criticism (SC), self-esteem (SEQ), and fluctuations in HASSLES scores during the follow-up interval (FU_HASSLES). As DEP, SC, and SEQ are between-subject predictors, DEP, SC, and SEQ scores were standardized prior to analyses. As FU_HASSLES is a within-subject predictor, HASSLES scores were centered at each participant's mean prior to analyses such that FU_HASSLES reflects upwards or downwards fluctuations in participants level of hassles compared to his or her mean level of hassles.

When fitting hierarchical linear models, one must specify appropriate mean and covariance structures. It is important to note that mean and covariance structures are not independent of one another. Rather, an appropriate covariance structure is essential in order to obtain valid inferences for the parameters in the mean structure. Overparametrization of the covariance structure can lead to inefficient estimation and poor assessment of standard errors (Altham, 1984). On the other hand, restriction of the covariance structure can lead to invalid inferences when the assumed structure does not hold (Altham, 1984).

In our analyses, we were interested in examining the effects of DEP, SC, SEQ, and FU_HASSLES on participants' BDI scores during the follow-up interval. Consequently, in line with Diggle, Liang, and Zeger's (1994) recommendation that one use a 'saturated' model for the mean structure while searching for an appropriate covariance structure, we chose a mean structure that included DEP, SC, SEQ, FU_HASSLES, and all two- and three-way interactions involving (1) DEP, SEQ, and FU_HASSLES and (2) SC, SEQ, and FU_HASSLES. Three additional effects were also included in this initial mean struc-

ture. First, in order to control for individual differences in baseline levels of depressive symptoms, participants' Time 1 BDI scores (T1_BDI) were included in the model. Second, as different participants are likely to exhibit different baseline levels of depressive symptoms (e.g., the levels of depressive symptoms experienced by an individual when he/she is experiencing his/her own average level of hassles), a random effect for intercept (RE_INTERCEPT) was included in the model. Last, given that FU_HASSLES is a within-subject predictor whose effect is expected to vary between participants, a random effect for slope (RE_SLOPE) was included in the model.

Commonly used covariance structures in studies in which multiple responses are obtained from the same individual over time (and consequently within-subject residuals over time are likely to be correlated) include compound symmetry, first-order autoregressive, heterogeneous autoregressive, and banded Toeplitz. In order to select one of these covariance structures for our analyses, we fitted models utilizing each structure and chose the 'best' fit based on Akaike information criterion (AIC and AICC) and Schwarz Bayesian criterion (BIC). The best fit was a first order banded toeplitz structure.

After choosing the appropriate covariance structure, we next examined the random-effects component of our model. Non-significant random-effect parameters were deleted from the model prior to examining the fixed-effects component. With respect to random effects, the RE_INTERCEPT ($p < .001$) was significant and thus were retained in the model. RE_SLOPE, however, was not significant and consequently was deleted from the model prior to examining the fixed effects.

Results with respect to the fixed-effects component of the model are presented in Table 1. Of primary importance, significant three-way, cross-level interactions emerged between (1) DEP, SEQ, and FU_HASSLES and (2) SC, SEQ, and FU_HASSLES. In order to examine the form the DEP \times SEQ \times FU_HASSLES interaction, the model summarized in Table 1 was used to calculate predicted BDI scores for participants possessing either low or high levels of dependency (plus or minus 1.5 SD), either low or high levels of self-esteem

Table 1. Predicting BDI Scores during the Follow-up Interval: Overall Hassles.

Predictor	b	SE	F	df
BDI	4.21	1.05	16.04***	1, 72
SC	1.56	0.80	3.85	1, 72
DEP	1.03	0.69	2.22	1, 72
SEQ	0.75	1.02	0.54	1, 72
FU_HASSLES	0.19	0.04	30.75***	1, 371
SC*FU_HASSLES	0.05	0.04	1.18	1, 371
DEP*FU_HASSLES	0.01	0.03	0.14	1, 371
SEQ*FU_HASSLES	0.06	.043	2.23	1, 371
SC*SEQ	0.67	0.56	1.41	1, 72
DEP*SEQ	0.06	0.60	0.01	1, 72
SC*SEQ*FU_HASSLES	0.07	0.03	3.86*	1, 371
DEP*SEQ*FU_HASSLES	-0.07	0.03	5.00*	1, 371

Note. BDI = Beck Depression Inventory. SC = Depressive Experiences Questionnaire, self-criticism. DEP = Depressive Experiences Questionnaire, dependency. SEQ = Rosenberg Self-Esteem Scale. FU_HASSLES = Hassles Scale, Total score. * $p < .05$. ** $p < .01$. *** $p < .001$.

