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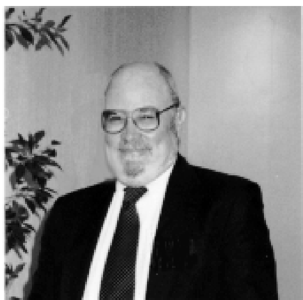
IN THIS ISSUE

- President's Column: The Society of Clinical Psychology: Proposed New Name for Division 12 1
- The Division of Clinical Psychology: A 50 Year Appraisal 3
- Proposed Changes to Division 12 Bylaws 10
- Division 12 Candidate Statements 23
- Confidentiality in the Age of Managed Care ... 30
- Confidentiality in the Age of Managed Care: From the MCO Perspective 34
- News 36
- Advertisements 38
- Instructions to Authors 40

APAGS-CEMA Presents Award to Division 12
See page 37

President's Column

The Society of Clinical Psychology: Proposed New Name for Division 12



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Elsewhere in this issue is a ballot for some proposed changes to the bylaws, one of which would officially change the name of this organization to The Society of Clinical Psychology, a Division of the American Psychological Association. This proposed name change was approved by the Division's Board of Directors and by the APA Council. It would not change the Division's number or anything about its legal relationship to APA but does convey, accurately in my opinion, the connotation that the field of clinical psychology has a certain degree of autonomy and does not exist only as a part of something else. I personally support the name change but above all encourage each member to participate in the decision about this and other proposed changes in the bylaws.

Perhaps this is an appropriate time to review the various name changes that this organization and its predecessors have been through over the last 81 years. We began as the American Association of Clinical Psychologists (AACP), founded as an independent organization in 1917. Two years later, in 1919, the AACP gave up its independence and became part of the APA as its Clinical Section. Then, in 1937, the Clinical Section of APA disbanded itself, and its members became the Clinical Section of the American Association for Applied Psychology (AAAP). The ambivalence shown by these early clinical psychologists in relation to the APA was based on the fact that in those days, APA explicitly supported the idea of psychology only "as a science". The clinicians also were concerned with "the practice of psychology".

"I personally support the name change but above all encourage each member to participate in the decision about this and other proposed changes in the bylaws"

In 1945, the old APA and the AAAP voted to merge, and this merger formed the modern APA, with its now familiar divisional structure. The Clinical Section of the AAAP was slated to become the Division of Clinical Psychology, Division 12, of the new APA. Another division

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was proposed that some readers may never have heard of. Its name was to have been the Division of Abnormal Psychology and Psychotherapy, and its number would have been Division 11. As things turned out, those who were to be members of the proposed Divisions 11 and 12 decided to join to become simply Division 12. (There is to this day no Division 11 of APA.) From 1945 to 1955, our organization was known as the Division of Clinical and Abnormal Psychology. In 1955 it acquired its present name of the Division of Clinical Psychology.

In my own previous writings, I have always traced the founding of clinical psychology to Lightner Witmer. Indeed, he was the one who founded the first psychology clinic in the world at the University of Pennsylvania in 1896. He was, so far as I know, the first to argue that the work of a psychologist should include trying to help people and not only studying them. Witmer provided clinical training to an entire generation of Ph.D. psychology students at the University of Pennsylvania. He coined the term "clinical psychology" and founded the first journal in the field, the Psychological Clinic, in 1907. I still think of Witmer as the founder of our field, but mainly of the part of it that is considered as an area of professional practice. Witmer was not the source of much rigorous clinical research, and his interventions were more like those used by special educators today rather than those of psychotherapists.

This year, in the course of my continuing historical investigations of clinical psychology, I came across a contrasting view of its history. Eugene I. Taylor, a historian of psychology in Cambridge, Massachusetts, argues that one might with some justice consider the founder of clinical psychology to be Jean Charcot, the French neurologist. Charcot after all was the first to introduce experimental psychotherapeutics to the world when he demonstrated that one could produce or remove hysterical symptoms by the use of hypnosis. In fact, Charcot was the one who thus rehabilitated hypnosis before a national commission in France in 1882. Charcot's influence on Freud is well known. Charcot also appointed Pierre Janet as the director of a psychology laboratory at the Salpetriere Hospital in Paris, in 1890. One can see in the work of Charcot and Janet the origins of a school of abnormal psychology and psychotherapy in Boston in the 1890s, including such luminaries as Morton Prince, William James, and Boris Sidis. William James in 1896 delivered the Lowell Lectures on exceptional mental states. These lectures were not published at the time, but the historian Eugene Taylor has done a service to the field by trying to reconstruct them. Morton Prince, a Boston physician, thought of psychopathology as a field that belonged to the liberal arts rather than in the medical school. He founded the Journal of Abnormal Psychology in 1906 and ultimately bequeathed it to the American Psychological Association. Prince also founded the Harvard Psychological Clinic in 1926 as a place for research activities rather than the delivery of mental health services.

One can thus see Charcot and Witmer as, perhaps, prophets whose teachings led ultimately to the plans for APA Divisions 11 and 12, and thus to the present Division 12, which, as we know, has always been a somewhat uneasy mixture of academic scientists and professional practitioners. The present proposed name change, to the Society of Clinical Psychology, is not an attempt to alter the balance of these groups in any way, but simply to recognize their autonomy in relation to other areas of science and practice. ■

Research Training Institute in Psychology of Aging

Nationally recognized experts in research methodology related to the psychology of aging will lead a training institute specifically designed for psychology faculty from 4-year colleges who received their doctoral degree at least 5 years ago. The institute, sponsored by APA's Division 20, and funded by the National Institute on Aging, aims to strengthen participants' knowledge and skills essential for developing an active agenda and integrating research in aging with teaching. The institute will be held in Duluth, MN, overlooking beautiful Lake Superior, from July 26 to August 7, 1998, with on-call consultation available during 1998-1999. In addition, participants will attend a one-week follow-up institute in summer 1999. Food, lodging, and travel support will be provided for the 15 applicants selected to participate in the program.

For details and application materials, please contact:

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Please see the web page for additional information:

http://www.css.edu/depts/drad/nia

The Division of Clinical Psychology: A 50 Year Appraisal*

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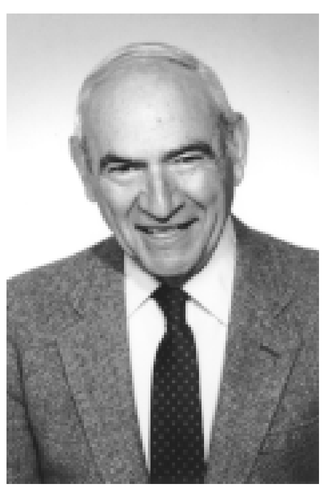

In this anniversary address, the author discusses some of the important developments and issues that have been prominent in the field of clinical psychology during the past 50 years. Among the developments have been the tremendous growth of clinical psychology, training standards, the increased participation in psychotherapy, the research contribution of clinical psychologists, increased specialization and acceptance of the field, and the significant growth in private practice. A major issue has been the increased conflict between scientists and practitioners, both in clinical psychology and in the American Psychological Association. The increase in managed care and the growth of related mental health workers has also presented problems for practitioners.

I am very pleased to have this opportunity to celebrate the golden anniversary of the Division of Clinical Psychology. Numerous and significant changes have occurred in both Division 12 and the field of clinical psychology during the past 50 years, and from the perspective of one who has observed and experienced these developments, I can truthfully say that neither I nor most of my contemporaries would have been able to predict them. Let me now discuss the developments that I believe have been of great importance for both the Division and the field of clinical psychology.

The Growth of Clinical Psychology

One of the most unexpected developments has been the phenomenal growth of psychology and clinical psychology in particular. Although the APA was formed in 1892, its early growth was slow by any standard. Almost 50 years later, in 1940, a year before I became a member, the total membership was 2,739, and only 272 members held clinical positions (Finch & Odorff, 1941). After World War II, however, the growth was phenomenal and was related in great part to the war and its aftermath. There were a large number of casualties resulting from psychopathology in our armed forces and a severe shortage of trained psychiatrists to care for them. As one response to this, clinical psychologists in the U.S. Army were commissioned as second lieutenants in the fall of 1944 and assigned to hospitals and other related military installations (Hutt & Milton, 1947). This was important historically for several reasons. Clinical psychology was officially recognized; psychotherapy was listed as a primary activity, although technically under the supervision of a psychiatrist; a number of us received our first real experience as psychotherapists; and the army's program served as a model for the subsequent activities of the Veterans Administration (VA).

The VA and, later the National Institute of Mental Health (NIMH), both made very significant contributions to the development of clinical psychology in the programs that they set up. The VA provided well-paid positions for clinical psychologists based largely on the job descriptions developed in the army, and also developed collaborative training programs with selected universities. Half time supervised traineeships for a period of four years provided both practicum experience and financial support for these university trainees. University clinical faculty also participated as consultants to the VA installations. Within a relatively short time, the VA became the largest employer of clinical psychologists in the U.S.

* *Invited Address, A Golden Anniversary of Divisions Event, Annual Meeting of the American Psychological Association, Chicago, IL, August 17, 1997.* *Address correspondence to Sol L. Garfield, PhD, Department of Psychology, Washington University, St. Louis, MO 63130.*

The NIMH also developed collaborative programs to stimulate and support the training of psychiatrists, psychiatric nurses, psychiatric social workers, and, last but not least, clinical psychologists. This program was exceedingly important for the expansion and improvement of university clinical psychology programs by providing both fellowships for graduate students and funds for some faculty salaries. Both of these programs have changed noticeably since that time, but their contribution was significant.

These first few post-war years were exciting ones as clinical psychology was beginning to grow and develop its new identity. Divisions were formed in the APA and in 1948, the Division of Clinical and Abnormal Psychology, the name of Division 12 until 1955 had grown to have 482 members (Routh, 1994). In fact, the growth of psychology was perceived as being so rapid that in 1950, Edwin Boring, a professor of psychology at Harvard University stated that if the growth curve of the APA continued, by the year 2100 AD, everyone in the United States would be a psychologist (quoted in Stanford, 1954) - a truly terrifying prediction. Luckily for all of us, Boring's prediction does not appear likely to occur. However, the membership of APA has grown to over 100,000, and Division 12, despite many fractionations, has over 6,000 members. The actual number of clinical psychologists, of course, is much larger than the number in Division 12.

Other interesting trends also became apparent as time went on. For example, in the 3-year period of 1978-1980, about 1050 clinical psychology students received their doctoral degrees each year ("Doctorate Production", 1981), and of this total of 3,353 graduates, 1414 were men and 1939 were women - another unpredicted development. This trend continues today. In 1995, almost 900 women received their doctorates in clinical psychology compared with just over 400 men. (Psychology Doctorates in Perspective, 1997).

The growth of clinical psychology has been accompanied by a number of other significant developments. One important early concern was deciding what type of training program was most desirable for clinical psychologists. Before 1946, there were no formal training programs in clinical psychology in the universities. In light of the events already described, the APA decided to implement a system of accrediting programs in clinical psychology. A Committee on Training in Clinical Psychology, chaired by David Shakow, was appointed and issued an important report in 1947. This led to the Boulder Conference in 1949 where the recommendations were discussed and guidelines for graduate training provided. The programs were to be Ph.D. programs and the clinical psychologist was to be trained as both a scientist and as a practitioner. In addition, a one-year internship was also to be required. Six academic areas were to be included and 15 positive personality attributes were listed as desirable for students planning to be clinical psychologists, which if actually used for screening purposes in the selection of graduate students would have precluded most of us from being here today! Just over 30 university training programs were approved for clinical training by APA in 1948, 45 programs in 1956, 83 in 1973, and by my calculations, 185 were approved in 1996. (APA-Accredited Doctoral Programs in Professional Psychology, 1996).

"The composition of Division 12 has changed from a more academic and research-oriented membership to a majority of clinical practitioners, particularly private practitioners."

During this 50-year period, a number of other changes have also taken place. The composition of Division 12 has changed from a more academic and research-oriented membership to a majority of clinical practitioners, particularly private practitioners. The growth of the latter has been quite significant over this period of time. In the 1940's and early 1950's, only a small percentage of Division 12 members were engaged in private practice (Garfield, 1957). However, as you know, the number of clinical psychologists engaged in private practice has increased noticeably from 23% in 1976 (Garfield & Kurtz, 1976) to 35% in 1989 (Norcross, Prochaska, & Gallagher, 1989) and to 40% in the recent survey reported by Norcross, Karg, & Prochaska, 1997.

The training of clinical psychologists has also changed in a number of important ways. Where once the Boulder model of the scientist-practitioner was the officially sanctioned model of training in clinical psychology (Raimy, 1950), today we have a variety of different training programs and even degrees and training institutions that did not exist 30 years ago. Also, it can be noted that one can't really identify the type of training by the degree a graduate has received. Independent free-standing professional schools of psychology admit much larger incoming classes of clinical students and graduate a larger number of such

students than do university programs, and do so in less time.

The growth in the number of clinical psychologists also had an impact on both Division 12 and the APA. Within the Division, conflicts between the practicing clinicians and the largely academic elected leaders of the Division were apparent, and at least in part, led to the gradual formation of a number of new divisions in APA that were clearly related to clinical practice such as Division 42 (Independent Practice), Division 31 (State Psychological Association Affairs), Division 39 (Psychoanalysis), and Division 49 (Group Psychotherapy and Group Processes). Although by 1960 (Kelly, 1961), a survey of Division 12 members indicated that psychotherapy was the primary activity of the members, for various reasons a new Division of Psychotherapy was approved by the APA Council in 1967 with many members belonging also to Division 12.

Clinical Psychology and Psychotherapy

As indicated by the 1960 survey as well as by the formation of several new divisions primarily concerned with the practice of psychotherapy, in a relatively few years psychotherapy was the primary concern of most clinical psychologists and has retained its prominence today. However, various changes have occurred with regard to the role that clinical psychology has attained in psychotherapy.

As noted previously, in the immediate post-war period psychotherapy was officially listed as a primary function of the clinical psychologist, but with certain restrictions. For example, the chief medical officer of the VA in an address delivered in 1946 stated the following:

> The clinical psychologist will also have psychotherapeutic duties, but in carrying these out, we believe he must always operate within the medical framework. This arrangement will protect him, in legal questions concerning the practice of medicine, and also make certain that the multiform inter-relationships between physical and mental diseases are under careful surveillance and control.
>
> Moreover, we believe that such therapeutic responsibilities should be delegated by psychiatrists only to clinical psychologists who are adequately trained in this field, and then only in the types of cases for which they are qualified, particularly in such fields as readjustment of habits; personality problems within the normal range; educational disabilities such as reading defects, speech impairments, or similar difficulties requiring re-education; or relatively minor psychoneurotic conditions without important somatic components (Hawley, 1946, p. 299).

