Canadian Clinical Psychologist

Editor: David S. Hart

Vol. 6. No. 1 Newsletter of the Clinical Section of the Canadian Psychological Association November 1995

MESSAGE FROM THE CHAIR.

Allan R. Wilson

Why should I belong to a Section? This is one of the common questions that I hear as I talk with my colleagues across the country. It is an important question. It reminds us that much of the work of the Clinical Section occurs behind the scenes and is not always visible to our members. I plan to use this column to keep you informed. I hope that you will agree that your membership fee was the best $20 that you spent this year.

The CPA Convention in Charlottetown was a great success. The Section on Clinical Psychology was highly visible, presenting a full convention program. The Clinical Section sponsored a preconvention workshop on the assessment and treatment of chronic pain, eight symposia, poster sessions, two conversation hours, and the Annual Section Business Meeting. It was a busy four days. I trust that many of you had the opportunity to participate in some of these Section activities.

Each year, the Clinical Section recognizes the significant contributions to the development of clinical psychology in Canada by awarding Fellow status to deserving individuals. The Awards Committee announced the selection of two new Fellows: Drs. Susan Pisterman and Janet Stoppard. The Awards Committee also announced the winner of the Student Award, based on a review of student submissions to the convention. Congratulations to Nadine DeWolfe from Dalhousie University (see a summary of her paper in this issue).

There are several projects that are the focus of our efforts this year. Allow me to highlight just a few. The Clinical Section has already produced an information and public education brochure entitled "The Clinical Psychologist in Canada". We plan to produce a french version of this brochure and develop new strategies for marketing and distribution.

One recommendation that emerged from the Mississauga Conference on Professional Psychology involved the development of an information kit on potential career options in professional psychology for beginning graduate students. The Clinical Section has taken the lead on this project by initiating contact with other CPA sections and psychology organizations to explore potential partnerships and sources of funding. I expect that this project will be a major emphasis of our work over the next year.

The "information Highway" is the phenomenon of the 90's with more people surfing the "net" for information each day. CPA has recently launched a Home Page on the web. Check it out (http://www.cycor.ca/Psych/home.html). The Clinical Section hopes to develop our own Home Page on the CPA web site. Look for this in the coming months. Plans are also underway to publish an email directory of Clinical Section members as another means of fostering communication and networking. Please email your name and email address to David Hart (dhart@play.psych.mun.ca) if you wish to be included.

Obviously, there is much work to be done. Please contact me, or any member of the Executive, if you would like to contribute to the activities of the Section this year. I hope that you will renew your membership for the new year and encourage a colleague to join, as well!

CONTENTS

STUDENT AWARD 1995

Student Award 1995: Ms Nadine A. DeWolfe

Editorial Note: *Paper Presented at CPA Annual Meeting as a part of a symposium on the Assessment and Treatment of ADHD in Preschool Children, Charlottetown, PEI, Thursday June 15, 1995. Requests for further information regarding this study can be made to Nadine DeWolfe, Joseph Byrne, or Harry Bawden at the Department of Psychology, IWK Children's Hospital, 5850 University Avenue, Halifax, Nova Scotia, B3J 3G9. Detailed information regarding the rationale and methodology of this study was not feasible due to space restrictions for this newsletter.*

Assessing ADHD in Preschoolers

Nadine A. DeWolfe, B.A. (Hon.)
Dalhousie University, Halifax, Nova Scotia
Joseph M. Byrne, Ph.D. and **Harry N. Bawden**, Ph.D.
Isaac Walton Killam Children's Hospital, Halifax,
Nova Scotia

Attention–Deficit Hyperactivity Disorder (ADHD) is the single most frequent disorder for which mental health services are requested in North America (e.g., Barkley, 1981; 1990; Earls, 1980; Quay, 1986; Ross & Ross, 1982; Shaywitz, Fletcher, & Shaywitz, 1994). ADHD has been the subject of much research and debate over the last 20 years; however, the overwhelming majority of research on ADHD has been conducted with school–age children. This is surprising given that the DSM–IV diagnostic criteria for AD/HD specifies that the presenting symptomatology must be present prior to seven years of age (DSM–III–R, 1987; DSM–IV, 1994) and that 50% of preschoolers presenting with significant behavior problems continue with a diagnosis of ADHD into childhood (Campbell, 1985; 1990; Campbell & Ewing, 1990).

Recently, research has begun to focus on investigating the characteristics and correlates of preschoolers with externalizing behavior problems (see Campbell, 1985; 1990; 1995 for review). The measures and procedures used in the assessment of ADHD with school–age children are clearly not appropriate or valid for application to the preschool–age population. Early identification of problem behavior would best be achieved through the development of age–appropriate, clinically valid, diagnostic protocols for preschool–age children. To do this, it is important to distinguish between behaviors reflecting emerging problems and behaviors reflecting normal age–related transitions in development (Campbell, 1995). In this regard, the purpose of the present study was to develop two "age–appropriate" measures which could be used in the assessment of ADHD with preschool children.

Method

Twenty–six 3-5 year olds participated in this study; 13 clinic referrals (ADHD) and 13 normal controls. Participants were matched on gender (4 females and 22 males) and age (? 6 months) and SES was entered into analyses as a covariate. Normal controls were recruited from preschools in Metro Halifax and clinic referrals were received by a clinical child psychologist at the IWK Children's Hospital.

Based on profiles (T scores) from the Child Behavior Checklist (Achenbach, 1991), Conner's Parent Rating Scale (Conners, 1985), and a DSM–III–R psychological interview with the child's parent, children were independently assigned to either the normal control or clinic (ADHD) group. All children were free from neurological, neurodevelopmental, or psychiatric (other than ADHD) disorders. The expressive and receptive language abilities of each preschooler were directly assessed using the Reynell Developmental Scales – Revised, (RDLS; Reynell & Huntley, 1985) and found to be within normal limits. All children participated in a 30–minute structured–form observation session and a 30–minute free–form observation.

Structured–Form Observation. We wished to determine whether a preschooler's behavior during a formal psychometric assessment would discriminate between those with and without ADHD. This task served the dual function of providing a direct assessment of language ability, as well as a structured opportunity to observe the child's attention, compliance, and cooperation.

The frequency of the following child behaviors were coded and analyzed: grabbing, squirming in seat, out of seat, and spontaneous verbalizations. The frequency of examiner's child directed requests and commands were also scored.

Free–Form Observation. The free play observation session allowed an opportunity to observe the child's activity level and task persistence in a relatively low–supervision setting, with tasks freely chosen by the child. Modifying the Roberts et al. (1985) school–age protocol, there were four preschool–size tables and chairs positioned in the room with the same set of three age– appropriate toys placed on each table. Each table was identical, thereby, circumventing the possibility that children would move among tables to seek novel play. One set of three distracter toys was located on the floor against the wall. Children were encouraged to play with any of the toys on any of the tables, but were specifically told that they were not allowed to touch or play with the distracter toys. The child's parent was seated behind a room partition, completing questionnaires.

The frequency of the following child behaviors were coded and analyzed: verbalizations to parent, mobility within room, out, of seat, seeks attention from parent, change in play with assigned toys, play with distracter toys, duration of time off– task, and child non–compliance. Frequency of parental requests and commands were also scored.

Results

The videotaped behavior was coded by a Research Assistant, who was blind to the purpose of the study, using the INTERACT software system (Dumas, 1990). Both coding systems were found to be reliable (range of kappas r = .73 to r = .98).

Results of the Structured–Form Observation analysis of covariance (SES not significant) indicated that the preschoolers with ADHD exhibited significantly more grabbing (at test materials) and their inattention and noncompliance required significantly more examiner commands. Results indicate that the preschoolers with ADHD exhibited more squirming, an effect which approached statistical significance. The preschoolers with ADHD were more frequently out of seat and exhibited more spontaneous verbalizations, but the differences do not reach statistical significance.

Results of the Free–Form analysis of covariance (SES not significant) indicated that the preschoolers with ADHD more frequently played with the distracter toys (77% vs. 0%). Results indicate that preschoolers with ADHD were more mobile and off– task. These differences approached statistical significance. The remaining behaviors, change in play with assigned toys, out of seat, verbalizing to parent, seeking attention from parent, parent commands, and child compliance were not found to be significantly different.

