



CANADIAN CLINICAL PSYCHOLOGIST

Clinical Section Newsletter

Vol 7, No. 1, November, 1996

Editor: David S. Hart

CONTENTS

Message from the Chair: Keith Wilson

Keith S. Dobson *Empirically validated treatments: Not the last word.*

1996 Student Research Award: David J.A. Dozois, University of Calgary

David J.A. Dozois & Keith S. Dobson

The Coping Strategies Questionnaire and Adjustment to Low Back Pain: Predictive Utility of Individual vs Composite Measures.

Banff Conference

NETWORKING

Home Page

E-mail Directory.

URLs of interest.

New Fellow

Clinical Section Business

Executive Officers

Financial Report

Budget

MESSAGE FROM THE CHAIR.

Keith Wilson

CPA Section on Clinical Psychology

As a firm believer that clinical psychology in Canada is best served by maintaining a strong and vital presence within a healthy national organization, it is a great pleasure for me to step forward and "do my bit" as the new chair of the CPA Section on Clinical Psychology. One of the main reasons that it is such a pleasure is that it offers me with an opportunity to give something back to the discipline. As I reflect on the decade (can it have been that long?) that has passed since my Ph.D. graduation, there have certainly been rocky moments, but on the whole I have the satisfaction of feeling that I made exactly the right career choice. You see, I really like being a clinical psychologist. I can't think of another job that would be nearly as interesting or rewarding. I'm lucky enough to have a lot of flexibility and variety in the work I do. As a clinician, I derive great satisfaction from helping clients and their families find their way through some of their darkest moments. As a teacher, I am invigorated by the enthusiasm and passion of the students, so keen at this stage of their careers, so brilliant and inquiring. As a member of an interdisciplinary team, I feel connected to colleagues and looked to respectfully for leadership in many ways. As a researcher, I appreciate the support I get to indulge my curiosity, to think and write about issues that are meaningful and important, and to meet other psychologists from around the world who have similar interests. And I actually get paid for this!

With all this going on, I sometimes feel that life gets pretty hectic and that I'm jumping back and forth between various crises, projects, or deadlines (sound familiar?). Like many psychologists, simply dealing with day-to-day demands doesn't leave me much time to reflect on the overall state of

the discipline. Besides, what can one person do on his or her own? This is why it is important that we support organizations like CPA and its affiliated sections, as well as the other national and provincial organizations that represent the interests of psychologists. Without coordination, direction, and leadership, I worry that future generations of psychologists may not enjoy the same advantages and opportunities that I have.

In many ways, this is an exciting time to be a clinical psychologist. There is a healthy diversity of sound conceptual and theoretical approaches to inform our clinical work. The relevance of psychology to a broad spectrum of health and social issues is well-recognized. An increased emphasis on evidence-based practice and the assessment of outcomes, while viewed warily by some, plays to the strengths of clinical psychology as an empirically grounded discipline. In research, we are seeing a push toward interdisciplinary teams, which opens doors to greater involvement by psychologists.

However, it is also a time of downsizing in our hospitals, universities, schools, and social service agencies. In some areas of the country, the likelihood of new graduates finding permanent, full-time employment in the public sector seems to diminish ever year. And with the recognition of the importance of psychosocial factors as determinants of health, other disciplines have started reading our journals. We are not "the only game in town" in the psychosocial and behavioural research arena.

In this context, I wonder what my next decade as a clinical psychologist is going to look like. I suspect that in some places, psychologists will be able to seize the emerging opportunities and continue to thrive. In others, we may feel the sting of economic forces beyond our control. I think we can learn from, support, and strengthen one another. But we have to have our forums to talk, meet, plan, and lobby, and

we have to get involved. Let's make the Section on Clinical Psychology that kind of place.

* * * * *

Empirically Validated Treatments: Not the Last Word

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This article was written at the invitation of the newsletter editor, and as an update on the empirically validated treatment (EVT) movement. Having now participated in the 1995 CPA symposium on this topic, co-chaired the 1996 Banff Conference on Behavioural Sciences (with Dr. Ken Craig), and now editing the resulting volume on this topic (Dobson & Craig, in press), this topic has been near and dear to me for some time.

