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MESSAGE FROM THE CHAIR.

Sam Mikail

Breathing is essential to life. Some use gills and some use lungs in the process, depending on the environment in which they live. Although psychology is not on the same order as breathing, for most of us it has become an essential part of our lives. It is the foundation of our livelihood, and likely has become entrenched as a central element of our identity. A well defined identity and a secure livelihood are critical to wellbeing and quality of life.

But, do we rely on "lungs" or "gills" in doing psychology? Whatever the answer, what is clear is that the environment in which we "do" psychology has changed dramatically, and continues to change. Perhaps the change has become as dramatic as having lived on land, and now finding that we are up to our waists in water. The water continues to rise steadily, and we need to begin thinking about alternative means of "breathing". Naturally, adjusting to a new environment is always difficult, and approached with some hesitation. It is better, however, to choose how one will adapt, as opposed to having a new process imposed.

It is for this reason that the National Conference on Professional Psychology was held last spring. The recommendation that core curriculum be defined, or redefined, is akin to pointing out that we are moving from land living to water living, and that we need to choose a new process for breathing. Many of you responded to the survey in the last issue of The Canadian Clinical Psychologist. Thank you for doing so. Similar surveys were sent to Directors of Clinical Training in Internship and academic programs. Results of the survey will be presented in a Conversation Session to be held during the upcoming CPA annual convention. We will be joined in that session by our colleagues for the sections on Neuropsychology, School and Educational Psychology and Counselling Psychology. I hope that you will attend and continue to contribute to the dialogue. It is essential that we "choose" how we will continue to evolve and survive, rather than having this imposed on us. This will require careful appraisal of the new environment, and a willingness to recognize the need for change; perhaps a change that is as dramatic as exchanging lungs for gills.

The Section on Clinical Psychology is sponsoring a comprehensive and stimulating program for the upcoming convention. A second conversation session will follow the core curriculum session. It will be chaired by Dr. John Hunsley and is entitled "Clinical Training in

Empirically Validated Treatments: Conceptual, Professional, and Pragmatic Issues." Panelists will include Drs. Keith Dobson, Pat McGrath, Linda McMullen, Sandra Pyke, and Dick Steffy.

Additionally, over 50 posters or papers have been accepted, as well as seven symposia covering a variety of topics such as "changing roles of hospital psychologists", "males and sexual abuse", "adolescent mental health", "assessment and treatment of ADHD", and others. The section is also sponsoring a preconvention workshop on assessment and treatment of chronic pain.

Finally, in closing, I would like to mention that two new executive members will be required for the upcoming year. The positions of chair-elect and member at large are due to be filled. This is an exciting time to be involved in the operation of the section. We will continue our work on core curriculum. We will also begin to look at means of orienting senior undergraduates to potential career paths in clinical psychology. 1996 is the centennial of clinical psychology and Section 26 has been asked to become involved in an international conference commemorating the centennial to be held in Philadelphia. I hope that you will consider putting your name forward for either of these two positions. See you in Charlottetown.

Sam Mikail

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Symposium - Marketing of Clinical Psychology

The following articles provide a summary of a symposium that was presented at the annual convention of the Canadian Psychological Association in June 1994 in Penticton, B.C. The symposium consisted of a brief introduction and then three separate presentations by Keith Dobson, Wolfgang Linden, and Harry Stevens breaking the topic down into (1) the marketing of clinical psychology as a mental health service, and (2) as a physical health service. The third presentation covered the more applied aspect of the first two presentations, using the business analogy to show how product, consumer, and producer of psychological service are sometimes disconnected and really need not be.