Discussion

In contrast to the school–age findings of Roberts and her colleagues (1990; 1985), our findings during the free–form observation revealed that preschoolers with ADHD were not more active, or inattentive, nor were they inclined to move more frequently from one activity to another. However, when a single restriction was imposed (i.e., not to touch the distracter toys), the preschoolers with ADHD were clearly distinguishable. That is, 77% of the preschoolers with ADHD could not inhibit the urge to play with the distracter toys, whereas, 0% of the preschoolers without ADHD played with or touched the forbidden toys.

These findings highlight the fact that, when no restrictions are placed on a preschooler's activity and attention (such as a free–form setting), preschoolers with ADHD will not behave in a manner substantially different from their counterparts who are without ADHD. This may reflect a normal developmental phenomenon whereby the majority of preschoolers lack sufficient control of attention and activity in a nonrestrictive task. Problems with impulse control, a core characteristic of ADHD, are more readily evident when demands are imposed on the preschoolers behavior (like in the structured–form observation and distracter toy paradigm). The choice of clinical measure becomes particularly important to assess preschooler's deficits in these areas (e.g., restricted toy, grabbing at materials, need for repeated requests to stay on task).

The results of this study support the view that the assessment of ADHD must be conducted within the context of a developmental model, particularly for preschoolers. The same measures found to be clinically valid for assessing ADHD at one age (for example, school–age), will not necessarily be appropriate for assessing the same disorder in younger children. In conclusion, the potential to over–identify or under–identify problem behaviors in young children will remain until more specific and developmentally appropriate criteria are developed which differentiate age–appropriate levels of activity, shifts in attention, and impulsivity (Campbell, 1990). Further development of existing and additional measures are in progress.

References

Achenbach, T. M. (1991). Manual for the Child Behavior Checklist 4-18. Burlington, VT: Author.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, (4th ed.). Washington:Author.

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders, (3rd ed., revised). Washington: Author.

Barkley, R. A. (1990). Attention–Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment, (2nd ed.). New York: Guilford.

Barkley, R. A. (1981). Hyperactive children: A handbook for diagnosis and treatment. New York: Guilford.

Campbell, S. B. (1995). Behavior problems in preschool children: A review of recent research. Journal of Child Psychology and Psychiatry, 36, 113-149.

Campbell, S. B. (1990). Behavior problems in preschool children: Clinical and developmental issues. New York: Guilford.

Campbell, S. B. (1985). Hyperactivity in preschoolers: Correlates and prognostic implications. Clinical Psychology Review, 5, 405-428.

Campbell, S. B., & Ewing, L. J. (1990). Follow–up of hard–to–manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. Journal of Child Psychology and Psychiatry, 31, 871-889.

Conners, C. K. (1985). The Conners Rating Scales: Instruments for the assessment of childhood psychopathology. Unpublished manuscript, Children's Hospital National Medical Center, Washington, D.C.

Dumas, J. E. (1990). The INTERACT Software System: User's Manual (version 3.0). Author.

Earls, F. (1980). Prevalence of behavior problems in 3–year–old–children. Archives of General Psychiatry, 37, 1153–1157.

Quay, H. C. (1986). Conduct disorders. In H. C. Quay and J. S. Werry (Eds), Psychopathological disorders of childhood (pp. 35-72). New York: Wiley & Sons.

Reynell, J. K., & Huntley, M. (1985). Reynell Developmental Language Scales Manual, (2nd ed.). Windsor, England: NFER–Nelson.

Roberts, M. A. (1990). A behavior observation method for differentiating hyperactive and aggressive boys. Journal of Abnormal Child Psychology, 18, 131-142.

Roberts, M. A., Milich, R., & Loney, J. (1985). Structured observations of academic and play setting (SOAPS): Manual. Iowa: Author.

Ross, D. M., & Ross, S. A. (1982). Hyperactivity: Current issues, research, and theory. New York: Wiley.

Shaywitz, S. E., Fletcher, J. M., & Shaywitz, B. A. (1994). Issues in the definition and classification of attention deficit disorder. Topics in Language Disorders, 14, 1-25.

SPECIAL SECTION

Special Section: *From the CPA Convention. I There were several symposia that begged to be given wider audience. I managed to persuade some of the presenters to provide copies of their contributions for inclusion in the Canadian Clinical Psychologist. They were intended to be controversial. Write or email the editor with your comments on the debate. The issues are important to our profession. Look for another symposium in the next number of CCP.*

Introductory Comments on "Clinical Training in Empirically Validated Treatments: Conceptual, Professional, and Pragmatic Issues"

John Hunsley, University of Ottawa

At the 1995 CPA convention, a conversation session entitled "Clinical training in empirically validated treatments: Conceptual, professional, and pragmatic issues" was held as part of the convention program for the Clinical Psychology Section. My co-discussants in the session were Keith Dobson (University of Calgary), Patrick McGrath (Dalhousie University), Linda McMullen (University of Saskatchewan), Sandra Pyke (York University), and Richard Steffy (University of Waterloo). The following comments are intended to provide a brief historical overview of recent efforts within the American Psychological Association (APA) to encourage training in empirically validated treatments.

In 1993, David Barlow, president of the APA Division of Clinical Psychology, constituted a task force charged with (a) developing criteria for determining whether an intervention has been demonstrated empirically to be effective and (b) suggesting methods for educating clinical psychologists, third party payors, and the public about effective psychotherapies. The Task Force on Promotion and Dissemination of Psychological Procedures, chaired by Dianne Chambless, included representatives of cognitive-behavioural, interpersonal, and psychodynamicapproaches in order to ensure that the Task Force would be able to promote all treatments that work, not just those from a specific orientation.

A preliminary version of the task force report was presented at the APA convention in August 1993 in order to obtain feedback. In October 1993 the report was adopted by the APA Division of Clinical Psychology. In February 1995, the final report was adopted by the APA Council of Representatives. As the report is too long to be reproduced in its entirety here, I will present excerpts of the document to illustrate some its key elements.

A significant aspect of the task force's work was to develop criteria for determining whether a treatment could be deemed to be empirically validated. (At this point, I should note that the preferred terminology has recently been changed to "empirically supported" in recognition of the fact that validation is an ongoing empirical process rather than a static endstate.) Tables 1 and 2 present the criteria developed to classify a treatment as "well-established" or "probably efficacious."

Table 1

Criteria for empirically-validated treatments: Well-established treatments

I. At least 2 group design studies, by different investigators, demonstrating efficacy by :
A. superior to pill, psychological placebo, or another treatment
B. Equivalent to an already established treatment, in studies with adequate statistical power

OR

II. A large series of single cases designs, demonstrating efficacy. Studies must have:
A. Used good experimental designs AND
B. Compared the intervention to another treatment, as in I. A.

III. Studies must be conducted with treatment manuals

IV. Characteristics of client sample must be clearly specified

Table 2

Criteria for empirically-validated treatments: Probably efficacious treatments

I. 2 studies showing treatment more effective then a waiting-list control group
OR
II. 2 studies otherwise meeting the well-established treatment criteria I, III, and IV, but conducted by same investigator.
OR
1 good study demonstrating effectiveness by these same criteria
OR
III. At least 2 good studies demonstrating effectiveness but flawed by heterogeneity of client samples
OR
IV. A small series of single case design studies otherwise meeting the well-established treatment criteria of II, III, and IV.

Although the task force recognized that an initial listing of treatments deemed to be empirically validated would likely be incomplete and require continual updating, they did present an initial list of treatments that met the criteria described in Tables 1 and 2. Examples of "well-established" treatments included Beck's Cognitive Therapy for Depression, Behavior Modification for Enuresis and Encopresis, Behavioral Marital Therapy, Cognitive Behavior Therapy for Panic Disorder, Exposure Treatment for Phobias, Family Education Programs for Schizophrenia, and Interpersonal Therapy for Bulimia. Examples of "probably efficacious" treatments included Brief Psychodynamic Therapies, Dialectical Behavior Therapy for Borderline Personality Disorder, Emotionally Focused Couples Therapy, and Lewinsohn's Psychoeducational Treatment For Depression.

