Lesley Graff

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Inside...

Message from the Chair

Lorne Sexton

I wish to use this first column as chair of the Clinical Section to briefly introduce myself and share with you some initial impressions as I enter my 'year at the helm.'

I graduated in 1980 and have been Head of Psychology (now called Psychology Practice Leader) at St. Boniface General Hospital in Winnipeg since 1986. I am also Associate Professor and Associate Head of the Department of Clinical Health Psychology in the Faculty of Medicine, University of Manitoba. I have been a member of the Board of Directors for the Manitoba Psychological Society for the past six years. Thus my domain has included clinical practice, health care administration, academics and professional promotion and advocacy. I'm sure I don't need to inform you that each of these domains have undergone profound stress and change in the 1990's. The approaching millennium has so far held little promise of slowing the pace. I will come back to these stresses and challenges in the following paragraphs.

One tends to be a member of the Clinical Section Executive for a very short period. My immediate predecessor, Charles Morin, remains on the Executive as Past President, to keep me on track. His predecessor and my recruiter to the task, Keith Wilson, has now "retired". His recent predecessors, such as Allan Wilson, Sam Mikail, and Janice Howe, I have met only briefly or not at all. I have, however, gone back and read many of their newsletter columns to gain a sense of the continuity and change.

Based on these readings, I sense a subtle shift in the mandate and focus of the Clinical Section. Historically, a primary activity of the Executive has been the amassing of speakers and programs for the annual C.P.A. Convention. Here we see the first subtle change. Mini-workshops on marketable clinical skills are clearly the most popular among convention goers in recent years. The well attended mini-workshops in Edmonton on sleep disorders (Charles Morin.), exposure techniques (Michael Dugas and Josée Rhéaume), and social phobia (John Walker and his colleagues) illustrate this trend. As Keith Wilson expounded on in this column, we are increasingly a free-market economy and survival requires skills in marketable, evidence-based approaches.

The issue of evidence-based practice marks a second, possibly less subtle change in the tasks of the Clinical Section Executive. Like many professional organizations, we have become more concerned with advocacy issues. Allan Wilson, in his column in June, 1996, described the elimination of psychology from health care institutions such as Sunnybrook as a "wake-up call for professional psychology in Canada." The profession clearly needed to promote itself more vigorously. One possible route of promotion, albeit controversial, is to draw government and public attention to empirically demonstrated effective psychological therapies. Thus, Allan Wilson also announced the formation of a Task Group to examine this issue. Their report is attached to this newsletter for your reactions and comment.

The issue of evidence-based practice is inescapable.

The issue of empirically validated or supported treatments was delineated for psychology in its present form by our sister Clinical Division of ARA. Managed care in the U.S.A. has forced this issue on all health

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Clinical Section Executive Officers 1998–1999

Chair
Lorne Sexton, Ph.D.
McEwen Bldg.
St. Boniface Hospital
409 Tache Ave.
Winnipeg, MB, R2H 2A6
Tel: (204) 235-3088, Fax: (204) 237-6264

Past-Chair
Charles Morin, Ph.D.
École de Psychologie
Université Laval
Pavillon FAS
Québec, QC, G1K 7P4
Tel: (418) 656-3275, Fax: (418) 656-5152
cmorin@psy.ulaval.ca

Chair Elect
Charlotte Johnston, Ph.D.
Dept. of Psychology
University of British Columbia
Vancouver, BC, V6T 1Z4
Tel: (604) 822-6771; Fax: (604) 822-6923
cjohnston@cortex.psych.ubc.ca

Secretary Treasurer
Deborah Dewey, Ph.D.
Alberta Children's Hospital
Behavioral Research Unit
1820 Richmond Rd. SW
Calgary, AB, T2T 5C7
Tel: (403) 229-7365; Fax: (403) 229-7221
deb@ach.ucalgary.ca

Member at Large
Lesley Graff, Ph.D.
PX246 - 771 Bannatyne Ave.
Winnipeg, MB, R3E 3N4
Tel: (204) 787-3490; Fax: (204) 787-4879
lgraff@exchange.hsc.mb.ca

Newsletter Editor
Sharon Cairns, Ph.D.
University Counselling Services
University of Calgary
2500 University Dr. NW
Calgary, AB, T2N 1N4
Tel: (403) 220-5893; Fax: (403) 284-0069
scairns@ucalgary.ca

A new captain for the ship

Lesley Graff

Once again, I have the job of saying thank you to a retiring editor and welcome to a new editor for our section's newsletter. I hope this will not become an annual event—it seems to me I was writing the same column last year at this time. On behalf of the Clinical Psychology section and the executive, I would like to say thank you to Dr. Alex Weinberger, who served as the newsletter editor this past year, and produced two excellent newsletters. He informed us in April that he would not be able to continue with his duties because of changes at his work place and an unexpected increase in demands on his time. We wish you all the best, Alex.

It is my pleasure to be able to introduce our new editor, who quickly "stepped up to the plate" when we started our search for a replacement. Dr. Sharon Cairns currently works at the University of Calgary Counselling Services, where she enjoys the combination of direct clinical work, research, and supervision of graduate students. She completed her Ph.D. in Clinical Psychology at the University of Manitoba in 1997. During her doctoral training, she worked with a domestic violence program in Winnipeg, and at the university's Counselling Service. Prior to returning to university for graduate work, she was employed for 12 years as a registered psychiatric nurse (RPN). Research and clinical interests include trauma, childhood physical abuse and interpersonal violence. Current research also includes client/therapist perceptions of the therapeutic alliance. I expect that this edition of the newsletter will be the first of many under your leadership. The executive looks forward to working with you to keep our section members informed.

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disciplines. The current C.P.A. Clinical Section Executive has had some preliminary contact with A.P.A. Division 12 (Clinical) Executive and we hope to have several or even all of the A.P.A. Division 12 Executive in attendance for discussions and open forums on this issue at the Halifax Convention.

The issue of evidence-based practice is inescapable. I encounter it continuously in my interactions with other medical and health-care specialties. Everyone is suddenly talking the language of R.C.T.'s (random clinical trials.). At the same time, ARA, Division 12's "empirically supported treatments" and practice guidelines have generated much controversy. They are seen as "premature" by the eminent researcher, Sol Garfield, or as holding the potential for "efficacy imperialism" and thus being too restrictive by Martin Seligman. What do you think? We need to know. The issue cannot be ignored.

But empirically-supported treatments are not the only issue facing psychologist. The organization of our profession in health-care settings has undergone dramatic change. At the 1997 Convention in Toronto, I was struck by how often I overheard in the hallways psychologists discussing "program management," and often in gloomy terms. Many, however, like myself, have survived this development. But it has been a severe challenge to psychology to maintain its self-regulation and development in a multidisciplinary climate that often favours generic professional labels and leadership, Keith Wilson, in his column in June, 1997, referred to the challenges facing psychology as we lose many of our "guild" protections.

We also have N.A.F.T.A. and the provincial Agreement on Internal Trade. The resulting harmonization pressures have forced to the surface again the issue of whether psychology is a Ph.D. or Masters-level profession, or something in between. Within this context, the C.P.A. proposal for Psy.D. programs as an alternative to Masters-degree programs and to provide midcareer training opportunities should be considered.

But many Ph.D. doctoral programs in clinical psychology are stressed after years of educational cutbacks and staff attrition. Based on some hallway conversations in Edmonton, the ability of these programs to sustain existing training, never mind take on new initiatives, may become a problem for the profession.

Due to various "wake-up" calls, all our professional associations are increasingly involved in advocacy and promoting the profession. We need associations and people who are prepared to meet the public, governments, regional health boards, and institutions to promote psychology positions and services. Of course, there are various other effective bodies such as provincial associations, the C.P.A. Board of Directors, C.P.A.P., and C.R.H.S.P.P. that play a lead role for many of these issues. But I believe that the Clinical Section is also evolving to meet these needs, and has a role to play.

Let us hear from you. Complete the survey on empirically-supported treatments. Write to us about other issues relevant to you. What role would you like the Clinical Section to have?

Submissions invited

The Canadian Clinical Psychologist/ Psychologue Clinicien Canadien invites submissions from Section members and others. Brief articles, conference or symposia overviews, opinion pieces, and the like, are all welcome. The thoughts and views of contributors belong strictly to the author(s), and do not necessarily reflect the position of either the Section, the Canadian Psychological Association, or any of its officers or directors. Please send your submission, in English or French, directly to the editor, preferably either on disk or via e-mail attachment. The newsletter is published twice a year. Submission deadlines are as follows: September 15 (October issue), and March 15 (April issue).