Although this official view appeared to definitely restrict the psychologist's participation and role in psychotherapy, the actual reality was otherwise. Although not all psychiatric settings were the same and not all psychologists were equally competent, the need for services in the VA was so great that within a few years, psychotherapy was engaged in by psychologists with little or no supervision at all by psychiatrists. I can tell you briefly of two early illustrative incidents from my own experience. In 1945 I was chief psychologist in a U.S. Army hospital when the hospital received an order from army headquarters in Washington DC requiring the hospital to appoint, immediately, a director of group psychotherapy to institute a group therapy program. Despite what the regulations said, guess who was appointed? I was, and received no supervision whatsoever. To tell you the truth I would have welcomed it. In my nine years in the VA I never received any psychiatric supervision, I had friendly relations with all the psychiatrists with whom I worked, and, in my first VA hospital in 1946, I was asked again to conduct group psychotherapy with schizophrenic patients in addition to my other duties.

Since that early period, things have changed drastically with many interrelated developments. Fifty or so years ago, psychiatrists were the main participants in psychotherapy. Not only have we overtaken them in this activity, but today it seems like everybody is doing it - "clinical psychologists, counseling psychologists, guidance counselors, marriage and family therapists, pastoral counselors, psychiatric social workers, psychiatric nurses, addiction counselors, so-called mental health workers, columnists, TV entertainers, and the like. It looks like everybody knows a good thing." (Garfield, 1994, P. 64). Even psychics are now participating according to an article in the January 5, 1997 issue of the St. Louis Post-Dispatch:

> Psychics are being looked to for their abilities not only to predict the future but also to counsel people...We're sort of a poor man's psychiatrist... (p. 2E).

The possible formation of a separate autonomous profession of psychotherapy was discussed in the past, and a three-day conference was held in New York in 1963. Thirty-two participants representing the fields of clinical psychology, psychiatry, psychoanalysis, and social work presented their views of what an ideal program of training

for psychotherapists should be and Robert Holt (1971) edited a book length report. As is evident today, the single autonomous profession of psychotherapy never became a reality, and I think today we can say with some degree of confidence that such a possibility is highly unlikely. The variety of help givers that now function in the broad field of psychotherapy and counseling does not appear likely to diminish in the near future. Thus, although psychotherapy is a primary professional activity of the clinical psychologist, it is not an exclusive function, but is shared, willingly or not, with many other groups and professions.

In addition to a diversity of types of practitioners of psychotherapy, we have also witnessed a tremendous growth in the different types of psychotherapy. As I have remarked on other occasions, this has been an unexpected and bewildering development. When I was a graduate student, we learned about Freud, Adler, and Jung. A few years later, a newcomer by the name of Carl Rogers appeared. In the mid-1960's, however, I collected around 60 different types or forms of psychotherapy and I thought this was "mind-boggling." However, as many of you know, this was just the beginning of this free enterprise development. In 1975, a report of the Research Task Force of the National Institute of Mental Health stated that there were now more than 125 different forms of psychotherapy available. This was followed by Herink's book in 1980, which listed over 250 different forms of psychotherapy, and just a few years later, Karasu (1986) referred to over 400 techniques. Needless to say, not all of them are taught in our approved clinical programs - and this proliferation is in addition to a variety of eclectic and integrative approaches to psychotherapy (Garfield, 1995; Norcross & Goldfried, 1992).

At the same time that all of these unexpected developments took place, some critics were raising doubts about the effectiveness of psychotherapy and ushering in the "age of accountability." Critical books were published by Tennov (1975) and Gross (1978) in the 1970's, by Masson in 1988, and in 1992 Dryden and Feltham modified a title of one of Freud's books and published *Psychotherapy and its Discontents*. Although these books contained strong criticisms of psychotherapy, and psychoanalysis especially, I personally don't believe that they have really had a strong impact on the field of clinical psychology and the members of Division 12, and I also believe that the body of existing research on the effectiveness of psychotherapy is largely responsible for this situation. Here I would also acknowledge the worth of the research training that graduates of university clinical programs received. In my completely unbiased view, clinical psychologists, largely members of this division, have made a major contribution in this area and have contributed greatly to the acceptance of clinical psychologists as significant participants in the field of psychotherapy.

However, there are two recent developments that also are clearly of some importance, particularly to clinical psychologists in private practice. One is the entire area of managed care and its impact on the practice of psychotherapy. Decisions as to length or type of psychotherapy as well as decisions on case management may be made by lesser-trained individuals and pose potential threats to the therapeutic relationship and its confidentiality. Since many of you have more direct experience with these critical matters than I do, I will do no more than just call attention to their importance here.

The other related development concerns the Division 12 task force report on validated or empirically supported forms of therapy (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Since I published an article on this report in the Division's journal, *Clinical Psychology: Science and Practice* (Garfield, 1996), and since a special section on the same topic has recently appeared in the *Journal of Consulting and Clinical Psychology*, my comments again will be brief.

I do believe strongly in empirical verification of our clinical procedures and in training our graduate students to value and respect empirical findings as an important basis for their clinical work. However, the possible implication that so-called "validated" therapies based on psychiatric diagnosis might be used for accreditation of training concerned me. First, there are many individuals who may not meet *DSM-IV* diagnoses, but who could be helped by psychotherapy. Second, the emphasis on type of therapy also tends to minimize the significance of patient and therapist variability. Furthermore, to do a decent job of training requires adequate time and thus only a few forms of therapy based on specific psychiatric diagnoses could be learned. How would these forms of therapy be selected? Would graduates of training programs be limited to working only with patients with the selected diagnoses? As one who has participated in both training and research in psychotherapy, as well as practice, this recent development did lead me to react with some critical comments, even though I value the emphasis on empirical verification of clinical procedures.

Other Developments: Science vs. Practice

As alluded to earlier, with the growth of clinical psychology and the increase in the number engaged in pri-

vate practice, there was also an increase in the tensions and conflicts between academic and scientifically oriented psychologists and clinical practitioners, both within Division 12 and within the APA as a whole. This change in the composition of APA also took place rather rapidly. By 1955, the Division of Clinical Psychology had almost three times as many members as the Division of Experimental Psychology, and as Kenneth E. Clark noted in his survey of America's psychologists at the time: "contrasted to the early days of APA, this is a startling shift, with many effects on the nature of the field and of the APA" (1957, pp. 17-18). Truer words were never spoken!

There were several indications of dissatisfaction and internal conflicts as time progressed. In 1959, for example, Kelly and Goldberg published a survey of clinical psychologists who had been VA trainees earlier. A surprising 40% of these psychologists indicated that they would select a different career if they had the chance to do it over. However, this pattern of dissatisfaction did not appear to continue. In a later survey of 855 members of Division 12 that I conducted with Kurtz in 1976, 90% of those surveyed indicated they were "quite satisfied" or "very satisfied." (Garfield & Kurtz, 1976). At the same time, however, there were indications of different value systems between the more research-oriented members of the Division and those primarily concerned with practice. Of interest here is an old study of members of Division 12 conducted by Shaffer (1953), an early president of this division. A scale to evaluate "intuitive" versus "objective" viewpoints was developed and given to this sample. Although the overall dispersion of scores was not very great, on a few items differences could be noted when comparing the most intuitive 27% with the most objective 27% of the sample. Two items were particularly discriminating:

1. The time which graduate students of clinical psychology now spend learning research methods would be more profitably spent in obtaining first-hand clinical experience.
2. One good test of statistical significance is more convincing than a lot of clinical intuitions. (Shaffer, 1953, p. 611).

As perhaps, you may have expected, 59% of the intuitive group agreed with the first item while 94% of the objective group disagreed. In terms of the second item, only 1% of the intuitive group agreed as compared with 43% of the objective group. There was also some relationship between these attitudes and the type of position held by the psychologist:

> "Psychologists who reported that their main duty was diagnosis or psychotherapy held intuitively tinged attitudes. Research was strongly associated with an objective attitude, teaching a little less so. (Shaffer, 1953, p. 615)."

The study of 855 members of Division 12 that Kurtz and I did over 20 years later found very similar results for these two items. (Garfield & Kurtz, 1976).

These value differences and conflicts are still with us, are clearly important, and in terms of more recent events, have become significantly more acute. Since our recent history is known to most of you, I will again just offer a few comments. The growing conflict between scientific psychology and professional, mainly clinical and private practice psychology, has led to the formation of the American Psychological Society (APS) in 1988 as an association of scientific psychologists. Although many members of this new organization have retained their membership in APA, the fact that the new society has grown to over 16,000 members and includes some very distinguished psychologists who have resigned from APA, reflects the seriousness of this conflict between scientific and professional psychologists.

One other recent indication of this conflict can also be mentioned. A new association of clinical and applied psychologists has been formed recently called the American Association of Applied and Preventative Psychology (AAAPP). This group is affiliated with APS and holds meetings in conjunction with that group. Some of the charter members of this group are very distinguished clinical psychologists, several of them former presidents of both Division 12 and the APA. Thus, both within psychology and clinical psychology, there has been an increased divide between those with scientific - research interests and those primarily concerned with issues of practice, particularly private practice.

These developments highlight the increased differences between the psychological scientists and the psychological clinical practitioners in terms of interests, activities, organizations, values, occupational milieus, journals, and the like. If shared interests and activities diminish, it is likely that the groups involved will also change their perceptions of each other, and usually in a more critical direction. As one who has long been identified with the Scientist-Practitioner model in clinical psychology, these conflicts between the two groups of psychologists has been a very disappointing development.

Growth and Specialization

Along with the visible growth of clinical psychology has come increasing specialization. Evidence of this was apparent in Division 12 with the formation of sections of the Division. As Don Routh (1994) points out, former Division 12 president E. Lowell Kelly proposed in 1960 that sections should be allowed to be formed to cope with the increased heterogeneity of its membership. The first section formed was the section on Clinical Child Psychology in 1962. Other sections were formed in the years that followed, and some have become either separate divisions or joined other divisions.

In more recent years we have witnessed other indications of specialization in clinical psychology in both predoctoral and post-doctoral training programs. As I have commented in a previous article:

> ...The new areas of specialization also have led to a greater diversity in the settings in which clinical psychologists work. For example, some clinical child psychologists have full-time faculty positions in university medical school departments of pediatrics. Other clinical psychologists have become members of departments of physical medicine and rehabilitation in medical schools and hospitals. One of the most visible developing areas is that of behavioral medicine and health psychology, a specialty area that deals with the applications of psychology to many types of illness as well as to the prevention of illness and the fostering of good health (Pomerleau & Rodin, 1986). Other psychologists have functioned as consultants to departments of internal medicine and surgery. Somewhat related is the development of the current specialty of neuropsychology, which is now viewed as a specific track or area of specialization in a number of graduate programs in departments of psychology as well as in departments of psychiatry or neuroscience. Neuropsychologists are engaged in both diagnostic and treatment activities as well as in research. Aging is another active area of psychology that has received special recognition and support from federal agencies. (Garfield, 1992, p. 13).

Well, time marches on, and so does clinical psychology.

Concluding Comments

In the past 50 years, as I have indicated, both unanticipated growth and unanticipated developments have occurred in the field of clinical psychology. From the small and slowly developing field that Lightner Witmer called clinical psychology in 1896, clinical psychology is now a large, prosperous, and recognized area of practice and research in the areas of psychopathology and mental health. To paraphrase a popular expression, "We've come a long way, baby." Without question, there are many aspects of this growth and development that we can take pride in and point to with real satisfaction. In the area of psychotherapy, for example, clinical psychologists have contributed innovative procedures, have played a leadership role in research, and in general have brought a more rigorous and empirically oriented emphasis to this area. As I have already mentioned, one could not have predicted this 50 years ago when our role was a much more limited one.

But, of course, all is not gold that glitters. The conflicts between the science of psychology and the largely private practice of clinical psychology are serious and have potentially damaging consequences. In my presidential address to Division 12 in 1965 I also commented on the progress made in the preceding 20 years and on the "increased disharmony between the science and profession of psychology" (Garfield, 1966, p. 354). In fact, these internal conflicts within psychology seemed at times to be more serious than the conflicts with the medical profession over such matters as professional role and licensing. Such value conflicts have actually increased since that time and have been visible in the power struggles within APA, various lobbying activities, and the composition of state psychological associations. There are of course, other concerns to practicing clinicians such as HMO's, third party payments, the practice of psychotherapy by a variety of non-doctoral practitioners, and related items that may be viewed more seriously than those pertaining to scientific psychology. However, for at least some of us, the latter is of some importance and is tied to the uniqueness of clinical psychology and its contribution to society. What distinguished clinical psychologists from all the other lesser clinical practitioners was our research training.

However, despite the potential problems we face, clinical psychology remains a vibrant scientific and professional field. I, personally, have been fortunate to have entered the field when it was just beginning to grow and become the important field that it currently is. During my 50 plus years in the field I have enjoyed both research and practice, and for 10 years was privileged to carry out official duties for the Division of Clinical Psychology. I am proud to have participated in the development of clinical psychology during our 50-year growth period and I wish the best for the future of our field and the Division of Clinical Psychology. ■

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DIVISION OF CLINICAL PSYCHOLOGY
American Psychological Association
April, 1998

Dear Colleague:

During the last year the Division 12 Board of Directors has been planning some changes, three of which require By-laws amendments:

1. Change the name of the division to *The Society of Clinical Psychology, a Division of the American Psychological Association* (Article I, Section A, and throughout). We believe this more accurately reflects who we are and what we do. The name change would not alter the relationship between the division and APA in any way. We have followed the APA procedure for a division name change, and are now ready for a membership vote.

2. Add a membership class of *Foreign Affiliates* (Article II, Section A; et seq as necessary). We decided to do this in response to a number of inquiries about affiliation from individuals and organizations in other countries. Like Student Affiliates, *Foreign Affiliates* would not vote and would not be eligible to hold office.

3. Add a standing committee, the *Committee on Science and Practice* (Article VII, Section D, new paragraph 10). The Board believed that the work of two of our Task Forces (Psychological Interventions and Effective Psychosocial Interventions: A Lifespan Perspective), should be an on-going initiative of the Division. The new committee will combine the two task forces and further develop and expand their work.

We have taken this opportunity to do a thorough review of the By-laws and make two other kinds of changes:

4. Give the Board of Directors the authority to set the special assessment (Article X, Section B). Division 12 is probably the only organization you belong to that requires a membership vote to set dues. The Board of Directors has no plan to raise the assessment in the foreseeable future, because such increases lead to members' resignations, which is counterproductive. However, inflation is still with us - for example, postage for both the Journal and the newsletter will probably be raised this year - and when an increase does become absolutely necessary, the Board could be ham-strung by having to wait for a ballot to be prepared and distributed.

5. Housekeeping changes throughout to make the document consistent with current practice and APA style:

   - Recognize that APA Council Representatives' terms are now defined by calendar years, not by February meetings, as in the past. (Article V).
   - Recognize that APA now conducts a Divisions' elections (Article VIII, Section E).
   - Recognize that we have a membership meeting, not strictly a "business" meeting at the convention, and that there is no longer a "second business meeting", because we no longer have a mid-winter program. (Article IX, Section B and old Sections C and D).
   - Recognize that we no longer require the Treasurer to be bonded (Article IV, Section E), and that the Sections' fiscal responsibilities (especially regarding federal tax filing) have changed. (Article VI, Section J, Paragraph 2).
   - Make the following changes throughout: "President-Elect" to "President-elect"; "Past-President" to "Past President"; "Chairperson" to "Chair"; eliminate "he/she", "him/her", etc. wherever possible.

