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# CLINICAL PSYCHOLOGIST

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



**Message from the Chair**

**Psychotherapy not only helps people get better, it also helps them stay better**

***Michel J. Dugas, Ph.D***.

In my final column as Chair of the Clinical Section, I have decided to address the important issue of the maintenance of treatment gains following psychotherapy. It is my belief that the prevention of relapse represents one the greatest strengths of psychotherapy. Over the past ten years, data from numerous clinical trials have shown that psychological treatments - such as those identified by the Clinical Section's Task Force on Empirically Supported Treatments - lead to impressive short and long term benefits. It is not uncommon to find that treatment gains are maintained over two years following treatment. In fact, there is now some evidence that psychotherapy can lead to positive outcomes as far as ten years following treatment for anxiety disorders.

Why does psychotherapy lead to such long standing changes? It appears that people learn many things over the course of psychotherapy. First, they learn to behave in different ways. A striking example of this is when individuals with anxiety related problems learn to approach rather than avoid anxiety provoking situations. This new way of dealing with these situations can certainly contribute to long lasting change. Second, people learn to think about situations in new ways during therapy. For instance, many people report that therapy helped them to see the "shades of gray" in many situations and helped them to better understand themselves as well as those around them. Third, people also learn to "live with" their emotions rather than seeing their emotions as something to be avoided. For example, research shows that the fear of anxiety can paradoxically lead to increased anxiety and greater discomfort. And finally, besides the behavioral, cognitive, and emotional changes described above, psychotherapy offers something else that is very important for long term maintenance: clients learn a new way to learn. They learn that their perceptions and interpretations are not facts, and that these ways of understanding can be tested in their daily lives. This new way of learning can have a profound impact on the person's problems, as many obstacles to our mental health are "artificial" and result from self-fulfilling prophecies. Although we are not yet in position to fully understand why psychotherapy leads to such long lasting change, these are just some of the many intriguing possibilities.

Why is long standing change so important? The issue of maintenance of treatment gains is obviously of the utmost importance for our clients. If we cannot offer the possibility of long term change, then clients will be caught in a never-ending cycle of seeking help for their psychological problems. But the issue of maintenance of treatment gains is also of the utmost importance for the development of our profession. In fact, long term maintenance of therapeutic gains may turn out to be clinical psychology's most important ally in its continuing efforts to take the place it rightly deserves in the Canadian health care system. The relapse of mental disorders following successful treatment is extremely costly to our health care system. Although the argument can be made that other forms of interventions can be more effective than psychotherapy in the short term, psychotherapy outshines these other therapeutic modalities in terms of its long term benefits. This important message must be heard by those shaping the future of Canada's health care system.

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## *Our Appreciation goes to....*

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**For reviewing submissions to the Clinical Section - 2002 CPA Convention in Vancouver.**

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**CLINICAL EVALUATION OF SUICIDE RISK**

Antoon A. Leenaars, Ph.D., C.Psych., CPQ

A patient committing suicide is not a rare event. Studies show that the odds are greater than 50% that a psychiatrist, and greater than 20% that a psychologist will lose a patient to suicide over the course of a career. These facts are associated with the very complexity of predicting suicide itself. It is a multidimensional event. Suicide risk assessment may well, in fact, be the most difficult clinical task psychologists, psychiatrists, and other mental health professionals face.

No one really knows how to assess suicide risk perfectly, not even my professor, Dr. Edwin S. Shneidman, a grandfather in the field, believes that he can. One of the most frequent questions asked about suicide risk is, "How do you predict suicide risk?", or, more specifically, "How do you assess and/or predict each unique individual's suicide risk?" If we are to confront this complexity, one will learn that assessment and prediction are interwoven with understanding. Let me here, in two parts (the Spring and Fall issues of our section's newsletter, Canadian Clinical Psychologist), present a few reflections on the diagnosis (understanding) of highly lethal suicidal people.

Prediction versus Assessment

In the 1960s and 1970s, there was a focus on the prediction of suicide, and suicidologists believed that it would eventually be possible to predict which individuals out of a population would ultimately complete suicide (Beck, Resnik & Lettieri, 1974)). However, it was soon realized that the statistical rarity of suicide and the imperfection of the prediction instruments led to an enormously large number of false positives, so many, in fact, that the prediction instruments were of little use to clinicians or to those planning suicide prevention services (Lester, 1974).