Editor
Sharon L. Cairns, Ph.D.
E-mail: scairns@ucalgary.ca

Assistant Editor
E. A. Meyen Hertzsprung
E-mail: eyhertzs@ucalgary.ca

Layout and Design
Evan Hertzsprung
E-mail: hertzspe@cadvision.com

The Wechsler Adult Intelligence Scale—Third Edition

Donald H. Saklofske
University of Saskatchewan[1]

The Wechsler Adult Intelligence Scale – Third Edition (WAIS-III) was published by the Psychological Corporation in 1997. The need to update the WAIS-R (1981) provided the opportunity to make some significant changes to this test, following the lead set by the WISC-III in 1991. Important advances in theory, research, and measurement (see Neisser et al, 1995) served to guide the creation of this newest test edition. The WAIS (1955) and WAIS-R have served psychologists very well over the decades so an effort was made to 'keep the best but make it even better'. Thus, it was decided that the WAIS-III should continue to measure general mental ability or "g", along with the factors measuring verbal and performance intelligence. However, by adding new subtests that tap other important and specific components of intelligence, it was possible to increase the number of factors measured by the WAIS-III.

Besides a variety of practical improvements (e.g., modified artwork, new record form), revisions and enhancements that were incorporated into the WAIS-III included:

- the development of new norms to reflect changing demographics and increased life span
- an extended floor
- a reduced emphasis on speed
- new subtests
- a four-factor structure to complement the more traditional VIQ, PIQ, and FSIQ
- extensive validation research
- statistical linking with the WIAT for 16-19 year-olds
- co-norming with the Wechsler Memory Scale – Third Edition (WMS-III)

Some of these changes were clearly needed. For example, the extended floor permits greater measurement specificity for individuals with mental retardation or where there are more severe cognitive impairments resulting from neuropsychological problems. The extended normative range of 16 - 89 years permits the assessment of older adults; this is further supported by use of enlarged item stimuli and a decreased emphasis on speed. Also, the much-discussed Flynn (1987) effect, which has suggested IQ gains of 1/3 to _ scaled scores per year in the more developed countries clearly indicated the need for new test norms. Changing demographics also require that test norms carefully reflect age, gender, education level, ethnicity and geographic region.

The most obvious change to the WAIS-III comes in the form of three new subtests, all of which were intended to support a 4-factor

Continued on page 6 "WAIS-III"

4-Factor Model

VCI	POI	WMI	PSI
Vocabulary	Block Design	Arithmetic	Digit Symbol
Information	Matrix Reasoning	Digit Span	Symbol Search
Similarities	Picture Completion	Letter-Num. Seq.	

"WAIS-III" continued from page 4

structure (see table) and permit the more precise measurement (index scores) of Verbal Comprehension (VCI), Perceptual Organization (POI), Working Memory (WMI) and Processing Speed (PSI). The **Matrix Reasoning** subtest measures abstract fluid reasoning and enhances PIQ and POI estimates. The **Letter-Number Sequencing** subtest correlates with both **Arithmetic** and **Digit Span** and therefore strengthens the **WMI**. The **Symbol Search** subtest will be familiar to WISC-III users and together with **Digit Symbol**, loads highest on the PSI factor. Several useful options are found in the **Digit Symbol-Coding** subtest which tap incidental learning (i.e., pairing and free recall) and graphomotor production and speed. Of interest is æææthat while **Object Assembly** was retained in this 3rd edition, it is an optional subtest that is not employed in the computation of either IQ or index scores.

The new WAIS-III now provides a wide sampling of abilities to measure FSIQ (11 subtests), VIQ (6 subtests) and PIQ (5 subtests). However, the factor structure suggests that "purer" measures of Verbal Comprehension (VCI) and Perceptual Organization (POI) may be assessed through the use of only three subtests each. With three subtests on the WMI and two on the PSI, the WAIS-III can be administered in whole or in part in to answer general or particular referral questions.

The WAIS and WAIS-R have served psychologists very well over the decades so an effort was made to 'keep the best but make it even better.'

The WAIS-III was carefully standardized in the USA according to key stratification variables (i.e., age, gender, education level, ethnicity, region) and further subjected to a number of validation studies to ensure psychometric integrity and clinical utility. Reliability coefficients are exceptionally high for the IQ and Index scores (.93 - .98) and slightly lower for PSI (.88). Interrater reliability coefficients all fall in the .90's. Stability coefficients are high and information is provided about the typical amount of score changes expected when retesting occurs within shorter time frames. Various concurrent validity studies demonstrated the relationship of the WAIS-III with such other tests as the WAIS-R, WISC-III, WIAT, WMS-III, and the Stanford-Binet IV. Intercorrelation studies supported the construct validity of the test and the resulting factor analysis argued for a "parsimonious and clinically useful" four-factor solution.

Of particular interest to practitioners is the inclusion of preliminary data from studies of various clinical groups including neurological disorders (Alzheimer's disease, Huntington's disease, Parkinson's disease, traumatic brain injury, multiple sclerosis, temporal lobe epilepsy), alcohol- related disorders (chronic alcohol abuse, Korsakoff's syndrome), schizophrenia, deaf and hearing impaired, and various psychoeducational and developmental disorders (mental retardation, AD/HD, math and reading disabilities). These studies provide preliminary indications of the performance of these groups pending the publication of further studies in the psychological research and clinical literature as has occurred with the WISC-III (e.g., Prifitera & Saklofske, 1998).

A most useful set of tables provides significance levels for differences between IQ's, index scores, and subtests that are further enhanced with tables indicating the frequency or prevalence of these differences. This information allows examiners to go beyond simply looking at the "value" of scores (e.g., VIQ = 84; PIQ = 104) or stating that VIQ falls in the low average range and PIQ is average. We now know that a VIQ-PIQ difference of 20 points is statistically significant at the $p < .05$ level and about 7% of examinees will show a score difference of this magnitude. Finally, because of the statistical linkages of the WAIS-III to both the WIAT and the WMS-III, it is now possible to compute both the simple-difference and the predicted-difference estimates and determine if such differences are statistically significant and more or less common. It should be mentioned that a scoring program is available for the WAIS-III and WMS-III (Scoring Assistant for the Wechsler Scales for Adults) and a report writer is forthcoming.

The "last chapter" in the standardization of the WAIS-III is close to being completed. Canadian psychologists have called for evidence that tests imported into Canada retain their psychometric properties and that test item-bias is minimized. As well, the norms for the test must be appropriate to the Canadian population, or such norms should be provided. It was for this very reason that the WISC-III was standardized and renormed in Canada and the results were published in a Canadian manual. In this instance, Canadian children scored significantly higher on all but two subtests and earned higher IQ scores, including being about 1/3 of a standard deviation higher on the PIQ. The results were not due to either item bias or sampling error. The WAIS-III "validity" study was begun two years ago under the sponsorship of The Psychological Corporation. The principal investigators are Dr. Don Saklofske and Dr. Denise Hildebrand. Data were collected following a sampling procedure based on age, gender, ethnicity, education level, and geographic region. Data analyses are currently underway; the results should be known soon and made available to WAIS-III examiners in Canada.

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[1] Donald H. Saklofske, Department of Educational Psychology, University of Saskatchewan, Saskatoon, SK, S7N 0X1. E-mail: Saklofske@sask.usask.ca

Editor's Note: Dr. Saklofske has agreed to write a follow-up article on the Canadian study for the April 1999 Edition of this newsletter.

Attention all section members

Empirically supported treatments

Enclosed with the fall newsletter is a full copy of a discussion document titled "Empirically supported treatments in psychology: Recommendations for Canadian professional psychology". As you will read in the introduction of the document, the section executive constituted a task force to consider the direction Canadian psychology should take with regard to the empirically supported treatments initiative that has evolved in the United States. The enclosed document is the task force's final report, following eighteen months of review, discussion, writing and revisions. At this point, the executive felt that the process required broader review and input. We would like direction from the membership regarding the views and recommendations, and we need a mandate for the next step.

We would encourage all members to read the document and provide feedback.

Thus, at some expense, we have mailed out copies to all section members for their feedback. We would encourage all members to read the document and provide feedback. The intention is to generate discussion at all levels of practice and training, and ultimately to generate direction for clinical psychology at the national level with regard to this initiative. To simplify the response process, we have included a brief questionnaire in which you can indicate your position on the recommendations from the task force, and provide some direction for the executive on the process from here. Of course, you do not have to limit your response to those questions. You are welcome to write or email additional comments. Please take the time to reflect and provide input on this document. Your contribution is needed.

How to get the internship you really want

Linda Carlson, David J.A. Dozois, Bob McIlwraith, Kerry Mothersill, and John W. Pearce.

Introduction by Dr. John W. Pearce
Coordinator of Training,
Alberta Children's Hospital, Calgary, Alberta.

Applying for internship is an arduous process that often provokes a lot of anxiety in students. The following commentaries were prepared by the four participants in a conversation session entitled "How to Get the Internship You Really Want" at the 1998 CPA Annual

Convention, held in June in Edmonton. Their hope is to give students some practical and useful information, as well as allaying their anxiety. Although the participants' opinions are derived from several different perspectives, the reader will quickly discern a number of common themes: the fact that nearly all Canadian applicants will get an internship position, the importance of being well-prepared for the selection interviews, and attaining a balance between the number of practicum hours and progress on the dissertation. The commentaries include some practical tips to make the application process less grueling and suggestions about making the most of the internship year.