In the By-laws that follow, additions are indicated in *italics* and deletions are indicated by [brackets].

PLEASE DETACH THE POSTCARD AND RETURN IT TO THE CENTRAL OFFICE FOR CONFIDENTIAL PROCESSING. DON'T FORGET TO SIGN IT!

Sincerely,

Donald K. Routh, PhD	Gloria Gottsegen, PhD	Laura C. Toomey, PhD
President	Co-chair, By-laws Committee	Co-chair, By-laws Committe

BYLAWS of the [DIVISION] *SOCIETY* OF CLINICAL PSYCHOLOGY
(DIVISION 12) of the AMERICAN PSYCHOLOGICAL ASSOCIATION

As Amended November, 1997

ARTICLE I
NAME AND PURPOSE

A. The name of this organization shall be the [Division] *Society* of Clinical Psychology (Division 12) of the American Psychological Association.

B. The purpose of this Society shall be to promote the general objectives of the American Psychological Association and to support and to encourage the evolution and development of the [specialty] *field* of Clinical Psychology in both its scientific and professional aspects.

C. Definition and Description of the Field

1. Knowledge Base and Professional Skills in Clinical Psychology: The field of Clinical Psychology involves research, teaching and services relevant to the applications of principles, methods, and procedures for understanding, predicting, and alleviating intellectual, emotional, biological, psychological, social and behavioral maladjustment, disability and discomfort, applied to a wide range of client populations. In theory, training, and practice, Clinical Psychology strives to recognize the importance of diversity and strives to understand the roles of gender, culture, ethnicity, race, sexual orientation, and other dimensions of diversity. Skills include, but are not limited to:

   a. Assessing and/or diagnosing the nature and causes and predicting the effects of subjective distress; of personal, social, and work dysfunctions; and of the psychological and emotional factors involved in, and consequent to, physical disease and disability. Procedures may include but are not limited to, interviewing, behavioral assessment, administering and interpreting tests of intellectual and cognitive abilities, aptitudes, emotions, motivations, personality characteristics, and other aspects of human experience and behavior relative to disturbance.

   b. Intervening at the primary, secondary and tertiary levels. This includes interventions directed at preventing, treating, and correcting the psychopathology, emotional conflicts, personality disturbances, and skills deficits underlying a person's distress and/or dysfunction. In addition to the treatment of diagnosed mental disorders, it also includes interventions to promote health and adjustment. Interventions may reflect a variety of theoretical orientations, techniques, and modalities. These may include, but are not limited to, psychotherapy, psychoanalysis, behavioral therapy, marital and family therapy, group therapy, social learning approaches, biofeedback, cognitive retraining and rehabilitation, and environmental consultation and design. Psychopathology is intended here to be interpreted broadly to include and transcend traditional categories of mental illness (e.g., the disorders of the Diagnostic and Statistical Manual of Mental Disorders). Included are all areas of mental, emotional, behavioral and psychological patterns that produce distress, dysfunction, disorder or disease. Clinical Psychological intervention promotes satisfaction, adaptation, social order and health.

   c. Professional consultation, program development, supervision, administration, and evaluation of clinical psychological services.

   d. The knowledge base of Clinical Psychology includes many areas that are not within the expertise of every Clinical Psychologist. An important example is the analysis, development and implementation of public policy in all areas relevant to the field of Clinical Psychology.

2. Areas of Knowledge in Clinical Psychology: The broad general areas of psychological knowledge not unique to Clinical Psychology are spelled out in many documents, such as the current criteria for doctoral program accreditation of the APA and the National Register of Health Service Providers in Psychology criteria for psychology graduate programs. They include course work in the biological, social, and cognitive/affective bases of behavior and in individual differences. Clinical Psychology has a focus on advanced work in the areas of personality and psychopathology. This work includes the full span of psychopathological disorders and conditions, their etiolo-

gies, their environments, their degrees of severity, their developmental levels, and the appropriate assessments and interventions that are associated with these conditions. Substantial course work in the areas of personality and psychopathology helps the Clinical Psychologist work toward a comprehensive understanding of normal and abnormal adjustment and maladjustment across the life-span. The Clinical Psychologist should be educated and trained to generate and integrate scientific and professional knowledge, attitude, and skills so as to further psychological science, the professional practice of psychology, and human welfare.

3. Major Skill Areas in the Field of Clinical Psychology include:

   a. Assessment: Assessment of adjustment and maladjustment involves the interviewing of the client/patient and often of significant others. It also involves being able to make appropriate behavioral observations, and to administer a wide range of psychological tests and techniques designed to assess the individual's intellectual, cognitive, emotional, and behavioral functioning. The ability to assess not only individuals but also group and family processes is another important capability of many Clinical Psychologists. Appropriate assessment involves selection of assessment methods, taking into account the applicability of norms and standards to particular populations, appropriate application of assessment tools, interpretation of results of individual tests, integration of results, and the recognition of psychological strengths in addition to psychological deficits. Preparation in Clinical Psychology ordinarily includes substantial course work in assessment plus additional supervised practica. Proper consideration should be given to issues relating to the appropriate use of assessments for special populations.

   b. Intervention: Formulation of an appropriate plan for treatment or intervention involves integration of knowledge of the client's adjustment and/or maladjustment from appropriate assessment, and theoretical and empirical understanding of adjustment and/or maladjustment, and from knowledge of intervention and treatment choices.

      Intervention involves informing the client of the treatment plan and options; establishing a working, collaborative relationship with the client/patient; the ability to implement the treatment plan over an appropriate period of time; evaluating the effectiveness of the program, and making changes in the treatment plan where appropriate. Preparation in Clinical Psychology ordinarily includes substantial course work in intervention techniques plus appropriate supervised practica. Due consideration should be given to issues relating to the appropriate use of treatments for special populations.

   c. Consultation with other professionals and nonprofessionals.

   d. The skill areas in Clinical Psychology include many areas that are not within the expertise of every Clinical Psychologist. Important examples are program development, supervision, administration of psychological services, and evaluation and planning of these services.

   e. The conduct of research contributing to knowledge in all the above areas, a formal demonstration of research skills, and knowledge of research methods is part of training in Clinical Psychology.

   f. Knowledge of ethical and professional standards and application of these in a consistent manner.

4. Populations: The Clinical Psychology profession includes Clinical Psychologists who deal with a wide variety of populations. The Clinical Psychology profession includes Clinical Psychologists who deal with the full range of adjustment and maladjustment from individuals with minor problems of living to seriously disturbed individuals requiring institutionalization. The Clinical Psychology profession includes Clinical Psychologists who deal with individuals at all developmental levels including infants and geriatric patients and who may work with a single individual or with groups (families, patients of similar psychopathology, organizations). In addition to those patients/clients who are maladjusted or mentally ill, Clinical Psychologists work with those with medical problems and disabilities where they help the patient adjust to their disability and altered life style. Clinical Psychologists also work with persons without mental illness to promote their adaptation, adjustments and personal development. The inclusion of individuals from special populations attests to the breadth and diversity of the field.

5. Service Settings: Clinical Psychologists, as well as other psychologists, work in a variety of settings including individual practice, mental health facilities and service units, managed health care organizations, hospitals, long term care facilities, rehabilitation centers, schools, universities, industries, legal systems, medical departments, counseling centers, government agencies, and military services.

6. Skill Areas in Clinical Psychology: No single skill is unique to Clinical Psychology. The uniqueness of Clinical Psychology comes from the fact that the field brings the integration of science, theory, and practice to bear on populations manifesting a wide range of physical health/illness, adjustment and/or maladjustment, and/or psychopathology. Clinical Psychologists use a wide variety of assessment, treatment, and intervention modalities. It is not only that the variety characterizes the field, but that individual Clinical Psychologists are broadly trained.
7. Education and Training Programs in this Field: We believe the APA accreditation process is the most reliable criterion for an appropriate training program.
8. Public Need and Pattern of Practice of Clinical Psychology: Epidemiological evidence suggests that psychopathology, maladjustment, and distress are wide spread throughout the world and, thus, Clinical Psychological services are widely needed.
9. Services Provided by Clinical Psychologists: Clinical Psychologists perform a wide range of activities in many different settings.
10. Efficacy of Clinical Psychological Activities: Research documenting the efficacy of Clinical Psychological activities is found in many journals including the Journal of Clinical Child Psychology, the Journal of Pediatric Psychology, the Journal of Abnormal Psychology, the Journal of Consulting and Clinical Psychology, Clinical Psychology: Science and Practice, and The Clinical Psychologist, among others. The contents of these journals, and other reputable psychological journals, report the empirical base of Clinical Psychology.
11. Ongoing Evaluation of Clinical Psychology: Clinical Psychology training programs engage in annual self-study as part of APA accreditation procedures.
12. Assessment and Identification of Qualifications for Practice in Clinical Psychology: Currently there are three widely recognized mechanisms for the identification of qualifications for practice in Clinical Psychology. Other mechanisms are available for specific purposes.
    a. Clinical Psychology programs are accredited by the American Psychological Association. Earned doctorates from Clinical Psychology programs represent a significant credential establishing participation in the field of Clinical Psychology.
    b. Licensing/certification as a Clinical Psychologist is a second form of identification, at least in some states. It should be noted that in many jurisdictions, licensure/certification is generic (i.e., one is licensed/certified as a psychologist and required legally and ethically to limit one's practice to areas of defined competence).
    c. At the advanced level is the American Board of Professional Psychology (ABPP) diploma in Clinical Psychology. Clinical Psychologists who apply for the diplomate status undertake a thorough evaluation by their peers on their knowledge and skills in Clinical Psychology.

ARTICLE II
MEMBERSHIP

A. There shall be [three] *four* categories of membership in the [Division] *Society* of Clinical Psychology: Member, Fellow, *Foreign Affiliate*, and Student Affiliate.

B. The minimum qualifications for election to the category of Member shall be:

1. Attainment of the category of Member or Fellow of the American Psychological Association;
2. Demonstrated interest in and active engagement in practice, research, teaching, administration and/or study in the field of Clinical Psychology with training appropriate to the conduct of such clinical activities as defined by the Council of Representatives of the American Psychological Association.

C. The minimum qualifications for election to the category of Fellow shall be:

1. Attainment of the category of Member of the [Division] *Society* of Clinical Psychology;
2. Nomination to the category of Fellow by the [Division's] *Society's* Committee on Fellowship and ratification of the nomination by the Division's Board of Directors, such nomination and ratification to be conducted in accordance with extant Bylaws and Association Rules of the American Psychological Association.

3. In order to be nominated by the [Division's] *Society's* Committee on Fellowship, a Member must be endorsed to the Committee by at least three (3) Fellows of APA, at least two of whom must be Fellows of the [Division] *Society* of Clinical Psychology;
4. Recommendations for Fellowship must be based upon the Member's having made an outstanding contribution to the science and/or to the profession of Clinical Psychology as attested to by the following:
   a. Prior status as a Member for at least one (1) year;
   b. Documentation of the ways in which the Member's activities, contributions, and/or performance have had a discernible and salutary effect on the development of Clinical Psychology as a science and/or as a profession.

D. *The minimum qualifications for election to the category of Foreign Affiliate shall be:*
1. *Attainment of the category of Foreign Affiliate of the American Psychological Association;*
2. *Demonstrated interest in and active engagement in practice, research, teaching, administration, and/or study in the field of Clinical Psychology.*

E. Persons enrolled in a graduate program or school of recognized standing and in a training sequence in Clinical Psychology may be accepted as a Student Affiliate of the [Division] *Society*.

[E.]*F.* A two-thirds (2/3) vote of the Membership Committee or of the Committee on Fellowship shall constitute a recommendation from those committees to the Board of Directors and shall be required to confirm recommendations for any category of membership.

[F.]*G*. The Secretary shall be responsible for communicating the actions of the Board of Directors with respect to the various categories of membership to the applicants in a timely fashion.

ARTICLE III
MEMBERSHIP RIGHTS AND PRIVILEGES

A. Members and Fellows of the [Division] *Society* of Clinical Psychology shall be entitled to the following:
1. To attend and to participate in the meetings of the [Division] *Society*;
2. To receive the publications *and communications* of the [Division] *Society*;
3. To hold office and to serve on committees of the [Division] *Society*.
4. To vote in regular and special elections.

B. *Foreign Affiliates* and Student Affiliates of the [Division] *Society* shall:
1. Be entitled to attend and to participate in the meetings of the [Division] *Society* and to receive its publications and communications;
2. Not be entitled to hold office, serve as voting members of Committees of the [Division] *Society*, nor vote in regular or special elections.

ARTICLE IV
OFFICERS

A. The Officers of the [Division] *Society* shall be a President, President-elect, a Past President, a Secretary, and a Treasurer.
1. No individual may run simultaneously for more than one elected [Division 12] Society office or Board of Director seat.
2. No individual may simultaneously hold two elected seats on the Board of Directors.
3. The Secretary and Treasurer offices may be held by an individual for no more than two terms, which may be consecutive.
4. No individual may hold the office of President more than once.

B. The President shall be the Fellow or Member who has just completed [his/her] *a* term as President-elect, [S/he] shall succeed to office by declaration at the close of the year after [his/her] election as President-elect, and shall serve for one year. The President shall preside at all meetings, shall be the Chair of the Board of Directors and shall perform all other usual duties of a presiding officer.

C. The President-elect shall be a Fellow or Member of the [Division] *Society*, elected for a term of one year. The President-elect shall be a member of the Board of Directors with the right to vote, and shall perform the duties traditionally assigned to a Vice-President. In the event that the President shall not serve [his/her]*a* full term for any reason, the President-elect shall succeed to the unexpired remainder thereof and continue to so serve through his/her own term.

D. The Secretary shall be a Fellow or Member of the [Division] *Society* elected for a term of three years. [During his/her term, s/he] *The Secretary* shall be a member and the Secretary of the Board of Directors with right to vote, shall safeguard all records of the [Division] *Society*, shall keep the minutes of the meetings of the [Division] *Society* and of the Board of Directors, shall assist the President in preparing the agenda for business meetings of the [Division] *Society* and of the Board of Directors, shall maintain coordination with the Central Office of the American Psychological Association, shall issue calls and notices of meetings, shall inform the membership of action taken by the Board of Directors and shall perform all other usual duties of a Secretary.

E. The Treasurer shall be a Fellow or Member of the [Division] *Society* elected for a term of three years. [During his/her term, s/he] *The Treasurer* shall be a member of the Board of Directors with right to vote, shall oversee custody of all funds and property of the [Division] *Society*, shall oversee the receipt of all money to the [Division] *Society*, shall direct disbursements as provided under the terms of these Bylaws, shall oversee the keeping of adequate accounts, shall aid the President and Board of Directors in the preparation of the annual budget, shall make an annual financial report to the [Division] *Society*, *shall prepare any forms required by the Internal Revenue Service*, and in general shall perform the usual duties of a Treasurer.