In the 1980s and 1990s, the focus shifted to assessment (Maris, Berman, Maltsberger & Yufit, 1992); that is, rather than predicting the future occurrence of suicide in people, the intent was to assess potentially suicidal people in a more general sense, taking into account all of their life experiences, and psychological characteristics which are relevant to future suicidal behaviour. Indeed, it is my belief that prediction and assessment are mutual processes and any separa-

*(Continued on page 4)*

## Submissions Invited

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

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*Please Note:*
*The guest editor for the April, 2002 issue is David Hart at David.Hart@ubc.ca*

*(Continued from page 3)*

tion is an artificial one. They are not separate categories.

Lethality and Perturbation

In assessing suicide risk in people, we need to be aware of behaviours that are potentially predictive of suicide. However, there is no such definitive behaviour. Suicide is a multidimensional malaise (Leenaars, 1999; Shneidman, 1985). Two concepts that have been found to be essential and helpful in understanding the malaise are lethality and perturbation (Shneidman, 1985). Lethality refers to the probability of a person killing him/herself, and on quantification scales ranges from low to moderate to high. It is a psychological state of mind. Perturbation refers to subjective distress (disturbed, agitated, sane-insane, decomposed), and can also be rated from low to moderate to high. Both have to be evaluated. It is important to note that one can be perturbed and not suicidal. Lethality kills, not perturbation. Perturbation is often relatively easy to evaluate; lethality is not. Lethality is likely best assessed by a professional with experience in the area of suicidology. The concepts of lethality and perturbation are, thus, critical in one's professional assessment and prediction.

Tests to Predict Suicide

Numerous attempts at constructing tests for suicide prediction and related phenomena have been made, most meeting with failure. In response to awareness of the inherent difficulties in predicting suicide, the National Institute of Mental Health (NIMH) of the United States organized a think tank in the assessment of suicidal behaviour (Lewinsohn, Garrison, Langhinrichsen & Marsteller, 1989) (they have recently reconvened this group). They reviewed all available assessment instruments used to study suicidal behaviour. Their conclusion: Few, if any, are useful. The NIMH group found numerous problems in the instruments; for example, ambiguity of the purpose of the instrument, insufficient attention to validity, the lack of discrimination between suicide risk and other forms of self-destructive behaviour, and the lack of theoretical models. Maris, Berman, Maltsberger and Yufit (1992), in the most comprehensive edited book on the topic to date, provided the same impression: Each test, by itself, has little utility. I agree (to date); of course, this is a clinical truism for most complex behaviour (e.g., psychopathy).

Despite this state of affairs, the NIMH group did isolate two instruments, designed for populations across the life span, that have some potential in predicting suicide risk, (i.e., the intent to kill oneself). They are as follows: 1) Beck Suicide Intent Scale (BSIS) (Beck, Kovacs & Weissman, 1979; Steer & Beck, 1988), 2) Lethality of Suicide Attempt Rating Scale (LSARS) (Smith, Conroy & Ehler, 1984). What is noteworthy about these instruments is that they are comprehensive interview guides to assess risk, not simplistic paper and pencil tests. This points to the fact that if one wishes to use psychometric scales in the assessment of risk, this procedure cannot be divorced from a clinician's understanding. There are, of course, other tests that have utility in understanding a person, including if suicidal. More comprehensive procedures of understanding the psychology of suicide, such as the Thematic Guide for Suicide Prediction (TGSP) (Leenaars, 1996), may prove to be more useful in the future than specific, simple measures. Suicide is simply not a category in DSM-IV-TR, nor will it ever be in future editions of that diagnostic manual. There is no one clue, disorder, test, and so on that will tell all.

Understanding Suicide as Assessment and Prediction.

Suicide is a multi-determined event. If one attempts to understand suicide, one becomes aware over time of its enormous complexity. This more than anything is what I learned (over and over) from my mentor, Dr. Edwin Shneidman (Leenaars, 1999). To state it symbolically, suicide is an intrapsychic drama on an interpersonal stage. From a psychological view, suicide, to date, has been theoretically understood from at least the following concepts (or constructs) with the first five being intrapsychic elements and the latter three being more the interpersonal factors. Let me make a few notes on the drama and the stage:

I Intrapsychic Drama

1. Unbearable Psychological Pain: The common stimulus in suicide is unendurable psychological pain, a heightened state of perturbation (Shneidman, 1985). This is Dr. Shneidman's maxim; he even coined a name for it, psychache (see Leenaars, 1999, for Edwin Shneidman's most essential papers). Although, as Karl Menninger (1938) noted, other motives (elements, wishes) are evident, the person primarily wants to escape (or to flee) from pain, such as feeling boxed in, re-

*(Continued on page 5)*

*(Continued from page 4)*

jected, and especially hopeless and helpless. The suicide, as Henry Murray (1967), Dr. Shneidman's mentor, noted, is functional because it provides relief from intolerable suffering.

