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Fond Farewell and a Warm Welcome

Lesley Graff

This newsletter is the first edition under the leadership of Alex Weinberger. He took over as editor from David Hart. David, who produced the newsletter for the past six years, has been instrumental in getting information out to clinical psychologists across the country. He has left as part of his legacy a home page for the section. You can visit it (and David) anytime at **http://play.psych.mun.ca/~dhart/clinical/**. Thank you David for your work, your vision, and your computer creativity.

I am very pleased to be able to introduce our new editor, Alex Weinberger, to the clinical psychology section. He comes to this position with excellent experience and a national perspective. He graduated with his PhD from the University of Windsor in 1980. Alex worked in the mental health field in Saskatchewan for 15 years. During that time, he was editor of the Saskatchewan Psychologist from 1982-86, and concurrently served as editor of the newsletter of CPA's Applied Division from 1983-88. He was the Registrar of the province's regulatory body, the Saskatchewan Psychological Association, from 1988-92. He has been a regular contributor to Psynopsis, writing a viewpoint column in our national newsletter. Alex moved to Ottawa in 1993. He works in the school psychology field, maintains a private practice, and teaches at Carleton University as a sessional lecturer. Thank you Alex, for stepping into this job. We are delighted to have you.

Submissions Invited

The Canadian Clinical Psychologist/Psychologue Clinicien Canadien invites submissions from section members and others. Brief articles, conference or symposia overviews, opinion pieces, and the like are all welcome. Submissions will be screened for merit and length as a condition of acceptance for publication. The thoughts and views of contributors are strictly those of the author(s) and do not necessarily reflect the position of either the Section, or the Canadian Psychological Association, or of any of its officers or directors. Please send your submission, in English or French, directly to the editor, preferably either on disk or via e-mail attachment. The newsletter is published three times a year. Submission deadlines for these issues are as follows: October 20 (November Issue), January 20 (February Issue), and April 20 (May Issue).

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The Millon Adolescent Clinical Inventory™

A brief self report adolescent personality inventory, which evolved from the Millon Adolescent Personality Inventory™. The MACI was designed with a more focused normative sample consisting of adolescents in various clinical treatment settings. Through a series of contemporary questions, it assesses an adolescent's reported concerns and clinical syndromes.

Applications

The MACI is used for adolescent assessment in outpatient, inpatient, or residential treatment settings. It can be used by psychologists, psychiatrists, school psychologists, juvenile justice professionals, and other mental health professionals.
It can be useful in:
- Initial evaluation of troubled adolescents to confirm diagnostic hypotheses and contribute to individualized treatment planning
- Measurement of treatment progress when used in pre and post-treatment assessment

The MACI contains 160 True/False items, is written at a sixth grade reading level, and most adolescents can complete the test in only 30 minutes. 111 of the 160 items on the MACI are new or rewritten from the original MAPI to reflect the additional clinical scales and DSM-IV changes.

Features

A summary of potential treatment strategies, tailored to each patient, is provided in the MACI Interpretive Report. This may help clinicians decide which issues to focus on in treatment and how to address them with the patient.

The normative population for the MACI consists of 1,017 adolescents involved in inpatient or outpatient assessment or residential treatment programs. The ease of administration and the depth of information provided by the MACI simultaneously serve the needs of both the patient and clinician in these settings.

Scales

The MACI contains 27 scales within three categories including Personality Patterns, Expressed Concerns and Clinical Syndromes. It also contains modifying indices that help identify test taking attitudes as well as confused or random responding.

Rural and Remote Communities:
Issues for Psychology Practice and Training*
Bob McIlwraith
Department of Clinical Health Psychology
University of Manitoba
Charl De Wet
High Prairie, Alberta
Keith G. Wilson
The Rehabilitation Centre
Ottawa, Ontario

Psychologists practicing in rural or remote communities face unique practical, professional , ethical and cross-cultural challenges. These are examined through description of two clinical services: a primary care psychology practice in a remote First Nations community in Manitoba, and a multidisciplinary travelling rehabilitation clinic in Northeastern Ontario. Implications for the training of psychologists to work in rural or remote communities are discussed, and a new programme which will train psychology interns and residents in rural and remote communities in Manitoba is described.

Charl De Wet, M.A., C. Psych., has been providing a general practice in psychological service to mainly First Nations people for five years in Northern Manitoba and then for two years in Northern Manitoba. He describes the main practical problems as:

Trust - The time that it takes to build trust may be disheartening to the beginning psychologist. Taking time to learn the culture of the community and its people is important. The quality of service that you provide, your flexibility in working at less traditional hours, and the compassion with which the service is provided are also important in building trust. Consumers may be uninformed about what psychological services entail and constant de-mystification of your service is necessary. Once you have established a practice however, extricating yourself from it may also be hard and painful.

Loneliness - It may be hard for colleagues in other places, used to substantial peer support and a referral network, to understand the professional isolation you experience.

Time Constraints - There is a fine line between underselling, being not busy enough, and overselling, and being impossibly busy. Working out a strategy to circumvent missed appointments is also of greatest importance to building a viable practice.

The main professional issues are:

Lack of Prescription Privileges - The inability to prescribe medications significantly reduces the efficiency of mental health services in remote communities, where the psychologist may be the most knowledgeable individual in the area on the subject of psychopharmacology and mental disorders. Resourcefullness is required in order to help patients who could benefit from medications to receive them.

Looking After Yourself - The lack of peer support will take its toll on the psychologist's professional functioning, compared with an environment where caring peers are bound to notice your needs. Looking after yourself becomes a priority.

Payment Policies - The fact that psychologists are not reimbursed for services by provincial governments amounts to an unfair subsidy to physicians. (Note: Psychological services provided to First Nations people by psychologists in independent practice are paid for by the Federal Government, but not by provincial governments.)

The main ethical issues facing psychologists in remote communities are:

Lack of Privacy - As the mental health expert you may find yourself under much public scrutiny. You may also have to adjust your private life to this reality.

Dual Relationships - The ethical guidelines about

seeing members of the same family are severely challenged in small communities. In many cases, a psychologist will see members of the same family for the same issues, or for different issues, or will discover once treatment is underway that the client is related to other clients. If the patient is sent to the city for treatment, colleagues there may question your judgment when they learn that you have been seeing multiple members of the same family.