In this paper I will summarize and add to the list of concerns that have been expressed about the EVT movement, and then discuss some of what I see as the most critical issues to which the field must focus its attention.

First, a brief update. Since the original 1995 Task Force report (Chambless, et al, 1995; see Hunsley, 1996 for a review), a revised report on EVTs has been prepared. This report adds a number of treatments to the list of what are now referred to as well established and probably efficacious treatments. In contrast to the first report, which listed 18 empirically validated and 7 probably efficacious treatments, the 1996 update lists a total of 22 well established and 25 probably efficacious treatments.

Although one can debate the categorization of the treatments, a rough break-down of the theoretical orientations represented in the treatments includes 20 behavioural, 21 cognitive or cognitive-behavioural and 6 other treatments. As the authors of the second Task Force report note (Chambless, et al, 1996) the growing number of therapies reflects the ongoing review of data. One can

reasonably expect this list to continue to grow.

Concerns with the EVT Movement

A number of well articulated statements of concern about the creation of a list of validated therapies exists, and I will not repeat these issues here in any detail (see Beutler & Baker, in press; McMullen, 1995; in press; Pyke, 1995; Steffy, 1995). Table 1 provides a non-exhaustive list of some of the concerns that have been raised. Note that some of these concerns are more theoretical/philosophical in nature, and likely reflect differences in the epistemological

viewpoints about the nature of science, human experience and the process of change between their authors and the developers of EVTs. These concerns cannot be dismissed, but must be debated in proper scientific and academic discourses. In contrast to the above concerns, most of the issues raised in Table 1 are more pragmatic, and should encourage appropriate cautions, including:

1. the need for continued debate about the criteria for declaring therapies as empirically established. It has already been noted (Hayes, in press) that the criteria developed by the APA Task Force are considerably more restrictive than those generally used by the FDA for new drug therapies,
2. the need for flexible practice in new, rare or invalidated treatment areas
3. the need to continue to examine and discuss effective ingredients of therapy,
4. the need to continue to consider individual differences that interact with treatment outcomes,
5. the need to resist premature rigidity in training, licensing or funding of psychotherapies, especially with regard to therapies that may not yet be validated, and
6. the need to continue funding psychotherapy research that promotes therapy development, integration and the understanding the processes of change.

The Future of the Empirical Validation

Notwithstanding the validity of many of the concerns in Table 1, it is clear that the EVT movement is not going to dissipate; if anything, it is gaining momentum. The

approach is now being applied to children through the Child and Adolescent Section of Division 12 of the APA, accreditation criteria have been written to require the training of EVTs in graduate programmes in professional psychology (how many, and to what level of proficiency is not yet clear), new treatments are being reviewed for the list of empirically supported treatments, and some funding agencies are now beginning to use the list of approved treatments to direct the funding of mental health services (Pallack, 1995). The logic of tying clinical practice to validated procedures is ineluctable, and resonates deeply with the scientist-practitioner model of training that is espoused in Clinical Psychology. The EVT movement is here and cannot be disregarded, except at one's own peril. Given the above, the six cautions just listed demand serious consideration. In addition, I would argue that three other issues need to be articulated and reinforced whenever empirically supported treatments are considered. In this final section I will briefly discuss these issues of practice guidelines, efficacy versus clinical utility, and dissemination.

EVTs are not Practice Guidelines

Although treatments that have empirical support are an obvious place to begin building sound professional training and practice, simply having a list of "approved", "validated", or "supported" treatments is not sufficient (Beutler & Davidson, 1995; Beutler & Baker, in press; Hayes, 1995). As a discipline, and as practitioners, we also need guidelines that direct when to use certain treatments, and how to adapt them to the host of issues that emerge in clinical practice (Fruzzetti, 1995). As we move from recognizing those treatments that work in psychotherapy research to applying these treatments in clinical practice, there will need to be attention to the issue of how to develop clinically sensitive, dynamic guidelines that recognize the legitimate role of clinical judgement in the application of validated methods. The Clinical Section of the CPA has taken a first step in this direction, by creating a Task Force on

