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Message from the Chair

Can we do more?

Establishing a stronger national presence

Lesley Graff

We can do more with what we have." That has been the message across the Canadian health care system in a wave of belt-tightening exercises over the last decade. As government funding decreased, administrators put the squeeze on programs and departments not only to use existing resources more efficiently, but to trim them further. The outcome? Longer waiting lists, and a shortage of professionals in many areas. So, perhaps this wasn't the right direction.

What about psychology—not just in the health care field, but in the broader arena? Can we do more with what we have?

A year ago in Halifax, when meeting with the APA Division 12 executive, I was struck by two things: (1) the large tasks on the table for Canadian psychology (diverse standards for independent practice, multiple professional organizations, pressure for best practice guidelines, funding and research support issues, as a few examples); and (2) the few people around the table who were working to respond to these tasks. Division 12's core executive was three times the size of ours; the APA membership at last count was just over 150,000 with almost 90,000 of those being regular members and almost 60,000 being student members. If you do the math (American population 10 times that of Canada; American psychologists presumably 10 times the number of Canadian psychologists), CPA should have a membership of approximately a tenth that of APA, or around 15,000. Some have estimated the number of Canadian psychologists at 19,000. The membership of CPA is well below both those numbers, at only

4,894 (of which 1,084 are student members).

Well, what do we have?

We have quality people. This is my fourth year on the Clinical section executive, having served two years as member-at-large before becoming Chair-Elect, and now Chair. Through these roles, I have had the pleasure of working and linking with quality people involved with CPA—individuals who have a vision for excellence in practice and science in the field of psychology. They willingly provide their time and expertise to a range of constituents: the government, the public, the media, and, of course, the profession. And all this is in addition to their 'real' work in private, academic or applied positions. These are people like our outgoing executive, Lorne Sexton and Deb Dewey, who played key roles in organizing CPA 2000 in Ottawa, as well as developing fact sheets for public education regarding psychological interventions. These are people like our incoming executive, Darcy Santor and Michel Dugas, who have already spent significant time planning next year's conference in Quebec City. These also include executive from other sections, board members, and those at CPA head office. And they include, you, the section members, who have responded to requests to review a paper, give a media interview, sit on a task force, complete a survey, or organize a symposium. Simply by your membership, you are providing support by joining a network that allows us to strengthen our profession.

We have a network. The Clinical section provides a forum for research, continuing education, and professional links through the annual convention. The section supports CPA

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...“Can we do more?” continued from front page

in its efforts related to research funding lobbies, psychology's role in health care, public education, and dissemination of information related to evidence-based practice. We are now considering the development of a national document to outline essential working conditions for quality psychology service, based on a charter of psychologist's rights developed and adopted in Alberta.

There is much that remains to be done, some of it urgent. To do more, we must draw in those in Canadian psychology who are still not part of CPA. Echoing the messages of previous Chairs in the Clinical section, we must be unified where it counts. A starting point is to build one strong, representative, national association.

To illustrate by an example that I am familiar with, psychology in Manitoba has changed significantly through the strong vision of a few and the unified support of the many. Resisting the trend toward decentralization of psychology services into other programs, psychologists from traditionally separate territories pulled together, lobbied for, and got their own clinical program across the whole Winnipeg Regional Health Authority. Psychology benefits through autonomy with regard to budget and programming. The public benefits through better access to services across many areas within the health care system. In addition, psychologists negotiated the establishment of an independent academic department within the Faculty of Medicine, which links psychologists in rural and northern communities to their colleagues in Winnipeg and other regions of the province. Not everyone had to be actively involved in these negotiations, but it did require a united front to carry it forward.

I recognize that those of you who are reading this newsletter have already decided, through your membership, that you want to support the national efforts of our profession, and so I am perhaps preaching to the converted. But I am asking you to recruit to CPA. Make it your new year's resolution. Make it your goal for the month of November. Ask your colleagues why they are not members of CPA. Encourage them to support our national organization, through their membership, and their involvement. In Canada, we have strong training programs, excellent academic sites and research centres, skilled consultants and practitioners. They should all be actively represented in our national association.