CALL TO ARMS: COST BENEFIT ANALYSES AS AN INSTRUMENT OF POWER

Keith S. Dobson, Ph.D.
University of Calgary

There is relatively little doubt that psychological interventions are effective in the mental health area, it is unfortunately the case that relatively little is known about the cost effectiveness of these procedures. Thus, although we can accept that "the evidence that has accumulated over the last 40 years is relatively clear: psychotherapy is a process from which most clients who remain involved for at least a few sessions will benefit" (Whiston and Sexton, 1993), the vast majority of research in the area of psychotherapy has been on its absolute effectiveness, rather than cost benefit analysis. We know approximately that 65% of patients who receive psychotherapy benefit, although the rate for some disorders is in fact much higher (e.g. phobias), and that the average effect size of psychotherapy is approximately one standard deviation (Whiston and Sexton, 1993). We also know that approximately 10% of clients who receive psychotherapy either decline in functioning, or are actually damaged by the process.

Much of the literature in psychotherapy is devoted to questions of assessing the effectiveness of different models of psychotherapy, and more recently, there has also been a trend towards examining client therapy interactions (examining different client variables as predictors of psychotherapy outcomes). A literature review examining the question of psychotherapy and cost effectiveness, conducted prior to the 1994 C.P.A. Symposium on which this article is based, yielded a total of 24 articles that used the words "psychotherapy" and "cost effectiveness" in the same article. Even within this scant literature, most of these articles only made reference to the issue of cost effectiveness in the discussion of the article, implying that significant treatment effects were evidence of cost effectiveness (when in fact no such analyses were even conducted).

There are good reasons why cost effectiveness analyses in psychotherapy are rarely conducted. As Schmid (1989) makes abundantly clear, the conduct of adequate cost-effectiveness analyses is highly complex

and should include examination of such issues as:

- 1) programme information structure (what is the product; how is it measured?),
- 2) the estimation of both direct and indirect programme effects including direct costs in both immediate and long-term fashion, as well as hidden costs, such as training, development and negative effects,
- 3) opportunity cost adjustments (the negative effects to other industries for the development of psychotherapy services),
- 4) changes in valuation of outcomes over time,
- 5) uncertainty estimations, and
- 6) political economy issues, including such issues as demand of services.

Notwithstanding the fact that relatively little data is now available to directly address the issue of cost effectiveness of psychotherapy, clinical psychology needs to be able to speak to the purchasers of psychotherapy in order to develop or augment the financial contribution for psychotherapy. In this context, it is critical for psychology to recognize who are the purchasers of psychotherapy and to be able to identify the kinds of decisional issues that private (e.g. individuals, insurance companies) and public (e.g. hospitals and community clinics) buyers of psychotherapy are interested in. Although a complete discussion of these issues is well beyond the scope of this brief article (see Atkinson, et al, 1991 for a discussion), it is notable that cost effectiveness is only one of the variables that purchasers consider when buy this type of service. Other considerations include the extent to which the other sector is involved in providing these services, the amount of available quality information about these services, market demand, and issues such as quality/public safety for public service providers, versus liabilities and risks in the private sector.

This brief article obviously only touches the very basic issues outlined in the valuing and marketing of psychotherapy in the mental health market. I have tried to argue that we now have adequate data speaking to the effectiveness of psychotherapy (although I would note that different types of psychotherapy have more or less claim to the empirical demonstration of their outcomes), and that the field must now move towards issues of cost benefit analysis and marketing strategy. There exists almost no literature upon which one could make a strong claim for the cost effectiveness of psychotherapy, notwithstanding the fact that such data could be obtained and likely would be positive. It will be critical for the field to move in the direction of doing this type of research in the near future, particularly as the field of mental health moves towards a more competitive, and mixed (i.e. having both public and private sector involvement) structure. While data on the absolute effectiveness of psychotherapy is important for its marketing, the full development of marketing for psychotherapy in the mental health economy sorely needs the accumulation of cost effectiveness analysis and the development of elaborate marketing strategies.