Table 1.
Concerns about empirically validated treatments (EVTs)

1. Why are the developed criteria appropriate for this purpose?
2. EVTs support a medical, disorder-specific orientation to treatment
3. Treatments without clear outcomes are disadvantaged, and cannot easily be validated
4. EVTs may lead to the over-simplification of treatment goals
5. The validation of treatments in new or rare areas of practice is almost impossible with the current criteria
6. The current criteria foster empirical validation, as opposed to qualitative evaluation
7. Manualization of treatment is unnatural and simple-minded
8. Treatments are multidimensional. What is really being evaluated?
9. EVTs promote discrete treatments, as opposed to psychotherapy integration
10. EVTs support the idea that techniques as opposed to other factors explain the change in psychological treatment
11. EVTs emphasize the treatment of homogenous populations; clinical problems are rarely so focussed
12. EVTs do not focus on individual differences that may interact with treatments
13. EVTs are not sensitive to cultural and other differences
14. EVTs may promote adherence to treatments, as opposed to competence
15. EVTs may lead to orthodoxy and rigidity in training programmes
16. EVTs may lead to the fractionated training of specific treatments
17. EVTs might lead to the licensing of specific treatments
18. Current training does not well match the goals of EVT dissemination
19. EVTs may limit academic and treatment prerogative
20. Lists of EVTs may prematurely close the development of new treatments
21. EVTs may be abused by third-party payers to limit funding of other treatments
22. A list of approved treatments can be abused by service providers who claim expertise they do not possess

practice guidelines, chaired by John Hunsley.

Efficacy and clinical utility

Knowledge about the effectiveness of treatments is not synonymous with understanding the clinical utility of these treatments. Treatment effectiveness is concerned with obtaining satisfactory outcomes (i.e. "What works for whom?"). Clinical utility, in contrast, is concerned with how usable effective treatments are in practice, and in this context clinical utility addresses such issues as cost effectiveness, training and implementation costs, cost offset, acceptability of treatments to clients,

therapists' desire to learn and practice treatments, and whether or not cheaper alternative treatments exist (Hayes, in press).

The issues related to clinical utility must be fully considered in order to make sound clinical practice and public policy. Unfortunately, our collective knowledge about many of the issues related to clinical utility is in its infancy.

Dissemination

The third issue that I want to highlight relative to the issue of EVTs is that of dissemination. Most validated treatments are developed in academic settings, with relatively stringent control over methodologies (e.g., homogeneous populations, random assignment), and are typically first documented in formal psychotherapy journals. Once the therapy has formal documented support, though, the question arises as how best to disseminate that approach to practitioners. The Division 12 Task Force requires a manual to be available that describes the treatment, and it is likely that the existence of a manual will help to ensure accurate translation of the approach outside of the research context. We know relatively little, however, of the "best" way to disseminate effective psychotherapies broadly. Is one workshop enough, do treatments require supervision (If so, by whom? Who qualifies the trainers?), is a full graduate programme required? And to whom can the dissemination effectively be made? Only licensed psychologists and psychiatrists? Graduate students? Generic mental health therapists? The answers to these and other dissemination questions are simply unknown at this point in time. Although I know of no current research programmes evaluating dissemination strategies, dissemination is quickly emerging as an important area for investigation.

Not the last word

If done well, the EVT movement has the potential to advance the goal of a unified science and practice of clinical psychology, and for this reason I submit deserves it cautious support. If done poorly, however,

the movement can become a tyranny of research over practice, and lead to premature closure on the development of the field of psychotherapy. Psychotherapy researchers, funding agencies and trainers of professional psychologists have a particular obligation to help ensure that the potential problems associated with the EVT movement do not transpire. This paper is clearly not the last word on the topic.

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Of Related Interest

Editor's Note: *I copied the following from an email forum. You may find it interesting to learn that concern for "evidence-based" practice is not confined to a few academic clinical psychologists. Rather than the last word, we have probably seen only the beginning of a deluge of words on the subject. At the same time we have increased respect for "alternative" treatment procedures. Some basic professional issues are being debated as a social decision in the western world. An evolutionary lurch could occur. It behooves us to be a part of the directing force.*

"The Royal College of Psychiatrists is extremely interested in the area of evidence-based mental

health, and several initiatives are in progress or planned.