2. Cognitive Constriction: The common cognitive state in suicide is mental constriction; i.e., rigidity in thinking, narrowing of focus, tunnel vision, concreteness (Shneidman, 1985). (Aaron T. Beck's works (and with associates) on this topic are a must read). The suicidal person exhibits at the moment before his/her death only permutations and combinations of a trauma (e.g., school failure, poor health, rejection by a spouse). This constriction is one of the most dangerous (deadly) aspects of the suicidal mind.

3. Indirect Expressions: There is often an indirectness (or obliqueness) in the suicidal mind, the speaker's own words, no more than a test(s), can reveal completely the drama, nor the stage. Dissembling is not uncommon.The suicidal person, for example, is often ambivalent. There are complications, concomitant contradictory feelings, attitudes and/or thrusts, often toward a person and even toward life. He/she, for example, both wants to live and to die. To restate, what the person is conscious of is only a fragment of the suicidal mind (Freud, 1917/1974; Leenaars, 1988).

4. Inability to Adjust: Although the majority of suicides may fit best into specific depressive nosological classifications (e.g., depressive disorders, manic-depressive disorders), only approximately 60% do so. Other disorders, for example, anxiety disorders, schizophrenic disorders (especially the paranoid type), brain (organic) dysfunction and/or disorders, substance abuse (e.g., alcoholism), and antisocial, borderline and narcissistic personality disorders, have also been related to some suicides (see Hawton & van Heeringen, 2000). Yet, there are many other disorders, not specified above, that may result in risk (for example, the group of disorders under a rubric of attention deficit/ hyperactivity disorders, and learning disability disorders are at specific risk). Many different people, with different disorders (and about 10% with no disorder) are at risk. What they share in common, however, is that suicidal people see themselves as weak and unable to adjust to life's demands. They cannot adjust.

5. Ego: The ego, with its enormous complexity (Murray, 1967), is an essential factor in the suicidal scenario. The Oxford English Dictionary (OED), Dr. Shneidman's favourite book, defines ego as "the part of the mind that reacts to reality and has a sense of individuality." Regardless of one's definition, I believe that ego strength is a protective factor against suicide. It allows for resilience (or self-efficacy). However, the suicidal person's ego, already at a young age, has been weakened by a history of traumatic life events [(e.g., loss, rejection, abuse, failure) (Zilboorg, 1936)]. The suicide's drama has a history.

## II Interpersonal Stage

1. Interpersonal Relations: The suicidal person has had and has problems in establishing and/or maintaining relationships (object relations). There is frequently on the stage, a disturbed, unbearable interpersonal calamity. Suicide appears to be related to an unsatisfied or frustrated attachment need, although other needs, may be equally evident, e.g., achievement, perfection, dominance, honor (Murray, 1967). Suicide occurs because of frustrated and unsatisfied needs.

2. Rejection-Aggression: The rejection-aggression hypothesis was first documented by Wilhelm Stekel in the famous 1910 meeting of the Psychoanalytic Society in Freud's home in Vienna (Friedman, 1910/1967, a must historical read). Loss is central to suicide; it is, in fact, often a rejection that leads to pain and self-directed aggression. Aggression is a common emotion in suicide; there are, in fact, essential biological links to this fact (Asberg, Traskman, & Thorien, 1976). Suicide may well be veiled aggression – it may be murder in the 180$^{th}$ degree (Shneidman, 1985).

3. Identification-Egression: Sigmund Freud (1917/1974, 1920/1974) hypothesized that intense identification (i.e., attachment) with a lost or rejecting person or, as Gregory Zilboorg (1936) showed, with any lost ideal (e.g., health, youth, employment, freedom) is crucial in understanding the suicidal person. There is a common loss of attachment in suicide, sometimes a narcissistic one. If this emotional attachment is lost, not met, or so on, the suicidal person experiences a deep pain (discomfort) and wants to egress. Suicide is escape.