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MARKETING OF CLINICAL PSYCHOLOGY AS A PHYSICAL HEALTH SERVICE

Wolfgang Linden, Ph.D.
University of British Columbia

The timing of this presentation is everything but an accident because I believe that health care, and the role of psychology in it, is currently undergoing dramatic changes that will also leave our profession changed for many decades to come. These changes are happening now and there is so much momentum that psychologists simply cannot afford a wait-and-see attitude. In fact, one can very well describe the current status as one of crisis, and as the definition of the word crisis implies, it allows for change for the worse and for change for the better. Which of the two outcomes is the more likely will depend largely on us, that is, psychologists, or clinical psychologists in particular. The overall purpose of this presentation is twofold: highlight how practitioners are not serving themselves and their clientele by ignoring recent advances in research, and secondly, I want to examine critically some of the traditions and habits of clinical researchers, again highlighting how some of those habits stand in the way of serving psychological practitioners, and prevent the best possible marketing job.

I will argue that we are dealing with two main problems. The first problem is that clinicians are not aware of, or do not use enough of the available scientific literature in order to pitch their own services. A second and by no means lesser problem is that researchers do not necessarily provide information that is inherently useful to practitioners. In challenging both sides to be more aware of the others' needs and skills it is hoped that ultimately there will also be a closer integration that facilitates marketing of services and that guarantees a future for clinical psychology as a health profession. I truly believe that clinical psychology can play a pivotal role in health care and that case needs to be made now.

Problem 1: Clinicians do not use enough scientific information. There has been ample documentation via surveys of clinical practitioners that suggest a widespread non-usage or underusage of what is published in scientific journals. When clinicians were asked to indicate where they acquire information for continuing education and for improvement of their skills, scientific journals were among the least popular and least frequently used forms of education and learning

(Cohen, Sargent, & Sechrest, 1986; Morrow-Bradley & Elliot). The reasons for that are not entirely clear, however, it is not difficult to speculate on them.

The first argument is that clinicians of course need to do clinical work for a living and in the case of the private practitioner, time is money. In the case of employed psychologists there is not the direct fee for service pressure but hospital administrators nevertheless need to require the psychologists and other health professionals to be efficient providers, and psychological services across the country tend to have long waiting lists especially when their services are free. This means that there is relatively little time left for practitioners to engage in continuing education and traditional skill learning.

A second argument is that of lack of easy access. This is somewhat due to recent rocket-like increases in price for many scientific journals as both the Canadian dollar lost buying power and journal publishing companies were trying to increase their profits. Fortunately, some of this can be counterbalanced by computer access to a variety of networks which may also help to overcome geographical obstacles. While not every psychologist can easily go to the university library, access to computer networks does not suffer from such geographical limitations.

A third argument, and that one is a clearly opinionated perspective on my part, is that a number of clinicians do hold what I consider truly antiscientific attitudes. They treat clinical psychology simply as an art and believe that nothing scientists have to offer is useful for practitioners. They perceive a deep schism between the universities and the "real" clinical world and simply do not want to deal with people on the other side of that canyon. Along these lines, I also posit that clinicians do not do enough standardized assessments and program evaluations in order to be able to demonstrate on an ongoing basis how much benefit their clients accrue from psychological services.

Problem 2: The other main problem that I have identified and will discuss in more length is that researchers do not necessarily conduct research on questions that are particularly important to clinicians, and often do not publish papers in such a manner that they actually facilitate the marketing of those findings by practitioners.

This critical approach to looking at how researchers conduct their work and publish their findings will be broken down into four main arguments, and finally a few recommendations for clinical research will be derived. The first argument is that researchers adopt a non-cumulative attitude towards outcome studies, the second argument is that clinicians do not use enough measures that are what I call "easy to sell" measures. The third argument is that researchers overly emphasize randomized standardized trials methodologies which actually lead to consistently over conservative outcomes, and lastly, that there is not enough effort made to explain cost and cost-effectiveness of clinical procedures. The good news is that there has been positive change on many fronts over the last few years and by describing such changes it is intended to invite clinicians to more carefully look at clinical research, to

consider collaborating with clinical researchers, and to start trusting that the other side also has an interest and a capability to help with the marketing of clinical psychology.