We have a programme to develop evidence-based guidelines which began in 1995. A College Council Report 'Clinical practice guidelines and their development' describes the background to the Programme and is available from our Publications Department. A series of articles has also been published in the Psychiatric Bulletin describing our work. The first evidence-based guideline under development is 'The management of violence in clinical settings'. This should be available by about Easter next year. We also produce a reference list of guidelines in mental health developed by others (most are not evidence-based, but a few are) with details on how you get hold of them, and we are currently working on producing an evidence-based mental health reference list.

Other initiatives are being developed in education, CME and the journals.

The American Psychiatric Association is producing evidence-based guidelines in mental health - the details for these are available in our reference list. And CRUFAD (Clinical Research Unit for Anxiety Disorders) in Australia are also working in this area. The British Psychological Association and UCL are undertaking work on evidence-based practice in psychology. We can provide contact details for all of these if you would like them. Finally, there is now lots of mental health info on the new version of the Cochrane Library.

Please contact us if you would like any contact details or more information (e-mail or post is most convenient for us).

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email: 100347.1145@CompuServe.com"

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

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NEWSLETTER SCHEDULE

The **Canadian Clinical Psychologist** will circulate three times per year: November, February, and May.

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STUDENT RESEARCH AWARD FOR 1996

Each year at the annual meeting, the Section presents an award to recognize excellence in student research. A special competition is held to select the most outstanding paper submitted by a student author for presentation at the annual convention. This year's winner is David Dozois, a doctoral candidate in the Clinical Psychology Programme at the University of Calgary. David's contribution to Canadian clinical psychology is already impressive. In addition to receiving numerous scholarships and awards for academic excellence, David has served as the chair of the CPA section on Students in Psychology, and is the author of eight articles and book chapters. A summary of David's award-winning research is published in this issue of CCP. Interested readers will be able to find the full report forthcoming in the journal, **PAIN**. Congratulations David!

In general, the quality of the submissions for the Student Award is gratifyingly high, and inspires confidence in the future of clinical research in the discipline. It is unfortunate that we are not able to give awards to all the deserving applicants. However, the Award Committee would also like to give an Honourable Mention to Yvette Scattolon of the Department of Psychology at the University of New Brunswick. Yvette's submission on attachment styles and depression was also considered to be outstanding. Congratulations Yvette, and keep up the good work!

* * * * *

The Coping Strategies Questionnaire and Adjustment to Low Back Pain (LBP): Predictive Utility of Individual vs. Composite Measures.

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Abstract. This study extended the findings of Jensen et al. (1992), by prospectively comparing the individual and composite scores of the Coping Strategies Questionnaire (CSQ) in the prediction of 4 types of adjustment to low back pain (LBP). Two hundred patients completed the CSQ, the Oswestry Index, the SCL-90R, and 4 lifting tasks at admission and discharge from a multidisciplinary pain clinic. Return to work was determined at 9-month follow-up. The CSQ scales were factor-analyzed to devise composite indices, and the 3 resultant factors were compared to the individual scales in the prediction of pain and other outcomes. The results indicated that the relative predictive utility of the composite or individual scales depended on which outcome measure was used to define adjustment.

The CSQ is the most widely used instrument to assess coping with pain (Swartzman et al., 1994). Rather than using individual scale scores, most of the research to date has investigated composite measures of the CSQ, by factor analyzing individual scale scores, and using the resultant scores to predict adjustment (e.g., Rosenstiel & Keefe, 1983; Keefe et al., 1991; Hill, 1993).

Composite measures enhance interpretability, statistical power, and the identification of general coping dimensions. However, composite scores also increase the probability of obscuring more specific relationships between coping and adjustment. Individual scale scores, on the other hand, allow for an idiographic assessment of particular coping strategies and how they relate to functioning, but have

lower reliability because they contain fewer items.