Commentary by Dr. Bob McIlwraith
Director of Internship Training
Department of Clinical Health Psychology
University of Manitoba Faculty of Medicine
Winnipeg, Manitoba

1. *Don't Panic.* Applying for internship is quite an anxious time. It's an important and exciting transition between graduate school and career; often it means preparing to move to another province, leaving behind a social network and an established status and reputation within your department and starting over in a new department. Students worry whether they will get the internship they want, or get an internship at all. We have all heard of hundreds of students in the United States not securing an internship on Uniform Notification Day (UND), but the situation is still quite positive in Canada. The message from the Canadian Council of Professional Psychology Programs data is: "Don't panic". Nearly all Canadian applicants will get an internship position. While it may be reassuring to know that you're likely to get some kind of an internship, the real question is: How do you get the internship you really want?

2. *How Many Hours of Practica Does it Take to Get the Internship I Really Want?* Discussions with internship directors suggest the sheer number of hours is not the most important factor considered in evaluating applicants relative to each other. Other important factors include the quality of the practicum experience: the balance between hands-on clinical work and observation, the type and intensity of supervision, the variety of cases, and the range of different settings and populations to which they have been exposed. For example, 1,000 hours of practica in which the student did assessments in a geriatric hospital, consultations in a child development clinic, and therapy in a women's shelter might impress the internship committee more than 3,000 hours all spent in a university clinic treating only one disorder with only one clinical method. Amassing larger and larger numbers of practicum hours may not be the best strategy if this leads to neglect of the dissertation, a paucity of research experience, or if it delays student's progress through the doctoral program.

3. *Internships Care about Your Dissertation.* Progress on the dissertation is an important consideration for internship selection committees in evaluating applicants. I often speak with students who have just met the minimum dissertation requirement prior to interviewing for internship, and have frequently been told they plan to defend before the internship begins. In my experience, that seldom happens, and anyone who has completed a dissertation will tell you many tales of the things that come up to extend even the most realistically-planned dissertations long beyond their expected time lines. Applicants who have their data collected by the time they

interview for internship are, all other things being equal, in a much stronger position.

It makes me sad to see what happens to interns who complete internship without their dissertations done. After a year of being treated like department members and making the transition from a graduate student identity to a professional identity, I'd like to see them continue on their ascending trajectory, receive their doctorate, start their first full-time clinical or academic job, get registered, and start making money. If the dissertation isn't done, however, they often have to return to the university they came from, find some kind of work, and struggle to complete the dissertation in the evenings and on weekends. It's little wonder that, after such an experience, many clinical psychologists do no further research! In some cases, there are jobs available in our department that we'd be happy to see them apply for, but they can't because they need to return to their university programs and be students again.

4. *Some Things That Can't Be Quantified Are Important.* As scientists we tend to prefer quantifiable things, which probably contributes to the inflation of practicum hours. But there are a number of hard-to-quantify variables that internship directors often mention as important in their programs' decisions: The most frequently-mentioned is a quality of "openness to learning"; the sense that the applicant is flexible and interested in trying some new things during internship. Speaking personally, this is certainly an important factor in our program where our philosophy emphasizes training generalists. While it may be hard to measure this factor, most internship directors will tell you that they "know it when they see it". More likely, they are skilled at recognizing its opposite: the intern who is not interested in being stretched by exposure to different theoretical models, populations, or clinical settings.

The second factor often mentioned is "goodness-of-fit" between the applicant's interests and training goals on the one hand and the program's philosophy and training opportunities on the other hand. An applicant who is "objectively" stronger in terms of number of publications, practicum hours, and grade point average, but who is seeking particular experiences that our program does not really offer, may be ranked lower than another applicant who is "objectively" less strong but whose training needs fit well with what we could offer.

Interpersonal skills are another important, but hard-to-quantify, factor. Interns become department members for the year, and the impression that they will make a positive contribution as department citizens can positively affect ranking.

5. *Don't Limit Yourself Geographically, If You Don't Have To.* One of the most commonreasons why applicants do not get placed in an internship on UND is that they have only applied to a restricted geographical area. Many of the matches made through the Clearinghouse involve internship programs to which the student did not apply because of where they were located.

While there are often important family or practical considerations to take into account in deciding where to apply for internship, I would advise students to not restrict themselves unnecessarily to particular locations. Don't just assume that there are whole areas of the country you'd never want to spend a year or longer in. Do some research, ask people you know about the quality of life in different parts of Canada, and talk to former interns from your university who interned in different places about what it was like living there. Consider the quality of the internship program first and how well it fits with our interests and training needs. Consider cost of living, employment prospects, and the state of the profession of psychology in the regions you are checking out. Maybe "the internship you really want" isn't where you thought it would be.

Common themes: nearly all Canadian applicants will get an internship position, the importance of being well-prepared for the selection interviews, and attaining a balance between the number of practicum hours and progress on the dissertation.

6. *Do Your Homework.* As mentioned above in several places, it is important to apply your research skill to this task of applying for internship. Talk to current or former interns and faculty members about programs. Read internship brochures carefully and compose

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questions to ask. Although there is a lot of emphasis on the selections made by the internship programs, the truth is that given the balance between the number of applicants and the number of positions, it's really the applicants who choose among internships as much as we choose among them.

7. *Rank Your Preferred Programs in Order and Stick to Your List.* The new APPIC computerized matching process that is going to be used in 1999 will actually remove a lot of the opportunities for mistakes, cheating, panicky changes of heart during the morning of UND, and will eliminate the need for fancy strategies, since you will simply be matched to your most-preferred program that has a position for you. The computer matching will be a great boon to students, and has been enthusiastically endorsed by the APA Graduate Student Section and by the Canadian Council of Professional Psychology Programs (CCPPP).

The best time to do the internship is after completion of research and dissertation submission.

Please note that it is important for every applicant and every internship program in Canada to participate in the APPIC computer match, since you have to be either completely in or completely out of the match; you can't apply to some programs that are participating in computer matching and some that aren't.

Commentary by Dr. Kerry Mothersill
Past-President, Canadian Council of Professional Psychology Programs

For the past several years, the CCPPP has held pre-CPA Participant Workshops where the Directors of Training from the academic and internship programs discuss ways to improve training in professional psychology. Here are some points from those discussions that achieved a large degree of consensus and which may be helpful for students preparing and applying for internship:

1. Arrive at a balance between the number of practicum hours and progress on the thesis. Internship directors have indicated 1200 to 1400 hours of practicum training are good enough and that numbers over this suffer from the law of diminishing returns. It would be more advisable for students to put the extra effort into making progress on their theses with a goal of at least having the data collected by the "Rank List Submission" date. Internship directors prefer to have interns who devote their energies to applied work. In addition, most directors are looking for a "goodness of fit" with their program and examine the overall combination of areas of interest, practicum hours, publications/ presentations, progress on the thesis, etc.

2. To keep the costs of interviewing down, check to see if the internship site accepts phone interviews and inquire if they have a preference. If traveling in person, arrange your schedule to accommodate as many sites as possible within the same area and take advantage of over-Saturday night fares. Arrange interviews early to obtain advanced booking discounts. Internship directors are being encouraged to arrange their interview schedules well in advance and to schedule times on Mondays and Fridays.

3. It appears internship programs and positions are currently in a stable position. Site closures seem to have stopped. The CCPPP Clearinghouse data for 1998 indicate a return to a balanced position with an equal number of interns and slots (10) being made known to the operator of the service. This was a significant improvement over 1997.

4. Internship programs are being encouraged to place more specific information in the directory so students can make a more informed choice concerning applications. The directory will be sent out early in August to facilitate a jump start on the process.

5. CCPPP has voted to follow the Association of Psychology Postdoctoral and Internship Programs Computer Match procedures and other application/notification policies. This should reduce the stress of the old "UND" and prevent students from making premature decisions as they wait for their program of choice.

Commentary by David J.A. Dozois
Mr. Dozois is currently enrolled in the Program in Clinical Psychology, University of Calgary. In September, 1998, he began his internship at Queen Elizabeth II Hospital in Halifax.

Internship applicants can improve the probability of obtaining their ideal placement by attending to five main stages of internship readiness. The main strategy involves careful preparation at each of the pre-contemplation, pre-application, application, interview, and

decision-making stages.

Many students do not realize that shortly after they enter graduate school (the Pre-Contemplation Stage), they need to do more than course work, practica, and theses. We are all familiar with the cliche, "it's not what you know but who you know." Networking at conferences or joining CPA Sections, committees or interest groups, can only help one's chances of success. Another important approach in this stage is to seek both breadth and depth of training. Internship directors consistently mention that the ideal candidates are individuals who have attained sufficient breadth in their training along with some degree of specialization. It is important, however, not to take so much on that the quality of an individual's work is diluted. Finally, students can save a substantial amount of time and energy by keeping close track of their practicum hours and making note of their direct and indirect service hours (APPIC forms can be downloaded from the internet to serve as a guide).

