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Inside...

Message from the Chair

Clinical psychology and victims of trauma

Michel J. Dugas

In this, my first column as chair of the clinical section, I had planned to write about ways of bridging the gap between practice and science. That was before Tuesday, September 11, 2001. As I write this column, one week has passed since the attacks on the World Trade Center and the Pentagon, and the grim reality of what took place is just beginning to sink in. Over the past week, I have watched countless television interviews with experts, mostly psychologists and psychiatrists, discussing the psychological impact of such a large-scale traumatic event.

I have learned many things as I watched these interviews, and discussed them with my colleagues. For instance, I have learned that a traumatic event, even if witnessed on television, can lead to posttraumatic stress symptoms. I have also learned that four groups of individuals are most vulnerable to developing posttraumatic stress symptoms from the events that we all witnessed on television: (1) older adults who have lived through the First or Second World War; (2) individuals who have previously experienced similar trauma, such as being physically assaulted; (3) individuals with "emotional proximity" to the victims, such as those working in well-known skyscrapers like the CN Tower; and (4) children. So it seems that although the traumatic event did not take place in Canada, many Canadians may develop posttraumatic stress symptoms as a result of the assault on the World Trade Center and the Pentagon. The implication of this is that as clinical psychologists, we would do well to be vigilant to signs of posttraumatic stress in our clients, even if they watched the events while sitting in their living room.

I have also been struck by the important role played by clinical psychologists in the aftermath of the attacks. For example, a colleague of mine who specializes in posttraumatic stress disorder (PTSD) has been interviewed seven times on national and local television. Although we hear, time and time again, that psychology is not doing a good enough job of "getting the word out there", it appears that our expertise is now being recognized not only within the scientific community, but also by the general public and the media that serves them.

Finally, I have been struck by the similar discourse of psychologists and psychiatrists who have been interviewed on national television. Both groups of mental health professionals have talked about the importance of debriefing, emotional validation, and exposure, all of which are components of empirically-validated treatments for PTSD that have been developed and tested by leading researchers in psychology. It seems that the high quality of research being carried out by clinical psychologists not only impacts the way we treat individuals with disorders such as PTSD, but also the way other mental health professionals address these disorders.

In summary, clinical psychology has played and will continue to play a key role in the aftermath of the recent attacks on the World Trade Center and the Pentagon. In crisis situations such as these, empirically validated psychological treatments for PTSD, which are both effective and have little potential for undesirable complications, have much to offer to all concerned.

Author's note: I wish to thank my colleague and expert on PTSD, Pascale Brillon, Ph.D., for her contribution to this column.

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The Economics of Psychology Internships

William J. Koch, Ph.D., ABPP
UBC Hospital

One of my observations from two years of editing the CCPPP Internship Directory is the disparity in stipends for psychology internships across our country. In looking at our current directory (being updated on May 16th), I see that there are 138 internship positions listed across Canada, 99 of which have some stipend attached to them, and 39 without ***any*** stipend. The range of stipends for paid internships is $1,000 to $35,251. If I delete outliers, the range is $20,000 - $35,251, with a mean stipend of $25,138. This means that the total stipend funds paid to psychology interns in Canada every year are approximately $2,328,630. I would be willing to bet that this total is less than the net worth of some individual senior psychologists approaching retirement.

When I talk to other faculty about this problem of funding students during the applied part of their training, their responses range from some quiet sympathy to indifference. Some even say things like "Well, it is only one year." With this sort of lukewarm concern, it is no wonder that Canadian psychology has no organized lobbying plan on either the federal or provincial level with respect to supporting psychology students during their professional training.

It seems to me that the state of internship stipends in Canada is a pretty sad story. It means that those students who end up completing an unpaid, or poorly paid, internship end up, on average, a lot less wealthy 35 years later. What can you do with $275,000? Take a cruise around the world, buy your grandchild a condo or the family a waterfront home in the Gulf Islands? The sorry state of internship stipends is a major reason why, on behalf of CCPPP, I am pressing for education, particularly student funding during education, to be one of the main foci of any renewed Canadian Psychology organization. These numbers should also motivate those of us who direct internships to take our internal lobbying for better stipends more seriously. After all, the financial pain for these students who underpaid or have no stipends lingers on into their retirement years.

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Students frequently complain to me about the short-term effects of these miserable stipends. We recently raised our own stipend from $24,000 to $27,000 and one of our current students, in commending me for arranging this raise, said "$24,000 isn't very much to live in Vancouver." No kidding! After this discussion, I began to wonder what the long term impact of inadequate (or non-existent) internship stipends might be on the lives of our students. And so, being the kind of guy I am with pocket calculator always handy, I computed the conservative cost to a psychologist at retirement age (65) of having no internship stipend during the year they were 29-30. Using conservative assumptions with which I won't bore you, it turns out that the difference between having a paid internship at the mean stipend shown above and having no stipend for that year compounds over 35 years to a difference in retirement savings of $275,426. Not pocket change by any means. One should point out that a smaller, but still very significant, difference in retirement savings occurs between those psychologists placed in the internship with the highest stipend versus those placed in internships with stipends of $20,000.

A Charter for Psychologists: An Update on Supporting an Environment for Competent and Ethical Practice

In an earlier volume of the Canadian Clinical Psychologist (10 (2), April 2000), Dr. Carter, Executive Director of the Psychologists' Association of Alberta, reported on PAA's development of a Charter of Professional rights for Psychologists. The full charter as adopted by PAA was also published at that time. Briefly, it states the basic work conditions needed by psychologists to provide ethical and competent service. It identifies five domains of work life and the needed conditions to best practice across those domains. The five areas are: the client-psychologist relationship, ethical professional practice, fairness, quality of life, and work environments. The clinical section executive was interested in the charter's applicability and utility at a national level. The section organized a conversation session at the convention in Quebec City this past June to present and discuss the adoption and/or further development of this charter on a national basis. Dr. Carter, Dr. Mikail (representing the CPA Board), and I all presented at the session. Examples were given of actual situations where such conditions were not available and the subsequent impact on the psychologists involved. Overall, there was support for the concept and for the charter as developed by PAA. Dr. Mikail forwarded the charter to the CPA Ethics Committee for review, and some wording revisions were suggested. At this point, Dr. Mikail has taken the charter forward to the CPA Board, with a request for them to consider adopting, disseminating, and supporting the charter nationally. The hope with this document is that adoption by the national organization will provide political 'weight' to support individual psychologists who may be faced with challenges to their professional working autonomy.