Can we do more with what we have? If we had them all at the same table — absolutely! I think we can and I think we must. ♦

The opinions expressed in this newsletter are strictly those of the author and do not necessarily reflect the opinions of the Canadian Psychological Association, its officers, directors, or employees.

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Empirically Informed Consultation to Parents Concerning the Effects of Separation and Divorce on their Children

Catherine Lee, Ph.D.
School of Psychology
University of Ottawa

A summary of her workshop presented at the Canadian Psychological Annual Convention, Ottawa, Ontario June 2000.

Divorcing parents are faced with concerns about the well-being of the children and the need to establish a new co-parenting relationship with the former partner. Traditionally, psychologists have assisted divorcing families with a number of services, including psychotherapy, custody evaluations, and mediation services (Lee, Beauregard & Hunsley, 1998a; 1998b; Lee, Picard, & Blain, 1994). The workshop focussed on the provision of psychological consultation in which parents are provided empirically informed information on the effects of separation and divorce on children. A wealth of longitudinal, controlled studies with psychometrically sound measures have established that although divorce is a painful process that requires all family members to adjust, the majority of children are resilient in the face of this stressor and are able to adjust to their parents' separation (Amato & Keith, 1991; Hetherington & Stanley-Hagen, 1999; Lee & Bax, 2000). A significant minority, however, experience prolonged symptomatology that may be traced to the disruptions of parental conflict, separation, and sustained hostility after the divorce (Emery, 1999).

Empirically informed divorce consultation involves the provision of psychoeducation based on the large body of research in this area to individuals who are in the process of separating from their marital partner. Professional issues discussed include: consent, limits of confidentiality, avoidance of assessment, fit with other mental health services, responding to parental distress, and record-keeping. The format of divorce consultation services was presented, including discussion of the timing

of consultation, the source of referrals, duration and frequency, and resources that are available for parents. Common themes covered in consultation include conflict, shared parenting, dealing with children's needs and emotions, parental distress, and developmental considerations.

It was noted that empirically based consultation is a preventive intervention offered to clients who may not be willing to engage in other psychological interventions. The efficacy of this approach has not yet been evaluated. Possible strategies for assessing the usefulness of the approach were discussed. Finally, illustrative case examples were presented. This approach is presented in greater detail in a forthcoming article in *Cognitive and Behavioral Practice* (Lee & Hunsley, in press).

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The workshop focussed on the provision of psychological consultation in which parents are provided empirically informed information on the effects of separation and divorce on children.

Dr. Janel Gauthier

Biographical Notes



Dr. Janel Gauthier

**Dr. Gauthier is
someone who has
given exceptional
service to national
and provincial
associations in
psychology.**

Dr. Janel Gauthier is Professor of Psychology at the School of Psychology of Laval University. He holds a Ph.D. degree that was awarded to him by Queen's University at Kingston in 1975. Dr. Gauthier began his professional career at Hotel-Dieu Hospital in Kingston as a registered psychologist and a director of psychological services. He held these two positions for three years. During that period, he became Assistant Professor both in the Department of Psychiatry and the Department of Psychology at Queen's University. In 1978, he accepted a full-time academic position at the School of Psychology at Laval University. In 1981, he was promoted to the rank of Associate Professor. In 1982, he went away to work for a full year with Professor Albert Bandura at Stanford University in California, something that he repeated in the summer of 1997. In 1985, Dr. Gauthier was promoted to the rank of Full Professor. Since he has been at Laval University, Dr. Gauthier has worked on several committees, including the Steering Committee of the School of Psychology and the Ethics Committee of Laval University. He has also been Director of the Clinic for Psychological Interventions for three years and Chair of the Master's programme in psychology for three years. He is currently Chair of the Clinical Doctoral Programme and Chair of the Committee for the development of the Psy.D. programme.