[1. The Treasurer shall be bonded in an amount and manner sufficient to protect all financial interests of the Division.

2. It shall be the duty of an incumbent Treasurer to arrange for bonding his or her successor before leaving office.

3. Should the Treasurer be incapable of performing the duty of bonding his or her successor, it shall become the responsibility of the President to make the necessary arrangements.]

F. The Past President of the [Division] *Society* shall be the most recently retired President of the [Division] *Society*, shall serve as a member of the Board of Directors with the right to vote, shall serve ex-officio with vote as Chair of the Committee on Nominations and Elections, and as Chair of the Committee on APA Policy Issues.

G. The Officers shall assume their positions on January 1 of each calendar year and shall maintain them until their successors are seated. During the period between their election and the assumption of office, the officers shall be given the title of officer-designate and shall be ex-officio members of the Board of Directors without vote.

H. In the case of death, incapacity, or resignation of any officer, except the President or the Past President, the vacant office shall be awarded to the defeated candidate for the position who was, at the time of the most recent past election the runner-up for the office in question. If the runner-up declines to serve or is for any other reason unavailable, the Board of Directors shall, by majority vote, elect a successor to serve [until the next annual meeting] *for the remainder of the calendar year* and*, if necessary* shall also undertake to conduct a special election from among eligible members to secure a permanent incumbent who shall complete the unexpired term.

I. The means for filling a vacancy in the office of President is specified in Article IV, Section C of These Bylaws. In the case of death, incapacity, or resignation of the Past President, such vacancy shall remain through the balance of the year in which it occurs.

ARTICLE V
BOARD OF DIRECTORS

A. There shall be a Board of Directors of the [Division] *Society* of Clinical Psychology. Its membership shall consist of the following persons:

1. The Officers of the [Division] *Society* as specified in Article IV, Sections A through F of these Bylaws.

2. Representatives to *the* APA Council of Representatives as specified in Article V, Section C of these Bylaws[;]. *They shall assume their positions on January 1 of the year following their election to office and shall maintain them until their successors are seated (or until incumbency must be terminated as described in Article V, Section B, paragraph 2). During the period between their election and the assumption of office, the Representatives shall be given the title of Representative-designate and shall be ex-officio members of the Board of Directors without vote.*

3. An elected Representative to the [Division] *Society* Board of Directors from each Section of the [Division] *Society* (as defined in Article VI, Section I of these Bylaws), elected by members of the Section who are themselves Fellows or Members of [Division 12] *the Society*. *They shall assume their positions on January 1 of the year following their election to office and shall maintain them until their successors are seated.* During the period between their election and the assumption of office, the Representatives to the [Division] *Society* Board of Directors from the Sections shall be given the title of Section Representative-Designate and shall be ex-officio members of the Board of Directors without vote;

4. The [Editor(s)] Editors of the [Division] *Society* newsletter and the [Division] *Society* journal who shall be [member(s)] members of the Board of Directors without vote. The [editor(s)] Editors shall be appointed by the President with the concurrence of the Board of Directors. The newsletter editor shall serve a four (4) year non-renewable term. The journal editor shall serve a five (5) year non-renewable term.

[B. The members of the Board of Directors shall assume their position on January 1 of the year following their election to office and shall maintain them until their successors are seated.]

[C.] B. The [Division] *Society* shall elect each year that number of Representatives to APA Council necessary to fill vacancies created by the ending of terms of current Council Representatives and/or vacancies created by changes in the APA apportionment ballot. Consistent with the APA Bylaws, Representatives to APA Council must be Members or Fellows of the [Division] *Society* and are ordinarily elected for a three (3) year term. The Representatives to APA Council shall perform those duties required of Council Representatives as specified in the Bylaws of the American Psychological Association. The [Division's] *Society's* Representatives to APA Council shall be members of the Board of Directors with vote. They shall be responsible for advising the Board of Directors about significant matters of business scheduled to come before APA Council. They shall also be responsible for informing the Board of Directors of significant actions taken by APA Council.

[1. Representatives to APA Council shall assume office at the close of the adjourned meeting of Council held in the year following their election. During the period between their election and the assumption of their office, they shall be given the title of Representative-Designate and shall be members of the Board of Directors without vote.]

[2.] 1. In the case of death, incapacity, or resignation of any Representative to APA Council, the vacant office shall be awarded to the defeated candidate who was, at the time of the most recent past election the runner-up in the election for Council seats. If the runner-up declines to serve or is for any other reason unavailable, the Board of Directors shall, by majority vote, elect a successor to serve [until the next annual meeting] *for the remainder of the calendar year* and*, if necessary,* shall also undertake to conduct a special election from among eligible members to secure an incumbent who shall complete the unexpired term.

[3.] *2*. If the [Division] *Society* loses one or more of its seats on APA Council as a result of that association's annual reapportionment, and if the loss cannot be offset by the ending of a term or terms of outgoing Representatives to APA Council, then the Board of Directors shall terminate the incumbency of the required number of Representatives elected most recently in inverse order of their having been declared elected.

[D.] *C*. The duties of the Board of Directors shall include:

1. Exercising full power and authority over the affairs of the [Division] *Society*, and the transaction of the necessary business of the [Division] *Society* provided, however, that the actions of the Board of Directors shall not conflict with these Bylaws or with the recorded votes of the membership;
2. Reporting of its activities to the members, and recommending matters for the consideration of the membership;
3. Approving the formation of or dissolving Sections;

4. Filling such vacancies [in any Office] of the [Division] *Society*, as so empowered under the terms of Article IV, Sections H and I *and Article V, Section B, paragraph 1* of these Bylaws;
5. Advising the President regarding the appointment of Chairs and members of Committees of the [Division] *Society* in accordance with these Bylaws;
6. Advising the Officers of the [Division] *Society* regarding the performance of their duties;
7. Advising the Representatives to APA Council as to matters concerning the relationship between the [Division] *Society* and the American Psychological Association and on issues either currently before or which may be desirable to place before APA Council;
8. Ratifying new Members to election on recommendation of the Committee on Membership, and new Fellows on recommendation of the Committee on Fellowship;
9. Adopting an annual budget;
10. Recommending or approving the disbursement of funds of the [Division] *Society* in accordance with Article X of these Bylaws;
11. Advising the President regarding the appointment of the Editor of any of the [Division's] *Society's* publications;
12. Setting policies for the conduct of its own affairs or for the affairs of the [Division] *Society*, provided, however, that such policies are not in conflict with any of the terms of these Bylaws.

[E.] *D.* The Board of Directors shall meet at least twice each year. Additional meetings may be called by the President with the concurrence of the Board of Directors.

[F.] *E.* Board of Directors meetings shall be open to all members of the [Division] *Society* except at such times as a majority of the Board of Directors may declare an executive session for the purpose of reviewing matters of personnel. Any member of the [Division] *Society* may place a matter on the agenda for a meeting. The President shall preside over the meetings of the Board of Directors, and the Secretary shall act as Recording Secretary. A majority of the voting members of the Board of Directors shall constitute a quorum, following due notice of the meeting. Each member present shall have one vote, and no member may vote by proxy. All decisions of the Board shall require assent by a majority of those voting, except as otherwise noted in these Bylaws. The Board of Directors shall be authorized to adopt and publish rules and codes for the transaction of the business of the [Division] *Society* in accordance with these Bylaws.

[G.] *F.* There shall be an Executive Committee of the Board of Directors which shall be composed of the President, President-elect, Past President, Secretary and Treasurer. The Executive Committee shall meet on the call of the President or of any other three Officers and conduct such affairs of the [Division] *Society* between meetings of the Board of Directors as may be needed to implement policy decisions adopted by the Board of Directors. During the interval between meetings, and should the Executive Committee declare there to be an emergency requiring immediate action, a mail or telephone ballot may be taken on the emergency matter from the full Board of Directors.

[H.] *G.* Any Officer or Representative to Council may be removed from office before the expiration of his/her term by a public two-thirds (2/3) vote of those present at a meeting of the Board of Directors if it appears that the best interests of the [Division] *Society* are not being served by the person in question.

ARTICLE VI
SECTIONS

A. Sections may be organized to represent scientific and professional interests that lie within the [Division] *Society*.

B. Any member of the [Division] *Society* may apply for membership in one or more Sections under the rules of eligibility and election established by the Section. Fellows, Members, *Foreign Affiliates*, or Student Affiliates may remain members or affiliates without affiliation with a Section. A Section may include as Associates those who do not qualify for or do not desire membership in the American Psychological Association or in the [Division] *Society*. It may determine its own qualification for its membership classes, provided only that the designation Fellow, Member, *Foreign Affiliate*, or Student Affiliate of the Section shall be reserved for members of the Section who are at least Fellows, Members, *Foreign Affiliates*, or Student Affiliates respectively of the [Division] *Society*.

C. Establishment of a Section shall be considered whenever petitioned for by at least two percent (2%) of the Fellows and/or Members of the [Division] *Society*. The petition must be accompanied by a set of proposed Bylaws. A majority vote of those present at any meeting of the Board of Directors is required for establishment of a new Section.

D. The Board of Directors may create such Sections provided that:

1. They represent an active and functionally unitary interest of a group of members;
2. Their proposed objectives fall within the scope of those specified in Article I of the Bylaws;
3. Their membership is not restricted on any basis other than psychological interests and qualifications;
4. The establishment of any new Section is not inimical to the welfare of any other Section already established.

E. Sections formed from existing societies or organized as new societies may use a society name provided they append to it the phrase: "A Section of [the] Division [of Clinical Psychology] of the American Psychological Association."

F. A Section may be dissolved by the Board of Directors whenever:

1. The number of members within the Section falls below fifty (50) Fellow*s* or Members of the [Division] *Society*;
2. The number of Associates, excluding *Foreign Affiliates and* Student Affiliates of the [Division] *Society*, exceeds the number of Fellows and Members of the [Division] *Society* who are members of the Section;
3. The Section votes to recommend dissolution.

G. Each Section shall draw up and maintain its own Bylaws and rules of procedure within the framework of these Bylaws. Each may elect such officers, appoint such committees, and adopt such regulations for the conduct of its business as it may desire.

H. Each section shall file with the [Division] *Society* Secretary a copy of its current Bylaws, regulations, names of persons serving in its governance structure, and a description of that structure.

I. An approved Section shall be accorded the following rights:

1. To collect assessments from its members in addition to [Divisional] *Society* dues and assessments and to control and disburse its funds, provided that it observes the responsibilities enumerated in Article VI, Section J, Paragraph 2 of these Bylaws;
2. To be granted from the [Division's] *Society's* allocation an amount of program time at the annual convention to be determined each year by the Board of Directors and to request additional program time when such requests are accompanied by specific program proposals. The [Divisional] *Society's* convention program, as printed in [Divisional] *Society* publications, shall identify meetings which have been sponsored by Sections;
3. To own and to operate journals provided that it observes the responsibilities enumerated in Article VI, Section J, Paragraph 3 of these Bylaws;
4. To elect a Section Representative to the Board of Directors, provided that it observes the responsibilities enumerated in Article VI, Section J, Paragraph 4 of these Bylaws. The term of such Section Representatives to the Executive Board shall be for three (3) years. They may [not] succeed themselves *for one additional term of three years*. In the event a Section representative cannot attend a meeting of the Board of Directors, an alternate, with vote, may be appointed by the Section;
5. To have access to space within the [Division's] *Society's* publications within reasonable limits and without cost. Subject to the approval of the Editor(s), additional space may be purchased at Section expense.

J. An approved Section must discharge the following responsibilities to the [Division] *Society*:

1. To maintain policies and to adopt only those amendments to its Bylaws as shall be and remain consonant with these Bylaws of the [Division] *Society*;
2. To [present an annual budget to the Division Board of Directors for informational purposes and for comment during the calendar year preceding the year covered by the budget in question, and to] submit *to the Society Treasurer, in a timely fashion,* a final financial report on its operations during the *preceding* year [following the one covered by the report];

3. To petition to the [Division] *Society* Board of Directors, for the right to own and to operate, should it so desire, a journal so that the [Division] *Society* Board of Directors, in turn, might petition the APA Council of Representatives, as specified by the Bylaws of the APA, for such permission. The [Division] *Society* Board of Directors shall not capriciously withhold its endorsement from such requests. Upon approval by APA, liability coverage for such publishing operations will be provided by APA [and the costs of the coverage shall be borne by the Division]. The Section, further, shall instruct the editor or editors of its publications to file such annual reports as are required by the APA Publications and Communications Board;
4. To adopt procedure for the election of a Section Representative in such a fashion as to ensure that the Representative is a Fellow or Member of the [Division] *Society* and that the Representative elected has received at least a plurality of votes cast. Procedures for filling vacancies in the position as may be subsequently created by death, incapacity, or resignation must be carried out in fashion consistent with these Bylaws.

K. A Section remains autonomous in all matters within its field not reserved to the [Division] *Society*.

ARTICLE VII
BOARD AND COMMITTEES

A. The Committees of the [Division] *Society* shall consist of such Standing Committees as are provided by these Bylaws and of such task force Committees as shall be established by the President with the concurrence of the Board of Directors. Unless reconstituted for a subsequent year or years, the existence of an ad hoc Committee shall terminate at the close of the year in which it has been established. All Committee meetings shall be open to all members of the [Division] *Society* except at such times as confidential matters concerning individual members or applicants are under discussion. In the conduct of Committee business, the Chair of the Committee shall cast a vote only in the case of ties.

B. Except as otherwise provided in these Bylaws, the members of the [Division's] *Society's* Committees shall be appointed by the President. The Chair and all members of Committees shall serve until their successors are appointed and qualify. In the case of a vacancy on a Committee, such a vacancy shall be filled by the President.

C. The President shall appoint a Chair for each standing Committee.

D. The Standing Committees of the [Division] *Society* shall be:

1. The Committee on Fellowship, which shall consist of six (6) Fellows of the [Division] *Society*, all of whom shall serve for staggered terms of three (3) years. It shall be the duty of this Committee to evaluate and to recommend applicants for Fellowship to the Board of Directors and, where necessary, to the APA Membership Committee;
2. The Membership Committee, which shall consist of six (6) members, all of whom shall serve for staggered terms of three years. It shall be the duty of the Committee to recommend applicants for the categories of Member [and of] *Foreign Affiliate, and* Student Affiliate to the Board of Directors. At least one (1) member of the Membership Committee shall be a Fellow of the [Division] *Society*. At least one (1) member of the Committee shall have received the doctorate within the five (5) years immediately preceding his/her appointment. The remaining members shall be broadly chosen to represent the spectrum of active interest in and/or engagement in practice, teaching, research and/or administration.
3. The Program Committee which shall consist of a Chair, a Chair-designate, the Immediate Past Chair, and a representative designated by each of the Sections, and such others as are necessary to conduct the business of the Committee for the year. It shall be the duty of the Committee to solicit, evaluate, and select scientific and professional contributions to be presented as part of the [Division's] *Society's* annual meeting program, in coordination with the Board of Convention Affairs of the American Psychological Association.
4. The Committee on Nominations and Elections as described in Article VIII, Section A.
5. The Finance Committee, which shall consist of three (3) members of the Board of Directors, serving staggered terms of three years and the Treasurer without vote. The Finance Committee shall oversee the fiscal practices and planning of the [Division] *Society*, monitor its financial records, and cause a final audit of the annual financing affairs of the [Division] *Society* to be prepared. [The Committee shall be responsible for preparing for the Board of Directors' approval any forms required by the Internal Revenue Service.]