According to CCPPP's 1996 survey of internship directors (Alden et al., 1996), the type of clinical experience and the strength of reference letters, stated goals and interests, and academic scholarship are some of the most important variables considered by internship faculty in their ranking of candidates. Quality of clinical experience was rated higher than quantity on the CCPPP survey. Students would be wise to round out their training during the Pre-Application Stage.

The next main step is the Application Stage. It is crucial to be organized, thorough, and accurate in the presentation of materials. Cover letters and personal statements should highlight one's experiences and strengths in a way that is positive but does not appear boastful. Acquire letters from individuals who have a good writing style, are reputable in the field, are familiar with a candidate, and who may know the internship faculty. Personal statements of goals and interests should accurately and succinctly outline relevant experiences, training objectives, career plans, rotations of interest, and the ways in which an applicant is a good match for a particular setting. Most sites want to see that individuals are clear with respect to their training objectives, but willing to go into the internship experience with an open mind.

Preparation at the Interview Stage entails learning about the internship faculty and site, formulating a list of insightful questions, and preparing responses to possible questions.

Information about an internship site may be obtained from program brochures, the CCPPP and APPIC directories, discussion with former interns, and information from academic and clinical faculty. Several books and articles (e.g., *Professional Psychology: Research and Practice* and the *APA Monitor*) provide lists of typical questions from internship directors. Applicants are frequently asked a broad range of both common and completely unexpected questions. Being prepared will help to relieve anxiety and bolster confidence.

Finally, during the Decision-Making Stage, it is important to ensure that a particular placement maximizes one's professional, personal, practical objectives. Information from each internship setting can be evaluated most objectively when multiple sources of information are analyzed simultaneously (see Grace, 1985, and Stewart and Stewart, 1996a, 1996b). To summarize, it is important to be as prepared as you can at each stage of the application process.

It is often advantageous to intern in the city where you plan to live.

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Commentary by Ms. Linda Carlson.
Ms. Carlson completed her internship at the CRHA-Adult Consortium in August, 1998.
She will be graduating from the Clinical Psychology Program, McGill University, in October, 1998.

When to do your internship:Internship directors are fond of telling students that the best time to do the internship is after the completion of their research and dissertation submission. I cannot reiterate strongly enough the wisdom of this choice. There are two major reasons for this. First is the issue of time. Interns work a minimum of forty hour weeks, and often more time is spent after-hours. It is extremely difficult to motivate and energize yourself to shift gears and work on research in the evenings and on weekends, which is required if you plan to make any research progress over the year. Ultimately, the quality of both your clinical work and your research will suffer, as will your mental health. This year should be one for personal growth, not burnout. Second, it is very difficult and professionally undesirable to go back to graduate school after having worked for a year in a professional setting. To return to student mode, with its low status and low pay, is to move backward rather than forward. Job opportunities will arise at your internship settings, and if you are available to shift easily into a new position at the end of the internship year, you will be a far more desirable candidate. It is far better to spend an extra year prior to applying for the internship to finish research and strengthen your application than to have to return to school.

Where to do your internship: It is often advantageous to intern in the city where you plan to live, as job opportunities are likely to arise from the contacts you make during the internship year. If you wish to work in academia you can be more mobile in choosing your internship, but always keep in mind that contacts and networking are crucial in the job search. If you are finished your dissertation and know where you want to live and work, your application in that setting will only be strengthened.

What to expect during your internship: Most interns work a forty-hour week; try to keep it at that for the sake of your mental health. You should receive about one hour of supervision and spend approximately two hours in direct contact with patients daily. Other time is usually spent reading charts, scoring tests, writing reports, attending inservices and staff meetings, attending rounds, and observing therapy. You should be treated more like a staff member than a student.

Life after your internship: Yes, there is life after the internship. Plan for it. Contact your provincial college of psychologists and get the information you need regarding licensure. Your internship hours may count towards your status as a chartered psychologist, depending on the regulations in your province. Always remember the internship is a year of transition from student to professional psychologist; look towards that goal. Consider what you want to do over the next thirty years so that you can tailor your internship to provide the skills and opportunities you will need. Good luck and enjoy your year.

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 March 31, 1999 to:

Charlotte Johnston, Ph. D.
Department of Psychology
University of British Columbia
Vancouver B.C. V6T 1Z4
Tel (604) 822-6771 Fax (604) 822-6923
e-mail: cjohnston@cortex.psych.ubc.ca

Psychological treatment of insomnia

Summary of a workshop presented at the annual meeting of the Canadian Psychological Association, Edmonton, Alberta (June 1998).

Charles M. Morin, Ph.D. Université Laval

Significance. Insomnia is a prevalent condition, both as a symptom and a syndrome. More than 10% of the adult population complain of persistent and troublesome sleep disturbances. Insomnia is more common among women, older adults, and individuals with psychological or medical problems. Chronic insomnia is not a benign problem as it can cause significant emotional distress, impairments of daytime functioning, and economic costs. It is also associated with increased risks of major depression and prolonged use of hypnotic medications. Despite its high prevalence and negative impact, insomnia is underrated and psychological interventions are underutilized for its clinical management.

Diagnostic Issues. Insomnia is a heterogeneous complaint reflecting impaired quality, duration, or efficiency of sleep. It can involve difficulties initiating sleep, trouble staying asleep, or early morning awakening. About one third of those who report insomnia suffers from a primary condition. However,, it can also be associated with medical disorders, substance abuse, other primary sleep disorders, or even with chronic usage of hypnotic medications (hypnotic-dependent insomnia). There is a high rate of comorbidity between insomnia and psychopathology, particularly with affective and anxiety disorders.

Treatment. More than a dozen non-pharmacological interventions (mostly cognitive-behavioural.) have been used for treating insomnia, and about half of them have received adequate empirical evaluation. Treatment methods that have been shown effective include stimulus control therapy, sleep restriction, relaxation-based interventions, cognitive therapy, and paradoxical intention. Two recent meta-analyses of more than 50 outcome studies (2000 patients) have shown that behavioral treatment modalities produce effect sizes of 0.88 for sleep latency, 0.65 for duration of awakenings, 0.42-0.49 for total sleep time, and 0.94 for sleep quality ratings. Between 700/o-800/o of insomnia patients benefit from behavioral treatment. In terms of absolute changes over time, sleep-onset latency is reduced from an average of about one hour before treatment to about 35 min. after treatment. Similar results are obtained for the duration of nocturnal awakenings. Total sleep time is increased by a modest 30-45 min. but patients are generally more satisfied with their sleep patterns and show less distress with residual sleep disturbances. Treatment gains are very durable over time, and sleep improvements are sometimes further enhanced at long-term follow-ups.

70%–80% of insomnia patients benefit from behavioural treatment.

Conclusions. The complaint of insomnia is often brought to the attention of clinicians either as a primary concern or perhaps more often in association with other medical or psychological problems. Effective behavioral interventions are available for treating this condition. Although most of the evidence available is based on controlled studies conducted with young, healthy, and unmedicated individuals, behavioral treatment modalities can also be used with older patients, patients with comorbid medical and psychiatric disorders, and even with those using hypnotic medications.

Suggested Reading:

Morin, C.M. (1993). *Insomnia: Psychological assessment and management.* New York: Guilford Press.

Morin, C. M., & Wooten, V. (1997). Psychological and pharmacological approaches to treating insomnia: Critical issues in assessing their separate and combined effects. *Clinical Psychology Review, 16,* 521-542.

Cognitive-behavioural treatment of insomnia secondary to chronic pain

Shawn R. Currie, Ph. D.
University of Ottawa

The present study represents the first randomized controlled trial of a nonpharmacological treatment for insomnia that is associated with chronic benign pain. Research indicates that pain is a leading cause of sleep disturbances among people with chronic pain conditions (Atkinson et al., 1988; Pilowsky et al., 1985; Wilson et al., 1998). With some pain syndromes, such as fibromyalgia, the attendant sleep disturbance can take on primary significance in the course of the disorder (Moldofsky, 1990). For most persons with chronic pain, however, fragmented sleep is a secondary, albeit highly distressing, aspect of their chronic pain condition that can increase the salience of their disability and emotional distress. Furthermore, prolonged sleep disruption may compound patients' risk of other long-term consequences such as exacerbated pain levels, fatigue, physical impairment, and vulnerability to psychological disorders.

Pharmacological approaches to manage sleep disturbances in chronic pain patients have not shown long-term efficacy.

Pharmacological approaches to manage sleep disturbances in this population have not shown long-term efficacy. In addition, the prolonged use of sleep medication may carry health risks, as well as lead to iatrogenic effects that can result in a continuing sleep problem. On the other hand, there is now a large body of research attesting to the efficacy of nonpharmacological treatments for primary insomnia (Murtaugh & Greenwood, 1995; NIH Technology Assessment Panel, 1996). Unfortunately, clinical trials of such treatments have historically excluded persons with insomnia secondary to medical conditions, on the assumption that these patients would be better served by treating the primary medical pathology. This becomes problematic, however, for persons with chronic pain conditions who have exhausted their options for obtaining relief from conventional medical treatments. As a result, patients' sleep problems can often go untreated for many years.