Twenty recommendations on the dissemination and promotion of empirically validated treatments were proposed by the task force. The following are some examples of the nature and scope of the recommendations. Recommendation 1: A complete list of treatments of documented efficacy should be established and updated as new evidence is provided. Recommendation 2: The development of more efficacy evidence on the outcome of psychodynamic therapies should be encouraged. Recommendation 5: Training in empirically validated treatments should be a criterion for APA accreditation. Recommendation 14: APA should foster the dissemination of findings about effective treatments to psychologists. Recommendation 18: APA should work to make the benefits of empirically documented therapies known to third party payors.

Since the acceptance of the task force's report by the APA Division of Clinical psychology, a number of important developments have occurred. Although not exhaustive, the following list of developments should convey the extent to which the report is rapidly influencing training and professional issues in the United States and, less directly, in Canada. Development 1: APA accreditation criteria now include the requirement that students be trained in empirically validated treatments. Development 2: In 1994, Martin Seligman, as president of the APA Division of Clinical Psychology, struck a committee, chaired by Dianne Chambless, to implement the recommendations of the prior committee. Development 3: Seligman appointed Peter Nathan to chair a task force to produce an edited volume on "Treatments That Work," to be published by OxfordUniversity Press. Development 4: Seligman also appointed William Grove to chair a task force on empirically supported assessment. Development 5: Current Division president Gerald Koocher appointed Suzanne Bennett Johnson to expand the work of the Chambless task force by attending specifically to interventions for children, adolescents, and the elderly. Development 6: The bulletin of the APA Division of Clinical Psychology, The Clinical Psychologist, is running an ongoing series of short descriptions of empirically validated treatments in which information on treatment manuals and the availability of training is listed. Development 7: The Council of University Directors of Clinical Psychology has taken the position that training in the use of empirically supported treatments should occur at all levels of training, including doctoral, internship, postdoctoral, and continuing education. Development 8: The Society for a Science of Clinical Psychology (Section III of the APA Division of Clinical Psychology) now produces an internship directory that lists information on the extent to which training in empirically validated treatments is available at each listed internship site.

It is clear that there is substantial momentum behind the drive to promote training in and the use of empirically supported treatments. The importance of this initiative for clinical psychology training and practice in Canada is self-evident, especially for university programs and internship sites accredited by the APA. The following commentaries from my co-discussants present perspectives from a range of Canadian clinical psychologists involved in university clinical programs. Hailing from programs, both old and new, across the country and differing in theoretical orientations, the views expressed by my colleagues succinctly highlight the broad spectrum of issues that must be addressed in our attempts to train future generations of clinical psychologists.

For readers interested in obtaining more details, copies of Chambless Task Force Report are available from: Judy A. Wilson, Administrative Officer, Division of Clinical Psychology, P.O. Box 22727, Oklahoma City, Oklahoma, USA 73123-1727 (Phone (405) 721-2792, Fax (405) 721-5005). The report was also published in the Winter 1995 issues (Vol. 48, No. 1) of The Clinical Psychologist.

Newt, Tammy, and the Task Force: What's Happened to Common Sense and Moderation?

Linda M. McMullen
University of Saskatchewan

Like Newt Gingrich's Contract with american and Tammy Faye Bakker's make-up, the initiative of the Task Force on Promotion and Dissemination of Psychological Procedures (1995) is vastly overdone. What began as an effort to identify ways to educate clinical psychologists, third party payors, and the public about effective psychotherapies has, in my view, become an initiative that is sorely lacking in moderation and common sense.

Since the focus of our discussion is on the advisability and the feasibility of training in empirically-validated treatments, I will limit my comments to this aspect of the Task Force's initiative. My comments will be centred on three issues: (1) the advisability of establishing a list of well-established and probably efficacious treatments, (2) philosophical and practical concerns regarding training, and (3) the use of treatment manuals for training.

The advisability of establishing a list of well-established and probably efficacious treatments

The criteria for empirically-validated treatments established by the Task Force and the list of well-established and probably efficacious treatments generated on the basis of these criteria seem to ignore two findings in the psychotherapy research literature: (1) Almost all psychological treatments have been found to be more effective than a waiting-list control group or so-called psychological placebos. It should not be surprising, then that examples meeting criterion I (i.e., that the treatment be demonstrated to be superior to, for example, a psychological placebo or a waiting-list control) have been found; and (2) With the exception of behavioural treatments for phobias and possibly panic disorder, differential effectiveness of specific therapies for specific disorders has not been demonstrated. We have known of the "Dodo Bird" verdict, i.e., that "everyone has won and all must have prizes", since Luborsky, Singer, and Luborsky's 1975 paper and little has changed in the past 20 years in terms of identifying specific treatment-disorder matches. Because homogeneity of client sample is, for all intents and purposes, a required criterion for inclusion on the Task Force's list of well-established treatments (indeed, heterogeneity of client samples is considered a flaw), it should not be surprising that the list of

empirically-validated treatments reads, for the most part, as a set of specific treatments for specific disorders. However, while this list might given the clear impression that treatments of choice have been identified for specific disorders, such an impression is misleading.

Both of these features—i.e., the relatively liberal standard for demonstrated efficacy and the listing of specific treatments for specific disorders—lead to the same outcome: the list of well-established and probably efficacious treatments will continue to grow longer and longer with many treatments being listed for the same disorder. Indeed, if the list is given any credibility by third party payors, the financial reward for being on it will ensure that the appropriate study or two will be done. Again, "everyone has won and all must have prizes."

Philosophical and practical concerns regarding training

The use of such a list for the training of students and practitioners raises philosophical as well as practical concerns. Promotion of the view that specific treatments have been found for specific psychological disorders and that the controlled outcome study is the research paradigm of choice reinforces the appropriateness of the medical model as a metaphor for psychotherapeutic intervention. Many theorists and researchershave long questioned the usefulness of this model, citing the inappropriateness of DSM diagnostic labels for the problems in living experienced by many clients (McLemore & Benjamin, 1979), the blurring of so-called specific and non-specific factors in psychotherapy (Butler & Strupp, 1986), and the general failure to find specific treatment-disorder relationships. Indeed, many leading psychotherapy researchers have now abandoned the medical model in favour of other approaches and methodologies (see Stiles, Shapiro, & Harper, 1994) and a renewed interest in common factors, such as those identified by Frank in 1961, is evident (Weinberger, 1995). Why would we want to reinforce a model that is clearly past its prime? The answer is perhaps obvious in the Task Force's reference to the survival of clinical psychology in the "heyday of biological psychiatry" (p. 3). Reinforcing the medical model has little to do with contemporary conceptual and methodological advances and much to do with economics.

And what is training in empirically-validated psychological treatments to encompass? According to the Task Force, "it seems possible that programs be able to provide some coverage of most, if not all, of the empirically-validated treatments in courses," e.g., students might briefly discuss the nature of the treatment per se and be made aware of the relevant research literature in preparation for training in specific treatments in the internship and post-doctoral years (p. 6). While this approach to training clearly does not preclude the provision of intensive training in a small number of therapies, there certainly is an expectation that students will be introduced (even in a cursory fashion) to many treatments. While I fully support the notion that students be trained to competence in at least two widely-used therapies and that they be made aware that other approaches are available, I fear that having site visitors examine the amount of coverage of empirically-validated treatments in pre-doctoral training programs could lead to an emphasis on the cursory coverage of dozens of therapies and to a corresponding view of psychological treatment as a fractured field, rather than as one that has slowly moved toward integration.

The use of treatment manuals for training

The Task Force's promotion of the treatment manual, both in their criteria for empirically-validated treatments and in their recommendations for training in such treatments, is also a concern for me. With the possible exception of psycho-educational treatments, the notion that particular interventions can be prescribed for certain times in therapy or, even more broadly, that the general course of therapy can be anticipated is, in my view, simplifying and unrealistic. Certainly it is the case that some so-called treatment manuals are general outlines of a therapeutic approach rather than a lock-step set of interventions; nevertheless, the privileging of manualized instruction is problematic for several reasons.

First, it reinforces the view that specific techniques, or interventions, are the curative factors. As Butler and Strupp (1986) argued, the distinction between "specific" factors (i.e., the techniques advocated by a particular "school" of therapy) and "non-specific" factors (i.e., interpersonal variables such asunderstanding, empathy, warmth, commitment, caring, etc.) is artificial. Or, as Strupp (1995) recently stated, "techniques per se are barren; instead, what counts more heavily is the nature of the interpersonal context in which they are embedded" and, furthermore, "what works well in one patient-therapist dyad may be far less productive in another" (p. 70). To instill in students that most of what needs to be learned about psychological treatment is contained in a reference manual downplays the complexity of the client-therapist interaction and perhaps even the difficulty of implementing change.

