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CLINICAL PSYCHOLOGIST

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

Chair's Message

I was attending the open house at my daughters' school last week when I ran into an old friend and former colleague. My friend noted that she had seen the *Psynopsis* article I had written as section chair announcing our Master Clinician session at the upcoming conference in St Johns. Her question for me was "what the heck does the section do"? She told me that she had thought about joining the section for a number of years when she was renewing her CPA membership but could not find a description of our activities (or, indeed, the activities of other sections). I thanked her for the feedback about our lack of visibility. I let my friend know about the website (www.cpa.ca/clinical/) and I told her about the Fact Sheets, and I described the conference program. I spoke about the Ken Bowers student awards and the recognition of psychologists through the fellowship awards. I described the newsletter and the listserv. As I was talking I realized that the list I was providing were all the benefits of membership for the *individual* clinical psychologist. I realized that there is another list of section activities that serve not the individual but instead serve the *profession of psychology*. We also do not publicize these activities very well. Some recent examples include:

- Providing feedback to CPA on the Joint Statement on Physical Punishment of Children and Youth.

- Providing media contacts for a broad range of topics such as worry, depression, aging, and child development issues.

- Drafting a CPA position statement on the use of physical punishment with children.

- Sponsoring a presentation on anxiety for the general public at CPA in St Johns.

- Nominating high profile psychologists for an award for advancing evidence-based decision-making in health care in Canada.

- Provision of information on efficacy of psychological services to mental health service providers and purchasers in Canada.

- Sponsorship of a presentation on the cost effectiveness of psychological services at the Healthcare Middle Management Conference.

I had a couple of additional thoughts about this advocacy work as I spoke to my friend. These initiatives mostly come from reacting to opportunities to enhance psychology as the opportunities arise. I am happy to report, however, that the executive of the section has recognized the need to move toward a more proactive stance. One example of this is Kerry Mothersill's project soliciting examples of the small initiatives that individual psychologists have made that serve to promote psychology. How many times in the past year have you noticed that psychology has been overlooked? Kerry provides the example of his efforts to gain recognition for psychological research at the Calgary Youth Science Fair. The Psychologists' Association of Alberta now provides a small prize, as does many other organizations, for high school students at this annual competition. Catherine Lee, also on our executive, provides a further example, having psychology listed as a treatment option along side other professions on an informational pamphlet on sexual abuse. In both these instances, individual psychologists noticed, and acted on an opportunity to promote psychology. A phone call or a letter was all that was required to make the change. Our section's plan is to develop and promote a list of advocacy efforts.

Continued on next page

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Continued from page 1

Chairs Message

Kerry Mothersill has been seeking examples from our membership and has an article in this issue of the newsletter. Please contact Kerry with any additional ideas to enhance further our list (Kerry.Mothersill@CalgaryHealthRegion.ca).

I want to take this opportunity to thank the members of the executive (Mike Coons, David Dozois, Susan Graham, Catherine Lee, and Kerry Mothersill) for their work over the past year. Mike is our student representative - our section membership's decision at the last AGM to include a student as a full member of the executive was an excellent move. I also want to acknowledge the long-term commitment of our newsletter editors, Keith and Deborah Dobson, and our web master, David Hart. Your efforts are much appreciated.

David Hodgins

Physical Punishment of Children: A Psychological Perspective

Catherine Lee, PhD.

In the summer of 2003, following consultation with the Sections on Clinical Psychology and Developmental Psychology, the Canadian Psychological Association endorsed the Joint Statement on Physical Punishment prepared by the Coalition on Physical Punishment of Children on Youth (for the full text see: http://www.cheo.on.ca/english/pdf/joint_statement_e.pdf).

The January 30th 2004 decision by the Supreme Court of Canada on Section 43 of the Criminal Code (http://canada.justice.gc.ca/en/news/fs/) has once again focused media attention on the issue of physical punishment of children. Reaction in newspapers and on-line media highlight the importance of the issue for Canadian parents. Pro-spanking commentators have equated an anti-spanking position with permissive parenting in which no limits are set for children and youth. Advocates of a ban on spanking note that the use of physical punishment increases the risk of child abuse.

Legal Status of Physical Punishment

Although eleven countries have banned the use of physical punishment, in both Canada and the United States parents are permitted to punish their children physically, as long as they do not inflict physical harm. The recent Supreme Court of Canada decision placed further restrictions on the use of physical punishment, setting age limits, banning the use of objects, and indicating that parents should not punish children in anger.

Research on Physical Punishment

In the debate around spanking there is controversy as to whether the burden of proof should rest with advocates, (i.e., for spanking to be condoned there must be evidence that it is beneficial), or with critics (i.e., for spanking to be banned there must be evidence that it is harmful). Another controversial issue relates to whether short or long-term outcomes should be evaluated. Critics of physical punishment consider that the use of force to ensure compliance in children lays the foundation for the use of force to resolve any kind of dispute (e.g., Hyman, 1995). Advocates of physical punishment see it as an effective child management tool when applied appropriately in the context of a loving relationship.

Research on the effects of physical punishment on children is notoriously difficult to conduct. First, ethical issues preclude random assignment to groups, so that groups that differ in terms of using or not using physical punishment also differ in terms of other variables that are highly salient to child adjustment such as socioeconomic status, ethnicity, and parental psychopathology (Belsky, 1993; Parke, 2002). Second, research in this area relies on self-report. This means that our knowledge of the extent of the use of physical punishment is based on parents' accounts of the behaviours in which they engage. Psychologists are familiar with the effects of social desirability on reports of the frequency with which we engage in socially undesirable activities.

Two recent reviews have examined the weight of evidence on the effects of physical punishment on children. Larzelere (2000) reviewed 38 studies of nonabusive and customary spanking of pre-adolescent children. He found consistent evidence that spanking was effective in obtaining immediate compliance. The greatest effects were obtained in children under age 6. In five out of 8 longitudinal studies that controlled for the effects of initial child misbehaviour, physical punishment had detrimental effects on child adjustment (e.g., externalizing problems, mental health problems, lower competencies).

In a meta-analysis of 88 studies on corporal punishment Gershoff (2002) concluded that parental corporal punishment and parental physical abuse are strongly linked. Gershoff reported that spanking frequency is positively related to child aggression and misconduct. Critics noted that Gershoff included in her meta-analysis under the umbrella of corporal punishment studies that included extreme abuse, thus attributing to all physical punishment negative effects that may only be attributable to severe abuse (Baumrind, Larzelere, & Cowan, 2002).