Urban vs. Rural Professionals - Diagnoses made by professionals in the city who may see your clients may very well disagree with your diagnosis, as patients may present quite differently in different environments. This can further strain your relationships at a distance with other professionals.

Cross-Cultural Competency - In order to be prepared for rural practice it is as important for psychologists to be competent in understanding culture and the therapy context as it is for psychologists to be proficient in any of the areas of knowledge historically associated with professional competence. More and more it is recognized that the barriers to effective cross-cultural psychotherapy reside in the therapist. Therapists must come to grips with their own characteristics, biases, stereotypic notions, and must be comfortable enough to allow for flexible interpretations of their therapeutic methods to fit patient requirements without becoming irrationally eclectic. For the psychologist practicing in a remote area, understanding the relativity of your own ethnic biases becomes insurance against closing down emotionally when confronted with ambiguity and differences in culture.

Rural practice requires a well-functioning psychologist who can live with ambiguity. You must understand bureaucracies and be able to perform despite them. You have to be culturally sensitive and wise as well as being a hardy person with a strong sense of coherence.

Keith Wilson, Ph.D., C. Psych., is the psychologist with the Terry Fox Mobile Clinic, an interdisciplinary rehabilitation outreach programme associated with the Rehabilitation Centre in Ottawa. The mobile clinic provides rehabilitation services for people with disabilities in 14 rural communities in Eastern and Northern Ontario. The clinic includes a physiatrist, nurse, physiotherapist, social worker, speech-language pathologist, occupational therapist, and other specialists in such areas as prosthetics and orthotics as needed. The team provides primarily consultative services to local health professionals, in-service education, and some direct service to individuals and their families. The psychologist specifically provides cognitive neuropsychological assessment, consultation on management of chronic pain, and mental health in disability, as well as education for professionals on depression, brain damage and behaviour, cognitive assessment and psychological aspects of medical conditions. Programme evaluation expertise is also provided by the psychologist.

The major practical challenges of this type of work include:

Lack of Community Resources - Although the mobile clinic's purpose is to enable people with disabilities to receive rehabilitation services in their own home towns to the greatest extent possible, frequently treatment recommendations made by the team may involve resources that are not available in the local community. As consultants, the team members are not well-integrated into the community and may not know what community resources exist or where they are.

Length of Time Between Visits - Continuity of care and follow-up are hampered by the episodic nature of home visits.

Demographic Trends - The demographics of rural communities also affect the availability of rehabilitation services for rural people. As younger people leave, rural communities are aging, and there are fewer supports for disabled older persons whose families may have moved to the city. As the populations of rural communities decline, their ability to attract and retain health professionals also declines, and most specialist services are, of course, based in large cities.

Role of the Consultant - Training for this sort of itinerant practice ought to emphasize consultation and teaching skills, in order to enhance the functioning of other professionals and family caregivers, as the psychologist can provide only limited direct service. Programme evaluation skills are also important, to assess whether the services being provided are effective.

Bob McIlwraith, Ph.D., C. Psych., is Director of Internship Training in the Department of Clinical Health Psychology at the University of Manitoba Faculty of Medicine. For the past several years the department has been developing a new rural and northern community-based psychology training programme which accepted its first interns and resident in 1997. Interns will spend six months of their training year in a rural or northern community, while the Resident is placed in a rural community for twelve months. During these placements, they will receive their supervision from psychologists who live in these rural or northern regions. The Department provides consultation and back-up supervision to two recently-hired clinical psychologists based in Thompson and in the Interlake and East-Man regions of the province. recruitment is continuing for a psychologist position based in The Pas, Manitoba.

As the federal government transfers responsibility for health care to First Nations Communities and their political organizations, and as the provincial government (at least in Manitoba) transfers responsibility for health to Regional Health Authorities, enormous opportunities for psychologists and other health professionals are opening up in rural and northern communities.

The major practical challenges of rural and northern communities include:

Recruitment and Retention - Professionals in small or remote communities typically have high turnover. Turnover among one's colleagues is a source of stress, due to the disruption in professional and peer support. Social contacts outside of work for single persons may be limited in small communities and employment opportunities for spouses may be limited for married persons.

Limits of Competence - Psychologists working in rural or remote communities will constantly encounter cases which require knowledge or skills beyond those they possess. No one psychologist can do everything, and if resources for consultation, back-up and referral do not exist or are not readily accessible, feelings of frustration, inadequacy, and burnout will surely follow. Psychologists risk being drawn into areas of practice where they are not competent, due to the acuity of needs in the community.

The rural and northern community-based psychology training programme aims to continually train new psychologists to replace others who may depart. Trainees completing their year of internship or residency are obligated to accept employment as psychologists for a year in rural communities in Manitoba, if such positions exist (if no position is available, they are released from this commitment). It is our hope that many of these individuals will stay on beyond this time commitment in some area of rural or northern practice. Many psychology students have never had experience in rural or northern communities, and although they may be interested in cross-cultural psychology or community mental-health, they may have inaccurate ideas about rural or northern communities, or may not know if they could function in such a setting. The rural and northern training programme gives interns and residents the chance to try it out for a while, to experience working in such a community, with the support of a supervisor on site.

The programme further aims to enhance the retention of psychologists in rural or remote communities by providing them with a professional support network through the University of Manitoba, Department of Clinical Health Psychology. Thus, psychologists in Thompson and Interlake-East-Man have regular weekly supervision and consultation (by telephone in the case of Thompson), and prompt referral to other psychologists who are specialists in areas such as neuropsychology, rehabilitation, child protection,

psycho-oncology, anxiety disorders, child therapy, and diagnostic assessment. Travel funds are also provided for these psychologists to visit Winnipeg, and from consultants from Winnipeg to visit outlying communities, as may be requested for assistance in identified areas of need. The psychologists in these regions have already commented in their first year in practice that they would find their jobs impossible without this support network.

Having residents and interns to supervise will, we hope, add additional intellectual stimulation and interest to these positions.

What we have learned from their experiences so far — besides the necessity for a support network — is that training for psychologists going into practice in rural or remote communities should include:

Generalist Skills for Primary Care - These include good assessment, triage, and treatment skills, team-work and team-building skills, consultation with other health professionals, and management of emergencies. Consultation with other primary service providers such as mental health workers and family physicians is an extremely important skill, because if the psychologist personally takes on all referrals he or she will become impossibly busy and thus inaccessible to the community.