There have been a few uncontrolled studies that suggest persons with chronic pain can benefit from psychological treatment approaches for insomnia. This small body of available evidence points to the potential value of nonpharmacological approaches to the management of secondary insomnia, although no protocols have yet been developed that are tailored specifically for this group. In the present study, a cognitive-behavioural treatment program for insomnia was developed by adapting an existing protocol by Morin (1993) to the specific needs of patients whose sleep problems are secondary to chronic pain. The intervention is based on the assumption that even though the major source of the insomnia may be the experience of pain that disrupts sleep, many people with chronic pain go on to develop behavioural habits that serve to exacerbate and maintain the problem. If so, then promoting better sleep habits would be expected to enhance the quality of sleep in these patients, even though the experience of pain per se is not the target of intervention.

The participants in the present trial were twenty-three m en and twenty-seven women (mean age = 44.5, SD = 8.3) with chronic benign pain. In addition to the medical diagnosis, each subject met DSM-IV criteria (as determined by structured diagnostic interview) for insomnia secondary to chronic pain. The average duration of sleep disturbances was 7.9 years (SD = 8.0). Following a baseline assessment of sleep using a standardized sleep diary and ancillary measures, each subject was assigned randomly to receive either cognitive-behavioural therapy (n = 25) or the minimal contact symptom monitoring/ waiting-list control (WLC) condition (n = 25).

The cognitive-behavioural treatment

program consisted of a structured multicomponent, intervention that integrated behavioural procedures, relaxation training, cognitive therapy, and sleep hygiene education. The core behavioural interventions were stimulus control and sleep restriction. These interventions are intended to help patients re-establish the bed as the dominant cue for sleep, regulate sleep-wake habits, and consolidate sleep over a shorter period. The treatment was conducted in a group format which extended over seven two-hour sessions, held once per week. In addition, each subject in the CBT condition received a copy of a patient-oriented manual which was written specifically to accompany the group treatment. Subjects randomized to the WLC condition continued to monitor their sleep using the sleep diary for a further seven weeks after the end of the baseline recording period. Each subject was contacted by phone on a weekly basis to encourage adherence with the self-monitoring protocol.

The results provided encouraging support for this treatment approach. Individual 2 x 3 (Group x Time) ANOVAs showed significant improvements in the diary measures of sleep efficiency, sleep onset latency, and wake time after sleep onset (all p's < .03) in the CBT subjects by the end of the treatment. Subjects in the active treatment also showed a significant increase ($p < .001$) in scores on the Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989), which was used as a global measure of treatment outcome. Furthermore, the treated subjects showed a significant decrease in pain severity ratings ($p < .05$) at posttreatment. There was good maintenance of the posttreatment gains at a three month follow-up assessment.

Additional analyses were undertaken to examine the clinical significance of the results using criteria that distinguish "good" from "poor" sleepers based on the individual's reported sleep pattern over a typical week. At posttreatment, ten CBT subjects (42%) met the clinical criteria for good sleep compared to two WLC subjects ($p < .01$), At follow-up, eight treated subjects (32%) remained good sleepers according to these criteria compared to one (4%) WLC subject ($P < .01$).

The present findings indicate that cognitive-behavioural therapy may be a viable and effective treatment for insomnia that is secondary to chronically painful medical conditions. Subjects in the CBT condition showed a significant reduction in the severity of their sleep onset and sleep maintenance difficulties. Importantly, CBT subjects also reported an increase in the overall quality and restfulness of their sleep and a decrease in their pain levels. The magnitude of these treatment effects are consistent with previous controlled research with primary insomniacs (Murtaugh & Greenwood, 1995). Posttreatment gains in these measures were maintained reasonably well at a 3-month follow-up, indicating that this treatment has the potential to help patients achieve long-term improvements in their sleep. The evaluation of the clinical significance of the results revealed that many of the CBT subjects became "good" sleepers after only seven weeks of treatment. This is an impressive finding given the chronicity of insomnia reported by these subjects, and the fact that the clinical criteria employed were developed for insomniacs who are otherwise physically healthy. Nevertheless, the overall magnitude of these changes must be placed in their proper context; the majority of subjects were still in the dysfunctional range of sleep at posttreatment and follow-up. This suggests that treatments of this type are unlikely to provide a cure for all of patients' sleep problems. The reality may be that "perfect sleep" is not attainable by most patients with chronic pain, but the severity of their insomnia can certainly be improved by means other than long-term medication. Furthermore, it appears that the intervention produces a secondary benefit of reducing pain levels, suggesting the CBT program may be helpful in breaking the cycle of poor sleep leading to increasing pain. Hence, the treatment offers great potential as a non-drug alternative for people with a variety of medical disorders whose sleep is persistently disturbed by pain.

Cognitive behavioural therapy may be a viable and effective treatment for insomnia that is secondary to chronically painful medical conditions.

Continued on page 19 "CBT Insomnia"

Bringing psychology to the public: An advocacy campaign kit

Alan MacDonald and Susan Jerrott, two doctoral students in clinical psychology at Dalhousie University, have developed a campaign called "Psychology Works!", aimed at raising public awareness of Psychology in Canada. They assembled a kit to conduct seminars for adults and high school students across the province of Nova Scotia. These seminars or advocacy talks took place in May, 1997. The seminars outlined the mechanisms and accessibility of psychological services, housed within the context of an issue of wide-spread interest — anxiety. The campaign was met by universal enthusiasm in all areas of the province and received generous coverage by provincial and local media. Susan and Alan recently discussed the campaign on a live call-in show on the Global television network, produced a presentation for cable television and conducted a conversation hour at the annual CPA conference in Edmonton. The project received financial support for the research and development phase from many professional psychology organizations, including CPA, CRHSPP, CPAP, and the Clinical Psychology Section of CPA.

The kit is available to professionals from all parts of Canada for use as an advocacy tool in their own geographical region. The kit contains videos of the cable television presentation, global interview, radio spots and video segments for use in the actual presentation. In addition, diskettes containing all audio visual materials are included. The kit also has a detailed manual which outlines the philosophy behind the campaign, tips on constructing an effective presentation, media relations, financial considerations in conducting the campaign, a "how-to" section which gives a step-by-step guide for putting the campaign together, a detailed presentation script, copies of newspaper articles and the results of an in-depth survey of provincial knowledge and attitudes about psychology.

The advocacy kit is currently being distributed by the authors at cost, in the amount of $100.00 (which includes shipping). A limited number of kits are available for preview. If there are any plans for advocacy of the discipline of psychology in your area , this kit will be an important step in raising public awareness regarding the value of psychology in Canada. To obtain the kit, the authors can be contacted at the following address:

Alan MacDonald & Susan Jerrott
Department of Psychology
Dalhousie University
Halifax, Nova Scotia
B3H 4J1
(902) 494-1580

email: alanmacd@is2.dal.ca
sjerrott@is2.dal.ca

Editor's note: In the previous issue of Canadian Clinical Psychologist (April, 1998), we featured an article on a Nova Scotia advocacy campaign, entitled "Psychology Works! The Development of an Advocacy Campaign" by Alan MacDonald and Susan Jerrott. The authors were invited to submit additional information on the availability of the kit for the current newsletter.

Les changements cognitifs impliqués dans le mécanisme thérapeutique de la pharmacothérapie du trouble panique avec agoraphobie (TPA)

S. Simard[1], J. Gauthier[1], D. Audet[2] & S. Bouchard[3]
[1]Université Laval, [2]CHUQ Pavillon St-François d'Assise, [3]Université de Québec à Hull.

Au cours des dernières années, plusieurs recherches cliniques ont entrepris d'éclaircir les processus de changements thérapeutiques des traitements cognitivo-comportementaux. Toutefois, bien que ces études (1, 2, 3, 4, 5) proposent que l'amélioration thérapeutique s'opère à travers les changements des croyances dysfonctionnelles et/ou les changements de l'efficacité personnelle, aucune d'elles n'est en mesure d'établir une direction dans la relation entre les changements de ces variables cognitives et l'amélioration thérapeutique.

À l'heure actuelle, la méthodologie la plus appropriée pour étudier cette problématique apparaît être l'analyse de séries chronologiques multivariées appliquée aux protocoles à cas unique (6). L'objectif principal de ce type d'analyse est de créer un modèle mathématique (ARMA) reflétant les relations temporelles entre différentes variables de l'échantillon des données. Cette procédure de modélisation permet de tester empiriquement la présence de relations de causalité (7, 8).