Benjet and Kazdin (2003) distinguished between three positions with respect to spanking: 1) violence begets violence—this is essentially a moral position that is backed by research that includes abusive behaviour in the definition of physical punishment; 2) mild or occasional spanking may not be harmful under some conditions—this position examines the context of spanking, taking into account parenting context, ethnicity and culture; this position does not lead to blanket condemnation but to guidelines of ways to ensure physical punishment is used in a non-abusive way; it notes that occasional physical punishment delivered in a non-impulsive way may not have harmful effects; 3) the view that to spare the rod is to spoil the child—this is a moral position that is not supported by research. Gershoff's review is consistent with the position that violence begets violence whereas Larzelere's is consistent with the view that mild or occasional spanking may not be harmful. Each reviewer's position with respect to spanking guided the criteria by which they selected studies for the review. Larzelere restricted his review to nonabusive spanking, whereas Gershoff included in her review a range of physical punishments including both mild and abusive behaviours.

Despite the differences in the reviews, Benjet and Kazdin identified important points of convergence: a) immediate compliance follows corporal punishment; b) age moderates the effects of spanking: short-term compliance effects are found in children under 6 and the clearest evidence of negative effects is in children aged 10-12; and c) frequent punishment is associated with negative outcomes such as externalizing problems, mental health problems and lower competencies. Benjet and Kazdin recommended that efforts should focus on promoting positive parenting as an alternative to spanking.

Continued on page 4

Continued from Page 3

Frequency of Use of Physical Punishment

In a Gallup survey in the US, Straus and Stewart (1999) found that 74% of parents with children under 17 use spanking as a discipline technique. No comparable Canadian data from a national sample are available. A recent small scale Canadian study found that 75% of student and community participants reported having been punished physically during childhood and 40% viewed physical punishment as a necessary means of discipline (Ateah & Parkin, 2002). The proportion of parents who view physical punishment as effective has declined over recent years. The fact that high numbers of parents report using physical punishment, even though they may see it as a last resort is a compelling case for the need for parent education on alternatives to physical punishment.

The argument that widespread engagement in an activity is an indication it should not be banned has been introduced as an obstacle to many public health initiatives and has been raised in the context of the discussion of physical punishment. However, despite initial objections to seat-belt laws, by-laws requiring the use of bicycle helmets, and restrictions in smoking in public places, legislation in combination with public education campaigns have been effective in ensuring widespread adoption of these practices.

CPA'S Public Statements

In the last twenty years, the Canadian Psychological Association has made a number of public statements on social issues of relevance to the science and practice of psychology (http://www.cpa.ca/documents/policy.html). These public statements are based on CPA's ethical principles and on psychological science and have taken an authoritative stance on controversial issues such as child care, the death penalty, violence against women, equality for lesbians, gay men, their relationships and their families, and convictions based solely on recovered memories. At its March 2004 meeting, the Board of CPA approved in principle the following Public Statement on *Physical Punishment of Children and Youth* proposed by the Executive of the Section on Clinical Psychology.

Physical punishment has been consistently demonstrated to be an ineffective and potentially harmful method of managing children's behaviour. It places children at risk of physical injury and may interfere with psychological adjustment. It is therefore recommended that the following steps be taken. First, to reduce the prevalence of physical punishment of children and youth, public awareness campaigns must deliver a clear message that physical punishment may place children at risk of physical and psychological harm. Second public education strategies that increase Canadians' knowledge of child development should be supported. Third, evidence-based programs for developing parenting skills should be supported.

The Executive of the Clinical Section believe that a Public Statement will promote knowledge in this area and will contribute to the protection of children and the well-being of families. The availability of a Public Statement on Physical Punishment on the website of the Canadian Psychological Association reflects a commitment to promoting evidence-based parenting programs.

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Recent Advances and Future Directions in the Treatment of Anxiety Disorders

Martin M. Antony, Ph.D.

Over the past few decades, effective treatments have been developed for all of the anxiety disorders. There are now multiple controlled trials showing that cognitive-behavioural treatments reduce symptoms associated with anxiety disorders, and a large number of medications have also been found to be useful. The purpose of this brief article is to summarize current treatments for anxiety disorders and to propose some areas for future research on this topic. A list of recommended recent books is provided at the end.

Current Treatments for Anxiety Disorders

Established treatments for anxiety disorders differ somewhat across anxiety disorders, though they share many features as well. A summary is provided below for each of the major anxiety disorders.

Panic disorder and agoraphobia. Most evidence-based psychological treatment protocols for panic disorder include psychoeducation, cognitive restructuring, exposure to feared situations (i.e., in vivo exposure), and exposure to feared sensations (i.e., interoceptive exposure). Breathing retraining (a relaxation technique involving teaching clients to breath more slowly) is also sometimes included in the treatment, though recent studies have questioned whether it contributes significantly to outcome. With respect to medications, controlled trials support the use of Selective Serotonin Re-Uptake Inhibitors (SSRIs), tricyclic antidepressants (in particular imipramine and clomipramine), certain other antidepressants (e.g., venlafaxine, phenelzine), and benzodiazepines (e.g., alprazolam, clonazepam). In addition, the antidepressant mirtazapine and the herbal supplement Inositol (a variant of glucose) have each been shown in one study to be as effective as an SSRI for treating panic disorder. Combinations of CBT and medication are useful, although evidence regarding whether combined treatments work any better than individual therapies is mixed.

Social phobia. Standard psychological treatments for social phobia include education, cognitive restructuring, exposure to feared situations, and role play exposure simulations. Some studies have also included social skills training, though it appears that this component is not necessary for a successful outcome in most cases. Effective medication treatments include SSRIs, venlafaxine, phenelzine, and benzodiazepines (e.g., clonazepam, alprazolam). There are no methodologically sound published studies on combining medication and psychological treatment for social phobia, though several such studies are near completion.

Obsessive compulsive disorder (OCD). Traditionally, psychological treatment of OCD has involved exposure to feared situations, objects, and thoughts, combined with prevention of compulsive rituals. Recently, however, investigators (including teams at the University of British Columbia and the Centre for Addiction and Mental Health, in Toronto) have begun to examine the use of cognitive therapy for OCD, and results have been promising. Effective medication treatments for OCD include the SSRIs and clomipramine. One study found venlafaxine to be as effective an paroxetine (an SSRI), and one uncontrolled study supported the use of St. John's Wort, an herbal supplement. In clients with poor insight, delusional symptoms, or a treatment refractory course, combining an SSRI with an antipsychotic medication may be useful.

Posttraumatic stress disorder (PTSD). A number of psychological approaches to treating PTSD have emerged over the past few years. Exposure-based treatments include confronting feared situations and exposure in imagination to feared traumatic memories. Treatment from an anxiety management perspective (e.g., cognitive restructuring, relaxation training) is another approach that has been found to be useful. Often treatment includes elements of both approaches. Research also supports the use of medications, including the SSRIs, venlafaxine, mirtazapine, and imipramine.