Accumulation of findings. One of the many problems with therapy outcome studies is that researchers tend to favor original studies over replications. In a review of 302 outcome studies published in three prestigious clinical psychology journals, we found that only 4% of the published studies were referred to as replications (Linden & Wen, 1990). This is particularly striking since most papers also stated in the discussion section that these findings really should not be trusted until replicated. Obviously, there cannot be an accumulation of findings if nobody conducts replications when everybody asks for them. It was further curious that our most subjective rating of these papers led to the conclusion that about 30% of these studies were either full or partial replications of previous studies and that the authors had seemingly made an effort at suppressing that fact. Clearly, it does not make much sense to request an accumulation of findings if the information is indeed available but is then actively not reported. Along these lines there have been published articles showing that one of the prime reasons for researchers not conducting or reporting replications is that they simply are not prestigious and that the reason for publishing is to gain prestige. The motivational dynamic of the research endeavors obviously needs to be considered if things are to change. Contributing to lack of accumulation via replication is the fact that in almost all university theses are required to be original pieces of work.

The suggested solution to this problem is to conduct research and publish review papers and especially meta-analyses in widely read journals that can be helpful to pull together information from different studies while conveying a joint message. We have also suggested elsewhere that publication of replications could be facilitated by changes in editorial policy such that editors truly encourage and reserve a sub-section of journals for replications. And lastly, universities can contribute by allowing students, for example, to conduct replications as theses. My experience is that there is absolutely no fear of a boring experience for this student since every single study even if it's a conceptual replication presents considerable logical, statistical, and conceptual challenges to the student.

Another suggestion is to establish one or more required measures for all studies. Consensus groups of expert researchers and clinicians could make the suggestions as to the one or two most useful measures for a given target problem, let's say depression, and then all studies that were to receive funding need to agree to have at least one of these measures included in their protocol. This would dramatically facilitate comparison of outcome across different studies.

We have argued elsewhere (Linden & Wen, 1990) that the types of measures clinicians and researchers are using can be coarsely broken down into what we call 'soft' and 'hard' measures. While this is a somewhat

arbitrary, dichotomous breakdown, the labels refer to the degree of reactivity inherent in these measures. Soft measures, like self-report and clinician ratings, tend to be highly reactive measures and often involve psychological constructs that do not have much inherent meaning to non-psychologists. On the other hand, hard measures include such things as physiological indices, reduced hospitalization rates, reduced medication intake, and are at least to some degree easier to understand for non-psychologists. Hence, the inclusion of hard measures will make it quite a bit easier to market the potential benefits of psychological treatment. We have noted that a relatively large number of studies do include hard measures and that over time the inclusion rate has actually risen from about 60 to 75% of all published studies (Linden & Wen, 1990).

In addition, there have been many reviews that can serve as examples for the benefits achieved with psychological treatments on hard measures (Mental Medicine Update, Special Report 1993). While the findings reported next are by no means complete, they can serve as exemplars of how one can demonstrate psychological benefits even to non-experts. One such example is from a U.S. study of emotional support given during childbirth. Three groups of 200 women each had been observed, one group had no psychological support provided during birth. One group had a 'doula' (a trained lay-person) assigned as a social support person, and another group had simply an observer assigned to function as a placebo control for the doula. Comparison of the control group versus the one that received active social support during childbirth revealed a drop of 56% in the rate of C-sections. A drop of 85% was noted in the need for epidural anesthesia, a drop of 70% in the need for forceps delivery, a drop of 61% in the need for oxytocin to facilitate delivery. The group with active support had a 25% shorter duration of labor and the neonates had a 58% lower likelihood of requiring post-birth hospitalization.