(plus or minus 1.5 SD) and who are experiencing either low or high levels of hassles in comparison to their own average level of hassles (plus or minus 1.5 × mean within-subject SD). The results of such calculations are presented in Figure 1. As both FU_BDI and FU_HASSLES are within-subject variables centered at each participant's mean, slopes are interpreted as the increase in a participant's BDI score that would be expected given that he or she scored one point higher on the HASSLES scale.

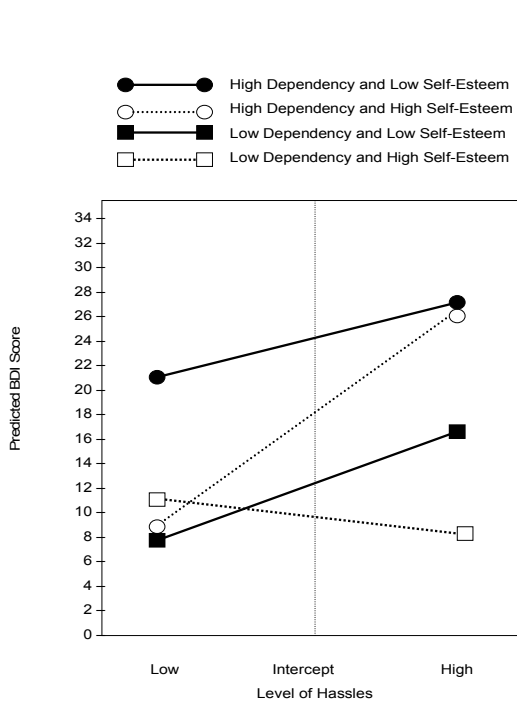


Figure 1. Predicted slope of the relationship between hassles and depressive symptoms as a function of dependency and self-esteem.

Analyses were conducted for each DEP × SEQ condition examining whether the slope of the relationship between hassles and depressive symptoms significantly differed from 0. Analyses indicated that participants possessing either (1) high levels of dependency and high levels of self-esteem ($t(371) = 2.21, p < 0.05$) or (2) low levels of dependency and low levels of self-esteem reported ($t(371) = 3.71, p < 0.001$) higher levels of depressive symptoms when experiencing high levels of hassles than when experiencing low levels of hassles. At the same time, level of depressive symptoms did not vary as a function of level of hassles for (1) participants possessing high levels of dependency and low levels of self-esteem ($t(371) = 1.49, ns$), or (2) participants possessing low levels of dependency and high levels of self-esteem ($t(371) = -0.75, ns$).

In order to examine the form of the SC × SEQ × FU_HASSLES interaction, the model summarized in the top panel of Table 1 was used to calculate predicted BDI scores for participants possessing either low or high levels of self-criticism (plus or minus 1.5 SD), either low or high levels of self-esteem (plus or minus 1.5 SD) and who are experiencing either low or high levels of

hassles in comparison to their own average level of hassles (plus or minus 1.5 × mean within-subject SD). The results of such calculations are presented in Figure 2. As both FU_BDI and FU_HASSLES are within-subject variables centered at each participant's mean, slopes are interpreted as the increase in a participant's BDI score that would be expected given that he or she scored one point higher on the HASSLES.

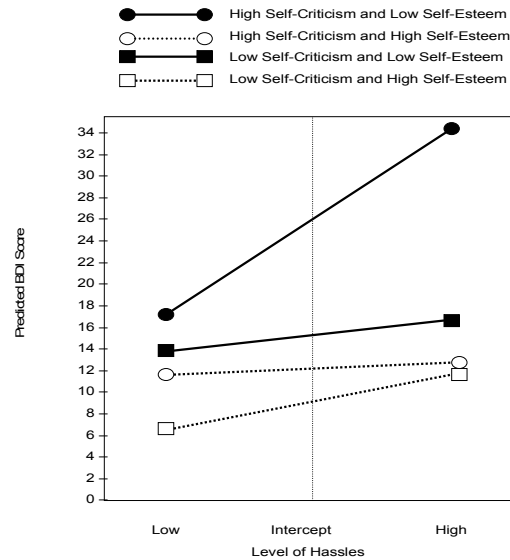


Figure 2. Predicted slope of the relationship between hassles and depressive symptoms as a function of self-criticism and self-esteem.