Dr. Gauthier is a researcher who is internationally renowned. He has authored or co-authored about 80 scientific publications dealing mainly with the behavioural and cognitive treatment of anxiety disorders and the biofeedback treatment of migraine. In addition, he has made some significant contributions to the understanding and management of grief reactions and has developed some of the most effective strategies to enhance social self-esteem. He has also contributed to the presentation of over 250 papers at various scientific provincial, national and international meetings.

He has served on the editorial board of several journals, including Behaviour Therapy.

He has also served on several committees for granting agencies such as the Medical Research Council and the Québec Council for Social Research.

Dr. Gauthier has 25 years of experience as a practitioner and an educator in clinical psychology. He is licensed to practice in both Ontario and Québec. He is a listee of the Canadian Register of Health Service Providers in Psychology (CRHSPP).

Dr. Gauthier is someone who has given exceptional service to national and provincial associations in psychology. From 1992 to 1999, he served on the Board of Directors of the Canadian Psychological Association (CPA). During this period, he chaired and co-chaired several committees including Publications, Education and Training, and Scientific Affairs. He became President of CPA in 1996 and did a second term as President in 1997. He organized and co-chaired the National Conference on Psychology as a Science in Aylmer (Québec) in 1997. He struck the Psy.D. Task Force that led to the Board of Directors unanimously approving a series of recommendations in support of the "Canadian" scholar-practitioner model of training in professional psychology in 1998. Dr. Gauthier is currently a member of the Scientific Committee of the Québec Foundation for Migraine and Headaches as well as co-president of the Québec Association for Anxiety Disorders.

Dr. Gauthier was formally recognized by his colleagues in the Canadian Register of Health Service Providers in Psychology for his distinguished contribution to Canadian psychology in 1998. Recently, Dr. Gauthier was elected Fellow of CPA. ♦

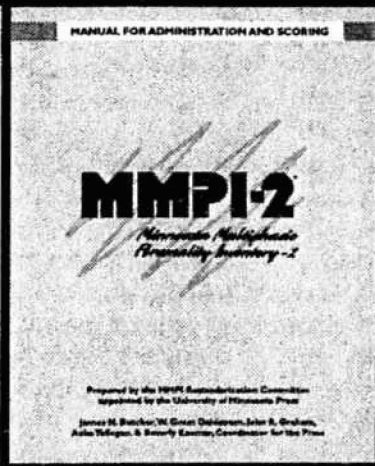
MEMBERSHIP RENEWAL

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.

The Classic Standard

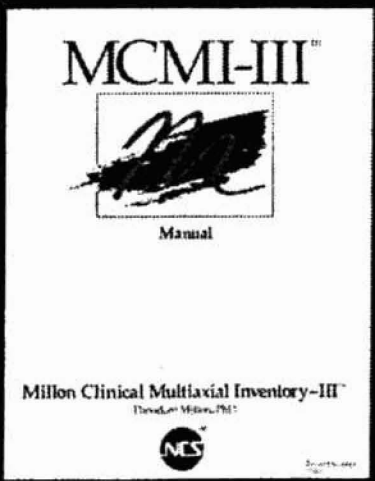
in contemporary settings

MMPI-2



The Minnesota Multiphasic Personality Inventory-2™ (MMPI-2) is an empirically based test of adult psychopathology. The MMPI-2™ is designed to assess the major symptoms and signs of social and personal maladjustment commonly indicative of disabling psychological dysfunction. The MMPI-2™ is used by clinicians in hospitals, clinics, counselling programs, and private practice to assist with diagnosis of mental disorders and the selection of an appropriate treatment method.

MCMI-III



The Millon Clinical Multiaxial Inventory-III™ (MCMI-III™) is a self-report instrument designed to assess DSM-IV™-related personality disorders and clinical syndromes coordinated with Millon's theory of personality. A significant revision of the MCMI-II, this instrument incorporates new items, a new weighting system, and new scales to provide insight into 14 personality disorders and 10 clinical syndromes.

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Generalized anxiety disorder: Differential diagnosis and cognitive behavioral treatment

Michel J. Dugas, Ph.D.