Similarly, a summary of many studies using behavioral medicine interventions (jointly classifiable as being psychological in nature) showed many benefits relative to a medical treatment only control group. In a summary of such studies it was revealed that the addition of psychological interventions reduced the need for ambulatory care visits by 17%, the need for office visits for acute asthma by 49%, the need for medical office visits by arthritis patients by 40%, and reduced the average length of hospital stay for surgery by 1.5 days. The latter finding is particularly important because one can directly translate this into a cost benefit keeping in mind that the average length of stay for surgery has now been reduced to 5-6 days per patients. As yet another example, we (Linden, Stossel, Maurice, & Kors, 1994) have conducted a meta-analysis of psychological treatments for patients with coronary artery disease. The primary study question was whether, or not the addition of psychosocial treatment to a standard treatment package consisting typically of medication and exercise would also lead to increased benefits for patients. Benefit was defined as the

likelihood of dying from coronary heart disease or having a coronary event. Follow-up data were broken down into short and long-term follow-up periods reflecting an average of one year follow-up and an average of 4-year follow-up respectively. This comparison revealed that psychosocial treatment which was often quite brief (10 sessions or less) accounted for a 42% reduction in mortality in the short follow-up and 26% reduction in mortality in the long follow-up. The recurrence of coronary events was similarly reduced by 61% in the short-term follow-up, and by 42% in the long-term follow-up.

Misuse of randomized clinical trials. Jacqueline Persons (1991), Roberts and his collaborators (1993) and Linden and Chambers (1994) have argued that standardized clinical trials do not test what clinicians are trained to do best now what they actually practice. Because standardization of treatment and random assignment to treatment conditions essentially wipes out differential expectancy effects, differences in therapist skill, and the individual tailoring of treatment goals to individual patient needs, these researchers have argued quite convincingly that randomized clinical trials give unnecessarily conservative estimates of what happens in clinical practice. Roberts et al. (1993) for example, showed that the nonspecific effects associated with psychotherapy are far more powerful than commonly reported in the therapy outcome literature. Again, total randomization and standardization removes the nonspecific effects from analysis and discussion and thereby reduces the chance of finding clinically important changes that indeed are likely to happen in clinical practice. Along these lines, our own research in psychological treatment of hypertension revealed that individualized psychological treatment could produce substantially greater treatment benefits than standardized psychological treatments. Another elegant demonstration of this point has been provided by Frasure-Smith (1991) who showed that patients receiving a stress reduction intervention showed dramatic reduction in mortality if indeed they were highly stressed during the first month after their heart attack, whereas patients not under psychological stress showed no benefit from receiving psychological treatment.

Cost of interventions. In many talks and papers it has now been shown that psychological interventions can be quite cost effective. Jack Wiggins, for example, in his 1993 Presidential address to the American Psychological Association showed that for every dollar spent on occasional rehabilitation \$7 are gained in saved rehabilitation costs. Also, Nick Cummings in 1992 concluded that in employee assistance programs providing psychological services, \$2 is saved for every dollar invested. Similarly, there have been demonstrations that a chronic pain treatment program with a psychological component was that admittedly costly to implement (roughly \$10,000 per patient), saved over a two-year period more than twice the amount invested due to reduced follow-up medical care costs. In essence, all of the findings suggest that by using predominately hard measures and paying attention to cost issues, one can demonstrate quite elegantly and

convincingly that psychological interventions are worth their cost and more. It is surprising that researchers do not indicate very often what the cost was of treatment.

Recommendations. The above points have lead me to argue for a number of recommendations that ought to be considered by clinicians and researchers. These recommendations are: (1) researchers should compare standardized with individually tailored interventions and should also test the effect of randomized versus patient self-selection into different types of interventions. (2) Researchers should also pay more attention to within patient changes, and not only study control versus active treatment group changes. This is particularly meaningful when the therapy target is one that is not reactive and where observed benefits are meaningful in and of themselves (reduction in blood pressure is an example). (3) All clinicians should make an effort to include some form of ongoing program evaluation in their work. (4) I would urge all researchers to include measures in their studies that will be easy to interpret by consumers, insurance companies, and policy makers. (5) I urge researchers to give an indication of the cost of treatment in every outcome paper, even if they cannot conduct the more troublesome and complex, full cost efficiency analyses that would otherwise be desirable. (6) Last but not least, I encourage researchers and clinicians to share the results of their efforts not only with their colleagues but also with the popular press. There is of course the opportunity to get misrepresented and I cannot say that this is risk-free, however I feel that it is absolutely necessary. We cannot afford to operate in isolation and ultimately lose the trust of the public that is paying for our services. In a nutshell, I believe we already have the ingredients for a more effective marketing of clinical psychology to the public, and to policy makers.