Generalized anxiety disorder (GAD). Most studies involving psychological treatment for GAD have included education about the nature of anxiety, cognitive restructuring, progressive muscle relaxation, or some combination of these approaches. Michel Dugas and his colleagues at Concordia University have developed a treatment that emphasizes teaching clients to tolerate uncertainty in their lives. In addition, investigators are now studying the benefits of other treatment strategies, including problem solving training, prevention of safety behaviors, mindfulness meditation, and exposure to feared imagery. With respect to medications, the SSRIs, venlafaxine, imipramine, certain benzodiazepines (e.g., diazepam, lorazepam), and buspirone have all been found to reduce GAD symptoms in controlled trials.

Specific phobia. The treatment of choice for specific phobias is *in vivo* exposure to feared objects or situations. There is also recent evidence supporting the use of computer-generated, virtual reality exposure for certain specific phobias, including phobias of heights and flying. In the case of blood and needle phobias, exposure is often combined with muscle tension exercises, which prevent fainting during the exposure practices. Although there are no established medications for specific phobias, preliminary studies suggest that some of the medications that work for panic disorder may also be useful for people with "situational" specific phobias (e.g., fears of driving or flying).

Continued on page 6

Continued from Page 5

Now that effective treatments for anxiety disorders are well established, researchers have begun to turn their attention to refining and expanding upon what we know about anxiety and its treatment. Some areas that are now under investigation, or are likely to be topics of future research include:

- Identifying methods of predicting who is likely to respond to one type of treatment versus another
- Learning more about heterogeneity within DSM-IV anxiety disorder categories in order to develop more refined treatments to target the symptoms of particular clients
- Developing strategies for treatment resistant cases (e.g., strategies for improving motivation for treatment, improving compliance, preventing relapse, and targeting more complex symptom profiles)
- Identifying the best ways to combine different treatment strategies (e.g., which strategies should be combined, and in what order should they be administered)
- Application of established anxiety treatments to related problems (e.g., body dysmorphic disorder, perfectionism, hypochondriasis)
- Developing more cost effective treatments (e.g., telephone administered treatments, teleconferencing, self help treatments, internet-based treatments, peer-administered treatments, group treatments, etc.)
- Understanding the effects of treatment on special groups (e.g., children, older adults, cognitively impaired individuals, culturally diverse groups)
- Understanding which elements of treatment are most important

Conclusion

Perhaps the time has come to begin to conceptualize anxiety disorders in terms of the most important dimensions that are either shared across disorders, or that distinguish among disorders. Treatments could then be developed to include modules targeting the core dimensions, such as fear, anxiety, avoidance, and behavioral excesses (e.g., compulsions), as well as secondary dimensions such as insight, anxiety sensitivity, skills deficits, and the context in which the symptoms occur (e.g., family factors). A dimensional approach to understanding and treating anxiety disorders would circumvent the need to sort people into diagnostic categories that often don't fit. A dimensional approach to understanding and treating anxiety disorders could also take into account factors such as comorbidity, motivation, and other variables that may affect the outcome of treatment.

Recommended Readings

Antony, M.M., & Swinson, R.P. (2000). *Phobic disorders and panic in adults: A guide to assessment and treatment*. Washington, DC: American Psychological Association.

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Note: This article is based on an invited address by the author at the 2003 meeting of the Canadian Psychological Association in Hamilton, Ontario, entitled "Recent Advances in the Treatment of Anxiety Disorders."

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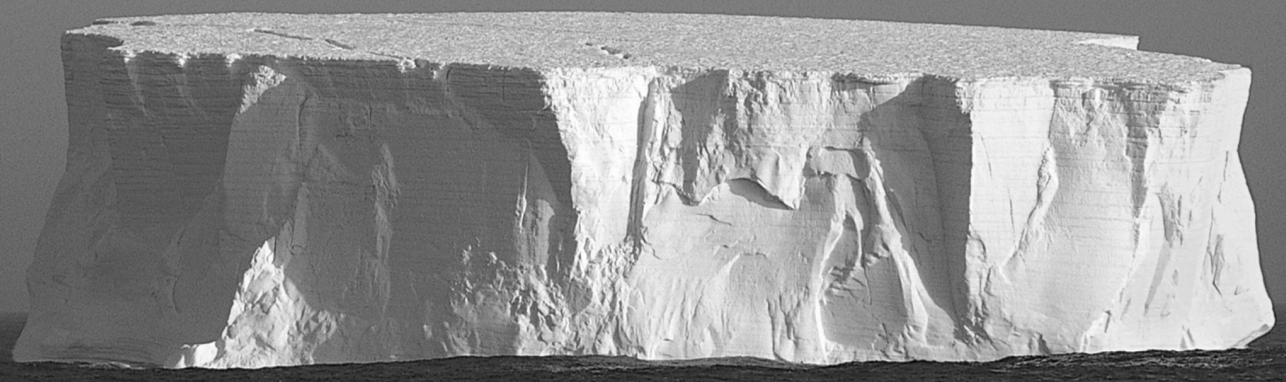

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CPA Section on Clinical Psychology
Unapproved Minutes of the Executive Committee
(Summary)
Mid-Winter Meeting, January 31st 2004

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

Secretary-Treasurer's Report

Financial report: Catherine presented the financial statement which is appended to the minutes. There is presently $5,072.68 in chequing and $3,906.77 in GICS. The GICs mature in February and March 2004. It was decided that we should reinvest the GICs. Once information is received about possible terms, we will confirm the preferred term via email. ACTION: Catherine

Membership: In January 2004, there are 146 student members and 349 non-student members of the section, for a total of 495 members. CPA confirmed that membership fluctuates over the years, it is lowest in January and increases throughout the year. So although 495 is below our 2003 end of year figure of 612, it is above our January 2003 figure of 459. Catherine reported that of the 146 student members, there are several who have graduated in recent years. According to CPA, student members are required to produce proof of student status at the time of their first registration with CPA. After that, CPA operates on an honour system, by which individuals are expected to inform CPA of their transition to non-student status. CPA has a policy of allowing graduates to continue paying student fees for one year if they are in a post-doctoral fellowship. In addition, CPA allows those in post-doctoral respecialization programs in clinical psychology to pay student fees. CPA is considering placing a notice in *Psynopsis* reminding students that they are expected to transfer their status on graduation. It was agreed that a letter will be sent to CPA expressing support for CPA taking action to remind student members of the necessity to change their status on graduation. A copy of the Clinical section letter to CPA will be sent to all section chairs. ACTION: David H & Mike.

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

Submission and review process: David D. reported that 116 submissions were received on-line. These included 6 conversation sessions, 2 theory review sessions, 91 posters, 14 symposia, and 3 workshops. Three submissions were rejected on the basis of poor scientific merit. The reviewers for the Clinical section submissions were: Graham Reid, Peter Hoaken, Rod Martin, Tavis Campbell, and Kristin Von Ranson. Catherine Lee and Susan Graham had agreed to review the French abstracts, but none were submitted.