Clients learn to
address the
uncertainty of the
problem-solving
process "head on"
by applying
promising
solutions rather
than waiting for
the perfect
solution.

This paper summarizes the workshop I had the pleasure of presenting at CPA 2000 in Ottawa. The workshop was divided into five sections: (1) Introduction and clinical presentation, (2) Differential diagnosis, (3) Cognitive processes, (4) Assessment, and (5) Cognitive-behavioral treatment. Each of these sections is briefly described below.

Introduction and clinical presentation

The main feature of generalized anxiety disorder (GAD) is excessive and uncontrollable worry and anxiety occurring more days than not for at least six months. Furthermore, the worry and anxiety are associated with at least three of the following six somatic symptoms: restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbance. Because the somatic symptoms are also found in other anxiety and mood disorders, clinicians should focus on worry when investigating the presence of GAD.

Differential diagnosis

Given that the DSM-IV is somewhat unclear about diagnostic boundaries between GAD and other disorders such as obsessive-compulsive disorder (OCD) and social phobia, the differential diagnosis of GAD can at times be quite challenging. For the 15 to 20 % of OCD clients who do not have overt compulsions, the GAD-OCD differential diagnosis rests on the form and function of the intrusive thought. For example, worries are often ego syntonic and made up of verbal-linguistic thought, whereas obsessions tend to be ego dystonic and to involve mental images. The GAD-social phobia differential diagnosis can be facilitated by remembering that GAD clients typically have many worry themes and that avoidance is often a secondary feature of the clinical picture, whereas the concerns of social phobics are oftentimes restricted to social issues and avoidance is frequently a central feature of the clinical picture.

Cognitive processes

Research suggests that a number of cognitive processes are involved in the etiology and maintenance of GAD. Our research group has identified four process variables that appear to be involved in GAD and thus represent important treatment targets: intolerance of uncertainty, cognitive avoidance, ineffective problem solving, and positive beliefs about worry. Of these four cognitive processes, intolerance of uncertainty appears to be the central process involved in high levels of worry and GAD. From a clinical perspective, we have found that GAD clients are highly intolerant of uncertainty. For example, GAD clients have told us things such as "I know there is only one chance in a million that my plane will crash, but I can't help worrying about it because it might just happen." In our clinical work, we have often used the metaphor of an "allergy" to uncertainty (where a very small quantity of a "substance" leads to a violent reaction) to help GAD clients conceptualize their relationship with uncertainty.

Assessment

Although many measures can be useful for the assessment of GAD and its consequences, we recommend that three measures be used with this clientele: the Penn State Worry Questionnaire, the Worry and Anxiety Questionnaire, and the Intolerance of Uncertainty Scale. The Penn State Worry Questionnaire contains 16 items that measure the tendency to engage in worry, regardless of worry content. The Worry and Anxiety Questionnaire includes 11 items that measure DSM-IV diagnostic criteria for GAD. Finally, the Intolerance of Uncertainty Scale contains 27 items relating to the idea that uncertainty is unacceptable, reflects badly on a person, and leads to frustration, stress, and the inability to act. All three of these self-report questionnaires can be completed as homework assignments at different times during therapy.

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Cognitive-behavioral treatment

The cognitive-behavioral treatment that we have developed helps GAD clients to increase their tolerance of uncertainty by cognitively exposing themselves to their core fears, applying sound problem-solving principles to current problems, and reevaluating their beliefs about the usefulness of worrying. For example, clients learn to address the uncertainty of the problem-solving process "head on" by applying promising solutions rather than waiting for the perfect solution. So far, data from our clinical trials has been quite encouraging. In a recently completed study, 77% of participants were in full remission at post-treatment and at one-year follow-up. In other words, the treatment not only helps most GAD clients get better, it also helps them stay better. ♦

... "Empirically Supported" continued from page 3

experience, and mediation practice.