Of course, these elements are interactive (dynamic) and, even more important, are not the only possible psychological constructions on the event (see Berman & Jobes, 1991). They are, however, the ones in our history of thought, with some empirical support (Leenaars, 1996) that one must consider in assessing suicide risk.

Case Illustration: Vince Foster Jr.

I will here illustrate one person's (mine) understanding of suicide with a clinical case. I chose Vincent Foster, Jr. – he has some historical appeal.

*(Continued on page 6)*

*(Continued from page 5)*

Vince Foster, Jr. was President Bill Clinton's deputy White House counsel, who shot himself, with his father's gun, on July 20, 1993. Vincent Foster was Clinton's friend. He was, 48, married and had three children. Foster had been in Washington for 6 months, when he was found dead in a park on the Northern Virginia side of the Potomac River. One of the best suicidal communications is the suicide note. It is a unique window to the suicidal mind – but so are our patients' protocols. Here is Foster's suicide note:

> *I made mistakes from ignorance, inexperience and overwork*
> *I did not knowingly violate any law or standard of conduct*
> *No one in the White House, to my knowledge, violated any law or standard of conduct, including any action in the travel office.*
> *The FBI lied in their report to the AG (attorney general)*
> *The Press is covering up the illegal benefits they received from the travel staff*
> *The GOP has lied and misrepresented its knowledge and role and covered up a prior investigation*
> *The Ushers Office plotted to have excessive costs incurred, taking advantage of Kaki (White House Designer) and HRC (Hilary Rodham Clinton)*
> *The public will never believe the innocence of the Clintons and their loyal staff*
> *The WSJ (Wall Street Journal) editors lie without consequence*
> *I was not meant for the job or the spotlight of public life in Washington. Here ruining people is considered sport.*

What can we learn from Vincent Foster Jr.'s suicidal narrative? Utilizing the integrated model outlined in the last issue, we learn the following:

I Intrapsychic Drama

1. Unbearable Psychological Pain – Vincent Foster's mind, based on the note, was permeated with pain – the pain of pain. The suicide was seen as an escape. Although there were likely many motives, the accusations by the FBI, Press, GOP and so on, of violating the law or standards of misconduct overwhelmed him. Mr. Foster was forlorn and distressed. He could not endure nor cope with the injustices, feeling hopeless and helpless.
2. Cognitive Constriction – Vincent Foster's mind was a constricted mind. He was "intoxicated" with the cognitions of his trauma – "ruining people is considered sport." His note is only permutations of that trauma.
3. Indirect Expressions – Vincent Foster Jr. was overwhelmingly angry. Yet, the anger became turned inward. Indeed, it is quite clear that the manifest aspects of his note imply much more latently. One may want to speculate on what the unconscious dynamics may have been that drove Foster to his death (or to read the psychological autopsy of his death for a clearer view, see Maris, Berman, and Silverman, 2000).
4. Inability to Adjust – Vincent Foster could not cope; he saw himself too weak to adjust to "the spotlight of public life in Washington." He is, in fact, so passionate in his last reverie on that topic. Indeed, his state of mind was indicative of a mental disorder. Vincent Foster likely suffered from, at least, depression at the time that he wrote the note. (There is also further support for a narcissistic disorder).
5. Ego – Vincent Foster's ego was weakened; he lacked constructive tendencies. There is such pain about his unresolved problem, the accusations. He feels so punished. Death awaits him.

II Interpersonal Stage

*(Continued on page 7)*

*(Continued from page 6)*

1. Interpersonal – Mr. Foster was weakened and defeated by the FBI, the Wall Street Journal, even the public, from his view. Indeed, Vincent Foster lists a long history to his pain, experiencing the world as overwhelmingly traumatic. Vince Foster committed suicide because of a frustration of needs – these included attachment, affiliation (The White House), autonomy, defendance (to defend or vindicate the self), harmavoidance, and infavoidance (to avoid humiliation).
2. Rejection/Aggression – Vince Foster felt so rejected. Indeed, the rejection was a narcissistic injury – narcissism, of course, is central to this type of executive suicide. He is so angry but so weakened by the lies of the Press, GOP, the public. Indeed, he is so weakened that he turns the aggressive impulses against himself. He kills himself, although his suicide, especially the note, was calculated to have an impact on the Press, the FBI, and so on. Vince Foster wanted revenge.
3. Identification-Egression – Vincent Foster Jr. was so attached to the Clintons, the White House, law, standards of conduct. These were deep ideals and identifications. With the loss of these attachments (ideals), he needed to escape, egress. Death became the only solution.