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THOUGHTS ON THE MARKETING OF PSYCHOLOGY

Harry Stevens, Ph.D., RPsych.
Health Services, R.C.M.P., Vancouver

Psychologists would benefit from learning to see their services as products that need to be marketed just as any other service does. For many psychologists this commercial approach feels foreign and uncomfortable. For some it feels more than just uncomfortable, it feels wrong. Historically, Canadian psychologists have had others do their marketing for them as access to clinical and counselling psychological services has primarily been via public agencies such as hospitals, schools or mental health centres. Psychology has therefore avoided any sense of being responsible for flogging its own wares. For better or worse obtaining psychological services through these government funded agencies is diminishing and even where it is still available the services are often poorly managed. We must recognize this fact and act on it.

It is psychology's responsibility to be aware of what is happening to its product. The marketplace knows all about such matters and we can learn much from it. There is no hiding from the fact that psychology needs to become knowledgeable and comfortable with the reality that the profession is now directly responsible for ensuring that its product is available to the public. There is no professional or public value in our taking a passive stance. We are into the fray whether we like it or not and if we are in it we might just as well decide to win rather than lose. Winning is always more fun and besides we can, as they say, win big.

In taking the marketing approach we need to have a serious look at our factories, inventory, quality control issues such as product shelf-life, sales distribution points, customer relations, etc. There are problems such as serious shortage of inventory due to a self-serving production line which feels no accountability to the sales team that is getting the product out to the market. The sales distributing points are archaic and managed by individuals that have no knowledge and little respect for the product the store is supposedly offering. Concern for customer service is a non-issue and the shelf-life of the product is hampered by a very poor maintenance plan. In fact things are so bad the opportunities were never better!

Psychology is lucky. We have a very real opportunity if we simply recognize that professionally we have no choice but to take over. Let's forget the problems with the factory for the moment and focus on the sales points. Look at them. Many should simply be closed. Customer demand is high and the inventory is needed elsewhere. The need for inventory retrieval applies to a number of the provincial government run psychology distribution points. In many of these stores the product is poorly treated if not actually abused. The customers don't see the wares properly displayed and

when it is in the window the customers have difficulty getting access to it. After sales follow-up is usually bizarre and the store's regarding service warranty has so much fine print that customers don't want to come back – often because they are not even sure of what they bought. This problem does not happen to manufactures of other product lines and it doesn't need to happen to psychology.

When inventory is scarce and the product is in demand any self-respecting manufacturer of widgets pulls their inventory from a poorly run store and walks down the street to a new distribution point. The manufacturer who has confidence in their product knows that they can't afford to have their goods represented this way. It is bad for product image, sales fall off, morale sinks and the word gets back to the factory. The time to act is now. Let's pull our inventory from all poorly run stores that refuse to shape up and open factory outlets that treat the product and the customer with respect.

Much of this is already underway. Psychological services to the public via employee assistance plans have made a real difference. There is clear evidence that providing public access to psychologists through non-government agencies is a bit from both the professional and public access point of view. However psychology can do even better. It can do what amounts to almost direct marketing through factory outlets that represent psychology products. I am referring to the not-for-profit health care insurance industry. Psychology has learned that its product is respected by this marketing industry. It treats the product with respect, is interested in after sales customer satisfaction and has a vested interest in quality control of the inventory. We need to learn about this industry and learn from our past experience with those who took over our sales distribution. We need to learn and remain in control in order to protect our product and the customers that need it.