Jensen and his colleagues (1992) were the first to compare the CSQ composite and individual scores in the prediction of adjustment. Multiple regression analyses, using self-reported physical dysfunction, psychosocial dysfunction and depressive severity as criterion measures, indicated that the individual scores generally yielded more information than the factor scores.

The objective of this study was to extend the findings of Jensen et al. (1992), by longitudinally comparing the predictive utility of the composite and individual scores on the CSQ in an outpatient sample of patients with LBP. For the purpose of this study, predictive utility was defined as the percentage of variance accounted for, or the success in classification as indicated by a particular dependent variable. Another important extension involved the use of four distinct measures of adjustment: perceived disability, functional status, psychological distress, and return to work.

Method

Subjects

The sample consisted of 141 males and 59 females who ranged in age from 18 to 63 years ($M = 39$). All subjects were unemployed at the time of admission to a work-hardening program. The average duration of LBP was 9.08 months. There were no significant relationships across the CSQ scale/factor scores and age, gender, education, marital status, or pain site. Age and gender were, however, controlled in the later analyses consistent with Jensen et al. (1992).

Predictor Variables

(a) Coping Strategies. The CSQ (Rosenstiel & Keefe, 1983) is a 48-item checklist in which subjects report the degree to which they utilize 6 cognitive and 2 behavioral coping strategies. The CSQ also contains 2 additional items related to the subjective ability to control and decrease pain. (b) Pain

Ratings. Pain intensity was assessed using a 101-point Numerical Rating Scale (NRS-101).

Outcome Measures

(a) Self-perceived Disability. The Oswestry Index, an instrument developed and standardized on a sample of patients with LBP (Mikail et al., 1993), was used to measure self-reported physical limitations related to pain. (b) Functional Status. Functional status was operationalized as the average of 4 different one-time maximal lifts (in kilograms) with higher scores reflecting higher functional capacity. (c) Psychological Distress. The Global Severity Index (GSI) of the Symptom Checklist-90 Revised (SCL-90R) was employed as a measure of psychological distress (Derogatis, 1983). (d) Return to Work Status. Return to work was determined at an average of 9 months after completion of the program. On the basis of their self-reports, clients were classified into two groups: employed and unemployed.

Procedure

Predictor variables and demographic information were gathered immediately prior to admission into the program. Perceived disability, functional status, and general psychological distress were assessed both upon admission, and at discharge from the program. Return to work status was determined at 9-month follow-up via telephone survey. One hundred and thirty-seven subjects were contacted, of which 84 had acquired employment.

Results

Factor Analysis

Principal-components factor analysis of the CSQ scales revealed three factors that had eigenvalues of greater than 1, and which met criteria for consideration from the scree analysis. These factors accounted for 63% of the variance in the CSQ responses.

Correlational Analyses

Factor I (Cognitive Coping and Suppression) did not correlate significantly with any of the outcome measures. Pain

Table 1. Correlations Between the Treatment Outcome Measures and the Pretreatment CSQ Factors, Scales and Ratings

CSQ Measure	Oswestry	Functional	GSI
Factor scores			
Factor 1	.03	.05	-.04
Factor 2	-.34**	.32**	-.45**
Factor 3	.26**	-.25**	.22**
Scale scores			
Diverting Attention	.13	-.14	.13
Reinterpreting Pain	.16	-.05	.11
Catastrophizing	.30**	-.30**	.45**
Ignoring Pain	.02	.11	-.04
Praying & Hoping	.28**	-.20*	.13
Coping Self-Statements	-.01	.05	-.10
Increasing Activities	-.05	-.01	-.01
Increasing Pain Behaviour	.18*	-.20*	.08
Ratings			
Control Over Pain	-.15	.31**	-.18*
Ability to Decrease Pain	-.19*	.21**	-.24**

*p < .05; **p < .01

Table 2. Results of the Discriminant Function Analysis of the Pre-Treatment CSQ Scores on Employment Outcome at 9 Month Follow-up