Second, the promotion of treatment manuals ignores the recent findings of the Vanderbilt II project, a study that was designed to investigate the effects of specialized training in time-limited psychotherapy. In the Vanderbilt II project, experienced therapists who were trained in a manual-guided form of time-limited dynamic psychotherapy successfully changed their technical interventions in line with the manualized protocol but also showed signs of unexpected deterioration in their interpersonal interactions. As Henry, Strupp, Butler, Schacht, and Binder (1993) stated, "one of the apparent paradoxical results of training was that at the same time therapists were becoming more intellectually sensitized to the importance of in-session dyadic process, they were actually delivering a higher "toxic dose" of disaffiliative and complex communications" (p. 439). After training, the therapists were judged to be less approving and supportive, less optimistic, and more authoriative and defensive. One additional finding is also worthy of note (see Henry, Schacht, Strupp, Butler, and Binder (1993)): more hours of previous supervision were associated with less technical adherence to the manualized treatment.

While it might be easy to dismiss the findings of the Vanderbilt II project as not applicable to beginning therapists (indeed, Henry, Schacht, et al. (1993) recommend the selection of competent but relatively

less experienced therapists as a way of maximizing positive manual-guided training effects), it is obvious that beginning therapists do not remain so for long. In my view, what these findings speak to is the significant difficulty of integrating new approaches into existing styles of interaction. As students' styles become more entrenched (as they certainly will with increased supervision), we can expect them to have more and more difficulty with manualized instruction. Training in psychological treatment is unlikely to be a simple matter of adding on one set of interventions after another. In a discipline so wedded to empirical demonstration, it is curious that the adoption and promotion of manualized instruction has occurred in the absence of empirical investigation. Given the findings of the Vanderbilt II project, it is not longer possible to assume that the educational effects of treatment manuals are solely benign.

Rather than getting mired in all of what I think is wrong with the Task Force's recommendations regarding predoctoral training, let me go back to the beginning. Did the Task Force really have anything to be concerned about in the first place? On the basis of a survey in which Directors of clinical trainingwere asked to check off those treatments in which their students received at least some training, the Task Force concluded with concern "that over 20% of programs do not teach anything about 75% or more of the empirically-validated treatments" (p. 6). While there might be considerable debate over whether this finding is, indeed, cause for concern, it is also not clear what the finding means. As the members of the Task Force note, no definition of training was provided and it is quite likely that Directors of training used quite different definitions. I, for example, used a very narrow definition and checked off only those treatments in which I was certain that our students received extensive, in-depth experience and supervision. I also did not check off, for example, cognitive behaviour therapy for panic disorder, if I was uncertain that our students had received explicit instruction in dealing with panic disorder, despite their having been trained in cognitive behaviour therapy for generalized anxiety disorder (although I would argue that the basic tenets and approaches of cognitive behaviour therapy are the same regardless of whether one is dealing with people with panic disorder or generalized anxiety disorder). If other Directors of training used a definition similar to mine and if the Task Force is satisfied with brief exposure to (rather than intensive training in) specific treatments, then there may be very few programs that are not providing the type and kind of coverage desired by the Task Force. In other words, there may be little, if any, cause for concern.

I will end with a call for common sense: Students need to be provided with intensive training in a few of the most widely-used treatments (e.g., cognitive therapy, behavioural therapy, interpersonal therapy, and brief dynamic therapy); they need to know that other forms of treatment are available and what the research literature has to say about psychological treatment in general. Most importantly, however, they need to be provided with training that fosters the development of interpersonal skills, specifically those skills that are required in handling complex human encounters.

References

Butler, S.F., & Strupp, H.H. (1986). "Specific" and "nonspecific" factors in psychotherapy: A problematic paradigm for psychotherapy research. Psychotherapy, 23, 30-40.
Frank, J.D. (1961). Persuasion and healing. Baltimore, MD: Johns Hopkins University Press.
Henry, W.P., Schacht, T.E., Strupp, H.H., Butler, S.F., & Binder, J.L. (1993). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses to training. Journal of Consulting and Clinical Psychology, 61, 441-447.
Henry, W.P., Strupp, H.H., Butler, S.F., Schacht, T.E., & Binder, J.L. Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. Journal of Consulting and Clinical Psychology, 61, 434-440.
Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparativestudies of psychotherapies: Is it true that "Everybody has won and all must have prizes?" Archives of General Psychiatry, 32, 995-1008.
McLemore, C.W., & Benjamin, L.S. (1979). Whatever happened to interpersonal diagnosis? A psychosocial alternative to DSM-III. American Psychologist, 34, 17-34.
Stiles, W.B., Shapiro, D.A., & Harper, H. (1994). Finding the way from process to outcome: Blind alleys and unmarked trails. In R.L. Russell (Ed.) Reassessing psychotherapy research. New York: Guilford.
Strupp, H.H. (1995). The psychotherapist's skills revisited. Clinical Psychology: science and practice, 2, 70-74.
Task Force on Promotion and Dissemination of Psychology Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. The Clinical Psychologist, 48, 3-24.
Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. Clinical Psychology: Science and Practice, 2, 45-69.

Empirically Validated Treatments: The Baby and the Bath Water*

S. W. Pyke
York University

As we explore the implications of a focus on empirically validated treatments for the education and training of psychologists, we should not lose sight of the contextual environment which fostered or promoted this agenda.

The Health Care Crisis

Health care costs are rising faster than any other segment of the economy, at a rate more than double general inflation. According to Resnick and DeLeon (1995), in 1993 in the United States, an estimated $884.2 billion was spent on health care. By the year 2000, health spending may consume 20% of the gross national product. Mental health expenditures currently constitute approximately one-tenth of total health care spending (Eckert, 1994).

At least some of the high cost of health care is alleged to be a consequence of fraud and abuse (10% of current costs) or the provision of unnecessary, inappropriate or ineffective services (20% of expenditures). The number of allegedly unnecessary hysterectomies, and the prohibitive cost and low

success rate of some of the reproductive technologies are cases in point. Closer to home, allegations of causing or creating false memories of sexual and ritual abuse have given clinical psychology a black eye and eroded public confidence in psychological care (Fox, 1995).

In spite of the prohibitive costs of good quality health care, many individuals lack protection against the potentially ruinous financial burden of health maintenance. Approximately 37 million Americans have no health insurance or grossly inadequate coverage (Resnick & DeLeon, 1995). Hence for many persons, access to necessary health care is limited. Since health insurance typically involves the selective avoidance of high-risk individuals, "those who need the insurance the most are least likely to have it. Many of these person include those with a history of mental illness." (Broskowski, 1995, p.157).

Managed Care

Against this backdrop, the phenomenon of managed care has surfaced. Managed health care is essentially a strategy for curtailing (i.e., managing) health care costs while ensuring that access to appropriate and cost effective high quality care is provided. Kaiser Permanente, one of the early health maintenence organizations (HMO) providing an integrated, comprehensive health service, has been touted as an exemplar of quality managed care. Cummings (1995) asserts that, 38 HMOs the size and efficiency of Kaiser-Permanente can treat 250 million Americans with only 290,000
physicians, half the present number, and with only 5% of the gross national product (GNP) instead of the current 14%." (p.13). Employers and/or insurance agencies purchase comprehensive health services for their employees or clients from the most competitive HMO. The HMO, in turn, subcontracts care to panels of individual providers who must agree to the terms of the contract which specify number of treatment sessions which may be provided.

Managed health care is clearly a growth industry. For example, it has been "reported that the chief executive officer of a major managed care firm received salary, bonus, and stock options last year of $9.8 million, plus dividends on his stock shares of $11.4 million!" (Fox, 1995, p.150). And, it has been estimated that the number of individuals covered by managed health systems is in the order of 102 million - almost 40% of the population of the United States.