En recourant à l'analyse de séries chronologiques multivariées, Bouchard et al. (9) montrent que les changements de la force des croyances dysfonctionnelles et/ou les changements du niveau de perception d'efficacité personnelle à contrôler une attaque de panique précèdent les changements dans le niveau d'appréhension des participants ne rapportant plus d'attaque de panique après un traitement cognitif ou comportemental. Ces résultats confirment l'importance d'intervenir sur ces variables cognitives afin d'obtenir une amélioration thérapeutique significative. Toutefois, certains auteurs soutiennent qu'il n'est pas nécessaire d'intervenir directement sur ces variables pour obtenir des changements significatifs (1, 3, 4).

La présente étude a pour objectif d'explorer la présence des changements cognitifs impliqués dans le mécanisme thérapeutique de la pharmacothérapie du TPA. Pour se faire, l'impact thérapeutique de la pharmacothérapie est d'abord évalué à partir de l'analyse des changements thérapeutiques obtenus afin de vérifier si la prise de médication donne lieu à l'amélioration thérapeutique attendue et nécessaire à l'étude des mécanismes thérapeutiques. Par la suite, à l'aide de l'analyse de séries chronologiques multivariées, la présence d'une dynamique précise des changements cognitifs est explorée dans le mécanisme thérapeutique de la pharmacothérapie.

Méthode

Participants. Les participants sont référés par des professionnels en santé mentale et des médecins généralistes ou se portent volontaires suite à des communiqués publiés dans les médias écrits. Ils sont évalués à l'aide du SCID for DSM-III-R (10) afin de s'assurer qu'ils répondent aux critères habituels de sélection.

Onze participants (64% femme, moyenne âge = 35.2 ± 10.4) souffrant d'un TPA sont sélectionnés et reçoivent une pharmacothérapie sans intervention cognitivo-comportementale. Le traitement choisi repose essentiellement sur l'effet anti-panique du Chlorhydrate de Paroxétine (PAXIL). La dose est ajustée individuellement pour chaque participant afin d'éliminer rapidement la symptomatologie associée au TPA.

Mesure. En accord avec les

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recommandations du consensus international sur l'évaluation du TPA en recherche (11), des questionnaires d'auto-évaluation (ACQ, BSQ...) et des journaux d'auto-enregistrement sont utilisés. Les journaux d'auto-enregistrement permettent, entre autre, d'évaluer quotidiennement la force de la croyance dysfonctionnelle, le niveau de perception d'efficacité personnelle à contrôler un attaque de panique et le niveau d'appréhension sur une échelle de «0» (nul) à «100» (énormément).

Procédure. La présente étude comporte 20 semaines d'expérimentation soit: 4 semaines de pré-traitement et 16 semaines de traitement. Les participants sélectionnés répondent, d'abord, aux questionnaires d'auto-évaluation et complètent quotidiennement les questionnaires d'auto-enregistrement afin de déterminer le niveau de base des variables à l'étude. Par la suite, ils reçoivent un traitement pharmacologique et répondent périodiquement aux questionnaires d'auto-évaluation (0, 4, 8, 12 et 16ième semaine). De plus, ils complètent quotidiennement les journaux d'auto-enregistrement, pendant les 16 semaines d'observation, afin d'explorer la dynamique des variables cognitives. Enfin, les participants ont la possibilité de poursuivre la prise de médication pendant un an afin de maximiser les effets thérapeutiques.

Les changements des croyances dysfonctionnelles et de la perception d'efficacité personnelle sont fortement associés a l'amélioration thérapeutique.

Résultats

L'impact thérapeutique. Des ANOVAs à mesures répétées sont effectuées sur chaque variable dépendante. Les résultats montrent un effet thérapeutique significatif de la Paroxétine sur la majorité des variables cliniques, cognitives et comportementales après 16 semaines de pharmacothérapie à une dose moyenne de 20 mg.

Les mécanismes thérapeutiques. Les participants ne présentant aucune attaque de panique lors des quatre dernières semaines d'observation, sont soumis individuellement à l'analyse de séries chronologiques multivariées. Les résultats montrent que les changements de la force des croyances dysfonctionnelles précèdent les changements dans le niveau d'appréhension chez 64% des participants. De plus, ils montrent que les changements du niveau de perception d'efficacité personnelle à contrôler une attaque de panique précèdent les changements dans le niveau d'appréhension chez 64 % des participants.

Discussion

En accord avec la littérature, les résultats obtenus montrent un impact positif de la pharmacothérapie sur la symptomatologie du TPA et suggèrent que les changements des croyances dysfonctionnelles et de la perception d'efficacité personnelle soient fortement associés à l'amélioration thérapeutique.

Aussi, les résultats des analyses de séries chronologiques multivariées montrent la présence d'une dynamique spécifique des changements cognitifs impliqués dans le mécanisme thérapeutique de la pharmacothérapie. Plus spécifiquement, ils révèlent la présence d'une dynamique des changements cognitifs semblable à la dynamique observée par Bouchard et al. (9) dans l'analyse des mécanismes thérapeutiques de la thérapie cognitive et comportementale. Enfin, il apparaît que les changements de la perception d'efficacité personnelle occupent un rôle central dans le mécanisme thérapeutique de ces deux types d'interventions puisqu'ils précèdent les changements de l'appréhension dans 70% des cas.

En conclusion, les résultats obtenus montrent la présence de changements cognitifs impliqués dans le mécanisme thérapeutique de la pharmacothérapie. De plus, ils suggèrent que la perception d'efficacité personnelle soit un ingrédient actif important dans les mécanismes thérapeutiques des traitements du TPA. Enfin, la similarité observée entre la dynamique des changements cognitifs dans le mécanisme thérapeutique de la pharmacothérapie et de la thérapie cognitivo-comportementale suggèrent l'existence de mécanismes thérapeutiques communs entre ces deux types d'interventions.

Sébastien Simard, M.Ps., Laboratoire de médecine béhaviorale, École de Psychologie, Université Laval, Pavillon Félix-Antoine Savard, Ste-Foy (Qc.), G1K 7P4. Tél: (418) 656-2131(4768); courrier électronique : sebastien.simard @psy.ulaval.ca

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"CBT Insomnia" continued from page 15

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Acknowledgments

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Editor's Note: Dr. Currie is the recipient of the Ken Bowers Research Award.

Clinical section e-mail directory

The spring edition of the newsletter will contain an e-mail directory listing addresses submitted to the editor for inclusion. You are invited to submit your name and address so that more of your colleagues can correspond with you on the internet. Send your e-mail address to: scairns@ucalgary.ca

Canadian research on clinical approaches to anxiety disorders

John R. Walker
University of Manitoba

In 1997, the Clinical Psychology Section sponsored a well received symposium on depression at the annual convention of the Canadian Psychological Association. In 1998 the executive issued an invitation to organize a symposium on anxiety disorders. Canadian researchers have been very active in the field of anxiety disorders and have been well represented at a variety of international conferences. In the 1997 and 1998 meetings of the Anxiety Disorders Association of America, for example, 30% of the new research posters have been presented by Canadian groups. With so many active research groups across the country, it was challenging to decide whom to invite to present at the symposium. Given the large number of clinicians and clinical students at the conference, it was decided to take a clinical focus in this year's presentation. What follows is a brief synopsis of each of the presentations along with a few references which may be helpful to the reader wishing to learn more about any of these areas.

It is estimated that 1 in 20 Canadians will suffer from Generalized Anxiety Disorder at some time in their life.

GAD: Key process variables and innovative treatment strategies

Michel J. Dugas, Concordia University &
Robert Ladouceur, Université Laval

It is estimated that 1 in 20 individuals will suffer from Generalized Anxiety Disorder (GAD) at some time in their life. Unfortunately, assessment and treatment methods for GAD have until recently provided disappointing results. Over the past six years, our research team has developed standardized assessment measures, identified key GAD process variables, and tested an innovative treatment program for GAD.

Several measures have proven to be helpful in the assessment of GAD. Our group has developed the Worry and Anxiety Questionnaire (WAQ), a self-report screening instrument for GAD. It is a concise and practical measure that evaluates the DSM-IV diagnostic criteria for GAD. Trials with clinical populations indicate that 89.5% of GAD patients meet the diagnostic criteria on the WAQ, while only 16.9% of nonclinical respondents meet the diagnostic criteria. The Penn State Worry Questionnaire has 16 items that assess the tendency to worry, regardless of worry content. This measure distinguishes persons with GAD from individuals with other anxiety disorders and from nonclinical respondents. Finally, our team has developed the Intolerance of Uncertainty Scale. This 27-item scale evaluates the degree to which individuals have a low tolerance for uncertain and aversive future events. Our research has shown that intolerance of uncertainty is specifically related to GAD and that changes in this variable precede changes in time spent worrying

The treatment program used in our centre emphasizes cognitive exposure to mental images associated with worry and problem solving training with an emphasis on improving problem orientation. Outcome data indicate considerable improvement in tolerance of uncertainty, tendency to worry, and depression which is maintained at 6 and 12 month follow up.