Variable	Wilks' λ	Loadings*	F
Factor Scores			
Factor 1	0.97	.83	3.74
Factor 2	0.94	-.99	8.83**
Factor 3	0.97	-.24	3.94*
Scale Scores			
Diverting Attention	0.97	-.32	3.68
Reinterpreting Pain	0.91	-.53	12.88***
Catastrophizing	0.96	-.17	5.50*
Ignoring Pain	0.96	-.46	4.90*
Praying & Hoping	0.98	-.13	2.22
Coping Self-Statements	0.99	.23	0.12
Increasing Activities	0.99	.61	0.33
Increasing Pain Behavior	0.99	-.13	1.58
Ratings			
Control Over Pain	0.99	-.21	1.31
Ability to Decrease Pain	0.98	-.25	2.75

Note. Total N = 137 (Employed n = 84; Unemployed n = 53).

* Standardized canonical discriminant functions.

*p < .05; **p < .01; ***p < .001.

however, demonstrated a significant positive relationship to functional status, and significant inverse relationships to both perceived disability, and general psychological distress. Factor III, Helplessness/Emotion-Focused Coping, was also significantly associated with the three main outcome variables. In contrast to Factor II, however, the correlations between the third factor and the adjustment measures

were opposite in direction. That is, Factor III was significantly and inversely related to functional status, but positively related to perceived disability and psychological distress (see Table 1).

When the individual scales of the CSQ were examined, only Catastrophizing, Praying and Hoping, Increasing Pain Behaviour, and the two control ratings were

significantly related to outcome. Catastrophizing was positively associated with both perceived disability and psychological distress, and negatively related to functional status. Both Praying and Hoping and Increasing Pain Behaviour demonstrated positive relationships to perceived disability, and negative relationships to functional status. Both control ratings were positively related to functional status and negatively related to psychological distress (see Table 1). Of the control ratings, however, only the Ability to Decrease Pain was significantly associated with perceived disability.

Discriminant Function Analyses

Two separate discriminant function analyses were used to determine whether the CSQ factor scores or the CSQ individual scales best distinguished between individuals who had later returned to work, and those who remained unemployed. These results are presented in Table 2.

When these analyses were performed using CSQ factor scores at admission as predictors, only Factors II (Pain Control and Rational Thinking) and III (Helplessness/Emotion-focused Coping) discriminated return to work outcome. Higher scores on Factor II were related to employment outcome, while higher scores on Factor III were associated with not returning to work. This analysis resulted in a 61% correct classification rate of group membership (sensitivity = 61%; specificity = 62%).

With the individual scales utilized as predictors of return to work, the total correct classification rate was 70% (sensitivity = 66%; specificity = 77%). Three of the scales significantly distinguished between employed and unemployed individuals at follow-up (see Table 2). Persons who were less likely to reinterpret pain sensations, catastrophize, or ignore their pain, were more likely than those individuals who utilized these coping strategies, to return to work.

Discussion

Overall, the results suggest that the

determination of whether factor scores or individual scores are better predictors of adjustment, depends on the operational definition of adjustment. With respect to the factor scores, Factor I (Cognitive Coping and Suppression) did not emerge as a significant variable in the prediction of adjustment for any of the outcome measures.

Factor II (Pain Control and Rational Thinking) emerged as a significant predictor of both psychological distress and return to work. The pattern of scores suggests that individuals who tend to use this type of coping are less likely to experience psychological distress and more likely to acquire employment, than those who do not. Factor III significantly predicted disability perception, functional status and return to work. In contrast to Factor II, persons who scored high on this factor were more likely to rate their disability as high, less likely to perform well on lifting tasks (functional status) and less likely to return to work.

Different individual scales also emerged as significant predictors, contingent upon the outcome measure examined. In the prediction of Time 2 subjective disability, Praying and Hoping and Increasing Pain Behaviour were both positively related to perceived disability, while the Ability to Decrease Pain was negatively related to this variable.

When functional status was employed as the criterion outcome, no individual scales predicted adjustment. This finding, coupled with the significant result from the Helplessness/Emotion-focused Coping factor, suggests that it may be the accumulation of emotion-focused coping which is related to poor functional performance, and not individual strategies per se.