Lesley Graff, Ph.D.

Recent Developments and Continuing Questions about Attention-Deficit/Hyperactivity Disorder (ADHD) in Elementary Age Children.

By Waschbusch, D. A. (2001, June). A paper presented in C. Johnston (Chair), ADHD Across the Lifespan. Symposium presented at the annual meeting of the Canadian Psychological Association, Quebec City, QC.

Elementary school is the most common age of referral for assessment and treatment of ADHD . In fact, the study of ADHD was almost exclusively restricted to elementary age until fairly recently. Thankfully, this situation is changing, with more and more research focusing on the assessment and treatment of ADHD in preschool (eg, Byrne, DeWolfe, & Bawden, 1998; Lahey et al., 1998), adolescence (eg, Smith, Waschbusch, Willoughby, & Evans, 2000), and adulthood (eg, Weiss & Hechtman, 1993). Nonetheless, the vast majority of research on ADHD focuses on elementary age children. The purpose of this paper is to briefly summarize some of the key developments about the diagnosis, assessment and treatment of ADHD in elementary age children, as well as to raise some important questions that remain to be addressed.

Diagnosis

Recent advances. One recent advance is the formalization of ADHD subtypes in DSM-IV. In contrast to DSM-III-R, which considered different types of ADHD symptoms (inattention, hyperactivity, impulsivity) as a single group, DSM-IV, differentiates symptoms as primarily inattentive or primarily hyperactive/impulsive. This differentiation is based on numerous factor analytic studies as well as on the DSM-IV field trials. The practical effect is that children with very different clinical presentations are no longer given a "one size fits all" diagnosis. A second advance within the realm of diagnosing ADHD is a greater emphasis on understanding and accounting for comorbidity. For example, one recent meta-analytic review found that ADHD co-occurs with conduct problems, anxiety, and depression at rate higher than expected by chance (Angold, Costello, & Erkanli, 1999), and researchers and clinicians are now recognizing that understanding the role of comorbidity in ADHD is of critical import (Hinshaw & Park, 1999; Pliszka, Carlson, & Swanson, 1999).

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Continuing questions. One continuing question concerns the developmental pathway of ADHD subtypes. Because nearly all of the work on the validity of ADHD subtypes focuses on elementary ages, it is currently unclear whether they are at preschool, elementary, adolescent, and adult ages. One could imagine that a child who is considered hyperactive/impulsive-only before school age may start to show problems with inattention when school starts and attention demands increase substantially. However, there is currently insufficient to address these speculations.

A second continuing question concerns not just *whether* ADHD is highly comorbid with other disorders, but *how* this impacts the lives of children with ADHD. A recent meta-analytic review of how co-occurring conduct problems influences children with ADHD is just one example (Waschbusch, in press).

A third continuing question about the diagnosis of ADHD is whether children with inattention-only should be consider in the same category as children with both hyperactive/impulsive-only or combined type.Both theoretical (Barkley, 1997) and empirical (Milich, Balentine, & Lynam, in press) arguments suggest that children with inattention-only represent are qualitatively distinct from other types of children with ADHD.

Assessment

Recent developments. In many ways, the ahe assessment of ADHD is still very much in its infancy. This is very true in preschool, adolescent, and adult years, but also in the elementary years. Despite decades of research, there is as yet no "gold standard" assessment tool or protocol for evaluating ADHD. Reasons for this, include: (1).The specific definition of ADHD changes frequently; (2) Continued debate on what constitutes the "core features" of ADHD; (3) ADHD is a very complex problem that is influenced by multiple factors (setting, informant, within-child variance, etc.), necessitating a complex assessment protocol. The lack of agreement on assessing ADHD is substantial, including confusion in research efforts, the inappropriate application of treatment, and decreased confidence in the validity of ADHD by the general public.

Despite these dire words, considerable progress has been made. Although the optimal approach to assessing ADHD continues to be parent and teacher report (via interview or ratings), there are promising data on performance measures of ADHD (Rapport, Quinung, Shore, Denney, & Isaacs, 2000). Of note is the stop signal task because it is theoretically elegant because it is supported by research (Oosterlan, Logan, & Sergeant, 1998). Further research on these promising measures seems warranted.

Continuing questions. One of the most important tasks about the assessment of ADHD is to gain a better understanding of the ecological validity of commonly used measures. Ecological validity, which can be thought of as evidence that an assessment measure relates to "real life" performance, is rarely documented for measures of ADHD (Barkley, 1991). For example, we know that the stop signal task discriminates ADHD and non-ADHD and shows change over development, but does it also relate to the peer problems, academic problems, adult-children relationship problems that these children have?

More research is also needed on how to measure peer relationships in children with ADHD. Peer relationships are almost universally impaired in children with ADHD (Pelham & Bender, 1982), but rarely evaluated. This is primarily because an accurate assessment of peer relationships requires asking children to rate other children, a task many parents and teachers find unacceptable. What is needed is a method of evaluating peer problems accurately and unobtrusively, without relying on child ratings.

A final assessment question is whether and how to take age and sex differences into account when evaluating ADHD. It may be that the appropriate method of evaluating ADHD is to use criteria specific to each age and sex. There are currently little or no data published that this possibility.