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Lee, C. M., Picard, M. C., & Blain, M. (1994). A methodological and substantive review of intervention outcome studies for families undergoing divorce. *Journal of Family Psychology*, 8, 3-15. ♦

Clinical Section Website

<http://play.psych.mun.ca/~dhart/clinical>

- Executive
- Purpose of Clinical Section
- Current Projects
- Notice Board (Events, Positions, Programs, Persons, Calls for Nominations)
- Brochure: The Clinical Psychologist in Canada (in French and English)
- Definition of Clinical Psychologist
- Fellows of the Clinical Section
- Ken Bowers Student Research Award Winners
- Annual Convention

Call for Nominations

Officers of the Clinical Section

An easy and meaningful way you can show your support for the Clinical Section is to participate in the election process. For 2001-2002, 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 1999-2000 will be Dr. Michel Dugas (Chair), Lesley Graff (Past-Chair), and Dr. Darcy Santor (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 March 31, 2001.

Send nominations for the Executive to:

Dr. Charlotte Johnston
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Brochure: The Clinical Psychologist in Canada

This brochure provides information on the nature of Clinical Psychology, the training required to become a Clinical Psychologist, and the types of services and activities Clinical Psychologists provide (e.g., service provision, research, and teaching).

Send Order To:

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FROM: _____

Comorbidity of Developmental Disorders

Deborah Dewey, Ph.D.
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Health professionals who study children with developmental problems, and those who educate and treat them, tend to speak of *diagnostic categories*. Researchers and clinicians have attempted to classify childhood developmental disorders into discrete diagnostic categories such as those found in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) (American Psychiatric Association, 1994) or the *International Classification of Diseases 10* (ICD 10, World Health Organization, 1992). In many cases, however, children with these disabilities do not display just one discrete disorder but several disorders. For example, children with reading disabilities often have Attention Deficit/Hyperactivity Disorder (ADHD), and children with ADHD frequently meet criteria for some other psychiatric condition. When this occurs, the term comorbidity is used to refer to the fact that few children fit neatly into one single discrete disorder.

"Comorbid" is a term that has been borrowed from medicine. Its original meaning indicated the presence of at least two diseases. An individual with diabetes and asthma, for instance, is said to be comorbid for these two diseases. In contrast, an individual reporting frequent urination and thirstiness is not said to be comorbid for these two conditions, because they are symptoms; their co-occurrence suggests morbidity for a single disease, diabetes. When the term "comorbidity" was transferred to the mental health world, there was one element missing that prevented its accurate application: the precise distinction between symptom and disease (or disorder). For instance, when a child has difficulties in

learning, moodiness, behaviour problems, and difficulties in printing/writing, the child could be viewed as displaying a learning disability, attention deficit hyperactivity disorder (ADHD) and/or developmental coordination disorder (DCD). The co-occurrence of these apparently disparate symptoms causes problems in both diagnosis and treatment. In addition, it raises questions about the etiology and mutual interdependence of various developmental disorders.

In this discussion of the issue of comorbidity of developmental disorders, the first question that will be addressed is this: How widespread is comorbidity across various developmental disorders? Research evidence suggests that 50–80 % of children with any diagnosis meet criteria for at least one other diagnosis (Biederman, Faraone, Keenan, Knee, & Tsuang, 1990). The co-occurrence of ADHD and dyslexia is well established (Gilger, Pennington, & DeFries, 1992). The rates of overlap are typically estimated from 30–50% (Dykman & Ackerman, 1991; Semrud-Clikeman et al., 1992). Several studies have also demonstrated that children with ADHD display a high prevalence of language problems (Carte, Nigg, & Hinshaw, 1996; Elbert, 1993). Similarly, a number of studies have reported that many children with learning disabilities also display DCD (Silver, 1992; Sugden & Wann, 1987). The overlap of ADHD with anxiety and/or depression in children, adolescents and adults has also been documented (Biederman, Faraone, Mick, Moore, & Lelon, 1996).