The only individual scale to predict psychological distress was Catastrophizing. Interestingly, of the composite measures, it was Factor II, and not Factor III, which predicted psychological distress. Examination of the beta weights indicated that Catastrophizing was positively related

to distress, while Pain Control and Rational Thinking were negatively related to psychological distress. These results suggest that both the individual and factor scores are important predictors of psychological dysfunction, but for opposite reasons. In particular, the individual scale of Catastrophizing strongly predicted psychological distress, while the Pain Control and Rational Thinking factor strongly predicted psychological adaptation.

Three of the individual scales significantly predicted return to work (Reinterpreting Pain, Catastrophizing, and Ignoring Pain). Individuals who scored higher on these variables were less likely to obtain employment at follow-up. The individual scores discriminated between individuals who returned to work, and those who did not, with a better correct classification rate than the factor scores. As with the prediction of psychological distress, however, the specific strategies one wishes to assess and change in treatment, may depend on whether one is attempting to enhance a patient's ability to return to work, or reduce the factors that interfere with returning to work. Factor II (Pain Control and Rational Thinking), for example, was positively associated with employment status at Time 2, while the individual scales were more predictive of not returning to work.

Although our results were somewhat different from Jensen et al. (1992), our conclusions are actually quite congruent. Jensen et al. found that the individual scales yielded more information overall than the factor scores, but concluded that composite measures should not be ignored. In this study, we found that both individual and composite scores are important to examine, and that their relative predictive efficacy varies as a function of outcome criterion and the direction of predictions.

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Author Notes

An extended version of this paper will appear in Pain (Dozois, D. J. A., Dobson, K. S., Wong, M., Hughes, D., & Long, A. [in press]. Predictive utility of the CSQ in low back pain: Individual vs. composite measures). This research was supported by Studentship from the Medical Research Council of Canada to David Dozois.

STRESS: VULNERABILITY AND RESILIENCE

The 29th Banff International Conference on
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Kenneth D. Craig, Psychology Department, UBC, 2136 West Mall, Vancouver, B.C., V6T 1Z4 604-822 3948

or

Keith S. Dobson, Psychology Department, University of Calgary, Calgary, Alberta, T2N 1N4

NETWORKING

Our Home Page

The Clinical Section home page is not yet created. It will be so.

Look for it via the CPA home page!

<http://www.cycor.ca/Psych/home.html>

Clinical Section E-Mail Directory

The email directory lists those addresses submitted to the editor for inclusion. You are invited to submit your name for inclusion so that more of your colleagues can correspond with you on the internet.

Are you interested in having a Canadian Clinical mail-list forum? Let us know. Send your email address to the editor : (dhart@play.psych.mun.ca)

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Consciousness anyone?

A newly formed email list, Psyche-B, now exists: "The aim is to provide a forum for discussion on consciousness within a biological and/or psychological framework. The sorts of areas that might be discussed include: attentional processes; neglect; blindsight; implicit memory. The sorts of things that won't be discussed: the hard

MEMBERSHIP

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

problem; Chinese room problem; zombies; etc." Apparently this list is being established as "an additional private refuge for discussion purely of the biopsych features of consciousness". There exists a parent list, Psyche-D.

To subscribe, send the following command to <listserv@iris.rfmh.org>:

SUB PSYCHE-B YourFirstName
YourLastName

Later, email me (dhart@play.psych.mun.ca) a note about the discussions and whether you would encourage others to subscribe so that our readers can be informed.

URLs OF INTEREST !

http://www.usask.ca/psychology/clinpsy_defn.html Carl von Baeyer initiated this page with the Clinical Section's (actually CPA's official) definition of a clinical psychologist.

Do a free MEDLINE search on the Web at:
<http://www.HealthGate/MEDLINE/search-advanced.html> (I have tried but was refused.. Can anyone connect?)

The National Center for PTSD announce that the quarterly update for October has been added to the PILOTS database. There are now 10,750 papers covered by this electronic index to the traumatic stress literature. For more information on the database, consult the Website at
<http://www.dartmouth.edu/dms/ptsd/> or send the message "send PILOTS info" to
ptsd@dartmouth.edu.