Treatment

Recent developments. One noteworthy development is the publication of empirical reviews of the treatment of ADHD. Pelham and colleagues (1998) reviewed the empirical basis of all treatments for ADHD and concluded that three treatments for ADHD with enough research backing to be considered empirically supported include behavior modification (48 classroom studies with collectively > 900 participants, and 80 parent training studies with over 5000 participant), stimulant medication (sixty years of studies, thousands of participants), and the combination of the two (10 classroom studies, with > 800 participants). Another review (Swanson, McBurnett, Christian, & Wigal, 1995) focused of the effects of stimulant medication as a treatment for ADHD. Among the conclusions were: (1) there is good evidence stimulants decrease negative behaviors in kids with ADHD, but do not increase positive behaviors; (2) there may be different dose-response curves for behavior (linear) vs. leaning (curvilinear) – although not all research is consistent (Smith et al., 1998); and (3) that there is insufficient research on whether the combination of behavior modification and stimulant medication provide advantages to either one alone.

A second recent development about the treatment of ADHD is the publication of the first set of results from the multisite treatment of ADHD (or MTA) study (MTA cooperative group, 1999a, 1999b). The MTA study was a large-scale randomized clinical trial designed to answer three important questions about ADHD: (1) What are the relative efficacies of BT and pharmacotherapy; (2) What are incremental benefits of these over either alone; and (3) How do these treatments compare to community-based treatments? The initial results from this study would seem to suggest that the answer to these questions are as follows: (1) that pharmacological interventions are more effective than behavioral treatments; (2) that adding behavioral treatments to medication resulted in only modest, non-significant additional benefit; and (3) that behavior treatments alone were no different than community controls, but medication treatments were superior.

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Continuing questions.

The MTA study described above is both a "recent developments" section and a continuing question. Alternative interpretations of the initial MTA data have been offered (Pelham, 1999), such as: (1) post-treatment measures of treatment were taken while children were on medication but were not receiving behavior therapy. Therefore, it should not be surprising that we find an active treatment (medication) outperforms a non-active treatment (behavior therapy); (2) Although the BT and community control group did not differ, they both improved, and 70% of the community group was being treated with stimulant medication, suggesting that BT worked as well as typically administered stimulant medication; (3) parents preferred behavioral treatment to medication treatment; (4) combined treatment children were much more likely to be rated as "normalized" by parent and teachers than any other groups. Further examination of the effects of the MTA study is an important "continuing question" that will lead to better information about the treatment of ADHD.

Another set of continuing questions is what factors influence the treatment of ADHD. There is growing consensus that behavioral and stimulant medication are the effective treatment approaches for ADHD. What remains almost completely unexamined is what factors determine whether these treatment work (Kazdin, 1999). Finally, a key question that remains to be addressed is the role of psychology in non-evidenced based treatments. Although our knowledge of evidence-based treatments has made great strides in recent years, so too has the proliferation of non-evidenced based treatments. Dietary restrictions and supplements, biofeedback, perceptual motor training and other forms of therapy are as widely spread, if not more, than ever (Waschbusch & Hill, in press). It has been suggested that there should be a regulating body for psychosocial treatments, just as there is for medication treatments (Weisz, 2000). Examining the advantages and disadvantages of this strategy is an important task. It is exciting that many important questions about ADHD have been addressed, but it is just as exciting that many more questions remain.

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SECTION ON CLINICAL PSYCHOLOGY 2000-2001 ANNUAL REPORT

Section executive

This year the executive included Lesley Graff as Chair, Charlotte Johnston as Past Chair, Michel Dugas as Chair-Elect, Deborah Dobson as Secretary-Treasurer and Darcy Santor as Member-at-Large. We had two in-person meetings and 2 teleconference meetings, as well as regular communication via email. It has been my pleasure to work with this group of colleagues, and I extend my thanks and appreciation for all of their contributions over the year.

Convention Program

The section contributed to a full program for the annual convention in Quebec City. The section reviewed 111 submissions, including 2 conversation sessions, 9 symposia, 5 theory reviews, and 4 workshops. The section recommended James Prochaska as a CPA invited speaker and Roy Cameron as a joint CPA and Clinical/Health sections speaker. Antoon Leenaars was invited for a preconvention workshop on suicide risk assessment and management. In addition, the section invited a mini workshop by Valerie Whiffen (couples therapy for depression), 2 symposia - chaired by John Walker (cost effectiveness of psychological treatments) and Charlotte Johnston (ADHD across the lifespan), and conversation sessions on internship selection (Dale Stack, Janice Cohen, Paul Basevitz) and a charter of rights for psychologists (Steve Carter, Lesley Graff, Sam Mikail).

Awards and Elections

In recognition for their service and contributions to clinical psychology, the section awarded fellow status to Bill Koch and John Hunsley.

Several submissions were received for the Kenneth Bowers Student Award. Sandra Sparkes of Dalhousie University was the recipient of the award this year, for her paper entitled "Association between parenting practices and childhood behavior problems in a community sample of elementary children".

Two positions were available on the section executive. Kerry Mothersill assumes the role of Chair-Elect, and David Dozois moves into the Secretary-Treasurer position, both by acclamation. Continuing on the executive, Michel Dugas moves to the position of Chair, Lesley Graff moves to Past-Chair, and Darcy Santor remains as MAL. Thank you to outgoing executive Charlotte Johnston and Deb Dobson, for their wise council, timely responses, and thoughtful management of the section's affairs.

Communications

The section publishes a biannual newsletter, *Canadian Clinical Psychologist*, that continues to receive positive reviews. The newest addition to the publication is a News Bulletin column that will highlight new developments in research and clinical practice. Sharon Cairns has done an excellent job in her role as editor. Regrettably, she recently resigned from this role due to other demands and the section is currently searching for a new editor. Dr. Cairns has offered to provide guidance to a new editor, during the transition period.

The section also maintains a website that keeps members informed of section activities and provides links to other relevant sites. David Hart has continued as the webmaster, and recently oversaw the move of our website to one housed at CPA. The new address is **www.cpa.ca/clinical**

The section has agreed to subscribe to a list server on a trial basis in order to facilitate timely and cost-effective communication with members through email. It has been provided at no cost through CPA.