6. The Committee on Publications and Communications shall consist of six (6) members, serving staggered terms of three years. This committee shall oversee the operation and publication of the [Division's] *Society's* journal, *The Clinical Psychologist*, and other [Division] *Society* sponsored publications and mechanisms for communications. Section publications and mechanisms for communications shall not be subject to review by this Committee.

7. The Committee on Awards shall consist of three members, each to serve a three (3) year term, in rotation. The President-elect, with concurrence of the Board of Directors, shall appoint one member to the Committee. The senior member of the Committee shall serve as its Chair for that year. The Committee shall be responsible for recommending awards of any kind by the [Division] *Society* and for nominating awardees to the Board of Directors, which shall take final action on all awards. Any award by the [Division] *Society* shall require a two-thirds (2/3) majority of those voting.

8. The Committee on APA Governance shall consist of three members, each to serve a three (3) year term. It shall be the duty of the Committee to solicit and support the candidacy of [Division 12] *Society* nominees for various positions, review the credentials and position statements of candidates for APA office, present recommendations to the Executive Committee of the [Division 12] *Society* Board of Directors for endorsement, and, in timely fashion, to promulgate information relevant to the Board's concerns to the appropriate bodies.

9. The Committee on APA Policy Issues shall consist of those [Division 12] *Society* Board of Directors members appointed as monitors and liaisons to the various APA governance bodies. The Chair of this committee shall be the current [Division 12] *Society* Past President. On the call of the Chair, the Committee shall prepare a report for presentation to the Board at each of its meetings the issues of concern then circulating through APA governance. This shall be done in such timely fashion as to permit proactive input by the Board to influence policy as necessary.

10. *The Committee on Science and Practice shall consist of a Chair and five (5) other members necessary to the work of the Committee. Members shall serve for staggered terms of three (3) years. It shall be the duty of the Committee to identify and to promote awareness of the scientific basis of psychological treatments, interventions, and assessments, with the goal of enhancing clinical science, training, practice, and public health.*

E. In addition to its responsibilities for carrying out those operations specified in Article VII, Section D of these Bylaws, each Standing Committee shall have the privilege of recommending procedures, new policy or policy changes, and/or amendments to these Bylaws to the Board of Directors.

F. It shall be the responsibility of the Chair of each Standing Board or Committee to submit an annual report on its operations and recommendations to the Board of Directors by November 30 of each calendar year.

G. The Board of Directors [in] *is* empowered to authorize the formation of Task Forces to accomplish the goals of the [Division] *Society*.

1. Each Task Force shall be appointed for one year, shall present a progress report when requesting reimbursement, and shall present a final written report at year's end to the Board of Directors.

2. The number of members, and terms of office of Task Force members shall be determined by the Board of Directors.

3. The members and Chair of each Task Force shall be nominated by the President for approval by the Board of Directors.

H. All persons serving on Committees and Task Forces of the [Division] *Society* must be Members or Fellows of the [Division] *Society*.

ARTICLE VIII
NOMINATIONS AND ELECTIONS

A. The Committee on Nominations and Elections shall consist of the Past President ex-officio as Chair and four other members, two of whom shall not be members of the Board of Directors. The members of the Committee on Nominations and Elections shall be appointed by the President with the concurrence of the Board of Directors. In the case of the death, resignation, or incapacity of the Past President, the President shall assume the duties of the [chair-person] *Chair*. The Committee shall be responsible for implementing the policies required for the nomination and election of

Officers and Representatives to APA Council. All aspects of nomination and election for positions on the Division's Board of Directors shall be conducted in conformity with the provisions of the Bylaws of APA, and shall be completed by the dates specified by APA and/or by the provisions of these Bylaws.

B. The Committee on Nominations and Elections shall distribute a nominating ballot to all Fellows and Members by January 15 of each calendar year. The nominations ballot shall provide spaces for writing in the names of three possible nominees for the office of President-elect and two possible nominees for any other vacancy to be filled on the Board of Directors.

C. The nominations shall be tallied by the Committee on Nominations and Elections. The name of any member who is willing to stand for election shall be placed on the ballot if nominated by at least one-half of one percent (.5%) of the membership in order of number of nominations received until the required number of candidates is listed. In the event of a tie for last position, the Committee on Nominations and Elections is empowered to break the tie by lot. In addition to those nominees who shall be placed on the ballot by virtue of having been nominated by one-half of one percent (.5%) of the membership, the Committee on Nominations and Elections shall be empowered, if required, to nominate such additional names for the election ballot as to ensure that there are at least four (4) candidates for President-elect and three (3) candidates for each additional position to be filled in a given year.

D. After a proposed final election ballot and its slate of nominees has been composed for submission to the membership by the Committee on Nominations and Elections, the Chair-person shall submit a report on its actions to the Board of Directors, noting those candidates who were placed on the ballot as a result of achieving nomination by one half of one percent (.5%) of the membership and those who were placed on the ballot by the Committee, with the Committee's rationales for the latter.

E. The Officers and Representatives to APA Council of the Board of Directors shall be elected by a preferential vote of the Fellows and Members on a mail ballot. The Committee on Nominations and Elections shall be responsible for overseeing the [mailing of ballots, the count of the votes, the notification to the Board of Directors of the result of the election, the notification to the members whose names appeared on the ballot, and the reporting of the election to the annual business meeting of the Division and in the pages of its publication] *election process*.

F. Special elections required to fill any vacancies on the Board of Directors as specified in Articles IV and V of these Bylaws, those brought about by death, incapacity, or resignation of a member of the Board of Directors and not capable of being filled by the appointment of the next-most-popular defeated candidate, shall be conducted by the Committee on Nominations and Elections in consonance with Article VIII, Sections A through E of these Bylaws.

ARTICLE IX
MEETINGS

A. The [Division] *Society* shall hold an annual scientific and professional meeting at the time and place of the annual convention of the American Psychological Association for the presentation of scientific papers and the discussion of professional matters in the field of the Division's interests. The [Division] *Society* shall coordinate its program with, and shall participate in, the program of the APA.

B. There shall be at least one [business] *membership* meeting of the [Division] *Society* that shall be held in conjunction with and in the locality of the annual convention of the American Psychological Association. The purpose of such meetings shall be to provide an opportunity for a personal exchange of information and perspectives about matters of mutual concern between the general membership and the members of the Board of Directors. Any member of the [Division] *Society* shall have the right to place a matter on the agenda of a [business] meeting for the [Division] *Society* by directing the matter to the Secretary at least forty-eight (48) hours before the scheduled meeting time.

[C. A second business meeting shall be held each year with the time and date set at the discretion of the Board of Directors.]

[D.] *C.* Other scientific, professional and/or business meetings of the [Division] *Society* may be called by the President with the concurrence of the Board of Directors.

[E.] *D.* All scientific, professional, and business meetings of the [Division] *Society* shall be published to the membership.

ARTICLE X
FINANCES

A. Membership dues are those amounts established each year for each member, paid to the [Division] *Society* by the American Psychological Association out of the member's annual fees paid to the Association.

B. The assessment of any additional or special membership fees beyond those specified in Article X, Section A of these Bylaws shall be decided by a two-thirds (2/3) vote of the Board of Directors. [Once so set by the Board of Directors, the proposed assessment shall be presented to the membership by mail ballot for ratification.]

C. Dues for *Foreign Affiliates and* Student Affiliates shall be set annually by the Board of Directors on recommendation of the Finance Committee, such dues not to exceed the extant assessment for Fellow and Members.

D. A special assessment, once ratified by the membership, shall remain in force each subsequent year unless changed by the Board of Directors and the membership in accordance with Article X, Section B of these Bylaws. A request for such a change may be initiated by any member of the Board of Directors. In addition, a petition signed by three percent (3%) or one hundred (100) Fellows and Members of the [Division] *Society*, whichever is greater, shall mandate the holding of a referendum on the assessment.

E. The Board of Directors, on recommendation of the Finance Committee and Treasurer, shall prepare an annual budget of anticipated income and expenditures which shall be presented for the review of the members at the annual meeting.

F. Disbursement of funds of the [Division] *Society* shall be made as follows:

1. The Board of Directors shall authorize disbursements within the amounts of the approved budget for purposes which are not inconsistent with the Bylaws of the [Division] *Society* or of the American Psychological Association, nor with the recorded actions of the membership.
2. The Treasurer, with the concurrence of the President, is authorized to reallocate unexpended funds from one category of the approved budget to another, provided only that the total expenses for the year are not exceeded.
3. Once a budget has been approved in accordance with Article X, Section E, disbursements of any amount for items not contained in the approved budget but for purposes harmonious with the objects of the [Division] *Society* may be authorized by a two-thirds (2/3) vote of the Board of Directors provided only that such expenditure will not require an increase in the approved assessment during the fiscal year in which it shall be made.

G. The Treasurer is authorized to sign checks on behalf of the [Division] *Society* or to direct the disbursement of funds duly approved under the provision of Article X, Sections E and F of these Bylaws. In the event of the incapacity of the Treasurer, or a vacancy in that office, the President-elect is authorized to serve in his/her stead.

H. All contracts and other financial documents, other than checks, necessary to undertake programs approved by the Board of Directors in accordance with these Bylaws shall be executed by the President and the Treasurer.

ARTICLE XI
AMENDMENTS

A. An amendment to these Bylaws may be proposed by a majority of the Board of Directors or by a petition of three percent (3%) or one hundred Fellows and Members, whichever is greater, presented to the Board of Directors. After an amendment has been reviewed by the Board, it shall be mailed within sixty (60) days to the last known post office address of each Fellow and Member along with statements which specify the arguments for and against the proposed change. Ballots shall be counted sixty (60) days after mailing, and the voting period shall then be considered closed. An affirmative vote of a majority of the Fellows and Members returning their ballots shall be required to ratify the amendment which shall then go into effect.

Candidates for Division 12

President Elect

Note: Election ballots will be arriving in the mail very soon. Each of the following candidates are running for division office and have submitted a statement describing their goals and qualifications. Please keep this information in mind as you deliberate and please participate in the Division by voting.

KAREN S. CALHOUN, PhD

Karen S. Calhoun is Professor of Psychology and past Director of Clincal Training at the University of Georgia. She received her PhD from Louisiana State University. A Fellow of Divisions 12 and 35, she has served as president of Section III of Division 12, and of the Southeastern Psychological Association. For the past six years she represented Division 12 on the APA Council. She has served as Program Chair and as a member of numerous Division committees. Currently, she is Associate Editor of *Psychology of Women Quarterly* and a member of a grant review panel for the Centers for Disease Control and Prevention. Her research on sexual assault and development of aggressive behavior has been supported by NIMH.

Clinical Psychology faces major challenges in a rapidly changing mental health field. Division 12 must continue to assert strong leadership in helping to shape future directions that honor our roots while forging creative new solutions. The Division leadership must continue its sensitivity to the impact a changing world can have on Clinical Psychologists in all their roles, current and future. In recent years the Division has made remarkable strides in meeting great challenges in spite of limited resources. It has done so, largely, by marshalling the talent and dedication of its members, fostering more open communication through computer networks and journals, and by targeting issues that, though difficult, have potential to make a great difference to the profession and the public we serve. The ongoing debate about identifying treatments that work is only one example. Many other issues are just beginning to be addressed. Finding common ground among ourselves in addressing them will be challenging and rewarding. I would be honored to serve the Division in the role of President.

W. EDWARD CRAIGHEAD, PhD, ABPP

W. Edward Craighead received his PhD from the University of Illinois at Urbana-Champaign in 1970 and joined the Pennsylvania State University Psychology Department faculty where he advanced to Professor and Director of Clinical Training. He was also Director of the Psychological Clinic and maintained a small private practice. In 1986, he joined the faculty of Duke University Medical Center where he was Professor and Clinical Program Director of the Mood Disorders Program; he split his time evenly among therapy, clinical research, and clinical supervision/ training. In 1990, he also became Professor and Director of the Clinical Program in the Duke University Department of Psychology: Social and Health Sciences. In 1995, he moved to the Department of Psychology at the University of Colorado, Boulder, where he is currently Professor and Director of the Clinical Program and maintains an active clinical practice.

Ed has been elected to leadership positions in several professional organizations, including serving on the Board of Directors of Division 12 and Treasurer for the past 5 years. In addition, he has served the Division as Chair of the Finance Committee, Chair of the Publications Committee, Chair of the Long-range Publications Committee which negotiated the contract for *Clinical Psychology: Science and Practice*, and Co-chair of the Committee which wrote the CRSPPP application for continued recognition of Clinical Psychology as a Specialty. He is a Fellow of the Division and a member of Sections I and III. He is a licensed psychologist in NC and CO, a diplomate of the American Board of Professional Psychology, and a member of the National Academies of Practice.

Ed has written/edited several books and has published extensively on the psychosocial aspects and treatments of Major Depression and Bipolar Disorders. He has served as Editor of Behavior Therapy and has served on the Editorial Boards of several journals, including Journal of Consulting and Clinical Psychology, Journal of Abnormal Psychology, Cognitive Therapy and Research, and Depression/ Anxiety. He also serves on the Treatment/Assessment Study

W. Edward Craighead, PhD, ABPP (continued)

Section of NIMH. He has conducted numerous national and international workshops on the treatment of Mood Disorders.

During the past few years, Division 12 has reassserted itself by taking a more active leadership role in APA and by addressing national and international issues facing Clinical Psychology as both a profession and a science. I believe the Division should continue to take such a proactive role, which will be most effectively accomplished by bringing together its professional and scientist members to anticipate and address issues of practice, science, education, and public policy involving clinical psychology. We need to be centrally involved in professional activities that have an impact on health care policy and on the practice of clinical psychology as well as the scientific and educational issues that affect that practice. The Division should facilitate the development, evaluation, and dissemination of more effective assessment and interventions thereby advancing the knowledge base of Clinical Psychology; this will allow us to be a stronger voice and advocate for Clinical Psychology both within and outside of APA.

The active and successful leadership of Division 12 of APA is essential to the survival of Clinical Psychology. During the time I have served on the Board, I have actively encouraged and supported the renewed involvement of the Division in its increased activities and advocacy for clinical psychology. Because of my long-standing balanced interest and involvement in clinical practice, professional, educational, and scientific activities, I believe I can adequately represent the diverse membership within the Division. As we move into the next century, I would be honored to serve the Division as its President.