The question remains, however, as to how extensive is the overlap of developmental disabilities. An answer to this question can be found in the results of the Ontario Child Health Study (Offord et al., 1987). This study reported that 13–22% of their epidemiological sample met the criteria for at least two of the following disorders: conduct disorder, ADHD, emotional disorder,

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der, somatization. In our own research carried out in Calgary we have also found very high levels of overlap of developmental disabilities (Dewey, Wilson, Crawford, & Kaplan, 2000; Kaplan, Crawford, Wilson, & Dewey, 2000). For example, 58% of our sample of children with ADHD also displayed reading disabilities and 27% of these children with ADHD had DCD. Further, 82% of our children with DCD displayed some other comorbid disorder. The results of this research suggest then that *comorbidity of developmental disorders appears to be the rule, rather than the exception.*

Based on the above evidence the question that must be asked is how can we better conceptualize the significant comorbidity among developmental disorders? The enormous overlap found among developmental disorders suggests that they are all reflective of a more general impairment of brain structure or function. This has been referred to as *Atypical Brain Development (ABD)* (Gilger & Kaplan, in press; Kaplan, Wilson, Dewey, & Crawford, 1997).

What is meant by this concept? Specifically, ABD can be viewed as a unifying concept that may assist researchers and educators to come to terms with the fact that developmental disabilities are typically nonspecific and heterogeneous, and that comorbidity of symptoms in children with developmental disabilities is the rule rather than the exception. ABD may be a function of both genetic and environmental factors, as well as the interaction of the two. It refers to the more generalized dysfunction in structure, activation, etc. underlying these developmental disorders. It is a term that can be used to address the full range of developmental disorders that are found to be overlapping much of the time in any sample of children with developmental disabilities. Further, ABD does not replace the common labels currently used in the field, but it provides a perspective from which we can view and investigate children with developmental problems.

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...continued on page 11 "Comorbidity"

Comorbidity of developmental disorders appears to be the rule, rather than the exception.

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 national, provincial, or local level; (3) leadership on clinical issues that relate to broad social issues; and (4) service outside one's own place of work. Note that clinical contributions should be equated with research contributions. In order for nominees to be considered for Fellow status by the executive council, nominations must be endorsed by at least three members or Fellows of the Section, and supportive evidence of the nominee's contribution to clinical psychology must accompany the nomination. Nominations should be forwarded by March 31, 2001 to:

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Mises en Candidature— Fellows de Section

Conformément aux procédures régissant les sections de la SCP, la section clinique invite ses membres à présenter des candidats pour le statut de Fellow en psychologie clinique. Les critères de sélection sont la contribution exceptionnelle au développement, au maintien et à l'accroissement de l'excellence dans la pratique scientifique ou professionnelle de la psychologie clinique. En guise d'exemples: (1) création et évaluation de programmes novateurs; (2) services rendus aux organismes professionnels de niveau national, provincial ou régional; (3) leadership dans l'établissement de rapports entre la psychologie clinique et les problèmes sociaux de plus grande envergure; et (4) services rendus à la communauté en dehors de son propre milieu de travail. À ces fins, les contributions cliniques et les contributions en recherche seront considérées comme étant équivalentes. Les dossiers des candidats seront examinés par le comité exécutif. Les mises en candidature doivent être appuyées par au moins trois membres ou Fellow de la Section et la contribution du candidat à la psychologie clinique doit y être documentée. Les mises en candidature devront être postées au plus tard le 31 mars 2001 à l'attention de:

Michel Dugas, Ph.D.
Département de psychologie
Université Concordia
7141, rue Sherbrooke ouest
Montréal, Québec, Canada, H4B 1R6
Tél: 514-848-2215
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...continued from page 8 "Comorbidity"

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- Sugden, D. A., & Wann, C. (1987). Kinaesthesia and motor impairment in children with moderate learning difficulties. *British Journal of Educational Psychology*, 57, 225-236.
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Submissions invited

The Canadian Clinical Psychologist/Psychologue Clinicien Canadien invites submissions from Section members and others. Brief articles, conference or symposia overviews, and opinion pieces, are all welcome. The thoughts and views of contributors belong strictly to the author(s), and do not necessarily reflect the position of either the Section, the Canadian Psychological Association, or 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 twice a year. Submission deadlines are as follows: September 15 (October issue), and March 15 (April issue).