Professional Identity - The psychologist's sense of professional identity can erode in multidisciplinary work settings where there are no other psychologists. There is a need to educate other professionals about the special requirements of psychological practice and professional boundaries specific to psychologists' work while not alienating oneself from other members of the team. Training must prepare psychologists with a solid sense of their professional identity and roles, but frequent contact with a larger network of other psychologists is important, especially for psychologists early in their careers.

Ethical Issues - Psychologists need to be prepared to understand the special ethical issues that arise in small communities, such as confidentiality, and boundaries between work and social relationships.

Canadian Contributions to Research on Depression

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At the last annual convention of the Canadian Psychological Association in Toronto, the Clinical Psychology Section sponsored a symposium highlighting Canadian research on depression and its treatment. The symposium consisted of five representative papers that provided a unique sampling of a long tradition in Canadian psychology of research into the psychopathology and treatment of affective disorders. Although it was not possible to represent all the significant areas of depression research contributed by Canadian psychologists, nevertheless the participants in this symposium are well-recognized both nationally and internationally for their work on depression theory, research and treatment. A special issue of the Canadian Journal of Behavioural Science is planned for 1998 based on this symposium. In the meantime the following is a very brief summary of each presentation.

In the first paper, Zindel Segal, with co-author Michael Gemar of the Clarke Institute of Psychiatry, discussed a fundamental construct in cognitive theories of depression, the negative schema. A definition of schemas was provided that emphasized the interconnection between basic elements or concepts, and the authors noted that early cognitive-clinical research failed to support a key prediction of the cognitive theory of depression; that negative schemas are vulnerability factors in depression with temporal stability and persistence beyond the depressive episode. Segal and Gemar noted that this failure to support cognitive vulnerability to depression may in part be attributed to the limitations of self-report questionnaires designed to assess negative self-schema content. They discussed a number of alternative methods to schema assessment pioneered in their own laboratory as well as in other Canadian facilities, based on the information processing paradigm, that may be more sensitive to the activation of depressive schematic constructs. These alternative procedures evaluate cognitive processes that may more directly reflect a heightened accessibility to negative constructs in depression.

David Zuroff, McGill University, discussed a reanalysis of the NIMH's Treatment of Depression Collaborative Research Project data set that tested the influence of the personality constructs of dependency and self-criticalness on short-term treatment outcome for depression and the quality of the therapeutic relationship. Based on the Dysfunctional Attitudes subscales of Perfectionism (self-criticism) and Need for Approval (dependency), Zuroff reported that Perfectionism but not Need for Approval was related to poorer outcome across the four treatment conditions of the NIMH study. The negative effects of perfectionism on outcome were especially pronounced during the second half of treatment with moderate and high perfectionists showing no further treatment improvement. Quality of the therapeutic relationship had no influence on positive treatment outcome for high or low perfectionists. However for individuals with moderate levels of perfectionism a poor therapeutic relationship was associated with worse treatment outcome. Based on these findings Zuroff speculated that perfectionists might find it more difficult to engage with a therapist in more active therapeutic work that characterizes the latter sessions of psychological treatment for depression such as questioning beliefs, doing home work and changing behavior with significant others.

Keith Dobson, University of Calgary, discussed outcome and process-oriented research on the efficacy of cognitive therapy for depression. In a published study with co-author Neil Jacobson of the University of Washington, cognitive therapy was found to be effective in treating two-thirds of their sample of depressed married women and to have as much effect on reducing marital distress as marital therapy. These results indicate that cognitive therapy can have both specific (i.e., antidepressant) and more general (i.e., improved relationships) treatment effects. In a second dismantling study, Dobson and Jacobson found that the effectiveness of cognitive therapy for depression may not be found in the specific cognitive ingredients of the therapy but rather in its behavioral activation components. That is, what makes cognitive therapy an effective treatment for depression may be that it systematically encourages the individual to become more active rather than in providing individuals with strategies for changing negative thought patterns. Dobson concluded by noting his involvement in a new five year NIMH

sponsored study comparing behavioral activation, cognitive therapy and three other treatment conditions, one involving the SSRI medication sertraline, in the treatment of depression.

Paul Hewitt of The University of British Columbia, with co-author Gordon Flett of York University, presented a review of their research on perfectionism and its role in the etiology and persistence of depression. They emphasized the importance of taking a multidimensional perspective on perfectionism based on a distinction between self-related or achievement-oriented and socially-oriented perfectionism. In their program of research, Hewitt and Flett have convincingly demonstrated the importance of these two perfectionism dimensions in depression as evidenced by their significant findings on depressive syndromal specificity, diathesis-stress congruence, temporal stability and associations with critical features of the disorder such as chronicity. The research on perfectionism as a predisposing factor to unipolar depression is particularly important with results from a number of studies indicating that self-oriented perfectionism may be the most important perfectionism dimension in terms of a stress-vulnerability factor in depression. The research program of Hewitt and Flett on perfectionism provides an excellent example of the important contribution personality research can make to understanding psychological disorders.

Finally, Heather Sears of the University of New Brunswick, with co-author Vicki Armstrong, discussed findings from a two-year longitudinal study they conducted on depressive symptoms in community-based adolescents. Their sample consisted of 149 adolescents from a rural Nova Scotia high school who were administered the Beck Depression Inventory, State-Trait Anxiety Inventory - State Scale, and a checklist of adolescent problem behaviour designed specifically for this study. Increase in depressive symptoms over time was closely linked to changing levels of anxiety, a finding consistent with the literature indicating a high degree of co-morbidity for anxiety and depression at both the symptom and syndromal levels. Behavioural problems were predictive of an increase in depressive symptoms only for adolescents with relatively high

levels of anxiety. These findings are a reminder that research on depression in children and adolescents may prove particularly difficult because of the complicated influence of co-occurring symptoms and disorders.

On Behaving Scientifically: Fallibilism, Criticism, and Epistemic Duties

William O'Donohue
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Clinical psychologists often talk about science. There is talk of the "scientist-practitioner" model of clinical psychology; talk of applying basic research findings to clinical phenomena; and talk associated with consuming and/or producing clinically relevant scientific research. Few clinical psychologists would argue that science is irrelevant to their professional behavior.