Ongoing Projects

The section has continued to support and develop fact sheets describing effective psychological interventions or contributions to health and mental health areas. A clear process for initiation, review and dissemination was delineated in cooperation with CPA head office, the prototype was further developed, and other sections have been encouraged to join this initiative. The current sheets have been posted on the CPA website; they have been positively received and widely used by practitioners for client information. The member-at-large is actively recruiting Canadian colleagues to prepare additional sheets on a variety of topics.

The executive has examined a charter of rights for psychologists developed by the Psychologists Association of Alberta, with consideration of its application nationally. The charter has been disseminated to section members through the newsletter, and will be discussed in a conversation session at the 2001 CPA annual convention.

The section's chair was a delegate to the Winnipeg conference on a national re-organization of psychology in May, 2001. A report of the deliberations and recommendations stemming from that working conference will be forthcoming to the section membership.

Public Relations

The section executive and members have continued to review documents of relevance to clinical psychology when called upon by the CPA Board, including the national outcomes data base proposal, and a survey of working conditions. The executive regularly responds to information requests from the media, and to foreign students and psychologists regarding work/training opportunities in Canada. In order to facilitate communication, the executive sends a summary of meeting minutes to CPA's Health section, the CPA Board, and CCPPP. Finally, the executive reviewed section membership promotion and developed a member benefits flyer, which has been widely distributed through various sources.

Lesley Graff, Ph.D.
Chair, Section on Clinical Psychology

The Business of the Clinical Section: Summary of Executive Meetings

Teleconference, April 6, 2001

- The executive agreed to proceed on a trial basis with a list server for the clinical section, in order to communicate quickly with section members on issues of importance.
- The website will be housed through the CPA website, with continued maintenance by David Hart.
- The Chair will represent the section at a national conference on reorganization of psychology in Canada, to be held in Winnipeg
- The member-at-large, Darcy Santor, completed drafts of the fact sheet template and process, and will continue recruiting submissions. As well he drafted a bulletin section for the newsletter.
- Deb Dobson, secretary-treasurer, reported a continued positive bank balance, and a slight increase in section membership. She noted the winter meeting expenses had come in right on budget.
- CPA conference planning – final details were reviewed for preconvention workshop promotion, introduction of speakers, and other conference-related preparation. The executive will pursue the question of routinely approving preconvention workshops for continuing education credits in time for the 2002 conference, as it is apparently too late to make arrangements for the 2001 meeting. Michel Dugas will also follow up with concerns regarding the review process for convention submissions.
- Charlotte Johnston reported that EST-related activities continue to be supported by the CPA board (e.g., national data base task force).
- Section fellow and student award decisions were made
- A new member benefits flyer was prepared and will be distributed through CPA mailing and Psynopsis

CPA executive meeting – June 23, 2001

- New executive members were welcomed.
- Much of the time was devoted to (1) debriefing regarding the Quebec City conference. Written feedback to be provided to convention committee; and (2) program planning for the 2002 conference in Vancouver.
- There was some discussion about increasing student support through awards, in response to ideas raised at the section's annual business meeting.

Lesley Graff attended the national reorganization meeting in May, and reported to the section at the annual business meeting. Further information to be provided to all section members through the list serve and mail out in early fall, and formal feedback to steering committee by October.

New Section Fellows: Dr. John Hunsley and William Koch

John Hunsley, Ph.D. is currently a Professor in the Clinical Psychology program (APA and CPA accredited) at the University of Ottawa and the Director the Centre for Psychological Services, which is the training clinic associated with the clinical program and which also operates an accredited (APA and CPA) internship in clinical psychology. In addition, he maintains a private practice focussing primarily on the assessment and treatment of anxiety, mood, and stress-related disorders. After obtaining a Ph.D. in clinical psychology from the University of Waterloo, he joined the faculty of the Department of Psychology at the University of Calgary. In 1988, he moved from Calgary to join the School of Psychology at the University of Ottawa. He has been a registered psychologist in Ontario since 1989, prior to which he was registered in the province of Alberta. In recent years he was made a Fellow of CPA and served as the chair of the CPA Clinical Psychology section task force on empirically supported treatments. Finally, he has published over 50 articles and chapters, dealing with a range of applied topics including (i) measurement and assessment, (ii) factors affecting psychological services and their delivery, and (iii) aspects of clinical psychology in Canada.

William (Bill) J. Koch, Ph.D., ABPP obtained his Ph.D. at the University of Alberta in 1981, and completed a post-doctoral fellowship in clinical psychology at the Health Sciences Centre Hospital in 1982. He is currently the Director of Psychology residency training at Vancouver Hospital and Health Sciences Centre and Clinical Professor of Psychiatry at the University of British Columbia. Bill is also an adjunct professor at Simon Fraser University where he is affiliated with the Mental Health, Law & Policy Institute, and teaches the graduate course in civil forensic psychological assessment. He publishes in the areas of psychological injuries following different types of trauma (sexual assault and harassment, as well as motor vehicle collisions), assessment and treatment of traumatic stress, and clinical judgment. He provides treatment to trauma survivors and has a private practice in forensic psychology. He has served as a volunteer acting registrar for the College of Psychologists of British Columbia as well as several years of committee work, a term on the Board of Directors and as President of the College. He has also performed volunteer work for various community groups and the College of Dentistry, and serves on the executive committee of the Canadian Council of Professional Psychology Program Directors.

Assessment and Treatment of Adults with Attention Deficit Hyperactivity Disorder

Candice Murray, M. A., and Margaret Weiss, M.D., Ph.D., University of British Columbia

Symposium presented at the annual conference of the Canadian Psychological Association, Quebec City, June, 2001.