Analyses were conducted for each SC × SEQ condition examining whether the slope of the relationship between hassles and depressive symptoms significantly differed from 0. Analyses indicated that participants possessing high levels of self-criticism and low levels of self-esteem reported higher levels of depressive symptoms when experiencing high levels of hassles than when experiencing low levels of hassles, $t(371) = 5.45, p < 0.001$. At the same time, level of depressive symptoms did not vary as a function of level of hassles for (1) participants possessing high levels of self-criticism and high levels of self-esteem ($t(371) = 0.11, ns$), (2) participants possessing low levels of self-criticism and low levels of self-esteem ($t(371) = 0.50, ns$), or (3) participants possessing low levels of self-criticism and high levels of self-esteem ($t(371) = 1.68, ns$).

Discussion

The results of the current study provide support for Blatt and Zuroff's (1992) hypothesis that self-criticism serves as a vulnerability factor to depressive symptoms following negative events. Individuals possessing high levels of self-criticism reported greater fluctuations in depressive symptoms following fluctuations in hassles than individuals possessing low-levels of self-criticism. More specifically, individuals possessing high self-

criticism reported higher levels of depressive symptoms when they were experiencing high as opposed to low levels of stress. Such a pattern of findings is consistent with Brown and Moskowitz's (1998) conceptualization of personality traits as "dynamic yet stable." In other words, although self-criticism may be a relatively stable trait, the affective, cognitive, physiological, and behavioral expressions of self-criticism are likely to vary over time as a function of situational factors. Although the current study examined fluctuations in depressive symptomatology at a broad level, future research is likely to benefit from taking a more fine-tuned approach towards examining the relationship between self-criticism, fluctuations in environmental factors, and fluctuations in specific types of affective states, cognitions, physiological symptoms, and behaviors. Such research will ultimately lead to a richer understanding of the mechanisms underlying the deleterious impact of self-criticism on distinct spheres of psychosocial functioning.

The results of the current study also highlight the importance of integrating Blatt and Zuroff's (1992) theory of personality predispositions to depression with self-esteem theory in order to foster a more thorough understanding of the relationship between situational factors and depressive symptoms in individuals possessing high levels of self-criticism. More specifically, the current results suggest that high levels of self-esteem buffer self-critical individuals against experiencing increases in depressive symptoms following increases in hassles. Therefore, self-criticism is indeed a vulnerability factor to the development of depressive symptoms following the occurrence of negative events but only in certain individuals: those with low self-esteem. Failure of past research to examine self-esteem in conjunction with self-criticism may be one of the factors that accounts for past inconsistent findings regarding Blatt and Zuroff's vulnerability hypothesis. Future research is likely to benefit from examining other cognitive (e.g., rumination) and/or interpersonal (e.g., social support) factors that may also moderate the association between fluctuations in hassles and fluctuations in depressive symptoms in self-critical individuals.

The results of the current study provide partial support for Blatt and Zuroff's (1992) hypothesis that dependency serves as a vulnerability factor to the development of depressive symptoms. In line with Blatt and Zuroff's theory, but contrary to our self-esteem buffering hypothesis, higher levels of dependency were associated with greater fluctuations in depressive symptoms following fluctuations in hassles in individuals who possessed high but not low levels of self-esteem. Unexpectedly, individuals who possessed high levels of dependency and low levels of self-esteem exhibited chronically elevated levels of depressive symptoms. Thus, rather than influencing the probability of whether or not individuals high in dependency experience increases in depressive symptoms following increases in hassles, our results suggest that low self-esteem may be more closely associated with the chronicity of depressive symptoms in dependent individuals. One possible explanation for why high self-esteem serves as a buffer against depressive symptoms in individuals possessing high self-criticism but not in individuals possessing high dependency is that dependent individuals rely on others to maintain their well-being whereas self-critical individu-

als rely on themselves and their achievements to do so. It may be that perceptions of support from others are a more potent buffer against depressive symptoms than self-esteem in individuals who possess high levels of dependency.