However, a major problem in our profession is that too few professionals seem to consistently behave in a way that shows that they actually understand, value, and engage in science. The modal number of publications is zero; the average number of articles or books read per year is quite low; and too few apply empirically validated treatments (see O'Donohue, Fisher and Curtis, 1985, for a review). Importantly, too few approach clients suffering from problems that we don't have known effective treatments in a way that is scientific (Barlow, Hayes and Nelson, 1984).

This state of affairs has sometimes produced considerable tensions between certain practitioners and certain researchers. The typical summary of this tension is that the practitioner claims that the researcher is not producing relevant research and the researcher feels that the practitioner does not properly consume what relevant research there is. There is an important asymmetry that needs to be noted here. This tension leaves the practitioner in a much more precarious position than it does the researcher. The researcher can claim with some legitimacy that their research was not designed to address that particular practical question, or any particular practical question. Basic research is a legitimate area of inquiry. However, if the practitioner's lament is true and no research is relevant to the practitioner's behavior, how can the practitioner legitimately represent what they are doing as being based on expert knowledge? And if they cannot claim that their behavior is based on expert knowledge, how can they legitimate their behavior, their fees, and the (implicit or explicit) representation to the client that they are behaving in a professional, expert manner?

Why all this approving talk about science in the abstract but so little concrete scientific behavior? Here are some of my conjectures. First, science and its correlative terms are clearly honorifics. To say that one is behaving scientifically is to attribute a certain value to one's behavior. Thus, one reason for the disparity between an abstract valuing of science and deficits in substantive scientific activity may be the general human tendency to speak highly of some socially valued activity (like giving to charity) to gain the attendant advantages of such posturing, while actually doing very little of it. As a result, we need to exert care to see if there is real substance behind claims of a relationship to science or this is merely a self-serving label.

Another reason may be that some are confused about what science is and in this confusion think that science is optional, too much hard work, not cost-effective, or takes too much talent. Some also can be distracted by the facade or trappings of science. Thus, part of the explanation for the dilatory behavior of so many regarding science is that there is not a clear understanding of what the essence of science is and a failure to see that a scientific approach to matters is not optional but essential for effective problem solving in clinical pursuits. I hope that if more were to see the essence of science and its indispensability for effective problem solving, more clinicians would

behave scientifically.

What is the substance of behaving scientifically? And why is it a good thing to behave in this manner? The Popperians have suggested that science begins with fallibilism. That is, the notion that our current beliefs, despite the fact that they are "ours" and despite all the attractions that they hold for us, may still be wrong. (Fallibilism. also applies to the previously stated belief, see Bartley, 1984, for his comprehensive critical rationalism.)

That our set of beliefs may not have optimal verisimilitude can be quickly discerned from a few considerations: First, we frequently encounter refutations of our beliefs in our daily life. Teams that we are sure to win, lose. People who we are sure will behave in one way, don't. The short cut, isn't. Another way we can see that we may be wrong is that people disagree with us. The logical principle of noncontradiction entails that when we assert A and someone else asserts not-A, one side is wrong.

Science is concerned with error and ways of eliminating error. A vigorous scientific attitude involves a desire to detect error in one's beliefs and to attempt to replace these beliefs with ones of greater accuracy. Science involves belief change, i.e., learning. (It is ironic that those committed to a thoroughgoing scientific approach are often called "dogmatic" as they are dedicated to the very process of belief change. It is those outside the purview of science that are in the most important sense dogmatic; they far less frequently experience the corrective potential of science.)

An assumption of psychometrics, for example, is that all measurement contains error. Statistical inference is concerned with errors or falsely rejecting the null hypotheses. Experimentation is concerned with valid (not invalid) causal inference, etc. This is as it should be: we need to be worried that our confirmation biases and other heuristic errors may be influencing us to believe something we ought not.

When we are conducting psychotherapy, we can make the following kinds of errors:

1. False descriptive statements. We can claim, for example, that our client never thought of suicide in the preceding week, when in fact she thought of it four times.

2. False causal statements. We can believe that our client's erectile dysfunction is caused by performance anxiety, when in fact it is caused by a neurological problem.

3. False ontic statements. We can believe that things exist when in fact they do not. We may believe that there is something like an inner child, when there is not.

4. False relational claims. We can believe that therapy X produces more change than therapy Y, when this is not the case.

5. False predictions. We can believe that therapy X in certain situations will result in the greatest change for this client, when it does not.

6. False professional ethical claims. we can believe that it is ethically permissible to have a certain kind of extra-therapeutic relationship with our client, when it is actually ethically impermissible.

Next, one must realize that all professional behavior is based upon knowledge claims. That is, when I recommend that my client take test T to measure his depression, this act is based on a knowledge claim, to wit, that in this situation test T is the most accurate, cost-efficient, etc. manner for my client's depression to be measured. Furthermore, this act is based on the knowledge claim, that I know that it is a priority to measure my client's depression in this situation. When I start treating my client with psychotherapy P, the knowledge claim is that my client has the kind of problem that therapy P should be given for and that therapy P is the most cost-effective way to treat this problem. O'Donohue (1991), for example, has attempted to explicate the beliefs associated with choosing a treatment:

1. Treatment goal G entails the realization of states of affairs S1...Sn.

2. F1...Fn are all factors that are known or hypothesized to be causally relevant to S1...Sn.

3. F1...Fn are cost-efficient methods to obtain S1...Sn.

4. F1...Fn are the least restrictive methods to obtain S1...Sn.

5. Client C is fully informed concerning alternative methods, the costs and benefits of these methods, and consents to the use of F1...Fn.

6. If premises 1, 2, 3, 4, 5 and ceteris paribus, then F1...Fn are the proper treatment methods to use in this case.

Ceteris paribus
Therefore: F1...Fn are the proper treatment methods to use in this case.

Next, one must realize that all knowledge claims need to be evaluated with respect to the quality of the epistemic procedures used to form these. If I claim that I know that tomorrow you will experience a serious stressor because I have read your horoscope, then one must evaluate horoscopes as a means of reliably attaining such knowledge.

Importantly, the decision regarding what epistemic methods we should use has been made for us. Our profession, through its training model and through its ethical code has explicitly stated that the way we seek to gain knowledge is through science. This is a wise decision because the application of science to problems has caused a historically unprecedented growth of knowledge. The problem is not that our profession is committed to a problematic epistemology. The problem is that too many clinical psychologists' commitment to this epistemology has been too superficial, sporadic, and rhetorical.