Although Attention Deficit Hyperactivity Disorder (ADHD) has traditionally been regarded a childhood disorder by mental health professionals, results from longitudinal studies in the past 15 years have altered this view. These studies of children diagnosed with ADHD in childhood and followed into early adulthood have indicated that when children with ADHD reach adulthood, 10 to 70% report experiencing ADHD symptoms that are severe enough to cause impairment (Barkley, 1998; Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1998; Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1993; Weiss, Hechtman, Milroy, & Perlman, 1985). The publication of these results, along with reports in the media concerning ADHD in adulthood, have fuelled both professional and public interest in adult ADHD. An important consequence of these events is that clinicians are increasingly faced with referrals to assess and treat ADHD in adults with limited empirically-based information to guide them. What follows is a summary of the current guidelines and controversies in assessing and treating ADHD in adulthood.

Assessment

Given the limited empirical research on ADHD in adulthood, the assessment of adults is guided by the criteria outlined in the DSM-IV (APA, 1994) and the process established for assessments of ADHD in children (American Academy of Child and Adolescent Psychiatry, 1997; Murphy & Gordon, 1998). Consequently, assessment guidelines involve establishing the presence of at least six of the nine DSM-IV inattentive and/or six of the nine hyperactive/impulsive symptoms, gathering evidence of chronicity (i.e., childhood onset of the symptoms), pervasiveness across situations, impairment, and ruling out differential diagnoses.

In the assessment procedure, there are several controversial issues. First, there are concerns about the developmental appropriateness of using the DSM-IV symptom list to assess adults, as the symptoms were developed on field trials of boys between the ages of 4 to 17 years (Applegate et al., 1995; Lahey et al., 1994). These concerns involve both the content of the symptoms and the recommended cutoff scores in the DSM-IV for a diagnosis of ADHD. To address the appropriateness of the word content of the items, adult rating scales have been developed which use the DSM-IV items but modify the wording to remove references to toys, homework, games, etc. (Barkley, 1998; Conners et al., 1999). The impact of changing the content of the symptoms awaits empirical research. For establishing the symptom cutoff required for a diagnosis of ADHD, adult rating scales have been developed that employ a statistical deviation from age-based norms (Barkley, 1998; Conners et al., 1999). Using statistical deviation from the norm as a guideline for adults, rather than the child-derived DSM-IV cutoff to establish the diagnostic threshold, appears justified as numerous studies indicate that the frequency of ADHD symptoms declines with age (Heilingenstein, Conyers, Berns, & Smith, 1998; Millstein et al., 1997; Murphy & Barkley, 1996). Consequently, the current DSM-IV cutoffs may be too stringent for adults, resulting in underdiagnosis. Again however, the validity of the norm-based cutoffs requires further research.

Beyond the issue of the developmental appropriateness of the DSM-IV symptom content and cutoffs, a second issue for the assessment of ADHD in adults is establishing chronicity. There is a consensus among researchers and clinicians that chronicity (i.e., child onset of ADHD symptoms) is an essential requirement for a diagnosis of ADHD in adulthood. The difficulty in establishing this criterion centers on the whether clients can accurately recall childhood symptoms of ADHD (Greenfield et al., 2001; Mannuzza et al., 1993; Murphy & Schachar, 2000). Research findings have been inconsistent on this issue and more studies are needed before this question can be resolved. Another issue with establishing chronicity of the ADHD symptoms involves whether the DSM-IV criterion of onset of symptoms before age 7 is clinically important. Barkley and Biederman (1997) have argued that there is no empirical justification for this criterion and therefore adherence to it is unnecessary. Until these problems in assessing chronicity can be resolved, experts in the field are recommending (1) that collateral information be used during the assessment to collect symptom information (e.g., a person who knew the client well as a child, or teacher comments from report cards) and (2) that the window for the onset of ADHD symptoms be adjusted to 12 years (Barkley & Biederman, 1997; Murphy & Gordon, 1998).

Information about the pervasiveness of the ADHD symptoms and impairment is best acquired using a clinical interview. Barkley (1998) has published a comprehensive clinical interview that covers developmental history, and functioning in academic, occupational and social realms. Finally, when a client meets diagnostic criteria for another disorder in addition to ADHD (e.g., generalized anxiety disorder), the clinician needs to establish whether there truly is a comorbid disorder or if overlapping symptoms can account for the dual diagnosis (e.g., poor concentration, motor restlessness). This distinction can be difficult to make. Often, examining data gathered during the clinical interview can be useful as ADHD typically has an earlier onset (i.e., early childhood) and a distinctive course (e.g., academic and social problems) compared to other disorders (Murphy & Gordon, 1998).

Treatment

Until a standardized assessment protocol is developed for adults with ADHD, treatment outcome research will be limited by heterogeneous assessment methods and samples across studies. To date, controlled studies examining the efficacy of methylphenidate, the medication most commonly used to treat children with ADHD, have indicated a variable response in adults (Wender, Reimherr, Wood, & Ward, 1985; Wilens & Biederman, 1992). However, a recent study by Spencer et al. (1995) employed current assessment guidelines in identifying adults with ADHD and found that methylphenidate was effective in reducing ADHD symptoms in the majority of participants. Establishing the efficacy of pharmacological treatments, although promising, awaits further research.

To date there is no controlled research examining psychological treatments for ADHD in adults. Ratey, Greenberg, Bemporad and Lindem (1992) conducted an uncontrolled study of 60 adults with current and childhood symptoms of adult ADHD and found that traditional psychodynamic therapy appeared to have a negative effect on clients (e.g., exacerbated feelings of frustration, incompetency). Clearly, the results of this study need to be replicated using a controlled research design before firm conclusions are drawn. In the meantime, psychotherapeutic recommendations for adults who have ADHD are guided by anecdotes and common sense rather than on empirically derived knowledge. In short, clinicians who have experience working with this population suggest structured and focused sessions that include psycho-education about ADHD, teaching specific problem-solving strategies to improve daily functioning, and addressing comorbid problems, such as depression, that may have developed as a result of the ADHD symptoms (Bemporad & Zambenedetti, 1996; Murphy, 1998; Ratey, Hallowell & Miller, 1997; Weiss, Hechtman, & Weiss, 1999; Wender, 1995).