SAMUEL M. TURNER, PhD

Samuel M. Turner received his PhD from the University of Georgia in 1975 and completed his clinical internship at the University of Mississippi Medical Center. In 1975, he joined the University of Pittsburgh's Western Psychiatric Institute and Clinic (WPIC) where he advanced to the rank of professor. At WPIC, he directed the Psychology Internship Program for 10 years. In 1992, he joined the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina where he directs the Anxiety Prevention and Treatment Research Center. His program of research primarily has been in the anxiety disorders, but the focus has been broad and include obsessive-compulsive disorder, social phobia and panic disorder. Studies have included children and adults, treatment outcome, treatment development, phenomenology and psychopathology, high risk longitudinal designs, and manifestation of anxiety in minority populations. He is the author or co-author of over 160 professional publications. His career is highlighted by an active interest in training at all levels, policy issues and psychology at the national level. He has been on numerous NIMH advisory committees including the Extramural Scientific Advisory Board. His APA service includes the Board of Educational Affairs, Board of Scientific Affairs, and Committee on Ethnic Minority Human Resources. He currently serves as co-chair of the APA Task Force on Test User Qualifications and member of the APA College of Professional Psychology. He served as editor of The Clinical Psychologist, and has served on Council (Div. 12), and on numerous division committees. He is a diplomate in both clinical and behavioral psychology, fellow in Divisions 1, 12, 25, and 45, the 1997 recipient of APA's award for Distinguished Contributions to Professional Knowledge, and recipient of the Association of Medical SchoolPsychologist's 1997 award for Distinguished Contributions to Medical Research. The future of clinical psychology is somewhat uncertain, owing to a host of changes in health care and society at large. Yet, change sometimes is the engine of opportunity and I believe this is the case in this instance. The venerable scientist-practitioner model has served the discipline well, and retaining and strengthening it will ensure that our students are well equipped to adapt to and seize new opportunities fostered by the changes taking place. It would be an honor to serve as Division 12 President and help to ensure that the discipline responds to this change in a positive manner.

ANTONETTE ZEISS, PhD

I am Director of Training and Director of the Interprofessional Team Training & Development Program at the VA Palo Alto Health Care System. I completed graduate work in Clinical Psychology at the University of Oregon in 1977. I am a Fellow of Division 12, a Charter Fellow of the American Psychological Society, Past-President of the Association for Advancement of Behavior Therapy (AABT), and President-Elect of Section II of Division 12 (Clinical Geropsychology).

I have published extensively, with research and scholarly interests including treatment of depression, depres-

sion in older adults, sexual function and treatment of dysfunction, and processes in interprofessional teamwork. I have served on six editorial boards and as a representative to several national health care planning groups. These groups have covered topics central to the future of clinical psychology, including psychology's role in primary care, changes in VA training of associated health care providers, the development of an interprofessional coalition to create empirically-based practice guidelines, the Human Capital Initiative report on a research agenda in aging, and the Mental Health and Aging component of the White House Conference on Aging.

As a clinical psychologist working in a non-academic setting, I see on a daily basis the changes in roles and opportunities for clinical psychologists in a changing health care system. Three issues stand out as vitally important in responding to and helping guide the changes currently occurring. First, we must maintain our commitment to the scientist-practitioner model; this sets us apart from every other profession providing health care and makes us invaluable in an era of rising expectations of effectiveness and accountability in health care. Second, we need to understand and embrace the interprofessional model which increasingly dominates health care services. We should look for opportunities to build coalitions and make the case for the essential role of clinical psychology on interprofessional teams throughout the health care system. Third, we need to recognize the changing demographics of health care and the increasing diversity of health care recipients, who expect and deserve increased sensitivity to their needs. My own focus has been on meeting the needs of older adults, as the mean age of the population increases and more people live into their 80s and 90s. We need to prepare clinical psychology service providers, researchers, and educators who understand and support the needs of all care recipients, across all dimensions of diversity.

Candidates for Division 12

Secretary

ELSIE GO LU, PhD

Since my graduation in 1966 from UCLA and joining APA, I have been a member of Division 12. I have subsequently been involved with my state association governance for over twenty years and served in many capacities including President in 1993 and currently its APA council representative. I have been involved with Division 12, Section VI (Ethnic Minority) for 12 years including its board representative this past three years. I know that as Secretary, I will be able to continue to contribute to the agenda of the Board. I am a scientist-practitioner and strongly support the vision of the division. My involvement in other APA governance as member of CAPP and committee/task force of other divisions have provided me with a broad perspective on the diverse issues psychology has to deal with.

I have practiced in the various public mental health settings as the state hospitals, community mental health centers, jails and prisons as a clinical psychologist. I have provided direct services to underserved individuals and their families as those seriously mentally ill adults and serious emotionally disturbed children. I provided supervision for interns and directed their dissertation researches. I developed programs for specialized populations as those with HIV/AIDS, homeless and ethnic minorities and administered these as Deputy Director of the largest county mental health program in the country with a budget of over $250 million. My work experiences and my involvement in APA and state association governances provides me with the best combination for the position of Secretary for the Division.

Candidates for Division 12

Secretary (continued)

ROBERT H. WOODY, PhD, ScD, JD

Robert H. Woody is Professor of Psychology (and former Dean for Graduate Studies and Research) at the University of Nebraska at Omaha. He received a PhD from Michigan State University, a ScD from the University of Pittsburgh, and a JD from the Creighton University School of Law. He is a Fellow of the Division of Clinical Psychology, and a Diplomate in Clinical Psychology and a Diplomate in Forensic Psychology, ABPP. He is admitted to the Florida, Michigan, and Nebraska Bars, and is a Licensed Psychologist in Florida and Michigan. He has authored twenty-seven books, and approximately one hundred and fifty articles. He serves on the APA Ethics Committee.

As a psychologist and attorney (representing and defending psychologists and other mental health professionals) and from my service on the APA Ethics Committee, I am aware of the justifiable consternation about managed care, standards, legal liability, and regaining self-regulation of the profession. If afforded the opportunity to be Secretary of Division 12, I will bring a creative and high-energy approach to problem solving on behalf of clinical psychology. Although our rich past must not be foolishly be discarded, clinical psychology cannot rest on its laurels. Innovations are needed if we are to reconceptualize clinical psychology to combat the challenges and compete successfully in the health-care marketplace. Clinical psychologists must shape managed care organizations as much or more than they shape our practices. Licensing boards must provide equal protection for consumers and psychologists by assuring a level playing field for processing complaints against psychologists. We must face the medical industry head on, with no cowardice in asserting to legislators that clinical psychology offers peerless benefits to the health of our nation, such as by prescription privileges. Training programs should be responsive to the contemporary practice scene, and not simply follow tradition for the sake of tradition. Being trained in both psychology and the law, I am confident that I can offer unique strategies to improve clinical psychology. I will appreciate your support for my candidacy for Secretary of the Division.

MAE LEE BILLET-ZISKIN, PhD

As one of the older divisions in APA, the Division of Clinical Psychology has deep roots which nurture and support the important interplay between psychological science and psychological practice. The integrity of our discipline depends upon continuing the scientific tradition while applying our clinical skills. It is a distinct challenge, in this age of specialization, to achieve that balance in our training and practice which enables us to emerge as competent clinicians and trainers. I believe Division 12 has a key role to play in promoting the linkage between the science and practice communities of psychology.

I seek the office of Secretary of the Division and bring a considerable history of experience in psychological association governance, as do the other candidates. I have served as Secretary, as well as in other leadership positions in APA Division 31, the California Psychological Association and it Division of Professional Practice, and the Los Angeles County Psychological Association. I am also familiar with APA governance having served on Council and on the Policy and Planning Board for two terms. I am currently serving on the Public Information Committee.

My professional career includes teaching, independent practice and community agency practice. I received a PhD in Clinical Psychology from the University of Southern California in 1966 and am licensed in the state of California. I am a Fellow of Divisions 12, 29, 31 and 42, and Member of Divisions 35, 43, 50 and 51.

Candidates for Division 12

APA Council Representative

NORMAN ABELES, PhD

Norman Abeles is currently the Past President of the American Psychological Association and is a Past President of Division 12. He is Professor of Psychology and Director of the Psychological Clinic and served as Director of Clinical Training at Michigan State University until two years ago.

As many of you know, Norm focused on assessment and intervention with older adults during his presidency of APA. One of his task forces developed Guidelines for assessment of dementia and age related cognitive decline and the other task force provided a brochure on What the Practitioner Should Know About Working With Older Adults. You can get this brochure by looking at the APA web page or calling 202-336-5700 and asking for the older adult brochure.

As a council member, Norm plans to further the aims of clinical psychologists. He attended the recent Supply and Demand Conference where job placement issues were discussed for individuals seeking academic jobs as well as for individuals in the practice of clinical psychology. Norm will be active in Council in continuing to push for ways of improving the job market, finding ways of preparing graduates for work in the next century, dealing with concerns of psychologists in the Veteran's Health Administration and trying to include psychologists under Graduate Medical Education (a 6.6 billion dollar program which funds hospitals to train medical practitioners but does not yet include training funds for psychologists). He is also very interested in the proposed plan by the Association of Psychology Internship Centers to institute a computerized matching of potential interns and internship sites. He is awaiting the decision of internship centers to see if they wish to begin this effort.

If you have questions on any of these topics, e-mail him at norman.abeles@ssc.msu.edu.

LILLIAN COMAS-DÍAZ, PhD

Lillian Comas-Díaz received her PhD in clinical psychology from the University of Massachussetts. She is Director of the Transcultural Mental Health Institute, Founding editor of Cultural Diversity and Mental Health, and maintains a private practice. Previously, she served as the Director of the Yale University School of Medicine Hispanic Clinic, and was Director of the APA Office of Ethnic Minority Affairs. Comas-Díaz is a scholar/practitioner, author of numerous publications, and serves on 7 editorial boards. She is a fellow of our division, a past president of its section 6, and currently serves a one year term as Council Representative.

I represent a voice reflecting our adaptability to change through affirmation of identity and receptiveness to innovation. My vast APA governance experience and ability to collaborate with different groups, can be of assistance in achieving our vision and goals. My commitment to clinical psychology's dual nature as a science and as a practice, is grounded in my public interest conviction. I feel that I can offer an effective voice for Division 12 and would be honored to do so.

ANNETTE LA GRECA, PhD

Annette La Greca received her PhD in Clinical Psychology from Purdue University. Dr. La Greca is a Professor of Psychology (University of Miami), and director of graduate-level clinical programs in clinical-child and pediatric psychology. Dr. La Greca has been involved with Division 12 activities for the past 20 years in a variety of capacities. She is a Fellow of Division 12, has served as President of Sections I (Clinical Child) and V (Society of Pediatric Psychology), and has received the Distinguished Service Award and Significant Research Contribution Award from Section V. She has also recently served as Editor of the Journal of Pediatric Psychology, and has just completed her three-year term on the Division 12 Executive Board. She currently serves as the Chair of the APA Committee on Children, Youth and Families.

Candidates for Division 12

APA Council Representative (continued)

Annette M. La Greca, PhD (continued)

Dr. La Greca's clinical/research interests are in the role of friendships in youngsters' psychological adjustment; child and family coping with stressors (traumatic events, chronic disease); and preventive interventions. She has authored over 100 publications and serves on five editorial boards. For 15 years, she has been actively involved in clinical training issues, on a national level.

"It is my impression that clinical psychology is at a pivotal juncture. Strong Division representation in Council is essential, around issues such as managed care, treatments that work, and the scientific basis of clinical psychology, and the recognition of specialties and proficiencies in psychology. I am strongly committed to helping Division 12 play a leading role in shaping APA's response to these challenges, and will work toward promoting a unified APA that facilitates collaboration among scientists and professionals."

JANET R. MATTHEWS, PhD

Janet R. Matthews, PhD, ABPP (clinical) received her PhD in clinical psychology from the University of Mississippi in 1976. She is a tenured Professor at Loyola University-New Orleans, a consultant to the pre-doctoral internship at the New Orleans VAMC, and in part-time private practice. She has been active in both Division 12 and APA governance. Among her Division 12 service is program chair and secretary-treasurer of the former Section 2; membership chair, secretary, and president of Section 4; three years on the Division Fellows committee; currently completing a three-year term as Division secretary. I was one of the two Division 12 representatives to the group which rewrote the CRSPPP clinical petition. Within APA, she has been a Council representative from Division 2, chair of the Assembly of Scientist-Practitioner Psychologists, member of both the Education and Training Board and Board of Convention Affairs, chair of both the Committee on Undergraduate Education and the Policy and Planning Board, and currently completing a term on the APA Board of Directors. She has also served for three years as the Board of Directors liaison to the Association of State and Provincial Psychology Boards.

I respectfully ask for your vote to be your representative on the APA Council of Representatives. I believe I bring a combination of experience with both Division 12 and APA governance which will allow me to be a strong representative for the interests of Division 12. My combination of academic and practice employment exposes me on a regular basis to a range of issues facing our discipline today. Having attended the recent Supply and Demand Conference as well as working with interns who are about to enter the marketplace, I am well aware of issues which need to be addressed here. I have tried to keep you informed through my minutes of your Division's activities and would very much like to continue my Division involvement as your Council representative.

LYNN P. REHM, PhD, ABPP

Lynn P. Rehm received his PhD from the University of Wisconsin and did his internship at the VA Hospital in Milwaukee. He has been on the faculties of UCLA-Neuropsychiatric Institute in Psychiatry; University of Pittsburgh in Psychology and Psychiatry; and the University of Houston, Psychology Department.

Lynn has held leadership positions in psychology at the multiple levels: President of Pittsburgh and Houston local associations, executive committees of Pennsylvania and Texas associations, President of Texas Psychological Association, Chair of the Council of University Directors of Clinical Psychology, Chair of the APA Board of Educational Affairs, and Chair of the licensing Examination Committee of ASPPB. In addition to being immediate past-president of Division 12, he is also a former Council Rep, former President of Section III, and former Federal Advocacy Coordinator for the Division. Lynn's research centers on depression theory, psychopathology, and treatment, and he has over 100 scholarly publications. He has made scientific presentations and given clinical workshops on Self-Management Therapy for depression nationally and internationally.

Psychology is facing major challenges in the 90s. Managed health care, national health reform, decreasing research funding, decreases in budgets for higher education, and the changing demographics of the country all have impact on Clinical Psychology. I would like to see Division 12 take a central role in responding to these challenges. Advances from our research need to be disseminated to the field and we need to speak our in areas where we have important expertise.

Division 12 has begun in recent years to reassert a strong leadership role in APA. The Division and its members are concerned with issues covering science, practice, education, and public interest. We can and should play an active role influencing developments in all of these areas within APA. APA is in the midst of debate as to how we define specialties and what should be the taxonomy of specialty designations. We need to assert Clinical Psychology's position among specialties. Division initiatives on effective treatments and other topics have had increasing impact on throughout APA. We need to be a center of communication and to take the initiative on Council. I know the Division well, and I know APA and Council well. I have been active in promoting an involved Division 12 and I can be effective in moving the Division forward as Council Representative.