David D. reported that notices of acceptance should be sent out by CPA in the near future. It was agreed that timely notification should be a priority and that this issue will be raised at the meeting of Chairs of Sections. ACTION: David H. We discussed issues related to on-line submission. CPA will be contacted to explore the possibility of submitting proposals for invited speakers via a different system. ACTION: David H.

David H. presented the clinical section program. Once CPA has established the conference schedule, it will be possible to assign responsibilities for introducing Clinical section presentations. We agreed to do this at the spring teleconference call.

Ken Bowers Award submissions: A list of student members will be sent to David D. who will contact those students whose submissions have been accepted, inviting them to submit a paper for the Ken Bowers award. ACTION: Catherine to send list; David D. to contact students.

Advertising for Pre-convention workshop: Announcements will be sent to addictions facilities as well as to the Newfoundland Psychological Association. ACTION: David H.

Section Activities

Student Member process: We reviewed the process decided at the 2003 ABM and agreed that the budget for the mid-winter meeting in 2005 should be adjusted accordingly. ACTION: Catherine

Call for Fellows: David D. reported that the call for Fellows was sent out in the fall. It was agreed that we will review submissions in the spring teleconference.

Revisions to descriptions of the roles of members of the executive: David H. distributed copies of the most recent descriptions of roles of the members of the executive. As the decision to include a Student representative was made at the 2003 ABM, no role description has yet been prepared. *Secretary-Treasurer:* It was agreed that the role of distributing minutes outside the section should be given to the newsletter. *Chair:* It was agreed that the duty of organizing pre-convention workshop will be shifted to the Member at Large to avoid scheduling conflicts with the Chairs of Sections business meeting. It was also agreed that each member of the Executive will review the description of his or her role and will distribute an electronic copy to members of the executive. ACTION: All members of the executive.

Media requests from CPA head office: David H. reported that media requests are regularly received from CPA and that we have been able to respond to many of these by identifying an appropriate member of the Clinical section. We agreed that facilitating media requests is an important public service as well as an advocacy activity. We agreed to publicize the media requests we have responded to in the report from the Chair in the newsletter. ACTION: David H.

It was agreed that members of the previous executives of the clinical section will be contacted about their willingness to receive media requests ACTION: David D.

Continued on page 9

Continued from page 8

Nominations for designated positions on the CPA board: David H. reported that sections are encouraged to make nominations for designated board positions. This process takes place in mid-July. We discussed strategies for identifying potential nominees. We agreed to discuss this issue in greater detail in the spring teleconference.

Section Projects

List Serve Update: Catherine reported that the List Serve continues to be used infrequently. We discussed various types of information it would be valuable to distribute via the listserve. We agreed to a one-year trial of posting Canadian job announcements. Those submitting job announcements will be asked to label the *Subject line: position opening at…..* We will review this in a year. ACTION: Catherine

Clinical Section Brochure: It was agreed that the Clinical Section Brochure should continue to be posted on the section website.

Fact Sheet Update: Susan distributed an update of factsheets that have been completed and those that are in preparation. In addition we agreed that factsheets should be solicited on the following topics: Male sexual dysfunction, Fire starters, Working with refugees and victims of torture, Bipolar disorder, Coping with family member with psychopathology, Evidence-based treatments. ACTION: Susan. We agreed to send a message through the listserve announcing that factsheets are available and listing topics. ACTION: Susan. We discussed ways to determine the usefulness of factsheets by determining the extent to which they are accessed and by inviting feedback from section members. First, we will ask CPA whether there are data on the number of hits on the factsheets. ACTION: Susan.

Members who have not renewed for 2004: Catherine reported that CPA provided data indicating that membership renewals take place from December-March. It was agreed that we will send reminder notices to lapsed members in April. A list of lapsed members will be prepared in April. ACTION: Catherine.

Psynopsis Submission: It was agreed that the submission will focus on the upcoming conference, highlighting the Master clinician presentation. In addition, the availability of the factsheets will be noted. ACTION: David H.

Spring Newsletter

We discussed the challenges encountered in emailing newsletters and the costs of mailing. A comparison of advertising revenues ($600.00) vs. printing and mailing costs (fall newsletter: $1478.23) indicates that the newsletter is consuming a significant proportion of the budget that might otherwise be directed to supporting student involvement or in advocacy activities. It is assumed that many members would be willing to receive the newsletter electronically if it does not take too long to download. We recognized that some members may prefer to receive a hardcopy. We could invite members to contact us if they prefer to have a hard copy mailed to them. We agreed to discuss the issue in the spring teleconference with Keith Dobson. ACTION: David H & Susan.

Advocacy Work Update

Kerry reported he is scheduled to attend the Health Care Middle Management conference in Toronto on April 21st 2004. He will make a presentation on cost effectiveness of psychological services within health care teams.

7. Internship Stipend Update

Mike reported on the large range of internship stipends across Canada. The average stipend for psychology interns in Canada is $25,000. CCPPP has identified this as a priority. We talked about the complexity of the issue and possible ways that programs could support students in the application process such as by providing facilities for videoconferencing for interviews or by travel allowances. It was agreed that the Clinical section executive would recommend to the CCPPP Task Force that they seek data from CPA on levels of funding that students receive during their programs to enable comparisons with internship stipends. ACTION: Mike

8. Strategic Planning

Travel bursaries for students: We discussed the possibility of offering travel bursaries. We will discuss this further at the spring teleconference.

CPA Website: There was general agreement that there could be greater use of the CPA website as well as support for CPA's review of the website. We agreed that it would be beneficial if the list of accredited programs and internships included links to those programs and internships. We will communicate with Dr. Hanigan. ACTION: David H. It will also be raised at the Section chairs meeting. ACTION: David H.

Advocacy: We discussed strategies to enhance the profile of psychology. We discussed both national strategies and lobbying that could be carried out by CPA as well as small initiatives that individual members have employed at a local level. We agreed to discuss with the editors the possibility of having a special issues on advocacy included in the Newsletter. ACTION: David H. We agreed to use the listserve to soliciting information from members on ways they have promoted a positive image of psychology. ACTION: Kerry. We agreed that a suggestion sheet could be developed which would be distributed at conference and possibly through Newsletter. This will be discussed further at the spring meeting. ACTION: David D.

9. Spring Teleconference

The spring teleconference is confirmed for April 26th from 10-12 MST 2004.

10. New Business

Canadian Health Services Foundation awards: David H. reported that CPA has circulated calls for nominations for Canadian Health Services Foundation awards. We agreed to make nominations for this award.

Post-doctoral position in gambling research project: David H. announced a Post-doctoral position coordinating a new gambling research project.

Respectfully submitted.
Catherine Lee, PhD.
Secretary Treasurer.

Small Steps Promote Psychology

Kerry Mothersill, Ph.D.

At times, large effects can be achieved with relatively small interventions. The following describe ways in which individual psychologists have taken steps to promote the profession.