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Current guidelines for the assessment and treatment of ADHD in adulthood are based on a combination of expert consensus, child ADHD research, and a limited body of research on adult ADHD. Empirical research is needed to determine the validity of the proposed assessment criteria and the efficacy of pharmacological and psychological treatments. Assessment issues that require clarification include whether the DSM-IV symptom list for ADHD is appropriate for assessing adults, the extent to which adults can accurately recall their ADHD symptoms from childhood, setting a meaningful limit for the age of onset of ADHD symptoms, how to define impairment, and how to establish comorbid or differential diagnoses. Until these issues can be resolved empirically, clinical practice should be guided by current standards and updated regularly as new, empirically-derived information materializes.

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THE MUTUAL RECOGNITION AGREEMENT FOR PROFESSIONAL PSYCHOLGISTS IN CANADA

On June 24, 2001, Canadian regulators in psychology gathered in Quebec City to sign an agreement that was the culmination of three years of discussion and negotiation. The Mutual Recognition Agreement (MRA) for the profession of Psychology was produced in response to the requirements of the Agreement on Internal Trade implemented by the Canadian government to reduce barriers to mobility for all workers in Canada. The MRA is significant for professional psychology in that it will facilitate a coordinated approach to the development, and implementation of regulatory requirements across Canadian jurisdictions based on a common conceptual framework.

An assessment of the licensing requirements for entry to the profession of psychology across Canada revealed high commonality with regards to the competencies assessed but low commonality in the methods used to assess competencies. The most significant difference between jurisdictions was the degree required for entry to the profession (Doctoral vs. Masters) but variations were also observed in the use of the Examination for Professional Practice in Psychology (EPPP), the requirements for post degree supervised practice and the use of oral exams. Rather than focus on the differences, regulators identified five common core competencies required for licensure across Canada and agreed on acceptable methods of assessing these competencies. These included competency in interpersonal relationships, assessment and evaluation, intervention and consultation, research, and ethics and standards.

Regulators in the eleven jurisdictions that license psychologists in Canada agreed to explicitly assess the core competencies by July, 2003. The methods used to assess competencies include a review of the content of the graduate degree in psychology, a knowledge exam such as the EPPP or equivalent, an oral exam, and a period of supervised practice. All new registrants will be required to demonstrate competency through these mechanisms and consequently, those licensed after July 2003 will be recognized in all jurisdictions in Canada. Doctoral level jurisdictions have reserved the right to apply a different title to masters level psychologists licensed in their jurisdictions.

Psychologists licensed in any jurisdiction prior to July 2003 who have five years of practice immediately preceding the date of application and who have no disciplinary sanctions will be recognized in a receiving jurisdiction. In addition, psychologists who meet one of the following criteria and have no disciplinary sanctions will be licensed at any time in a receiving jurisdiction:

1. Possess a graduate degree in psychology from a program accredited by the Canadian of American Psychological Association;
2. Be a registrant of the Canadian Register of Health Service Providers in Psychology or the National Register in the United States;
3. Possess a current Certificate of Professional Qualification from the Association of State and Provincial Psychology Boards.

Psychologists who do not meet any of the criteria described above will go through regular licensing procedures of the jurisdiction of choice.

Although not perfect, the MRA reflects considerable compromise and accommodation by all jurisdictions. It is an evolving agreement that can be modified as needed by securing consensus from the signatories.

Lorraine J. Breault, Ph.D., C. Psych.
Chair: Psychology Sectoral Workgroup on the Agreement on Internal Trade (PSWAIT)

Clinical Section List Serve

The CPA Section on Clinical Psychology initiated its list server, in August 2001, in order to inform members about important news and events, and to disseminate information generated from the Executive of the Section. Two mailouts have been sent to Section members, and we expect that there will be a total of 5 or 6 mailouts per year.

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

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

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

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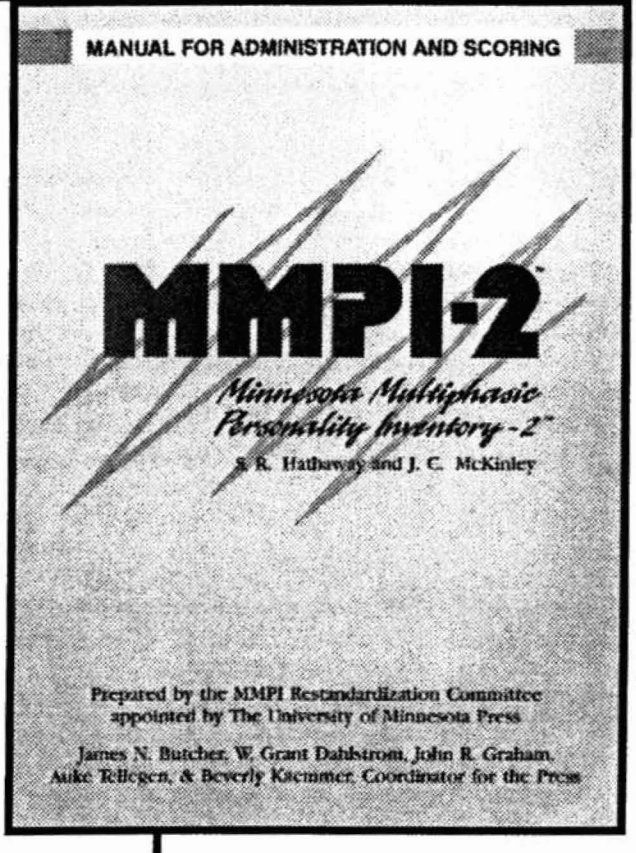

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Editors' note: Sandra Sparkes (see announcement, page 15) was the winner of the 2001 Ken Bowers Student Research Award at the 2001 CPA convention in Quebec City. The following article, based on her presentation, was invited for this issue.