Next, one must realize that epistemic errors in clinical practice can cause serious harm. When we make a descriptive claim about a client that is not true, for example, we can miss something that actually required treatment and thus prolong the client's suffering. On the other hand, over-diagnosis can stigmatize clients and cause them to have negative beliefs about themselves that are not true. Practicing therapies that we erroneously believe cause change, when they do not, wastes everyone's resources. Treating a client with therapy A when therapy B is more effective, needlessly prolongs the client's suffering and results in an inefficient expenditure of resources. Economists state that all activities have opportunity costs: engaging in one has the cost of forcing the actor to forge engaging in another. All ineffective therapies have opportunity costs in that they displace the opportunity to engage in other more productive options.

Let me not mince words here. Our epistemic mistakes can cause a lot of harm. Children can be abused again and severely injured or killed. Suicides can be committed. Wives can be beaten. Overdoses can be taken. Marriages can end. Arrests can occur. Illnesses can be exacerbated. As clinical psychologists we can be meddling with situations in which the stakes are very high.

To behave scientifically is to behave in an explicitly critical manner, particularly in a self-critical manner. That is, one acknowledges that one's beliefs may be in error and one seeks to rigorously criticize one's beliefs to see if they are in error and thus in need of revision. Why is this a good thing? Because we are often wrong and because criticism allows error to be eliminated and knowledge to grow.

Before I discuss this characterization of science in more detail, I want to acknowledge that this answer might be somewhat surprising. Some might think that science involves the inductive building of generalities from observations of particulars. However, this is not the case due both to the problems in establishing a sound logic of induction and because this is simply a special case of the more general property of science: criticism. That is, if one is trying to criticize the belief that all swans are white, it is reasonable to examine a large sample of swans. However, what one is actually doing is attempting to criticize the universal claim by seeing if one can uncover a non-white swan. Others may claim that they thought

of science as uncovering a puzzle solving paradigm which comes to be an exemplar for future problem solving (following Kuhn). However, Kuhn's methodology for coming to this generalization is quite problematic as he studied a few instances in the history of science and then extrapolated to all sciences (see O'Donohue, 1993, for a critique of Kuhn's metascientific claims). Moreover, there is still an important role of criticism as Kuhnian scientific revolutions occur when a new paradigm exceeds the problem solving ability of the older paradigm by producing fewer anomalies.

The characterization of science that I am giving here is a neo-Popperian one. In this view, science is simply an epistemological way of knowing. The view is that we all start out with a "web of belief". For example, a clinical psychologist may hold beliefs such as "If I do therapy X with this client, she will improve"; "Multiple personality is caused by child sexual abuse"; and, "I can accurately measure someone's sexual preferences by a clinical interview". Science begins when one realizes that one's current beliefs, no matter how 'commonsensical', no matter how well they seem to cohere with other beliefs, no matter how much they are generally accepted by others, and no matter how many times they have appeared to be confirmed by one's experience, may still be false. Science begins with the epistemologically humble attitude of: I may be wrong.

The next step is exposing beliefs to criticism to see how well they withstand criticism. This step involves designing tests of the belief to see how they stand up to these tests. Sometimes, testing beliefs is easy. If I believe my wife is on the phone, I simply need to pick up the extension. Because we have only one line, if I hear a dial tone then I've falsified my belief. In another example, if I believe that all depressives make internal, stable, global attributions, then a reasonable form of criticism is to gather a decent sample of depressives and accurately measure their attributions and see if this experience contradicts the prior belief. If I believe some proposition that is expressed more tentatively, such as "More people who are depressed make global attributions than people who are not depressed", I essentially do the same thing. I just

need to get a little more mathematically sophisticated as I need to look at correlations or conditional probabilities.

However, the distinction I want to make here is between the details of criticism and the general commitment to criticism. The details (research design) can get complicated as one attempts to investigate subtle or complicated criticisms. However, the general process remains the same: one is testing some claim by allowing it to be exposed to criticism; and one is not being critical for the sake of being critical. Rather, criticism is the means to detect error and thus a way of experiencing a growth of knowledge, and thus a way of basing your professional acts upon less error.

Note that this general characterization nicely captures what is learned in research methodology. Research methodology is essentially a codification of some standard criticisms. Why do we seek a representative sample to begin our research? Because we are not vulnerable to the criticism that our sample was biased and therefore the results were skewed. Why do we seek random assignment to groups? Because we do not want to be vulnerable to criticism that observed differences at the end of the experiment were due to initial differences. Why do we worry about manipulating one variable at a time? Because if we want to say that differences were due to one variable, then in order to make the criticism that some other variable also changed we need to make sure we only manipulate one at a time. Why do we make sure our conclusions are worded so that they cover only the domains that we studied? Because we do not want to be vulnerable to the criticism that we are generalizing to facets not directly studied, etc.

Now let me describe how this plays out in the day to day activities of a clinician. First, clinicians, in order to begin to treat, must commit to some descriptive claims. That is, their actions are based on beliefs that predicate something about the client. The clinician must commit to claims such as: "This is a 6 year old boy". "His parents are having marital problems, particularly around communicating about sex." "The boy is wetting his bed on average about four nights

a week. "The boy does not meet the diagnostic criteria for ADD as listed in the DSM-IV." And so on.

Now, both fallibilism and the criticism principle come into play. The clinician may be wrong in any of these claims. The clinician may think the parents are experiencing real problems, when they are not. The child may be wetting 6 nights and not seven, etc. The clinician must recognize that he or she may be wrong. This is why we worry about the psychometrics of our measurement instruments. When a measured instrument has not been shown to be reliable and valid, we do not know how much error and how much 'signal' it gives us. We have little reason to believe its readings because it has not been shown to be accurate. Because we know that all of our tests contain error, we develop strategies such as the late Donald Campbell's independent measurement approach. In this approach there are reasons to believe that there are measurements that differ in a number of important regards will each contain different kinds of error. (In our terms, they are criticizable as having a certain degree of inaccuracy but we exploit the likelihood that they have different kinds of inaccuracies.) However, when multiple independent measurements all yield similar results, this result is less criticizable because of the convergence of independent measures.