Although there would seem to be consensus on the need for reform, the jury is still out on the question of the overall merits of managed health care for our discipline. Representing the polarity of views on the issue are Bertram Karon (1995) who refers to managed health care as a growing crisis and national nightmare (also see Fox, 1995) versus Nick Cummings (1995) who finds the challenges of managed health care both exciting and energizing.
Regardless of one's personal perspective, it seems clear that "psychologists now share with every health-related science and profession the public's demand for research-based evidence of cost-effective solutions to individual and community-wide health problems." (Broskowski, 1995, p.156).

Some General Concerns

We are in the throes of a major revolution in health care delivery as we move from a cottege industry of the independent practitioner operating out of a den at home to the large scale corporation with its emphasis on cost curtailment. The "big business" aspect of managed care has lead some to conclude that it is the corporate executive, not the health care provider who is central in the contemporary health market. Fox (1995), for example, points to the increasing number of corporate takeovers, mergers and buyouts in the health field. In Jurassic Park prose, Fox exclaims that "we have exchanged a mere blooksucking leech that sapped our strength for a ravenous carnivore that poses a much more fundamental threat to our very existence." (p.147). As practitioners are increasingly steered into large group practices or organized care systems and away from private practice and individual entrepreneurship, "a precious and personal kind of caring and caregiving will be lost (Fox, 1995, p.148) - a case of throwing the baby out with the bath water. He also has concerns about values and moral responsibility, about standardization and conformity, and about issues of confidentiality in the world of corporate health care.

Prepaid capitation rates, another feature of the managed health care environment, change the construal of client needs in subtle and invidious ways. The question becomes, what's the minimum amount of (effective and efficient) care I will have to provide in order to satisfy the client and referring physician. Under a fee-for-service arrangement the question for the therapist is, what's the maximum amount of care that I can be provide to a client and still be reimbursed by the insurer (Broskowski, 1995).

Both Fox (1995) and Karon (1995) decry the built in bias of HMOs against long-term, intensive, depth-oriented, psychodynamic/psychoanalytic psychotherapy. Cost-based limitations on the number of treatment sessions that are allowed may impair the quality of care and in fact, prove more expensive in the long run -another instance of both baby and bathwater going down the drain.

Prioritizing financial considerations encourages the belief that less well qualified and less expensive providers will deliver comparable services to those more qualified. But, the treatment repertoire of the less well qualified may be restricted to only one or two treatment models. When the only tool one has is a hammer, all the world looks like a nail. So, if one is familiar with only one form of therapeutic intervention, that's the approach that is applied regardless of its appropriateness. "This is precisely the problem with many of the less well-trained practitioners who are supposedly able to serve as substitutes for psychologists." (Fox, 1995, p. 150). Again, in the interest of economizing, we have discarded the baby along with the bath water.

Rationing Care

With an expanding and aging population and pressure for universal access, even with the very best reform efforts, health costs will continue to escalate. Hence some form of rationing health care seems inevitable. The preferred mechanism for rationing, consistent with the current ethos on accountability, is based on a determination of which treatments work or don't work for which disorders/diseases. And now we come to the theme of today's Conversation Hour – empirically validated treatments (EVTs). (Another variable relevant to rationing concerns the severity of the consequences of the disease).

Few, if any, psychologists would argue against the desireability of evaluating the efficacy of various treatment regimens in alleviating symptoms and/or producing positive outcomes. Nor would many query the appropriateness of including training in such validated treatments in the curricula of clinical programmes. That said, there are many thorny issues associated with this matter that stimulate debate.

For example, clinical psychology encompasses an array of more than 400 different treatments. We are a long way from testing the effectiveness of each and every brand name. And, as Sherlock Holmes pointed out, absence of evidence is not evidence of absence. By focussing exclusively on those treatments that have been empirically assessed with good results, we are in danger of eliminating or ignoring a number of valid treatments not yet tested, or tested in an insufficient number of studies or tested under conditions not unanimously recognized as sufficiently rigorous. Again, we run the risk of jettisoning the baby along with the dirty water.

In some sense, all psychological treatments work although relatively few treatments may have highly specific effects. So, it has been argued that in most cases, it is not the treatment variables per se that are most relevant but rather, a non-specific factor, the nature of the therapeutic alliance, as described by Greenson and Borden among others, that determines outcome. The psychotherapeutic relationship or working alliance is fundamental to any therapy intervention; it transcends the particular technology. Any treatment approach will work, will be effective at least to some degree, if the working relationship between client and therapist is characterized by rapport, empathy, trust, acceptance and hope along with agreement on task and goals. It is virtually impossible to separate the efficacious effects of these non-specific relationship variables from the salubrious effects of the application of the mechanics of the technology. The humanistic and experiential therapy orientations which speak most directly to the working alliance are, of course, not represented among the EVTs. In our eagerness to point with pride to our empirical successes, we mustn't assume that what's left is only bathwater.

Some critics of the EVT bandwagon have suggested that there is a political subtext to this debate which should be taken into account. It is alleged that the American Psychological Association (APA) or at least the Clinical Division of same is dominated by psychologists of a cognitive/behavioural persuasion. They constitute a power group and hence it is no surprise that the majority of empirically validated treatments reflect this orientation. Interestingly enough, EVT has not been high on the agenda for the Society of Psychotherapy Research, an organization which does not have the same concentration of cognitive/behavioural researchers. Keith Dobson (1995), in his CPA Presidential address, suggests that Canadian psychology has a leg up on our American counterparts in terms of EVTs. He reports "that Canadian clinical psychologists are more likely than their American colleagues to adopt a behavioural or cognitive–behavioural model..., models with stronger connection to empirical validation and the experimetal tradition." (p. 3). Parenthetically, it is interesting to observe the cross–over in psychology's two cultures (Conway, 1992; Kimble, 1984) with respect to EVTs. Professional psychology by and large reflects the Humanistic orientation (emphasizing the importance of context, holism, and the like) while academic psychology, the Scientific orientation, reveres objectivism, reductionism, determinism. Yet, the EVTs currently identified, are those revealed through the application of the scientific rather than humanistic orientation.

A medical model is implicit in the application of EVTs in the sense that client conditions or problems which often involve a highly complex and dynamic network of interrelated issues, require a specific diagnosis which in turn is linked to a specific treatment. The problem is more serious than simply distaste for the medical model with its emphasis on labelling, on disease rather than wellness, on remediation rather than prevention. Pairing of a disease/disorder with a specific treatment may be counterproductive in our field since research has indicated that the type of client, not just the type of treatment, predicts whether a treatment will be effective. In other words, a given treatment may be helpful only for a subset of the clients who suffer from the same disorder. Lack of empirical validation therefore shouldn't necessarily be taken to imply that all that's there is scummy water and a ring around the tub.

Implications for Training

Those treatments that have been empirically validated, such as David Barlow's treatment strategy for panic attacks, should certainly be covered in the curricula of graduate programmes in clinical psychology. If these were the only treatment approaches represented, however, the programme would be deficient. Many babies would be lost. By advocating breadth, we do not endorse eclectism, which has come to mean haphazard. Rather, the attempt is to adopt an integrative philosophy, i.e., to expose thestudent to an array of options and to explore how best to integrate these alternatives in a systematic fashion and within a theoretical framework. As noted by Nicholas Cummings (1995), "the lines of demarcation

among the various schools of psychology are blurring in favor of psychotherapy integration." (p.11).

Training programmes should eschew the artifical dualism of technology and relationship. Therapy is much more than technology, it is an art form. To focus solely on treatment technology is to destroy, at least in the view of some, the very essence of therapy – i.e., the working alliance.

A recent survey of 129 accredited programmes conducted by Mayne, Norcross and Sayett (1994) investigated the extent to which clinical faculty subscribed to the following five major theoretical orientations: psychodynamic/psychoanalytic; behavioral/applied behavior analysis; systems/family systems; humanistic existential/phenomenological; cognitive/cognitive–behavioral. Each of these orientations were endorsed by about 10% or more of the clinical faculty in these programmes. However, programmes differed in their faculty concentrations in these theory systems. "Research–oriented programs had a greater percentage of cognitive–behavioral faculty, whereas practice–oriented programs had a greater percentage of psychodynamic faculty." (p.809–810). These findings lead Broskowski (1995) to conclude that "the dominant ideologies for training psychologists have not kept pace with contemporary realities. Training for clinical psychology is dominated either by a clinical practice model that stresses solo practice and tradiional long–term therapy methods or a scientist–professional paradigm geared to forms of basic research but not health services research". (p.161).