Associations between Parenting Practices and Childhood Behavior Problems in a Community Sample of Elementary Children

Sandra J. Sparkes & Daniel A. Waschbusch
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Previous literature has consistently shown that one important factor in the development of clinically significant childhood behavior problems, such as those that characterize Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (DSM-IV, APA, 1994), is parenting (Frick, Christian, & Wootton, 1999; Frick, 1998; Patterson, Reid, & Dishion, 1992; Loeber & Stouthamer-Loeber, 1986). Though research has clearly shown that parenting and conduct problems in children are related, a number of uncertainties remain about this association that need clarification. For example, the specific relationship between parenting practices and behavior problems in a community sample needs to be clarified, as does the role of child age, child sex, and mother versus father report in this relationship. These three variables have been shown to be relevant in past research on disruptive behavior (Silverthorn & Frick, 1999; Frick et al., 1999, 1994; Pakaslahti, Spoof, Asplund-Peltola, & Keltikangas-Jarvinen, 1998; Pakaslahti, Asplund-Peltola, & Keltikangas-Jarvinen, 1996; Offord et al., 1987). This study thereby endeavored (1) to clarify the relationship between four specific parenting practices and ODD/CD in a community sample, (2) to determine the role of child age, child sex, and parent sex in this relationship, and (3) to make a general comparison between these relationships in a community sample and those found in a previously published study that used a clinical sample (Frick et al., 1999).

Method

Participants were the parents/guardians and teachers of 831 children in Atlantic Canada. The children were students in grades kindergarten through six in seven public elementary schools and included 403 females (48.5%) and 428 males (51.5%) who ranged in age from 5 to 12 (M = 8.11, SD = 1.90) years.

Parenting practices were examined by a modified version of the Alabama Parenting Questionnaire (APQ; Frick, 1991). The modified version consists of 38 Likert ratings asking raters to indicate the frequency that they engage in various parenting practices. Item responses were summed to create the following five subscales: Involvement (10 items), Positive Parenting (6 items), Poor Monitoring/Supervision (9 items), Inconsistent Discipline (6 items), and Other Discipline Practices (7 items).

Childhood behavior problems were assessed by the Assessment of Disruptive Symptoms, DSM-IV (ADS-IV; Waschbusch et al., in progress). The ADS-IV is a checklist of disruptive behavior disorder symptoms as specified in the DSM-IV (DSM-IV; APA, 1994). Item responses were scored to create two continuous scores, one for ODD and one for CD, by computing the mean rating of the symptoms across mothers, fathers, and teachers.

Results

Table 1. Correlations Between Parenting Practice Subscale Scores (as Reported by Mother/Father) and Average CD/ODD Score

APQ Subscale	ODD Score		CD Score	
	Mother	Father	Mother	Father
Involvement	-.20 [A]	-.13 [B]	-.14 [A]	-.03
Positive Parenting	-.06	-.05	.00	-.02
Poor Monitoring/Supervision	.21 [A]	.27 [A]	.24 [A]	.26 [A]
Inconsistent Discipline	.32 [A]	.24 [A]	.13 [A]	.18 [A]

Notes:
(1) n for each correlation ranged from 381 to 790 due to missing data.
(2) Correlation is significantly different from 0 at an alpha level of .01 (2-tailed), [A] .05 (2-tailed). [B]
(3) Other Discipline Practices subscale scores were removed from analyses, given poor reliability by both mother and father report.

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Discussion

A number of interesting results emerged from this study. First, parental lack of involvement in children's activities, poor monitoring/supervision, and inconsistent use of discipline, but not lack of positive parenting, were shown to be significantly associated with ODD and CD symptoms in a community sample (see Table 1). The same pattern of results had been previously found using the APQ in a clinical sample (Frick et al., 1999). This result suggests that it is the presence of negativity in parenting practices, rather than the absence of positive affect and behaviors, that is most relevant in understanding the relationship between parenting and childhood behavior problems. Furthermore, the regressional analyses conducted in this study showed that neither child sex nor child age influence the associations in a community sample. The correlational and regressional analyses conducted in this study both showed, however, that there are distinct, though seemingly small, differences in the associations between mother-reported parenting practices and father-reported parenting practices and that of childhood behavior problems in a community sample.

Comparisons between the findings of the current study and those of Frick et al. (1999) showed that the associations between parenting practices and ODD/CD are generally stronger in a clinical sample (Frick et al., 1999), as compared to a community sample, though the associations were not always found to be statistically significant in the clinical sample in cases where they were significant in the larger community sample (likely a reflection of differences in power). Furthermore, age was shown to influence the associations in the clinical sample (Frick et al., 1999) whereas no age trends were evident in the current study. Overall, the results of this study support the notion that understanding parenting is central to the understanding of childhood behavior problems (Frick et al., 1999; Frick, 1998; Patterson et al., 1992; Loeber and Stouthamer-Loeber, 1986). The results of this study also highlight the need for further research on community versus clinical sample differences in the relationship between parenting and disruptive behavior.

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Waschbusch, D. A., Sparkes, S. J., & Behavior Education Support & Treatment Committee. (in progress). Assessing attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) using teacher, mother, and father ratings: Are normative comparisons useful?

Canadian Psychology Responds to the September 11th Terrorist Attacks in the United States

What follows is a summary of some of the activities that organized psychology groups across Canada undertook to assist and support the victims, as well as all of us who have been influenced by the tragedy. The Canadian Psychological Association has developed a press release article that was sent to all media outlets and was posted on the CPA web site (www.cpa.ca). APA and the Canadian Red Cross as well as other associations and organizations were contacted, in order to lend assistance. CPA contacted Foreign Affairs and offered assistance to those stranded in Canada or directly affected such as grounded passengers or U.S. embassy staff. Volunteers among CPA members were solicited to help, if the need arose. John Service was interviewed on numerous media outlets across Canada on the effects of trauma and CPA was offered as a resource to the media outlets via email to help them find psychologists to comment on tragedies and terrorism.