Several limitations of the current study should be noted. First, self-report measures were used to assess depressive symptoms during the follow-up portion of the study. Although the BDI possesses high degrees of reliability and validity, it is difficult to make conclusions about clinically significant levels of depressive symptoms based on self-report questionnaires. Second, self-report measures were also used to assess hassles. Although measures of hassles that solely require participants to indicate how frequently an event occurred are less likely to be influenced by informant bias than those that ask subjects to rate the subjective impact of each event, more sophisticated methods of assessing stress are likely to provide more precise measurements of stress. Last, the current study utilized a high-risk community sample. Although such a design leads to a strong test of theories of vulnerability to depression in that it maximizes the number of participants who experience elevations in depressive symptoms during the course of study, results cannot be generalized to low-risk populations. Future research should examine the integration of the Blatt and Zuroff's theory of personality predispositions to depression and self-esteem theory in a low-risk community sample.

In conclusion, discovering the personality traits that confer vulnerability to the development of depressive symptoms provides clinicians with a tool for identifying individuals who are vulnerable to developing future depressive episodes. The identification of cognitive factors that buffer vulnerable individuals against the deleterious impact of negative life events provides clinicians with mechanisms to strengthen in an effort to prevent future depressive episodes in such individuals. Future research using more sophisticated assessments of stress and depressive symptoms, and low-risk community samples is likely to help us to gain a deeper understanding of the cognitive and interpersonal processes underlying the relationship between self-criticism, dependency, self-esteem, negative life events, and vulnerability to and resiliency from depressive symptoms.

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**Workshop Review:
The Light of Mindfulness:
Prevention of Recurrent Depression with MBCT**

Paul A. Frewen, Clinical Psychology Program, The University of Western Ontario.

Lauren C. Haubert, Clinical Psychology Program, The University of Calgary

On June 8th, we had the benefit of attending Dr. Zindel Segal's pre-convention workshop, "Prevention of Recurrent Depression with Mindfulness-Based Cognitive Therapy" (MBCT), at the 66th annual Canadian Psychological Association (CPA) Convention in Montreal, Quebec. Dr. Segal is Professor of Psychiatry at the University of Toronto, heads the Cognitive Behaviour Therapy Unit at the Centre for Addiction and Mental Health in Toronto, and is a founding fellow of the Academy of Cognitive Therapy. He is internationally renowned for his studies of cognition in depression, and of cognitive mechanisms of change associated with cognitive therapy of depression. Dr. Segal is a widely respected workshop leader, and co-developed MBCT as a relapse/ recurrence prevention program for depression (MBCT; Segal, Williams, & Teasdale, 2002).

MBCT is a unique intervention combining principles of cognitive therapy for depression (CT; Beck, Rush, Shaw, & Emery, 1979) with formal mindfulness practice. The mindfulness practices included in MBCT were adapted from those outlined in the mindfulness-based stress reduction (MBSR) program developed by Jon Kabat-Zinn (1990), and include sitting meditation, body scans, and

yoga. Unlike in CT, in MBCT there is minimal focus on changing the content of patients' thoughts; rather, MBCT focuses on changing an individual's awareness of and relationship with his or her thoughts. Two randomized clinical trials support the efficacy of MBCT, relative to treatment-as-usual, in preventing relapse/recurrence of depression following acute phase antidepressant treatment, in patients with a history of chronic depression (defined as three or more previous depressive episodes; Ma & Teasdale, 2004; Teasdale et al., 2000). The notion that integrating mindfulness training with cognitive therapy methods could help prevent depressive relapse/recurrence, and promote psychological well-being, has recently sparked considerable academic, clinical, and public interest. Consequently, Dr. Segal's workshop on this topic was particularly timely and, not surprisingly, very well attended in Montreal.

Dr. Segal began his workshop by reviewing the clinical course of major depressive disorder. Untreated clinical depression is often marked by a chronic course, with phases of acute depression, followed by remission, and then subsequent relapse/recurrence. Relapse/recurrence risk appears to increase linearly with the number of previous episodes a patient has already endured. Cognitive models of depression posit that negative self-referential thoughts (e.g., beliefs concerning worthlessness, hopelessness, and guilt) play a role in depression etiology. During remission and while in a neutral or elated mood, however, the negative self-referential thinking patterns that are often characteristic of acute depression typically abate. However, formerly depressed individuals often

Continued on next page

remain vulnerable to depressive relapse/recurrence when their previously negative ways of thinking about themselves become revived in states of mild sadness or following negative life events (Lau, Segal, & Williams, 2004).