Lesley Graff noted that the Psychology program within the Winnipeg Regional Health Authority has revised all of the CPA fact sheets (as organized by the Clinical Section) into pamphlet format (with CPA's blessing). Multiple copies are printed and made available in the psychology waiting areas at the 7 hospitals within the Region. They will also be sent to family physicians for their information.

Bruce Hutchison's letter to *Maclean's* magazine advocating for psychology appeared in the December 22, 2003 issue. He had responded to an article lamenting the shortage of physicians. In the letter, Bruce pointed out that general/family physicians spend much time providing counselling and psychotherapy. However, psychologists are more highly trained in providing this health service. Coverage of psychologists' services on provincial health care plans may result in physicians having more time to provide medical care and reduce the need to recruit more physicians.

Jean Seguin advised that Rose-Marie Charest, the president of the Ordre des Psychologues du Québec (http://www.ordrepsy.qc.ca/public/joindre/08contact.asp), is on air once a week (Tuesdays AM) at the top French morning show in Montréal (Radio-Canada, program C'est bien meilleur le matin, 95.1 FM, http://radio-canada.ca/radio/bienmeilleur/ see the 7:51AM item - will be accessible in audio format after 10AM via the web). She appears on two or three occasions for about 5 minutes each time. On the show, she addresses current issues and talks about everyday concerns.

Ian Schulman indicated that he has given talks in the community over the past few years to promote the discipline as well as his practice. Issues that he has covered have included managing stress in the workplace (to teachers) and the stresses (and joys) of raising a special needs child (to a regional Down's Syndrome support group). He is planning to address high school students about thinking and questioning (i.e., cognitive restructuring basics) to help inoculate against later problems. In addition, a connection has been made with a local GP to join her in a peer support and supervision group to be attended by physicians and professionals.

Sandra Byers reported that over the past several years a small prize has been established and funded at the local high school for a graduate who is planning to go into psychology.

Perhaps these or similar initiatives can be replicated in your area. The examples may serve to stimulate additional ideas for promoting psychology at the local level. More examples of local initiatives and projects would be welcome! Send them to kerry.mothersill@calgaryhealthregion.ca .

Submissions Invited

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

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

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

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

Editors:

Deborah & Keith Dobson
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A Dialectical Approach to the DBT Outcome Literature

Martin C. Scherrer, M.A.
Clinical Psychology Graduate Student
The University of Calgary

Dialectical behavior therapy (DBT) has enjoyed a substantial growth in popularity since its introduction in the late 1980s (Linehan, 1987), resulting in a common perception of DBT as the optimal cognitive-behavioral intervention for borderline personality disorder (BPD). Yet, some commentators have begun to question the general—and oftentimes uncritical—enthusiasm for the approach, which points to the crux of the issue: a gap between the available data on the efficacy of DBT and the conclusions that have been drawn from them (Westen, 2000).

Increasingly, the empirical basis of DBT has come under scrutiny, and shortcomings within the available outcome literature have informed the conclusion of one recent reviewer that, in fact, "the jury is still out on DBT" (Scheel, 2000, p. 82). Given the already widespread and growing popularity of DBT, careful and critical examination of the evidence for its efficacy is clearly warranted. Reviewing the available DBT outcome literature serves to elucidate numerous strengths and weaknesses, which in turn point to a number of areas ripe for future research.

Dialectical Behavior Therapy (DBT)

Evolved from standard cognitive behavioral therapy (CBT) but drawing on a range of theoretical (e.g., dialectical philosophy, Zen practice) and therapeutic (e.g., psychodynamic, cognitive, client-centred) positions, DBT is predicated on Linehan's biosocial theory of borderline personality disorder, which suggests that the disorder represents primarily a dysfunction of the emotion regulation system (e.g., Linehan, Cochran, & Kehrer, 2001). Treatment proceeds through a number of stages, and is delivered through four distinct modes, including individual therapy, psycho educational group sessions, phone consultation with the therapist, and regular therapist supervision/consultation. Dialectic strategies permeate therapy and essentially involve advocating a "middle path" in opposition to extremes and rigidity in behavior and thought. This dialectical approach is further reflected in the balancing of the core strategies of validation (an acceptance strategy) and problem solving (a change strategy).

Though necessarily brief, the preceding outline of DBT does reflect its central emphasis on balance in favor of extremes. The primary texts on DBT, Linehan's 1993 treatment manual, Cognitive-Behavioral Treatment of Borderline Personality Disorder, and the accompanying Skills Training Manual for Treating Borderline Personality Disorder, provide significant coverage of both the theory and therapy of DBT.

Examining the Efficacy of DBT for BPD

Pivotal to the establishment of the efficacy of DBT are a number of reports published by Linehan and colleagues (Linehan et al., 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994) based on the first randomized clinical trial to compare DBT to treatment as usual (TAU) in treating BPD.

Linehan et al. (1991) compared DBT to TAU in a group of 44 randomly assigned women with BPD. DBT was delivered in manualized format and supervised by Linehan herself, who trained all therapists, reviewed audiotapes of sessions, and conducted the weekly supervision meetings. TAU consisted of referral to a range of alternative therapies, treatment for both conditions lasted for one year.

Three major findings emerged from this study: a significant reduction in the frequency and medical risk of parasuicidal behavior, significantly lower attrition, and significantly fewer days of inpatient psychiatric hospitalization among those receiving DBT compared to controls. No differences were observed between groups for patients' depression, hopelessness, suicide ideation, or reasons for living, indicating that while DBT appeared to be effective in reducing behaviors common to borderline patients, it did not appear to ameliorate the underlying symptoms such as hopelessness or suicide ideation that may give rise to them.

Employing the same sample, a similar finding is reported in a 1994 study carried out by Linehan and colleagues that examined a range of interpersonal outcome variables. Despite improved ratings of adjustment compared to TAU, DBT patients displayed no gains in general satisfaction which, along with the finding of clinically significant scores on measures of depression, hopelessness, suicidal ideation, and reasons for living for both DBT and TAU groups in the 1991 outcome study, is taken by these authors to suggest that "subjects in the dialectical behavior therapy group acted better but were still miserable" (p. 1775).

One limitation of the 1991 Linehan et al. study is its lack of follow up beyond treatment completion, which was later addressed by these investigators. Linehan et al. report significantly higher ratings of employment performance and global adjustment among DBT completers over the year of follow-up; superiority of DBT for measures of parasuicidal behavior, anger, and self-report social adjustment over the first six months; and

Continued on page 12

Continued from page 11

superiority of DBT for inpatient days and interviewer-rated social adjustment during the last six months. No significant difference was observed between groups on parasuicidal behavior during the second half of the follow-up, suggesting that DBT "may not be "sufficient for long-term 'cure'" (1993, p. 974).