The clinical psychologist seeks and accepts the status of expert. This expert status is associated with the privileges that we accept as clinical psychologists: e.g., high fees, special titles, and a fairly respected social role. However, with the status of "expert" come responsibilities. A central responsibility is that we are supposed to have special knowledge. It is this special knowledge that I would suggest is key to allowing us to enjoy our special privileges. Our 'customers' come to us because they believe they are purchasing extraordinary knowledge. And this is how the professions work. My ordinary knowledge of what might be causing my dog to limp soon becomes exhausted. I may look to see if he has a thorn in his paw, or to see if his ankle is swollen. When these "lay" tests are exhausted, I then seek the expertise of a veterinarian. I am willing to pay a high fee (many times minimum wage) because I expect that the veterinarian will have specialized knowledge that I do

not have. I believe that this specialized knowledge will result in a more efficient cure to this problem than my own efforts. I argue that professionals are experts because of their specialized knowledge. Lawyers know how to write wills that will stand legal tests, physicians how to best combat various medical problems, and psychologists how best to measure and change psychological conditions. Thus, I argue that the supreme duty that we hold as professionals is an epistemic duty. Respect for the truth can be seen as an intellectual duty, in much the same way as respect for human life can be seen as a moral duty. In short, clinical psychologists not only pursue truth as the ultimate goal, they also see it as that goal which everyone in other than the profession ought to recognize and pursue ardently and competently. For example, the pursuit of truth must take precedence over the possibility of forming a more enticing pursuit of pleasure, financial rewards, etc., because valuing something more highly than truth would result in an erosion of one's intellectual virtue. Also, the desire for truth must be courageous and dispassionate; one leaves self-interested biases aside, and honestly seeks out those objections he or she may find emotionally disturbing. As Code (1987, p.37) describes:

"Intellectually virtuous persons value knowing and understanding how things really are. They resist the temptation to live with partial explanations where fuller ones are attainable; they resist the temptation to live in fantasy or in a world of dream or illusion, considering it better to know, despite the tempting comfort and complacency a life of fantasy or illusion (or one well tinged with fantasy or illusion) can offer."

An individual who is motivated by something other than truth when forming a belief will be epistemically irresponsible and cowardly insofar as he or she will consider only the evidence that supports his or her prematurely formed conclusion. For instance, suppose a therapist holds the belief that facilitated communication is the most effective treatment for the problems of autistic children, and his or her motivation for holding that belief is to enjoy the popularity with parents that a quick cure provides, to enjoy the financial rewards, as well as to avoid the hard work

of an intensive, long term, behavior analytic treatment program. Moreover, the therapist refuses to read journals that provide critiques of facilitated communication and refuses to read or receive training in a behavior analytic approach. This selective consumption of information allows the therapist to feel confident that what he or she is prescribing is sound. Although the individual's holding such a belief may enable him or her to derive a number of personal outcomes, maintaining that belief is epistemically irresponsible because he or she is motivated by his or her own happiness rather than an earnest desire for truth. The therapist is failing in his or her epistemic duties as an expert in this field.

Thus, we must have at least a competent grasp of the scientific knowledge contained in our profession. It is our duty to actually know what is known in our field to justify the public and our consumers treating us as experts. It is our duty to master this knowledge so as to maximize our beneficial effect on our clients. We must meet our epistemic duties in order to minimize the harm we do (unintentionally) to the people who are affected by our actions. We must meet our epistemic duties to honestly meet the reasonable expectations of our consumers regarding what we as professionals know. Knowledge-based action is what we are supposed to be selling. But this, of course, depends on the question of do we actually know what we think we know?

My last major contention is that the only way we can meet our epistemic duties as clinical psychologists is to have a firm grasp of the state of scientific evidence for our actions and to honestly convey this evidence to our publics, and to seek to participate in the growth of knowledge of our profession. To do this is to actively exemplify what has been previously discussed in this article: We must acknowledge that our beliefs may be in error. We must rely on beliefs in our clinical practice that have best survived past criticism (or, roughly, have been vindicated by past scientific research; see McFall, 1991). We must realize that even these beliefs may still contain error and seek to expose these beliefs to further criticism to advance knowledge. We must do all of this to deserve our expert status and to minimize harm we do to

people who trust us and pay us their hard won resources. Thus, practically, we must:

1) Accept the general attitude that we may be wrong.

2) Seek to see if our beliefs are beliefs most consistent with the scientific literature (i.e., where these beliefs and their competitors have been evaluated).

3) Seek criticism from our peers, particularly peers who have greater relevant scientific expertise. Ask an objector group what criticism they may have of our beliefs/actions.

4) Conduct clinical practice in a way in which you can gain critical feedback regarding your beliefs. Conduct client satisfaction surveys. Seek to do program evaluation. Seek to engage in long-term follow-up to see relapse rates. Compare these to those in the literature. Conduct single subject experimental designs (Barlow, Hayes, & Nelson, 1984).

5) Give criticism to others. I believe this field has for too long tolerated psychologists not meeting their epistemic duties. We have, out of some misguided sense of professional courtesy, bit our tongues when colleagues give assessment devices that have no psychometric data, or therapies that have no outcome research. This must stop. I propose that another duty we have to the public is to explicitly criticize these practices.

6) Impress upon our students that when they accept expert status they are concomitantly accepting the attendant epistemic duties and that to meet these duties they must have at least a competent knowledge of epistemologically sound knowledge claims and that this involves a knowledge of the scientific literature.

Finally, the above is not rendered irrelevant simply because there is no 'empirically validated treatment' for the problem, or because the problem is subclinical, or because the problem does not meet a definition of typicality for some case. The epistemic duties involved in our representations as experts

require the following: 1) clearly informing the client or responsible parties about the state of relevant evidence. This portrayal needs to be full and accurate; 2) offering to behave only in an epistemologically appropriate manner by perhaps suggesting that they participate in a clinical trial of an experimental protocol. This, of course, should be reviewed by an institutional review board. McFall (1991) and Barlow, Hayes, and Nelson (1984) provide useful explications of how to do this.

References

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Recommendations for Students Applying for Clinical Internships

David J. A. Dozois

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A 1996 APPIC survey of graduate departments and professional schools in North America indicated that the number of clinical students seeking internship placements was 1,871. Seventy-eight percent of individuals obtained a placement on Uniform Notification Day (UND). Of those remaining, 22% did not procure a placement, 28% dropped out of the process, and 48% were eventually placed through the Clearing House (the remaining 2% were unaccounted for due to missing data). In 1997, 470 students in the United States and 11 students in Canada were without placements on UND (after placements were allocated through the Clearing House, these numbers were reduced to 148 and 5, respectively).