Suggested Reading:

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Comparative efficacy of cognitive and behavioral treatment of OCD

Maureen L. Whittal, Peter D. McLean, Dana Thordarson, Steven Taylor, William I Koch, & Randy Paterson, University of British Columbia and UBC Hospital

Obsessive-compulsive disorder (OCD) was once thought to be a chronic disorder, unresponsive to treatment. However, in the past 25 years, psychosocial treatment, primarily exposure and response prevention (ERP), has been successful in the treatment of OCD. Approximately 70% of people who complete treatment receive some benefit and maintain their gains over time (Foa, Steketee, & Ozarow, 1985). However, approximately 20-30% of people who present for treatment either refuse to begin treatment or drop out (Stanley & Turner, 1995). Moreover, the majority of those people who do benefit from treatment continue to experience residual symptoms upon termination of 12-16 sessions of behavior therapy.

Salkovskis (1985, 1996) introduced a contemporary cognitive-behavioural theory and treatment for OCD. The theory rests on the cornerstone that intrusive thoughts are essentially a universal experience. When these thoughts, images, or urges are appraised in a threatening or personally significant way, it leads to the urge to neutralize or to engage in a behavior that reduces the perceived threat or personal significance. These appraisals are the target for treatment. Salkovskis (1985, 1996) and others have reasoned that altering appraisals and beliefs, and not exclusively relying on habituation, will further improve upon the efficacy of treatment and make it easier to tolerate, thereby decreasing the drop/refusal rate.

The aim of the current study was to test the efficacy of Cognitive Behaviour Therapy (CBT) for OCD in a group setting while comparing it to standard behavior therapy. Sixty-three people completed 12 consecutive weeks of group treatment (2.5 hours each week) (31 people in the CBT condition and 32 people in the ERP condition). After two individual assessment sessions, subjects were randomized to ERP or CBT. Half of the subjects in each condition received immediate treatment and the other half received treatment after a 3-month delay. Questionnaire packets and structured interviews were completed at pre treatment, post-, treatment, and 3 months after termination. The interested reader is referred to Whittal and McLean (in press) for a description of the CBT protocol and van Noppen et al. (1997) for a description of the ERP protocol.

For each of the dependent variables, subjects remained stable during the wait-list and there were no significant between group differences at pre-treatment. Most importantly, severity of OCD symptoms (as assessed by the Yale-Brown Obsessive-Compulsive Scale, YBOCS; Goodman et al., 1989) significantly declined during treatment. There was, however, no significant difference between the groups at post-treatment. At the three month follow-up, the CBT group had slipped slightly whereas the ERP group had either maintained their gains or improved upon them slightly which produced a significant group difference.

Scores on the Inventory of Beliefs Related to Obsessions, Thought Action Fusion Scale, and the Responsibility Scale declined significantly during treatment and people maintained their gains at follow-up, but there was no significant group difference. Using diagnostic status as a measure of treatment success, an advantage emerged for ERP over CBT. Surprisingly, significantly more people refused CBT compared to ERP, however, once treatment had begun, significantly more people dropped out of ERP compared to CBT. As expected, there were significantly more refusers in the delay condition compared to immediate treatment. Post-hoc tests revealed that drop-outs had significantly higher pre-treatment YBOCS and Beck Depression Inventory scores compared to completers.

Overall, the results indicate that OCD is amenable to group treatment. The question of differential efficacy based on type of psychosocial. treatment remains to be answered. It may be that method of treatment delivery is particularly important for CBT as it is difficult to identify and challenge idiosyncratic cognitive processes in the context of group treatment.

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Phenomenology, epidemiology, assessment, treatment, and new research on panic disorder

Janel G. Gauthier, Université Laval

In recent years, panic disorder has become one of the most researched syndromes in psychopathology. It has also been a topic of intense controversy, with sharp disagreements along disciplinary lines among biological psychiatrists, cognitive-behavioural psychologists, and epidemiologists concerning its syndromal validity, epidemiology, etiology, and treatment. This presentation reviewed information on the phenomenology of panic as well as the research on the prevalence and incidence of panic disorder and agoraphobia in the population. The advantages and disadvantages of the assessment measures recommended by the U.S. National Institute of Mental Health were discussed.

An overview of the psychological and psychopharmacological treatments were presented and have been described *in* the references below . The acceptability of the treatment to the patient and family members, the impact on the patient's quality of life, including functional impairment, the time needed to show results, the cost of treatment, and the ease with which the treatment can be taught to professionals and made available to the public was considered when comparing the effectiveness of various treatment approaches. The presentation ended with a look toward future developments.

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Posttraumatic Stress Disorder: Prevention, exacerbation, and treatment

William J. Koch, Ingrid Fedoroff, Nichole Fairbrother, Ingrid Sochting, Steven Taylor, & Grant Iverson, University of British Columbia and LJBC Hospital

Posttraumatic Stress Disorder (PTSD) is a highly prevalent mental health condition resulting from traumatic injury or life-threatening experiences. In terms of lifetime prevalence, PTSD is a mental health problem affecting more than 5 percent of adults, with a disproportionately higher prevalence in women. The most common precipitants of PTSD are motor vehicle accidents (MVAs) and sexual assault. Because the precipitants of PTSD are wellknown, preventive interventions offer hope for reducing the prevalence of this condition. The most common preventive intervention related to PTSD at this time involves rape prevention programs that are very common on university campuses.

Prevention of rape

Many rape prevention programs attempt to change beliefs or attitudes that are assumed to be risk factors for sexual assault. Alternatively, a rape prevention program may attempt to build behavioural skills that inoculate women against sexual assault. Our central thesis is that too much emphasis in rape prevention has been placed on attitude/belief change and insufficient energy devoted to skill development.

Some attitude change programs have found pre-post attitude changes on measures of rape-myth acceptance, sex-role stereotypes, and acceptance of interpersonal violence. There appear to be a significant rebound effects in attitudes found at one or two month follow-up in some studies. Didactic interventions may have weak effects on the incidence of sexual assault because they focus on attitudes and information rather than some of the main behaviors that may be related to sexual assault. Investigations using any type of behavioral change or rates of victimization as outcome measures in this area are rare.

Too much emphasis in rape prevention has been placed on attitude/belief change and insufficient energy devoted to skill development.

The research on resistance strategies and their relationship to rape avoidance is all of a retrospective nature and involves post-trauma interviews of victims of attempted and completed rape to determine the behavioural differences between these two groups. These studies have found that: physical resistance is consistently associatedwith rape avoidance, forceful verbal resistance has been consistently related to rape-avoidance, nonforceful verbal resistance has been consistently shown to be ineffective, use of multiple rape resistance strategies is associated with successful rape avoidance, and immediacy of resistance predicts rape avoidance. Given the results of retrospective studies of rape resistance, it is logical to integrate self-defense training for women into rape prevention programs. Evaluation of the effects of these programs on future experience of sexual assault has not yet been evaluated. The empirically supported risk factors for rape victimization include alcohol and drug use, miscommunication and sexual assertiveness deficits, and deficits in danger recognition. While strategies to intervene in these areas hold out a promise for prevention, a great deal of work needs to be done to evaluate the impact of these interventions.

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Treatment of Posttraumatic Stress Disorder

Treatment outcome studies with respect to PTSD have blossomed over the past two decades. Shelly Van Etten and Steve Taylor (in press) recently completed a meta-analyis of 61 treatment trials for PTSD, primarily having to do with combat veteran or crime-related PTSD. Within this meta-analysis, the psychological treatments generally fared better than the drug treatments, and the behaviorally oriented treatments fared better than the non-behaviorally oriented treatments.

However, to date there have been no controlled trials for PTSD resulting from motor vehicle accidents. We are currently conducting a controlled trial of cognitive-behavioral therapy for NAVA-PTSD. Other controlled trials of behavioral or cognitive therapy for MVA-PTSD are also taking place in New York (Ed Blanchard's clinic) and Oxford (David Clark's clinic).

The study design is a comparison of CBT versus a wait list control. The WL controls are reassessed after 12 weeks and then commence treatment. Our preliminary results are based on a comparison of 6 treatment completers and I I wait list controls.Our big success story was on selfreported avoidance with an effect size of over 2 standard deviations for the treatment group. This was offset somewhat by an effect size over 1.0 for the wait list control suggesting that these patients were gradually remitting even on the wait list. However, all other treatment effect sizes are quite modest. These are disappointing preliminary results. While we hope these results improve as we treat more patients, we are prepared to admit that our treatment does not fully address the diverse difficulties faced by this particular population of PTSD sufferers. We suspect that there are several factors associated with MVA-PTSD that are relatively unique among the anxiety disorders and may explain their modest response to treatment.