At present, there is little evidence of proaction among Ph.D. and Psy.D. accredited clinical programmes vis a vis the health revolution and the emphasis on EVTs. A survey of 135 clinical programs conducted by the APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures: Recommendations for predoctoral Clinical Training Programs (1993) revealed considerable variability in the extent to which programs teach EVTs. They conclude that in one out of every five APA approved programs, EVTs are under–emphasized. Twenty percent of programs do not teach anything about 75% or more of the EVTs. With reference to other aspects of the revolution, Cummings (1995) contends that we continue to train excellent practitioners for the environment of the 80s and appauds the action of the California School of Professional Psychology, Los Angeles campus for implementing the first managed care track. Resnick and DeLeon (1995) are similarly impressed with the joint MBA/Psy.D. program at Widener University which presumably will better equip psychologists to respond effectively to the corporate realities of health care.

The identification of EVTs is based on investigationsemploying classical methods of research design reflective of the scientific orientation. Fueled in part by feminist critiques of traditional scientific praxis (Agnew & Pyke, 1994), utilization of more qualitative research approaches has been advocated. Training in these methods, long eschewed by mainstream experimental psychology, is a must for the new generation of psychologists. Not only do we need to expand our repertoire of research methods, but the topics recognized as legitimate areas of investigation must not be artifically constrained to the traditional themes. Psychologists can contribute to the identification of the appropriate organization and delivery of services, of the most suitable organization structures, of the procedures most likely to enhance patient acceptance of responsibility for her or his own health and so on (Broskowski, 1995).

En passant, I cannot resist alluding to the irony that in the current zeigeist of accountability, significant diminutions in overall support for research combined with significant expansion of government intervention seriously undermine injunctions to find more effective low cost treatments.

In sum, professional training must be expanded to include not only EVTs but a broad range of other treatments, with an emphasis on systmatic integration; training should encompass not only quantitative but qualitative research methods to assess efficacy of interventions; training should be extend to a broad range of health–related issues (i.e., not restricting the curriculum to mental health) – in essence further diversifying psychological practice (Hersch, 1995).

Recommendations

We should not lose sight of the fact that the EVTs movement grew out of an environmental context which differs in significant respects from the Canadian scene. Strategies adopted as appropriate and relevant south of the border may not necessarily export well to Canada, in spite of the North American Free Trade Agreement (NAFTA). It would be most unfortunate if the Canadian Psychological Association and the Accreditation Panel and provincial licensing bodies became tails wagged by an APA dog. There are already signs of this in other areas. To illustrate, consider the focus in accreditation reviews by both CPA and APA on ethnic diversity , a focus which fails to take into account relevant legislative and cultural differences (e.g., pluralism versus melting pot) between the two jurisdictions. The move toward specialty designation (Service, Sabourin, Catano, Day, Hayes & Macdonald, 1994) may be another case in point.

We should also resist pressures to pigeon–hole psychologists –to restrict us to primary provider roles for the mentally ill. Psychologists have studied and have much to contribute to a variety of health–related matters ranging from breast cancer to diabetes, from sports to pets. As Cummings (1995) and others(Browskowski, 1995) predict, the professional psychologist of the future will be primarily a health psychologist. Beyond the relevance of psychology to the health field in general, psychologists possess the necessary research acumen which should ensure a central role in the search for the most effective, least expensive treatments in all areas of health care.

And, we should resist the pull to pigeon-hole ourselves, to paint ourselves into a corner, through the application of inflexible regulations and/or the inforcement of rigid adherence to accreditation criteria and/or the restriction of acceptable research methods. Standardization is neither desireable nor adaptive, a principle recognized in the new APA accreditation guidelines (Custer, 1994). There are, as Dobson (1995) asserts, many psychologies; our strength lies in our diversity and must be protected.

This revolution in health care offers our discipline a tailor-made opportunity to complement the medical model with its focus on disease, remediation and compartmentalization, with a wellness model and a focus on prevention and the whole organism.

In conclusion, the press for accountability and the search for efficient and efficacious treatments will inevitably have a salutary effect on the discipline especially in a context of respect for diversity, in treatment approaches, in research methods, in theory and ideology, and in areas of focus.
There are many many babies in the tub; let's not lose any of them.

References

Agnew, N.McK., & Pyke, S.W. (1994). The science game (6th Edition). (pp.303-322). Englewood Cliffs, NJ: Prentice Hall.
American Psychological Association Division 12 (1993). Task Force on Promotion and Dissemination of Psychological Procedures: Recommendations for Predoctoral Clinical Training Programs. Author.
Broskowski, A.T. (1995). The evolution of health care: Inplications for the training and careers of psychologists. Professional Psychology: Research and Practice, 26(2), 156-162.
Conway, J.B. (1992). A world of differences among psychologists. Canadian Psychology, 33, 1-22.
Cummings, N. (1995). Impact of managed care on employment and training: A primer for survival. Professional Psychology: Research and Practice, 26(1), 10-15.
Custer, G. (1994). APA revamps its accreditation process. APA Monitor, November, 40-42.
Dobson, K.S. (1995). Psychology in Canada: The future is not the past. Canadian Psychology, 36(1), 1-11.
Eckert, P.A. (1994). Cost control through quality improvement: The new challenge for psychology. Professional Psychology: Research and Practice, 25(1), 3-8.
Fox, R.E. (1995). The rape of psychotherapy. Professional Psychology: Research and Practice, 26(2), 147-155.
Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. Professional Psychology: Research and Practice, 26(1), 16-26.
Karon, B.P. (1995). Provision of psychotherapy under managed health care: A growing crisis and national nightmare. Professional Psychology: Research and Practice, 26(1), 5-9.
Kimble, G.A. (1984). Psychology's two cultures. American Psychologist, 39, 833-839.
Mayne, T.J., Norcross, J.C., & Sayette, M.A. (1994). Admission requirements, acceptance rates, and financial assistance in clinical psychology programs: Diversity across the practice-research continuum. American Psychologist, 49(9), 806-811.
Resnick, R.J., & DeLeon, P.H. (1995). The future of health care reform: Implications of 1994 elections. Professional Psychology: Research and Practice, 26(1), 3-4.
Service, J., Sabourin, M., Catano, V.M., Day, V., Hayes, C., & Macdonald, G.W. (1994). Specialty designation in psychology: Developing a Canadian model. Canadian Psychology, 35(1), 70-87.

Footnote

* *I would like to express my appreciation to several colleagues who shared their views with me on the issue of empirically validated treatments.*

Some Concerns About the Listing of "Manualized" Therapies: Beware the Procrustean Bed

Richard A. Steffy
University of Waterloo

In Greek mythology the evil Procrustes offered a bed to weary travellers, but then took advantage of their sleep by robbing them of possessions and shearing off any portion of their legs that happened to stick out over the edge of the bed. With this grisly image in mind, I ask you to consider some of the potential costs to therapy research and practice that may arise from resting our expertise heavily on a bed of empirically-supportable (manualized) treatment procedures. I know that I could have chosen a less harsh caution (like co-presenter Sandra Pyke's, "don't throw the baby out with the bath water"), but perhaps Procrustes' savagery may better reflect the amputations to practice that may arise if we are not cautious in the use and advertising of a favoured set of "manualized" treatment strategies.

Before mentioning my exact concerns, you will need assurance that I am proud to be a card-carrying, Boulder model-believing scientist-practitioner, dedicated to empirical research intotherapy. I see the advantage to the use of manuals and to treatment efficacy research. Therapy research puts muscle into our technologies. Who could complain about being accountable? But the difficulty is how these developments are used, and the policies that may derive from the existence of a "sacred list". Four concerns follow:

I. Impact on Current Therapy Practice: Restricted Initiatives

One of the first questions to spring to mind is: "What about the other 500 treatments (Mahoney, 1995) that have not made the empirically-supported list?" Lord knows, many of them lack quality and we might want Procrustes to cut some of them right at the neck. But be wary of what may happen if swords start to swing — e.g., concerns derived from restrictive government or insurance company policies that declare Ph.Ds to be redundant because there is no data showing that they can create therapy outcomes any better than paraprofessionals (Dawes, 1994). The manual-based procedures will be very attractive to those who would wish to trim many treatments from their list of acceptable services. This is a dangerous prospect because it may preclude treatments that are less easy

to manualize or to press into efficacy studies than others, but are still good tools in the hands of practitioners who can use them skillfully and creatively. Take note that if my own carpentry performances were part of a validation study, the hammer, the saw and the drill would be outlawed.