Could we, aspiring to rescue, have assessed Foster's suicidal risk? What tests could have helped? How could we have assessed the wide array of factors associated to his death? Equally important, could we have saved Foster? Would psychotherapy have helped? This is the subject of my new book, Psychotherapy with Suicidal People.

## Assessment of Suicide Risk: A Final Note

Suicide is a multidimensional event. It is likely that no one behaviour, including a test score or an interview, will provide all of the information needed to assess and predict suicide. Some patients will answer the question "During the last 24 hours, I felt my chances of actually killing myself (committing suicide) were: absent, mild, medium, moderate, high?" (or one can use a subjective scale from 1 to 9). Others can not and some will not (dissembling). Others are chronically suicidal. The fact is that suicidality is often a moving target. Suicide risk often cannot be assessed at one time by one test, one interview, etc. Each bit of information (like a test score, an observation) will have to be placed in the context of that person's life. It is likely that a number of tests, interviews and scales will be needed to ongoingly predict such a complex human behaviour as suicide. No one test or behaviour or observation may be the answer. There is no one "bump on the head" that will tell us whether a patient is suicidal or not, much less how suicidal that person is. Furthermore, all predictions ultimately depend on the skill of the clinician. In that sense, suicide prediction is a task like many others that a clinician faces: a problem of understanding a number of evaluations of the same person. Again, I welcome your thoughts.

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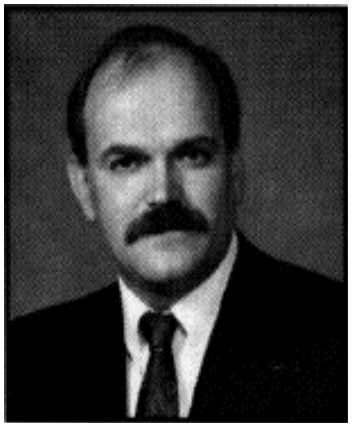
*Dr. Leenaars is a registered psychologist in private practice in Windsor, Canada, and was a member of the Faculty at the University of Leiden, The Netherlands. He was the first Past President of the Canadian Association for Suicide Prevention (CASP), and is a past President of the American Association of Suicidology (AAS). He has collaborated with over 50 colleagues in 20 nations, and has published over 100 professional articles/chapters on suicide, trauma, homicide, gun control, and related issues. He has published 10 books, most recently, Lives and Deaths: Selections from the Works of Edwin S. Shneidman, and is Editor-in-Chief of Archives of Suicide Research. Dr. Leenaars is a recipient of The International Association for Suicide Prevention's Stengel Award, CASP's Research Award and AAS's Shneidman Award for outstanding contribution in research in suicidology. He is recognized for his international efforts in suicide prevention, and has served as an expert witness in legal cases dealing with wrongful death, suicide and homicide.*



**The Business of the Clinical Section:**
**Summary of Executive Meetings**

**Teleconference: September 14, 2001**

***Financial***

· Section continues to have a positive bank balance; over $4000 with most bills paid; plan to review GIC investments and upcoming projects.

***Communications***

· 2/3 of section members have provided their email address and are now on the section list server; positive feedback from members.

· section member benefits flyer will be posted in Psynopsis and included with every CPA new member package

***CPA Convention***

· 2002 CPA conference section-sponsored presenter ideas were generated; potential speakers to be contacted as soon as possible.

· executive would like to establish Continuing Education credits for the preconvention workshop annually; plan to clarify process with CPA Education & Training Committee.

· executive was dissatisfied with the changes in the submission
requirements for the conference (1000 word summaries); will provide feedback to Convention Chair

***Section Activities***

· the Ken Bowers Student Award monetary value was increased to $300 and a second student award of the same monetary value was added, both to be available for the 2002 convention

***Section Projects***

· Clinical Psychologist brochures to be updated and made available primarily on the web site

· Recruitment for ***Psychology Works!*** fact sheet authors is continuing, and additional information sheets are gradually being sent in

· Feedback from section members regarding the national reorganization initiative was positive

**Winter Meeting, Montreal: January 26, 2002**

***Financial***

· GICs are all maturing within the next few months; executive will reinvest 2 of the 3 GICs, using a guide of 50% of annual operating expenditures in investments.