There are several systemic and individual factors contributing to this ominous trend. For example, some internship settings that previously offered placements are no longer able to do so because of cutbacks. According to APPIC's data, there are also 3 principal individual-specific factors contributing to the high number of unsuccessful applicants: (1) geographical restrictiveness, i.e., not applying broadly enough, (2) applying only to the most competitive programs, and (3) applying to too few programs. Although these variables have made the ratio of applicants to positions seem worse than it actually is, there still appear to be a substantial number of unplaced applicants after the Clearing House resources have been depleted each year.

Apart from the obvious importance of attempting to remedy this situation by applying more broadly to a wider range of programs, there are additional steps that applicants can take to improve their chances of obtaining quality internships.[1] These strategies involve careful preparation at each of the pre-application, application, interview, and decision-making stages.

The Pre-Application Stage

According to CCPPP's 1996 survey of internship directors, the type of clinical experience and the strength of reference letters, stated goals and interests, and academic scholarship, are some of the most important variables considered by internship faculty in their ranking of candidates.[2] Given that quality of clinical experience was rated higher than quantity, students would be wise to round out their clinical experience, to the extent possible, by balancing both bandwidth and fidelity (e.g., attaining some degree of specialization while also gaining experience in different therapeutic modalities, and with diverse populations).

By the time internship candidates reach the application compilation stage, they should have as many program requirements completed as possible. Demonstration that one is near completion of the Ph.D., not only provides the internship setting with the assurance that a candidate will be able to focus fully on the internship experience, it also allows more experience to accumulate which can be used in the assessment of one's suitability for a program.

The Application Stage

When completing applications, it is crucial to be organized, thorough, and accurate in the presentation of materials. Most internship settings require a cover letter, a curriculum vitae (CV), 3 letters of reference, academic transcripts, a statement of internship readiness, and a completed APPIC application form. One advantage for students applying for the 1998-1999 year, is that the majority of settings have begun to adopt the standard APPIC application form, which should save time and promote more polished responses to the information required.

Cover letters and personal statements reflecting both breadth and depth, and letters of recommendation that support the candidate personally, professionally and academically, are recommended. Letters of recommendation should be acquired from persons who have a good writing style, are credible and trustworthy, are familiar with the candidate's work, may know the internship faculty, and are reputable. Personal statements of goals and interests should accurately

and succinctly outline previous experience, training objectives, career plans, rotations of interest (and reasons for their appeal), and the ways in which one is a good match for a particular setting. The curriculum vitae (CV) should similarly be as concise as possible. CVs should highlight one's education, work/ practica experience, awards and honours, any editorial, administrative, teaching or supervisory experience, professional publications and conference presentations, as well as manuscripts submitted for publication.

The Interview Stage

Some things worthy of consideration for interview preparation include learning about the internship faculty and site, formulating a list of questions, networking at conferences (and previous involvements in professional organizations and committees), being able to explain one's research project(s), and arranging to meet with the current interns. During the interview, it is important to be respectful and professional (remember that internship faculty talk both within specific settings and across settings), to keep discussion about one's school and advisor positive, to be comfortable (but not lackadaisical), to ask questions that demonstrate interest, and to be honest and genuine.

The Decision-Making Stage

Assuming that there will be a choice as to which internship setting one is ultimately placed in, it is also important to ensure that this placement will maximize not only professional goals, but personal and practical ones as well. A few studies have examined variables that intern applicants deem important in the determination of their ideal placements. Such variables include geographical location (e.g., whether one's spouse is able to find work in a given area, financial ramifications of certain locations), future job prospects, specialty training (e.g., empirically-validated treatments) and types of rotations offered, diversity of experience, and stipend. Information from each internship setting is most helpful if it is gathered in a manner akin to a comprehensive psychological assessment (i.e., multiple sources of convergent data). Information can be gathered through internship brochures, informal interactions with

internship faculty, discussions with current and past interns, advise from academic faculty, and interactions during the interview proper. Once this information is accumulated, objectively sifting through one's set of criteria and determining how each setting meets them, can facilitate unbiased decision-making as to which internship setting is most appropriate for one's unique training and personal needs.

Footnotes

[1] Several of these steps were highlighted at a joint symposium/conversation hour (sponsored by the Section on Students in Psychology and the Section on Clinical Psychology) which was held at the 1997 CPA conference in Toronto, Ontario. This column represents a synopsis of the main points covered in these presentations.

[2] It should be noted that two American-based surveys found that academic/research productivity ranked further down the list of criteria. Dr. Martin Antony, of the Clarke Institute of Psychiatry, however, noted that while this may represent the mean ranking of internship directors, one must not ignore the sigma (i.e., some institutions rank academic credentials and research productivity higher than others).

CALL FOR NOMINATIONS SECTION FELLOWS

In accordance with the by-laws for CPA Sections, the Clinical Section calls for nominations from its members for Fellows in Clinical Psychology.

Criteria for fellowship are outstanding contribution to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Some examples are: (1) Creation and documentation of innovative programs; (2) Service to professional organizations at the national, provincial, or local level; (3) Leadership on clinical issues that relate to broad social issues; (4) Service outside of one's own place of work; and, (5) Clinical supervision should be equated with research supervision.

In order for nominees to be considered for Fellow status by the Executive Council, nominations must be endorsed by at least three members or Fellows of the Section, and supportive evidence of the nominee's contribution to clinical psychology must accompany the nomination.

Nominations should be forwarded by April 30, 1988, to:

D. Lorne Sexton, Ph.D.
McEwen Building (M5)
St. Boniface General Hospital
409 Taché Ave.
Winnipeg, Manitoba R2H 2A6
Tel (204) 235-3088 / Fax (204) 237-6264

DEMANDE DE PRÉSENTATION DE MISES EN CANDIDATURE SECTION DES FELLOWS

Conformément aux procedures régissant les sections de la SCP, la section clinique invite les membres à présenter des mises en candidature pour le statut de Fellow en psychologie clinique. Les critères de selection sont la contribution exceptionnelle au développment, le maintien et l'accroissement de l'excellence dans la pratique scientifique ou professionnelle de la psychologie clinique. En guise d'exemples: (1) Création et évaluation de programmes novateurs; (2) Services rendus aux organismes professionnels de niveau national, provincial ou régional; (3) Leadership dans l'établissement de rapports entre la psychologie clinique et les problèmes sociaux de plus grande envergure; (4) Services rendus à la communaute en dehors de son propre milieu de travail; (5) La contribution clinique est équivalente à la contribution en recherche.