While they do provide support for the efficacy of DBT, the three studies carried out by Linehan and colleagues are not without limitations, both individually and as a group. In addition to such factors as sample size and homogeneity as possibly limiting the generalizability of the results, other issues that have been raised in reviews of the outcome literature include the lack of experimental control for treatment hours in DBT versus TAU; high levels of training, supervision, and motivation among DBT therapists; and the pervasiveness of Linehan herself throughout much of the available research on DBT, which raises the possibility of inadvertent experimenter bias (Scheel, 2000).

Studies examining the efficacy of DBT from alternative researchers, however, have begun to appear in the literature as well. In the United States, Koons et al. (2001) compared DBT to TAU among a sample of 20 women with BPD treated within the VA system. Major findings were generally consistent with those of Linehan and colleagues, and indicated the efficacy of DBT compared to TAU on a number of variables. Unlike Linehan et al. (1991), these researchers also found that DBT was superior to TAU on depression, hopelessness, and suicidal ideation, which may reflect this study's less behaviorally extreme sample.

Similarly, in Europe, a recent randomized clinical trial conducted in the Netherlands found a significantly lower attrition rate and greater reduction in self-mutilating behaviors and self-damaging impulsive acts among DBT patients versus TAU (Verheul et al., 2003). Both the Koons et al. and the Verheul et al. studies are important in providing further evidence for the efficacy of DBT that moves beyond Linehan's limited sample of severely dysfunctional women and Linehan's body of research itself. Both, however, are also limited in terms of their comparing DBT with TAU, which precludes conclusions regarding the effect of DBT compared to other manual-based approaches.

Koerner and Linehan (2000) discuss a number of studies that have moved beyond a TAU design in order to compare DBT to more rigorous control conditions. For example, Linehan and her colleagues have compared DBT to treatment by experts in the community (TBE), with results generally favoring DBT in terms of reduction of suicidal behaviors, higher treatment retention, and decreased hospitalization. Such findings are clearly important not only as further evidence for the efficacy of DBT, but also in their ability to rule out alternative explanations for effects observed, such as differences in availability of services or therapist factors, across treatment conditions.

In the first experimental test of DBT-oriented treatment to employ a comparative psychotherapy condition, Turner (2000) compared modified DBT to client-centred therapy (CCT) treatment. Results generally supported the superiority of DBT over CCT on a range of behavioral and emotional indices. This study is limited, for example, by its small sample size and lack of a control condition. However, it not only cross-validates earlier research such as that carried out by Linehan and colleagues, but also represents an important step in research on the efficacy of DBT in its comparison of DBT not simply to TAU but to another psychotherapeutic approach.

Taken together, findings from Linehan and colleagues, from other researchers both within the United States and in Europe, and from studies that have compared DBT to alternative forms of psychotherapy, though not without limitations, provide compelling evidence for the efficacy of DBT in outpatient treatment of BPD, with more recent outcome studies beginning to address some of the limitations of prior ones.

DBT for BPD with Substance Abuse

As many as 67% of individuals with BPD also meet criteria for a current substance abuse disorder (Linehan et al., 1999), and researchers have recently turned their attention to the efficacy of DBT in treating this population.

Linehan et al. (1999) recently reported results of a randomized clinical trial that examined the efficacy of modified DBT compared to TAU in treating 27 drug-dependent women with BPD. Major findings included a significant reduction in substance abuse, a significantly higher retention rate, and significantly greater improvements in social and global adjustment at follow-up, among DBT versus TAU patients. A number of limitations (e.g., differences in therapist adherence to DBT, DBT patients receiving more treatment than TAU) notwithstanding, this study's results are promising nonetheless.

Dimeff, Rizvi, Brown, and Linehan (2000) recently described a pilot study that employed a modified DBT protocol for treating methamphetamine-dependent women with BPD. While only two participants completed treatment and all assessments, the results were encouraging and included a steady decline in drug use over time, abstinence by six months, and lack of suicide attempts over the 12-month assessment period.

In the first study to examine the influence of comorbid substance abuse on the efficacy of standard DBT on borderline symptomatology, van den Bosch, Verheul, Schippers, and van den Brink (2002) found standard DBT to be as effective, when suicidal and self-destructive behaviors are the focus of treatment, for substance abusing BPD patients as for non-substance-abusing ones. However, standard DBT was found to be no more effective in reducing substance use problems than TAU. Thus, it appears that DBT must be modified from its standard format in order to have an impact on substance use behaviors.

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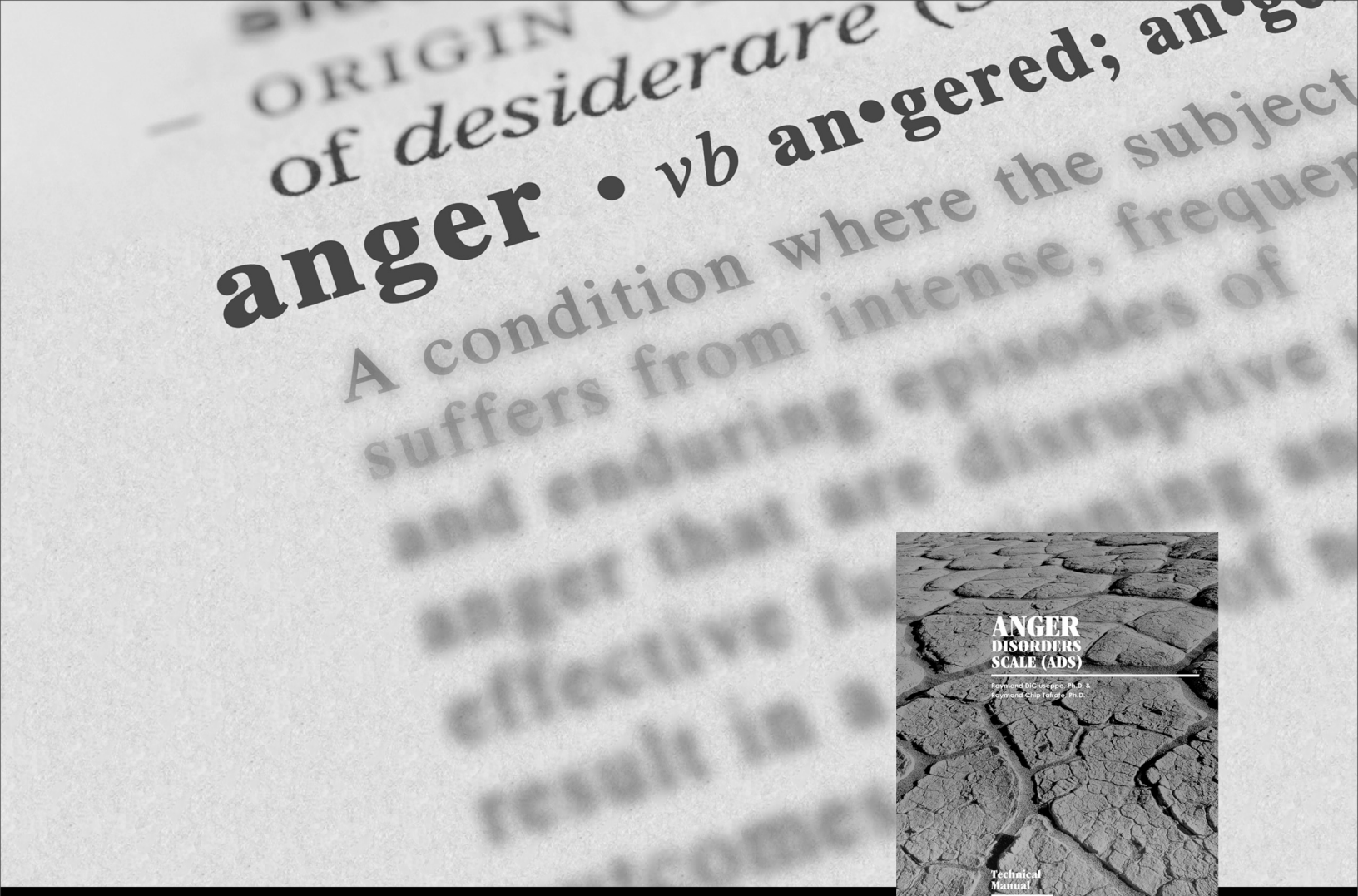