Segal and his colleagues reasoned that an intervention that aimed to undermine associations between transient negative mood states and negative cognitive processing patterns would theoretically be an effective way to prevent depressive relapse. In his workshop, Dr. Segal explained how via formal practice of mindfulness-meditation, supplemented by supportive psychoeducation about cognitive models of depression taught in-session, MBCT participants practice being aware of their current experiences, with a sense of non-attachment toward whatever is happening. In this way, MBCT participants learn to 'let go of' negative thoughts about themselves that might arise in their consciousness, coming to realize that their thoughts are 'just thoughts', simply a momentary object of attention that inevitably will pass. MBCT participants learn not to identify with negative thoughts, nor consider their thoughts necessarily to be accurate reflections of reality, but simply the products of prior conditioning. With practice, metacognitive awareness develops (Teasdale et al., 2002).

Dr. Segal's workshop included both didactic discussions concerning the topics of each of the eight sessions of the MBCT program, comparisons between MBCT and standard cognitive therapy, and distinctions between mindfulness and concentrative forms of meditation. Importantly, the workshop also included several focused experiential exercises drawn directly from MBCT sessions. Group participants were introduced to the 'raisin exercise', and engaged in a 30-minute silent sitting practice. After each of these exercises, Dr. Segal inquired about our experiences in the therapeutic style of an MBCT therapist. Intentionally eluding conceptual and analytical discussions, Dr. Segal instead focused on the basic essence of our experiences during each exercise. In response to workshop attendees' characterizations of their experience of the mindfulness exercises, Dr. Segal would reply: "So you noticed ____" or "So you had a sense of ____", embodying the mindfulness principles of non-judging, decentering, and direct-experience. Specifically, whatever one experienced during the exercises was accepted as 'okay' – as just an experience – neither 'good' nor 'bad'.

In addition to giving attendees the opportunity to engage in mindfulness techniques first-hand, Dr. Segal's use of data from empirical literature throughout the workshop was further enhanced by insights based on his own personal mindfulness practice. Toward the end of the workshop, attendees also watched a documentary video on Jon Kabat-Zinn's MBSR program, giving them an opportunity to see mindfulness-based practices at work in a clinical population. It became clear to most attendees

how assuming this non-judging, accepting, and de-centered stance toward one's moment-to-moment experience could lead to a sense of openness, freedom, and insight during both pleasant and stressful times. If mindfulness practice is capable of unveiling the experiential wonders inherent even in the simple touch, sight, and taste of a raisin, shining the light of mindfulness over our lives as a whole, from moment-to-moment, could serve to illuminate and enrich our existence. The hope of MBCT is that this 'light of mindfulness' might provide a sense of energy, equilibrium, and vision to those at risk of falling again into the dark hole of depression.

On behalf of all those who attended his workshop, we thank Dr. Segal for introducing us to the MBCT program, and look forward to further research studies attesting to its efficacy as a clinical intervention.

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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 its members for Fellows in Clinical Psychology. Criteria for fellowship are outstanding contribution to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Some examples are: (1) creation and documentation of innovative programs; (2) service to professional organizations at the national, provincial or local level; (3) leadership on clinical issues that relate to broad social issues; and (4) service outside one's own place of work. Note that clinical contributions should be given equal weight 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, 2006 to:
 Dr. Christine Purdon, Chair-Elect
 Department of Psychology
 University of Waterloo
 Waterloo, Ontario, N2L 3G1
 Phone: 519-888-4567 x3912
 email: clpurdon@uwaterloo.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 2006 à l'attention de :
 Dr. Christine Purdon, Chair-Elect
 Department of Psychology
 University of Waterloo
 Waterloo, Ontario, N2L 3G1
 Phone: 519-888-4567 x3912
 email: clpurdon@uwaterloo.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 Calgary in 2006; (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 31, 2006. Submissions in either English or French should be sent by email to: clpurdon@uwaterloo.ca. If you have any questions about the submission process, please do not hesitate to contact Dr. Purdon by email or by phone (519-888-4567 x3912).

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 2006, 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 Calgary; (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 31 mars, 2006. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées par courriel à clpurdon@uwaterloo.ca. Si vous avez des questions au sujet du processus de soumission, n'hésitez pas à contacter le Dr. Purdon par courriel ou par téléphone au : 519-888-4567, poste 3912.