Victim-Assistance - look at
<http://www.mnsi.net/~rmccall/homepage.html>
 a text-only listing for Ontario's Victim Service Units and Victim/Witness Programs. Links have also been established to Canada's Federal Dept. of Justice, Kathy Copely's Victim Advocate page, and New York City's Victim Service site.

For stuff on anxiety and panic:
www.algy.com/anxiety/anxiety.html

Do let us know of any sites you have created or visited that could be valuable for your colleagues. We will add them to our directory (i.e., publish them in the next newsletter).

* * * *

**A NEW ADDITION TO THE
 RANKS OF FELLOWS OF THE
 SECTION ON CLINICAL
 PSYCHOLOGY:
 DAVID S. HART.**

At the annual business meeting in Montreal, we honoured David Hart as a Fellow of the Section on Clinical

psychology, a distinction of which he is truly deserving. David received his doctorate in clinical psychology from Queen's University in 1965. From 1962 until his retirement (as full professor) earlier this year, he was a faculty member of the Psychology Department at Memorial University of Newfoundland, where he served a 15-year term as director of the M.Sc. Programme in Clinical Psychology.

David's contribution to CPA has been equally distinguished. He has been a CPA board member (1992-1995), served two terms on the Clinical Section executive, and he founded the Special Interest Group on Disaster and Trauma (which he has chaired since 1993). Importantly, since 1991, David has tackled the onerous responsibilities of editing the **Canadian Clinical Psychologist**, a job that he has handled with loving care and more than a little gentle wit. Thanks David! (Don't let it be said that editing CCP is a thankless job!)

Since his retirement, David has traded coasts and moved to Vancouver. Happily however, the transition has not slowed him down. He was recently on the Steering Committee for the highly successful conference, *Canadian Forum on Traumatic Stress*, and he is continuing in its wake to work toward the formation of a national traumatic stress association. We wish David the best of luck in this important endeavour, and offer warm congratulations on his appointment as a Fellow of the Clinical Section.

Keith Wilson
 The Rehabilitation Centre

* * * *

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CLINICAL SECTION BUSINESS

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FROM _____

Financial Statement: July 1 1995 to June 30 1996

Budget:		Income	
\$4500.00	Membership Dues (to June 30)		\$4322.95
\$500.00	Brochure Sales		98.35
	Advertising		249.71
	Workshop Proceeds		1658.46
	Bank Interest		25.14
<u>\$5000.00</u>			<u>\$6354.61</u>
		Expenses	
\$1600.00	CCP (incl mailing & correction for June 1995 estimate)	\$1932.68	
2800.00	Winter Executive Meeting	2826.23	
800.00	Telephone/Fax/Mailing	793.19	
250.00	Awards	250.00	
200.00	Stationery	197.02	
200.00	Special Projects (translation)	224.57	
1500.00	Prof. Dev. (Workshop Honorarium)	600.00	
200.00	ABM ('95) Refreshments	115.44	
0.00	Brochure Printing	349.31	
<u>\$7550.00</u>		<u>\$7288.44</u>	<u>\$7288.44</u>
	Excess Income Over Expenses		(933.83)
	Balance Forwarded July 1 1995		\$8298.49
	Balance on Deposit July 1, 1996		\$7364.66

Submitted & Signed by Deborah Dobson, Secretary-Treasurer.
Audited & Signed by Candace Konnert

Revised Budget for 1996-97

Income	
Balance forwarded (July 1 st , 1996)	\$1364.66
Estimated membership dues	4400.00
Other income	500.00
GICs	6000.00
GIC interest	200.00
	<u>\$12646.66</u>
Expenses	
CCP (3 issues, including mailing)	\$1900.00
Telephone/Fax/Mailing	800.00
Winter executive meeting	3500.00
Awards	250.00
Stationery	0.00
Brochures	0.00
ABM (1996) refreshments	50.00
Special Projects (EVT Project and Public Education Project)	1000.00
Mississauga Conference	500.00
Professional Development Fund	500.00
	<u>\$8600.00</u>
Estimated assets (as of June 1997)	\$4046.66

Signed by Deborah Dobson, Secretary-Treasurer