· Financial planning guided by concurrent discussion of section's strategic directions, including support of students, education for members through improved programming at convention, and support for advocacy/lobbying efforts for psychological services Communications.

· List server – still about 1/3 of members not on list server; request to members via newsletter to provide email address to section if have one; executive identified that likely underutilizing list server; plan more regular updates to members.

· Newsletter – excellent job by new editors Deborah and Keith Dobson; David Hart to serve as guest editor for spring; executive considering move to electronic distribution of newsletter over next few years once most members on list server; discuss at section annual business meeting

· Website – time to update look and organization of website; may hire student to do so, obtain ideas from other sites

***CPA Convention***

· Executive were congratulated on successful recruitment of presenters including John Livesley as a conference keynote speaker.

· Submission rates were down by about 15%; impact of new submission requirements was discussed and various concerns raised; feedback to be solicited from reviewers to determine use and value of required summary; feedback to be provided to Convention Chair.

· Plan to advertise preconvention workshop (Gambling – R. Ladouceur) in local newspaper after early registration, allowing CPA members first opportunity to register; will approach 1-2 local section members to assist in further advertising workshop among local mental health professionals.

· Preconvention workshop fees re-examined; concern that too high given other costs of attending conference; reduced fee schedule proposed for implementation for 2003 conference; section member rebates to be provided for 2002 preconvention workshop as it is past deadline to include planned member discount in 2002 fees.

***Section Activities***

· Students with clinical research submissions to the conference will be invited to apply for the section student awards.

· Discussed clinical student representation advisory to executive – one year term, advisory role, recruit from Section on Students.

· Darcy Santor, Member-at-Large regretfully resigned his position due to a heavy workload; executive will assume his responsibilities for the 5 month interim.

***Section Projects***

· Clinical Psychologist brochure still to be updated; plan to complete that over next few months.

· No new fact sheets have been put on the CPA website for several months; executive to follow up.

· Feedback to national reorganization steering committee pending; report to formally communicate support and provide initial response to consultation questions to be completed prior to February CPA board meeting.

· Charter of Rights for Psychologist now before the CPA Board, who are considering adopting it as a national policy statement, with revisions .

· Executive noted the excellent lobbying done by CPA re: Romanow Commission; decided against making a separate presentation through the public forum.

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# CPA CONVENTION 2002

## CLINICAL SECTION SPONSORED EVENTS

### *Pre-Convention Workshop: Wednesday May 29th, 8:30 AM – 5:00 PM*

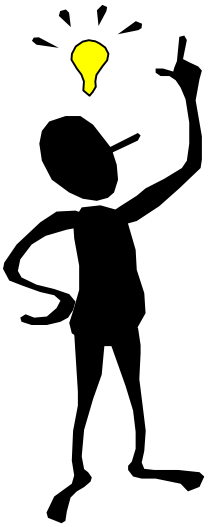
### Cognitive and Behavioral Treatment of Pathological Gamblers
### Robert Ladouceur, Ph.D. & Tony Toneatto, Ph.D.

| | | |
|---|---|---|
| CPA/BCPA Members | $149.80 | ($140.00 + $9.80 GST) |
| CPA/BCPA Student | $64.20 | ($60.00 + $4.20 GST) |
| Non-Member | $176.55 | ($165.00 + $11.55 GST) |

**Note**: Members of the CPA Clinical Section will be rebated $20.00 and student members of the Clinical Section will be related $5.00. Lunch and refreshments are included in the workshop fee. Registrants prior to April 29th are eligible for a reduced Convention fee.