The government run stores are in something of a shambles in many cases and their managers are not listening. We must not give up trying to work with them but we must distance ourselves and cancel their exclusive franchise for our product line. It has been my experience that many of the government stores have not respected our sales representatives because our sales people have lacked the confidence and the knowledge that the product is in wide demand and can be distributed through other outlets. The government managers will learn to listen but only after we have heard the message ourselves and have become confident in our ability to manage our own stores.

Let's get down to business but in doing so we need to understand that we will soon have to turn our attention to the factories.

Networking

Acton House Publishing – Call for Proposals.

Acton House is committed to publishing practical clinical material such as therapy handbooks, treatment manuals, assessment strategies and protocols, therapy games, intervention techniques, training materials, and the like. The mission of the publishing house is to offer the many skills and strategies used by clinicians to psychologists, social workers, and counsellors throughout North America. As such, psychologists are asked to write to Acton House if they believe they have work that may be useful to other clinicians. The publishers would be interested in hearing from psychologists in the fields of clinical psychology, educational psychology, counselling psychology, and clinical social work that would include a wide range of clients including child, adolescent,

adult, marital, family, and group.

If you have developed any of these types of materials please do not hesitate to call to inquire about the process of developing a proposal. As well, if you know of a colleague who has created something that you believe is of value please let them know about this request or call Acton House directly and your colleague will be contacted by them.

Please write, fax, or call:

Bob Acton, Ph.D., C. Psych.
Publisher, Acton House Publishing
260-1032-17th Avenue, SW
Calgary, Alberta
T2T 0A5

Clinical Section Business

Call for Nominations of Officers of Clinical Section (1995-96)

One of the most obvious and meaningful ways you can show your support for the Clinical Section is to participate in the election process. For 1995-96 the election requires nominations for the position of the Chair-elect (a three year term, rotating through Chair and Past-Chair) and Member-at-Large. Continuing members of the executive for 1995-96 will be Allan Wilson (Chair), Sam Milkall (Past-Chair), and Debbie Dobson (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 candidate indicating his/her willingness to stand for office, and (b) a letter of nomination signed by at least two Members or Fellows of the Section. Deadline for receipt of nominations is 9 April, 1995.

Send nominations for the Executive to:

Janice Howes, Ph.D.
Elections Chair, Section on Clinical Psychology
Psychology Department
Camp Hill Medical Centre
Halifax, NS B3H 3G2

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 organisations at national, provincial, or local level; (3) Leadership on clinical issues that relate to broad social issues; (4) service outside one's own place of work; (5) Clinical supervision should be equated with research supervision.

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

Nominations should be forwarded by April 9, 1995 to:

Allan Wilson, Ph.D.
Chair, Fellows and Awards
Department of Psychology
The Nova Scotia Hospital
Dartmouth, NS B2Y 3Z9CL1

NEWSLETTER SCHEDULE

The SECTION 26 NEWSLETTER will circulate three times per year: August, November, and March (or late February).

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.

Clinical Section (26)

Executive Officers 1993-94

Chair

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

Chair Elect

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

Member-at-Large

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

Past Chair

Janice Howes, Ph.D.
Psychology Department
Camp Hill Medical
Centre
Halifax, NS B3H 3G2
Tel 902-496-2639
Fax 902-496-4873

Secretary Treasurer

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

POSITION AVAILABLE PSYCHOLOGIST/COUNSELLOR

Duties:

To provide personal and vocational counselling for both individual and groups for university students. To develop outreach programs for the university community. To partake in the Inservice program. To assist in the training of clinical or counselling psychology students. To provide consultation to faculty and staff about problems with students.

Supervision Received:

Works under the supervision of the Director or Senior Psychologist when the Director is not present.

Required Qualifications:

Education: A Ph.D. in Counselling, or Clinical Psychology is preferred. Must be eligible for registration in British Columbia.

Experience: One year experience at the Doctorate level, preferably 2-3 years in a university or college counselling service. Experience is necessary in vocational counselling and vocational assessment.

Appointment: Commencing September 1, 1995.

The University is committed to the principle of equity in employment.

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