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Continued from Page 12

DBT for Eating Disorders

Difficulties in affect regulation, viewed as central to DBT theory of BPD, have also been proposed for eating disorders such as bulimia nervosa (BN) and binge eating disorder (BED; Safer, Telch, & Agras, 2001). Consequently, it would be expected that DBT, an approach that specifically targets emotion regulation, might show promise in treating such disorders, an assumption that has recently received increasing attention.

Telch, Agras, and Linehan (2001) recently examined the efficacy of modified DBT that emphasized adaptive emotional regulation skills compared to wait list control with a sample of 44 women with BED. Major findings included significant improvement among the DBT patients compared to controls on measures of binge eating and eating pathology. No significant differences on measures of weight, mood, and affect regulation, however, were observed between treatment conditions, a finding that is similar to other reports of DBT as effective in reducing particular behaviors, but not in altering underlying mood.

Similar results were reported in the first randomized controlled study to examine the efficacy of DBT in treating bulimia nervosa (BN). Safer et al. (2001) compared a modified DBT intervention consisting of 20 weekly individual sessions focusing on emotion regulation skills to wait list control, and reported a significant decrease in rates of binge eating and purging among DBT treatment completers. However, no significant differences between treatment conditions were observed on measures of mood, self-esteem, positive and negative affect, and anger.

As with research on DBT applied to substance abuse, results from studies examining its efficacy in treating eating disorders are promising. Yet, clearly, BPD becomes all the more complex in the presence of comorbid conditions such as substance abuse or eating disorder. While much of the available evidence suggests the efficacy of DBT in treating such populations, enthusiasm for its application must be tempered with caution in that the research base is clearly in its infancy, and much further work is warranted.

Concluding Comments

"DBT's empirical base," it has been noted, "is both slim and impressive: slim when considered against its already substantial dissemination into clinical practice, and impressive when considered against the relative absence of published empirical exploration of any alternative treatment to date" (Swenson, 2000, p. 87). A range of factors may contribute to the popularity of DBT, including the substantial "cost" of BPD itself, which makes any treatment for it particularly appealing, and its offer of pragmatic help within a comprehensive treatment model geared toward long-term recovery (Swenson, 2000). Undoubtedly, the current popularity of DBT will continue to grow; hopefully, the research base can keep pace.

We can take a cue from Linehan's DBT itself in terms of adopting a "dialectical approach" when evaluating the literature on DBT, one that avoids extremes and attempts to find the "middle path," one that balances acceptance with a critical eye and aims for an empirical stance regarding claims for the efficacy of this promising approach. The limitations seen in the available research discussed above are important in suggesting areas of research that warrant future attention. Such areas include more general examinations of the approach by researchers not closely affiliated with Linehan and the site of its initial development, replications of past findings with larger and more diverse clinical samples, more dismantling studies on both standard and modified forms of DBT to determine its effective features, more research on the stages of DBT, more examinations of the efficacy of DBT with populations other than individuals with BPD, more effectiveness research to determine its applicability in community settings, and more studies that move beyond the TAU design to compare DBT to other psychotherapeutic interventions. Such research would serve to further bolster empirical support for the efficacy of DBT in treating BPD and other conditions, and most likely in time support its inclusion in the category of empirically supported treatments.

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Clinical Section List Serve

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

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

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

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

CPA Invited Speaker
Patrick McGrath
FRIDAY JUNE 11, 2004, 10:00 – 11:00

"Psychosocial issues in pain in infant, child and youth health: A potpourri"

In the past fifteen years, research has transformed our understanding and treatment of pediatric pain. I will review some of the major developments in research on pain in infants, children and youth with a particular emphasis on the contributions of Canadian researchers in psychology and other disciplines.

Pain is often considered a phenomenon that is best understood at the biological level of analysis. However, psychosocial aspects of pain are critical for both the science of pain and the management of pain. Melzack, a Canadian psychologist, developed the Gate Control Theory of pain that introduced the modern era of pain research and included psychosocial inputs. More recent psychosocial models have detailed psychosocial issues.

The mapping of the prevalence of pain at all ages has clarified how common pain is. Measurement is a major challenge in pain especially in infants and young children and these challenges have led to the development of sophisticated behavioural measurement systems. The impact of pain on development, the role of families in pain, pain in different disorders and the development of psychological interventions have been the focus of well developed pain research programs.

Dr. Patrick J McGrath, OC, Ph.D, FRSC

Dalhousie University and IWK Health Centre

Dr McGrath is a Killam Professor of Psychology, and Professor of Pediatrics and Psychiatry, and Canada Research Chair at Dalhousie University where he directs the Ph.D. program in clinical psychology. Dr. McGrath is one of the world's leading researchers on pediatric pain. He has also developed a research program on distance treatment aimed at increasing access of Canadians to psychosocial health care. His pain research has been recognized by appointment to the Order of Canada (Officer) and election to the Royal Society of Canada. He has received numerous other awards including a Distinguished Scientist Award from the Medical Research Council, the Distinguished Career Award of the Canadian Pain Society, Distinguished Contribution to Psychology award from the Canadian Psychological Association, the Wilbert Fordyce Award for Clinical Research from the American Pain Society and a Bristol Myers Squibb Award for pain research. He is the Principal Investigator of the Canadian Institutes of Health Research Strategic Training Program on Pain in Child Health and has held numerous other CIHR grants as well as grants from the Social Sciences and Humanities Research Council, the Canadian Foundation for Innovation and foundations in the US and Canada. He has published over 280 articles, book chapters, abstracts, comments and editorials, 11 books and 5 internationally translated and distributed patient manuals including Pain, Pain Go Away, a booklet for parents with children who have pain and Making Cancer Less Painful. His latest professional book is Pediatric Pain, Biological and Social Context (2003) published by the International Association for the Study of Pain.