LAURA C. TOOMEY, PhD

In many ways, you have a win-win situation in your choices for APA Council Representative. We are all Boulder Model trained clinical psychologists who are knowledgeable about issues facing our discipline and familiar with APA and Division 12 governance.

But I offer a unique contribution: I represent public institutional practice. I have been practicing and helping to train clinical psychology interns in a state mental health system for 25 years. During much of the same period I have been involved with Division 12 governance, as a committee member, Treasurer, and Council Representative, and typically I have been the only non-academician at the table. My viewpoint is different from those of academics and private practitioners: I understand the special problems facing psychologists in Public institutions.

As you rank-order the Council candidates, please consider the value of keeping a voice for public service on the Division 12 Board.

Board Certification Exam for Senior Clinical Psychologists

The American Board of Clinical Psychology has been utilizing a streamlined Board Certification Exam for Senior Clinical Psychologists. Fellows of the Division who are Clinical Psychologists and twenty years into their career may apply.

The application process is "user friendly". After application, a "Professional Statement" will be requested and "Work Sample". The "professional Statement" and "Work Sample" have been significantly modified for Fellows of the Division. The "Professional Statement" is a copy of a recent Curriculum Vitae. The "Work Sample" describes contributions to Clinical Psychology. This "Work Sample" may describe the applicant's clinical practice or it may be a copy of a professional publication, or description of teaching, training, or clinical research project which relates to the practice of clinical psychology. A clinical evaluation and intervention sample will not be requested but may be submitted.

After the "Work Sample" is accepted, the examination will be scheduled. The Oral Examination Committee will consist of Senior Experienced Board Certified Clinical Psychologists who recognize the importance of high standards in the practice of clinical psychology and have demonstrated collegiality.

Interested Fellows of the Division should contact us for information and application material.

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Confidentiality in the Age of Managed Care

Jeffrey E. Barnett
Chesapeake Center of Annapolis

Confidentiality has long been viewed as one of the cornerstones of the psychotherapy relationship. Its security helps provide the safe environment in which patients may address difficult and troubling issues. Without it, many might choose not to seek out much needed treatment. In the cost-conscious era of managed behavioral health care, the laudable goal of cost-containment often comes at great risk to confidentiality. This brief article examines these important issues through case examples that illustrate potential dilemmas that may confront psychologists, and through discussion of relevant legal and ethical standards. Specific recommendations are offered so that clinicians may better preserve and safeguard confidentiality, even in the age of managed care.

Case Examples

1. A Managed Care Organization (MCO) requires that you complete a detailed form about a patient and her treatment prior to authorizing any additional coverage for services provided.

2. An MCO requires you to discuss with utilization review personnel patient treatment information prior to authorizing any further reimbursement. In addition to questions about the patient and her treatment, utilization review personnel ask detailed questions about her spouse and other family members.

3. You are notified by an MCO that a retrospective review of a patient's treatment is being conducted. You are required to forward all records of treatment to date in order to justify the treatment provided. If you refuse to comply with this request reimbursement for the treatment provided will be retroactively denied and payments made would have to be returned.

4. A patient is alarmed when she learns that you must complete and forward to her MCO a detailed form, which includes information she considers private. She is upset to learn that the issues she discusses with you in psychotherapy are not truly confidential as she had assumed and hoped.

Discussion

For the clinical psychologist, as with mental health professionals in general, the issue of confidentiality is of great importance. Patients come to treatment sharing thoughts, ideas, worries, fears, concerns, and fantasies in what they hope will be a safe and secure environment. The psychotherapy relationship is one that is based upon trust. If the patient were to feel unsure about the confidentiality of information shared in the psychotherapy relationship her or his comfort with sharing that personal and private information might be undermined. This could likely result in the process of psychotherapy being jeopardized and the benefit to the patient greatly reduced.

Confidentiality is widely viewed to be a cornerstone of the psychotherapy relationship. An issue, which underlies confidentiality, is that of privacy. As stated by Shah (1969) "the concept of privacy recognized the freedom of the individual to pick and choose for himself the time, circumstances, and particularly the extent to which he wishes to share or withhold from others his attitudes, beliefs, behavior, and opinions" (p.57).

This concept has held a significant role in psychology's codified ethical standards from our original ethics code (APA, 1953) to the present (APA, 1992).

It is widely recognized through statutes on the state level that information shared by individuals within certain special professional relationships (e.g. attorney/client and psychologist/patient) is protected and that the individual has the right to decide when and under what circumstances this information may be disclosed (Cohen and Mariano, 1982).

With confidentiality being so important to a successful outcome in psychotherapy one might assume that it is, or can, be safeguarded. In fact, most individuals assume that all the material discussed in psychotherapy is confidential (Miller & Thelen, 1986). While many assume and expect that confidentiality in the psychotherapy relationship is absolute, in reality it is only relative confidentiality that exists, as is highlighted in the case examples provided earlier.

There are many potential limits to confidentiality. Widely accepted limits include the duty to warn in situations of dangerousness to self or others, the duty to report suspected child abuse or neglect (and elder abuse in some jurisdictions,) and the requirement to respond to lawful

court orders. The most common exception to confidentiality, however, is when a patient consents to the release of previously confidential treatment information.

For such releases to be held valid, informed consent by the patient must first occur. As Stromberg et al. (1988) recommend this consent should be documented in writing, and the patient must have an understanding of the specifics and scope of the information to be disclosed, with whom it will be shared, and the general purpose(s) for which it will be provided (p. 391).

In the era of managed care, practitioners are frequently required to share treatment information with utilization review personnel to justify treatment so that coverage of services rendered will be provided. There is a decision-making process that occurs throughout the course of each patient's treatment. The psychotherapist and patient work collaboratively to plan and implement the treatment plan, which they agree upon. Unfortunately, when managed care is involved there are third parties involved who intrude on this therapist/patient collaboration and insert themselves into this decision-making process. The psychotherapist and patient can no longer plan the course of treatment together based solely upon their assessment of the patient's treatment needs. It ceases to be their private matter. Frequently, the need for, type of, and length of treatment must be justified to utilization review personnel.

The inclusion of utilization review personnel in the psychotherapy relationship poses a great threat to confidentiality and in many ways jeopardizes the psychotherapy relationship. It is true that when consumers purchase health insurance they sign a number of forms, one of which may authorize the insurer or MCO access to treatment records. Typically this is covered in terms of the need to justify the medical necessity of any treatment provided. While this might be a laudable goal the standards used for determining this are vague at best.

With regard to informed consent, this authorization signed by the patient is not adequate. To refer back to Stromberg et al.'s (1988) earlier recommendation this procedure seems wholly inadequate. Such authorizations typically do not limit the specifics and scope of information to be released, they do not specify with whom it will be shared, and they are vague about the general purposes for which they are provided (utilization review/judging medical necessity).

The principle of informed consent implies that patients have the right to know and understand the expectations of their MCOs that may affect their treatment. Specifically, patients have the right to know in advance any expectations for the release of treatment information, if there is a utilization process, how treatment decisions are made, and by whom (Barnett, 1993). Psychologists should provide patients with thorough explanations of these requirements *before* the information is released. As is further stated in Standard 1.21, Third Party Requests for Services (APA, 1992), "When a psychologist clarifies to the extent feasible, at the outset of the service, the nature of the relationship with each party, this clarification includes the role of the psychologist...the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality" (p. 1602). In effect, there should be no surprises to the patient. Any requirements for utilization review, such as those indicated in the first case example provided earlier, should be fully explained to the patient from the outset. While this may seem rudimentary to some, Baird and Rupert (1987) found that only one-half of the psychologists they surveyed even mentioned or alluded to specific limits of confidentiality from the outset of the psychotherapy relationship. The other half often said nothing at all or indicated that everything said in treatment was confidential.

One flaw inherent in the utilization review process is a pressure to provide the reviewer with more information than is actually necessary as was indicated in the second case example. As Pope (1990) cautions, one should release only the minimum amount of information required. All too often, especially when utilization review is conducted by telephone, requests for information are made that go far beyond determining medical necessity. Responding to such requests is tempting for the practitioner who is dependent on the outcome of the utilization review process for authorization. It is easy to share more information than is necessary in the hope of obtaining a much-needed authorization for coverage of needed treatment.

Another difficulty arises when a request is made for complete treatment records to be forwarded to the MCO or insurer such as is highlighted in the third case example presented earlier. Releasing specific information to demonstrate medical necessity may be acceptable to some, but sharing an entire treatment record is not justifiable. Few safeguards exist for how this information will be used and little justification can be provided to offset the great risk to both confidentiality and the integrity of the psychotherapy process. Many psychologists have found that challenging such requests in writing can be very effective. By asking the MCO to justify the need for the record and by asking what specific questions about the treatment they may have, such dilemmas may at times be resolved.

A letter to the MCO from a patient's attorney demanding justification of the request may be helpful in these situations as well.

Clearly, it is preferable to answer specific questions to meet utilization review criteria. Releasing a patient's treatment record should be avoided if at all possible, even if the patient consents to its release. Once a patient's record is released, the psychologist is unable to control the use of the information. Numerous cases (e.g. Courtney, 1995; Jarvis, 1995; Sussman, 1995) exist where sensitive information was used inappropriately or re-released to unauthorized individuals. Few guarantees exist concerning how this sensitive information is used or safeguarded once the MCO has access to it. Thus, releasing the minimal amount of information possible helps protect the patients' best interests and helps safeguard their welfare.

To be in compliance with psychology's ethical standards as well as working to best meet patients' treatment needs, psychologists must ensure that each patient understands the limits of confidentiality from the outset of the psychotherapy relationship. This should include a discussion of the patient's options regarding treatment, the use of insurance, the implications of limits of confidentiality for the psychotherapy process, and other alternatives available.

Keith-Spiegel and Koocher (1985) provide a sample statement that psychotherapists may share with patients:

> If you choose to use your coverage, I shall have to file a form with the company telling them when our appointments were and what services I performed (i.e., psychotherapy, consultation, or evaluation). I will also have to formulate a diagnosis and advise the company of that. The company claims to keep this information confidential, although I have no control over the information once it leaves my office. If you have questions about this you may wish to check with the company providing the coverage. You may certainly choose to pay for my services out-of-pocket and avoid the use of insurance altogether, if you wish (p. 76).

When MCOs are involved it would also be appropriate to include a discussion of the utilization review process as well as the nature and extent of the information to be shared. These precautions will help ensure that the patient's consent is informed and the integrity of the psychotherapy relationship is preserved. Learning of such releases of information assumed to be confidential after the fact can only serve to damage the patient's trust of, and confidence in, the psychotherapist as highlighted by the fourth case example provided earlier.

An additional area of action for psychologists to become engaged is that of advocacy and political action. Individually and through state and national psychological associations psychologists can take action to correct these systemic deficiencies. For example, in Maryland psychologists have worked closely with other providers and the State Department of Health and Mental Hygiene to develop a uniform treatment plan that became the only authorized mechanism for MCO utilization review in the state. This brief form is completed by the practitioner who checks boxes indicating presence, absence, and severity in areas of behavioral, emotional, physical, and interpersonal functioning. There is also a symptom checklist and a place to include diagnoses, the use of medication, and the modality of treatment. The amount of information provided is very limited and is uniform among MCOs in the state. Its goal is to provide the minimum amount and type of information necessary to demonstrate medical necessity and the need for ongoing treatment. Similar attempts to address these important issues through regulation and legislation are occurring throughout the country. Psychologists not presently involved in these efforts should contact their state psychological association and become actively involved. Other areas to be addressed legislatively include placing limits on the number of MCO employees who have access to patient information, requiring training in confidentiality to those who have this access, mandating the destruction of patient records after utilization review decisions are made, setting higher standards for computer system security, and greatly increasing the penalties and fines for unauthorized disclosures of protected clinical material.

. . .psychologists must ensure that each patient understands the limits of confidentiality from the outset of the psychotherapy relationship.

Recommendations

- Have a written informed consent procedure for all patients. Ensure a sufficient understanding of expectations that are documented in writing.

- Clarify confidentiality from the outset. Patients should know what is truly confidential and what information will need to be released to the MCO.
- Communicate with third parties in writing only, if possible. When communicating by telephone, ensure the identity of the person with whom you are speaking.
- Use faxes and the on-line transfer of sensitive information with great caution. Unintended disclosures to other parties may occur if one is careless. Label all confidential materials as such.
- Do not disclose treatment information beyond the scope of the patient's written release.
- Share the minimum amount of information necessary to justify "medical necessity."
- Do not distort the information to be released. While it may be tempting to overstate pathology to obtain treatment authorization, this is fraudulent and may have negative consequences for both psychologist and patient.
- Review information with each patient prior to releasing it. This helps increase trust, reduce misunderstandings, and minimize inaccuracies and distortions.
- Finally, be an advocate for patients. Get involved politically and work toward increased regulation of MCOs. Fight for greater protection of patient confidentiality. ■

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Outstanding Dissertation Award

Every year, the Society for a Science of Clinical Psychology (Section III of Division 12) honors the best students in our field with the Outstanding Dissertation Award. This Award recognizes original research, conducted as a doctoral dissertation, and published in one of the principal refereed journals in the field of clinical psychology. The prize has the purpose of rewarding the achievement of a clinical psychologist who has recently entered the field and whose work shows promise of advancing clinical psychology as an experimental-behavioral science. To be eligible for the award, a dissertation (by definition, an original contribution to knowledge) must be on a topic that is relevant to the understanding of the etiology of a clinical problem or to the assessment, treatment, or prevention of such a problem. The award is presented at the Annual Convention of the American Psychological Association for a dissertation published in the previous calendar year.

The executive committee of SSCP is responsible for determining each year's recipient. If you, or one of your students, should be considered for this award, please send a brief supportive note and the reference for the article to current president, Alan Bellack, Department of Psychiatry, University of Maryland at Baltimore, 685 West Baltimore Street, Baltimore, MD 21201, abellack@umabnet.ab.umd.edu, 410-706-0892.

Confidentiality in the Age of Managed Care: From the MCO Perspective

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Health insurance, as it was originally conceived, protected against financial loss due to illness. In traditional indemnity plans, the health insurer paid claims based on the advice of the treating provider. The providers made the decisions and the insurance companies paid the bills. But, medical cost inflation has resulted in the payor becoming more and more involved in the treatment decisions. Today, managed care organizations (MCOs) are exercising what they view as their right to decide how the benefit dollars are to be spent. MCOs not only want to know what it is they are buying, they also want input into the treatment decisions. If they are expected to pay for a service, they want to determine how often, and for what time period, that service is to be provided.

Under the former indemnity insurance system, there was rarely a need for the payor to view the medical record. The medical record (and the term extends to the psychotherapy note as well) was for the use of the treating provider. Psychologists wrote their notes considering themselves as the primary readers, with the potential that the record may be sent to another provider of health services if the need arose. The record was personal, private, and confidential. The confidentiality of the record was sacrosanct, and the right to divulge information contained in the record lay solely with the patient, with only a few exceptions.