Les dossiers des candidats nommés pour le statut de Fellow seront examinés par le comité exécutif. Les mises en candidature doivent être appuyées par au moins trois membres ou Fellow de la Section et la contribution du candidat à la psychologie clinique doit y être documentée.

Les mises en candidature devront être postées au plus tard le avril 1998 à l'attention de:

D. Lorne Sexton, PhD
Édifice McEwen (M5)
Hôpital général St. Boniface
409 Taché Ave.
Winnipeg (Manitoba) R2H 2A6
Tel (204) 235-3088/Fax (204) 237-6264

CALL FOR NOMINATIONS FOR THE CLINICAL SECTION EXECUTIVE COMMITTEE

One of the most obvious and meaningful ways you can show your support for the Clinical Section is to participate in the election process.

For 1997-98, the Section requires nominations for the position of Chair-Elect, (a three-year term, rotating through Chair and Past Chair) and Secretary-Treasurer (a two-year term). Continuing members of the executive for 1997-98 will be Lorne Sexton (Chair), Charles Morin (Past-Chair), and Lesley Graff (Member-at-Large).

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

Nominations shall include (a) a statement from the nominee confirming his/her willingness to stand for office, and (b) a letter of nomination signed by at least two members or Fellows of the Clinical section.

Deadline for receipt of nominations is April 15, 1996.

Send nominations for the Executive to:

Keith Wilson
The Rehabilitation Centre
Department of Psychology
505 Smyth Road, Suite 2405
Ottawa, Ontario
K1H 8M2

STUDENT RESEARCH KEN BOWERS AWARD

Each year, the Section of Clinical Psychology reviews papers that have been submitted by clinical students for presentation at the annual CPA convention. The most meritorious submission is recognized with a certificate and an award of $250. In order to be eligible, you should: (1) Be the first author of a submission in the area of clinical psychology that has been accepted for presentation in Edmonton; (2) Submit a brief (i.e., up to 10 pages, double-spaced) manuscript describing the project, and (3) Be prepared to attend the Clinical Section Business meeting at the Edmonton Congress, where the award will be presented.

The deadline for submission of applications is April 30, 1998. Submissions may be in either English or French.

D. Lorne Sexton, PhD
McEwen Bldg (M5)
St. Boniface General Hospital
409 Taché Ave.
Winnipeg, Manitoba R2H 2A6
Tel (204) 235-3088 / Fax (204) 237-6264

CONFERENCES

American Psychosomatic Society
56th Annual Scientific Meeting
March 12-14, 1998
Clearwater Beach, FLA
ampsychsoc@aol.com or 703-556-9222

Society of Behavioral Medecine
19th Annual Meeting
March 25-28, 1998
New Orleans, LA
info@socbehmed.org

Anxiety Disorders Association of America
18th National Conference
March 26-29, 1998
Boston, Mass.
ADAA Head Office: 11900 Parklawn Dr.
Suite 100, Rockville Maryland USA

PRIX KEN BOWER POUR RECHERCHE EFFECTUEE PAR UN ÉTUDIANT

Chaque année, la Section de Psychologie clinique passe en revue les communications qui ont été soumises par les étudiants en vue d'une présentation au congrès annuel de la SCP. Un certificat et une bourse de 250$ seront remis à l'étudiant ayant soumis la présentation la plus méritoire. Pourêtre admissible, vous devez: (1) être le premier auteur d'une présentation touchant le domaine de la psychologie clinique. cette derniere doit être acceptée pour le congrès de Edmonton; (2) soumettre un bref résumé de 10 pages à double interligne décrivant l'étude; (3) être present à la réunion de la section des affaires cliniques du congrès de edmonton lorsque le prix sera decerné.

La date limite pour soumettre une application est le 30 avril 1998. Les demandes peuvent être formulées en français ou en anglais à l'attention de:

D. Lorne Sexton, PhD
Édifice McEwen (M5)
Hôpital général St. Boniface
409 Taché Ave.
Winnipeg, Manitoba R2H 2A6
Tel (204) 235-3088 / Fax (204) 237-6264

SPOTLIGHT ONTARIO: PANEL OF EXPERTS ON CHILD PROTECTION - A REQUEST FOR SUBMISSIONS

The Minister of Community and Social services has appointed a panel to review the province's Child and Family Services Act in light of a number of recent instances where children have died while they were receiving services or care from a children's aid society. The panel, chaired by Judge Mary Jane Hatton, has been asked to address the following questions:

• Does the legislation reflect the right balance between the protection of children and family preservation?

• Does the legislation adequately address the issue of children suffering from neglect?

• Is the burden of proof for finding a child in need of protection at an appropriate level?

• Is the legislation being properly interpreted and applied at key decision points (e.g., intake, type of services delivered, court proceedings and planning for the stable and long term placement of children)?

• Is the legislation clear about the roles and responsibilities of different sectors (e.g., medical, legal, justice, educational, law enforcement, social service)?

The deadline for submissions is tight, it being January 16, 1998. Please contact Michael Batrie, project coordina- tor, at (416) 327-5932, for further information.

WEB SITES - CHECK IT OUT!

Canadian Sites

Canadian Government
http://canada.gc.ca

Canadian Human Rights Commission
http://www.chrc.ca

Canadian Professionals' Attention Deficit Disorder Centre, University of Saskatchewan
www://usask.ca/psychiatry/CPADDC.html

Canadian Psychological Association
http://www.cpa.ca
(For Position Openings visit cpa.ca/ads.html)

Learning Disabilities Association of Canada
http://educ.queensu.ca/~lda

Canadian Clinical Psychologist/Psychologue Clinicien Canadien
http:\\play.psych.mun.ca/~dhart/clinical/

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· Fellows of the Clinical Section
· Ken Bowers Student Research Award Winners

American Sites

American Psychological Association
http://apa.org
(For Position Openings in Canada visit apa.org/ads/canada.html)

Autism Society of America
http://www.autism-society.org

Epilepsy Foundation of America
http://www.efa.org

Eric Clearinghouse - Council of Exceptional Children
http://www.cec.sped.org/ericec

Psychology Internet Resources
www.rhodes.edu/psychtmls/psychnet.html