| Thursday May 30th | Friday May 31st | Saturday June 1st |
|---|---|---|
| Clinical Poster Session 11:00 – 12:55 | Clinical Section Business Meeting (with coffee and muffins) 8:00 – 8:55 | (Sy) Cognitive & Behavioral Mechanism in Children with ADHA: **Robin Mc Gee et al.,** 9:00 – 10:55 |
| (Wk) Psychotherapy for Abused and Neglected Children: **John Pearce**, 1:00 - 2:00 | *CPA Invited Speaker* The Pharmacological & Behavioral Basis of Tobacco Dependence: **Ovide Pomerleau**, 10:30 – 11:25 | (Wk) Triaging Psychiatric Emergencies: **Dennis Ewanyk,** 9:00 – 10:55 |
| (Wk) Innovative Methods of Service Delivery & Compensation: **Robert Wilson**, 1:00 – 2:55 | (Sy) Chronic Post Traumatic Stress Disorder: **Victor Colotla et al.**, 10:30 – 12:25 | (Wk) The Use of Virtual Reality in the Treatment of Anxiety Disorders: **Stephane Bouchard**, 9:00 – 10:55 |
| (Cs) How Should We Disseminate Evidence Based on Psychological Treatment? **Dan Bilsker**, 1:00 – 1:55 | (Cs) Integrating Research & Science Into Internship Training: **Janice Cohen**, 12:00 – 12:55 | (Sy) Developmental Psychopathology & Children's Mental Health: Ongoing Projects at the CRHD at Concordia University: **Lisa Serbin et al.**, 11:00 – 12:55 |
| *Section/CPA Invited Speaker*, The Effectiveness of Cognitive Behavioral Therapies: **Thomas Borkovec**, 2:00 – 2:55 | (Sy) Cognitive and Personality Vulnerability to Depression: **David Dozois et al.**, 12:30 – 2:25 | (Sy) Problem Gambling in the Canadian Context: Nature & Treatment: **Brian Cox et al.**, 11:00 – 12:55 |
| (Ps) Abuse: **Linda McLean et al.** 3:00 – 4:25 | (Cs) Finding an Internship that Works: **William Koch** 1:00 – 1:55 | (Wk) Empowering Individuals with Psychotic Disorders: **Nicola Wright** 11:00 – 12:55 |
| (Sy) Psychological Aspects of Occupational Disability: **Jane Mc Ewan et al.** 3:00 – 4:55 | *CPA Invited Speaker*—Why are Personality Traits Organized Into Clusters & What Does This Mean for Therapists? **John Livesley** 3:00 – 3:55 | (Tr) Measurement in Depression: **Darcy Santor** 11:00 – 11:25 |
| (Sy) Program Discrimination Across Culture, Development Translation, Implementation & Evaluation: **Randy Paterson et al.** 3:00 – 4:55 | Current Issues in the Assessment and Treatment of Generalized Anxiety Disorders: **Sarah Newth** 4:00 – 4:55 | (Sy) Post-Traumatic Stress Disorder: **Steven Taylor et al.** 1:00 – 2:55 |
| (Tr) Somata Flashbacks: **Timothy Saloms** 4:30 – 5:00 | | (Cs) How to Get Tenure –Track Job in Clinical Psychology: **Adam Radomsky** 1:00 1:55 |

# We Want You!



*Did you know…*

**That the Clinical Section of CPA**

- **Has twice yearly newsletters with clinically-relevant, up-to-date information**
- **Has a list serve to keep its members informed in a timely manner**
- **Organizes a large portion of the CPA convention Program including clinical symposia, mini workshops, full day workshops, and key note speakers**
- **Recognizes outstanding achievements of clinical students and section members through student and Fellow awards**
- **Initiates and/or supports special projects on nationally relevant clinical issues such as empirically-supported treatments, public advocacy (Psychology Works project), and patient/client education materials (fact sheets by Canadian experts)**
- **Facilitates networking with classmates, colleagues, and supervisors**
- **Provides you with an opportunity to have your voice heard and have an influence on current issues in clinical psychology**
- **Has a dedicated and hard-working 5 member executive, as well as a newsletter editor and website editor**
- **Is offering a member rebate for the preconvention clinical workshop at the 2002 CPA conference, as well as introducing reduced preconvention workshop fees for 2003**

## WHAT ARE YOU WAITING FOR?
## JOIN NOW

**MEMBER APPLICATION**

**CANADIAN PSYCHOLOGICAL ASSOCIATION – CLINICAL SECTION**

***I would like to join the CPA Section on Clinical Psychology***

**Name:** _____

**Address:** _____
_____
_____

**Telephone:** **Work:** _____ **Home:** _____

**E-Mail:** _____

**Area(s) of Interest:** _____

**Fees:** **Full Member** **$21.40 (includes GST)**

**Student** **$ 5.35 (includes GST)**

**Amount Enclosed:** _____

Please make cheque or money order payable to:
Canadian Psychological Association*
**note: must be member of CPA to join CPA sections*

Send completed registration and membership fee to:

Canadian Psychological Association
151 Slater St., Suite 205
Ottawa, Ontario
K1P 5H3

**If you are already a member, please pass this form on to a colleague**