Today, however, the patient signs away the right to view the record to the insurance company or MCO as a condition of becoming a subscriber. And, unlike the days of indemnity plans, the MCO is likely to view that record, or at least some of the information contained therein, at one time or another. Psychologists no longer write their notes with themselves and other health care providers in mind as the readers. Today, psychologists write their notes with the payor in mind as the reader. This development has certainly influenced the kind of information which becomes a part of the patient's medical record.

The article in this issue by Jeffrey E. Barnett discusses ethical concerns the mental health professional should keep in mind with regard to the medical record. This paper discusses ethical considerations which should be of concern to the MCO. But first, some discussion of what should be in the medical record, from the payor's point of view, is warranted.

The MCO will review a medical record to determine if the services being provided meet *medical appropriateness and necessity* criteria. These terms may be foreign to many psychologists. Psychologists would prefer *psychologically appropriate and necessary*, but the accepted term in the industry is medical. Almost every policy in this country has as a contract exclusion "care which is not medically appropriate and necessary." How are these criteria defined? At present, there are not universally accepted industry standards. In Minnesota, the state legislature has enacted a law that includes a definition of *medically necessary* care for mental health. Central to the definition is language to the effect that "care must be consistent with the generally accepted practices of a mental health care provider's peers." Most payors have similar language in their contracts. The phrase "professionally-recognized standards" is often used to describe what is meant by *medically appropriate and necessary*. Benefit plans will state that no benefits are available for services that the company determines are not medically appropriate and necessary. Benefit plans often go on to say that the company (as opposed to some external body) reserves the right to determine what is medically appropriate and necessary.

When requesting confidential information, the only information actually required by the MCO is that relating to *medically appropriate and necessary*. The required information may vary by payor, but, at the most basic level, the reviewer of the record should be able to determine the problem, the current severity of the problem, what is being done about the problem, and what progress has been made.

Psychologists often include detailed information in their notes which does not relate to the needs of the MCO, but may be useful for the psychologist to review later or to pass on to subsequent health providers. An example of this practice may be to include in the chart forms used by the

patient on which he or she has listed and evaluated dysfunctional beliefs since the last session. It may be useful to keep these forms in the chart for future reference. But, the MCO does not need to see the content of these dysfunctional beliefs to determine medical appropriateness. The payor only needs to know that cognitive behavior therapy is being used, that there are dysfunctional beliefs, and that the patient is "doing his/her homework." Another example may be the content of an obsessive patient's sexual fantasies. In order to determine if the treatment is medically appropriate and necessary the payor does not need to know the content of the thoughts, but only that the patient is having disturbing fantasies which cause significant distress.

This issue raises a question: Should psychologists be keeping two sets of notes, one containing information demonstrating that treatment is *medically appropriate and necessary* for submission to the MCO if requested, and additional session notes containing details which are necessary only for continued therapy? There are certain legal implications of this idea. For example, it would be necessary to indicate, in the notes going to the MCO, that there exists in the medical record further information on the session.

A related issue is the patient's awareness of the level of detail in the notes being sent to the MCO reviewer. The right of confidentiality belongs to the patient, not the provider. Should not the patient be a part of the decision regarding what information should be shared with the MCO? Even though the patient may have signed a form giving the MCO the authority to review the medical record, the patient has the right to rescind that decision. When the MCO requests a record, or information regarding a particular case, should the patient be given the option at that time to either have the information sent, or pay for the therapy session out-of-pocket? If we give the patient this choice, he or she may want to know exactly what information will be sent. The patient may ask to read the medical record. Although the patient has the right to review this information, it is seldom requested. The patient trusts his or her mental health care provider, and believes that the record is kept to help the therapist provide appropriate care. But, when the patient is made aware that the payor wants to see the record, he or she is reminded of another use of the medical record. The patient is not likely to have the same trust in the MCO that is placed in the psychologist. A patient asking to review his or her record raises its own ethical concerns and certainly has implications for the therapeutic relationship. Such issues have yet to be addressed.

Another concern in this era of managed care is as follows: What happens to the chart note once it gets to the MCO? The National Committee on Quality Assurance (NCQA) is a voluntary accrediting agency for MCOs. It is desirable from a marketing standpoint for an MCO to receive NCQA accreditation. The accreditation standards require that the MCO have a confidentiality policy in place and that "medical records be maintained in a manner that . . . permits effective and confidential patient care and quality review." Also, practitioners who contract with an MCO must have explicit policies about confidentiality. What details should be included in such policies is not stipulated, with the exception that the MCO must provide patients the opportunity to approve or deny the release of identifiable personal information by the MCO except where required by law. NCQA standards also require that the MCO systematically review medical records at least every two years to ensure compliance with standards for record keeping. Thus, utilization review is not the only reason that the MCO may review the record. MCOs with NCQA accreditation must also review the record to determine adherence to standards for record keeping.

The NCQA establishes standards regarding the release of information outside the MCO, but no rules are included regarding who within the MCO has access to the medical record. In the clinic, the notes are usually kept under lock and key. Care is taken that no unauthorized persons (such as cleaning personnel) have access to the record. In the clinic where I practice, the notes are kept in a locked room at night, in locked filing cabinets. Is the same care being taken to protect confidentiality when the record is sent to a reviewer for the MCO? Are the notes locked up at night, or are they sitting on desks, interoffice mail carts, etc. Who has access to those charts? There are no universal standards regarding the qualifications of persons given access to medical records. Do MCOs establish and enforce policies regarding who has access and how the confidential information is to be kept?

Ethical considerations concerning confidentiality in the era of managed care have yet to be resolved. As described above, these issues from the MCO perspective include the type of information and level of detail required to determine *medical appropriateness and necessity*, compliance with record keeping standards, management of the confidential information once it is in the hands of the MCO reviewer, qualifications of MCO reviewers, and patients' rights once the MCO requests confidential information.■

News from the Midwinter Meeting of the Council of University Directors of Clinical Psychology (CUDCP) San Diego, CA, Jan 30-Feb 1 1998

CUDCP is the national training council representing approximately 160 scientist-practitioner doctoral programs across the United States and Canada. Membership information can be obtained through electronic mail to Patricia Wisocki, secretary-treasurer, at <wisocki @psych.umass.edu>.

A topic given considerable coverage at the midwinter meeting was a follow-up to November, 1997's APA/ APPIC co-sponsored Supply & Demand conference in Orlando Florida. Several resolutions passed at the S&D conference were related to providing truth in advertising to potential students. CUDCP has moved toward a leadership role in this area by unanimously resolving to develop mechanisms for the systematic provision of program-specific and aggregate data to potential applicants and the public. Examples include student-faculty ratios, internship placements, student funding, and post-graduate employment. George Allen (U. Conn.) is chairing this effort. Since the APA office of accreditation can provide only aggregate data, CUDCP feels that it is the obligation of every training program to provide such individual data in order to facilitate realistic decision-making on the part of the potential student. Although CUDCP is prepared to publish its own directory if necessary, it was thought that modification of the program descriptive section of the Graduate Study in Psychology directory would be a more widely publicized forum for such information. CUDCP is in the process of developing a standardized format through which each member program will provide truth-in-advertising information. We will start by putting program-by-program information on the CUDCP Web page (under construction).

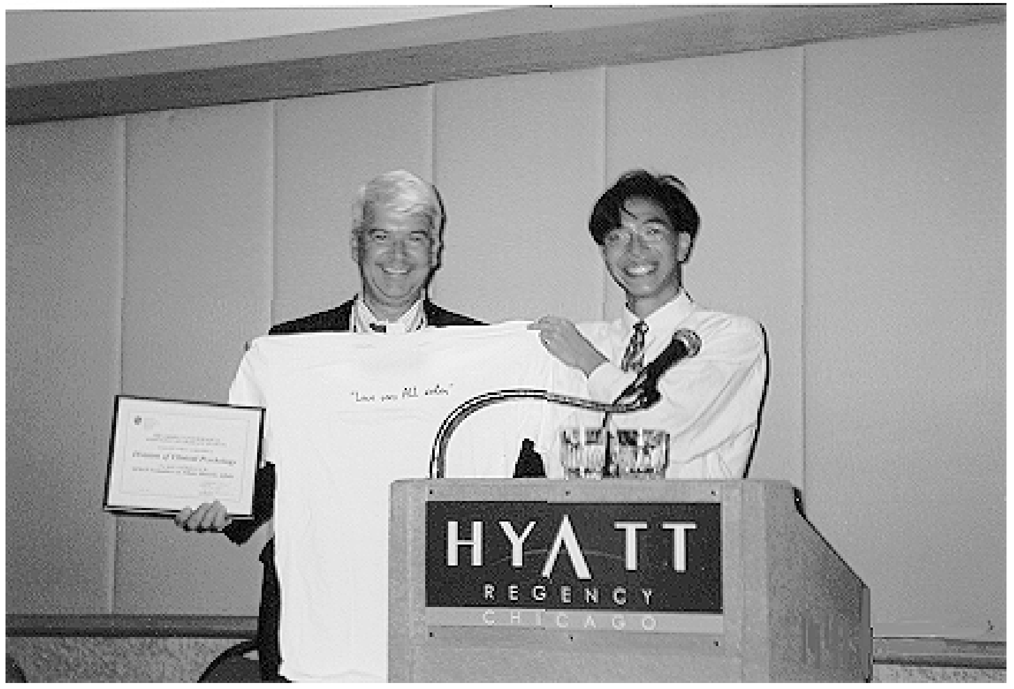
Linked to the supply & demand issue, there is a growing concern regarding a perceived internship shortage for predoctoral clinical, counseling and school psychology students. In the past few years, the APPIC Clearinghouse has received over 300 requests from students who remained unplaced after Uniform Notification Day. Since the Clearinghouse data reflected only absolute numbers and not placement rates, CUDCP spearheaded a 1997 survey of Director's of Training to determine actual internship placement rates and other pertinent information. This year, CUDCP has secured the co-sponsorship of NCSPP (Professional), CCPTP (Counseling), & CDSPP (School) in order to get a broader sampling of the internship placement rates across types of doctoral training programs. Questions relevant to the APPIC prohibition of "first-choicing" were also asked in this year's survey. Preliminary data will be reported at the Council of Chairs of Training Council meeting March 18-19, 1998.

One of the hottest topics carried over from the January 1997 midwinter meeting was the vote by a majority of CUDCP attendees to move the timing of the clinical internship to post-doctoral. The issue was thought to be so important that a follow-up mail ballot of the membership was taken, and affirmed the majority's desire to change the timing of the internship. By no means a landslide within the organization, the vote was even more controversial outside CUDCP, with APPIC, CCPTP, NCSPP, and CDSPP reaffirming predoctoral internship timing after learning of CUDCP's action. The CUDCP vote was viewed by many of its members as a call for the relevant training and organizational bodies to examine the issue of internship timing - not as a move to rush headlong into an immediate change. In direct response to CUDCP's efforts, the BEA has appointed a working group (including the Council of Chairs of Training Councils) to conduct an impact study on moving internship training from pre-to post-doctoral and to summarize the implications of such for quality of training, financial and administrative support, accreditation, and licensure.

At the San Diego meetings, CUDCP unanimously passed another resolution related to internships. In the 1997 internship survey it became evident that student applicants were spending, on average, over $1,000 on application and interviews to secure a one-year position as an intern. Rumors abound that the 1998 year cost students even more money because internships supposedly interviewed more applicants in response to the prohibition against asking applicants for rank-orderings. Given our concern with apparent rising costs, in terms of both time and money, of the current internship interviewing process, CUDCP resolved that APPIC work with relevant organizations to develop mechanisms to mitigate these costs.

Beverly Thorn, PhD
Chair, Executive Board
Council of University Directors of Clinical Psychology

APAGS-CEMA Thanks Division 12



Last year the Division of Clinical Psychology decided to support a request made by the APA Graduate Student Committee on Ethnic Minority Affairs. A $1,000 grant was awarded to the committee to organize networks of students regionally. At the annual convention in Chicago, Lawrence Yang, Co-Chair of the APAGS-Committee on Ethnic Minority Affairs, presented a certificate to Lynn Rehm, President, in appreciation for the Division's support. The money was used to support five conferences, which occurred across the United States in 1997 and served to bring together different perspectives in an attempt to educate about the importance of multiculturalism within clinical practice and research. These events took place in Boston, MA; New York, NY; Chicago, IL; Philadelphia, PA; and Vermillion, SD, were multi-state in scope and attendance, and provided a valuable networking experience for students. APAGS-CEMA thanks Division 12 for its support of multiculturalism among graduate students.

Join Division 12

Membership includes subscriptions to the quarterly, The *Clinical Psychologist*, and the journal, *Clinical Psychology: Science and Practice*. Members also receive a 25% discount on Oxford University Press books on psychology.

Assessments are only $40 per year for members and $22 per year for student affiliates. Student affiliates must be enrolled in Clinical Psychology doctoral programs.

For applications, contact: Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Telephone (303) 652-3126. Fax (303) 652-2723. E-mail: lpete@indra.com.

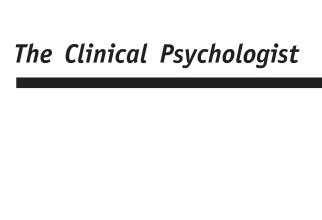
Education and Training Awards

The Board of Educational Affairs is requesting nominations for its 1998-1999 Awards for Distinguished Contributions to Education and Training in Psychology.

The awards for Distinguished Contributions to Education and Training in Psychology and Distinguished Contributions for Applications of Psychology to Education recognize psychologists who make traditional contributions, who provide innovations, or who are involved in developmental phases of programs that influence education and training in psychology or psychologists who develop applications of psychology in programs that educate or train specific individuals or demographic groups.

All nominations must include a letter of nomination citing the award for which the nomination is made, and, specifically, the Contributions to Education and Training in Psychology) or the major contribution for applications to education and training of the nominee (Distinguished Contributions for Applications of Psychology to Education Award). Nominations must also include a current vita and two supporting letters.

Send nominations and supporting materials to Shirley Matthews, Education Directorate, APA, 750 First Street, N.E., Washington, D.C. 20002-4242. The deadline for receipt of this information is June 1, 1998.



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INSTRUCTIONS TO AUTHORS

The Clinical Psychologist is a publication of the Division of Clinical Psychology of the American Psychological Association. Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, training, and practice, as well as changes in the field and social changes that may influence all or part of clinical psychology. Also included will be material related to particular populations of interest to clinical psychologists. Manuscripts might be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, or data based surveys. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* will include archival material and official notices from the Divisions and its Sections to the members.

Material to be submitted should conform to the format described in the *Publication Manual* of the American Psychological Association. Submit four copies of manuscripts along with document file on computer disk for review. Manuscripts should not exceed 20 pages including references and tables. The Editor must transmit the material to the publisher approximately three months prior to the issue date. Announcements and notices not subject to peer review would be needed at that time. Inquiries may be made to:

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