II. Impact on Training Programs: Academic Perogative

Of special concern to academics is the effect of a sanctified listing of treatments on professional training programs. When John Hunsley asked me to give this talk, I asked colleagues what they knew of "manualized therapy". Don Meichenbaum knew immediately, but three others asked me if it is a form of "massage therapy". Fortunately the unenlightened trio brightened when the term "empirically-supported" was used, but they all foresaw restrictions of educational perogatives.

The first question a scholar must pose is how solid and representative are the efficacy studies that have been used to create the list, the very question that Parloff (1984) raised about the sampling of approaches included in the Smith, Glass and Miller (1980) meta-analyses. Parloff argued that the bulk of psychotherapy research is biased toward treating specific behavioural problems — work that permits tidier criteria and greater clarity of operations than is characteristic of psychodynamic approaches.

Academia will be pleased to have students learn manualized techniques in order to develop practical skills. However, academia offers a lot more than skill training. It also aims to elevate students' capacity to conceptualize complex problems. Conventional therapy practice is a major route to the developmentof a broad perspective. Students must learn that clients have more than specific symptoms needing to be excised; they also have family dynamics, special strengths, loadings of Big 5 traits, possible vulnerabilities to all matter of outcomes ranging from baldness to schizophrenia, and a need to maintain the dignity of the life journey. I would hate to see students' opportunity to grasp these "big picture" concerns eclipsed by training that may be centered solely on technical mastery of a limited set of therapy procedures, focussed mainly on symptom reduction.

III. Quality of Service: Possible Oversimplification of Treatment Goals

Internship agencies wishing to have their training program advertised in an internship directory published by APA's Division 12 (Section III) are asked to indicate which of a set of empirically-supported treatments are trained in their program. Scanning that list (part of which was presented in Hunsley's opening paper) reveals the fact that manualized approaches tend to address a restricted set of behavioural deviations. My problem is that I rarely see clients whose difficulties can be neatly described by a few specific symptoms. Even those who enter our service with a crisp presenting problem — a phobia, a depression — tend within a few sessions to lose sight of the initially-stated problem. In my experience most clients quickly expand their focus to a wider plane — with regrets over thwarted life goals, concern over personal integrity, needs to remedy sour interpersonal relationships, and various other woolly problems.

As an illustration of this point, I recall a young adult entering treatment as an overwhelmingly anxious, perfectionistic individual striving in an elite academic program for very high grades. The client reported long-persisting discomforts (sleepless nights, physical symptoms of anxiety and intense worries over academic survival). Within three sessions the student therapist, who was struggling to grasp this individual's experiences and deal with a barrage of intellectualized and highly energized verbage, witnessed a remarkable calming. The severity of the anxiety response dissolved and therapy discussion was refocussed onto relationship issues with family, teachers and peers, and it quickly shifted thereafter to intimacy issues, topics which continued to take center stage over the next few months. Only occasional miniscule flashes of anxiety were seen after the first visits.

My student and I had been tempted to put a manual into effect to assist anxiety management, but with the fast refocussing of the case, we had no occasion to do that. In retrospect we now feel that an anxiety-reduction strategy would not have helped, since the big problem seemed to be the client's proneness to provoke an anxiety reaction, rather than to cope with it after it was fired up. In short, the salient features of this person's problem seemed to take time to emerge, and this observation feeds my concern that a manualized strategy delivered in a lock-stepfashion would hazard clients' fullest development. Time and time again in training psychodynamic approaches, students are cautioned to listen actively to their clients. Shapiro (1989) gives elegant testimony to the way in which the style of problem presentation can be more important than is the presenting problem itself. And so I am worried that the manualized strategies may be indelicately applied, especially if their use encourages practitioners to jump right onto the so called "presenting symptoms", without a concern for the place of the symptoms in the overall economy of the client.

IV. The Frontier: Reduced Creativity

It is safe to say that no therapy procedure is completely satisfactory, and we would hope that the field is dedicated to continuous improvements. If an empirically-supported list helps this goal, we all profit. If a listing overly focusses research and practice onto techniques, it may curtail new initiatives; and we shall be sadder for it. Therapy is more than its techniques. Therapist qualities, for example, account for a large portion of variance (Beutler, Machado & Neufeldt, 1994; Dobson & Shaw, 1988; Lambert, 1989). Dawes (1994) argues that client motivational factors are another large influence. If this is so, then elevating a set of particular procedures into high status, may reduce consideration of vital therapist and client qualities, to the detriment of our quality of service and our theories of change.

Various attempts to harness the potential of client and therapist style differences that may interact with treatment procedures are on the horizon. Two that come to mind I label "fitting" and "tailoring" techniques. Fitting is used in the way that Frances, Clarkin and Perry (1984) choose treatment setting, format, orientation, and mode of therapy most appropriate to the clients' particular level of functioning. Tailoring modifies an established treatment procedure in order to accommodate receiver–qualities of the client. Illustrating tailoring, our lab a few years ago altered smoking cessation treatments in ways that capitalized on several individual differences relevant to the problem for which clients sought help, e.g., their motivation to quit smoking and their locus of control scores (Best & Steffy, 1971; 1975). Research designs were formulated that investigated the match of subjects' "locus" tendencies and their motivation to quit (called "mocus") to various treatment procedures given a personality–tailored "focus". Although this may sound like so much "hocus pocus", in fact, the congruent subject x treatment conditions did remarkably better — not at the end of treatment but in the follow–up period — than did the incongruent matches.

Another tailoring strategy is found in an interpersonal therapy which applies circumplex technologies to choose a therapist style to help shift their maladaptive interpersonal behaviour patterns (Kiesler, 1983). Both Kelsler's and our work modifies established treatments in order to accomodate client andtherapist features. I am concerned that a too vigorous embrace of simple–strategy "validated procedures" may thwart treatment developments that employ complex features of client and therapist style.

Concluding Remarks

I have made cautionary remarks, but I do not wish to discourage efforts to validate therapeutic techniques. My main concern has been that we do not allow the empirically–supported approaches to be lifted into a "heavenly" status, thereby curtailing future development and putting treatment perspectives into the hands of subprofessionals charged with client management. Worry about such a spectre made me accept Hunsley's kind invitation to the panel where speakers could remind the audience that therapies are still in a formative phase, vulnerable to thwarted growth. Therapeutic process has features much like the development of knowledge in educational strategies and the development of affiliation in family life; all three require a continuously maturing process. Therefore, in a melodramatic and grouchy voice, I must conclude that those who nap in the Procrustean bed of a limited practice set, may lose more than a few limbs, they may lose their heart as well.

References

Best, A. J. & Steffy, R. A. (1971) Smoking modification procedures tailored to subject characteritics. Behavior Therapy, 2, 177-191.

Best, A. J. & Steffy, R. A. (1975) Smoking modification procedures for internal and external locus of control clients. Canadian Journal of Behavioural Sciences, 7, 155-165.

Beutler, L. E., Machado, P. P. P. and Neufeldt, S. A. (1994) Therapist Variables. In A. E. Bergin & S. L. Garfield (Eds.) Handbook of psychotherapy and behavior change. New York: Wiley, 229-269.

Dawes, R. M. (1994). House of Cards: Psychology and Psychotherapy Built on Myth. New York: The Free Press.

Dobson, K. S. & Shaw, B. F. (1988) The use of treatment manuals in cognitive therapy: Experience and issues. Journal of Consulting and Clinical Psychology, 56, 673-680.

Frances, A., Clarkin, J. and Perry, S. (1984) Differential Theraputics in Psychiatry. New York: Brunner/Mazel.

Kiesler, D. J. (1994) Standardization of intervention: The tie that binds psychotherapy research and practice. In P. F. Talley, H. H. Strupp & S. M. Butler (Eds.) Psychotherapy research and practice: Bridging the gap. New York: Basic Books, 143-153.

Kiesler, D. J. (1983) The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. Psychological Review, 90, 185-214.