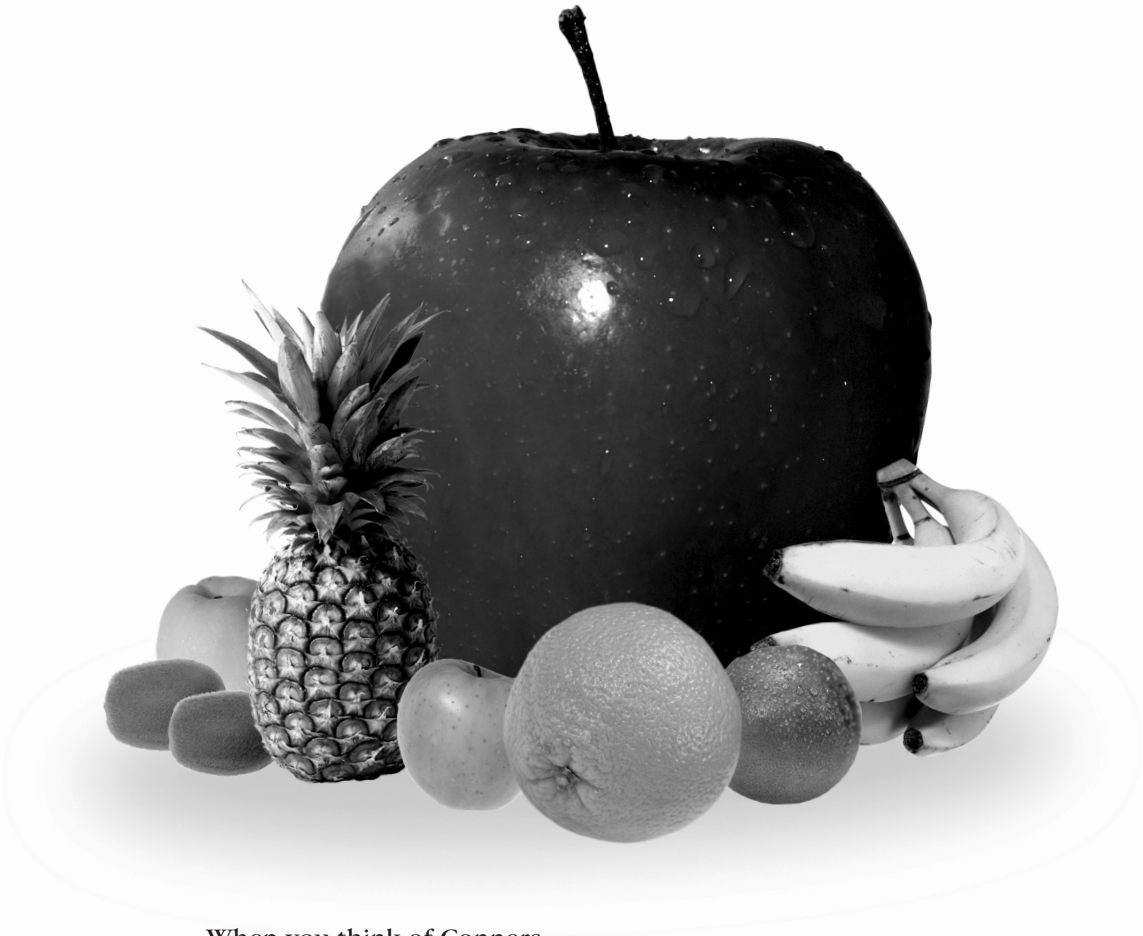
Our Thanks!

Appreciation is extended on behalf of the CPA Clinical Section to the following people, who reviewed abstracts for the 2004 CPA Convention:

- Rod Martin
- Graham Reid
- Peter Hoaken
- Kristin von Ranson
- Tavis Campbell

- David Dozois, Chair-Elect

Think Big



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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.

Please contact an MHS Client Services Specialist for a free sample report of any of the MMPI-A™, MACI™, and MAPI™ tests, or for more information on these leading assessments. Quote item# A035.

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416.492.2627 416.492.3343

CPA CONVENTION 2004

St. Johns, Newfoundland

*CLINICAL SECTION-SPONSORED EVENTS**

WEDNESDAY JUNE 9, 2004

Pre-convention workshop:
Dr. Sherry Stewart
"Substance Use Disorder Treatment and Early Intervention: Cognitive-Behavioural Strategies Matched to the Motivational Bases Underlying Substance Misuse" (9:00 AM - 4:30 PM)

CPA Clinical Section Members	$90.00 + $6.30 GST = $96.30
CPA Members	$110.00 + $7.70 GST = $117.70
Student Clinical Section Members	$50.00 + $3.50 GST = $53.50
Student CPA Members	$55.00 + $3.85 GST = $58.85
Student Non-Members	$60.00 + $4.20 GST = $64.20
Non-Members	$130.00 + $9.10 GST = $139.10

Public Lecture: Dr. David A. Clark -- "A rising tide of fear and despair: Effective psychological treatments for anxiety and depression" (7:00 – 9:00 PM)

St. Johns, Newfoundland

THURSDAY JUNE 10, 2004

11:00 – 1:00 (Workshop)
Michael Vallis "Motivational enhancement and behaviour change"

3:00 – 5:00 Clinical Posters (Session C)

FRIDAY JUNE 11, 2004

8:00 – 9:00 (Section Business Meeting)

10:00 – 11:00 (CPA Invited Speaker)
Patrick McGrath "Psychosocial issues in pain in infant, child and youth health: A potpourri"

12:00 – 1:00 (Conversation Session)
Kerry Mothersill "Preparing for your pre-doctoral internship"

1:00 – 3:00 (Workshop)
Christine Chambers "Life as an early career clinical psychologist: A how-to guide for getting started on research, teaching, and clinical practice"

3:00 – 4:00 (*Master Clinician Series*)
David A. Clark "Cognitive behavioural treatment of unwanted intrusive thoughts in anxiety and depression"

4:00 – 5:00 (Reception)
Join us for a Clinical Section reception following Dr. Clark's master clinician presentation.

SATURDAY JUNE 12, 2004

9:00 – 11:00 (Symposium)
Christine Chambers, Kenneth Craig, Patrick McGrath "Psychological aspects of pain in children"

11:00 – 12:00 (Conversation Session)
Catherine Lee "Women in academe"

*Note: Many other non section-sponsored clinical activities will also be held during the conference.

For further information about registration, go to:
www.cpa.ca