Factors that maintain or exacerbate Posttraumatic Stress Disorder

Predictors of PTSD can be roughly categorized into (a) victim characteristics preceding the trauma (predisposing.factors), (b) characteristics of the traumatic event (including the victim's immediate subjective response to the trauma, objective severity'of the trauma, severity of physical injuries caused by the trauma - *event.factors)*, and (c) post-trauma coping by the victim or posttrauma stresses. The post-event variables that have been associatedwith psychological disturbance include: litigation/compensation status, slow recovery from physical injuries, post-trauma pain severity, avoidant coping style, low social support, maladaptive emotions such as guilt or anaer, and recent trauma to family members. Our group is continuing to study factors related to treatment outcome with a particular emphasis on litigation stress.

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Exposure in the treatment of anxiety disorders: Principles and clinical applications

Michel J. Dugas, Ph.D., Concordia University, Department of Psychology
Josée Rhéaume, Ph.D., Hôpital Hôtel-Dieu de Lévis, Département de Psychiatrie

The purpose of this paper is to summarize the workshop we had the pleasure of presenting at CPA 1998. The workshop was divided into five sections: (1) Facts about exposure, (2) Preparing the client for exposure, (3) Principles of exposure, (4) Exposure methods, and (5) Common problems. Each one of the sections is briefly described below.

Facts about exposure. Exposure is an essential treatment component for most (if not all) anxiety disorders and empirical evidence clearly indicates that exposure-based therapies are highly effective (Rachman, 1996). Exposure methods have considerably evolved over the past 10 years; in many cases, the targets of exposure are now more highly related to ideographic case formulations (e.g. Freeston et al., 1997).

Preparing the client: Anxiety information. Unfortunately, exposure-based therapies have at times been associated with high dropout rates. We believe that providing appropriate information about anxiety in the context of exposure can help decrease dropout rates. The primary goal of providing anxiety information is to facilitate acceptance and adherence to the exposure procedures. At the very least, therapists should inform their clients that anxiety is not physically dangerous in the short term (as always, this issue led to an interesting discussion during the workshop) and that the intensity of anxiety reactions is limited (i.e. there is a "ceiling" effect). We have found that using graphs that depict anxiety level over time is quite helpful in presenting the notions of avoidance, escape, neutralization and exposure.

Principles of exposure. Ideally, exposure should be prolonged, repeated and functional. It should be prolonged because decreases in anxiety often do not occur until 30 to 45 minutes of the exposure session have elapsed. We ask our clients to remain in the fearful situation until their anxiety level returns to normal, which can be anywhere from 30 to 90 minutes. Exposure should also be repeated, with relatively short time intervals between exposure sessions. Clients should try to carry out at least one exposure session a day to optimize the benefits of exposure. Finally, exposure should also be functional, that is to say it should be devoid of all avoiding and neutralizing activities. Therapists should keep in mind that it may take some practice before exposure truly becomes functional and that clients often need much support during the early stages of exposure therapy.

Exposure Methods. In vivo exposure is typically used for specific phobia, agoraphobia, obsessive-compulsive disorder and social phobia. In many cases, a "phobic companion" may be of great use in facilitating (but not too much!) initial exposure sessions. Clients need to learn to monitor their thoughts during in vivo exposure because cognitive avoidance will of course decrease its effectiveness. Many of our agoraphobic clients have reported imagining themselves elsewhere when being in exposure situations (e.g. "seeing" oneself at home when one is carrying out an exposure session at the shopping center). *Interoceptive exposure* is typically used for panic disorder. However, it may be quite useful for all anxiety disorders when anxiety information is insufficient to dispel clients' fears about anxiety. Hyperventilating, breathing through a straw, spinning in a chair and stair climbing are examples of interoceptive exposure exercises. Finally, *cognitive exposure* is often used for generalized anxiety disorder, obsessive-compulsive disorder and posttraumatic stress disorder. It may be therapist-directed or self-directed (by imagining the feared situation, reading about it or listening to a looped audiotape describing it). Cognitive exposure

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methods have rapidly evolved over the past decade and have proven quite helpful in extending the scope of exposure-based therapies (Dugas & Bouchard, 1997).

Common problems. The first common problem with exposure occurs when a client shows no anxiety response during the exposure session. For all methods of exposure (in vivo, interoceptive and cognitive), the exposure target may need to be redefined. We have found that subtle changes in the exposure target have led to surprising increases in anxiety responses for many of our clients. If a client shows no anxiety response when carrying out cognitive exposure, he/she may have difficulty generating the fearful image. In such cases, imagery training may be a helpful adjunct to exposure therapy (see e.g. Craske, Barlow, & O'Leary, 1992). A second common problem with exposure occurs when the client's anxiety level does not decrease during prolonged exposure. In this case, the therapist should carefully look for all types of neutralization as all effortful or voluntary activity used by the client to control the image impedes truly functional exposure. A final (very) common problem occurs when clients report that after a number of exposure sessions, the exposure "doesn't work anymore" because their anxiety level no longer rises in response to being exposed to the fearful stimulus. In many cases, what clients fail to recognize is that the exposure has in fact "worked".

Imagery training may be a helpful adjunct to exposure therapy.

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Conferences of interest

4th International Conference on Long Term Care Case Management
December 10-13, 1998
San Diego
Contact:
American Society on Aging
833 Market St., Suite 511
San Francisco, CA
94103-1824
(415) 974-9600
info@asa.asaging.org

Annual Meeting of the American Psychological Association
August 20-24, 1999
Boston, Massachusetts
Proposals Due: December 2, 1998
Contact:
APA Convention Office
750 First St. NE
Washington, DC
20002-4242
(202) 336-6020

International Association for the Study of Pain
9th World Congress on Pain
August 22-27, 1999
Vienna, Austria
Contact:
IASP Secretariat
909 NE 43rd St., Suite 306
Seattle., WA, USA
98105-6020
(206) 547-6409
IASP@locke.hs.washington.edu

XXVII International Congress of Psychology
July 23-28, 2000
Stockholm, Sweden
Contact:
Congress Secretariat
P.O. Box 3287
S-103 65 Stockholm. Sweden
Tel: +46 8 696 97 75
psych.congress.2000@psykologforbundet. se

Empirically Supported Treatments in Psychology -
Response to the Discussion Document

Thank you for taking the time to review the enclosed discussion document on empirically supported treatments in psychology. The section executive felt it was essential to obtain feedback from the full membership on the views and recommendations in this document, in order to guide future policy and development of this initiative in Canada. This document does not represent the final position of this section or CPA, at this time. To simplify the response process, we ask you to answer the questions below. Of course, you do not have to limit your response to those questions. You are welcome to write or email additional comments. Send your replies no later than **December 15, 1998.**

Please return the questionnaire to:
Dr. Lorne Sexton, Section Chair
M5 McEwen Building
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, MB. R2H 2A6

or email your responses to:
Dr. Lesley Graff, member-at-large
lgraff@exchange.hsc.mb.ca

1. Do you agree in principle with the need for evidence-based or empirically supported psychological treatments? Yes No

2. Do you have any general concerns regarding the empirically supported treatment (EST) initiative? Yes No
If yes, please describe (use additional pages if needed).

_____

_____

_____

3. Do you have any specific concerns regarding the task force report? Yes No
If yes, please describe below (use additional pages if needed).

_____

_____

_____

4a. The task force report lists twelve recommendations (pages 22-24) for future action by Canadian psychology. Please indicate your *support* or *disagreement* for each individual recommendation. The recommendations are briefly stated below; please review the full text of the recommendations in the report. The Section on Clinical Psychology should:

1) endorse APA's work on ESTs Yes No
2) encourage CPA to have Canadian representation on APA Task Force committees Yes No
3) encourage CPA to have Canadian representation in APA practice guidelines meetings or develop our own practice guidelines Yes No
4) encourage training in ESTs for doctoral & internship programs Yes No
5) encourage development of continuing education in ESTs Yes No
6) encourage knowledge & training in ESTs as a registration requirement Yes No
7) inform government health ministries about the use and limitations of ESTs and promote funding for those services Yes No

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8) inform health insurance companies about the use and limitations of ESTs Yes No

9) develop a clear public statement on the importance of evidence based treatment, but limitations in routine practice Yes No

10) encourage CPA to implement accreditation criterion and continuing education opportunities in outcome evaluation. Yes No

11) encourage national data base on treatment outcome to assess practice effectiveness Yes No

12) lobby granting agencies for funding support for treatment efficacy and effectiveness research Yes No

4b. If you answered "no" to any of the above recommendations, please indicate which recommendation(s) and elaborate on your response in the space provided below. If you answered "yes", but would like to qualify your support of a particular recommendation, please indicate the recommendation(s) and elaborate on your response. Use additional space if needed.

_____

_____

_____

_____.

5. What should be the next step for the section executive with regard to the task force report on empirically supported treatments and Canadian psychology?

a) Further discussion at the annual business meeting at CPA Yes No

b) Panel discussion/presentation in conversation session at CPA Yes No

c) Accept the report in full and recommend to CPA as policy Yes No

d) Accept the report in full, but proceed with only some of the recommendations, depending on the response from the members Yes No

e) Other suggestions _____

_____

_____

6. Please use the remaining space for any further comments, questions or concerns. Append pages if needed.

Thank you for your time and your input.