Lambert, M. J. (1989) The individual therapist's contribution to psychotherapy process and outcome. Clinical Psychology Review, 9, 469-485.

Luborsky, L. & DeRubeis, R. J. (1984) The use of psychotherapytreatment manuals: A small revolution in psychotherapy research style. Clinical Psychology Review, 4, 5-14.

Mahoney, M. J. (1995) The modern psychotherapist and the future of psychotherapy. In B. Bongar & L. E. Beutler (Eds.) Comprehensive Textbook of Psychotherapy. New York: Oxford University Press, 474-488.

Parloff, M. B. (1984) Psychotherapy research and its incredible credibility crisis. Clinical Psychology Review, 4, 95-109.

Smith, M. L., Glass, G. V. and Miller, T. I. (1980) The Benefits of Psychotherapy. Baltimore: The Johns Hopkins University Press.

Shapiro, D. (1989) Psychotherapy of Neurotic Character. New York: Basic Books, Inc.

NETWORKING

National Forum on Traumatic Stress.
Included with the mailing of this number of CCP is a notice of the Frist National Forum on Traumatic Stress. Traumatic stress is a problem that has only recently begun to be addressed. Our response requires social action as well as scientific and professional work. The conference is ambitiously attempting to (a) educate about the nature and prevalence of traumatic stress,(b) establish links between service providers, researchers and the consumers of traumatic stress services, and (c) form an organization which will continue these aims. We believe that this project will contribute substantially to effective response to the occurrence of traumatic experience which affects our emergency workers and ordinary folk as well as the significant disasters. Please respond to the notice personally or forward it to someone who will.

E-mail Directory.
Your email address svp!
There are many of us who like to exchange ideas and comments on the Internet. Allan proposes that you send your email address to the editor (dhart@play.psych.mun.ca) so that he can compile a list for publication in a future Canadian Clinical Psychologist. That directory will enable you to quickly contact a colleague and permit colleagues to readily mail to you. Let us know of your comments about this initiative or related ideas.
David Hart expects to create a Clinical Section home page during the christmas holidays. Look for it via the CPA home page!

Manuals List for Empirically Validated Treatments. Sheila Woody and William C. Sanderson, both members of APA's Division 12 Task Force on Psychological Interventions, have compiled a "Manuals List for Empirically Validated Treatments". To quote from my source, Clinical Science, Summer 1995, "we wrote to leading investigators in the respective areas of treatment research, particularly those whose work formed the basis for judging a particular treatment to be efficacious.These investigators provided citations for those published manuals. Many of them offed to provide copies of unpublished manuals to other clinicians. The list also contains information about training opportunities in empirically validated interventions.

The list is available through Division 12 Central Office, PO Box 22727, Oklahoma City, OK 73123, USA. Send a stamped self-addressed envelope and $1.50 for handling.

The World of Psychotherapy: The First Congress of the World Council for Psychotherapy is scheduled for Vienna 30 June to 4 July, 1996. Paper submission deadline is past, but you can still make plans to attend. Among those presenting papers are H.J. Eysenck, Viktor E. Frankl, Don Meichenbaum, and Thomas Szasz. Topics of symposia range from #1, Psychoanalysis to #5, Behavior Therapy, #9, Systemic Family Therapy, #11, Catathym Imaginative Psychotherapy, #24, Neurolinguistic Programming, #25, Body Psychotherapy, and #28, Hypnotherapy. Topics for symposia will include psychotherapy as science and art, psychotherapy in various cultures around the globe, psychotherapy as a profession and its role in various aspects of society, psychotherapy and medicine, and special areas such as crisis intervention, homosexuality, concentrative motion therapy, music therapy, sexual abuse, rural areas, and psychotic people.

For information, contact:
ICOS Congress Organization Service GmbH
Johannesgasse 14,A – 1010 Wien
Tel: +43/1/512 80 91 0 Fax: +43/512 80 91 80

(The editor has two copies of the conference announcement booklet with registration forms which you may obtain on request)

MEMBERSHIP

Your membership is very important to the health of the Clinical Section. Please ensure that you renew your section membership when you renew your membership in CPA. That done, go one step further and encourage a colleague to join. We can only be an effective voice for clinical psychology in Canada if we have a large membership.

ORDER FORM
THE CLINICAL PSYCHOLGIST IN CANADA BROCHURE

TO
Debbie Dobson, Ph.D.
Foothills Hospital
1403 – 29 St. N.W.
Calgary, Alberta
T2N 2T9
Tel 403-670-4804
Fax 403-670-2525
ddobson@acs.ucalgary.ca

FROM: _____

_____

_____

_____

_____

I wish to order ____ brochures @ $0.35

My cheque for $ _____ is enclosed

(Make cheque payable to Clinical Section CPA)

CLINICAL SECTION BUSINESS

Financial Statement: July 1, 1994 to June 30, 1995

Budget	Income		
$5,500.00	Membership dues		
$4,572.25			
	(To June 30th, 1995)		
400.00	Brochures		206.50
	Advertising		300.00
	Bank Interest		26.21
$5,900.00			$5,104.96
	Expenses		
$1,700.00	Canadian Clinical Psychologist 1165.93 & 430.00 (Estimated June issue)		$1,595.93
1,000.00	Brochure & Definitions	403.81	
800.00	Telephone/Fax/Mailing	51.83	
250.00	Awards	250.00	
2,300.00	Winter Executive Meeting	2,256.02	
200.00	Stationary	0.00	
300.00	Special Projects	0.00	
2,000.00	Professional Development Fund	372.50	
100.00	Misc.	0.00	
$8,650.00		$4,930.09	$4,930.00
	Excess Income Over Expenses		174.87
	Balance Forwarded August 8, 1994		$8,123.62
	Balance on Deposit July 1, 1995 -430.00 (Estimated)		$8,298.49

Respectfully Submitted,

Deborah Dobson, Ph. D.
Secretary-Treasurer

Audited by,

David Hodgins, Ph.D.
Section Member

Revised Budget (1995-96)

Income		
Balance forwarded (July 1, 1995)		$8,298.49
Estimated Membership Dues (1996)		4,500.00
Estimated Other Income (Advertising, brochures, etc.)		500.00
		$13,298.49
Expenses		
Canadian Clinical Psychologist (incl. mailing)	1,600.00	
Telephone/FAX/Mailing	800.00	
Winter Executive Meeting	2,800.00	
Awards	250.00	
Stationary	200.00	
Special Projects (Poster-Conference)	200.00	
P.D. Fund	1,500.00	
AGM (1995) Refreshments	200.00	
	$7,550.00	
Estimated Assets (As of June, 1996)		$5,748.49

Respectfully Submitted,

Deborah Dobson, Ph.D.
Secretary-Treasurer

NEWSLETTER SCHEDULE

The CANADIAN CLINICAL PSYCHOLOGIST will circulate three times per year: November, February, and May.

Clinical Section
Executive Officers 1995–96

Chair
Allan Wilson, Ph.D.
Psychology Department
The Nova Scotia
Hospital
Dartmouth, NS B2Y 3Z9
Tel 902–464–3184
Fax 902–464–3460
awilson@ac.dal.ca

Past Chair
Sam Mikail, Ph.D.
Psychology Department
Rehabilitation Centre
505 Smyth Road
Ottawa, K1H 8M2
Tel 613–737–7350 ext 5565
Fax 613–737–7056

Chair Elect
Keith Wilson, Ph.D.
Psychology Department
Rehabilitation Centre
505 Smyth Road
Ottawa, K1H 8M2
Tel 613–737–7350 ext 5608
Fax 613–737–7056

Secretary Treasurer
Debbie Dobson, Ph.D.
Foothills Hospital
1403 – 29 St. N.W.
Calgary, Alberta
T2N 2T9
Tel 403–670–4804
Fax 403–670–2525
ddobson@acs.ucalgary.ca

Member-at-Large
Paul Hewitt, Ph.D.
Department of Psychology
University of British Columbia
2136 Wesbrook Mall
Vancouver, BC V6T 1Z4
Tel 604–822–5827
Fax 604–
PHewitt@cortex.psych.ubc.ca

Newsletter Editor
David S. Hart, Ph.D.
Memorial University
of Newfoundland
St. John's, NF
A1B 3X9
Tel 709–737–7683
Fax 709–737–2430
dhart@play.psych.mun.ca