The Canadian Provincial Associations and Colleges responded quickly to the tragic events of September 11th. Associations were quick in developing lists of those who were prepared to offer pro bono psychological services in the U.S. as part of the APA, NY and DC psychology responses as well as offer pro bono services at stress points in Canada (e.g., airports, U.S. embassy and consulate staff in Canadian cities) and talk to or consult with community groups and schools as well as the media about trauma and terrorism.

A sampling of some of the specific responses includes:

Ontario:
Dr. Catherine Yarrow, Registrar of the College of Ontario Psychologists, communicated almost immediately with CPA, OPA and OAPA as to what needs might be required and where psychologists could be of help. She stressed the importance that efforts be coordinated through the appropriate authorities. Members with expertise in working with trauma were encouraged to volunteer through CPA, OPA or OAPA. She noted that OPA had begun collecting names of those wishing to offer pro bono services to those Americans or Canadians directly affected, as well as those interested in speaking to the media. Ruth Berman reported that OPA contacted both the Ministry of Health and the office of Emergency Services of Ontario informing them of the professional volunteers available. A number of media requests were responded to. All members on the OPA list serve were kept up to date.

Quebec
In Quebec, OPQ President Rose Marie Charest appeared on CBC in Quebec (Radio Canada). A list of psychologists specializing in post-traumatic intervention who were ready to volunteer was developed.

British Columbia
Geraldine Brooks reported that a number of psychologists in B.C., including Bill Koch and Yaya deAndrade were involved in media interviews on the impact of the terrorist attacks. The latter psychologist also served as a coordinator for BCPA volunteers, which were recruited through their list-serve. Jim Ogloff reported that Vancouver psychologists were organizing meetings for the public on the psychological aspects of the tragedy. Cheryl Fraser, a psychologist who has a radio talk show put out a call to psychologists for story ideas and psychological perspectives on the crisis. Many members shared information with colleagues, clients and the general public.

Alberta
Stephen Carter responded to several media requests, both newspaper and television. He also put together a fact sheet for media responses in regards to children's reactions. A team of volunteer psychologists in Calgary was on stand-by for emergency distress counseling should the need arise at the Calgary airport, as planes were diverted to that airport.

Human Resources Request

Consistent with the CPA vision statement, *"Advancing Psychology for All"*, CPA has entered into a 3 year agreement with HR.com to publish 1200 word essays on virtually any subject that might be of interest to human resource managers. The essays are to be sent to Gary Latham (latham@rotman.utoronto.ca). Members of the Clinical Section have much expertise to offer in this area, and are encouraged to write on topics such as depression, personal issues that affect job performance (e.g., mental difficulties), work-life balance, back pain, and ways to reduce stress. The outline for an essay is straightforward: What is it? How can the HR manager or the person's boss recognize or be alert for it? What action or steps can the employee, employee's colleagues, boss and/or HR manager take on behalf of the employee? Contact HR.com and then enter Canadian Psychology Association to see existing articles. They are written primarily by I/O psychologists, however, contributions from clinicians are more than welcome.

Gary Latham

KEN BOWERS STUDENT RESEARCH AWARD/ PRIX KEN BOWERS POUR RECHERCHE EFFECTUÉE PAR UN(E) ÉTUDIANT(E)

Sandra Sparkes from Dalhousie University was announced as the winner of the 2001 Ken Bowers Student Research Award at the 2001 CPA convention in Quebec City.

The article, **Associations between Parenting Practices and Childhood Behavior Problems in a Community Sample of Elementary Children,** based on her presentation, was invited for this issue (see pages 12– 13 for the full text).

Congratulations to Sandra for this accomplishment.

Submissions Invited

The Canadian Clinical Psychologist/ Psychologue Clinicien Canadien invites submissions from Section members and students.

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

Please send your submission, in English or French, directly to the editors, preferably either on disk or via e-mail attachment. The newsletter is published twice per year. Submission deadlines are as follows: September 15th (October issue) and March 15th (April issue).

Editors:
Deborah & Keith Dobson
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Please Note:
The guest editor for the April, 2002 issue will be David Hart at David.Hart@ubc.ca

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 2002-2003, the Section requires nominations for the position of Chair-Elect (a three-year term, rotating through Chair and Past Chair) and Member-at-Large (a two-year term). Continuing members of the Executive for 2002-2003 will be Dr. Kerry Mothersill (Chair), Dr. Michel Dugas (Past-Chair) and Dr. David Dozois (Secretary-Treasurer).

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 29th, 2002. Send nominations for the Executive to:

Dr. Lesley Graff, Past Chair
PX246-771 Bannatyne Avenue,
Winnipeg, Manitoba, R3E 3N4

Phone: (204) 787-3490
Fax: (204) 787-3755
email: lgraff@exchange.hsc.mb.ca

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 29 mars 2002 à l'attention de:

Kerry Mothersill, Ph.D.
Outpatient Mental Health Program
Calgary Health Region - CBH
1213 - 4th Street SW
Calgary, Alberta T2R 0X7

Tel: (403) 541-2145
Fax: (403) 541-2141
Email:Kerry.Mothersill@Calgaryhealthregion.ca

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; 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 29, 2002 to:

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Outpatient Mental Health Program
Calgary Health Region - CBH
1213 - 4th Street SW
Calgary, Alberta T2R 0X7

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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 $300. 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 Ottawa; (2) Submit a brief (i.e. up to 10 pages, double-spaced) manuscript in APA format describing the project, and (3) Be prepared to attend the Clinical Section Business meeting at the Ottawa convention, where the award will be presented.

The deadline for submission of applications is March 29, 2002. Submissions may be in either English or French and should be forwarded to:

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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. En 2002, deux bourse seront remises. Un certificat et une bourse de 300$ seront remis aux deux étudiants(es) ayant soumis les communications les plus méritoires. 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 Vancouver; (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 Vancouver lorsque les prix seront décernés.

La date limite pour soumettre les candidatures est le 29 mars, 2002. Les demandes peuvent être formulées en français ou en anglais et doivent être envoyées à:

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