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Convention Rates

The Board of Directors has unanimously passed two motions concerning convention registration rates.

Student Convention Registration Rates

Following the successful trial in 2000, the Board has decided to make the change to student convention rates permanent. Here are the new rates:

- **Student Affiliates**
 - Early Registration: \$25 (all rates +GST)
 - Late Registration: \$100
- **Student Non-affiliates** (these rates include Student Affiliate membership for the convention year)
 - Early Registration: \$77
 - Late Registration: \$152

These discounted rates can't be combined with other reductions; these rates apply to all students (including departmental student representatives).

One Day Convention Registration Option

In recognition that some people can't attend the entire 3 days of the convention, the Board has decided to offer a one-day registration rate to Members and Non-Members. This is a two-year trial, and will be re-evaluated following the 2001 and 2002 conventions.

- **One-day Convention Registration**
 - Member Early: \$93
 - Member Late: \$133
 - Non-member: \$198
- **One-day Convention Registration—Workshop Discounts**
 - Member: \$80
 - Non-member: \$168

The rates are 50% of the full convention rate for each category. One-day attendees will receive the convention abstracts book and will have the right to attend all events on the day of their registration. The one-day rate is not available to groups with other discounts (Honourary Life Members, Student Affiliates, companions, exhibitors).

Please pass your newsletter on to non-section members and encourage them to join. People can join the section at any time of the year through:
CPA, 151 Rue Slater St.,
Suite 205,
Ottawa, Ontario,
K1P 5H3,
1-888-472-0657.

Psychology Works Series

There is a new series of information on the web site.

Find a Psychologist: A Referral Portal for Psychologists in Canada

<http://www.cpa.ca/find.htm>

This site links visitors to referral sources in the provinces and to CRHSPP.

Did You Know That Psychology Works for....

<http://www.cpa.ca/factsheets/main.htm>

This site is linked to the first on finding a psychologist. These are short fact sheets on such conditions and diseases as GAD, ADHD, insomnia, perfectionism, etc.. They are an ongoing project of the Clinical Section and are available to web flyers, clinicians who want to download the information for clients and patients, students, public policy planners and implementers and so on.

Your feedback is appreciated. Let us know what you think.

Sam Mikail and John Service

John Service, PhD
Executive Director/Directeur général
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Ken Bowers Student Research Award

Each year, the Section of Clinical Psychology reviews papers that have been submitted by clinical students for presentation at the annual CPA convention. The most meritorious submission is recognized with a certificate and an award of \$250. In order to be eligible, the student should: (1) be the first author of a submission in the area of clinical psychology that has been accepted for presentation in Quebec city; (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 Quebec Congress, where the award will be presented. The deadline for submission of applications is March 31, 2001. Submissions may be in either English or French and should be forwarded to:

Michel Dugas, Ph.D.
Department of Psychology
Concordia University
7141 Sherbrooke St. West
Montreal, Quebec, Canada, H4B 1R6
Tel: 514-848-2215
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E-mail: dugas@vax2.concordia.ca

Prix Ken Bowers pour Recherche Effectuée par un(e) Étudiant(e)

Chaque année, la Section de Psychologie Clinique évalue les communications soumises par les étudiants(es) en vue d'une présentation au congrès annuel de la SCP. Un certificat et une bourse de 250\$ seront remis à l'étudiant(e) ayant soumis la communication la plus méritoire. Pour être admissible, l'étudiant(e) doit: (1) être premier(ère) auteur(e) d'une communication touchant le domaine de la psychologie clinique ayant été acceptée pour le congrès de Québec; (2) soumettre un résumé de 10 pages à double interligne décrivant l'étude; et (3) être présent(e) à la réunion d'affaires de la Section Clinique du congrès de Québec lorsque le prix sera décerné. La date limite pour soumettre les candidatures est le 31 mars, 2001. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées à:

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